AMERICAN ACADEMY OF FAMILY PHYSICIANS
STRONG MEDICINE FOR AMERICA

August 29, 2012

Marilyn Tavenner
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS–1589–P
P.O. Box 8013
Baltimore, MD 21244–1850

Re: Solicitation of public comments regarding outpatient status

Dear Ms. Tavenner:

On behalf of the American Academy of Family Physicians (AAFP), which represents more than 105,900 family physicians and medical students nationwide, I write in response to the solicitation of public comments regarding outpatient status as included in the proposed hospital outpatient prospective and ambulatory surgical center payment systems and quality reporting programs; electronic reporting pilot; inpatient rehabilitation facilities quality reporting program; and quality improvement organization regulation that was published in the July 30, 2012 *Federal Register*.

Section XI from this regulation contains a request for public comments on potential "policy changes" that could be made *to improve clarity and consensus among providers, Medicare, and other stakeholders regarding the relationship between admission decisions and appropriate Medicare payment, such as when a Medicare beneficiary is appropriately admitted to the hospital as an inpatient and the cost to hospitals associated with making this decision*.

The AAFP supports efforts to improve clarity and consensus regarding the relationship between admission decisions and appropriate Medicare payment. Medicare payment policies are statutorily different for inpatient and outpatient hospital services, with different implications for hospital payment, beneficiary liability, and beneficiary benefits (e.g., as it relates to coverage of a subsequent skilled nursing facility (SNF) stay). However, the AAFP observes that this inpatient versus outpatient distinction is not the material driver of physicians' admission decisions.

As CMS notes, *the physician or other qualified practitioner must decide whether to admit the beneficiary for inpatient care or treat him or her as an outpatient.* And as CMS notes elsewhere, and in which the AAFP fully agrees …the *need for admission is a complex medical judgment that depends upon multiple factors…* Thus, the AAFP argues that what is clinically best for the patient drives the physician's decision, not the artificial distinctions between inpatient and outpatient Medicare payment policy *dictated* by current law. Thus, there is a fundamental disconnect between the framework of the underlying statute and the reality of how physicians make

2021 Massachusetts Ave., N.W. • Washington, DC 20036-1011 • 888.794.7481 • 202.232.9033 • Fax: 202.232.9044 • capitol@aafp.org

admission decisions in hospitals, and simple “policy changes” will not address this fundamental problem.

As further observed by CMS, this fundamental disconnect is exacerbated by the fact that, when the physician admits a beneficiary and the hospital provides inpatient care, one of several Medicare claims review contractors regularly second-guesses the physician's decision, determines that inpatient care was not reasonable and necessary, and subsequently denies the hospital inpatient claim for payment. These denials are too commonplace and unfair, as hospitals are unreimbursed for associated Part A charges. Instead, the hospital is only able to capture certain Part B charges, which would have been payable had the patient been declared "outpatient" from the outset. The AAFP finds it telling that CMS and its contractors in these situations are not questioning whether the patient needed hospital services; rather they are only questioning whether or not the appropriate level of service was "inpatient" or "outpatient," terms that are a meaningless distinction for both physicians and patients.

We also find it telling that when such services are denied, little information is provided regarding the reason for denial. This lack of rationale is probably reflective of the inadequate CMS guidance on admissions decisions noted elsewhere in this letter. In any case, the facility has the option to appeal this decision, but the “burden of proof” is clearly that of the facility and the admitting physician. The AAFP would find it more appropriate to establish a process where any denial of an admission by the contractor must accompany documentation that clearly states the evidence-based reason behind the denial, thus increasing the “burden of proof” for the contracted reviewer. The AAFP further recommends that, prior to a Medicare contractor denying an admission, a physician review and confirm the denial. This is especially important since the decision to admit is a complex process that can only be understood by someone with medical training and actual experience of deciding whether a patient requires inpatient care.

Hospitals expend similar resources whether a patient is considered outpatient or inpatient: therefore, the AAFP believes payments should be consistent. If CMS truly wants to address this issue, the AAFP calls on CMS to move beyond simple policy changes and instead work with Congress to modify the law to allow Medicare to reimburse hospitals for services at a consistent rate, whether the patient’s status is outpatient or inpatient, and eliminate the distinction for hospital payment purposes. This approach directly addresses CMS commentary about *aligning payment rates more closely with the resources expended by a hospital…*

At this exciting and innovating time in which CMS is able to experiment with bundling payments and other pilot programs, the historical need to separate Part A (inpatient) and Part B (outpatient) hospital services makes little sense. Furthermore, the AAFP considers the artificial distinction between inpatient and outpatient as a product of the equally artificial distinction between Part A and Part B. The AAFP calls for policies that progress beyond this silo mentality and instead simply reimburse for healthcare services.

If CMS is going to continue paying hospitals differently for the same services simply because of the distinction between inpatient and outpatient, then clear rules are needed to determine when a patient should be admitted as an inpatient or outpatient and when the patient moves from one category to another. CMS references that they *issued instructions that state that, typically, the decision to admit should be made within 24 to 48 hours, and that expectation of an overnight stay may be a factor in the admission decision (Section 20.6, Chapter 6 and Section 10, Chapter 1 of the Medicare Benefit Policy Manual (Pub. 100–02)).* The AAFP finds this citation particularly

troubling since this guidance contains contradictions. After first stating *Physicians should use a 24-hour period as a benchmark, i.e., they should order admission for patients who are expected to need hospital care for 24 hours or more, and treat other patients on an outpatient basis,* in the subsequent paragraph on the same page of the manual, CMS states, *Admissions of particular patients are not covered or noncovered solely on the basis of the length of time the patient actually spends in the hospital.* How can physicians effectively use a 24-hour period as a benchmark, if coverage of admissions is not made on the basis of length of time? The AAFP finds this policy confusing in that it puts forth a benchmark for physicians and then minimizes that benchmark.

With respect to moving from one status to another, CMS states that it is *interested in hearing from stakeholders regarding whether it may be appropriate and useful to establish a point in time after which the encounter becomes an inpatient stay if the beneficiary is still receiving medically necessary care to treat or evaluate his or her condition.* Limiting payment for outpatient observation services to a set period of time before converting the patient's status to inpatient is an intriguing idea and would increase clarity relative to the current situation. It would also protect the beneficiary from excessive Part B charges and potential denial for subsequent SNF coverage. However, it would still leave the facility at risk if the inpatient admission was denied. Thus, the AAFP cannot recommend this approach unless there is greater clarity and transparency in inpatient admission criteria.

Since CMS and the AAFP both seek clarity around this issue, we urge that CMS move toward a bright line benchmark or standard or at least more definite guidance than is currently provided in the Medicare Benefit Policy Manual. For instance, the current general admission criteria could be replaced or clarified through the use of evidence-based guidelines covering a variety of conditions frequently involved in the hospitalization decision-making process. Examples of these guidelines include the Agency for Healthcare Research and Quality (AHRQ) National Guidelines Clearinghouse and other sources such as various medical specialty societies. The process of incorporating these guidelines within the admission criteria should include participation of the medical community, and any changes made in the admission criteria should be coupled with a comprehensive educational campaign for physicians and hospitals concerning these new policies.

The AAFP strongly recommends that CMS be clear and transparent in its admission coverage criteria. Without such clear policy, physicians and hospitals will continue to struggle comparing these complex medical judgments against those of a CMS contractor.

As CMS acknowledges, as long as the agency reimburses differently for inpatient versus outpatient care, there will continue to be confusion over billing requirements, which then necessitates CMS to audit claims in an attempt to detect a potentially improper payment. Clear rules will simplify CMS's job in this regard and provide physicians and hospitals with some sense that they will not be penalized for playing by the rules, a sense that is lacking among them at this point.

We appreciate the opportunity to provide these comments and urge CMS to also review the AAFP's comments regarding Subsequent Hospital Observation Care as made in a December 22, 2010, letter sent in response to the final 2011 fee schedule. We would be happy to answer any

questions you may have or clarify anything regarding this letter. Please contact Robert Bennett, Federal Regulatory Manager, at 202-232-9033 or rbennett@aafp.org.

Sincerely,

Roland A. Goertz, MD, MBA, FAAFP
Board Chair