NATIONAL COALITION ON HEALTH CARE

Working Together for an Affordable Future

January 28, 2015

The Honorable Kevin Brady
Chairman, Sub-Committee on Health
Committee on Ways and Means
United States House of Representatives
Washington, DC 20515

Dear Chairman Brady:

The National Coalition on Health Care (NCHC) commends you for the leadership and commitment to reform the current hospital payment system reflected in your discussion draft of the *Hospital Improvements for Payment (HIP) Act*.

NCHC is a coalition of more than 80 member organizations—representing health care providers, purchasers, payers, and consumers—committed to promoting an affordable, high-quality health system in the United States. As the nation's oldest and most diverse group working to achieve comprehensive health system reform, we recognize the importance of establishing a hospital payment system that can curb rising health care costs and increase efficiency, while at the same time incentivizing improved care.

The two midnight rule established a standard for hospital classification of inpatient vs. observation status based on expected duration of care, where patients whose length of care was expected to extend across two consecutive midnights were to be admitted as inpatients. The standard was intended to address the 88 percent rise from 2006 to 2012 in the number of outpatient observation claims (MedPAC, 2014).[1] This rise was largely attributed to hospitals classifying patient care under observation codes as a safeguard against the threat of not being reimbursed for care, which could occur if Recovery Audit Contractors (RAC) judge that an inpatient admission was not appropriate. The increase in observation services—which are covered under Medicare Part B—has had negative consequences for Medicare beneficiaries, who can incur greater out-of-post expenses and be denied coverage for skilled nursing facility services.

Since its introduction, the two midnight rule has received strong criticism from health care stakeholders and policymakers alike. Providers point out that a two-night stay is an arbitrary standard, given that many of the same procedures and services can be delivered to both inpatients and outpatients. They argue that the rule undermines clinicians' judgment of appropriate length of stay and level of care (AMA/AHA, 2013).[2] From the policymakers' perspective, the two midnight rule creates a financial

[1] http://www.medpac.gov/documents/reports/mar14_ch03.pdf?sfvrsn=0
[2] https://download.ama-assn.org/resources/doc/washington/x-pub/two-midnight-suspension-letter-08nov2013.pdf

disincentive for hospitals to increase their care efficiency, since the payment rates to hospitals are substantially higher for inpatient care as compared to outpatient care (MedPAC, 2014).[3]

Congress' previous decision to delay enforcement of the two midnight rule and CMS' calls for the submission of ideas for improvement underscore the need for a better policy. NCHC supports the *HIP Act*'s repeal of the two midnight rule. As the discussion draft recognizes, the reciprocal relationship between the oversight of the RAC program and hospitals' inpatient/outpatient classifications is equally crucial to reforming the current system. At this time, however, we cannot take a position in support of the proposed Hospital Payment Prospective System. Members of NCHC representing health systems and health professionals have raised substantive concerns regarding the potential for duplication with existing payment systems, and the impact on medical education.

Several other elements of the *HIP Act* would substantially contribute to cost-containment and quality-improvement efforts in our health care system. NCHC supports the inclusion of Rep. Paul Ryan's *Expanding the Availability of Medicare Data Act* (H.R. 4418), which would expand Qualified Entities' access to Medicare data. We view a more flexible, effective Qualified Entity program as essential to broader deployment of consumer transparency tools that provide understandable information about quality and price at the point of care. Additionally, we strongly support the inclusion of Reps. Diane Black and Richard Neal's *Comprehensive Care Payment Innovation Act* (H.R. 3796), which would establish a comprehensive, voluntary bundled payment program. While not appropriate for every diagnosis, episodic bundling can drive down costs and drive up quality for a range of common, high-volume procedures and associated post-acute care. By expanding this proven payment model, Congress can better align Medicare policy with the most innovative payers in the states and private sector.

Overall, it is imperative that hospital payment systems become more consumer- and provider-friendly; hospitals and physicians should not be unnecessarily encumbered in delivering and being reimbursed for care, and patients should not be saddled with extra costs nor unnecessarily denied coverage for supportive health services. NCHC applauds the Committee for the release of this draft legislation during the lame duck session of the former Congress, and hopes that it will spur progress during the 114th Congress. We look forward to working with you to further develop this legislation.

Sincerely,

John Rother
President and CEO,
National Coalition on Health Care

[3] http://www.medpac.gov/documents/comment-letters/medpac-comment-on-cms%27s-acute-and-long-term-care-hospitals-proposed-rule.pdf?sfvrsn=0