Society of Hospital Medicine
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Jennifer Dupee RN, JD, MSN, MBA
Nurse Consultant, Provider Compliance Group
Office of Financial Management
Centers for Medicare & Medicaid Services

Dear Ms. Dupee,

The Society of Hospital Medicine (SHM) would like to thank you and your colleagues for taking the time to discuss issues surrounding the implementation of the Two-Midnight rule for inpatient admissions. SHM represents the more than 40,000 hospitalists currently practicing in the United States who provide care to more hospitalized patients, including Medicare beneficiaries, than any other specialty. Hospitalists are clearly on the front lines when it comes to implementing any changes in admissions criteria.

We understand that CMS' current objective is to make implementation of the Two-Midnight rule as smooth as possible for providers and our hope is that the experience and suggestions from hospitalists will help in achieving this goal. However, we feel that it is important to note that from the hospitalist perspective, CMS is trying to fine-tune a system that is fundamentally flawed. The whole concept of admissions criteria needs to be seriously re-evaluated and possibly restructured from the ground up. As it currently stands, any admissions timeframe chosen will lead to very confusing and medically inappropriate situations for both providers and patients. With that said, our suggestions for the Two-Midnight rule itself are as follows:

Patient Education

- Need to clarify within patient education materials that, in general, intensity of care is not the definitive determining factor, but patient status is determined purely by expected length of stay, which may or may not be mediated by intensity of care needed. Patients should also be made aware that 2 midnight exceptions may occur (loss of attributable transfer midnights, or midnights that may not "count" if there is a delay in care, such as over a weekend).

- CMS needs to educate Medicare recipients so they are aware that asking or demanding to stay in the hospital to meet the 2 midnight benchmark would constitute Medicare fraud. There is currently an appearance that the physician is the arbiter of a patient's ultimate financial burden (inpatient v.

observation), which often puts unnecessary strain on the physician-patient relationship.

The two-midnight rule does not ameliorate this strain placed on the physician-patient relationship and may, in practice, create a perverse set of incentives for both physicians and patients.

Provider Education

- Clarification on how and why ICU care could be considered outpatient. In theory, fewer than two midnights in an ICU will still largely be under observation status, which merits extensive provider education. In general, ICU physicians are not anticipating that the care they deliver could be considered observation/outpatient.

- Clear guidance is needed to cover events where the expected length of stay is longer than two-midnights (inpatient), but unexpectedly resolves in fewer than two midnights. **Although the rule seems to indicate that such patients should retain inpatient status, physicians will face significant pressure to change the inpatient status back to observation.** This will lead to greater administrative burden for providers than the rule intended. For example, the following situations are not uncommon and leave both providers and hospital compliance staff confused about admission status

  1. Patient with HIV/ AIDS and history of CNS toxoplasmosis in the past, presented with headache, nausea, vomiting, and diarrhea. In the ER, he was dehydrated and had multiple brain lesions on his CT. Given the differential, workup needed, and potential severity, any physician would anticipate a >2 midnight stay. Patient is given IV fluids, an LP and MRI, outside records were obtained including previous MRI, and stools are tested. All studies were unremarkable, the MRI was unchanged from previous, and all symptoms resolved on IV fluids, so patient was discharged at about 18 hours, which was <2 midnights.

  2. A 93 year old male with dementia with high c-spine fracture following a fall. Neurosurgeon saw in the ER and thought he probably wouldn't be a surgical candidate, but he needed external spine stabilization and IV pain management lasting longer than 48 hours. In less than 2 midnights, family decided that they want comfort measures only, and his pain was controlled adequately to transfer back to nursing home with hospice care.

Suggestions to Increase Comfort Level With the Audit Process

- Make and publicize some clear guidance for dissemination to auditors. Guidance could include details of how to evaluate expected length of stay and the resulting admissions decision. Provider and hospital comfort level with the rule may increase if they are aware of some of these specific details in advance.

- Publicly release de-identified results of the 'probe and educate' audits as they occur. A broad opportunity to review these reports well before April 1, 2014 would give a clearer picture of what status decisions are being denied and why.

Considerations for the Future

- We ask that CMS reconsider how the rule will impact ICU stays. ICU care at many hospitals still requires an ICU resource level (and thus costs) such as higher RN to patient ratios, different monitoring requirements, respiratory therapy and other protocols that are more cost intensive than for general care. To potentially penalize hospitals for delivering the right level of care for patients in their facility is counterproductive, and needs to be reconsidered.

- There is a widespread and legitimate mistrust of RACs. Simplifying Medicare inpatient status determinations in the face of audits while maintaining provider autonomy was clearly the intent of the two-midnight rule. However, from the clinical perspective these decisions have a degree of subjectivity that is exploitable for second-guessing as often occurs during the RAC process. Regardless of the simplicity of any new admissions rules that CMS issues, they will never function well as long as the existing auditing system is in place. CMS should use regulatory authority to temper the RACs, further limit number of cases RACs can audit, and should institute penalties the RAC must pay to a hospital if an audit is overturned after hospital appeal. While there is currently legislation addressing these issues (H.R. 1250 and S. 1012), CMS should use whatever authority available to address these problems more immediately.

Final Remarks

SHM greatly appreciates the opportunity to work with CMS in helping to facilitate the implementation of the two-midnight rule. Hospitalists are often at the center of inpatient admissions decisions and we hope our experience and perspective will continue to be of assistance to CMS.

Should you have further questions or concerns, please do not hesitate to contact Josh Boswell, Senior Manager of Government Relations at jboswell@hospitalemdicine.org.

Sincerely,

Ronald Greeno, MD, FCCP, MHM
Chair
SHM Public Policy Committee