June 13, 2016

Regulations Coordinator
Department of Human Services
Office of Medical Assistance Programs
Health and Welfare Building, Room 515
Harrisburg, PA 17120

To the Regulations Coordinator:

I am writing on behalf of the Safety-Net Association of Pennsylvania (SNAP), which represents many of the state's leading private safety-net hospitals, in response to the *Pennsylvania Bulletin* notice "Payment for Observation Services" (46 Pa.B. 2475), published on May 14, 2016.

SNAP has long supported the concept of a Medical Assistance fee-for-service rate for observation services and welcomes the Department of Human Services' (DHS) decision to create such a rate and associated policies. At the same time, however, we have concerns about four aspects of the proposed policy. They are:

1. the proposed observation rate
2. the potential for classification battles between the provider, payer, and auditor over whether a patient should be classified as having a short inpatient stay or an observation visit
3. the manner in which the state proposes financing observation care
4. program integrity issues

We address each of these concerns individually below.

The Proposed Observation Rate

SNAP believes the all-inclusive rate of $974 that DHS has proposed for fee-for-service observation care is too low. We base this conclusion on several considerations.

First, the best frame of reference for a Medicaid observation rate, we believe, is Medicare's observation rate. The Medicare rate – $2174 – is much higher.

Second, while the very creation of an observation status and payment policy suggests recognition that such care goes well beyond the services hospitals provide to ordinary emergency patients, the proposed payment does not reflect this at all. In fact, we fear that in some cases, the new policy could actually result in hospitals receiving less money for providing more care – the care their patients need – because of the all-inclusive nature of a payment that SNAP believes is too low.

Third, SNAP disagrees with the methodology DHS used to set the proposed rate. Notwithstanding the explanation of that methodology in the *Pennsylvania Bulletin*, safety-net hospital leaders tell us that this methodology yielded a rate that it is lower – much lower, on average – than the observation care rates they have negotiated with the HealthChoices managed care organizations whose encounter data were ostensibly the basis for the rate calculation. The hospitals in question are safety-net hospitals located in southeastern Pennsylvania, and they inform us that the all-inclusive rates they receive, on average, from their HealthChoices managed care organizations are generally closer to $2,000, or more than twice the $974 DHS has proposed.

Fourth, SNAP disagrees with the proposal to employ a single, state-wide rate. Such an approach, we believe, does not reflect differences in what HealthChoices managed care organizations are paying for observation services in different parts of the state and differences in the cost of delivering care in different parts of the state. By not reflecting regional variations in the cost of delivering care, a single, state-wide rate would overpay some providers and underpay others. A single, state-wide rate also does not reflect the additional costs teaching hospitals or high-volume Medicaid hospitals incur when caring for patients. Such hospitals can be found throughout the state, but under the proposed system they would be paid no differently than any other hospital despite the higher cost structure associated with teaching programs and caring for large numbers of Medicaid patients that the state has consistently acknowledged over many years in other types of Medicaid payments.

For these reasons, SNAP proposes an alternative approach to observation care rate-setting:

1. Create regional rates based on the HealthChoices zones that reflect the observation rates that hospitals have negotiated with the current HealthChoices managed care organizations in the individual zones. This would account for the cost of delivering care in the individual regions, including the costs associated with the many low-income patients some hospitals serve because those patients are inherently more challenging to treat, and therefore more expensive to treat.

2. Adjust these rates for teaching hospitals. Working in an emergency department is one of the vital, irreplaceable parts of medical education and training new physicians in emergency care unquestionably involves incurring additional costs that have a long and lasting benefit to society in general and to the communities teaching hospitals serve in particular.

Inpatient vs. Outpatient Status

Observation care is an outpatient service but resides in a grey area when there is some question whether an individual requires inpatient admission. SNAP believes payment for outpatient observation services should be introduced in tandem with a short inpatient stay rate for inpatient services that would be reimbursed at the same level as the final observation rate.

Medicare employs a similar observation policy under its payment systems and over the past several years that policy has led to protracted classification battles between providers and RAC auditors over whether cases were appropriately categorized as inpatient or observation. These battles also occur during the claims review process. In most cases, by the time the situation is resolved, the period to re-bill under the alternate status (if necessary) has already elapsed and a provider ends up receiving no payment at all. Additionally, the impact of re-categorizing short inpatient stays as outpatient observation would have payment repercussions beyond the Medicaid program: it would reduce the number of Medicaid inpatient days hospitals report for determining Medicare DSH payments that are made by the federal government, thereby lowering federal payments to Pennsylvania hospitals.

Creating an observation status code under which hospitals can be reimbursed for observation services simultaneously with a short inpatient stay payment equal to the observation rate would enable physicians to code a patient's status as they deem appropriate while reducing the incentives for second guessing the physician's decision. The state of Michigan recently implemented a short stay inpatient payment policy, apparently aimed at addressing these very concerns we described above. Initially Michigan had a policy that was substantially similar to the one DHS is currently proposing. Congress is also considering a similar amendment to Medicare payment policies to address short stays versus observation stays.

The Manner in Which the State Proposes Financing Observation Care

While SNAP appreciates the state's willingness to establish a new payment policy for hospital observation services, we believe it is unfortunate that the state's share of the new policy would be financed entirely by proceeds from Pennsylvania's hospital tax, the Quality Care Assessment.

The overarching objective of the Quality Care Assessment was to address state Medicaid payments that had widely come to be viewed as inadequate for many, many years. Assessment proceeds were never intended as a tool for establishing and underwriting new policies and programs unrelated to addressing inadequate payments, yet under the proposed observation care policy, about one-half of the new observation payments would be funded by hospitals – the same entities providing the care; the other half would be financed by the federal government. Not a single Pennsylvania General Fund dollar would be involved – in fact, the state has not added any new General Fund money to the fee-for-service program since 2008. In no other area of endeavor in state government are providers of services – essentially, vendors – expected to finance their own payments, yet hospitals have taken on that responsibility over the years to help rectify the long-running inadequacy of state payments. Over the past six years (fiscal years 2011 through 2016), hospitals have provided more than $700 million to the state in this manner. In our view, this latest attempt to extract additional funding from hospitals for their own payments is inappropriate and we urge the state to finance observation care with General Fund dollars and not Quality Care Assessment proceeds.

Program Integrity Issues

SNAP is concerned that the proposed observation care policy does not address program integrity issues such as how, and the degree to which, decisions to classify patients under observation care will be reviewed. As a result of this omission, we are not in a position to comment further upon a matter that is potentially of great importance to Pennsylvania's safety-net hospitals. SNAP urges DHS to provide stakeholders with more information about its intentions in this area before it formally implements any new policies.

At the same time, however, we would like to note that introducing an inpatient short-stay policy could reduce the potential impact of these classification issues by allowing hospitals to submit both inpatient and outpatient claims as physicians deem appropriate without a negative financial consequence such as losing the ability to bill for services and receive payment. This would enable program integrity measures to continue without significantly increasing the stakes of those decisions.

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The Safety-Net Association of Pennsylvania appreciates your consideration of our suggestions and welcomes any questions you may have about the views we have expressed or their underlying rationale.

If you have any questions about the issues we've raised in our comment letter please contact us at (717) 234-6970.

Sincerely,

Michael C. Lane
Executive Director