CALIFORNIA HOSPITAL ASSOCIATION

Providing Leadership in Health Policy and Advocacy

March 13, 2015

Sean Cavanaugh
Deputy Administrator & Director
Center for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

Dear Deputy Administrator Cavanaugh:

On behalf of the more than 400 member hospitals and health systems in California, the California Hospital Association writes to urge CMS action on a number of issues important to hospitals and the patients we serve in our communities every day. We appreciate the opportunity to share a number of these concerns with you and will follow up with your office to schedule a meeting to discuss these matters further.

In summary, CHA urges CMS to consider the following issues important to California's hospitals:

Two-Midnight Rule
CHA urges CMS to continue non-enforcement of the two-midnight policy until October 1, 2015 at the earliest and continue to prevent recovery audit contractors (RACs) from review of these cases; repeal the 0.2 percent reduction to the standardized amount that was applied in FFY 2014; exclude critical access hospitals (CAHs) from inclusion in this policy; exclude inpatient psychiatric admissions paid under the inpatient psychiatric facility prospective payment system (IPF PPS); and move forward with development and evaluation of a potential payment alternative for hospital stays less than two midnights.

Recovery Auditor Contractors
We urge CMS to undertake comprehensive RAC reform. Recent draft recommendations by MedPAC do not go far enough in addressing the significant concerns raised by hospitals. The December 31, 2014 changes by CMS, while a step in the right direction, are only a first step. CHA urges CMS to move swiftly in implementing the additional changes detailed below as soon as possible.

Application of the Area Wage Index Rural Floor
CMS should continue its work with Congress and other stakeholders on meaningful area wage index reform. In the interim, CMS should not support efforts by Congress to begin to dismantle the current system by changing some provisions and not others. More specifically, CHA does not support changes in the application of budget neutrality to the rural floor. Every other wage index change is budget neutral to the entire system. Carving out this provision and applying budget neutrality at the state level rather than at the national level will only replace one inequity with another. This change would cost California hospitals more than $190 million in Medicare payments, as well as additional Medi-Cal payments that also utilize area wage index.

ICD-10
CHA continues to strongly support ICD-10 implementation scheduled for October 1, 2015. Hospitals and health systems have worked with their physicians and invested millions of dollars to educate staff and

499 So. Capitol Street SW, Suite 410, Washington, DC 20003 • *Telephone:* 202.488.3740 • *Facsimile:* 202.488.4418
1215 K Street, Suite 800, Sacramento, CA 95814 • *Telephone:* 916.443.7401 • *Facsimile:* 916.552.7596 • www.calhospital.org
Corporate Members: Hospital Council of Northern and Central California, Hospital Association of Southern California, and Hospital Association of San Diego and Imperial Counties

update internal billing systems. We urge CMS to work with Congress to ensure that there are no further delays in implementation.

CONTINUE NON-ENFORCEMENT OF THE TWO-MIDNIGHT RULE

In February, Noridian, the Medicare administrative contractor (MAC) for California, reported that during phase II of the probe and educate process, 78 percent of hospitals remained in the moderate concern range, having had between two and six denials out of 10 claims reviewed. An additional 15 percent had seven or more claims denied out of 10 claims reviewed. Overall, hospitals have had, on average, 20 cases pulled for review out of thousands of inpatient admissions. CHA is concerned that while the overall denial rate is dropping, this policy continues to present significant implementation challenges.

During the last year, hospitals have reported variation in the education provided during the probe and educate process. CHA believes a number of factors have contributed to this variation, causing confusion in the field and among contractors. First, CMS has continued to make a number of changes and clarifications to the policy. The most recent was in the outpatient prospective payment system final rule, removing the requirement for physician certification of an inpatient admission effective January 1, 2015. While CHA supports this change, it has raised a number of questions. CMS noted in the final rule that it would issue subregulatory guidance to further clarify the policy, but that information has not been released. These changes, which on the surface are straightforward, cause additional physician confusion, require re-education and, in some cases, changes to the electronic medical record.

Second, it is our impression that the MACs were delayed in providing hospital education due to a lack of CMS-approved educational materials. This delay, coupled with an evolving policy and limited number of trained and qualified staff to take on such a significant education effort during a short amount of time, only slowed provider implementation of the policy. We see that in the most recent probe and education statistics in California.

CHA believes that this policy continues to present implementation challenges to physicians and hospitals and that, to ensure compliance, additional time is needed for provider education. We urge the agency to continue non-enforcement of this policy until October 1, 2015 at the earliest. In addition, CMS currently prohibits RACs from conducting post-payment patient status reviews for claims with dates of admission from October 1, 2013 through March 31, 2015, and we ask that this moratorium continue until October 1, 2015 at the earliest. Finally, as previously stated in our inpatient prospective payment comments, we urge the agency to repeal the 0.2 percent reduction to the standardized amount that was implemented in FY 2014.

EXEMPT CRITICAL ACCESS HOSPITALS FROM THE TWO MID-NIGHT RULE

The 30 critical access hospitals (CAHs) in California are all paid cost based reimbursement for their Medicare hospital inpatient admissions. However, they remain subject to the two-midnight policy. While subject to the policy, CAHs were exempt from the probe and educate process and have had none of their inpatient claims reviewed, nor did they receive additional one-on-one education unless they proactively reached out and asked the MAC for education.

In addition, the two-midnight rule is further complicated for CAHs because of the CMS condition of payment requiring that the patient be transferred or discharged within 96 hours, and a condition of participation requiring that CAHs not have an average length of stay more than 96 hours. This time-based policy does not make sense for CAHs.

CHA urges CMS to exempt CAHs from this policy. This is a burdensome payment policy that only causes confusion with the current condition of payment and conditions of participation. Further, it

would be unfair to subject CAHs to such a policy on April 1, when they have had zero claims reviewed or one on one provider education that has been afforded to PPS hospitals.

EXCLUDE INPATIENT PSYCHIATRIC ADMISSIONS FROM TWO-MIDNIGHT RULE

CHA represents 27 freestanding IPFs and more than 100 units across California. Members of CHA's Center for Behavioral Health board have expressed concerns related to the two-midnight rule and its appropriateness for patients with acute psychiatric needs. We are particularly concerned with its applicability to the IPF PPS, which currently pays on a per-day basis, unlike the DRG system in acute care hospitals.

Early on, CHA, along with our colleagues at AHA and NAPHS, expressed concern to CMS regarding the applicability of the two-midnight policy to IPFs paid under the IPF PPS. **The expectation of a patient staying two midnights is irrelevant for the purposes of payment under the IPF PPS, as they are only paid for each day they receive services. Therefore, we believe this policy is inappropriately being applied.**

This is particularly problematic when patients are considered a danger to themselves or others and admitted on an involuntary hold. If a Medicare fee-for-service patient is brought in on an involuntary hold, the patient would be subject to the two-midnight rule, requiring documentation of the expectation of a two-midnight stay. Due to the unique clinical circumstances of patients in psychiatric crisis, this policy potentially jeopardizes a patient's chances of receiving the appropriate care. Said differently, there is expressed concern about the inability to admit patients with behavioral health conditions under this policy and the unintended consequences this creates in the quality of patient care.

There have been a limited number of cases available for review by the MACs. CHA is aware of only one recent claim denial under the two-midnight audits related to the admission of a patient with a behavioral health condition. The patient presented in an acute care facility and, after evaluation, it was determined appropriate and medically necessary to admit the patient, as they were a danger to themselves and to others. The patient was admitted to a freestanding IPF, and only stayed one midnight. The case has been denied, and we understand the facility was successful in its appeal. **If this policy moves forward, we will have a number of hospitals appealing claims that we believe will be over turned, but the process will cost providers and CMS significant resources that could and should be directed to patient care. CHA urges CMS to exempt IPF PPS admissions from inclusion in the two-midnight policy.**

SHORT-STAY PAYMENT ALTERNATIVE

CHA supports the American Hospital Association's efforts to evaluate a number of proposed payment solutions that will address the short-stay policy issues. Their letter to you on February 13 lays out the challenges, but presents some opportunities for additional consideration and analysis. We believe a comprehensive approach inclusive of RAC reforms and changes to the two-midnight rule is part of a long-term solution, but that the agency should also put significant efforts into evaluating a payment solution. CHA understands the challenges and complexities of developing a payment system that maintains the integrity of the current prospective payment system while still ensuring payment adequacy for short stays and limiting significant redistribution of payments among hospitals.

The most challenging aspect of the two-midnight rule is the documentation of the expectation of two midnights. Physicians and hospitals are struggling to make admission decisions using this new criteria, when they're taught to make a determination that is in the patient's best interest, leading to the highest quality outcome. A payment alternative for a stay of less than two midnights provides more certainty and reimburses hospitals appropriately for cases that justifiably require inpatient level of care but do not meet the time-based requirement. We ask that CMS engage with stakeholders on this important issue.

RECOVERY AUDITOR CONTRACTORS

We urge CMS to undertake comprehensive RAC reform. Recent draft recommendations by MedPAC do not go far enough in addressing the significant concerns raised by hospitals. Moreover, the CMS December 31, 2014 changes, while a step in the right direction, are only a first step. CHA urges CMS to move swiftly in implementing additional changes as soon as possible.

More specifically, CHA urges CMS to consider changes to the RAC contingency fee structure to a flat payment rate such as that of other Medicare contractors (e.g., MACs). By eliminating the contingency fee, CMS can continue to appropriately audit providers, without giving RACs a continued incentive to excessively audit and erroneously deny claims.

CMS should also consider penalties for poor RAC performance and hold its auditors to the same types of performance standards as it hold hospitals. In particular, CMS should penalize RACs that have high over turn rates and consider additional metrics for evaluation and public reporting. CHA believes additional transparency in this program is needed and that making performance standards available for public consumption on a regular and timely basis will promote accountability by contractors.

Moreover, we have continued to urge CMS to limit the medical necessity reviews to the information that was known to the physician at the time a decision to admit was made. Allowing the RAC to take into account the entirety of the medical record and second guess the physician's decision based on information not known to that clinician at the that time is unfair and should not be rewarded.

Finally, we urge CMS to eliminate the application of the one-year timely filing limit to denials based on patient status, and to allow the provider to rebill within 180 days of a final determination, whether that is a denial by a Medicare contractor or an appeal decision. If RACs have the ability to look back three years and collect a percentage of that payment, we believe hospitals should be afforded the same opportunity to rebill and collect a portion of that payment.

APPLICATION OF THE AREA WAGE INDEX RURAL FLOOR

CMS should continue its work with Congress and other stakeholders on meaningful area wage index reform. In the interim, CMS should not support efforts by Congress to begin to dismantle the current system by changing some provisions and not others. CHA does not support changes in the application of budget neutrality to the rural floor. Every other wage index change is budget neutral to the entire system, by carving this one provision out and applying budget neutrality at the state level rather than at the national level, we will only replace one inequity with another.

ICD-10

CHA continues to support the agency's move toward ICD-10 implementation on October 1, 2015. Hospitals and health systems have worked with their physicians and invested millions of dollars to educate staff and update systems. We urge CMS to work with Congress to ensure there are no further delays in implementation.

With that said, we ask that CMS move quickly to publish all the proposed changes to hospital quality measures — as well as the changes in the hospital value-based purchasing, readmissions and hospital-acquired conditions penalty programs — that will be impacted by this transition. It is our hope that CMS will provide as much detail as possible in the FFY 2016 inpatient proposed rule and solicit input on various planned solutions. Hospitals are monitoring these measures closely and want to better understand the impacts of ICD-10 on their quality scores and payments. CMS must move quickly to make this information available so that hospitals can provide input on next steps and understand future implications.

We appreciate the opportunity to share our views and look forward to setting up a meeting to discuss these matters in the near future. If you have any questions, please do not hesitate to contact me at (202)488-4688 or akeefe@calhospital.org

Sincerely,

/s/
Alyssa Keefe
Vice President Federal Regulatory Affairs

CC: Patrick Conway, MD, CMS
Marc Hardstein, CMS
Ing-Jye Cheng, CMS
Daniel Duvall, MD, CMS
George Mills, CMS
Melanie Combs-Dyer, CMS