Emergency Department EDPMA Practice Management Association

June 16, 2016

Andrew M. Slavitt
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1655-P
P.O. Box 8011
Baltimore, MD 21244-1850

RE: RIN 0938-AS77; CMS-1655-P; Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long- Term Care Hospital Prospective Payment System and Proposed Policy Changes and Fiscal Year 2017 Rates; Hospital Notification Procedures Applicable to Beneficiaries Receiving Observation Services

Dear Acting Administrator Slavitt:

The Emergency Department Practice Management Association (EDPMA) is one of the nation's largest professional physician trade associations focused on the delivery of high-quality, cost-effective care in the emergency department. EDPMA's membership includes emergency medicine physician groups, as well as billing, coding, and other professional support organizations that assist healthcare providers in our nation's emergency departments. Together, **EDPMA's members deliver (or directly support) health care for about half of the 136 million patients that visit U.S. emergency departments each year**. We work collectively and collaboratively to deliver essential healthcare services, often unmet elsewhere, to an underserved patient population who often has nowhere else to turn.

EDPMA appreciates the opportunity to provide comment on proposed revisions to the hospital inpatient prospective payment system; specifically, provisions related to the recently enacted Notice of Observation Treatment and Implication for Care Eligibility Act (NOTICE Act) and rate adjustment for the two-midnight policy.

Proposed Implementation of the NOTICE Act Provisions

CMS proposes new regulations that would specify a process for hospitals and Critical Access Hospitals (CAHs) to notify an individual, orally and in writing, regarding the individual's receipt of observation services as an outpatient and the implications of receiving such services. Specifically, hospitals and CAHs would be required to furnish notice to such an individual entitled to Medicare benefits if the

individual receives observation services as an outpatient for more than 24 hours. CMS proposes the use of a standardized notice, referred to as the Medicare Outpatient Observation Notice (MOON), to be used by all applicable hospitals and CAHs.

While emergency department physicians are not directly required to provide the notice as mandated under this proposal, they will be expected to understand the regulations and answer questions from beneficiaries they are treating.

To that end, we have reviewed the draft MOON and offer the following comments:

- Explanation of the beneficiary's circumstance that necessitates "observation": The draft MOON does not provide a place for the hospital to provide a detailed explanation to the beneficiary for why s/he is being consider an outpatient, which many of today's more astute beneficiaries are likely to question. We support providing beneficiaries an explanation for why their stay has been deemed "observation," particularly given the financial consequences that result from that status.
- 3-day stay waivers: The draft MOON does not consider patients who are part of certain Medicare Accountable Care Organizations (ACO), such as Pioneer and Next Generation, where the 3-day stay requirement prior to a skilled nursing facility (SNF) admission may have been waived. CMS should make clear that in these situations that it is not necessary to include information related to the SNF eligibility implications of outpatient status where the 3-day SNF requirement has been waived.
- Potential Cost Implications: The draft MOON should advise the beneficiary that there are potential cost implications associated with observations status that may not otherwise occur had the beneficiary been admitted directly to the hospital as an inpatient under the traditional sense of the word.

IPPS Rate Adjustments for Two Midnight Policy

CMS is proposing to permanently remove the -0.2 percent adjustment it implemented in the FY 2014 IPPS/LTCH PPS final rule (and its effects for FYs 2014, 2015, and 2016) to account for an estimated increase in Medicare expenditures due to the Two Midnight Policy. CMS is proposing to accomplish this by increasing FY 2017 payment rates by 0.8 percent.

EDPMA supports CMS' proposal to permanently remove the Two Midnight payment adjustment, yet we are disappointed that CMS has not addressed the underlying Two Midnight rule, a policy that is arbitrary, undermines the judgment of physicians, and creates administrative and financial burden for hospitals.

In its 2015 FY IPPS comments, EDPMA provided a list of 10 principles for any short stay payment methodology, given it was our understanding that the two-midnight policy, which was first implemented in October 2013, was only intended to serve as an interim measure as CMS developed a more permanent policy toward addressing short hospital stays.

Physicians in the Emergency Department frequently deliver patient care at a level of intensity similar to hospital inpatient care provided a decade ago. The typical hospital Emergency Department provides rapid diagnosis, results, and access to specialists. The services provided in an Emergency Department often avert a hospitalization or take the place of an observation stay or an admission. Frequently,

patients cannot obtain these important services from their primary care physician and may not be able to access needed services efficiently in other areas of the health system (or on their own).

As a short-term measure, prior to the adoption of new payment policies for "short stays," CMS should consider adopting an approach geared towards the resource utilization required to address the patient's condition. While elements of time are involved in diagnosis and treatment, the most significant issues are the level of care and resources required to address the patient's illness. Long-term, CMS should consider discontinuing distinctions such as "inpatient" and "outpatient" and consider using more useful distinctions - such as the need for hospital-based care, which should include patient care provided in an inpatient unit, an ICU, a hospital-based "short stay," and care provided in a hospital-based Emergency Department.

Thank you for considering our comments on these important proposals. Please let us know if you have any questions or if we can provider more detail about our recommendations. Should you have any questions, please contact Elizabeth Mundinger, Executive Director of EDPMA, at emundinger@edpma.org if we can be of further assistance.

Sincerely,

Timothy Seay, MD, FACEP
Chairman, EDPMA Board of Directors