August 25, 2015

Andrew M. Slavitt
Acting Administrator
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building
200 Independence Ave, S.W., Room 310G.05
Washington, DC 20201

RE: CMS-1633-P, Medicare Program: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs; Short Inpatient Hospital Stays; Transition for Certain Medicare-Dependent, Small Rural Hospitals under the Hospital Inpatient Prospective Payment System

Dear Mr. Slavitt,

The American Case Management Association (ACMA) appreciates the opportunity to submit comments on proposed rule CMS-1633-P. The ACMA is comprised of nearly 6,000 nurses, social workers, physicians, educators, administrators, and other professionals - representing approximately 985 U.S. hospitals, nearly 40% of all U.S. hospitals – responsible for providing case management and transitions of care services in hospitals or health systems.

As you know, health care delivery system case managers and transitions of care professionals are clinically-competent practitioners who serve as daily advocates on behalf of both patients and the organization for which they work. As such, the changes and issues detailed in this proposed rule are of particular concern to our membership – specifically, the proposed revision to the “Two-Midnight Rule.”

It is our understanding that the Two-Midnight Rule was created with the intent of establishing a clear distinction between inpatient and outpatient care. However, the rule has resulted in confusion and has placed an undue burden on health care providers rather than offering clarification and relief.

Physicians within ACMA’s membership and beyond report that they are still having difficulty determining when to order admission, and their uncertainty - coupled with hospitals’ fear of payment denials for short inpatient stays – has resulted in an increase in the use of observation, the opposite of the agency’s desired result in creating the Two-Midnight Rule.

While CMS stated in CMS-1633-P that the number of long outpatient stays has decreased by 11% between 2013 and 2014, hospitals consistently report an overall increase in observation cases not addressed by CMS.
The changes proposed in CMS-1633-P are not helpful to providers, but rather, have complicated the issue further by proposing in the 2016 Outpatient Prospective Payment System (OPPS) rule to expand the definition of the "rare and unusual circumstances" exception to the two midnight expectation by allowing the physician to determine the need for admission on a case by case basis regardless of the expected length of stay. This presents two problems:

1. The proposal assumes the decision to admit will be based on the difference between inpatient and outpatient care – an indefinable distinction and one that CMS has said does not exist. This does not appear to be an improvement, as it brings back the opportunity for Medicare contractors to dispute the physician's judgment and deny payment, reactivating the process that “clogged” and ultimately froze the appeals system.

2. The proposal does not clarify what threshold would exist for a “rare and unusual circumstance” to justify ordering hospital admission and leaves the decision of whether to pay the hospital or deny payment to the auditor’s “clinical judgment.”

Our association recommends a “One-Midnight Rule” as a solution that would address many of the issues related to the Two-Midnight Rule.

One-Midnight Rule Proposal

Under a one-midnight rule, any Medicare beneficiary who required overnight hospital care (other than a patient in the emergency department (ED) or routine recovery following surgery or a procedure) would be admitted and the hospital paid by diagnosis related group (DRG) under Medicare Part A. Under this approach, with the exceptions noted, any patient requiring a midnight in the hospital for hospital-level care would be an inpatient. This rule would eliminate confusion regarding physician intent or expectation of length of stay. The only issue subject to review would be whether the night in the hospital was medically necessary – and this is already a requirement for admission and Part A payment.

Outpatient observation would be eliminated under this proposal and a new APC payment for “extended outpatient evaluation,” would be created – essentially an extended ED visit that could include care in a special unit (like a current observation unit) or in a hospital bed on the floor. An order would not be required since “extended outpatient evaluation” would be a continuation of ED care and not, like observation, a separately identifiable outpatient service. The hospital would be paid at a rate similar to the current rate for observation patients.

A physician’s (or other eligible practitioner’s) admission order would be required, as it is now, but by this proposed one-midnight rule, and with the exception of “late ED arrivals” mentioned below, an admission order would become effective at midnight on the day it was given. With this approach, the problem of determining payment for an unexpected early discharge would disappear – all patients released prior to the first midnight would be treated as outpatients (paid as extended outpatient evaluations) even if there was an admission order in the record, because the admission order would not be effectuated if the patient was released prior to midnight. So the
requirement for admission would be actual (not anticipated) hospital time and medical necessity for hospital care.

As long as the beneficiary had at least one midnight of medically necessary hospital care and had an admission order prior to discharge, Part A billing would be appropriate.

Since there is no benefit to beneficiaries in having the admission order authenticated prior to discharge, that requirement should be removed and replaced with signature prior to billing.

Treating short stays as inpatient admissions allows the hospital to bill Medicare Part A for all medications provided, eliminating beneficiary billing for self-administered medications.

Late ED arrivals would present a challenge: On initial evaluation, some patients obviously require admission, while for most a period of time is required to evaluate the clinical problem and determine if hospital care will be required. Admission rules should not delay admission and urgent care for the former group so for patients who arrive at the ED and begin treatment after a specified time (e.g., after 4 PM) an admission order could be given but it would not be effective until the second midnight. Nonetheless, for these patients the first night in the hospital following the admission order would count toward the three-night inpatient stay requirement for coverage of care in a skilled nursing facility (SNF). Thus if the “late arrival” ED patient were admitted, recovered more quickly than expected, and was discharged before the second midnight, the entire stay would be paid under Part B.

Under this proposed rule, the inpatient only list would no longer be needed. Any surgical patient who required a medically necessary overnight stay following routine recovery for any procedure would be admitted. Documented medical necessity for the post-op hospital care would be required, of course. When a patient had what is currently an “inpatient only” procedure and was stable for discharge before the first midnight, the hospital would be paid as outpatient services (billed on a 13X TOB). New APCs would be required. In keeping with the intent of designating some procedures as “inpatient only” for safety reasons, procedures currently identified with Status Indicator “C” on Addendum E (the “Inpatient Only List”) would have to be performed in a hospital (never in a free-standing outpatient surgical center or ambulatory surgical center).

Some have proposed creating a "short stay DRG" or reducing payment for a given DRG based on length of stay but neither would be required if CMS set the DRG payment for those diagnoses that would generally have been managed in observation (such as syncope, chest pain, and gastroenteritis) at the amount a hospital would have been paid for observation. If the initial evaluation established a more serious underlying condition, the DRG would be driven by that new diagnosis. For instance, the hospital would be paid under a chest pain DRG for a patient with chest pain found to be of non-cardiac origin. But if the patient had an acute myocardial infarction, the payment would automatically be higher based on that diagnosis plus any procedures that were performed.
What about exposing beneficiaries to the inpatient deductible for short stays? This could be prevented by reducing the deductible for one- and two- night stays, perhaps making it 1/3 for one night, 2/3 for two nights, and the full deductible for a stay of three nights or more. In addition, every night would count toward the three-night SNF requirement so the problem of beneficiaries not qualifying for SNF care because they spent a night in observation would not exist.

A one-midnight rule as outlined above would simplify the admission decision, reduce denials, and reduce appeals. It would reduce the administrative burden on hospitals, eliminate confusion and clarify the process. We urge CMS to seriously consider this recommendation as an option for addressing the existing confusion and adverse effects related to the Two-Midnight Rule.

Thank you for your time and consideration of our requests and recommendations. We appreciate your willingness to listen to the concerns of health care delivery system case management professionals.

Should you have any questions, please feel free to contact me at 501-907-2262 or lgcunningham@acmaweb.org.

Cordially,

/s/

L. Greg Cunningham, MHA
CEO
ACMA