June 5, 2000

Nancy-Ann Min DeParle, Administrator
Health Care Financing Administration
Department of Health and Human Services
Hubert H. Humphrey Building, Room 309-G
200 Independence Avenue, SW
Washington, DC 20201

Dear Ms. DeParle:

The American College of Physicians–American Society of Internal Medicine (ACP–ASIM), representing 116,000 physicians who specialize in internal medicine and medical students, wishes to express its concerns regarding the Health Care Financing Administration’s (HCFA) forthcoming Operational Policy Letter (OPL) to Medicare+Choice organizations regarding use of hospitalists. This is in follow-up to our letter to Tom Gustafson of your staff, dated February 9, 2000, which provided our comments on the draft OPL entitled “Use of Hospitalist by Medicare+Choice (M+C) Organizations.” A copy of our previous letter is attached.

On May 3, 2000, members of your staff met with a number of healthcare industry representatives to unveil a revised version of the above OPL. In attendance at that meeting was Dr. Paul Gitman, an ACP–ASIM Governor. He informed us that HCFA opted to ignore our key recommendation and that of the National Association of Inpatient Physicians, that the use of hospitalists be entirely voluntary and solely at the discretion of the M+C enrollee in consultation with his/her primary care physician. Unfortunately, the revised OPL clearly leaves the decision of whether the use of hospitalists will be mandatory or not entirely to the discretion of each M+C organization.

This has serious implications for the quality and continuity of patient care. By making use of a hospitalist mandatory, an M+C plan could completely bar an enrollee’s primary care physician from participating in the decision to admit the patient and to care for the patient while in the hospital. This total exclusion of the primary care physician, who likely knows the patient’s condition and needs better than any other practitioner, represents a clear threat to the continuity and quality of care.

We were also disappointed to learn that HCFA has retreated from its position in the draft OPL that would require M+C organizations to limit implementation of hospitalist programs to the beginning of the calendar year, allowing beneficiaries to make an informed choice of M+C plan. Instead, HCFA has now opted to allow M+C plans to implement hospitalist programs at any time throughout the year, which is extremely unfair to enrollees who elected enrollment on the basis of believing their primary care
physicians would manage their inpatient care. Again, this could have a disruptive effect on M+C enrollment and turnover. We would thus vigorously urge HCFA to limit institution of hospitalist programs to the beginning of the calendar year, since it truly represents a change in an M+C plan’s benefit package. Such a policy will be even more critical once HCFA implements a one year lock-in requirement for M+C enrollees.

Whatever final direction HCFA takes on the issue of mandatory hospitalists, we feel it is vital that the following recommendations be addressed to assure the highest level of patient care when hospitalists, even on a voluntary basis, are involved in that care:

1. To make an informed decision on which M+C plan in which to enroll, beneficiaries must be given a clear written explanation of the pros and cons and consequences of having their inpatient care placed completely in the hands of a hospitalist, removing their primary care physician from the process of care. This information can come directly from HCFA, or from M+C plans using hospitalists (subject to HCFA review and approval).

2. The decision to admit a patient for inpatient care on an elective basis should reside solely with the primary care physician, unless the enrollee voluntarily delegates this authority to the hospitalist.

3. Concerning exchange of medically critical information, in cases where an enrollee is under the care of an M+C plan hospitalist:

   (a) The primary care physician will provide the M+C plan hospitalist with all medically critical information pertinent to the patient’s health status, admitting condition, and inpatient care needs; and,

   (b) The M+C plan hospitalist will routinely update the primary care physician on the status of his/her patient, consult with the primary care physician as necessary, and inform the primary care physician when the patient is to be discharged, and discuss what the patient’s continuing care needs will be after discharge.

4. It is vital that HCFA closely monitor the impact of utilizing hospitalists by M+C organizations, relative to quality and continuity of patient care, timely exchange of patient medical information between hospitalist and primary care physician, patient satisfaction, and impact on M+C enrollment/turnover rates.

In summary, ACP–ASIM continues to strongly oppose mandatory hospitalist programs in a managed care setting, and would ask HCFA to issue a final OPL which leaves the decision to use a hospitalist to the Medicare beneficiary and his/her primary care physician, rather than to the discretion of an M+C organization. Whether hospitalist programs are voluntary or mandatory, we believe it is vital HCFA implement the above recommendations to assure the highest level of patient quality, as well as minimize the disruptive impact institution of hospitalist programs could have under Medicare+Choice.
Any questions concerning this correspondence should be referred to Mark Gorden, Senior Associate for Managed Care and Regulatory Affairs, at (202) 261-4544.

Sincerely,

Sandra Adamson Fryhofer, MD, FACP
President

cc: Tom Gustafson, HCFA
    Paul Gitman, MD

Attachment: 2/9/00 Letter to Tom Gustafson