AMA
AMERICAN MEDICAL ASSOCIATION

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September 11, 2017

The Honorable Seema Verma
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

Re: Medicare Program: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs Proposed Rule for CY 2018 (CMS-1678-P)

Dear Administrator Verma:

On behalf of the physician and medical student members of the American Medical Association (AMA), I am pleased to offer our comments to the Centers for Medicare & Medicaid Services (CMS) regarding the proposed rule for calendar year (CY) 2018 for the Medicare Hospital Outpatient Prospective Payment System (OPPS) and Ambulatory Surgical Center (ASC) Payment Systems, published in the *Federal Register* on July 20, 2017. A number of the policies in this rule take steps to address issues of long-standing concern to the AMA. Specifically, the AMA supports:

- CMS' proposal to delay the implementation of the Outpatient and Ambulatory Surgery Consumer Assessment of Healthcare Providers and Systems (OAS CAHPS) survey-based measures.

- CMS' request for information on the role of physician-owned hospitals in the delivery system, whether physician-owned hospitals could play a more prominent role in the health care system and the impact of current requirements of the physician self-referral law on physician-owned hospitals. The AMA believes physician-owned hospitals represent the type of coordinated care that is needed for the future of health care delivery.

- CMS' proposal to expand ASC-covered surgical procedures, which will expand access for patients and increase patients' ability to select the most cost-effective location for the services they receive.

- CMS' proposal to change the Medicare Part B Laboratory Date of Service (DOS) policy. The AMA supports altering the DOS for all molecular pathology tests and strongly urges that the date of DOS should be the date of the final report for all tests.

There are also policies included in this proposed rule that the AMA thinks can be improved or need additional analysis. These include:

- CMS' proposed continuation of long-standing policies that have created and are widening a very large gap between payments in hospital outpatient departments (HOPDs) and ASCs. We appreciate CMS' request for information on ASC payment reform, and believe CMS should increase ASC rates to eliminate this disparity.

- CMS' proposal to pay separately payable, non-pass-through drugs purchased at a discount through the 340B drug pricing program at the Average Sales Price (ASP) minus 22.5 percent rather than ASP plus 4.3 percent. Given the 340B program's focus on low-income patients, it is imperative to ensure that an across-the-board 22.5 percent reduction actually reflects the size of the 340B discount for each 340B covered drug to avoid creating barriers to access should both physician practices and the HOPDs be unable to cover actual acquisition costs.

- CMS' request for information on how to reduce payment disparities between inpatient and outpatient settings. The AMA agrees in principle that payment policy should be site-neutral across different sites of care; however, CMS is limited by statutory provisions in adopting a payment policy to address differentials in payment between Medicare inpatient and outpatient sites of service. In addition, payment systems for inpatient and outpatient services are fundamentally different, with one making a single payment for all services the hospital provides and the other making multiple payments depending on the services being provided.

I. Delay of Outpatient and Ambulatory Surgery Consumer Assessment of Healthcare Providers and Systems Survey-Based Measures

The AMA supports CMS' proposal to delay the implementation of OAS CAHPS survey-based measures, which assess patients' experience with care following a procedure or surgery in an HOPD. In this proposed rule, CMS states that it plans to delay OAS CAHPS survey-based measures in the calendar year 2020 payment period and beyond, until further action in future rulemaking. The agency notes it lacks operational and implementation data necessary to incorporate the measures.

The AMA has repeatedly expressed our concerns regarding patient experience of care surveys, and we opposed CMS' proposal in the 2017 proposed rule to add five new survey-based OAS CAHPS measures starting in 2018. We noted our concerns that the survey is too long—asking patients to answer 37 questions following an ASC or HOPD procedure. Furthermore, we noted that requiring each facility to collect at least 300 completed surveys is unnecessary and disadvantages low-volume facilities. Specifically, we had concerns that collecting 300 surveys over each 12-month reporting period would be extremely difficult for small facilities. Therefore, we support CMS' decision to delay the implementation of the OAS CAHPS survey-based measures. The Hospital Consumer Assessment Healthcare Providers and Systems survey for hospitals was introduced gradually, and we urge CMS to do the same for HOPDs and ASCs.

II. Request for Information on Physician-Owned Hospitals

The AMA appreciates the opportunity to provide comments on physician-owned hospitals. We believe physician-owned hospitals provide quality care to patients and needed competition to the health care industry. The AMA supports competition between and among health care providers and facilities as a means of promoting the delivery of high quality, cost-effective health care. Providing patients with more

choices for health care services stimulates innovation and incentivizes improved care, lower costs, and expanded access.

Appropriate Role of Physician-Owned Hospitals in the Delivery System

The AMA believes physician-owned hospitals should be allowed to compete equally with other hospitals in the delivery system. Limiting the role of physician-owned hospitals only reduces access to high quality health care for patients. Physician-owned hospitals are a benefit to patients and their communities and represent the type of coordinated care that is needed for the future of health care delivery. These hospitals provide: tens of thousands of jobs nationally; a local economic engine through property taxes and higher-wage jobs; and patient access to high quality health care. Furthermore, the presence of physician-owned hospitals has not had an impact on the financial viability of surrounding hospitals showing no effect on inpatient volumes, revenues, or profits.

Physician-owned hospitals can also serve the role of adding much-needed competition into the hospital market. Hospitals continue to merge and consolidate. For example, in 2017, four large health system mergers have already occurred.[1] Hospital mergers and consolidation generally results in higher prices. This is true across geographic markets and different data sources. When hospitals merge in already concentrated markets, the price increases can be dramatic, often exceeding 20 percent.[2]

Thus, the appropriate role of physician-owned hospitals includes having these facilities act as a true competitor with other hospitals. Competition forces traditional hospitals to improve and innovate. This benefits patients and the health care system as we work to improve care. In addition, in physician-owned hospitals, physicians—who are fundamentally responsible for the existence of the hospital and the maintenance of its standards—can manage hospital costs through innovation and improved efficiency, which increases value. Physician-owned hospitals already are more likely to have operating rooms that they use more efficiently than traditional hospitals.[3] Physician-owned hospitals are also more engaged in general medical and surgical care than other hospitals.[4] Accordingly, by allowing physician-owned hospitals to compete with other hospitals, the delivery system benefits from increased competition and patient choice.

Current Scope of and Restrictions on Physician-Owned Hospitals Affect Health Care Delivery

CMS also requested information on the current scope of and restrictions on physician-owned hospitals that affect health care delivery. In short, the **restrictions have a negative effect on health care delivery and patient choice**.

The restrictions on physician-owned hospitals have effectively eliminated the formation of new hospitals and additional choices for patients to receive quality care. For example, the restrictions resulted in freezes

[1]Dave Barkholz, *Hospital Mega-Mergers Hit Fast and Furious in Q1*, Modern Healthcare (Apr. 29, 2017), available at http://www.modernhealthcare.com/article/20170429/MAGAZINE/170429835.
[2]Martin Gaynor & Robert Town, *The Impact of Hospital Consolidation – Update*, Robert Wood Johnson Foundation (June 2012) available at http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2012/rwjf73261.
[3]Elizabeth Plummer & William Wempe, *The Affordable Care Act's Effects on the Formation, Expansion, and Operation of Physician-Owned Hospitals*, Health Affairs 35, no. 8 (2016) available at http://content.healthaffairs.org/content/35/8/1452.full.pdf+html.
[4]*Id.*

on the construction and expansion of 45 partially completed physician-owned hospitals.[5] In Texas, 13 physician-owned hospitals were formed after enactment of the Affordable Care Act (ACA); however because of the restrictions, they did not accept any Medicare or Medicaid patients.[6] Currently, all of these physician-owned hospitals have either been sold or are part of bankruptcy filings.

The restrictions on physician-owned hospitals are without merit and have no valid justifications. Physician-owned hospitals provide better or same quality care at the same costs as other hospitals and do not cherry pick or lemon drop patients.

Quality and Cost

The AMA disagrees with critics who contend that physician-owned hospitals provide lower value care as compared to traditional hospitals. Several studies have shown high levels of quality care and patient satisfaction in physician-owned hospitals. Recently, the *British Medical Journal* found that physician-owned hospitals performed comparably with other hospitals on both disease specific and composite measures of mortality, congestive heart failure, readmissions for myocardial infarction, and pneumonia. Furthermore, physician-owned hospitals had similar costs and payments for episodes of care for these services. Studies have also shown that these hospitals provide more net community benefits through uncompensated care and taxes than not-for-profit competitors as a share of total revenues.

High Risk Beneficiaries

There is no evidence that physician-owned hospitals treat fewer high risk beneficiaries. In fact, a comprehensive, peer-reviewed study of all physician-owned hospitals in the United States published in the *British Medical Journal*, found that physician-owned hospitals see the same patients as hospitals without physician ownership and are not leaving their competitors with sicker, lower-income patients. The lead author—Daniel Blumenthal, MD, a clinical fellow at Massachusetts General Hospital—said, "By and large, physician-owned hospitals have virtually identical proportions of Medicaid patients and racial minorities and perform very similar to other hospitals in terms of quality of care."[7]

Accordingly, physician-owned hospitals should play an integral role in the delivery system as a true competitor with no restrictions. The inability of physician-owned hospitals to address the growing demand for high quality health care services in their community is bad for our entire health care system and does nothing but penalize patients who should have the right to receive care at the hospital of their choice.

III. Definition of Covered Surgical Procedures

CMS requests feedback on whether surgical services that are described by Category 1 Current Procedural Technology® (CPT®) codes that fall outside of the surgical range (10000 through 69999), or Level II

[5] D M Blumenthal, *Access, quality, and costs of care at physician owned hospitals in the United States: observational study*, British Medical Journal (2015) available at https://doi.org/10.1136/bmj.h4466.
[6] Elizabeth Plummer & William Wempe, *The ACA's Effects on the Formation, Expansion, and Operation of Physician-Owned Hospitals*, Health Affairs 35, no. 8 (2016) available at http://content.healthaffairs.org/content/35/8/1452.full.pdf+html.
[7] D M Blumenthal, *Access, quality, and costs of care at physician owned hospitals in the United States: observational study*, British Medical Journal (2015) available at https://doi.org/10.1136/bmj.h4466.

Healthcare Common Procedure Coding System codes or Category III CPT codes that do not directly crosswalk and are not clinically similar to procedures in the CPT surgical range, should be covered when furnished in the ASC setting. The invasive cardiology codes and the anesthesia codes are examples of codes where payment and coverage decisions made solely on code numbers can create inconsistencies between the ASC setting and the inpatient setting.

The AMA/Specialty Society RVS Update Committee utilized a specialty society review process to identify surgical codes outside the 10000-69999 range of CPT (for example, invasive cardiology codes in the 90000 section of CPT). CMS has utilized this list in the development of professional liability insurance (PLI) relative values for years. The complete list may be found on the CMS website.

The AMA supports policy changes that move toward site neutral payments, and expand coverage and access to patients. **Accordingly, we support expanding ASC coverage beyond the surgical range and changing the definition of ASC covered surgical procedures as needed.**

IV. Potential Revisions to the Medicare Part B Laboratory Date of Service (DOS) Policy

CMS proposes to change the Medicare Part B Laboratory DOS. The AMA, along with other stakeholders, believes that molecular pathology testing has rapidly evolved over the past five years. Previously, molecular pathology testing was used for prognosis as part of standard diagnostic procedures and services. As such, it was appropriate for such services to be a part of the OPPS packaging policy. However, now molecular testing is performed as a separate set of services in the targeting of treatment and the OPPS packaging does not account for these additional services.

Furthermore, as molecular pathology continues to rapidly evolve, it is not reasonable to expect the OPPS packaging policy to keep pace in the foreseeable future. **Therefore, it is more appropriate that all laboratories performing molecular pathology testing bill Medicare directly.** The AMA does not support limiting this policy to advanced diagnostic laboratory test (ADLT) services as there is no rational basis to distinguish between ADLTs and other molecular pathology test services as the same patterns of practice apply to both. **The AMA also supports providing a bright line rule to eliminate ambiguity as to the DOS and urges that CMS utilize the date of final report.**

V. ASC Payment Update

CMS requests comments on ASC payment reform. Specifically, the agency requests feedback on potential reforms to the current payment system including the rate update factor applied to ASC payments and other ideas to improve payment accuracy for ASCs. In this rule, however, CMS proposes to continue its policy of updating the ASC conversion factor by a measure of inflation in the Consumer Price Index for all Urban Consumers (CPI-U), while updating the OPPS conversion factor with the hospital market basket (HMB) index. **The AMA believes that CMS should use the inpatient HMB index to update the ASC conversion factor to create greater parity among payments for similar services in different sites of care.**

Fair and Adequate Reimbursement for ASCs

The AMA fully supports the ability of physicians to select the most appropriate site of service for their patients, in consultation with patients and families, for surgical procedures as well as other services. To

ensure the ability of physicians to select the most appropriate site for their patients, we believe CMS should increase ASC payments to level the playing field between HOPDs and ASCs. There are similar costs for delivering similar care in HOPDs and ASCs. Therefore, as the AMA has stated in prior comments, CMS should use the same index to update the conversion factor for both ASCs and HOPDs.

In this rule, CMS proposes to continue its policy of updating the ASC conversion factor by a measure of inflation in the CPI-U. We believe that CMS should instead use the inpatient HMB index to annually update ASC payment rates. The CPI-U is not suitable for updating ASC payments because it measures changes in the prices of consumer goods, only a very small portion of which are related to health care, and is therefore flawed for the purposes of the ASC payment system. The ASC payment system is also among the last to continue to be tied to the CPI-U, along with the fee schedules for ambulances, clinical labs, and durable medical equipment.

The HMB, on the other hand, is an available proxy for ASC costs and is superior to the use of the CPI-U. The HMB includes data reflecting the cost of items and services necessary to furnish outpatient surgical procedures, so it is a more appropriate adjustment factor than the CPI-U. The HMB is also used to update the OPPS payment rates. Because the OPPS cost structure looks much like the cost structure of ASCs, if the HMB is appropriate for updating OPPS payment rates, then it is also appropriate for updating ASC payments. The HMB index is used for updating Medicare payments for hospice and inpatient hospitals, in addition to the hospital OPPS. We therefore urge CMS to adopt the HMB instead of the CPI-U to update ASC payment rates for inflation.

Since the OPPS update is based on the HMB, this would reduce some of the widening disparity between HOPD and ASC rates and create a more level playing field. We also urge CMS to use the same wage index values for hospitals and ASCs. This disparity creates a considerable financial incentive to perform these procedures in hospital settings, whereas for many patients, the ASC is the more appropriate setting to receive care. Higher reimbursement for HOPD procedures also increases aggregate costs for the Medicare program.

VI. Payment for Drugs and Biologicals ("Drugs") Purchased with a 340B Program Discount

The AMA shares the Administration's interest in addressing the rising cost of drugs and biologicals which will continue to negatively impact patient access and impose an unsustainable burden on the health care system, if new policies are not implemented. The AMA also appreciates that CMS is proposing to address a long-standing concern that the current payment policy for Part B drugs[8] creates strong incentives to move Medicare beneficiary care from lower cost sites of care (physician offices) to higher cost sites of care (hospital outpatient departments).

Because the ASP includes payments that are heavily discounted to reflect volume, prompt pay and other such adjustments, it does not reflect the true prices paid by many physician practices with relatively low-volume purchases. Even with the current ASP add-on, Medicare reimbursement may not cover actual costs, especially for practices that face high wholesaler fees or state and local drug taxes. This general problem is exacerbated by other issues such as drug compounding regulations and other potential new

[8] Drugs paid under Medicare Part B generally fall into three categories: (1) drugs furnished incident to a physician's service in the office or HOPD; (2) drugs administered via a covered item of durable medical equipment; and (3) other categories of drugs explicitly identified in the law.

safety-related rules that reduce drug availability and/or increase cost of drug storage and administration. The latter will also impact hospital outpatient departments (HOPDs).

As noted in the rule, the 340B program has enabled certain HOPDs and clinics to purchase drugs at prices far below the rates they are paid by Medicare and other payers. A study by the MedPAC found discounts of at least 22.5 percent. The Office of the Inspector General cited a 33.6 percent average discount. The Government Accountability Office concluded that for 35 drugs, the beneficiary co-payment exceeded the hospital's cost. Not surprisingly, 340B participation has mushroomed and as noted by MedPAC, there are now concerns that drug makers may raise prices to other purchasers to offset reduced prices for 340B drugs.

Even without this potential upward influence on drug prices, it is already the case that many smaller practices have had to refer cancer and other patients who need chemotherapy and other expensive life-saving drugs to HOPDs, thereby undermining continuity of care and creating burdens for frail and medically compromised patients. A study by the Moran Company puts the shift in chemotherapy services for Medicare patients at 30 percent between 2005 and 2011. Data from the Medicare Payment Advisory Commission came to a similar conclusion, specifically noting that Medicare Part B drug expenditures in HOPDs grew at 20 percent a year between 2009 and 2012 compared to 5 percent a year in physician offices. A 2012 study by Avalere concluded that after adjusting for patient risk, commercial insurance companies paid 24 percent more for an average course of chemotherapy in the HOPD than in a physician office. It found that the insurers' cost of chemotherapy in the HOPD exceeds their costs in the office by 42 percent to 67 percent, with the cost of the drug itself coming in at 25 percent to 47 percent higher in the HOPD.

For CY 2018, CMS is proposing to pay separately payable, non-pass-through drugs (other than vaccines) purchased at a discount through the 340B drug pricing program at the ASP minus 22.5 percent rather than ASP plus 4.3 percent.[9] The AMA has noted for numerous years that physician practices have found it challenging to recover the cost of purchasing Part B drugs under the current ASP plus 4.3 percent and their patients have had to instead receive their treatments in HOPDs—which the AMA has strongly advocated must be addressed. Given the 340B program's focus on low-income patients, however, it is imperative to ensure that an across the board 22.5 percent reduction actually reflects the size of the 340B discount for each 340B covered drugs to avoid creating barriers to access should both physician practices and the HOPD's be unable to cover actual acquisition costs. While adding further variables and potential fluctuation into the calculation of payment for Part B drugs is not desirable, it is essential that a bright line policy does not inadvertently deleteriously impact patient access in all sites of care. MedPAC, for example, recommended only a 10 percent reduction in the ASP. Finally, while this policy alters the relative disparity between payments for some HOPDs and physician practices, it still does not address the persistent challenges physician practices face in obtaining payment that covers acquisition costs. We look forward to working with CMS to address this issue.

[9] Due to the budget sequestration legislation that is now law, actual reimbursement for Part B drugs today is ASP+4.3 percent, not ASP+6 percent.

VII. Eliminating Inappropriate Medicare Payment Differentials for Similar Services in the Inpatient and Outpatient Settings

CMS requests comments on options to address the issue of payment differentials between hospital services provided in inpatient and outpatient settings. CMS indicates that "differential may exist because different statutory provisions and different payment methodologies apply. CMS is committed to eliminating inappropriate Medicare payment differentials for similar services in the inpatient and outpatient settings…" CMS further references Medicare Payment Advisory Commission's (MedPAC's) June 2015 Report to Congress where MedPAC stated "the high profitability of one-day stays under the inpatient prospective payment system (IPPS) and the generally lower payment rates for similar care under the OPPS have heightened concern about the appropriateness of inpatient one-day stays." The proposed rule indicates that both hospitals and CMS have had the opportunity to gain experience under the various policy changes that have occurred with respect to short inpatient hospital stays since the last time CMS requested public comment on payment policy options for addressing differentials between inpatient and outpatient payment for the same services in the CY 2016 OPPS/ASC final rule.

In principle, the AMA agrees that payment policy should be site-neutral across different sites of care. However, as pointed out in the rule, in a world of widely divergent payment systems, each with its own set of legislative and regulatory requirements, accurate accounting and comparison of costs across sites can be a very difficult task. And even where differences can be accurately identified, the modifications that would be required to create site-neutral rates may not be possible within the constraints of the current payment systems.

As CMS notes, it has requested comments on "payment policy options" to address this issue in the past. However, it has been unable to find a payment policy option to address its concern about this issue for precisely the reason that CMS states in the proposed rule comment solicitation—differentials exist because of different statutory provisions and different payment methodologies. These statutory provisions affect not only the payment systems under which Medicare makes payment for inpatient and outpatient services but also the benefit structure for Medicare beneficiaries. Medicare beneficiaries are eligible for inpatient hospital benefits under Medicare Part A. The Medicare Part A deductible is $1,316 in 2017. The Part A benefit is structured to provide Medicare beneficiaries with inpatient hospital benefit days during a spell of illness. Under this structure, Medicare beneficiaries receive 60 days of benefits in each spell of illness after paying the Part A deductible. After 60 days, the patient pays coinsurance for an additional 30 days and also has 60 lifetime reserve days under which additional coinsurance is also paid. However, beneficiaries are eligible for outpatient hospital services under Medicare Part B which has a completely different benefit structure not based on benefit days. Beneficiaries pay a Part B deductible of $183 for all of 2017 (not a spell of illness) and 20 percent coinsurance on each service above the outpatient deductible. Further complicating this issue, Medicare beneficiaries are eligible for skilled nursing facility (SNF) care under Medicare Part A after a three-day prior inpatient hospitalization. Time spent as an outpatient does not count towards the three-day prior hospitalization to be eligible for SNF care. From the AMA's perspective, the differential benefit structure for Medicare Part A and Part B would also need to be considered for CMS to address the concern being raised in the proposed rule. Of course, CMS does not have the authority under current law to address the different Medicare benefits for Part A and Part B. Most, if not all, of these complexities could only be addressed through changes in law.

CMS is also limited in its ability to address this issue as inpatient hospital services are required to be paid using the IPPS under section 1886(d) of the Social Security Act. Outpatient hospital services are paid

using the OPPS under section 1833(t) of the Act. These payment systems are very different. IPPS is based on diagnosis and procedure codes and provides hospitals with a single bundled payment from admission to discharge and also will include payment for most preadmission services provided by the hospital. OPPS is based on procedure codes some of which are packaged with a more expensive procedure and not paid separately. The OPPS rate will reflect a weighted average cost for services in the same payment group despite the fact that there may be a very wide cost range among the included services. Under the IPPS, however, payment is based on a diagnosis which may often involve one of the expensive services in the OPPS package but never include other less expensive services. Also, the OPPS, but not the IPPS, will allow for more than a single payment to be made. Care in the Emergency Department can be billed separately under the OPPS system but is bundled into the IPPS system if the patient is admitted.

Further, IPPS is intending to pay for all of the services provided by the hospital including routine costs such as room and board as the patient will generally be staying overnight or for multiple nights. Under the OPPS, except in very limited circumstances (comprehensive APCs), there is no payment for routine services as the patient is intended to be treated and released without requiring an overnight stay. As the patient is receiving room and board as well as ancillary services under the IPPS in most cases, the higher payment for inpatient services than outpatient services is appropriate.

We submit that the patients who are admitted to the hospital for a specific condition or procedure typically are there because they needed more complex and higher cost care than other patients treated for the same condition or procedure in the outpatient department. Examples include patients who had multiple procedures, needed anti-coagulation drugs after surgery, may need treatment due to complications of other care, or came in through the emergency room.

The issue for CMS to address is when it is appropriate to admit the patient versus when the patient can be treated safely on an outpatient basis. CMS' 2-midnight rule addresses this issue but through criteria for when the patient is admitted to the hospital as an inpatient, not through a change in how Medicare pays for inpatient and outpatient services. CMS' initial foray into this policy concerned the AMA because the determination of whether a patient should be admitted or treated on an outpatient basis was determined completely based on the expectation of whether the patient was expected to stay two nights in the hospital. In the AMA's view, this policy interfered with the physician/patient relationship and the physician's obligation to make a determination of how the patient should be treated. A subsequent change to the 2-midnight rule effective in 2016 made improvements to the policy by allowing for physician judgment and discretion to admit patients even when the patient's stay is expected to last less than 2-midnights if, in the physician's judgment, the patient requires care on an inpatient basis. The AMA believes this change was an improvement to the policy but continues to maintain that the decision of whether to admit a patient as an inpatient remains a decision for the patient's physician to make based on the medical condition of the patient and not a time expectation.

In summary, the AMA believes:

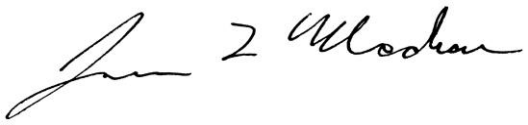
- CMS is limited in adopting a payment policy to address differentials in payment between Medicare inpatient and outpatient by statutory provisions;
- IPPS and OPPS are fundamentally different payment systems with one making a single payment for all services the hospital provides and the other making multiple payments depending the services being provided;

- Payment under the IPPS should be higher as it is paying for room and board which are not costs that are generally expected to be incurred by hospitals under the OPPS;
- While AMA remains concerned about the 2-midnight rule, its purpose is to provide guidance for when patients are appropriately admitted as inpatients and when they can be safely treated as outpatient; and
- The AMA continues to believe that the three-day prior hospital stay required for coverage of SNF care is unnecessary and should be eliminated.

Conclusion

The AMA appreciates the opportunity to provide our comments and thanks CMS for considering our views. If you should have any questions regarding this letter, please feel free to contact Margaret Garikes, Vice President of Federal Affairs, at margaret.garikes@ama-assn.org or 202-789-7409.

Sincerely,



James L. Madara, MD