June 25, 2013

Marilyn Tavenner
Administrator, Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1599-P
P.O. Box 8011
Baltimore, MD 21244-1850

Jonathan Blum
Deputy Administrator, Centers for Medicare and Medicaid Services
Hubert H. Humphrey Building
200 Independence Avenue, SW
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 (Federal Register, Vol. 78, No. 91, May 10, 2013 (78 FR 27486).

Submitted via electronic upload at http://www.regulations.gov

Dear Ms. Tavenner and Mr. Blum:

These comments are in response to the request by the Centers for Medicare and Medicaid Services (CMS) for comments relating to the Proposed Inpatient Prospective Payment Systems Rule ("Proposed Rule") which would significantly amend the regulations and guidance surrounding inpatient admission determinations. We, the Care Continuum Alliance and the National Coalition on Health Care, thank you for the opportunity to address the proposed changes through this comment period.

Care Continuum Alliance is a non-profit association of almost 200 companies. We convene all stakeholders in the population health management industry. Our members design and provide services, programs and tools to better coordinate care for all patients along the continuum, from the healthy to those with chronic conditions. Through advocacy, research and education, Care Continuum Alliance advances strategies that increase quality in the health care system while reducing costs.

The National Coalition on Health Care is a nonpartisan, nonprofit organization of organizations, working together to build an affordable health care future. Our growing Coalition represents more than 80 participating organizations, including medical societies, businesses, unions, health care providers, faith-based associations, pension and health funds, insurers, and groups representing consumers, patients, women, minorities, and persons with disabilities. Collectively, our organizations represent, as employees, members, or congregants, more than 100 million Americans.

Currently, CMS guidance treats admissions as a complex medical decision, and includes an expectation of a hospital stay of 24 hours or greater as one of the elements to consider when evaluating a potential admission. The Proposed Rule, however, proposes that hospital inpatient admissions "spanning at least two midnights" would presumptively qualify as appropriate for payment under Medicare Part A.

While we appreciate CMS's stated goal of providing more guidance on when a patient is appropriately treated and paid by Medicare as an inpatient, we are concerned, however, that the new emphasis on a time-based presumption for inpatient hospital stays will have unintended, negative consequences on beneficiaries and providers, and ultimately, runs counter to CMS's overall goal of improving health outcomes.

The proposed "two midnight" threshold sets a precedent that potentially compromises the delivery of quality care to beneficiaries. Implementing a process by which complex admission decisions are based on time (versus evidence based medical necessity criteria and/or the treating physician's medical judgment) will have implications on certain typical inpatient procedures. The proposed role relies on simplistic, technical criteria which can be used to audit and deny admissions after the fact, rather than ensuring that hospitals have a quality process in place to make correct admission decisions and provide appropriate care upfront.

We are concerned that this approach will lead to a greater financial burden and frustration among beneficiaries. For example, an unintended consequence of the proposed policy is an unexpected increase in cost-sharing for beneficiaries who believe they were inpatient, but because the "two midnight" threshold was not met, would now face higher outpatient out-of-pocket costs. While intended to simplify a complex decision-making process and assuage hospital uncertainties about payment, this approach will only serves to introduce more confusion for providers and beneficiaries.

Recommendation: CMS has long held that "the decision to admit a patient is a complex medical judgment which can only be made after the physician has considered a number of factors, including the patient's medical history and current medical needs." In keeping with this philosophy, CMS should refrain from implementing the proposed "two midnight" policy and should restore accountability to the provider to make the appropriate care setting decision for their patients.

Thank you again for the opportunity to provide you with our comments and recommendations.

Yours Truly,

John Rother
President and CEO

Vicki Shepard
Chair of the Government Affairs Committee