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June 30, 2014

Ms. Marilyn Tavenner
Administrator
Centers for Medicare & Medicaid Services
ATTN: CMS-1607-P
7500 Security Blvd.
Baltimore, MD 21244-8013

Dear Ms. Tavenner:

Re: FY 2015 Inpatient Prospective Payment System Proposed Rule, File Code CMS-1607-P

The Association of American Medical Colleges (AAMC) welcomes this opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS' or the Agency's) proposed rule entitled "Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long Term Care Hospital Prospective Payment System and Proposed Fiscal Year 2015 Rates; Quality Reporting Requirements for Specific Providers; Reasonable Compensation Equivalents for Physician Services in Excluded Teaching Hospitals; Provider Administrative Appeals and Judicial Review; Enforcement Provisions for Organ Transplant Centers; and Electronic Health Record (EHR) Incentive Program," 79 *Fed. Reg*. 27978 (May 15, 2014). The AAMC is a not-for-profit association representing all 141 accredited U.S. medical schools; nearly 400 major teaching hospitals and health systems, including 51 Department of Veterans Affairs medical centers; and nearly 90 academic and scientific societies. Through these institutions and organizations, the AAMC represents 128,000 faculty members, 83,000 medical students, and 110,000 resident physicians.

The FY 2015 IPPS proposed rule includes a 1.3 percent hospital payment update. The overall impact on all hospitals is 0.8 percent, yet the impact on major teaching hospitals is -1.3 percent. Much of this negative impact is driven by the implementation of two Affordable Care Act (ACA) mandated provisions: the Medicare disproportionate share hospital (DSH) cuts and the Hospital Acquired Condition (HAC) Reduction Program. Given the disproportionate and negative impact of these and other proposals on teaching hospitals, the AAMC urges CMS to reconsider certain policies that are within the Agency's ability to reverse. In particular, the AAMC encourages changes to the Two-Midnight rule and to the HAC Reduction Program methodology and payment application.

Two-Midnight Rule

The Two-Midnight Rule finalized in the FY 2014 rulemaking cycle continues to cause numerous problems and have damaging effects for teaching hospitals and Medicare beneficiaries. These include inadequate reimbursement for hospitalizations and complete loss of policy add-on payments that support physician training, care for low income patients, and provide other community benefits. The rule also has been a source of increased financial liability and confusion for Medicare beneficiaries. Further, the rule is a disincentive to efficient care, a source of administrative burden, and inappropriately creates a disconnect between a physician's complex medical judgment about the most appropriate site of care for the patient and reimbursement for medically necessary hospital services. **The AAMC urges CMS to revise or replace the Two-Midnight Rule with a policy that does not sacrifice the critical role of medical judgment and adequate reimbursement for medically necessary short hospitalizations. This policy should also be easily understood by patients and should not unreasonably increase their financial responsibility for short inpatient stays. An interim solution is needed now, with additional time being devoted to developing permanent policy in a later rulemaking cycle.**

The AAMC does not support using time as the permanent basis for determining which stays should be characterized and reimbursed as inpatient and which as outpatient instead of relying on the historical and appropriate deference to complex medical judgment. When determining whether to admit a patient, clinicians rely on their training, medical judgment, and clinical protocols to determine whether the patient's medical needs would be better served in the inpatient or outpatient setting. This judgment depends on factors such as the severity of the patient's condition, the risks of complications and adverse events, and the nature of the services needed. Given the factors that ultimately guide the admission process, the presumption that a short length of time in the hospital makes the care less clinically relevant or worthy of full inpatient reimbursement is flawed.

Because CMS has not promulgated a sufficiently detailed proposal for a revised policy during this comment period, the AAMC strongly encourages CMS to adopt an interim policy in the FY 2015 final rule. The part of the Two-Midnight Rule that applies to medically necessary stays longer than two midnights should be maintained to ensure that these stays are appropriately paid as inpatient stays. At the same time, for stays shorter than two midnights, the interim policy should return to the policy before the Two-Midnight Rule went into effect (i.e., before 10/1/13). This would mean removing the documentation requirement for the expectation of a stay longer than two midnights and a return to the longstanding practice of relying on a physician's judgment about the inpatient admission supported by the medical record to determine when these stays should be paid for under Part A. The AAMC also welcomes further engagement on broader policies to address the shortcomings of Medicare's current observation stay policy, RAC process, and other payment issues.

The AAMC looks forward to collaborating with CMS and the hospital community to ensure that short hospitalizations are appropriately reimbursed. In the meantime, the AAMC strongly urges CMS to finalize an interim policy that maintains the current presumption that hospital stays expected to exceed two midnights are to be paid under Part A, but return to CMS' previous policy of deferring to clinical judgment for hospital stays lasting fewer than two midnights.

HAC Reduction Program

CMS will implement the HAC Reduction Program for the first time in FY 2015. As this program begins, the AAMC is extremely concerned that CMS' policies for implementing the program disproportionately affect teaching hospitals in two ways. First, the HAC program is the only performance program where penalties could apply to add-on payments as well as base diagnoses-related group (DRG) payments. Second, the current measure scoring methodology disproportionately identifies teaching hospitals as poor performers, which may be because of technical issues related to measurement rather than true differences in quality. The AAMC urges CMS to use the Agency's administrative authority to ensure teaching hospital performance is appropriately measured and not disproportionately impacted. In particular, the AAMC requests that CMS use its administrative authority under section 1886(d)(5)(I)(i) of the Social Security Act to limit the HAC penalty to base operating DRG payments only, at least for a transition period. In addition, the AAMC asks CMS to consider hospital comparisons within peer cohorts to remove any systematic bias that could affect comparisons across different hospital provider types.

Our comments below focus on the following areas:

- ACA Price Transparency Requirements (pg. 49)
- Cost Reporting and Appeals Regulations (pg. 49-50)
- Outlier Payments (pg. 50-52)
- Medicare Disproportionate Share Hospital (DSH) Payments (pg. 52-57)
- Updates to the Reasonable Compensation Equivalent (RCE) limits on Compensation for Physician Services Provided in Providers (pg. 57-58)
- Survey, Certification, and Enforcement Procedures for Transplant Centers (pg. 58)