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June 19, 2013

Marilyn Tavenner  
Administrator  
Centers for Medicare & Medicaid Services  
Hubert H. Humphrey Building  
200 Independence Avenue, S.W., Room 445-G  
Washington, DC 20201

***RE: CMS-1599-P, Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Proposed Fiscal Year 2014 Rates; Quality Reporting Requirements for Specific Providers; Hospital Conditions of Participation; Medicare Program; Proposed Rule (Vol. 78, No. 91), May 10, 2013***

Dear Ms. Tavenner:

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, and our 43,000 individual members, the American Hospital Association (AHA) appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) proposed changes to admission and medical review criteria for hospital inpatient services. We will submit comments separately on CMS's other proposed changes to the hospital inpatient prospective payment system (PPS) and the long-term care hospital PPS.

We appreciate CMS's effort to clarify what is required for payment of inpatient hospital services under Medicare Part A, particularly in light of the focus by Medicare Recovery Audit Contractors (RACs) on the medical necessity of short inpatient stays. Unfortunately, CMS's proposed time-based presumption of medical necessity is not reflective of the way hospitals function today: while it might address some problems, it likely would generate others. **In lieu of a time-based presumption, the AHA urges CMS to issue instructions to the RACs and other contractors explaining how to review the medical necessity of Part A inpatient hospital stays.** We believe that such instructions, and related changes to the RAC program, are likely to obviate the need for a time-based presumption and several of the related changes contained in the proposed rule. However, if CMS nevertheless elects to adopt a time-based presumption, it should be modified in several major respects. We address below the problems with the proposed time-based presumption and our recommended alternatives or modifications.



## A “TWO-MIDNIGHTS” TIME-BASED PRESUMPTION IS UNWARRANTED

CMS proposes that its medical review contractors presume an inpatient hospital admission is reasonable and medically necessary if a beneficiary requires more than one “Medicare utilization day,” which the agency defines as an encounter “crossing two midnights.” The proposed trigger to start the “clock” for this two-midnights presumption is “when the beneficiary is moved from any outpatient area to a bed in the hospital in which the additional hospital services will be provided.” At the same time, CMS proposes that its contractors presume that hospital services spanning less than two midnights should have been provided on an outpatient basis unless:

- (1) clear documentation is present in the medical record supporting the admission order and physician expectation that the beneficiary would require care spanning two midnights;
- (2) the beneficiary is receiving a service or procedure designated as inpatient-only; or
- (3) an unforeseen circumstance, such as beneficiary death or transfer, arises before two midnights passes.

Part of the impetus for CMS’s proposal is its concern about the growing number of Medicare beneficiaries who receive observation services for more than 48 hours. Like CMS, the AHA believes “that the inpatient admission decision is a complex medical judgment that should take into consideration many factors, such as the patient’s medical history and medical needs, the types of facilities available to inpatients and outpatients, the hospital’s bylaws and admission policies, the relative appropriateness of treatment in each setting, patient risk of an adverse event, and other factors.” Yet, our member hospitals tell us that the medical judgment of treating physicians is all too often second-guessed by RACs, which are able to evaluate a beneficiary’s admission in hindsight, looking at the entire medical record rather than only the information that was known to the physician at the time of the admission. It is no coincidence that the increase in observation services occurred with the advent of the RAC program. **Therefore, to help address what CMS sees as troubling growth in observation care, we suggest that, rather than adopt a time-based presumption, the agency instead make changes to the RAC program.**

Specifically, much of the concern around observation care and the RAC program could be eliminated by making three changes to the program. **First, the AHA urges CMS to limit RAC review to only the information in the medical record that was known to the physician at the time of the decision to admit, excluding from medical review information from after the patient’s admission.** Currently, unlike a treating physician, the view of RACs and other federal contractors is always in hindsight and, therefore, can consider the patient’s length of stay and final outcome rather than focus on his or her presenting condition. Thus, it is not surprising that RACs and other federal contractors frequently conclude, for example, that many patients who were admitted as inpatients could instead have been placed in observation status. In fact, likely driven by the financial incentives, RACs largely have concentrated their attention on hospital claims for short inpatient stays. Denying payment for an entire inpatient stay is far more lucrative for the contractors than identifying an incorrect payment amount or an unnecessary medical service.

**Second, we urge CMS to instruct the RACs to focus their audits on those other factors that the agency has said are relevant to the admission decision, including patient history and comorbidities, the severity of signs and symptoms, the risk of an adverse event, and health risks presented by a decision to send a beneficiary home rather than admit him or her, instead of only factors like the patient's length of stay and outcome.** Typically, the RACs have elevated the importance of factors like the patient's length of stay and outcome in making patient status determinations. Because the inpatient admission decision is a complex medical judgment, focusing on only a couple of factors, as the RACs seem to do, is, by definition, arbitrary and unfair. If anything, it would be more appropriate to establish a presumption of medical necessity based upon the physician's admission order. After all, the physician's decision to admit a beneficiary is an expert medical judgment that already includes an expectation that the beneficiary will need hospital care for more than 24 hours. Such a decision is by definition difficult to evaluate months later based on the cold medical record. CMS's proposal to give no presumptive weight to the admission order seems inconsistent with the agency's recognition of the complexity of medical judgment involved. It also seems inconsistent with making a physician order a condition of payment, as we discuss below.

**Finally, we urge CMS to penalize RACs for incorrectly denying an inpatient stay – not just to recoup their contingency fee – to provide some check on the strong financial incentive RACs have to conclude that beneficiaries should not have been admitted.** Specifically, we urge CMS to create a substantial penalty that would be triggered for each denial that is overturned upon appeal, as well as a penalty that would be triggered by poor performance (such as a high percentage of overturned denials) and assessed periodically. As alluded to above, the RACs have a strong financial incentive to deny claims – the more claims the RAC denies, the more the RAC is paid, and denying payment for an entire inpatient stay is far more lucrative than identifying an incorrect payment amount or an unnecessary medical service. Although CMS currently recoups the RAC's contingency fee if a denial is overturned on appeal, the multi-level appeal process is expensive and cumbersome for hospitals. No matter the merits of their cases, there is a limit to the number of denials hospitals can realistically shepherd through the appeals process, making CMS's current "penalty" an ineffective disincentive to discourage improper denials.

**If these three changes are made to the RAC program, we do not believe a time-based presumption would be needed.** That is, by giving due weight to the physician's medical judgment to admit a beneficiary and appropriately considering, for example, the risk of an adverse event if a beneficiary is discharged to home, many inpatient stays that are currently being denied would instead be deemed reasonable and medically necessary. This also would ensure that beneficiaries do not inappropriately face new out-of-pocket costs under Part B, as they could if a hospital rebills under Part B an inpatient Part A claim that was denied on the basis that the care could have been delivered in an outpatient setting.

## **IF CMS ADOPTS A TIME-BASED PRESUMPTION, IT MUST BE SIGNIFICANTLY MODIFIED**

As stated above, we suggest that CMS make changes to the RAC program rather than adopt a time-based presumption. However, if CMS elects to adopt one or both of the presumptions it has proposed, we urge the agency to modify them in two important respects:

- The trigger to start the “clock” for the time-based presumption for an inpatient admission should be the earliest of: (1) when the physician writes an order for admission or observation; (2) when the beneficiary is treated in the emergency department (ED); or (3) when the beneficiary is placed in a bed for observation; and
- In addition to the time-based presumption exceptions proposed by CMS, there should be an exception for when a beneficiary leaves the hospital against medical advice before one Medicare utilization day passed.

Our members tell us that large numbers of beneficiaries are admitted to the hospital as inpatients after having been treated in the ED. In some cases, however, these beneficiaries are not physically moved from a bed in the ED to a different bed. There are many reasons for this, including the unavailability of another bed or care needs of other patients taking precedence over moving a beneficiary. In such situations, the inpatient team comes to the beneficiary in the ED, where inpatient treatment begins and continues for considerable time. Regarding beneficiaries under observation, these beneficiaries are receiving an inpatient level of care while physicians evaluate whether or not admission is appropriate.

**In light of this, we believe that all care and services furnished to a beneficiary in the ED or in observation, who is subsequently admitted for an inpatient stay, is inpatient care even if the patient remains in the ED or the observation bed.** Therefore, we urge that the “clock” for any time-based presumption begin not “when the beneficiary is moved from any outpatient area to a bed in the hospital in which the additional hospital services will be provided,” as CMS has proposed, but when the physician writes the admission order or when the beneficiary begins to be treated in the ED or is placed in a bed for observation, whichever is earliest. Viewing ED and observation services in this manner is consistent with Medicare’s three-day payment window policy, which bundles admission-related services furnished to beneficiaries during the three days preceding their admission into Medicare’s payment for that admission.

Further, we ask that CMS make an additional exception to any time-based presumption for a stay where documentation in the medical record supports the admission order, but the patient left against medical advice before one Medicare utilization day passed.

In addition, although we do not believe a time-based presumption regarding medical necessity is needed, if the agency takes a different view, we ask that it make several important clarifications. First, CMS proposes that its contractors would review the appropriateness of patient status for lengths of stay greater than two midnights only if the agency suspects that a provider is abusing the new benchmark by unduly delaying the provision of care. If CMS adopts this proposal in a final rule, we urge that this language, which is clearly intended to limit a contractor’s review of stays meeting the benchmark, be strengthened to require that Medicare contractors be permitted

to conduct a review of these claims only when and for as long as, there is clear evidence of a wide-spread, systematic pattern of abuse by the provider. Contractors should not be permitted to use vague, unsubstantiated or baseless assertions about abuse of the benchmark to turn the review process into a routine fishing expedition to search claim by claim for potential evidence that care was unduly delayed.

Second, one of the agency's proposed exceptions to its two-midnights presumption is when a beneficiary is receiving a service or procedure designated as inpatient-only. If CMS adopts this exception in a final rule, the agency must clarify that the exception does not allow an auditor to presume that a stay should have been provided on an outpatient basis simply because it is absent from the inpatient-only list. In other words, while it is correct to conclude that an inpatient stay is presumptively reasonable and medically necessary because it is on the inpatient-only list, the inverse conclusion – that an inpatient stay is presumptively medically *not* reasonable and medically necessary because it is *not* on the inpatient-only list – is not correct. Many beneficiaries have co-morbidities or other risk factors that make an inpatient admission reasonable and medically necessary even where the procedure or service is not on the inpatient-only list.

Finally, CMS proposes to apply the two-midnights policy to 1861(e) hospitals and critical access hospitals (CAHs). We note that in addition to general acute-care hospitals, inpatient rehabilitation hospitals are encompassed in the 1861(e) definition. These hospitals serve very different types of patient populations than general acute care hospitals and do not provide observation services. Therefore, applying the two-midnight policy to these types of hospitals would be confusing and even more impractical than applying it to the other 1861(e) hospitals. In addition, CMS specifically did not propose to apply this policy to inpatient psychiatric hospitals, defined at 1861(f), or long-term care hospitals, defined at 1861(ccc), and we agree it would be inappropriate to include them.

#### **AN ADMISSION ORDER SHOULD NOT BE A CONDITION FOR PAYMENT UNLESS THE ORDER MAKES THE ADMISSION PRESUMPTIVELY REASONABLE AND MEDICALLY NECESSARY**

CMS proposes to make a physician order to admit a beneficiary a condition for payment of a Part A inpatient stay. **The AHA is concerned that creating such a requirement would have very troubling unintentional consequences.** Specifically, noncompliance with payment requirements triggers liability under the *False Claims Act*. Therefore, we are concerned that this proposed requirement often would be used by auditors looking for a way to deny a claim or by unscrupulous relators in *False Claims Act* cases. The Medicare program has functioned perfectly well for 48 years without conditioning payment for an inpatient hospital stay on a physician admission order. Moreover, requiring a physician order for a hospital admission is contradicted by a plain reading of the section of the Medicare statute, as well as its statutory and legislative history.

Section 1814(a)(3) of the *Social Security Act* sets forth conditions and limitations for payments. It requires a physician to certify that inpatient hospital services “which are furnished over a period of time” are required to be given “on an inpatient basis for such individual’s medical

treatment.” However, it is clear from both the text of the statute itself and its statutory and legislative history that this physician certification requirement applies *only* to certain long-term stays. The short-stay inpatient admissions CMS attempts to address in the proposed rule are, therefore, exempt for the certification requirement.

When Medicare was enacted in 1965, it required a physician to certify that inpatient hospital services were required. Two years later, in the *Social Security Amendments of 1967*, the statute was amended to limit the requirement for physician certification to only “inpatient hospital services . . . which are furnished over a period of time.” Thus, since 1967, Medicare has not required a physician admission order for inpatient hospital services except in long-stay cases.

Moreover, if the language of the statute were not clear enough on this point, Congress explicitly and repeatedly explained its 1967 decision to eliminate the requirement for a physician order for most hospital admissions. Both the House and Senate explained the statutory change by saying it “eliminate[d] the requirement for hospital insurance payments that there be a physician’s certification of medical necessity with respect to admissions to hospitals which are neither psychiatric nor tuberculosis institutions” and that such a certification is required “only in cases of hospital stays of extended duration.” The legislative history also explains the reason for the change, stating that “admissions to general hospitals are almost always medically necessary and the requirement for a physician’s certification of this fact results in largely unnecessary paperwork.” Based upon all of the above, CMS simply cannot make a physician order a condition of payment for an inpatient stay.

Moreover, by proposing to require a physician admission order as a condition of payment, but according no presumptive weight to that order in determining the medical necessity of the admission, CMS has turned Congress’ conclusion on its head: Congress found that admission orders are not required for Medicare payment because hospital admissions are almost always medically necessary. Even if CMS now believes that a physician order to admit a beneficiary should be a condition of Medicare payment for an inpatient hospital stay, **CMS should at least conclude that the stay is presumptively reasonable and medically necessary by virtue of the physician’s order.**

**Further, if CMS makes a physician admission order a condition of payment, notwithstanding the contrary language in the statute and legislative history, the agency should clarify that that the order may come from *any* physician in the hospital who is knowledgeable about the beneficiary’s condition and has admitting privileges.** In the proposed rule, CMS says that the “order must be furnished by a qualified and licensed practitioner . . . who is responsible for the inpatient care of the patient.” As noted above, many beneficiaries are admitted as inpatients from the ED where an ED physician, often in consultation with another physician, makes the decision to admit. This means that an ED physician or a physician in the hospital who consults with the ED physician, but is not ultimately responsible for a beneficiary’s inpatient care, could order a beneficiary’s admission. Therefore, CMS should modify its proposal to reflect the way admission decisions are frequently made in hospitals today.

## **CMS SHOULD DELAY THE EFFECTIVE DATE OF ANY NEW RULES GOVERNING INPATIENT HOSPITAL ADMISSION AND MEDICAL REVIEW CRITERIA**

As noted in the inpatient PPS proposed rule, CMS has issued a separate proposed rule that would change existing policy to permit hospitals to rebill services under Part B when a Part A inpatient stay is denied due to inappropriate patient status. The agency also issued an Administrator's Ruling to permit hospitals to rebill services under Part B in the period before a final Part B billing rule takes effect. CMS has provided some guidance to hospitals regarding implementation of the Administrator's Ruling, but our members tell us that many questions remain.

In addition, as illustrated above, modifying Medicare rules regarding when inpatient hospital admissions are appropriate, as well as medical review of those admissions, is complicated and would be logistically burdensome for hospitals. Many internal policies and procedures would need to be re-evaluated and potentially changed and education of the hospital staff undertaken.

In light of the uncertainty and confusion engendered by the Part B rebilling Administrator's Ruling and proposed rule, and of the logistical challenges that would be involved in implementing CMS's proposed changes to the policies governing inpatient hospital admission and medical review criteria, if CMS adopts any of its proposed changes discussed in this letter, the AHA requests the agency delay the effective date of those changes until *at least* fiscal year 2015. This will provide hospitals time to take actions needed under the inpatient PPS rule, the Administrator's Ruling and any new Part B billing rule.

## **PROPOSED PAYMENT REDUCTION SHOULD NOT BE IMPLEMENTED**

CMS estimates that its proposed policies would increase inpatient PPS expenditures by \$220 million. Therefore, the agency proposes to offset this additional expenditure by permanently and prospectively reducing the operating PPS standardized amount, the capital standard federal payment rate, sole community hospitals' and Medicare-dependent hospitals' hospital-specific rates, and the Puerto Rico-specific amount each by 0.2 percent. CMS cites its special exceptions and adjustments authority under section 1886(d)(5)(I)(i) of the *Social Security Act* in proposing this offset. **The AHA opposes this proposal and is disappointed that CMS believes such prospective payment reductions are appropriate. For the reasons discussed below, we strongly urge the agency not to finalize these reductions.**

**First, CMS's proposal attempts to resolve a problem of the agency's own making – it is inappropriate to cut hospital payments to pay for such resolution.** Medicare contractors, especially the RACs, have inappropriately ignored the central role that the treating physician plays in hospital admissions by routinely second-guessing those decisions after the fact, improperly denying millions of claims, and netting billions of dollars in contingency fees on the basis that the care should have been provided in the outpatient setting. However, only the treating physician has both the familiarity with the patient and the medical expertise to weigh these considerations and determine which treatment setting is most appropriate in a given case with oversight from the hospital and input from the beneficiary. These fact- and time-sensitive

medical judgments do not lend themselves to second-guessing by outside individuals and government auditors years later. Yet, CMS has allowed this second-guessing to run rampant, leading to widespread confusion and inconsistency among hospitals. The agency itself acknowledges in the proposed rule that “the appropriate determination of a beneficiary’s patient status is a systemic and widespread issue and is not isolated to a few hospitals.” In turn, hospitals have responded to the huge financial risk of admitting Medicare beneficiaries for inpatient stays that may later be denied by electing to treat beneficiaries as outpatients receiving observation services, rather than admitting them as inpatients. If CMS had been more clear and straightforward with its contractors to begin with, these beneficiaries would have been treated in the inpatient setting all along. Hospitals would not have been forced to move them to the outpatient setting and they would not *appear* to be moving back to the inpatient side under the proposed policy.

**Second, these reductions are an inappropriate use of CMS’s special exceptions and adjustments authority.** The agency has rarely used this authority in the past, and when it has, it has generally been to more fully or appropriately implement a recent congressional requirement. For example, we believe that the first time the authority was used after implementation of the inpatient PPS in 1983 was to address an issue created by the *Omnibus Budget and Reconciliation Act of 1989*. The law had increased disproportionate share hospital (DSH) payments significantly, but due to a drafting error, the higher DSH payments were not exempted from budget-neutrality requirements. The chairmen of the Senate Finance and Ways and Means Committees sent a joint letter to the Secretary noting the oversight and requesting that the Secretary use exceptions authority to exempt the increases from budget neutrality. In addition, the letter stated that the chairmen would soon sponsor a statutory technical correction to fix the problem, which was subsequently enacted in 1990. Since that initial use, the special exceptions authority has been used rarely, and never so broadly as the application included in the proposed rule for FY 2014.

**Finally, there is no statutory requirement that CMS make budget-neutrality adjustments for changes in coverage decisions or service volume.** It is clear that this proposal would, in fact, be a coverage decision, or a clarification of policy, that the agency believes would lead to an increase in volume. Specifically, hospital services would be covered under Part A if the physician expects that the beneficiary’s length of stay will exceed a two-midnight threshold or if the beneficiary requires a procedure specified as inpatient-only, and the agency purports that this coverage decision would lead to a net increase of 40,000 in inpatient hospital admissions. However, we emphasize that the proposal would *not* increase *payment rates* for inpatient cases, which are made budget neutral as part of the annual rate adjustment process. **Moreover, applying budget neutrality to coverage decisions or volume changes would violate the fundamental structure and policy that has governed the inpatient PPS since its inception in 1983.** Specifically, the inpatient PPS adjusts automatically to both the service mix and volume of hospital admissions, which vary from year to year based on many factors. CMS has never made budget-neutrality adjustments for these changes.

Ms. Marilyn Tavenner

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Thank you again for the opportunity to comment. If you have any questions, please feel free to contact me or Joanna Hiatt Kim, vice president of payment policy, at (202) 626-2340 or [jkim@aha.org](mailto:jkim@aha.org).

Sincerely,

/s/

Rick Pollack

Executive Vice President