June 7, 2013

Marilyn Tavenner
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-2013-0084
P.O. Box 8013
Baltimore, MD 21244-1850

Dear Administrator Tavenner:

I am writing on behalf of the National Association of Professional Geriatric Care Managers (NAPGCM). With over 2,000 members, the NAPGCM is dedicated to the advancement of professional geriatric care management through education, collaboration, and leadership. A Geriatric Care Manager is a health and human services specialist who helps families who are caring for older relatives.

In the proposed Medicare inpatient hospital reimbursement rule published on May 10th, the Centers for Medicare & Medicaid Services (CMS) again consider observation status. Under this new approach, CMS proposes "a time-based presumption of medical necessity for hospital inpatient services based on the beneficiary's length of stay."

Under the proposed rule, Medicare presumes that an individual is an inpatient if the physician documents that the patient requires **more** than two midnights in the hospital **following an inpatient admission**. The "starting point for this time-based instruction would be when the beneficiary is moved from any outpatient area to a bed in the hospital in which the additional hospital services will be provided." Medicare assumes that hospital services spanning **fewer** than two midnights should be considered outpatient observation. For patients whose inpatient stay was fewer than two midnights, CMS would pay for inpatient care only if the services were identified on Medicare's inpatient-only list or "in exceptional cases such as beneficiary death or transfer."

While the proposed time-based presumptions significantly change current practice, they would not help many beneficiaries who are currently caught in observation status. In fact, the new policy likely exacerbates the problem for beneficiaries.

Observation Status Defined

Observation status refers to the classification of hospital patients as "outpatients" receiving observation services even though, just like inpatients, observation patients stay for days and nights in the hospital, receive medical and nursing care, diagnostic tests, treatments, medications, and food. Patients in observation status may, and increasingly do, spend multiple days in the hospital.

Although care for such outpatients is often indistinguishable from the care provided to individuals who are called inpatients, the implications of outpatient status for Medicare beneficiaries are substantial. Most significantly, patients who need medically necessary post-acute care in a skilled nursing facility (SNF) are unable to obtain coverage for that care under Medicare Part A solely because they were labeled outpatients by the hospital. The Medicare statute requires that patients have an inpatient hospital stay of three or more consecutive days to meet Medicare coverage criteria for SNF care. Observation stays do not qualify patients for Medicare Part A coverage of a subsequent SNF stay. Patients who cannot afford to pay privately for their SNF stay (and who do not have another payment source for the SNF stay) may forego needed post-acute care in a SNF, although they could be eligible for either post-acute care in an inpatient rehabilitation facility, or for home health care, or both.

Increasing Numbers of Beneficiaries Affected by Extended Stays in Observation

CMS addresses observation status in a section of the proposed rules entitled "Policy Proposal on Admission and Medical Review Criteria for Hospital Inpatient Services under Medicare Part A." CMS begins its discussion of its proposed changes by describing, again, the impact on Medicare beneficiaries of hospitals' increasing use of extended observation status.

CMS acknowledges that increasing numbers of Medicare beneficiaries are spending more than 48 hours in a bed in an acute-care hospital in observation status. As before, CMS reports that the percentage of patients in observation for more than 48 hours increased from 3% to 8% between 2006 and 2011.

Current and Proposed Rules

Current CMS policy relies on physician judgment and evaluation of a patient's needs to determine inpatient admission status. CMS's Manual instructs physicians to use a 24-hour period as a benchmark for inpatient status. Under the new rule, CMS proposes rules that would establish new time-based criteria, distinct from the physician's judgment. The new rule specifically indicates that the physician's "order and certification regarding medical necessity" are not entitled to any "presumptive weight" and are "evaluated in the context of the evidence in the medical record." In other words, the physician's order and certification are "granted consideration" but "are not considered by CMS to be conclusive evidence that an inpatient hospital admission or service was medically necessary."

The Proposed Rules Do Not Help Most Medicare Beneficiaries in Observation Status

NAPGCM has several concerns about the proposed rules, which would *not* address the problems for beneficiaries who find themselves placed in observation status.

First, CMS bases coverage decisions on time rather than medical care, and is extending the time in the hospital that is needed to create a presumption of inpatient status – from overnight (current Manual) to two midnights (proposed rule). Moreover, the proposed two-midnight rule begins to run only after the patient has been formally admitted as an inpatient. Observation time before formal inpatient admission would not be counted as inpatient time. Consequently, for the many observation patients whose entire hospital stay is classified as outpatient observation, the proposed rules make no change whatsoever.

Second, CMS requires new documentation from physicians about whether a patient arriving at the hospital needs to be an inpatient.

Third, by declining to give the physician's order and certification "presumptive weight," CMS requires Medicare's reviewers to make retrospective decisions about a patient's need for inpatient care. Instead of reviewers determining whether the patient appeared to need inpatient care *at the time the patient was first seen at the hospital,* CMS requires reviewers to look at patients *after* they have been treated and to decide, retroactively, based in part on the medical care that was provided while the patient was hospitalized, whether the patient needed to be an inpatient. This after-the-fact analysis improperly second-guesses the physician's decision.

Finally, there is a major disconnect between the way CMS describes observation status and the way observation status is used and applied by hospitals. CMS repeats that short-stay claims errors occur when patients receive "minor surgical procedures or diagnostic tests" on an outpatient basis, are admitted overnight for observation, and are discharged the following morning. CMS does not explain how this description of observation status relates to the dramatic increase in observation stays exceeding 48 hours that occurred between 2006 and 2011.

As stated earlier, rather than resolving the situation, the rule further exacerbates the uncertainty faced by Medicare beneficiaries when placed in hospital observation status. The proposed approach continues to impose a financial burden on Medicare beneficiaries and imposes even more uncertainty into the situation. Often, beneficiaries are unaware of the costs and barriers imposed by a classification as “observation status” at hospital admission. The NAPGCM opposes this approach. Instead, we support changes to observation status that are embodied in the bipartisan legislation pending in Congress, the Improving Access to Medicare Coverage Act of 2013. This bill counts *all* time in the hospital toward meeting the three-day qualifying hospital stay. We believe this approach is appropriately beneficiary focused.

We look forward to working with you to resolve this issue. If you should have questions or comments, please contact Susan Emmer at 301.320.3873.

Sincerely,

President
National Association of Professional Geriatric Care Managers