The Association of American Medical Colleges (AAMC) welcomes the opportunity to comment on the discussion draft of the *Hospital Improvements for Payment Act of 2014*. We appreciate the Committee’s serious effort to address many significant issues facing the hospital industry and health care community, and we appreciate the Committee’s willingness to seek stakeholder input and incorporate constructive feedback. We look forward to an ongoing conversation about these challenges and the full array of potential legislative solutions.

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 148,800 faculty members, 83,000 medical students, and 115,000 resident physicians.

On behalf of the nation’s medical schools and teaching hospitals, the AAMC would like to offer its full support for the following provisions of the draft *Hospital Improvements for Payment Act of 2014*:

*Repeal of the Two Midnights Payment Reduction*: The AAMC wholeheartedly agrees with the Committee’s conclusion that the impact assumptions made by CMS in assessing the two-midnights policy may have been in error, and supports the Committee’s restoration of the 0.2 percent cut to the IPPS baseline implemented in the 2014 IPPS final rule. The repeal of this payment cut is an essential step in the effort to address the failures of the two-midnights policy.

*Extending the Moratorium on RAC Audits of Short Stays*: The AAMC supports both the six-month extension of the RAC audit moratorium and the further extension of the moratorium to inpatient “short-term” discharges through fiscal year 2019. The two-midnights policy needs to be repealed and replaced due to challenges associated with implementation, the new obstacles that the policy has created for both providers and patients, and the policy’s failure to address the problems it was designed to correct. To achieve this, a transitional period to repeal and replace the two-midnights policy is necessary and during this transitional period, RACs should not be permitted to audit short-term inpatient discharges.

*Establishing Beneficiary Equity in the Hospital Readmission Program Act*: Reducing readmissions is a key priority for all hospitals and the AAMC is leading efforts to
understand and reduce preventable readmissions in our member institutions. The causes of readmissions are complex, and strong evidence clearly links low socioeconomic status to higher rates of readmission. Socioeconomic status is associated with access to primary and mental health care, familial and social support networks, and availability of stable housing and nutrition – all of which affect adherence to care regimens, health outcomes, and thus the possible need to be readmitted to the hospital.

Because the current Hospital Readmission Reduction Program (HRRP) does not account for the socioeconomic status of patients served, hospitals serving the most vulnerable are dramatically more likely to incur the greatest penalties, and are the least likely to avoid penalties altogether. This means that for reasons largely beyond their control, hospitals treating the poorest patients have even fewer resources to dedicate to care coordination efforts aimed at preventing those readmissions that are avoidable.

We believe the Establishing Beneficiary Equity in the Hospital Readmission Program Act, as included in the Committee’s discussion draft, requiring that CMS adjust hospital performance in the HRRP according to the hospital’s proportion of patients who are dually-eligible for Medicare and Medicaid will help to level the playing field and is an essential improvement to the HRRP.

Creation of a Permanent Bundled Payment Program: Academic medical centers around the country are participating in episode-based payment models that drive efficiency, coordination, and quality. The AAMC has been designated as a facilitator-convener in the Center for Medicare and Medicaid Innovation’s Bundled Payment for Care Improvement (BPCI) program, and in this role has been a national leader since the program’s inception almost three years ago. We are now working with 30 academic medical centers undertaking this work. Our learnings from this program have been rich and encouraging, and we support a permanent and national bundled payment program. The AAMC looks forward to offering more technical feedback on the Comprehensive Care Payment Innovation Act to incorporate best practices identified by our work in the BPCI program and better integrate BPCI into a comprehensive alternative payment program.

Policy Principles for Short Hospital Stays
The AAMC commends the Committee for considering the complex issue of relatively brief inpatient admissions and relatively lengthy observation stays. Short-stay hospitalizations have been the frequent target of RAC audits and are the focus of CMS’s controversial two-midnights policy, both of which are vexing to academic medical centers, whose highly trained clinicians serve the most complex patients and those with unique individual needs. Though these issues demand resolution, the AAMC cautions against the creation of an entirely new payment system for short hospital stays, which would permanently alter the DRG system. Instead we support the
following principles:

- **Commitment to Medical Judgment**: Individual health circumstances – comorbidities, frailty, acute onset of symptoms, or key risk factors – must be the basis for clinical decision-making, including the decision to admit a patient to the hospital for an inpatient stay. Though we encourage the study of outliers and anomalies to better inform provider judgment, we firmly believe that a doctor’s assessment of medical necessity is the only reasonable standard for inpatient admission – not an arbitrary time-based cut-off.

- **Support for a Balanced DRG System**: Hospital payments are organized by diagnosis-related groups (DRGs) that set pre-determined reimbursements for different conditions, adjusted by severity. Setting rates based on diagnosis, rather than case-specific resource use, relies on a system of averages: some cases will be more resource intensive, some less, some cases will be longer, some shorter. Any policy to address improper hospitalizations must be carefully evaluated and crafted to ensure that it does not penalize efficiency or disrupt the balance that underlies the entire system.

- **Maintenance of Essential Policy-Based Payments**: AAMC member institutions are dedicated to core social missions, in addition to providing the highest quality clinical care. These missions include serving the uninsured, maintaining costly trauma centers and burn units, infectious disease readiness, conducting ground-breaking research, and training the next generation of medical professionals. Our hospitals’ commitment to meeting these community needs does not diminish simply because of arbitrary decisions that only some hospital care will be reimbursed as “inpatient,” and neither do the costs these hospitals incur to keep training programs running, their doors open to all comers, and their lifesaving research underway. The AAMC firmly asserts that any thoughtful reimbursement reform regarding length of stay must not jeopardize add-on payments for indirect medical education (IME) and disproportionate share (DSH) payments, or calculations of Direct Graduate Medical Education (DGME) payments or redistribute these payments to providers not demonstrably committed to these missions. These funding streams were established by Congress to support specific missions that remain national priorities.

- **Recognition of Site of Service Differences**: Inpatient hospital settings differ dramatically from outpatient settings in several distinct ways. Only a limited set of treatments and procedures could reasonably be conducted in either setting, and even these depend on the clinical condition of the patient. Each setting has its own role on the spectrum of patient care, as well as its own staffing requirements, emergency readiness standards, and overhead costs. The AAMC enthusiastically supports delivering the right care, in the right place, at the right time – and we also recognize that inpatient wards and outpatient
offices are two distinctly different places that are understandably reimbursed in different ways.

At this time, we do not believe a new short stay policy is necessary and believe that modest reforms to existing hospital payment and oversight can accomplish the goal of more consistent payment while staying true to these principles. Were a new payment system to be developed, we would urge a period of robust stakeholder collaboration, adherence to the principles outlined above, and an independent impact analysis before the enactment of such sweeping legislation.

*Establishment of a Site-Neutral Prospective Payment System*

The AAMC’s most serious concerns with the Committee’s discussion draft are with policies that diverge from the principles described in the previous section. In particular these include:

- **Unprecedented Removal of IME/DSH Funding**: The AAMC is alarmed that the Committee’s discussion draft proposes to cut DSH and IME payments from hospital reimbursements for those stays newly designated as ‘short’ and redistribute this funding into the new HPPS base rate. This will mean that IME and DSH funding will be significantly reduced and redistributed to providers that are not committed to training residents, providing specialized services, or to treating a large proportion of low-income patients. The current two-midnights policy has already delivered an unsustainable blow to the community missions undertaken by academic medical centers, particularly training and serving the uninsured. For all teaching hospitals, add-on payments account for 19 percent of all Medicare payments for short stays, and among Council of Teaching Hospitals institutions it is 26 percent. The discussion draft’s expanded definition of hospitalizations would inappropriately place these resources at further risk and jeopardize teaching hospitals’ ability to continue providing high-quality care.

We find the proposed cut to DSH and IME payments particularly egregious because the Committee’s draft treats short-stay hospitalizations as Part A inpatient expenditures for all other significant purposes, including readmission and HAC penalties and the determination of beneficiary cost-sharing. These designations make clear that the Committee joins the AAMC in viewing these stays as inpatient hospitalizations, yet the draft proposes to inappropriately remove IME and DSH funding from the hospitals delivering valuable community services in favor of other funding priorities. That the discussion draft would propose to redistribute these vital funds across all hospitals -- irrespective of their roles in training new clinicians, emergency preparedness, or delivery of uncompensated care – does not recognize the unique role academic medical centers play in supporting these essential missions for their entire communities, and the dire need for public funding of community benefits that have no other sustainable business case. As is current practice, these funds should be directed toward entities that are clearly fulfilling
the mission and purpose of the add-on payments. The AAMC strongly opposes redistributing funds to other, non-teaching entities that are not accredited or prepared to fulfill these roles and believes this policy could negatively impact patient care across the nation.

- **Expansion of “Inpatient Short-Term Hospital Stay” Definition:** The AAMC remains concerned about policies that elevate time-based standards over clinical judgment in determining the appropriate setting for patient care. The discussion draft exacerbates this dynamic beyond CMS’s already problematic policy by lengthening the ‘short stay’ requirement from two midnights to three days and by removing the exception for a physician’s expectation that a hospital stay would be lengthier. Further, the discussion draft categorizes a hospital stay longer than three days as ‘short-term’ if its DRG has historically had an average length of fewer than three days. This provision does not account for patients that develop complications or are more complex than average, which will disproportionately affect teaching hospitals. It also runs directly counter to the way the DRG system was designed, and the understanding that care will vary based on patient complexity.

- **Unpredictable Cuts to Healthcare Financing:** The offsets described to finance the new prospective payment system are large and unpredictable cuts from the IPPS and OPPS payment systems upon which thousands of providers, including nearly all hospitals, rely. There is insufficient detail in the Committee’s discussion draft for us to determine the initial impact of this cut on academic medical centers, but our largest concern is around the ongoing year-to-year unpredictability of this offset that would wreak havoc on hospital financial planning and sustainability.

- **Per-Diem Payment Rate for Short Lengths of Stay:** The AAMC again expresses strong concern regarding policies that undermine the balance of the DRG system itself such as the discussion draft’s proposal to reimburse stays longer than three days but shorter than the DRG’s average length of stay on a reduced per-diem basis. The per-diem approach to short lengths of stay also inherently skews the average lengths of stay to which the Committee’s own proposal is tied. We believe this is prohibitively complex to implement, unsustainable, undermines efficiency and technological advancements, and incentivizes hospitals to retain patients in the hospital for longer than their conditions require.

- **Duplicative Claims Submission:** The AAMC opposes the proposal to require hospitals to submit every claim for a short stay as both an inpatient and an outpatient claim in FY 2016, and that failure to do so will result in a payment reduction of 10 percent. Submitting dual claims is extremely burdensome, and for hospitals to implement this
requirement in time for FY 2016 will require huge investments in IT systems and personnel training, diverting staff and money from more pressing needs.

We would like to re-emphasize that the effects of the Committee’s discussion draft would extend well beyond its stated focus on short hospital stays, and would instead upend the entire DRG system that currently governs hospital payment across both public and private sectors. This would lead to dramatic upheaval, significant cost increases, and would require further legislation to address these extensive unintended consequences.

**Improvements to the Recovery Audit Contractor (RAC) Program**

Despite being charged with ensuring the accuracy of Medicare payments, RACs do not have a strong record of finding legitimate errors in hospital claims. According to a report from the Department of Health and Human Services’ (HHS) Office of Inspector General, 72 percent of RAC denials that were appealed were overturned in favor of the hospital. In fact, some hospitals have appeal success rates above 95 percent. But these appeals are lengthy and costly, and they occupy precious resources that are better devoted to patient care. Additionally, Medicare beneficiaries are hurt when their inpatient stays are inaccurately denied by RACs, resulting in higher out-of-pocket expenses and, in some instances, bills that otherwise would have been covered by Medicare.

Given this deeply broken system, America’s academic medical centers welcome any alleviation of the burdens currently created by RACs. For this reason, we support the Committee’s proposals to shorten the look-back period for RAC review from four years to three, to place limits on “additional documentation requests” that mire hospitals in paperwork, and to establish a discussion period for providers to communicate with the RACs before a collection is initiated. These are all useful reforms.

The AAMC also urges the Committee to undertake more robust RAC reforms that address the underlying incentives that perpetuate overzealous auditing. Presently, RACs retain a percentage of every claim they deny, but face no penalty for erroneous or spurious claim denials. The RACs should be held financially accountable for errors and indiscriminate auditing. They should also be directed to use data mining techniques to recognize outliers and direct their audits there. We look forward to working with the Committee to strengthen its proposals for fundamental RAC reform.

**Hospital Assessment Data**

As with this opportunity to comment on a discussion draft, the AAMC appreciated the chance to provide feedback on an early draft of what would later become the *Improving Medicare Post-Acute Care Transformation (IMPACT) Act of 2014*. The AAMC was ultimately supportive of that legislation and looks forward to working with the post-acute care community to implement
its quality improvement provisions. During that collaborative process between the Committee and stakeholders, the AAMC raised serious concerns about the proposed requirement for hospitals to collect functional status assessment data on every Medicare patient. We are disappointed to see this significant regulatory burden reappear in the draft of the *Hospital Improvements for Payment Act*.

As we previously discussed, the reporting burden introduced by this new data collection is significant and will require extensive financial and human resources. This is not simply a matter of reporting information already gathered, but new data collection that can only be gathered by trained clinicians qualified to conduct mental health assessments, which very few hospitals have in sufficient volume to assess every patient.

We oppose the implementation of this new assessment requirement, but were it to be pursued we refer the Committee to our technical feedback submitted on May 12, 2014 to mitigate the imposed burden. Further, we are alarmed at the inclusion of a 2 percent penalty for failure to immediately report on these extensive new measures. Collection of this detailed data by trained clinicians will demand a reallocation of resources away from patient care and towards administrative work, which is difficult – if not impossible – for a hospital to achieve quickly and seamlessly.

**Cost Information on Hospital Payments**

The AAMC understands and shares the Committee’s interest in providing reliable information to patients about the costs of their health care. In survey after survey, patients express that understanding their own financial obligations for care is what they hope to gain out of price transparency efforts. Academic medical centers want that for our patients too – it strengthens the trust in the doctor-patient relationship, helps us create care plans patients can adhere to, and reduces the likelihood of bad debt.

Although the Committee’s draft proposes that data on hospital collections be displayed in language the typical consumer can understand, we believe this type of data to be of little use to patients concerned about out-of-pocket costs and comparing the relative value of providers. Gross hospital collections by patient insurance status, DRG, and zip code will mask differences in patient complexity, and will cloud the patient’s obligation with the amounts paid by insurers in a wide array of contractual arrangements. This partial data will leave out payments made to physicians, will not illuminate patient cost-sharing agreements with insurers, and will not compare the value associated with higher or lower collections.

The AAMC would like to work with the Committee to develop tools to help patients come to a meaningful understanding of their likely financial obligations prior to receiving care; as drafted
we believe the current provision implements a significant new reporting burden while falling short of its worthy goal.

Conclusion
Again, the AAMC is grateful for the opportunity to review and comment upon this discussion draft and we look forward to ongoing discussions with the Committee on these topics. Should the Committee find it useful as the legislation continues to develop, we are always available to provide additional technical feedback or propose legislative text. Please do not hesitate to Len Marquez, AAMC director of government relations, at 202-862-6281 or lmarquez@aamc.org if we can be of further assistance.