

June 3, 2014

Subcommittee on Health
House Ways and Means Committee
1100 Longworth House Office Building
Washington, DC 20515-0001

Dear Members of the Subcommittee on Health:

The Missouri Hospital Association submits the following comments regarding the subcommittee's May 20, 2014, hearing on current hospital issues in the Medicare program.

The two-midnight standard was developed by CMS to bring clarity to the process of determining the need for inpatient or outpatient hospital services. For those cases which meet the two-midnight standard, the standard is clear. However, for those cases in which the patient is not expected to stay over two midnights, CMS' regulatory standards remain murky and generate unnecessary cost and administrative burden. For these cases, hospitals fall back on proprietary indicia of medical necessity such as Milliman or Interqual but find themselves second-guessed by the Medicare Recovery Audit Contractors, whose contingency fee reimbursement system gives them strong incentives to challenge health care provider claims.

The two-midnight standard acknowledges that those services designated as "inpatient-only" under Addendum B of the Medicare outpatient prospective payment system should be exempt from the two-midnight standard. However, the current billing and reimbursement system does not capture the CPT or other data needed to identify whether a particular admission qualifies as an "inpatient-only" course of treatment. Without that data, hospitals and regulators are compelled to return to the costly and subjective practice of compiling and reviewing medical record case files.

Beyond the challenges of addressing designated "inpatient-only" procedures, the Missouri Hospital Association welcomes the opportunity to work with CMS and others to explore the potential of adapting the Medicare payment standards for short-stays to address the issues that gave rise to the two-midnight standard. In applying this short-stay methodology, it is crucial that full weight be given to the medical judgment of the ordering physician. Failing to do so will create a system focused on subjective disputes over medical necessity that will do nothing to improve the complexity and administrative burden of the current system.

Sincerely,



Daniel Landon
Senior Vice President of Governmental Relations

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