Provider Roundtable

January 26, 2016

Mr. Andy Slavitt, MBA
Acting Administrator
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W., Room 445-G
Washington, DC 20201

Dear Mr. Slavitt,

Re: Medicare Program Inpatient Prospective Payment System 0.2 Percent Reduction.

The following comments are submitted by the Provider Roundtable (PRT), a group composed of providers who gathered to generate comments on the Medicare Program Inpatient Prospective Payment System 0.2 Percent Reduction.

The Provider Roundtable (PRT) includes representatives from 14 different health systems, serving patients in 35 states. PRT members are employees of hospitals. As such, we have financial interest in fair and proper payment for hospital services under Medicare, but do not have any specific financial relationship with vendors.

The members collaborated to provide substantive comments with an operational focus that we hope CMS staff will consider during its policymaking process. We appreciate the opportunity to provide our comments to CMS. A full list of the current PRT members is provided in **Attachment A.**

Please feel free to contact me at 314-733-6757 or via email at: *Kathi.Austin@ascensionhealth.org*.

Sincerely,

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Carolinas HealthCare System (NC, SC)

Community Hospital Anderson (IN)

Erlanger Medical Center (TN)

Forrest General (MS)

Franciscan Missionaries of Our Lady Health System (LA)

Harris Health System (TX)

Hartford Hospital (CT)

Holy Name Medical Center (NJ)

Kaiser Permanente, Southern California Permanente Medical Group (CA)

Ohio Valley Health Services and Education Corporation (OH, WV)

Robert Wood Johnson University Hospital (NJ)

University of Pittsburgh Medical Center (PA)

Provider Roundtable Comments:
Medicare Program Inpatient Prospective Payment System 0.2 Percent Reduction

The Provider Roundtable (PRT) is pleased to take this opportunity to comment on the Medicare Program's Inpatient Prospective Payment System (IPPS) 0.2 percent reduction.

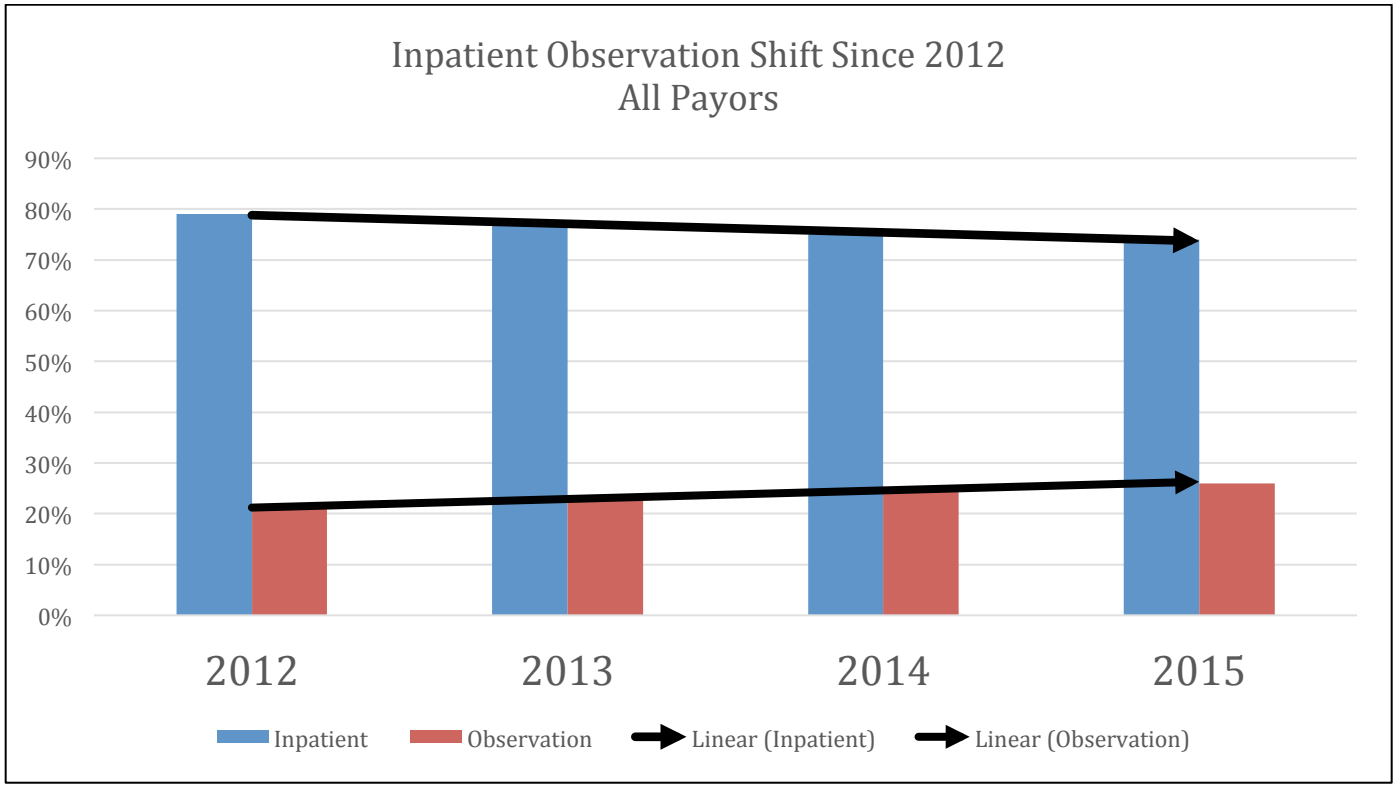
In FY 2014, CMS enacted a 0.2 percent reduction to hospital payment rates. This change was made in order to offset the agency's expected net increase in inpatient admissions resulting from its implementation of the 2-midnight rule. At the time, CMS estimated that the 2-midnight rule's net effect would be an annual increase of 40,000 inpatient discharges.

The PRT appreciates that CMS released additional information in response to industry inquiries about the methodology it used to develop its original estimate. This information allowed stakeholders to better understand the assumptions CMS used to generate its 0.2 percent reduction. The PRT has reviewed CMS' methodology carefully and also examined data from our member organizations to assess whether it could validate CMS' projected shift from observation status to inpatient admissions.

Our general finding was that our data do not indicate such a shift occurred. In fact, data from the PRT members, which is discussed below, contradict what CMS' actuaries expected to occur. Nine PRT members shared their organization's experiences with shifts occurring between the inpatient setting and outpatient observation in the wake of the 2-midnight rules' implementation. We primarily looked at all patients, as we believe that patients are treated similarly with respect to admission criteria, regardless of payor (graph 1, page 2). In addition, some of our members were able to further isolate their Medicare patient data (graph 2, page 2).

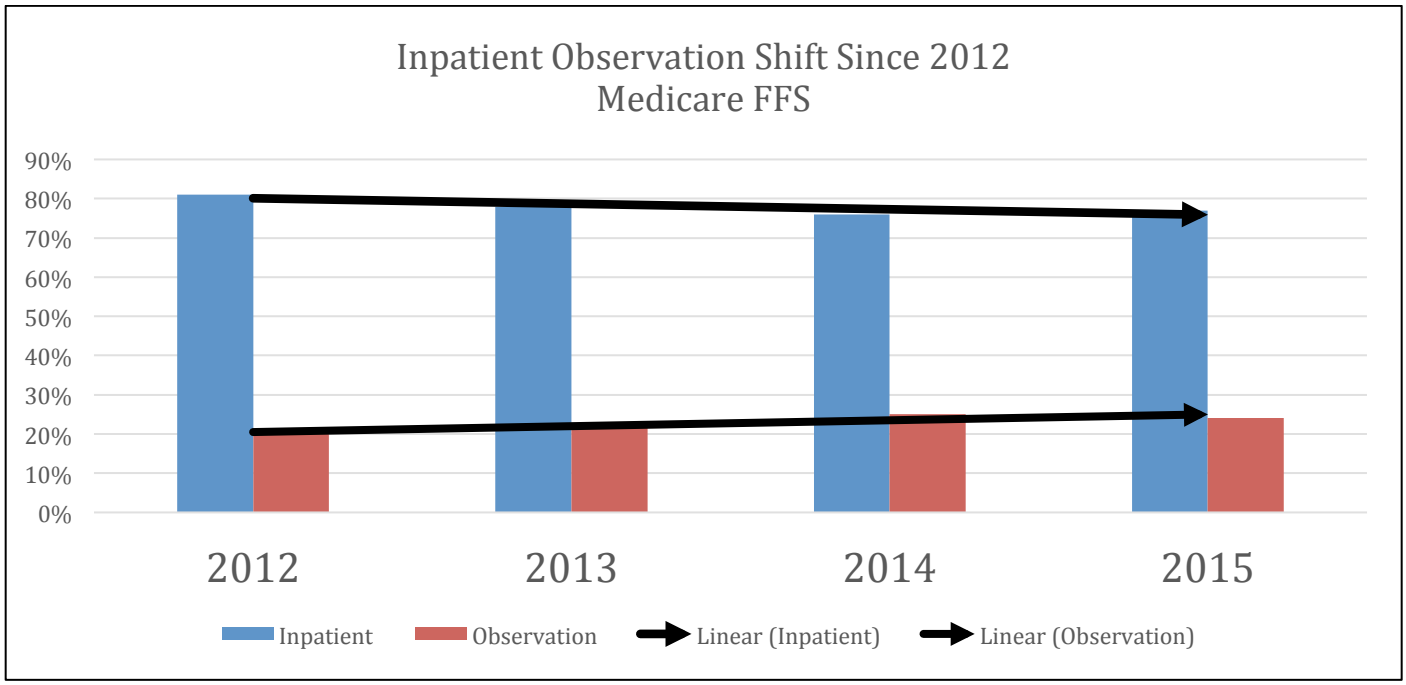
Our data, as shown in the graphs below, do not support CMS' assumption that the implementation of the 2-midnight rule would result in a shift from observation status to inpatient admission. In contrast, we found that, as a whole, our organizations experienced a shift in the *opposite direction* from that predicted by CMS' actuaries: our data illustrate a shift from inpatient admission to observation status (rather than the reverse). We found that this shift (i.e., from inpatient to observation) was similar for both all payors as a whole, and for Medicare-only claims.

Graph 1: Inpatient Observation Shift Since 2012 for All Payors



Data from 9 PRT healthcare systems including 72 acute care hospitals

Graph 2: Inpatient Observation Shift Since 2012 for Medicare FFS Only



Data from 4 PRT healthcare systems including 16 acute care hospitals

We believe one reason that our facilities saw no shift from outpatient to inpatient status after implementation of the 2-midnight rule is because one-day stay inpatient medical cases moved to the outpatient setting either as true outpatients, or as outpatients who receive observation services. Again, these cases, which were previously one-day inpatients, are now both treated and registered as hospital outpatients.

We recognize that our review is limited to a small number of institutions, but believe that it is important for CMS to consider the PRT members' results. We suspect that other providers may also be seeing the same shift, which is inconsistent with CMS' expectations.

With regard to CMS' actuarial assumptions, we were interested to note that CMS actuaries *excluded* medical MS-DRGs from their calculations. CMS states that medical MS-DRGs were excluded because, *"It was assumed that these cases would be unaffected by the policy change."*

CMS continues that: *"...actuaries excluded medical MS-DRGs when developing the -0.2 percent estimate because they believed that[,] due to behavioral changes by hospitals and admitting practitioners[,] most inpatient medical encounters spanning less than 2 midnights before the current 2-midnight policy was implemented might be reasonably expected to extend past 2 midnights after its implementation and would thus still be considered inpatient."*

We disagree with this assumption — for the very reasons that CMS believes it to be true.

CMS states, *"...the clinical assessments and protocols used by physicians to develop an expected length of stay for medical cases were, in general, more variable and less defined than those used to develop an expected length of stay for surgical cases."* The fact that protocols are more variable for medical MS-DRGs could, in fact, lead to more cases migrating from inpatient to outpatient observation. This would occur because the larger variables would naturally result in a greater variability in the expected length of stay (LOS) compared to more predictable surgical MS-DRGs. Also, if admitting physicians lacked medical case protocols upon which to reasonably rely in order to certify a 2-midnight expectation, then these patients would be admitted as outpatients; if they subsequently improved after one day, they would be discharged and billed as outpatients.

We agree with CMS that a single diagnosis can cover a broader spectrum of possibilities, for medical admissions. We disagree, however, with the agency's assumption that this variability would not cause a measurable shift from inpatient to outpatient for medical conditions such as a minor stroke, chronic obstructive pulmonary disease (COPD), or congestive heart failure (CHF). In fact, CMS itself notes that strokes may be minor, allowing for a brief diagnostic workup. This very type of medical scenario is more likely to result in an observation stay than an inpatient admission under the 2-midnight rule. Because medical diagnoses do not come with a predictable, reasonably consistent set of activities, it is quite possible for medical protocols to vary greatly — resulting in either longer or shorter LOS and/or treatment in the outpatient setting.

The PRT believes that CMS actuaries should have factored in the probable movement of short-stay inpatient medical MS-DRGs to the outpatient setting as observation cases. To illustrate this view, we reviewed several medical MS-DRGs from the 2014 IPPS Final Rule files/tables that have a geometric LOS of two or fewer days. There are sixty (60) medical MS-DRGs with a mean geometric LOS of less than 2.4 days and one hundred and twenty-four (124) medical MS-DRGs with a mean geometric LOS of less than 3.0 days.

These include:

- Chest Pain (MS-DRG 313), which has a mean geometric LOS of 1.8 days;
- Other Circulatory System Diagnosis without CC/MCC (MS-DRG 316), which has a mean geometric LOS of 2.0 days; and
- Syncope & Collapse (MS-DRG 312), which has a mean geometric LOS of 2.4 days.

It is important to remember that — prior to the 2-midnight rule's implementation — an overnight stay was generally supportive of an inpatient admission. In fact, Section 10 of Chapter 1 of the Medicare Benefit Policy Manual, Inpatient Hospital Services Covered Under Part A, states that:

> *"Generally, a patient is considered an inpatient if formally admitted as inpatient with the expectation that he or she will remain* ***at least overnight*** *and occupy a bed even though it later develops that the patient can be discharged or transferred to another hospital and not actually use a hospital bed overnight."* (Emphasis added.)

Therefore, prior to the 2-midnight rule's implementation, a hospital stay of a single midnight supported an inpatient admission. There are a large number of medical MS-DRGS with a geometric mean LOS of three or fewer days, which means that a significant proportion of these stays will span fewer than two midnights. Therefore, it is very probable that the implementation of the 2-midnight rule resulted in a shift from inpatient to observation in a number of medical MS-DRGs, perhaps even more so than the shift expected for surgical MS-DRGS.

Given this fact, the PRT contends that it was <u>not</u> reasonable for CMS to assume that medical MS-DRGs would not be measurably affected by the 2-midnight policy change. We believe that CMS should have assumed that at least <u>some</u> percentage of patients with medical MS-DRGs would shift from inpatient to observation due to the 2-midnight rule, and should have included this in its actuarial estimation. Had this been included, we believe there might not have been a need for the .02 payment reduction. For the reasons described, the PRT does not agree with CMS' exclusion of medical MS-DRGs from its actuarial estimates. Since CMS' actuaries are now conducting an analysis of claims experience for FY 2014 and FY 2015, we request that CMS assess whether its prior assumptions regarding medical MS-DRGs were reasonable. Furthermore, we note that CMS has at least partial claims data for 2015 and we encourage CMS to use these data to validate their assumptions.

Attachment A: 2016 Provider Roundtable Members

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