CURRENT HOSPITAL ISSUES IN THE MEDICARE PROGRAM

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES

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CURRENT HOSPITAL ISSUES IN THE MEDICARE PROGRAM

TUESDAY, MAY 20, 2014

U.S. HOUSE OF REPRESENTATIVES,
COMMITTEE ON WAYS AND MEANS,
SUBCOMMITTEE ON HEALTH,
Washington, DC.

The subcommittee met, pursuant to call, at 9:39 a.m., in Room 1100, Longworth House Office Building, the Honorable Kevin Brady [chairman of the subcommittee] presiding.

[The advisory announcing the hearing follows:]

ADVISORY

FROM THE COMMITTEE ON WAYS AND MEANS SUBCOMMITTEE ON HEALTH

FOR IMMEDIATE RELEASE
May 13, 2014
No. HL-12

CONTACT: (202) 225-3625

Chairman Brady Announces Hearing on Current Hospital Issues in the Medicare Program

Emphasis on the Medicare two-midnights policy, short inpatient stays, outpatient observation stays, auditing and appeals

House Ways and Means Health Subcommittee Chairman Kevin Brady (R-TX) today announced that the Subcommittee on Health will hold a hearing on current hospital issues in the Medicare program, with an emphasis on the Centers for Medicare and Medicaid Services (CMS) two-midnights policy, short inpatient stays, outpatient observation stays, auditing and appeals. **The hearing will take place on Tuesday, May 20, 2014, in 1100 Longworth House Office Building, beginning at 9:30 A.M.**

In view of the limited time available to hear from the witnesses, oral testimony at this hearing will be from the invited witnesses only. However, any individual or organization not scheduled for an appearance may submit a written statement for consideration by the Committee and for inclusion in the printed record of the hearing.

BACKGROUND:

On an annual basis, CMS updates Medicare reimbursement for hospitals through two distinct regulatory proposals—the inpatient prospective payment system (IPPS) and the outpatient prospective payment system (OPPS). In the fiscal year 2014 IPPS final regulation, CMS implemented a new policy commonly referred to as "two-midnights." If a Medicare beneficiary is treated in a hospital for a minimum of two-midnights, the hospital stay is deemed "generally reasonable and necessary" as an inpatient stay. However, if a beneficiary is treated for less than two-midnights (so-called short stays), it is not assumed that the inpatient stay is reasonable and necessary.

In part, CMS established the two-midnights standard because "hospital errors are identified more frequently for shorter lengths of stay." The majority of improper hospital payments pertain to these short stays, which CMS believes "are due to inappropriate patient status—that is, the services furnished were reasonable and necessary, but should

have been furnished on a hospital outpatient, rather than hospital inpatient, basis." Under the auspices of CMS' belief regarding the potential "inappropriateness" of billing status, the Recovery Audit Contractors (RACs) have been auditing short stays. Congress authorized CMS to implement the RAC program—first as a pilot in the Medicare Modernization Act in 2003 and later as a full program in the Tax Relief and Health Act in 2006.

Prior to implementation of the two-midnights standard, RACs were denying shorts stays at high rates. Many hospitals assert that these RAC denials were in error and have appealed nearly all RAC short stay denials. In its administration of the first two levels of appeal, CMS has upheld a vast majority of the RAC denials. However, hospitals have found success in achieving reversal of the denials during the third level of appeal—Medicare Administrative Law Judges (ALJs). The influx of hospital cases at the ALJ level is the greatest contributor to the three-year backlog of cases. Beginning on October 1, 2013, CMS placed a moratorium on RAC audits on most hospital claims related to medical necessity in an attempt to stem the backlog of audits and appeals. With the passage of P.L. 113-93, the Protecting Access to Medicare Act of 2014, Congress further codified this moratorium through March 31, 2015, in order to provide more time to find a solution to these issues.

Further exacerbating the problems caused by the implementation and delay of the two-midnight policy, at the beginning of the year, the Obama Administration "temporarily suspended the assignment of most new requests for an ALJ hearing. In just under two years, the [appeals] backlog has grown from pending appeals involving 92,000 claims for services and entitlement to appeals involving over 460,000 claims for services entitlement, and the receipt level of new appeals is continuing to rise."

In addition to major increases in RAC audits and a backlog in Medicare appeals, the utilization of outpatient observation services has also dramatically increased. Some policy experts have connected the increase in observation stays to the unintended consequence of hospitals attempting to avert RAC audits. The Medicare Payment Advisory Commission (MedPAC) has found that observation cases (those with a combination of inpatient status and observation status) increased nearly 60 percent from 2009 to 2012—the period just prior to CMS' implementation of the two-midnights standard. Regarding the growth in observation cases, CMS has stated that the two-midnights policy is meant "to reduce the frequency of extended observation care when it may be inappropriately furnished."

Importantly, short stays are not the only area of concern when addressing RAC audits, appeals and an increase in observation stays. For example, there are a number of durable medical equipment and prosthetic/orthotic cases that are also held up at the ALJ appeal level. Proposals to change the appeals process would likely have an effect on the entire Medicare program and must be carefully considered to ensure a positive outcome for all Medicare stakeholders.

In announcing the hearing, Chairman Brady stated, **"There are a number of problems associated with short hospital stays, and the way hospitals are audited. The Ways and Means Committee fought hard to ensure that patients are getting the care they need, and that Medicare is properly paying hospitals for the care they provide. While we were able to provide some relief last March, it was only a temporary fix. We must work on a permanent solution. We don't want providers unnecessarily looking over their shoulders for auditors. We want hospitals to be accurately reimbursed so that they can focus all of their time on providing the right type of care for patients."**

FOCUS OF THE HEARING:

The hearing will touch on all current issues relevant to hospitals in the Medicare program and specifically focus on the current incentives around short inpatient stays and the unintended consequences of those incentives such as auditing by RACs, a massive backlog of Medicare appeals and excessive growth of outpatient observation stays.

DETAILS FOR SUBMISSION OF WRITTEN COMMENTS:

Please Note: Any person(s) and/or organization(s) wishing to submit for the hearing record must follow the appropriate link on the hearing page of the Committee website and complete the informational forms. From the Committee homepage, http://waysandmeans.house.gov, select "Hearings." Select the hearing for which you would like to submit, and click on the link entitled, "Click here to provide a submission for the record." Once you have followed the online instructions, submit all requested information. ATTACH your submission as a Word document, in compliance with the formatting requirements listed below, **by the close of business on Tuesday, June 3, 2014**. Finally, please note that due to the change in House mail policy, the U.S. Capitol Police will refuse sealed-package deliveries to all House Office Buildings. For questions, or if you encounter technical problems, please call (202) 225-1721 or (202) 225-3625.

FORMATTING REQUIREMENTS:

The Committee relies on electronic submissions for printing the official hearing record. As always, submissions will be included in the record according to the discretion of the Committee. The Committee will not alter the content of your submission, but we reserve the right to format it according to our guidelines. Any submission provided to the Committee by a witness, any supplementary materials submitted for the printed record, and any written comments in response to a request for written comments must conform to the guidelines listed below. Any submission or supplementary item not in compliance with these guidelines will not be printed, but will be maintained in the Committee files for review and use by the Committee.

1. All submissions and supplementary materials must be provided in Word format and MUST NOT exceed a total of 10 pages, including attachments. Witnesses and submitters

are advised that the Committee relies on electronic submissions for printing the official hearing record.

2. Copies of whole documents submitted as exhibit material will not be accepted for printing. Instead, exhibit material should be referenced and quoted or paraphrased. All exhibit material not meeting these specifications will be maintained in the Committee files for review and use by the Committee.

3. All submissions must include a list of all clients, persons and/or organizations on whose behalf the witness appears. A supplemental sheet must accompany each submission listing the name, company, address, telephone, and fax numbers of each witness.

The Committee seeks to make its facilities accessible to persons with disabilities. If you are in need of special accommodations, please call 202-225-1721 or 202-226-3411 TTD/TTY in advance of the event (four business days notice is requested). Questions with regard to special accommodation needs in general (including availability of Committee materials in alternative formats) may be directed to the Committee as noted above.

Note: All Committee advisories and news releases are available on the World Wide Web at http://www.waysandmeans.house.gov/.

Chairman BRADY. Good morning. The subcommittee will come to order. Thank you all for joining us this morning.

In every dollar hospitals spend on inaccurate Medicare audits and appeals, are dollars lost that should have been used to care for seniors. We are here to discuss the problems facing the hospitals today but also to find solutions to bring sense to our Medicare program and improved care for America's seniors. Today's hearing will examine hospital issues including those related to CMS's Two Midnight Policy, as well as audits and appeals. This is a bipartisan concern shared by many different stakeholders, the Medicare program itself, and lawmakers on this committee.

In order to understand why CMS chose to pursue a Two Midnight Policy, we have to first explore the events leading up to the policy. After we review those events in today's hearing, Congress will be able to make an informed judgment about the merits of the policy and potentially pursue alternative solutions.

Our first panel will educate us on the different aspects of inpatient and outpatient payments and services for hospitals. If we want behavior to change and improve outcomes, we need to change the incentives.

Our second panel will feature national experts commenting on how Federal laws affect everyday medical practice. We will be hearing perspectives from across the spectrum of providers, auditors, researchers, and beneficiary advocates. As I have talked to stakeholders about current issues in the Medicare program, the Two Midnight Policy comes up over and over again.

In listening to a variety of different perspectives, I have come to understand the following. There are misaligned incentives in CMS's inpatient and outpatient payment systems, but hospitals are

not doing anything wrong. They are simply responding to the incentives. No matter if the service is inpatient or outpatient, hospital still uses the same equipment and the same medical staff to deliver care. Yet there are two vastly different payment systems, and the systems don't relate to each other in any way. They are based on different coding rubrics, and they pay for different things. And often all this is decided after doctors have provided care.

Take for example, reimbursement for medical education. If the service is billed inpatient, the hospital qualifies for an extra medical education payment. However if the same service is billed to outpatient, the hospital doesn't receive any medical education money. So if you are a large teaching hospital and you could bill under either payment system, why would you ever submit the bill for anything other than inpatient reimbursement. It is all about the underlying incentives.

Now let's examine the next piece of the puzzle, audits. I have heard from hospitals that audits are causing undue burdens. I have here from recovery audit contractors, or RACs as they are known, that they are simply responding to what CMS has defined as improper payments. Their emphasis on short hospital stays is due to, well, you guessed it, the underlying incentives. RACs are able to keep a percentage of any improper overpayments they recoup. Prior to the Two Midnight standard, there were no definitive rules governing which payment system was correct for short stays. I think we can all agree that RACs are an important program integrity tool. They are focusing on a legitimate discrepancy of Medicare payment. They, too, are responding to the incentives.

Although an important tool, auditing also causes unintended behavior changes. We will hear from several of our witnesses today that around the same time the RAC short- stay audits were in full swing, there was also an unprecedented spike in outpatient observation services. Observation is meant to be a temporary tool allowing clinicians to closely monitor patients without using full-blown inpatient hospital resources. However, observation services are now being used as a tool to avoid certain adverse effects, including RAC audits, in some cases avoiding readmission penalties.

The saga continues when we turn to the appeals process. Hospitals disagree with RAC audit denials for short stays. As a result, they appeal the decision. Hospitals have found a high level of success at overturning RAC denials at the Administrative Law Judge, or ALJ level. Same thing, responding to incentives, ALJ equals more likely to have an appeal overturned, so appeal every time. So much activity at the ALJ level has led to an extensive backlog of appeals.

Earlier this year the Obama administration suspended the assignment of new appeals at the ALJ level. Again we see unintended consequences, denying providers their basic due process rights occurring as a result of poor incentives. We intended to have a witness from the Department of Health and Human Services here today to testify on behalf of the Medicare appeals process. Unfortunate Chief L.J. Nancy Griswold was unable to join us, but HHS is committed to briefing the Ways and Means member bipartisan manner on this important topic.

At the conclusion of today's story, lies the heart of the issue, the Two Midnight Policy. In response to the inpatient-outpatient payment predicament, RAC audits, increase in observation stays, and backlog of appeals, CMS took its best shot at a solution, Two Midnight. Today we will hear from all of our witnesses on whether the Two Midnight solution is solving all or any of various problems identified in this tale.

I commend my colleagues on this committee, members on both sides of the aisle who have introduced bills to pursue different alternatives to the Two Midnight Policy. My colleague, Mr. Gerlach, along with original co-sponsors, Mr. Crowley, Mr. Reed, Mr. Roskam, Mr. Kind, have offered a sound proposal for our committee to work from.

Before I recognize Ranking Member Dr. McDermott for the purposes of an opening statement, I ask as always unanimous consent that all members' written statements be included in the record. Without objection, so ordered.

Chairman BRADY. I now recognize ranking member Dr. McDermott for his opening statement.

Mr. MCDERMOTT. Thank you, Mr. Chairman.

This hearing today is really about serving the greater good. When this rule was proposed, the Two Midnight Rule, I submitted on the 22nd of July last year my comments about it, and much of what I thought was going to happen is now here, and we are going to hear about it today; and I am pleased that you are having this hearing.

I would like to enter into the record that letter so that it gets in the record.

Chairman BRADY. Without objection.

[Document not provided]

STATEMENT OF THE HONORABLE JIM MCDERMOTT, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF WASHINGTON

Mr. MCDERMOTT. In recent years hospitals have been asked to do more with less. We have slowed the rate of growth of their payments and asked them to work harder to improve quality and decrease unnecessary readmissions. Furthermore although Congress just delayed yet again the transition to the ICD–10 classification system, hospitals have had to take steps to move to the new system while continuing to implement the meaningful use requirements and participate in delivery system reform efforts.

Many of these activities support the noble goal of improving care for patients that they serve, such as the accountable care organizations and the patient-centered medical home, while reducing long-term costs, but they require up-front capital investments. Hospitals are employing people and providing good and stable benefits for their employees, something other sectors should emulate. Hospitals are doing all of this in the face of a number of regulations and justifiable scrutiny.

The Administration recognizes the sacrifice this sector has put forward. As an example, the Administration has made efforts to reduce the unnecessary regulatory burden. Just this month the Administration released Part 2 of the final rule to reduce unneces-

sary, obsolete, or excessively burdensome regulation on health care providers and suppliers.

I commend CMS for walking a fine line between regulating provider conduct and attempting to make these things easier from a burden standpoint. This is the agency's second foray into the ensuring that regulations make sense and they serve a purpose.

Unlike some of my Republican counterparts, I believe some level of regulation is necessary to ensure that we protect Medicare's finite resources for future generations. I think everyone in this room would agree that protecting Medicare as a bedrock institution of American life, thereby serving the greater good, does require some sacrifice. This necessary sacrifice must be shared and proportional. To that end I am among the first to call for reforms to the Medicare recovery audit contractor audit program, and I mentioned the letter that I put in.

As a result I suggest CMS reconsider the policy in this regard. Now, of course, several stakeholders have raised concerns that the recovery auditor contractors will be overzealous in pursuing recoveries related to this policy. People knew it when it was put in. It is not that I believe that the RAC should disappear. They perform a critical role in protecting taxpayer dollars, but I do believe that the program needs reform from a fairness and equity standpoint, and I am pleased CMS has taken some affirmative steps in this regard.

I have also been among the loudest voices calling for reform of some of the fraud and abuse laws to allow broad participation among providers and suppliers to participate in innovative partnerships that promote care coordination such as gain sharing and other shared saving programs while ensuring programmatic protections under the fraud and abuse laws remain in place.

I have also introduced H.R. 4658, which would make a modification to the civil monetary penalty law to allow providers to more easily participate in care coordination programs. I have also introduced H.R. 3144, the Fairness For Beneficiaries Act, which recognizes that the three-day stay often has negative ramifications for the Medicare beneficiaries and would eliminate that requirement.

Finally, as the author of the self-referral disclosure protocol provision included in the Affordable Care Act, I have been deeply involved with urging CMS to make certain changes to ensure overpayment disclosures made pursuant to the protocol can be settled in a timely and efficient manner.

All in all, hospitals are making shared sacrifices. They are going through a period of unprecedented change. They have demonstrated a willingness to work with us as we move to new delivery system models, and they have taken some financial hits. I appreciate the work that hospitals do but also recognize that giving the improper payment rate on the Medicare fee for service program and the Medicaid programs, they must be subject to some scrutiny by various contractors including the recovery auditors.

I think we would like to ensure that going forward, we will alleviate the regulatory burden where appropriate and ensure that Medicare dollars are being used in a way that sustains the Medicare program for future generations. Hospitals have demonstrated a willingness to work with us as a pursuit of these goals, and I

think that we will hopefully from this hearing today be able to evolve some legislation.

I yield back.

Chairman BRADY. Today, we will hear from witnesses on two panels. Sean Cavanaugh, Deputy Administrator and Director of the Center for Medicare at the Centers for Medicare and Medicaid Services.

Jodie Nudelman, the Deputy Inspector General for Audit Services at the Offices Inspector General of the Department of Health and Human Services.

And on the second panel we will have Amy Deutschendorf, Senior Director of Clinical Resource Management at Johns Hopkins Hospital Health System.

Dr. Ellen Evans, Medical Director of HealthDataInsights. Dr. Ann Sheehy, faculty on behalf of the Society of Hospital Medicine, and Toby Edelman, Senior Policy Attorney, Center for Medicare Advocacy.

Mr. Cavanaugh, congratulations on your new position at the CMS. The Ways and Means Committee is happy to welcome your first congressional testimony in your new role, and Mr. McDermott promises to take it easy on you.

You are now recognized for five minutes.

And I should say both to those testifying and the members today, we have two panels. We are going to be tight on time. We are going to hold real fast to the five-minute rule.

So, Mr. Cavanaugh, welcome.

STATEMENT OF SEAN CAVANAUGH, DEPUTY ADMINISTRATOR AND DIRECTOR, CENTER OF MEDICARE, CENTERS FOR MEDICARE AND MEDICAID SERVICES

Mr. CAVANAUGH. Thank you, Chairman Brady. As you point out, I just became Deputy Administrator at CMS a few weeks ago. However, I point out that I started my career in health care in this committee room working for a member of the Health Subcommittee. I have great memories of working in this room with colleagues from both sides of the aisle to improve the Medicare program, and I have deep respect for the role Congress plays and this subcommittee play in setting Medicare policy and doing appropriate oversight of the operations of the program. So it is an honor to return here today to this committee room representing the agency that administers Medicare.

When a patient arrives at a hospital needing care, one of the critical decisions that physicians or other qualified professionals must make is whether to admit the patient for inpatient care. This decision is often a complex medical judgment taking into account the patient's medical history, comorbidities and other factors. However, as Chairman Brady pointed out, because of statutory requirements, Medicare pays hospitals different rates for inpatient and outpatient services. So the decision about whether to admit a patient has implications for provider reimbursement, for beneficiary cost sharing, and also for post acute care benefits the beneficiary may qualify for.

Two years ago hospitals and other stakeholders were requesting that CMS provide additional clarity regarding the definition of in-

patient care. Hospitals were growing frustrated with the administrative and financial burden incurred when recovery auditors denied a claim for services after care had already been provided. At the same time, CMS was hearing from its contractors that Medicare was reimbursing hospitals for inpatient care that should have been provided in a less costly outpatient setting.

Some hospitals reacted to the scrutiny of auditors by treating more patients on an outpatient basis, often in an observation status. Some observation stays lasted three, four or even more days. This caused problems for beneficiaries because it subjected them sometimes to higher cost sharing under the Medicare Part B benefit, and it also disqualified them from the post acute skilled nursing facility benefit since they weren't accruing the three inpatient days they need for that benefit.

In 2012, we solicited public feedback on possible criteria that could be used to determine when an inpatient admission is reasonable and necessary. We received a large number of responses, but there was not a consensus around any single approach. Last year CMS finalized a proposal that has become known as the Two Midnight Rule. The rule sets a physician expectation based benchmark for when CMS and its contractors will consider inpatient hospital admission and payment appropriate.

CMS, as we crafted that policy, we were seeking to balance several principles that I think many of us share. We wanted criteria that were clear to providers. We wanted criteria that were consistent with good, sound clinical practice and respected physician judgment. We wanted criteria that reflected the beneficiaries' medical needs, and finally, we wanted criteria that were consistent with the efficient delivery of care to protect the trust funds.

In November of last year, CMS announced a probe and educate strategy around the new standard in which the MACs are now conducting prepayment reviews on a sample of short stay inpatient claims from each hospital to determine compliance with the Two Midnight Rule. Claims for inpatient admissions that are not reasonable and necessary are denied, and the MACs work with the hospitals to educate them on this criteria.

As part of this strategy, we also prohibited the recovery auditors from conducting any post-payment reviews of claims for the medical necessity of the inpatient status through March of 2014. We used this opportunity to engage in a dialogue with stakeholders on the Two Midnight Rule. As we began hearing from stakeholders that more time was needed to understand the policy, we extended the probe and educate strategy through September, and Congress subsequently extended it through March 31, 2015. We believe these extensions are allowing hospitals time to fully understand the benchmark and for CMS to learn more about how this policy is being implemented and understood by hospitals.

In fact, preliminary data suggests that as a result of the Two Midnight Rule, the proportion of long outpatient stays is beginning to decline. However, in recognition of the continued calls from stakeholders for additional clarity around short stays, this year CMS is soliciting public input on two related issues.

First, we solicited comment on the advisability of creating a Medicare payment policy for short stay inpatient cases. Specifically

we requested public comment on how to define short stays and how an appropriate payment might be designed. These comments are due to the agency at the end of June.

Second, we reminded the public that we are inviting feedback on creating additional exceptions to the Two Midnight Rule. We look forward to reviewing stakeholders' suggestions on these two subjects. Mr. Chairman, Ranking Member, I look forward to hearing this subcommittee's ideas regarding the Two Midnight Rule and the Recovery Audit Program. CMS is always looking to improve our policies and procedures, so we welcome this opportunity to hear from Congress and stakeholders.

With that I would be happy to take questions.

[The prepared statement of Mr. Cavanaugh follows:]

Statement of Sean Cavanaugh on
Medicare Payment Policy on Short Hospital Stays
House Committee on Ways and Means, Subcommittee on Health
May 20, 2014

Chairman Brady, Ranking Member McDermott, and members of the Subcommittee, thank you for this opportunity to discuss short hospital stay payment policy in the Medicare program. Because of statutory requirements, the Medicare payment rates for inpatient and outpatient hospital stays differ. It is important to recognize that not every patient who receives care in a hospital setting requires inpatient care. Therefore, when a Medicare beneficiary arrives at a hospital in need of medical or surgical care, the physician or other qualified practitioner must decide whether to admit the beneficiary for inpatient care or treat him or her as an outpatient. The inpatient admission decision is often a complex medical judgment. These decisions also have significant implications for provider reimbursement and beneficiary cost sharing.

Through the Recovery Audit program, we identified high rates of error for hospital services rendered in a medically-unnecessary setting (*i.e.*, inpatient rather than outpatient). At the same time, hospitals and other stakeholders have requested additional clarity regarding the definition of 'inpatient,' and expressed concern for beneficiaries experiencing extended outpatient stays, causing confusion about their eligibility for skilled nursing facility services. In 2012, we solicited feedback on possible criteria that could be used to determine when inpatient admission is reasonable and necessary for purposes of payment under Medicare Part A.

In response to this feedback, in 2013, the Centers for Medicare & Medicaid Services (CMS) finalized a proposal addressing Medicare payment policy regarding the benchmark criteria that should be used when determining whether inpatient admission is reasonable and necessary, a policy that has become known as the "two midnight" rule. CMS sought to balance principles that I believe are shared by all stakeholders, including beneficiaries, hospitals, physicians, and the Congress: the need for criteria that are clear, are consistent with sound clinical practice, reflect the beneficiaries' medical needs, respect a physician's judgment, and are consistent with the efficient delivery of care to protect the Trust Funds.

CMS has been conducting extensive outreach and education efforts to hospitals and other stakeholders on this new policy. In November 2013, CMS began a probe and educate strategy whereby Medicare Administrative Contractors (MACs) conducted pre-payment reviews on a sample of short stay inpatient claims from each hospital, for dates of admission between October 1, 2013 and March 31, 2014, to determine compliance with the two midnight rule. Claims for inpatient admissions that were determined not reasonable and necessary pursuant to the two midnight rule were denied, and the MACs provided further education regarding the rule. As part of this strategy, we also prohibited the Recovery Auditors from conducting any post-payment medical necessity inpatient status reviews of claims with dates of admission between October 1, 2013 and March 31, 2014. CMS used this opportunity to engage in a dialogue with stakeholders on the two midnight rule. As we began hearing from stakeholders that more time was needed to understand the policy, we extended the medical review probe and educate strategy through September 30, 2014. The Congress further extended the probe and education strategy and the limitation on the Recovery Auditors through March 31, 2015. We believe these extensions will allow hospitals and other stakeholders time to fully benefit from the probe and educate strategy. However, despite CMS' efforts to educate hospitals and other stakeholders on the two midnight rule, stakeholders have provided feedback that the rule introduced confusion for providers.

Therefore, we recently solicited feedback through a notice of proposed rulemaking published April 30, 2014, on an alternative payment methodology as CMS seeks to address the issue of Medicare payment policy for these short stays. We are interested in public comments on such a payment methodology; specifically, how to define short stays and how a more appropriate payment might be designed. We look forward to working with the Congress and others to find a path forward that achieves our shared goals.

Medicare Program Payment Policy

CMS pays acute-care hospitals (with a few exceptions specified in the law) for inpatient stays under the Hospital Inpatient Prospective Payment System (IPPS) in the Medicare Part A

program. CMS largely sets payment rates prospectively for inpatient stays based on the patient's diagnoses, procedures, and severity of illness. A hospital receives a single payment for the case based on the payment classification—Medicare Severity Diagnosis-Related Group (MS-DRGs) under the IPPS. The IPPS payment includes the operating costs for labor and supplies, and capital costs such as depreciation, rent, and taxes that efficient facilities are expected to incur when furnishing inpatient services. Adjustments or additional payments are made to the IPPS payment for area wage index, teaching hospitals, disproportionate share of low-income patients, hospitals in rural areas, and outliers. Beneficiaries pay an inpatient Part A deductible for each benefit period, $1,216 for 2014.

In contrast, the Hospital Outpatient Prospective Payment System (OPPS) is paid under the Medicare Part B program and is a hybrid of a prospective payment system and a fee schedule, with some payments representing costs packaged into a primary service and other payments representing the cost of a particular item, service, or procedure. Payment amounts vary according to the Ambulatory Payment Classification group to which a service is assigned. Adjustments are made to the OPPS payment for area wage index, outliers, certain cancer hospitals, and certain types of rural hospitals. Generally, OPPS payments reflect the number and type of items and services furnished to a beneficiary during an outpatient stay. Beneficiaries are responsible for the copayments for hospital outpatient services provided, after they meet the Part B deductible.

Roles of the Medicare Administrative Contractors & Recovery Auditors

Compliance with CMS payment rules is monitored primarily through two types of contractors: Medicare Administrative Contractors (MACs) and Recovery Auditors. These contractors work directly with health care providers on behalf of CMS: together, they process Medicare claims, educate providers, and address improper payments. Recovery Auditors primarily identify and correct Medicare improper payments.

Medicare Administrative Contractors

As required under the Medicare Prescription Drug Improvement, and
Modernization Act of 2003, CMS reformed Medicare claims processing and established MACs

as multi-state, regional contractors responsible for administering both Medicare Part A and Medicare Part B claims. CMS relies on a network of MACs to process Medicare claims, and MACs serve as the primary operational contact between the Medicare Fee-For-Service program and approximately 1.5 million health care providers enrolled in the program. MACs enroll health care providers in the Medicare program and educate providers on Medicare billing requirements, in addition to answering provider and complex beneficiary inquiries. Collectively, the MACs and the other Medicare claims administration contractors process nearly 4.9 million Medicare claims each business day, and disburse more than $365 billion annually in program payments. MACs also conduct prepayment and post-payment review on Medicare claims to ensure proper Medicare payments.

Recovery Auditors

The Recovery Audit Program's mission is to identify and correct Medicare improper payments through the efficient detection and collection of overpayments made on claims of health care services provided to Medicare beneficiaries, and the identification of underpayments to providers. CMS uses the vulnerabilities identified by the Recovery Auditors to implement actions that will prevent future improper payments nationwide. Since full implementation in FY 2010 through the first quarter of FY 2014, the Recovery Auditors have returned over $7.4 billion to the Medicare Trust Fund.

Recovery Audit Program Improvements

CMS is currently in the procurement process for the next round of Recovery Audit Program contracts and plans to award these contracts this year. In February 2014, CMS announced a number of changes to the Recovery Audit Program that will take effect with the new contract awards as a result of stakeholder feedback. CMS believes that improvements to the RAC program will result in a more effective and efficient program, including improved accuracy, less provider burden, and more program transparency.

Admission and Medical Review Criteria for Inpatient Services

When a beneficiary arrives at a hospital, the physician must decide whether it is medically reasonable and necessary to admit the beneficiary as a hospital inpatient, or whether to treat the beneficiary as an outpatient. Services furnished to hospital inpatients are generally billed under the IPPS, while services furnished to outpatients are generally billed under the OPPS. Both the decision to keep the beneficiary at the hospital and the expectation of needed duration of the stay are multifactorial decisions, based on such complex medical factors as beneficiary medical history and comorbidities, the severity of signs and symptoms, current medical needs, and the need for prolonged nursing, diagnostic, and treatment services during the time period for which hospitalization is considered.

In some cases, when the physician admits the beneficiary as a hospital inpatient and the hospital provides inpatient care, a Medicare claims review contractor, such as the MACs or the Recovery Auditors, determines that inpatient care was not reasonable and necessary under section 1862(a)(1)(A) of the Act and denies the hospital inpatient claim for payment, or attempts to recover the payment. These reviews necessarily occur after care is furnished and the claim has been submitted, which presents challenges for all parties.

When a MAC or Recovery Auditor determines a payment was made that should not have been—for example, because it was made for an ineligible service—CMS considers the payment to be "improper." The majority of improper payments under Medicare Part A for short-stay inpatient hospital claims have been due to inappropriate patient status (that is, the services furnished were reasonable and necessary, but should have been furnished on a hospital outpatient, rather than hospital inpatient, basis).

These high rates of error for hospital services rendered in inpatient rather than outpatient settings suggested to CMS that greater clarity on the inpatient hospital admission criteria might be useful for stakeholders. Additionally, CMS heard from stakeholders that hospitals appeared to be responding to the financial risk of admitting Medicare beneficiaries for inpatient stays that may later be denied upon contractor review by electing to treat beneficiaries as outpatients receiving observation services, often for extended periods of time, rather than admitting them as hospital

inpatients. This practice created confusion and hardship for beneficiaries, who were liable for additional cost-sharing for post-hospital skilled nursing facility services if their hospital stays did not span three inpatient days. In addition to increased observation utilization, CMS also heard concerns from hospitals about Medicare Part A to Part B rebilling policies when a hospital inpatient claim was denied because the inpatient admission was not medically necessary.

In response to these concerns, CMS solicited stakeholder feedback in the Calendar Year (CY) 2013 OPPS proposed rule on the definition of 'inpatient,' and in the CY 2013 OPPS Final Rule, CMS discussed the stakeholder feedback received on criteria for inpatient services. Stakeholders suggested a variety of ways to determine when a patient is appropriately admitted to the hospital as an inpatient including, among other suggestions: (1) using a measure of time to determine inpatient status; (2) developing criteria-based tools for when a patient should be admitted as an inpatient; and (3) relying on physician judgment. There was no consensus among the public commenters on the best alternative to what was then a combination of physician judgment and an expectation that the patient would stay at least overnight or 24 hours in the hospital.

In the FY 2014 IPPS proposed rule, CMS proposed to establish a new benchmark for purposes of the physician or other qualified non-physician practitioner's decision to order an inpatient admission and asked for public comments on this new benchmark. On August 2, 2013, CMS issued the FY 2014 IPPS Final Rule, which finalized the "two midnight rule." The two midnight rule refined CMS' longstanding policy on how Medicare contractors review inpatient hospital admissions for payment purposes. Under this Final Rule, in addition to services designated as inpatient-only, surgical procedures, diagnostic tests and other treatments are generally appropriate for inpatient hospital admission and payment under Medicare Part A when the physician: (1) expects the beneficiary to require a stay that crosses at least two midnights; and (2) admits the beneficiary to the hospital based upon that expectation.

The Final Rule specifies that the timeframe used in determining the expectation of a stay surpassing two midnights begins when the beneficiary starts receiving services in the hospital. This includes outpatient observation services or services in an emergency department, operating

room or other treatment area. While the Final Rule emphasizes that the time a beneficiary spends as an outpatient before the formal inpatient admission order is not inpatient time, it also provides that the physician—and the Medicare review contractor—may consider this period when determining, as part of an admission decision, if it is reasonable to expect the patient to require care spanning at least two midnights. Documentation in the medical record must support a reasonable expectation that the beneficiary will require a medically necessary stay lasting at least two midnights.

In that Final Rule, CMS also recognized that there could be inpatient stays where the patient was reasonably expected to need two nights of care in the hospital but actually was discharged in less time due to unforeseen circumstance, such as beneficiary transfer, death, or departure against medical advice. In such instances, inpatient admission and Part A payment would still generally be appropriate, so long as the medical record supports the physician's reasonable expectation of the need for medically necessary hospital care spanning two or more midnights and documents the unforeseen, interrupting circumstance. CMS also provided exceptions to the two midnight rule for cases in which the physician expects the medically necessary hospital care to span less than two midnights but inpatient admission would nonetheless be appropriate. Exceptions to the rule include: (1) surgical procedures on the inpatient only list; and (2) other rare and unusual circumstances to be identified through subregulatory instruction. To date, newly initiated mechanical ventilation has been identified as a rare and unusual exception to the two midnight benchmark.

In addition, the FY 2014 IPPS Final Rule adopted provisions relating to the rebilling of services under Medicare Part B if a claim is denied under Part A because the inpatient admission was not medically necessary. The Final Rule permits such rebilling for a broader range of services than had been permitted under our prior policy. Under this Final Rule, a hospital can also bill and be paid for these inpatient services under Part B if—after the patient has been discharged—it determines through self-audit (utilization review) that the patient should not have been admitted as an inpatient.

Inpatient Hospital Reviews

Following implementation of the two midnight rule, CMS issued guidance on how it would review affected inpatient hospital claims. CMS instructed the MACs and Recovery Auditors not to review Part A claims spanning two or more midnights after formal admission for appropriateness of inpatient admission (*i.e.,* patient status reviews), absent evidence of systematic gaming, abuse, or delays in the provision of care in an attempt to qualify for the two midnight presumption. CMS specified that prepayment probe reviews would be conducted for inpatient claims spanning less than two midnights after formal admission for claims with dates of admission on or after October 1, 2013 but before April 1, 2014. Specifically, MACs would conduct patient status reviews using a probe and educate strategy for claims submitted by acute care inpatient hospital facilities, long-term care hospitals, and inpatient psychiatric facilities for dates of admission on or after October 1, 2013 but before April 1, 2014. That is, MACs would select a sample of 10 claims for prepayment review for most hospitals (25 claims for large hospitals). Based on the results of these initial reviews, MACs would deny claims that did not comply with the two midnight rule, conduct educational outreach efforts, and repeat the process where necessary.

CMS decided to extend the inpatient hospital prepayment review probe and educate review process for an additional 6 months, through September 30, 2014, to allow more time for CMS to provide continued education and for hospitals to understand and fully comply with the two midnight rule. During this period, MACs will continue to select a sample of claims for the probe review and education. CMS has been working closely with the MACs to ensure the accuracy of claim reviews and identify recurrent provider errors. The probe review and education process is well under way and results of the reviews are being closely monitored in order to focus future educational outreach efforts.

In addition, CMS postponed post-payment enforcement of the two midnight rule for FY 2014. Recovery Auditors were instructed not to conduct any post-payment patient status reviews for claims with dates of admission October 1, 2013 through September 30, 2014. Per the recently enacted "Protecting Access to Medicare Act of 2014," CMS will continue the probe and

education process while prohibiting the Recovery Auditors from conducting post-payment patient status reviews of inpatient claims with dates of admission through March 31, 2015.

Alternative Payment Approaches for Short Inpatient Stays

In the FY 2015 IPPS proposed rule, CMS solicited comments on the general concept of an alternative payment methodology under the Medicare program for short inpatient hospital stays and specifically, how such a methodology might be designed. One issue for consideration is how to define a short inpatient stay for determining appropriate Medicare payment. Another issue would be how to determine the appropriate payment once a short stay has been identified. Some have suggested a per diem amount, perhaps modelled after the existing transfer payment policy. We recognize that payment for similar short-stay cases would be very different under the OPPS and the IPPS depending upon whether the beneficiary has been formally admitted to the hospital as an inpatient. We also solicited comments regarding the circumstances under which the IPPS payment should be capped at, or higher than, the OPPS payment. We welcome input on these and other issues related to a potential alternative payment methodology for short inpatient hospital stays.

Conclusion

The current limitation on Recovery Auditor patient status review now in place through March 31, 2015, for inpatient claims provides an opportunity to revisit short hospital stay payment policy and to engage with stakeholders on how to address this issue. CMS is soliciting comments on alternative payment approaches for short inpatient stays and is working closely with stakeholders to explore the possibility of additional exceptions to the two midnight rule. Concurrently, CMS believes that the improvements made to the next phase of the Recovery Auditor program will reduce provider burden and diversify the kinds of compliance issues Recovery Auditors investigate—improvements that will help ease the implementation of new payment policies. CMS looks forward to continuing to work with stakeholders and the Congress to address the complex question of how to further improve payment policy around the complex issues surrounding short hospital stay payment policy.

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Chairman BRADY. Thank you.
Ms. Nudelman, you are recognized for five minutes.

STATEMENT OF JUDI NUDELMAN, REGIONAL INSPECTOR GENERAL FOR EVALUATION AND INSPECTIONS, NY REGION OFFICE OF THE INSPECTOR GENERAL, DEPARTMENT OF HEALTH AND HUMAN SERVICES (OIG–HHS)

Ms. NUDELMAN. Good morning, Chairman Brady, Ranking Member McDermott and other distinguished Members of the Subcommittee. Thank you for the opportunity to discuss the Office of Inspector General's work to improve the Medicare program.

My testimony today has three key takeaways. One, the Two Midnight hospital policy must be carefully evaluated.

Two, CMS should enhance its oversight of the recovery audit contractors; and, three, fundamental changes are needed in the Medicare appeals system.

I will begin with the Two Midnight Rule. The new policy provides guidelines for when hospitals bill for inpatient stays and outpatient services such as observation. These decisions have significant impact. They affect how much Medicare pays the hospital, how much beneficiaries must pay, and beneficiaries' eligibility for skilled nursing facility services.

Prior to the policy, OIG evaluated the hospital's use of observation stays and inpatient stays. Our findings continue to be relevant. We found that beneficiaries were in observation and short inpatient stays for similar reasons, but short inpatient stays were more costly. On average Medicare paid nearly three times more for short inpatient stays than observation stays. Beneficiaries paid almost two times more.

We also found that hospitals vary. Some hospitals use short inpatient stays for less than 10 percent of their stays. Others use them for more than 70 percent. Lastly, we found that some beneficiaries spent three nights or more in the hospital but did not qualify for the skilled nursing facilities under Medicare. That is because their stays did not include three inpatient nights.

Switching to our work on recovery audit contractors, or RACs, we found that these contractors play a critical role in protecting the fiscal integrity of Medicare. In fact, in fiscal years 2010 and 2011, RACs identified improper payments totalling $1.3 billion. Most of the recovered improper payments came from hospital inpatient claims. However, we also found that CMS needs to enhance its oversight of RACs.

Finally, OIG has found that the Medicare appeals system needs fundamental changes. We reviewed the third level of appeals which is handled by administrative law judges, or ALJs. Although this work predated the recent surge in appeals, our findings and recommendations are relevant to the current challenges. We found that ALJs decided fully in favor of appellants in over half of the cases and Part A hospital stays were most likely to receive favorable decisions.

Several factors led to ALJs reaching different decisions than the prior level. One is that some Medicare policies are unclear. This leads to more favorable decisions for appellants and to more variation among adjudicators. In fact, there is wide variation among ALJs. Their rate of favorable decisions range from 18 to 85 percent. We also found that improvements were needed such as ALJs mov-

ing to electronic files and CMS increasing its participation at hearings.

In closing, clear payment policies, strong oversight, and an effective appeals system are critical for Medicare to work well. CMS policy, the RACs, and the appeals system must each fulfill their important purposes. If they do not, beneficiaries, taxpayers and the Medicare program suffer. OIG is committed to continuing our efforts to improve Medicare.

Thank you for your interest and for the opportunity to discuss some of our work. I will be happy to answer any questions.

[The prepared statement of Ms. Nudelman follows:]

Testimony of:
Jodi D. Nudelman
Regional Inspector General for
Office of Evaluation and Inspections
Office of Inspector General
U.S. Department of Health and Human Services
Hearing Title: "Current Hospital Issues in the Medicare Program"
House Ways and Means Committee
Subcommittee on Health

Good morning, Chairman Brady, Ranking Member McDermott, and other distinguished Members of the Subcommittee. Thank you for the opportunity to testify about the U.S. Department of Health and Human Services (the Department) Office of Inspector General's (OIG) work to improve Medicare oversight and reduce waste, fraud, and abuse. Fighting waste, fraud, and abuse in Medicare is a top goal for OIG.

OIG has recommended numerous actions to advance this goal. The Department has implemented many of OIG's recommendations, resulting in cost savings, improved program operations, and enhanced protections for beneficiaries. In fiscal year (FY) 2013, OIG reported estimated savings of more than $19 billion resulting from legislative and regulatory actions supported by OIG recommendations. However, more remains to be done. In March 2014, OIG issued its *Compendium of Priority Recommendations*,[1] which highlights additional opportunities for cost savings and program and quality improvements. Implementing these recommendations could result in billions of dollars saved and more efficient and effective programs.

As you requested, my testimony today summarizes OIG's work in three areas that are key to improving the Medicare program for taxpayers and beneficiaries. They are: hospital observation and short inpatient stays; Recovery Audit Contractors (RACs); and the Medicare appeals process. In each of these areas, we identified significant issues and made recommendations to address them. The key takeaways from my testimony today are: 1) the two-midnight hospital policy must be carefully evaluated, 2) the Centers for Medicare & Medicaid Services (CMS) should enhance its oversight of RACs and follow through on program vulnerabilities that lead to improper payments, and 3) fundamental changes are needed in the Medicare appeals system.

The Two-Midnight Hospital Policy Must Be Carefully Evaluated

Last October, CMS implemented a new hospital policy. The new policy provides guidelines for when hospitals should bill for inpatient stays and when hospitals should bill for outpatient services, such as observation. These inpatient-versus-outpatient decisions significantly affect

[1] Office of Inspector General's *Compendium of Priority Recommendations*, available online at http://oig.hhs.gov/reports-and-publications/compendium/index.asp.

how much Medicare pays the hospital, how much the beneficiary must pay, and the beneficiary's eligibility for skilled nursing facility (SNF) services when he or she leaves the hospital.

We evaluated hospitals' use of observation stays and short inpatient stays before the implementation of the new hospital policy.[2] Our findings highlight important issues that require continued attention. They are summarized below.

Short inpatient stays were often for the same reason as observation stays, but Medicare paid nearly three times more for a short inpatient stay than an observation stay, on average

We found that beneficiaries in both short inpatient and observation stays were most commonly treated for chest pain. Additionally, 6 of the 10 most common reasons for short inpatient stays were also among the 10 most common reasons for observation stays. However, short inpatient stays were far more costly to Medicare than observation stays. Medicare paid an average of $5,142 per short inpatient stay, but it paid an average of $1,741 per observation stay. For each of the most common reasons the beneficiary was in the hospital, the average Medicare payment was always higher for short inpatient stays than for observation stays.

Beneficiaries also paid far more for short inpatient stays than for observation stays, on average

Beneficiaries paid almost two times more for a short inpatient stay than an observation stay on average—that is, $725 per short inpatient stay compared to $401 per observation stay. For all but two of the most common reasons for treatment, beneficiaries paid more, on average, for short inpatient stays than for observation stays. The two exceptions were stays for circulatory disorders and for coronary stent insertions. Only 6 percent of beneficiaries in observation stays paid more than they would have paid had they been in an inpatient stay.

Hospitals varied widely in their use of short inpatient and observation stays

Some hospitals were far more likely to use short inpatient stays while others were far more likely to use observation stays.[3] Nationally, just over one-quarter of these stays were short inpatient stays. However, some hospitals used short inpatient stays for less than 10 percent of their stays, while others used them for over 70 percent of their stays.

Some beneficiaries had hospital stays that lasted three nights or more but did not qualify for SNF services under Medicare

Beneficiaries had almost 618,000 hospital stays that lasted 3 nights or more but did not include 3 inpatient nights. Because their stays did not include three inpatient nights, these beneficiaries

[2] OIG, *Hospitals' Use of Observation Stays and Short Inpatient Stays for Medicare Beneficiaries*, OEI-02-12-00040, July 2013. Short inpatient stays are inpatient stays that lasted one night or less.

[3] This analysis includes outpatient stays that lasted at least one night, but were not coded as observation stays. For some of these stays, hospitals may have provided observation services without coding the claims as observation stays. Hospitals are not always paid a separate amount for coding claims as observation stays.

did not qualify for SNF services under Medicare. For about 25,000 of the 618,000 hospital stays, beneficiaries received SNF services following their discharge from the hospital. Medicare nearly always paid (inappropriately) for these SNF services. However, for about 2,000 of the hospital stays, Medicare did not pay for the SNF services, and the beneficiary was charged an average of about $11,000.

The new hospital policy must be evaluated

The issues that we highlighted in the July 2013 report continue to be relevant. CMS's new policy will affect hospitals' use of observation stays and short inpatient stays, which in turn will affect Medicare and beneficiary payments to hospitals. The new policy may also affect beneficiaries' access to SNF services. Information about the impact of the new policy is needed to ensure that policymakers take these issues into account as they move forward.

CMS Should Strengthen its Oversight of RACs and Follow through on Vulnerabilities That Lead to Improper Payments

Recovery Audit Contractors (RACs) play a critical role in identifying improper payments and protecting the fiscal integrity of Medicare. An OIG review found that RACs identified improper payments totaling $1.3 billion in FYs 2010 and 2011.[4] While most of these improper payments were overpayments and resulted in dollars returned to the Medicare Trust Funds, some were underpayments and resulted in dollars returned to providers. Approximately 88 percent of the recovered and returned improper payments came from inpatient hospital claims. Medical services delivered in inappropriate facilities accounted for about a third of the improper payments. This includes claims in which the RAC found that services provided to a beneficiary in an inpatient setting could have been provided in an outpatient setting.

Providers did not appeal RAC decisions for about 94 percent of claims identified as overpayments. Of the 6 percent that were appealed, almost half were decided in favor of the appellant.

CMS should enhance its follow-through on improper payment vulnerabilities identified through RAC audits

CMS uses RAC audits to identify vulnerabilities and develop corrective action plans to prevent future improper payments. CMS identified 46 program vulnerabilities in FYs 2010 and 2011. These included vulnerabilities such as indicating the incorrect place of service on claims or billing for services or supplies for deceased beneficiaries. By June 2012, CMS had taken corrective actions to address the majority of these vulnerabilities. These corrective actions were not considered closed, however, because CMS had not yet evaluated their effectiveness, an

[4] OIG, *Medicare Recovery Audit Contractors and CMS's Actions To Address Improper Payments, Referrals of Potential Fraud, and Performance,* OEI-04-11-00680, August 2013.

important step in its process. Thus, it is not clear to what extent these corrective actions have prevented improper payments from recurring.

CMS performance evaluations of RACs lacked some key metrics

Although CMS completed performance evaluations for all of its RACs in 2010 and 2011, these evaluations lacked metrics related to some key contract requirements. Most notably, CMS did not evaluate RACs on the extent to which they identified improper payments. In addition, four of eight performance evaluations did not include information on the RAC's ability, accuracy, or effectiveness in identifying overpayments. In response to our report, CMS noted that it has revised its RAC evaluations to incorporate metrics on identification of improper payments and accuracy rates.

Key recommendations to CMS include:

- Evaluate the effectiveness of corrective actions to prevent Medicare overpayments.
- Strengthen performance evaluation metrics and better ensure that contractors meet performance standards.

The Medicare Appeals System Needs Fundamental Changes

The administrative appeals system is an essential component of the Medicare program. Appeals decisions affect providers, beneficiaries, and the Medicare program as a whole. It is imperative that the appeals system be efficient, effective, and fair.

The system has experienced an unprecedented surge of appeals over the past two years. According to the Office of Medicare Hearings and Appeals (OMHA), the number of appeals reaching Administrative Law Judges (ALJ)—the third level of appeals—doubled from FY 2012 to 2013.[5] Further, OMHA estimates that its backlog will reach a million claims by the end of this fiscal year. A concerted effort by all key players—including OIG, CMS, OMHA, and Congress—is needed to address this issue and to maintain the integrity of the appeals system.

Before the recent surge, OIG completed work that focused on the ALJ level of appeals.[6] Although the work covered FY 2010, many of the findings and recommendations are relevant to understanding and addressing the current challenges.

A small percentage of providers account for a large number of appeals

Medicare providers make up the vast majority—85 percent—of appellants at the ALJ level of appeal. Beneficiaries filed 11 percent and State Medicaid agencies filed 3 percent of appeals. Moreover, only 2 percent of these providers accounted for nearly one-third of all ALJ appeals.

[5] Department, *Justification of Estimates for Appropriations Committees, Fiscal Year 2015, OMHA*.
[6] OIG, *Improvements Are Needed at the Administrative Law Judge Level of Medicare Appeals*, OEI-02-10-00340, November 2012.

Specifically, 96 providers filed at least 50 appeals each with 1 provider filing over 1,000 appeals. These providers were twice as likely as others to file appeals regarding medical supplies, such as wheelchairs. During interviews, ALJ staff raised concerns that some providers appeal every payment denial and may have incentives to appeal because a favorable decision is likely.

For over half of appeals, ALJs decided fully in favor of appellants

In FY 2010, ALJs reversed prior-level decisions and decided fully in favor of appellants for 56 percent of appeals. In comparison, Qualified Independent Contractors (QICs)—the second level of appeals—decided fully in favor of appellants for only 20 percent of appeals. At the ALJ level, appellants were most likely to receive favorable decisions for Part A hospital appeals (72 percent) and least likely for Parts C and D appeals (18 percent and 19 percent, respectively).

Differences between ALJ and prior-level decisions were due to different interpretations of Medicare policies and other factors

Several factors led to ALJs reaching different decisions than those in the prior level of appeals. We found that ALJs tended to interpret Medicare policies less strictly than did QICs. In addition, ALJ and QIC staff commonly noted that some Medicare policies are unclear. Many noted that unclear policies lead to more fully favorable decisions for appellants and to more variation among adjudicators.

ALJs and QICs also differed in the degree to which they specialized in Medicare program areas and in their use of clinical experts. In contrast to QICs, ALJs do not have medical directors and clinicians on staff. Several ALJ staff said ALJs tended to rely on testimony and other evidence from treating physicians.

In addition to variation between the two levels of appeals, we also found variation among ALJs. In particular, the fully favorable rate for appellants ranged from 18 to 85 percent among the 66 ALJs. According to many ALJ staff, different philosophies among ALJs contribute to the variation in fully favorable rates. They said that given the same facts and the same applicable Medicare policy, some ALJs would make decisions that are favorable to appellants, while others would not.

CMS participation in ALJ appeals affects the outcome

CMS participated in 10 percent of ALJ appeals in FY 2010. When CMS participated, the ALJs were less likely to decide fully in favor of the appellant. The role of CMS participation was most striking with appeals involving medical supplies; the appellant was about half as likely to receive a fully favorable decision when CMS participated.

Current practices regarding appeals documents are highly inefficient

Both CMS and ALJ staff identified problems with case files. They reported that a case file at the ALJ level often differed in content, organization, and format compared to the same appeal's case

file at the QIC level, creating inefficiencies in the appeals system. Because the QICs' case files are almost entirely electronic and ALJs primarily accept only paper case files, the QICs must convert the files to paper format before sending to the ALJs. Most staff noted that this process is resource intensive and prone to error.

Key recommendations to OMHA and CMS include:

- Identify and clarify Medicare policies that are unclear and interpreted differently.
- Develop and coordinate training on Medicare policies.
- Standardize case files and make them electronic.
- Continue to increase CMS participation in ALJ appeals.
- Implement a quality assurance process to review ALJ decisions.

Further Action Is Needed To Ensure that Hospital Payment Policies, RACs, and the Medicare Appeals Process Work Efficiently and Effectively

Ensuring that the Medicare program works effectively and efficiently for beneficiaries, taxpayers, and providers is of paramount importance. Clear policies, strong oversight of contractors, and an appeals system that is effective, efficient, and fair are critical to accomplishing this goal. This requires a concerted effort by a number of key players, including CMS, CMS contractors, providers, OIG, and Congress. It also requires a commitment to evaluating and implementing smart policy, exercising vigilant oversight of contractors, and implementing innovative solutions to improve the appeals process. Such actions are essential for fighting fraud, waste, and abuse and for protecting Medicare beneficiaries and the Medicare Trust Funds.

OIG is committed to continuing its strong oversight. At stake are billions of dollars, the solvency of the program, and the health and well-being of beneficiaries. We will continue to audit and evaluate these critical program areas and recommend solutions to improve efficiency and effectiveness. We are challenged in meeting this mission by declining resources for Medicare and Medicaid oversight at a time when these programs and our responsibilities are growing. By the end of this fiscal year, we expect to reduce Medicare and Medicaid oversight by about 20 percent. Full funding of our 2015 budget request would enable us to provide more robust oversight and advance solutions to protect programs, beneficiaries, and taxpayers.

Thank you for your interest and support and for the opportunity to discuss some of our work. I am happy to answer any questions you may have.

Chairman BRADY. Thank you, Ms. Nudelman.

I think both witnesses have made the point that Two Midnight Policy, the inpatient, outpatient, the audits and the appeals all really work together, which is why we are doing this hearing all together.

So, starting with Mr. Cavanaugh, I am interested to hear your thoughts on the barriers to compare inpatient and outpatient services. Obviously we should be trying to find the best quality of care at the right site with the most cost effective payment.

So can you give me an example of a reimbursement difference, for a service that can be billed both inpatient and outpatient by a teaching hospital in a major city; what would be an example?

Mr. CAVANAUGH. Well Chairman, as you pointed out in your opening statement, the outpatient payment system and the inpatient payment system are fundamentally different, and they start with different coding; so it is often hard to compare payments because we can't put the same claim through the outpatient system and the inpatient system. They are coded differently.

But on the inpatient system, we tend to pay a fixed amount, meaning a DRG-based payment. That DRG-based payment will include adjustments for possibly IME, for DSH. It could include a readmissions penalty or a hospital-acquired condition penalty, but it tends to be a fixed payment for the types of patient and the types of service being delivered.

On the outpatient side, it is more disaggregated, where we tend to pay per service. I think you heard from the OIG, and I think it is similar to data we have, that the magnitude of the difference in payment is quite substantial. The OIG mentioned that the short stay inpatient payments tended to be three times as costly to Medicare as the outpatient observation stays. That is consistent with data we have seen at the CMS. So that gives you a sense, that the systems for deriving the payment are different, and the magnitudes are quite different.

Chairman BRADY. How do you address that?

Mr. CAVANAUGH. I am not entirely sure how we address it. One idea that we received from stakeholders, and I know that it had some support in Congress, is to create a payment system that splits that difference, a short stay inpatient payment system and as I mentioned in my opening statement, we are soliciting comments on how to create such a payment system. I would say there are challenges.

Some of the cases that come in as short stay inpatient payments already have very low lengths of stay. Chest pain DRG, for example, has a two-day average length of stay. So the question is how would you create a short-stay payment around a type of case that is already fairly short. Those are the sorts of technical questions that we are asking for public input in the proposed rule this year.

Chairman BRADY. Thank you.

Ms. Nudelman, you know, in your analysis do you think the Two Midnight standard will reduce observation stays or increase them, the length of them?

Ms. NUDELMAN. Again, our analysis is prior to the Two Midnight stay, and it is difficult to predict how things will look. What we did find is that hospitals extremely vary and, therefore, it is im-

portant to look at all of the data because their starting point is very different, and so it may impact hospitals very differently.

Chairman BRADY. Mr. Cavanaugh, thanks for your emphasis describing the different cost-sharing implications affecting our Medicare beneficiaries. It often gets lost in this discussion and the difference between inpatient and outpatient. It is unfortunate the Medicare program has such vastly different cost-sharing rules for our seniors or Medicare beneficiaries between the two benefits.

This committee has focused earlier on the advantages of combining Medicare Parts A and B with the out-of-pocket costs to make sure we protect seniors in part because we are concerned about what seniors pay for cost sharing.

So, can you give us your thoughts on combining Parts A and B and how that might be helpful in trying to contain those cost sharing challenges for seniors?

Mr. CAVANAUGH. I recognize that one of the goals is to speak to one of the problems that we have here, which is that inpatient versus outpatient generates very different liabilities for the patient. I would want to hear more about the proposal that the subcommittee is considering, and we have technical staff at CMS who can come provide assistance to you in the drafting of the bill if required and if that would be beneficial to you.

Chairman BRADY. So you have not taken a look at the proposed combining Part A and B in the President's budget or in earlier health care proposals?

Mr. CAVANAUGH. We don't have a proposal on that at this time, but like I said, if the committee has a proposal, we would love to see it and learn more about it.

Chairman BRADY. Okay. Okay, final question. Mr. Cavanaugh, even though CMS doesn't have a direct role in the ALJ level Medicare appeals that Ms. Nudelman talked about, CMS must still be part of the solution to solve the backlog.

Does HHS have a working group to address Medicare appeals, and if so has HHS crafted recommendations to solve the backlog issues going forward?

Mr. CAVANAUGH. Yes, Mr. Chairman. As you point out, there is an HHS-wide work group to address the backlog. CMS is part of that. I would be glad—we are in the process of coming up with recommendations. I don't believe they are finalized yet.

Chairman BRADY. What is the timetable on that?

Mr. CAVANAUGH. I think we could brief the committee on them fairly shortly.

Chairman BRADY. Right. Thank you Mr. Cavanaugh and Ms. Nudelman.

I now recognize Ranking Member Dr. McDermott for five minutes.

Mr. MCDERMOTT. Thank you, Mr. Chairman.

From a patient's standpoint you walk into the emergency room or whatever, and you get put in one of these statuses or the other. Does it make any difference to the patient, to the beneficiary, which status they are put in, as to how they are treated?

Mr. CAVANAUGH. As to how they are treated, not from a benefit perspective; Is that the question?

Mr. MCDERMOTT. Yes, I am talking about how they are treated as a patient.

Mr. CAVANAUGH. I would hope not. I would hope that the patient is receiving all the services they need medically, that are medically indicated.

Mr. MCDERMOTT. So then the difference is in the payment that is received by the hospital or that the patient has to make depending on which category they are in; is that correct?

Mr. CAVANAUGH. Certainly the statute creates a stark difference between inpatient and outpatient care, yes, sir.

Mr. MCDERMOTT. Give us the amount of difference for a hospital, what they receive and what the patient has to pay, so we get some idea of who is bearing the weight here.

Mr. CAVANAUGH. The amounts both that the hospital will receive and that the beneficiary would be liable for would vary tremendously on individual circumstances, so I can't give you a precise answer. I would say that when we did a rebilling initiative where we had hospitals take short inpatient cases and rebill them as outpatient, which involves some work, we did find that the outpatient payment to the hospital was about 30 percent of what the inpatient payment would have been.

Mr. MCDERMOTT. So they are getting 70 percent more if they bill them as an inpatient. Is that in Medicare payment for the DRG, the diagnosed-related group, or is it the indirect medical education payment and the DSH payment on top.

Mr. CAVANAUGH. It includes everything.

Mr. MCDERMOTT. Okay. So you are saying you are including everything?

Mr. CAVANAUGH. Yes, sir.

Mr. MCDERMOTT. So it is to the hospital's best interest to bring them in as an inpatient?

Mr. CAVANAUGH. Certainly it generates more revenue.

Mr. MCDERMOTT. From a revenue standpoint. Because we said it doesn't make any difference how they are treated as people and as patients, so the only difference is how much money the hospital makes off of it; is that correct?

Mr. CAVANAUGH. Again, it certainly makes a significant financial difference.

Mr. MCDERMOTT. Now, I have heard, and I think almost every member on this committee has heard from their hospitals, the usual assumption is that the RACs are overzealous and that somehow when we take them up to appeal, when we finally get to the appeal process, almost always it comes down in our favor. Could you give us the numbers of how many are overturned on appeal?

Mr. CAVANAUGH. Certainly, Congressman. We had a report to Congress on the RAC program in the year of 2012, and in that report we showed that when the RAC denies a claim, when a RAC denies a claim, only 7 percent of those are ultimately overturned at some level of review all the way up through the ALJs.

Mr. MCDERMOTT. Only 7 percent are overturned.

Mr. CAVANAUGH. That is correct.

Mr. MCDERMOTT. Where do the hospitals get the figure that they say, well, they are all overturned. When we finally go through

this long, arduous process that is backlogged and everything else, it is always overturned. Where do they come up with that.

Mr. CAVANAUGH. There could be two sources of the difference in these numbers. The first is any individual hospital's experience may vary tremendously. Some may have a better success rate. The other is, some of the numbers that I have seen quoted by the industry, they are using as the denominator only those that they choose to appeal, not all those that were denied, which a lower denominator would generate a higher rate of success.

Mr. MCDERMOTT. Does it get to more than a half?

Mr. CAVANAUGH. In the numbers that we have seen that CMS has generated, I haven't seen anything that would get that high, no sir.

Mr. MCDERMOTT. The number I saw, I mean, you are holding back on the numbers you got. The ones that I have seen say 27 percent are the number that are overturned.

Mr. CAVANAUGH. So, again, I don't mean to hold back the numbers. These are numbers that are in our public report to Congress, ultimately, and I will just state it as clearly as I can, of all the ones the RACs deny, only 7 percent are ultimately overturned.

If you took a low number of the ones the RACs denied and the ones the hospitals chose to appeal, it would generate a higher overturn number. I just don't happen to know that number. 14 percent.

Mr. MCDERMOTT. Fourteen percent?

Mr. CAVANAUGH. I am being helped, yes.

So it essentially doubles the rate, but it doesn't get as high as some of the numbers you may have heard from others and, again, an individual hospital's experience may vary.

Mr. MCDERMOTT. Can you give us an explanation for why this problem? I mean, generally Congress doesn't run in and pass laws, and you don't make rules and regulations without there having been something to generate that. What is it that drove this in the first place?

Mr. CAVANAUGH. I think it was a confluence of a number of factors. We were hearing from hospitals and beneficiaries who were really concerned about these long observation stays. That was causing confusion for beneficiaries including they didn't understand their status, and they also thought they were qualifying for the skilled nursing facility benefit.

We were hearing from hospitals who thought just dealing with the RACs, with what the hospitals would characterize as an unclear standard for inpatient care was a difficult situation to put them in and all these forces came together, and that is why CMS solicited input and tried to make a clearer policy. Because our goal is not to have a successful RAC program or to drive down the number of overturned appeals. Our goal is to have hospitals understand the rules, agree with the rules, and bill correctly at the outset.

Chairman BRADY. Time is expired.

Mr. Johnson.

Mr. JOHNSON. Thank you, Mr. Chairman.

Mr. Cavanaugh, the value-based purchasing program which was enacted as part of ObamaCare is the Federal Government's most extensive effort yet to hold hospitals financially accountable for patient outcomes. Medicare compared hospitals on how faithfully they

followed basic standards of care and how patients rated their experiences. In the first year of CMS value-based purchasing program, physician-owned hospitals demonstrated they thrive in delivering high-quality, low-cost care. Amazingly 9 of the top 10 and 53 of the top 100 hospitals were physician-owned hospitals.

CMS also recently released data that summarizes the utilization and payments for procedures and services provided to Medicare. Based on this release of information, we have now confirmed what many of us have known for some time, and that is that, physician-owned hospitals are costing Medicare less than hospitals without physician ownership.

And that doesn't consider all the cost savings associated with the higher quality of care they provide. The irony of all this is that the very law that created the hospital value-based purchasing program, ObamaCare, bans the same hospitals. This new accountability measure says they are some of the very best in the country. ObamaCare prohibits any new physician-owned hospitals from treating Medicare and Medicaid patients. This clearly discriminates against some of the most vulnerable patients in our health system.

While the law permitted those physician-owned hospitals that received Medicare certification to be grandfathered under the law, it prevents these same hospitals from being able to expand to meet the access and quality demands in their community. This makes no sense, and it flies in the face of the Administration's own benchmarks for quality of care and cost savings.

Mr. Cavanaugh, do you stand by the results of the value-based purchasing program which validates the quality of physician-owned hospitals?

Mr. CAVANAUGH. Yes, the agency stands by the results of the value-based purchasing program.

Mr. JOHNSON. Do you stand by the data released by CMS showing the cost differential between treating patients at physician-owned hospitals versus hospitals without any ownership by physicians?

Mr. CAVANAUGH. I apologize, Congressman. I am not familiar with those data, but I am happy to look at them and review them.

Mr. JOHNSON. I appreciate it if you would. I hope you all can support a bill that I have out there, H.R. 2027, which would establish a level playing field for physician-owned hospitals and ensure that patients will continue to have a choice in where they receive their health care.

Mr. CAVANAUGH. Certainly we look forward to reviewing that legislation.

Mr. JOHNSON. Thank you, sir.

Thank you, Mr. Chairman.

Chairman BRADY. Thank you.

Mr. Thompson is recognized.

Mr. THOMPSON. Thank you, Mr. Chairman, and thank you for holding this hearing today. I think this is something, as Mr. McDermott said, we are all hearing a lot about in our district.

Mr. Cavanaugh, I would like to just revisit the issue of the reversed audits, and you had mentioned 7 percent. Mr. McDermott said that he hears from his constituents that every one of them are

overturned. I am hearing that it is in the 40 percent from my hospitals, 40 percent and change and is there any way to qualify how these missed billing are done? Are they intentional? Are they mistakes? What is your experience?

Mr. CAVANAUGH. Certainly my experience, which actually predates my time at CMS, as I mentioned in my opening statement I have only been the Director of Center for Medicare for a few weeks, but I do have experience working in the hospital industry. My experience has been most of them are not fraudulent. It is misinterpretation——

Mr. THOMPSON. So they are honest mistakes, or they find the process is confusing, have trouble getting to where they need to be?

Mr. CAVANAUGH. Certainly that is what I have heard from much of the industry. I would also say by monitoring these very closely, the agency has at times found suggestions of fraud in some areas; but I don't think that is generally what is driving this.

Mr. THOMPSON. And is it pretty easy to recognize the mistakes vis-a-vis the fraud?

Mr. CAVANAUGH. I would have to defer that question to my colleague who runs the program integrity side of CMI, CMS excuse me.

Mr. THOMPSON. I would like to know that if you could.

Mr. CAVANAUGH. We would be happy to circle back with you after the hearing.

Mr. THOMPSON. Whichever it is, when a hospital has to go through the process of defending their claim, there is a lot of expense associated with that.

Mr. CAVANAUGH. That is true.

Mr. THOMPSON. Are you able to qualify that?

Mr. CAVANAUGH. Well, we don't collect data on what the hospital's expense is, but certainly my experience——

Mr. THOMPSON. They hire, what, lawyers?

Mr. CAVANAUGH. At times.

Mr. THOMPSON. And they hire consultants——

Mr. CAVANAUGH. Or consultants. There is also just the time and——

Mr. THOMPSON. And all the opportunity cost. They are defending their billing practices rather than providing health care to patients?

Mr. CAVANAUGH. Yes, Congressman. And, again, that is why we feel perfecting the appeals process is important, but what is more important is having very clear guidelines at the outset of how these cases should be billed.

Mr. THOMPSON. And is there any way to minimize the cost to hospitals if their claim is reversed? They have to pay one way or the other, I guess.

Mr. CAVANAUGH. Yes, if it is reversed. There are some things that we are doing. The recovery auditor contracts are being recompeted as we speak, and we hope to award new contracts this summer. In that process, as we set new terms with the appropriate auditors, we are trying to take steps to make things less burdensome for the hospitals. We are trying to revise the requests the auditors do for documents from the hospitals to try to limit that burden somewhat.

We are trying to ensure that there is an exchange of information between the auditors and the hospitals so the hospitals can make their case before they have to file a formal appeal, that they can work with the auditor to explain why they think it was appropriate as an inpatient case. So we are always looking for ways to improve this. And I think there is——

Mr. THOMPSON. Does the process incentivize the auditors to go after more than they should?

Mr. CAVANAUGH. I don't think there is an incentive for them to go after more than they should, and I think the very low overturn rate that I quoted suggests that they are largely going after the right types of cases, but again I would rather they have——

Mr. THOMPSON. That's its overturn rate that you quoted, the 7 percent.

Mr. CAVANAUGH. Correct.

Mr. THOMPSON. But if it is closer to what Mr. McDermott said, where they are all overturned, or even if they are what my hospitals are experiencing at about 40-some-odd percent, it is not quite as low.

Mr. CAVANAUGH. If I believed that——

Mr. THOMPSON. They say there is lies; there is damn lies, and there is statistics.

Mr. CAVANAUGH. I just wanted to agree with you, though, that if there were overturn rates of 40 to 50 percent, I think that would be indicative of a larger problem than just the guidelines.

Mr. THOMPSON. What would that problem be?

Mr. CAVANAUGH. I think it would indicate that the recovery auditors were not going after cases that were——

Mr. THOMPSON. Auditors are what?

Mr. CAVANAUGH. That the recovery auditors, if they were getting over turned 40 or 50 percent of the time, it would indicate they were probably going after cases that were appropriately billed to start with but, again, that is not what we see in our data.

Mr. THOMPSON. So Mr. Chairman, can we further examine that, because if that's the case, they are being incentivized or for some reason they are going after cases they shouldn't.

Chairman BRADY. At some point today, I am going to recognize Mr. Roskam, but at some point today I would like Ms. Nudelman to weigh in. I want to reconcile the differences in the numbers. I may be missing something here. And at some point—I don't want to take Mr. Roskam's time.

Mr. Roskam.

Mr. ROSKAM. Thank you, Mr. Chairman.

Mr. Cavanaugh, I just want to pick up on one of the themes that Mr. McDermott articulated in his opening statement where he said that he wanted to protect Medicare's finite resources, and I agree with that and you agree with that. I think one of the challenges is that there is a zero-sum game element to Medicare reimbursement right now, and so I want to draw your attention to an issue that I am sure is familiar with you.

That is Nantucket Cottage Hospital. As you know, that was part of the process by which the Affordable Care Act was passed. There is I don't think any celebration in this in that it is a zero-sum game proposition. I come from Illinois, and my home state is losing under

this equation. Massachusetts, based on this manipulation, will essentially get $3.5 billion over 10 years. You recognize that that is a problem, don't you?

Mr. CAVANAUGH. I am familiar with the provision you are talking about, and I would just simply say CMS is faithfully executing the law as written.

Mr. ROSKAM. You don't think that is a good allocation of resources, do you?

Mr. CAVANAUGH. Again, I would just say that we are implementing the laws as required.

Mr. ROSKAM. Well, if it takes from my state and gives to another state, and what it does is it manipulates the definition of a rural hospital so that now Nantucket is now defined as rural, which boosts everybody up, because you know these rules better than I do, the entire state of Massachusetts is the beneficiary of one hospital in a particularly luxurious area, is now redefined as rural and therefore poor. That is a manipulation, isn't it?

Mr. CAVANAUGH. Congressman, I think you have accurately described the mechanism of what is happening; and, again, we are bound to implement the law.

Mr. ROSKAM. But it is not a good idea, is it?

Mr. CAVANAUGH. We are faithfully executing the law in this regard, sir.

Mr. ROSKAM. Well, you recognize there is bipartisan support to repeal this, don't you? This is one of these areas where there is a tremendous amount of bipartisan interest in trying to get back to this.

Senators McCaskill and Coburn have come alongside with one another. There is dozens of members of the House of Representatives, who have recognized this, and this is a situation where one state based on one statute is getting a disproportionate benefit, and it is not getting a disproportionate esoteric benefit. In other words, this isn't just simply borrowing from a future generation. This is saying, well, we are going to take from Illinois, and we are going to give to Massachusetts. That's a breakdown, isn't it? Isn't that a failure?

Mr. CAVANAUGH. So, Congressman, the provision does involve some of the technical aspects of Medicare rate setting, and we have a lot of experts at CMS who we would be happy to bring down and provide you technical assistance if you have a legislative proposal in this request.

Mr. ROSKAM. Well, is a technicality when a luxurious vacation area is categorized as rural, thereby boosting every other hospital in the state and having an adverse impact on many other states?

I mean, so Massachusetts according to our staff that put this together in 2013 and 2014, is going to be receiving a benefit of $425 million. My home state of Illinois is down $62 million. Congressman Price's home state of Georgia is down $30 million. You just go on and on through the list. Congressman McDermott's home state is down $12 million. This is beyond just a technicality, wouldn't you say?

Mr. CAVANAUGH. What I was suggesting is that it is a function of very technical parts of the rate setting within Medicare, and we

are happy to look further into it and look at your bill and provide——

Mr. ROSKAM. Isn't that an over characterization to say it is a technicality? It is not just technically taking millions of dollars from my home state and these other states across the country to benefit one state through the boosting of this sort of hospital definition.

And if that is a technicality, then I shudder to think what is a big deal. It is more than a technicality. Wouldn't you acknowledge that?

Mr. CAVANAUGH. I didn't mean to suggest it was a technicality. What I was trying to say is that it was a function of technical aspects of the rate setting system. As you said, the provision has a meaningful impact on Medicare rates.

Mr. ROSKAM. And wouldn't you technically think it is a bad idea?

Mr. CAVANAUGH. Congressman, we are faithfully executing the law. If you have a provision to change it, we are happy to provide any technical assistance you might need.

Mr. ROSKAM. Thank you.

I yield back.

Chairman BRADY. Thank you.

Mr. Pascrell.

Mr. PASCRELL. Thank you, Mr. Chairman. I think we can work together, I really do, to find solutions that work for hospitals and for patients.

I have been hearing from hospitals in my state, Mr. Cavanaugh, about the various reporting requirements in programs that impact the work that those hospitals do. I don't think anyone here will disagree that there is much room for improvement in the RAC program, in policies related to short-term, as well as observation stays. However, we need to strike the right balance between ensuring that hospitals can comply and that Medicare has the ability to ensure program integrity. It sounds easy, but it is not.

One area of particular interest to me is the increased use of observation stays and how it impacts the beneficiary. So I cosponsored along with Joe Courtney and Tom Latham, it is bipartisan, the Improving Access to Medicare Coverage Act which would allow observation stays to be counted toward the three-day mandatory inpatient stay for Medicare coverage of skilled nursing facility services.

So here's my question then, Mr. Cavanaugh. A number of independent reports from Medpac, the HHS Inspector General, Brown University, very interesting study, indicated that there has been a substantial increase in the number of observation stay claims and a decrease in the number of inpatient stays.

According to Medpac, outpatient observation claims grew by 88 percent from 2006 to 2012. A Brown University study found that the average length of stay in observation increased by more than 7 percent. Could you tell me what is contributing to this trend and the rise in observation stays?

Mr. CAVANAUGH. Certainly. CMS is aware of the growth in observation stays as well. One of the things we believe is contributing

to it is the behavior of some hospitals that want to avoid auditors reviewing whether an inpatient stay was appropriate.

Mr. PASCRELL. Do you want to write that on the record please?

Mr. CAVANAUGH. Excuse me?

Mr. PASCRELL. What do you mean; what are the hospitals doing?

Mr. CAVANAUGH. And again, this is anecdotal having talked to some hospital associations and some individual hospitals that some hospitals have decided they would rather take the patient in observation status as an excess of caution rather than risk having an inpatient admission subsequently denied.

Mr. PASCRELL. And what does that lead to?

Mr. CAVANAUGH. Well, first of all, what I think is unfortunate, as you point out, is if the patient should have been receiving inpatient care, they are not accruing the days they need to qualify for the post-acute skill nursing facility benefit.

Mr. PASCRELL. And that is pretty troubling. Under the current law, under what exists right now, Medicare requires that a patient be classified as an inpatient during a hospital stay for three days in order to qualify for coverage in a skilled nursing facility after they leave the hospital.

So, a number of Medicare beneficiaries have been cared for in the hospital on outpatient observation status rather than admitting them as inpatients, which has caused problems for Medicare coverage. That is serious.

Mr. Cavanaugh, do you believe that the three-day inpatient stay requirement for Medicare coverage of skilled nursing facility services is appropriate?

Mr. CAVANAUGH. Congressman, I think CMS shares your interest in trying to find ways to improve the use of skilled nursing facility benefit. I am pleased to tell you there is two examples of where we are exploring very specific alternatives to this.

In the Affordable Care Act, the Secretary and CMS were given the authority to waive certain provisions of Medicare in order to test new payment and service delivery models. In the pioneer ACOs, which is run by the Innovation Center, and the bundled payments for care improvement also run by the Innovation Center, were running tests where participants in those models have waivers from the three-day prior hospitalization rule. We chose those environments in which to test this because we feel in those environments the providers have both a clinical and a financial, heightened clinical and financial responsibility, so we feel that it is the best possible environment to waive the rule without having excess utilization.

Those tests are fairly new, and we are going to evaluate them very closely, and when we have data to share, we would be happy to share them with this committee.

Mr. PASCRELL. Thank you.

Thank you, Mr. Chairman.

Chairman BRADY. Thank you.

Mr. Gerlach is recognized. We will move to two-to-one questions so we can balance questions from now on.

Mr. GERLACH. Thank you, Mr. Chairman.

Thank you for testifying this morning to both of you.

On this Two Midnight Rule issue, in staying with the questions that my predecessors here have just posed, I think a lot of this can be boiled down to some of the information that we get from our subcommittee staff that summarizes the issues for the hearing today, and let me read if I can from that because, again, I think it crystallizes on the Two Midnight Rule where we are, and "For fiscal year 2014, CMS maintains 751 diagnostic-related group bundling codes for inpatient hospital payment. The outpatient payment system is focused on current procedural terminology, or CPT codes, that are maintained by the American Medical Association. The CPT codes map to ambulatory payment classifications, or APCs, for outpatient service reimbursement. For calendar year 2014, CMS maintains 813 APCs. There is no one-to-one matching of DRGs to APCs nor international classification of disease codes to CPT codes. Hospitals are responsible for knowing two different coding systems and two different payment systems for Medicare reimbursement." Seems to me that's the problem, isn't it? A patient comes into a hospital, presents with certain symptoms and certain complaints, but there is two different coding systems that a hospital is then required to utilize in terms of the reimbursement it will ultimately receive for whatever service is provided to the patient.

So does not the answer lie obviously to a new methodology that somehow blends these codes or smoothens these two different payment systems, one outpatient, one inpatient, so there is a fair way to reimburse for the service provided, not the length of stay on an arbitrary basis. Mr. Cavanaugh?

Mr. CAVANAUGH. Thank you for that question, Congressman. I do think in this year's rule in which we requested input on a short-stay inpatient payment system, we were suggesting that we are open to the kind of thing you are talking about, which is trying to see if the solution here is to minimize the payment differences. I don't want to prejudge the result of that. We are waiting to receive public comment on how that might look, but I think it is an openness to a step in the direction you are discussing.

Mr. GERLACH. Is that openness towards getting to a system where again the reimbursement to the hospital is based upon a more simplified methodology, and the methodology that is tied to the nature of the service that is provided, not an arbitrary time period for which that patient is in the hospital?

And I would also, Mrs. Nudelman, if you would also reply to that as well.

Ms. NUDELMAN. I mean I defer to CMS and to Congress to make the policy, but I think the overall objective is going back to, you know, not paying vastly different amounts for beneficiaries that receive similar care. At the very least, a standardized crosswalk that crosswalks the outpatient and the inpatient procedures would be a useful tool.

Mr. GERLACH. Well, typically an inpatient reimbursement would be about three times what an outpatient reimbursement would be, so there would be a fundamentally unfair situation where somebody is discharged from the hospital at 10 p.m. before the second midnight and therefore the hospital receives a third of the reimbursement for the services that were otherwise provided or could have been provided if you just kept the person three more

hours and discharged him or her at 1 a.m. after the two midnights had passed by and get three times the reimbursement.

So isn't there a fundamental flaw in just arbitrarily setting up a Two Midnight or any particular time period for determining reimbursement versus just the nature of the service that is needed to treat the patient, as Mr. Cavanaugh you alluded to some moments ago, that is the goal here, getting the patient properly cared for in the hospital setting, based upon the symptoms and problems and then the diagnosis that is made to deal with that.

Mr. CAVANAUGH. I think, Congressman, it is fair to say CMS shares your goal. What I would caution you is anytime we create a new payment, there is a lot that goes into creating payment systems, and what you are articulating, I think, is a very worthy goal of a seamless payment system. It presents many technical challenges. However, again, we have expressed openness in our proposed rule to exploring payment solutions to this, so we look forward to hearing any ideas this subcommittee has, and we look forward to working with you on this.

Mr. GERLACH. Thank you both.

Chairman BRADY. Thank you.

Mr. Smith.

Mr. SMITH. Thank you, Mr. Chairman, and thank you to our panelists here today.

It would seem the more regulations we have, the more difficult it becomes, at least to medical providers that tell me that it is more difficult to do their job and especially to—it becomes more difficult to do the right thing.

And Mr. Cavanaugh, similar to concerns raised about the Two Midnight Rule, there is another regulation CMS announced it will begin enforcing this year pertaining to the 96-hour rule at critical access hospitals. This regulation requires, as you know, physicians to certify at the time of admission they do not believe a patient will be there more than 96 hours or must transfer the patient or face non-reimbursement. I understand CMS has walked back this rule, allowing more time to file the certification. Is that true?

Mr. CAVANAUGH. That is true. We have provided guidance to some of the hospitals that we will allow the certification to occur anytime up to 24 hours before the bill is submitted, and I think that will be coming out more formally sometime soon.

Mr. SMITH. Okay. I assume that you have received a good bit of feedback, as have I, from hospitals and physicians. Can you reflect a little bit briefly, if you might, on the kind of feedback you received that would have prompted walking the rule back a bit?

Mr. CAVANAUGH. Certainly we got a lot of input about the timing and the burden and whether the trade-off between what we were seeking and what the hospitals were requesting, whether there was any loss in the assurances we needed that the patient was seeing the appropriate level professional, and I think hospitals made a convincing case that there was room for some adjustment in the policy.

Mr. SMITH. It would seem that the rule is unnecessary and even arbitrary. How did you arrive at the actual number of 96 hours?

Mr. CAVANAUGH. Sir, that part is in the statute. The statute requires that the physician make a certification that the expecta-

tion, when the patient arrived, was that they would need no more than 96 hours.

Mr. SMITH. What is the background on that 96 number?

Mr. CAVANAUGH. I apologize. I don't know the story there. I just know it is statutory based.

Mr. SMITH. And CMS has not enforced it up until they finally decided to start enforcing that, is that accurate? They had not been previously?

Mr. CAVANAUGH. Again, I apologize. I have been in the job for just a couple of weeks. I do know that the requirement does trace back to the statute.

Mr. SMITH. Okay. I have introduced a bill, H.R. 3993, the Critical Access Hospital Relief Act of 2014, which would repeal the regulation, and I would certainly encourage the agency's support of that. I think it might even make a lot of folks' jobs more easy to carry out, and I know that we have got other burdens on the critical access hospitals such as the physician supervision, again arbitrary, hard to determine how that ever even came about in terms of a rule or regulation, and it is very discouraging for medical providers to be facing all of these regulations that, like I said earlier, make it difficult for the good actor to do the right thing.

I know we have seen advertising on television about addressing fraud in Medicare/Medicaid and other areas, and yet I still think that all of these regulations are making it more difficult for the provider to do the right thing. I am not convinced that it is actually preventing fraud. I can appreciate the fact that there are limited resources, that you acknowledge that and that we are all trying to operate in a world of limited resources, and yet I think that many of these regulations are accomplishing the exact opposite of what they were intending to accomplish, and it is a huge burden and I would hope that the agency would really reflect on that fact as we do move forward.

I thank you, Mr. Chairman.

Chairman BRADY. Thank you.

Mr. Kind.

Mr. KIND. Thank you, Mr. Chairman. Thank you for holding this hearing. I want to thank our panelists for your testimony here today.

Just to maintain the momentum of some of my colleagues, especially my friend from Pennsylvania. As I have been talking to a lot of our providers back home in Wisconsin over the Two Midnight Rule, their sense is that it is awfully arbitrary, and they are having some definitional problems too, as far as what constitutes inpatient care versus observational status, outpatient care.

Has CMS, Mr. Cavanaugh, been working with the provider community to provide better definition or clarity in regards to those type of services, and what is the difference? I f they are in there under on observational status versus inpatient care, is there things you can point to that clearly distinguishes between the two types?

Mr. CAVANAUGH. So, first on the first half of your question about whether we are working with providers. I would say we certainly are. I think it was a big part of our attitude, going into this year, as you recall, we suspended the recovery auditors looking at these cases for these purposes because we wanted to work with

providers and we wanted to do it. So we have, as I said, the MACs going into each hospital and taking a small sample of cases and seeing whether they are complying with the rule.

And in instances where hospitals are, they are left alone for the rest of this year. In instances where hospitals are having trouble understanding or in implementing the new rule, the MACs are working with them to educate them.

So, I do feel like we have taken this pause in the recovery audit program, looking at these types cases, for the very reason you say which is to work with the hospitals and again, the origin of the rule was to respond to the request from the NG4 clarity. One of the things we may be look learning is that additional clarity is needed, or as we discussed, perhaps additional payment solutions are needed. We will wait to see how these discussions go. But I do think you raise an important point, that this is dialogue between us and the industry, and we do hope to learn quite a bit during this time.

Mr. KIND. Well, are there clear distinctions that can be made between inpatient and outpatient status, observational status within the hospital setting?

Mr. CAVANAUGH. Certainly observation status is supposed to be used for a short period for the purposes of determining whether a patient needs an inpatient level of care, and during that time, there ought to be diagnostic and other monitoring being conducted. I would hesitate to go any further into distinctions because I am not a clinician, but I think your point is well taken, which oftentimes these are based on complex medical judgments that are difficult to translate into payment policy.

Mr. KIND. You mention that CMS is moving forward on a short stay payment rule right now, and you are starting to get some feedback, some comments on that. What are the various factors, just for the committee's benefit, what are the various factors that you are taking under consideration in putting that rule together?

Mr. CAVANAUGH. The two questions we posed specifically in the proposed rule were, one, how would you define short stay cases, and there are examples of this. There are other payment systems out there that do use short stay payments, so it is not unprecedented, but it is a bit challenging here, as I mentioned earlier, in that some of the cases that are inpatient that are subject to RAC review are often already very short stay, even when they are legitimately inpatient, meaning they have an average length of stay of 2 days, so how do you—cases are typically 1, 2, or 3 days already, how do you carve out a short stay.

And the second, and this has been the subject of several questions. The second question we posed to public was, how would you construct this new payment? I think questions have arisen, would it include the IME and DSH adjustments, and learnings like that, and I think these are real important issues where we need some pubic feedback before we move forward.

Mr. KIND. Is uncompensated care or underinsured individuals, is that going to be a factor, too, in the short rule?

Mr. CAVANAUGH. Well, the way that currently gets into Medicare payment is typically through the DSH adjustment, and I think that is the fair question of whether it should be part of this as well.

Mr. KIND. Let me take you in a different direction. Obviously, recently, CMS did their physician reimbursement data dump that received a lot of attention, a lot of articles, a lot of focus, especially on some reimbursements that seemed outside the norm or other parameters than that.

We hear from the doctors in the follow-up questions that it wasn't just them. There were multiple docs or whatever using the same code in order to submit the billing information. Does that sound plausible to you that, that is what, in fact, what is taking place and why some doctors are being reimbursed 12 or $14 million in a single year?

Mr. CAVANAUGH. It is true that in certain instances multiple providers can bill under the same identification number.

Mr. KIND. Why are we allowing that?

Mr. CAVANAUGH. I will have to look into at that and get back to you, but I think there are legitimate reasons for that.

Mr. KIND. I would like to follow up. It just seems if we are trying to bring greater transparency, allowing multiple providers to use the same code seems to work against that issue. It is something that I think we are going to have to address.

Thank you, Mr. Chairman.

Mr. CAVANAUGH. Be happy to look into that.

Chairman BRADY. Thank you.

Dr. Price.

Mr. PRICE. Thank you, Mr. Chairman.

I want to thank the panelists as well. I think this is an incredibly important topic, and as a physician for over 20 years, know that we often times don't put the patient at the center of these discussions, and it is sometimes hard to do, especially when we are talking about money.

Mr. Cavanaugh, I was struck by the difference in the numbers that we hear recounted on the number of appeals that are either overturned or not, and your number of 7 percent astounds me because it is one that I have never heard before, so I suspect that includes all RAC audits that are done throughout the entire country. I don't want the answer to that, but I would like it in writing later.

But I think the question that we really need to ask is, of those cases that hospitals have appealed, that are inpatient stays denied due to medical necessity, what percent of those are overturned at the QIC level and then at the ALJ level. Do you have those numbers?

Mr. CAVANAUGH. I don't believe I have them handy, but they are, we can get them, and we will get them to you soon.

Mr. PRICE. I would appreciate that. One, there is a hospital system in my area where 72 percent are overturned. 72 percent. So I would urge you to look at your testimony that says when you are however 40 percent or thereabouts, something is wrong, something is wrong with the system.

I want to revisit that in a minute, but I want to touch on the Two Midnight Rule. When does—when a patient presents to the emergency room and is being admitted, when does the physician—when is there a physician that has to sign that says that this admission is medically necessary?

Mr. CAVANAUGH. That says the admission is medically necessary?

Mr. PRICE. And would qualify for the inpatient, for the Two Midnight?

Mr. CAVANAUGH. The physician can give the order—or other qualified professional can give the order verbally but has to countersign it at some point. It doesn't——

Mr. PRICE. But the order has to be given at the time of the admission?

Mr. CAVANAUGH. Yes. For a patient to become officially an inpatient, a physician or other qualified personnel has to give an order.

Mr. PRICE. So we are asking our doctors to predict what is going to happen to that patient over the next two midnights; is that right?

Mr. CAVANAUGH. It is based on a physician, the Two Midnight Rule is based on a physician's expectation, which this is expectation based on what they know at that time, and if a physician's expectation isn't fulfilled, meaning if the patient recovers or something else intervenes, the rule is not what happened but what the physician reasonably expected.

Mr. PRICE. Wouldn't we be better off if we said that doctors and patients and families ought to be making these decisions and not CMS?

Mr. CAVANAUGH. Well, again, CMS, we are trying to leave it largely at to a doctor's discretion, but we are also, as I said in my opening statement, we are trying to balance many goals here.

Mr. PRICE. No, I got you. I got you. But many physicians out there will tell you that they don't feel that you are trying to allow them to practice medicine. Are there clinical studies or reports that back up the Two Midnight Rule?

Mr. CAVANAUGH. I am not sure I understand the question, sir.

Mr. PRICE. Are there any clinical studies, scientists that have done studies, and say, yeah, this Two Midnight Rule makes sense from the patient's perspective and being treated?

Mr. CAVANAUGH. Again, we crafted the rule——

Mr. PRICE. Is there any clinical studies?

Mr. CAVANAUGH. The Two Midnight Rule is relatively new. I am not aware of any studies of it at this time.

Mr. PRICE. If you are, I would love to hear about it because I am not aware of any either. CMS contracts with these recovery audit groups to go get that money, right?

Mr. CAVANAUGH. CMS contracts with recovery auditors to review improper——

Mr. PRICE. And you pay them a percent.

Mr. CAVANAUGH. A contingency fee, yes.

Mr. PRICE. And when they—when an appeal is overturned, do you go get that money back?

Mr. CAVANAUGH. Yes, we do.

Mr. PRICE. From the RAC. How much is that?

Mr. CAVANAUGH. I am sorry?

Mr. PRICE. How much money is that?

Mr. CAVANAUGH. In total or any individual case?

Mr. PRICE. Total.

Mr. CAVANAUGH. I would be happy to go back and find that number. I don't know it off the top of my head.

Mr. PRICE. Good. Okay, can different RACs have different criteria for what's medically necessary?

Mr. CAVANAUGH. They are all supposed to tie to Medicare policy.

Mr. PRICE. And what is the clinical input that RACs are required to have to define what is medically necessary?

Mr. CAVANAUGH. If you mean, the RACs are required to have a medical director who is supervising all of their medical policies.

Mr. PRICE. And do medical specialty societies have an opportunity to review all of that?

Mr. CAVANAUGH. Of the work of the RACs?

Mr. PRICE. Yes.

Mr. CAVANAUGH. Not directly, sir.

Mr. PRICE. All of this money that is used to comply with all of these rules and regulations cost money, doesn't it? The hospitals, it costs money?

Mr. CAVANAUGH. Yes, sir.

Mr. PRICE. Millions of dollars, maybe more. Where does that money come from?

Mr. CAVANAUGH. Well, Congressman, I think you are getting at a point that I would concede right away, which is our goal is not to have a lot of these cases reviewed, not to have a lot of cases overturned. Our goal is to have clear policies that hospitals agree with and can comply with.

Mr. PRICE. Comes from patient care though, right? Doesn't it? If the hospital has to put that money into complying with the rules from CMS that get more and more laborious, then that money is not going into caring for that patient, so when we hear one of our colleagues here say this really isn't affecting the patient, that is really not true, is it?

Mr. CAVANAUGH. It is not a productive use of money, and it is why we are trying to reduce the need for this type of review.

Mr. PRICE. Thank you very much.

Chairman BRADY. Thank you.

Mr. Renacci.

Mr. RENACCI. Thank you, Mr. Chairman. I want to thank the panel.

Mr. Cavanaugh, Mr. McDermott asked you a question about—talked a little about three people entering the hospital, and I just was interested in a response. You said, "I would hope that the patient receives all the benefits they are entitled to." I want you to keep that in mind when we go through a couple of questions I have for you.

Due to the increase in the length of observation days, more and more Medicare beneficiaries are losing out on skilled nursing coverage. The OIG found beneficiaries had over 600,000 hospital stays that lasted three nights or more but did not qualify them for SNF services, skilled nursing facility services.

I have spent the majority of my career, almost 25 years in the long-term care industry. I recognized the barrier to access that the current 3-day inpatient requirement has created for our seniors. For this reason, I have actually introduced legislation, H.R. 3531,

the CARES Act that not only removes this barrier but also encourages hospitals and nursing facilities to communicate with each other before discharge.

Mr. Cavanaugh, the seniors in my district are often unaware of the 3-day inpatient requirement, and furthermore, seniors and their caregivers are unaware whether or not their hospital stays was billed as inpatient or observation. So I want you to think about that patient that enters the hospital, and they are entitled to long-term care under Medicare, and they end up in this quagmire of in observation day, not an inpatient day, and quite frankly, they probably could go directly to a nursing home in many cases because the doctor is only sending them to the hospital because that is a requirement, and it is actually costing the Medicare system dollars to send them through to that hospital just to get them the path to that nursing home.

So, if you think about that patient, and again, going back to your comment, "I would hope the patient receives all the benefits they are entitled to," you send the, we send this patient into a hospital because it is a requirement, they go through 3 days, they have to, you know, to get to the nursing home. The doctor already says they belong in a nursing home. Again, I was in the industry for 25 years. I can tell you these patients belong in that nursing home, and they get caught up in this observation day, but here is the problem. Then they are sent to the nursing home, and when they are sent to the nursing home, for 2,000 of the hospital stays, Medicare did not pay for NSF services, and the beneficiary was charged an average of $11,000.

So now we have this patient who started in the hospital, ended up in observation day, probably should have never went in the hospital if we had a different system that actually my bill would allow, lets them go directly into the nursing home because the doctor says that is the care that is needed.

So, has CMS implemented any policies that would really decrease the instances in which seniors, and again, that is what I am talking about, that person you talked about, the benefits that they are entitled, where there were seniors who were caught off guard and left off on the hook for thousands of dollars in medical bills.

Mr. CAVANAUGH. Congressman, I think you raise a very important issue and one that was one of the driving factors to us looking at the Two Midnight Rule. I tell you two things. One, one of the impacts we are seeing, at least preliminarily of the effect of the Two Midnight Rule, is we are seeing a decrease in these long observation stays, and I believe those are probably shifts to inpatient status so potentially helping the beneficiaries you are talking about, but you are also talking about a larger issue of whether these patients need to go through the hospital in order to—or should need to go through the hospital in order to access the skilled nursing facility benefit and as I mentioned to an earlier question, we are interested in exploring alternatives to that, too.

We currently have a subset of the pioneer ACOs, several of whom have had the 3-day hospitalization rule waived so they can test whether there are safe and effective ways for patients to be admitted to the SNF without the prior hospitalization, and we are, this year, also allowing some of the participants, both hospitals and

post-acute care providers to do that as well in our bundled payment initiative. So we are hoping we will gain clinical and financial evaluation results from that, that we can share with this committee and maybe apply to broader Medicare policy.

Mr. RENACCI. You would then agree—it sounds like these studies will give us some of those answers, but you would agree sending somebody to the hospital and having the cost, the burden of that person in that hospital when it really could go to a nursing home might be a way of saving some dollars if we sent them directly to the nursing home?

Mr. CAVANAUGH. We do feel there is potential there, but again, we are testing it, and I don't want to prejudge the results of these tests.

Mr. RENACCI. All right. Thank you.

I yield back.

Chairman BRADY. Thank you.

Mr. Crowley.

Mr. CROWLEY. Thank you, Mr. Chairman.

Thank you, Chairman Brady and Ranking Member McDermott for allowing me to join with you all at this hearing today.

And welcome, Mr. Cavanaugh. Good to have you here. I know I speak for all my colleagues when I say we look forward to working with you in your new capacity, new role at CMS.

Mr. CAVANAUGH. Thank you.

Mr. CROWLEY. So, I represent parts of New York City, Queens and the Bronx. I know you are familiar with those areas quite well. We are fortunate to have a number of highly regarded hospitals and medical institutions, many of which are also academic medical centers, and I know you are familiar with all those as well.

These hospitals and others across the country are struggling with the implementation of the Two Midnight Rule, and while I appreciate CMS' efforts to try and clarify when the patient should be admitted as an inpatient, I have serious concerns about the overall policy. Our New York hospitals focused primarily on providing the best medical treatment with great efficiency rather than on what time the patient is admitted. The Two Midnight Policy sets an arbitrary standard that does not always reflect the clinical judgment of the treating physician.

Several months ago, Representative Gerlach and I introduced legislation to delay the enforcement of the Two Midnight Policy. I am glad that this delay was included in the most recent doctor's payment fix, and I thank the committee for all of its work in achieving that delay. But the problems with the underlying rule remain, and they need to be addressed. That is why our bill also orders the CMS to implement a new payment methodology for short inpatient stays that don't fit neatly into the divides of the Two Midnight Policy.

I was very pleased to see that CMS' proposed Medicare inpatient rule for next fiscal year includes requests for feedback on establishing a short stay inpatient methodology, which could help both providers and beneficiaries. I hope that CMS will continue to work closely with hospitals and patients in establishing this process and in taking into account the costs associated with operating, teaching, and safety in our hospitals. It is important a new payment sys-

tem protect graduate medical education and disproportionate share hospital payments.

Now, I know the rulemaking process is under way, but can you comment at all on how you see this issue being addressed as you move forward, if there are any possible methods you have considered and are willing to consider?

Mr. CAVANAUGH. Thank you, Congressman, and thank you for your kind words. I do know New York and the hospital industry there quite well, having worked there, and in one hospital and closely with many of the others.

You are correct. First of all, you are correct that Congress extended, and based on your legislation, the pause in the RAC review of medical necessity of inpatient stays until March of next year. I think that does give us all, both Congress and the administration, some time to think about how the policy is working and whether there are additional steps that are needed to make a clearer payment policy that we can all agree on.

One of those areas that we are going to spend a significant amount of time and resources on is exploring the possibility of a short stay outlier. I don't want to prejudge how we would do this because we are soliciting public input, but as I have said in response to several other questions, it is an intriguing idea, but it also poses, you know, real conceptual challenges. We are up to those challenges, but I don't want to under estimate them.

One of the things I would point out is, if it is going to be an inpatient short stay thing, we are still going to need a definition of when inpatient care is necessary because you will still have a distinction between inpatient and outpatient. We are going to have the challenge of how do you create short stay payment when certain DRGs are already very short stay. But I know, as I said, there is some very great minds up in the New York hospital industry that I know are working on this, and they have been in touch with us, we have been in touch with the other association, so we eagerly await their input.

Mr. CROWLEY. Thank you, Mr. Cavanaugh. I look forward to continuing to work with you in your new capacity, and I hope that you have that same open mind approach when you are dealing with the committee and the chairman and the ranking member as well, so thank you for being here today.

Mr. CAVANAUGH. Thank you, sir.

Chairman BRADY. Thanks. Mrs. Black.

Mrs. BLACK. Thank you, Mr. Chairman. I want to thank you for allowing a non-committee member to be here to listen to the testimony and have an opportunity to be able to ask a question.

Ms. Nudelman, in your written testimony, you talk about some hospitals use a short stay inpatient for less than 10 percent, excuse me, of their stays and others use it over 70 percent. Did you find any tends when you were looking at these vast differences between how hospitals use these and whether there is any type of hospital, in particular, that uses them differently?

Ms. NUDELMAN. Thank you for your question. As you know, we did see a lot of variation, but we did not look at whether there are certain types of hospitals that are more likely to use short inpa-

tient stays. If the trend continues under the new policy, you know, this is a really important question to look into further.

Mrs. BLACK. I certainly think that, that is one that would give us a lot of information because if you are using it for certain types of hospitals is it cardiac hospitals, were they looking at orthopedic, I think it would be very interesting to take a look at the wide variance that is there between 10 and 70 percent.

And let me go to another area that seems to be a lot of variance, and that is, in your testimony on page number 5 underneath of the appeals, you note that about 72 percent of those who appeal are successful and yet we keep on hearing this number of 7 percent. There is a real disparity there. Can you break that down? There is something else there that we are not exactly understanding.

Ms. NUDELMAN. Sure. Let me try to do that. I think what we are seeing is there is about six, most of the appeals from RACs are not appeals. Most of the RAC decisions are not appealed, so according to our statistics, about 6 percent of the RAC decisions are appealed. Now, once those are reached higher levels, about half of those are overturned, so that maybe can help reconcile some of those issues.

Where the 72 percent comes into play is when we looked at the third level of appeals, the ALJ level, they overturn about 72 percent of hospital claims. That would include both RACs, that would include other issues than just the inpatient.

Mrs. BLACK. So, just to be clear.

Ms. NUDELMAN. Sure.

Mrs. BLACK. About 7 percent, 6 or 7 percent, depending upon who is talking about that number, but somewhere in that range of those decisions that are made by RACs are appealed, and of those that are appealed, in this case of Part A hospitals, 72 percent of those prevail, correct?

Ms. NUDELMAN. Overturn.

Mrs. BLACK. Overturn.

Ms. NUDELMAN. At the ALJ level.

Mrs. BLACK. ALJ level. Okay. Well, that makes a lot more sense because there is a lot of disparity between 6 percent and 70 percent, and so that helps me to understand a little bit better about where those numbers are coming from. Thank you very much.

Thank you, Mr. Chairman.

Chairman BRADY. Thank you, Mrs. Black.

I am now confused about the appeal process. Can I, I don't mean to intervene here for a minute before I go to Ms. Jenkins. But, so 94 percent of the claims identified as overpayments on appeal, 6 percent left half, almost half are decided in favor of the appeal, is that right? So the over payments, 97 percent of them, at the end of the day, are considered accurate.

Ms. NUDELMAN. Just repeat that last part of your sentence. I just didn't hear that.

Chairman BRADY. Of the RAC decisions on claims identified as overpayments, 94 percent aren't appealed. Of the 6 percent that are left, half are overturned, so——

Ms. NUDELMAN. That is according to our numbers.

Chairman BRADY [continuing]. You are saying 97 percent of those overpayments are upheld?

Ms. NUDELMAN. Yes.

Chairman BRADY. Half of 6, 3, 94.

Ms. NUDELMAN. Yeah. And that is prior to the surge, and that is in fiscal years 2010 and 2011, so that could also be part of the issue.

Chairman BRADY. Is there a dollar figure attached to that? For example, you may not appeal a $10 overpayment but you would a $10,000 one. Does your analysis show of those that were appealed a higher dollar value of those?

Again, Mrs. Black, I don't mean to jump, but you were leading down the right road. What do you know about that?

Ms. NUDELMAN. I don't have the dollar values in terms of what is appealed in terms of dollar amounts.

Chairman BRADY. Can you try to figure that out?

Ms. NUDELMAN. We can.

Chairman BRADY. Give us a little more texture about——

Ms. NUDELMAN. Absolutely.

Chairman BRADY. Of that 6 percent, what do they look like, you know, and are the higher dollar values, are they in a certain area. And then 72 percent, tell me about that?

Mrs. BLACK. That is of the hospitals, the Part A hospitals are 72 percent. So, according to what I am reading here, at the ALJ level, appellants were most likely to receive favorable decisions for Part A hospital appeals at 72 percent.

And if I may, Mr. Chairman, just interject one other thing that I thought about that I keep hearing from these hospitals. Is the length of time it takes them to go from the original decision that is made by the RACs, to the time that they reach the ALJ level, can you give us an idea about how much time period there is in that typically?

Ms. NUDELMAN. Sure. I mean, particularly now with the postponement of assigning appeals, which the—Omaha just put into place, and they are projecting just from what is publicly available that cases will not be assigned for at least 2 years, so that is pretty significant.

Mrs. BLACK. So there is a cost to the facility in that time period where they are trying to appeal it and the payments, they have been taken back, so thank you very much.

Chairman BRADY. No agreements, so Mrs. Black, thank you.

And Ms. Jenkins, you probably never thought we would get to you. You are recognized for 5 minutes.

Ms. JENKINS. Well, Mr. Chairman, I just thank you for allowing me to join you at today's subcommittee hearing, and I appreciate this panel for being here.

These issues affect hospitals all over the country, and I have heard countless stories from Kansas hospitals, about the difficulties they face surrounding the Medicare program. Lawrence Memorial Hospital in Lawrence, Kansas has asked that I share their perspective on recovery audit contractors.

The hospital currently has $4.7 million being withheld because of RAC audits. It has appealed nearly all RAC audits, and so far has demonstrated a 96 percent success rate in the appeals process. So, Lawrence Memorial has brought to my attention what is a valid concern that I am hoping you will take into consideration.

The hospitals are forced to disallow Medicare days and discharges that are currently held up in the RAC audit process because of the massive backlog at the ALJ level of appeal, and the hospital is concerned that these audits, which are likely to be resolved in their favor, will not be completed within the 3-year window during which it can reopen a cost report window and count towards their meaningful use requirements. This is just one of countless hospitals in Kansas that is experiencing the immediate and similarly effects of the current flawed system.

As we continue to discuss a way forward on this topic, please take this problem into account. Secondly, I would like to highlight a program with the 83 critical access hospitals in Kansas and others around the country and what they are experiencing. I received a letter from the Anderson County Hospital in Garnett, Kansas, and I would ask that chairman's consent to insert the letter into the record.

Chairman BRADY. Without objection.

[The information follows: The Honorable Diane Black]

Department of Health and Human Services

OFFICE OF
INSPECTOR GENERAL

IMPROVEMENTS ARE NEEDED AT THE ADMINISTRATIVE LAW JUDGE LEVEL OF MEDICARE APPEALS

Daniel R. Levinson
Inspector General

November 2012
OEI-02-10-00340

EXECUTIVE SUMMARY: IMPROVEMENTS ARE NEEDED AT THE ADMINISTRATIVE LAW JUDGE LEVEL OF MEDICARE APPEALS
OEI-02-10-00340

WHY WE DID THIS STUDY

Administrative law judges (ALJ) within the Office of Medicare Hearings and Appeals (OMHA) decide appeals at the third level of the Medicare appeals system. In 2005, among other changes, ALJs were required to follow new regulations addressing how to apply Medicare policy, when to accept new evidence, and how the Centers for Medicare & Medicaid Services (CMS) participates in appeals. Medicare providers and beneficiaries may appeal certain decisions related to claims for health care services and items.

HOW WE DID THIS STUDY

We based this study on an analysis of all ALJ appeals decided in fiscal year (FY) 2010; structured interviews with ALJs and other staff; structured interviews with Qualified Independent Contractors (QIC), which administer the second level of appeal, and CMS staff; policies, procedures, and other documents; and data on CMS participation in ALJ appeals.

WHAT WE FOUND

Providers filed the vast majority of ALJ appeals in FY 2010, with a small number accounting for nearly one-third of all appeals. For 56 percent of appeals, ALJs reversed QIC decisions and decided in favor of appellants; this rate varied substantially across Medicare program areas. Differences between ALJ and QIC decisions were due to different interpretations of Medicare policies and other factors. In addition, the favorable rate varied widely by ALJ. When CMS participated in appeals, ALJ decisions were less likely to be favorable to appellants. Staff raised concerns about the acceptance of new evidence and the organization of case files. Finally, ALJ staff handled suspicions of fraud inconsistently.

WHAT WE RECOMMEND

We recommend that OMHA and CMS: (1) develop and provide coordinated training on Medicare policies to ALJs and QICs, (2) identify and clarify Medicare policies that are unclear and interpreted differently, (3) standardize case files and make them electronic, (4) revise regulations to provide more guidance to ALJs regarding the acceptance of new evidence, and (5) improve the handling of appeals from appellants who are also under fraud investigation and seek statutory authority to postpone these appeals when necessary. Further, we recommend that OMHA: (6) seek statutory authority to establish a filing fee, (7) implement a quality assurance process to review ALJ decisions, (8) determine whether specialization among ALJs would improve consistency and efficiency, and (9) develop policies to handle suspicions of fraud appropriately and consistently and train staff accordingly. Finally, we recommend that CMS: (10) continue to increase CMS participation in ALJ appeals. OMHA and CMS concurred fully or in part with all 10 of our recommendations.

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OBJECTIVES

1. To describe the characteristics of appeals decided by Medicare administrative law judges (ALJ) in fiscal year (FY) 2010.
2. To describe differences between ALJ and prior-level decisions and differences among ALJs.
3. To determine the extent to which the Centers for Medicare & Medicaid Services (CMS) participated in ALJ appeals in FY 2010.

BACKGROUND

Medicare providers and beneficiaries may appeal certain decisions related to claims for health care services and items.[1] The administrative appeals process includes four levels; ALJs decide appeals at the third level. In 2005, the responsibility for conducting ALJ appeals was transferred from the Social Security Administration (SSA) to the Department of Health and Human Services (HHS).[2]

Among other changes, ALJs were required to follow new regulations that addressed how Medicare policy must be applied, when new evidence may be accepted, and how CMS can participate in appeals.[3] Before these changes were introduced, two Office of Inspector General (OIG) reports found a number of problems with Medicare appeals.[4] In particular, OIG found that the different levels of appeal did not consistently apply the same standards and that CMS's ability to defend its decisions was limited. The 2005 regulatory changes were intended to address many of these concerns.

This report is the first to assess the impact of these changes on ALJ appeals. In particular, it describes the characteristics of appeals decided by ALJs, differences between ALJ and prior-level decisions, differences among ALJs, and CMS's participation in ALJ appeals.

The Medicare Administrative Appeals Process

There are four levels of appeal:

- Level One, administered by CMS Medicare Administrative Contractors;

[1] For the purposes of this report, we use "provider" to refer to both providers and suppliers that provide items and services under Medicare Parts A and B.

[2] The Medicare Prescription Drug, Improvement, and Modernization Act of 2003, P.L. 108-173 § 931.

[3] 42 CFR §§ 405.1010, 405.1012, 405.1028, and 405.1062(a).

[4] OIG, *Medicare Administrative Appeals: ALJ Hearing Process*, OEI-04-97-00160, September 1999; OIG, *Medicare Administrative Appeals: The Potential Impact of BIPA*, OEI-04-01-00290, January 2002.

- Level Two, administered by CMS Qualified Independent Contractors (QIC);
- Level Three, administered by ALJs; and
- Level Four, administered by the Medicare Appeals Council.[5]

When a party is dissatisfied with CMS's payment decision on a claim, that party may appeal. The party that files an appeal is called the appellant. If appellants receive unfavorable decisions at one level, they may appeal to the next level.[6] Appellants include Medicare beneficiaries; Medicare providers, such as physicians, suppliers, and hospitals; and State Medicaid agencies. State Medicaid agencies may appeal when there is a question of whether Medicare, rather than Medicaid, should pay for the services or items received by beneficiaries who are eligible for both Medicare and Medicaid coverage (known as dually eligible beneficiaries).

The first level of appeal is administered by the CMS contractors that make the initial decisions to pay or deny claims.[7] At the second level, two QICs conduct Part A appeals; two conduct Part B appeals; and one conducts appeals for durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS). At the first two levels, decisions are made after the contractors review the evidence in the case files.[8]

The third level of appeal is conducted by ALJs and differs substantially from the first two levels. One of the major differences is that the appellant has the right to a hearing before an ALJ. Under certain circumstances, however, the ALJ may not conduct a hearing and instead may make a decision after reviewing the evidence in the case file (known as an on-the-record review).[9]

An ALJ may make a decision that is fully favorable, partially favorable, or unfavorable to the appellant.[10] These decisions must be based on evidence in the

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[5] The third and fourth levels apply to most types of appeals, but the first two levels apply only to appeals related to Medicare Parts A and B claims.

[6] The first two levels of appeal do not require a minimum dollar amount to be at issue, but the ALJ level does. In FY 2010, this threshold was $130. See 42 CFR § 405.1006. None of the levels of appeal require appellants to pay a filing fee.

[7] Of the 1.1 billion Parts A and B claims that CMS contractors processed in 2010, 117 million were denied and 2.7 million were appealed to the first level. See CMS, Fact Sheet: Original Medicare (Fee-For-Service) Appeals Data – 2010. Accessed at https://www.cms.gov/Medicare/Appeals-and-Grievances/OrgMedFFSAppeals/Downloads/Factsheet2010.pdf on August 8, 2012.

[8] The case file refers to the administrative record and includes claims, medical records, and other evidence. See 42 CFR § 405.1044(b).

[9] An ALJ may make a decision after an on-the-record review if the parties waive their right to a hearing or if the evidence supports a fully favorable decision for the appellant.
See 42 CFR §§ 405.1000(e)–(g). See also 42 CFR § 405.1038.

[10] Under certain circumstances, an ALJ may also dismiss an appeal or remand it to the prior level. See 42 CFR §§ 405.1034 and 405.1052.

case files and on hearing testimony.[11] The law protects ALJs' independence to ensure that their decisions are impartial and free from HHS influence.[12] Any party who is dissatisfied with the ALJ's decision may appeal to the Medicare Appeals Council. When deciding appeals, adjudicators at all four levels conduct a new, independent review of the evidence and are not bound by the prior levels' findings and decisions.[13] After exhausting the four levels of the administrative appeals process, parties may seek judicial review in Federal District Court.

Changes to Medicare ALJ Appeals

In 2005, HHS established the Office of Medicare Hearings and Appeals (OMHA), which created a group of ALJs dedicated to deciding Medicare appeals. These ALJs were required to follow new regulations that addressed how Medicare policy must be applied, when new evidence may be accepted, and how CMS may participate in appeals.

Prior to 2005, ALJs were bound by Medicare laws, regulations, and National Coverage Determinations when making decisions, but were not bound by Local Coverage Determinations or CMS program guidance. In 2005, new regulations were introduced that required ALJs to "give substantial deference" to these latter policies and to provide an explanation if they decline to follow one of these policies in an appeal.[14]

Prior to 2005, appellants were allowed to submit new evidence at the ALJ level without restrictions. Beginning in 2005, an appellant must explain in writing the reason for submitting new evidence and ALJs may accept the new evidence only if they determine that the appellant had "good cause" for waiting until the ALJ level to submit it.[15]

Before 2005, CMS was not allowed to participate in ALJ appeals, which were established as a nonadversarial system for appellants to present their cases before neutral judges.[16] Under the new regulations, however, CMS may choose to participate in ALJ appeals as either a participant or a party. As a participant, CMS

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[11] 42 CFR § 405.1046(a).

[12] 5 U.S.C. § 554(d).

[13] This type of review is referred to as *de novo*. See CMS, *Medicare Claims Processing Manual*, Pub. No. 100-04, ch. 29, § 110; 42 CFR §§ 405.948, 405.968(a)(1), 405.1000(d), and 405.1100(c).

[14] 42 CFR § 405.1062(a)–(b). Prior to these regulations, Federal case law established that adjudicators should give deference to agency guidance, such as Local Coverage Determinations. See Shalala v. Guernsey Memorial Hospital, 514 US 87 (1995). QICs are also bound by Medicare laws, regulations, and National Coverage Determinations and must give substantial deference to Local Coverage Determinations and CMS program guidance. See 42 CFR § 405.968(b).

[15] 42 U.S.C. § 1395ff(b)(3). This restriction applies to providers and represented beneficiaries, but not to unrepresented beneficiaries. It also does not apply to oral testimony presented during the hearing. See 42 CFR §§ 405.1018(c) and 405.1028.

[16] Before 2005, CMS participated occasionally when an ALJ requested its participation. See 70 Fed. Reg. 11459 (Mar. 8, 2005).

may submit position papers and provide testimony during the hearing.[17] As a party, CMS may also submit evidence to the ALJ, call or cross-examine witnesses during the hearing, and appeal to the next level.[18] CMS contractors, rather than the agency, typically participate in ALJ appeals.

Related Work

This report is part of OIG's continuing work on Medicare ALJ appeals. Two OIG reports evaluated ALJ appeals when they were administered by SSA.[19] These reports found that the different levels of appeal did not consistently apply the same standards and that CMS's ability to defend its decisions was limited. OIG recommended requiring the different levels of appeal to apply the same standards, creating a dedicated ALJ corps for Medicare, and allowing increased participation from CMS at the ALJ level.

In addition, two OIG reports evaluated ALJ appeals after the transition from SSA to OMHA.[20] These reports were focused on the timeliness of ALJ appeals and on the format of ALJ hearings, which included, for the first time, telephone and video teleconference hearings in addition to the in-person hearings used by SSA. The reports found that OMHA did not decide a number of its cases in a timely manner during its first 13 months of operation, but that timeliness improved by its third year of operation. In addition, OIG found that most appellants who were interviewed were satisfied with their hearing formats.

METHODOLOGY

We based this study on an analysis of: (1) data on appeals decided in FY 2010; (2) structured interviews with ALJs and other OMHA staff; (3) structured interviews with QIC and CMS staff; (4) policies, procedures, and other documents; and (5) data on CMS participation in ALJ appeals.

Appeals Data

We obtained data on ALJ appeals from the Medicare Appeals System (MAS), a database that tracks appeals at the second and third levels. Using these data, we examined several characteristics of the appeals decided by ALJs in FY 2010.

We calculated the percentage of ALJ appeals for each appellant type—beneficiaries, providers, and State Medicaid agencies. We determined whether

[17] 42 CFR § 405.1010(c).

[18] 42 CFR § 405.1012.

[19] OIG, *Medicare Administrative Appeals: ALJ Hearing Process*, OEI-04-97-00160, September 1999; OIG, *Medicare Administrative Appeals: The Potential Impact of BIPA*, OEI-04-01-00290, January 2002.

[20] OIG, *Medicare Administrative Law Judge Hearings: Early Implementation, 2005–2006,* OEI-02-06-00110, July 2008; OIG, *Medicare Administrative Law Judge Hearings: Update, 2007–2008*, OEI-02-06-00111, January 2009.

the different types of appellants were more likely to file appeals related to certain Medicare program areas (e.g., Part A hospital appeals).[21] We also calculated the number of appeals associated with each unique appellant and identified the appellants who filed frequently.[22] We considered appellants to be frequent filers if they had 50 or more appeals decided in FY 2010.

Next, we calculated the percentage of appeals associated with each type of ALJ decision: fully favorable to the appellant, partially favorable to the appellant, unfavorable to the appellant, or other.[23] In addition, we determined the extent to which the fully favorable rate varied by Medicare program area and by appellant type.

We then analyzed how the fully favorable rate varied by ALJ.[24] We determined whether the variation in fully favorable rates was associated with some ALJs' deciding more appeals in certain Medicare program areas than other ALJs. To conduct this analysis, we compared each ALJ's actual fully favorable rate to that ALJ's expected fully favorable rate.[25] In addition, we determined the extent to which frequent filers received different favorable rates from different ALJs. Finally, we determined whether certain ALJs were more likely than others to decide appeals after an on-the-record review of the case file.

We also obtained data from MAS on appeals that QICs decided in FY 2010. We used these data to calculate the percentage of QIC appeals that were fully favorable to appellants.

Structured Interviews With ALJs and Other OMHA Staff

We conducted structured interviews with the Chief ALJ, the Executive Director of OMHA, the Managing ALJ from each field office, and a sample of ALJ teams.[26]

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[21] We analyzed DMEPOS appeals separately from other Part B appeals throughout the report.

[22] To identify unique appellants, we took into account appellant information, such as name and Medicare identifier. In MAS, the Medicare identifiers include National Provider Identifiers and Health Insurance Claim Numbers, among others. Additionally, for appellants who were providers, we linked Medicare identifiers to information in CMS's Provider Enrollment, Chain, and Ownership System to determine which providers were part of a chain. We considered all providers that had the same Medicare identifier or that were part of the same chain to be unique appellants.

[23] Under certain circumstances, ALJs may dismiss appeals or remand them to the prior level; appellants may also escalate appeals to the next level if ALJs do not make timely decisions. See 42 CFR §§ 405.1034, 405.1052, and 405.1104.

[24] For this analysis, of the 72 ALJs, we included the 66 who decided at least 50 appeals as fully favorable, partially favorable, or unfavorable during FY 2010. These ALJs accounted for 99 percent of all appeals.

[25] To determine each ALJ's expected rate, we first calculated the fully favorable rate among all ALJs for each Medicare program area; next, we multiplied these rates by the percentage of appeals that the ALJ had in that program area and summed the results.

[26] OMHA's central office and one of its field offices are located in Arlington, Virginia. The other three field offices are in Miami, Florida; Cleveland, Ohio; and Irvine, California. At the time of the interviews, the Virginia field office had 4 ALJ teams and the other three had 13, 21, and 18 ALJ teams, respectively. For the purposes of this report, we refer to all respondents as ALJ staff.

We randomly selected 20 percent of the ALJ teams from each field office, for a total of 12 ALJ teams. The teams were each made up of an ALJ, an attorney, and other staff. We interviewed the ALJ and the attorney from each team. Our questions focused on ALJs' approaches to decisionmaking, including their application of Medicare policies and their acceptance of new evidence, and on their experience with CMS participation in appeals. We conducted these interviews in December 2010 and January 2011.

Structured Interviews With QIC and CMS Staff

We conducted structured interviews with key staff from the three CMS divisions that oversee the contractors that administer the first two levels of appeal, as well as other contractors that participate in ALJ appeals.[27] We also conducted structured interviews with key staff from each of the five QICs and the Administrative QIC, which provides support to the QICs.[28] Our questions focused on the QICs' and other contractors' experience participating in ALJ appeals and on the QICs' approaches to decisionmaking. We conducted these interviews in August and September 2011.

Review of Documentation

In the fall of 2010, we requested and reviewed written policies, procedures, and training materials from OMHA and CMS. We used these documents primarily to validate the information from our interviews.

CMS Participation Data

We obtained data from CMS regarding its contractors' participation in ALJ appeals that were decided in FY 2010.[29] For each appeal, CMS indicated which contractor participated, whether the contractor was a participant or a party, and whether it submitted a position paper or testified at the ALJ hearing. We merged these data with the MAS data.

We then calculated the percentage of all ALJ appeals in which CMS participated and assessed how the rate of participation varied by Medicare program area and by type of contractor. We also determined the extent to which CMS was a participant versus a party and the extent to which it submitted position papers versus testified at ALJ hearings. Lastly, we compared the ALJ favorable rates when CMS participated to when it did not participate.

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[27] These other contractors include the Zone Program Integrity Contractors, Program Safeguard Contractors, and Recovery Audit Contractors, all of which take steps to recoup inappropriate Medicare payments.

[28] For the purposes of this report, we refer to CMS and contractor respondents as CMS staff.

[29] These data were limited to Medicare Part A, Part B, and DMEPOS appeals. CMS does not participate in Parts C and D appeals, which typically involve disputes between appellants and their private plans.

Standards

This study was conducted in accordance with the *Quality Standards for Inspection and Evaluation* issued by the Council of the Inspectors General on Integrity and Efficiency.

FINDINGS

Providers filed 85 percent of the appeals decided by ALJs in FY 2010

Providers filed 85 percent of the 40,682 appeals that ALJs decided in FY 2010. These providers included physicians, suppliers, and hospitals, among others. As shown in Table 1, beneficiaries filed 11 percent of the appeals, while State Medicaid agencies filed 3 percent. State Medicaid agencies may appeal when there is a question of whether Medicare, rather than Medicaid, should pay for the services or items received by a dually eligible beneficiary.

Table 1: Percentage of ALJ Appeals by Appellant Type, FY 2010

Type of Appellant	Number of Appellants	Number of Appeals	Percentage of Appeals
Provider	6,102	34,542	85%
Beneficiary	4,429	4,631	11%
State Medicaid Agency	5	1,361	3%
Unknown	120	148	<1%
Total	**10,656**	**40,682**	**100%**

Source: OIG analysis of MAS data, 2012.

Providers, beneficiaries, and State Medicaid agencies tended to file different types of appeals. Providers were more likely than other appellant types to file Part B and DMEPOS appeals, while beneficiaries were more likely to file Parts C and D appeals. State Medicaid agencies were more likely than other appellant types to file Part A appeals, especially home health, hospice, and skilled nursing facility appeals. For example, 90 percent of State Medicaid agency appeals were Part A appeals, while only 40 percent of provider appeals and 16 percent of beneficiary appeals were Part A appeals. See Appendix A for more information on appeals by appellant type.

A small number of providers accounted for nearly one-third of all appeals

Certain providers filed appeals much more frequently than others. On average, providers filed six appeals each. However, 96 providers were frequent filers that filed at least 50 appeals each, with 1 provider filing 1,046 appeals. While these providers represented 2 percent of all providers, they accounted for nearly one-third of all ALJ appeals in FY 2010. These providers were twice as likely as other providers to file DMEPOS appeals. No beneficiaries were frequent filers. However, 4 State Medicaid agencies filed at least 50 appeals each; 2 of these filed more than 500 appeals each.

Many ALJ staff raised concerns about the frequent filers. Several staff noted that some of these appellants appeal every payment denial. A few staff said that these appellants have an incentive to appeal because the cost is minimal and a favorable decision is likely.

For 56 percent of appeals, ALJs reversed prior-level decisions and decided fully in favor of appellants

ALJs may decide appeals in several ways: fully favorable to appellants, partially favorable to appellants, or unfavorable to appellants.[30] As shown in Table 2, ALJs reversed prior-level decisions by QICs and decided fully in favor of appellants in 56 percent of appeals in FY 2010. In contrast, QICs decided fully in favor of appellants in 20 percent of appeals in FY 2010.

Table 2: Percentage of ALJ Appeals by Decision, FY 2010

Appeal Decision	Percentage of Appeals
Fully favorable to the appellant	56%
Partially favorable to the appellant	6%
Unfavorable to the appellant	24%
Dismissed, remanded, or escalated	14%
Total	**100%**

Source: OIG analysis of MAS data, 2012.

The ALJ fully favorable rate varied substantially across Medicare program areas. As shown in Table 3, the fully favorable rate was the highest for Part A hospital appeals at 72 percent, while the rates were the lowest for Parts C and D appeals at 18 and 19 percent, respectively. Several ALJ staff noted that an ALJ typically has less discretion when deciding Parts C and D appeals because the beneficiary has agreed to a contract with a private plan that covers or does not cover the specific service or drug.

[30] Under certain circumstances, appeals may be dismissed, remanded to the prior level, or escalated to the next level.

Table 3: Percentage of ALJ Appeals That Were Fully Favorable to Appellants, by Medicare Program Area, FY 2010

Medicare Program Area	Percentage Fully Favorable to Appellants
Part A	**62%**
Hospitals	72%
Home Health/Hospice Agencies	62%
Other Part A	61%
Skilled Nursing Facilities	51%
Part B	**59%**
Transportation	67%
Diagnostic Testing	63%
Practitioner Services	60%
Other Part B	48%
DMEPOS	**53%**
Other*	**26%**
Part D	**19%**
Part C	**18%**

Source: OIG analysis of MAS data, 2012.

* This category includes appeals about beneficiary premiums and entitlement to Medicare.

The fully favorable rate also varied substantially by appellant type. For providers, it was 61 percent. In contrast, the fully favorable rate was 28 and 22 percent for beneficiaries and State Medicaid agencies, respectively. The rate was lower for beneficiaries than for providers, partly because the majority of beneficiary appeals dealt with Parts C and D, while providers rarely filed such appeals. Overall, the fully favorable rate for providers who were frequent filers differed only slightly from the rate for other providers. See Appendix B for more information about the fully favorable rates for each appellant type, as well as for providers that were and were not frequent filers.

Differences between ALJ and QIC decisions were due to different interpretations of Medicare policies and other factors

ALJs differed from QICs in their interpretation of Medicare policies, in their degree of specialization, and in their use of clinical experts. These differences contributed to different decisions at the ALJ and QIC levels.

ALJs tended to interpret Medicare policies less strictly than QICs

Most ALJ and QIC staff agreed that reasonable people can interpret Medicare policies differently, and several staff emphasized that some policies need to be flexible to cover a wide range of beneficiary circumstances. At the same time, both ALJ and QIC staff indicated that ALJs tended to interpret Medicare policies

less strictly than QICs. Most ALJ staff noted that ALJs often decided in favor of appellants when the intent, but not the letter, of a Medicare policy was met. In contrast, most QICs noted that they try to follow Medicare policy strictly. One QIC added that it approaches appeals expecting to uphold prior-level decisions unless the evidence to reverse is compelling.

ALJ and QIC staff offered several examples to illustrate their differences in interpreting Medicare policies. In one example, QICs denied home health services because beneficiaries did not meet the requirement to be homebound; then ALJs determined that the home health services were reasonable and necessary without focusing on the homebound requirement. In another example, QICs denied payments because beneficiaries met only 9 out of 10 criteria in the Local Coverage Determination, but ALJs found that the beneficiaries met the broader intent of the policy and reversed the decision.

In addition, ALJ and QIC staff commonly noted that some Medicare policies are unclear. Several staff cited examples of policies with vague definitions, such as coverage for beneficiaries who have "unique characteristics" or are "declining." Many ALJ staff emphasized the need to write policies more narrowly or more clearly, noting that unclear policies lead to more fully favorable decisions and to more variation among ALJs.

ALJs and QICs differed in the degree to which they specialized in Medicare program areas and in their use of clinical experts

Each of the QICs specializes in a Medicare program area: two QICs are responsible for Part A appeals, two for Part B, and one for DMEPOS. In contrast, ALJs typically decide appeals involving all Medicare program areas because their appeals are usually randomly assigned.[31] Several ALJ staff noted that increased specialization would make the appeals system more efficient. As one ALJ respondent noted, "In a month, I will have 10 Part A, 10 Part B, 3 Part D … [going] back and forth between different regulations … it's hard."

Additionally, ALJs and QICs used clinical experts to different degrees. QICs have medical directors and clinicians on staff to review decisions. In contrast, ALJs do not have medical directors and clinicians on staff. Several ALJ staff said ALJs tended to rely on testimony and other evidence from treating physicians. For example, one ALJ staff member said, "[The ALJ] will listen to the treating physician and will give deference to the physician's opinion."

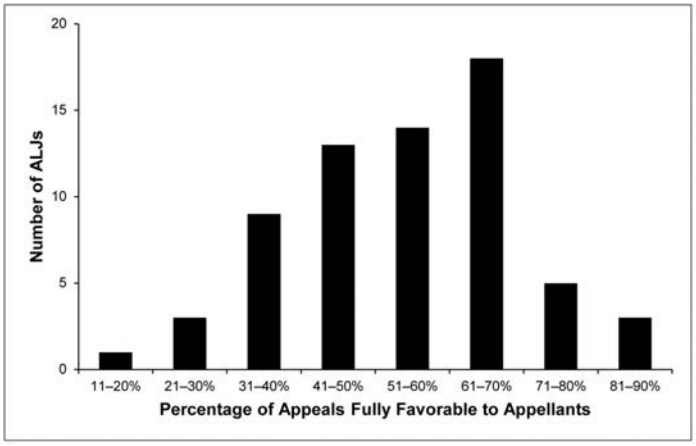
The favorable rate varied widely by ALJ

Some ALJs were much more likely than others to make decisions that were fully favorable to appellants. Among the 66 ALJs, the fully favorable rate ranged from

[31] ALJ appeals must be assigned "in rotation so far as practicable." See 5 U.S.C. § 3105.

18 to 85 percent.[32] As shown in Figure 1, while about two-thirds of ALJs had fully favorable rates between 41 and 70 percent, 8 ALJs had fully favorable rates higher than 70 percent and 13 had fully favorable rates at or below 40 percent. Very little of this variation was associated with some ALJs' deciding more appeals in certain Medicare program areas than other ALJs. See Appendix C.

Figure 1: Number of ALJs by the Percentage of Appeals That Were Fully Favorable to Appellants, FY 2010



Source: OIG analysis of MAS data, 2012.

Moreover, frequent filers often received fully favorable decisions at very different rates from different ALJs. For example, a supplier with nearly 600 appeals received fully favorable decisions at rates ranging from 7 to 100 percent from the 17 ALJs who decided at least 10 of the supplier's appeals.

According to many ALJ staff, different philosophies among ALJs contribute to the variation in fully favorable rates. They said that given the same facts and the same applicable Medicare policy, some ALJs would make decisions that are favorable to appellants, while others would not. One ALJ concluded, "Some [ALJs] pay, some deny." Another ALJ stated, "I go towards protecting the Medicare Trust Fund[s]."

[32] The analysis for this finding was limited to ALJs who decided at least 50 appeals as fully favorable, partially favorable, or unfavorable during FY 2010.

ALJs also varied in their use of on-the-record reviews. An ALJ may make a decision after an on-the-record review of the case file, instead of after a hearing, if the appellant waives the right to a hearing or if the evidence supports a fully favorable decision for the appellant. Among all ALJs, the percentage of appeals decided after on-the-record reviews ranged from less than 1 to 65 percent.

CMS participated in 10 percent of ALJ appeals; these appeals were less likely to be decided fully in favor of appellants

Overall, CMS participated in 10 percent of the appeals that ALJs decided in FY 2010.[33] Participation varied substantially across Medicare program areas, with CMS participating in 18 percent of DMEPOS appeals, 9 percent of Part A appeals, and 5 percent of Part B appeals. In 61 percent of the appeals in which CMS participated, it provided testimony during hearings. In the remaining 39 percent of appeals, CMS submitted position papers to the ALJs. CMS rarely chose to be a party, which would have allowed it to submit evidence, call or cross-examine witnesses, or appeal to the next level.

When CMS participated, ALJs were less likely to decide fully in favor of appellants. Overall, 44 percent of ALJ decisions were fully favorable to appellants when CMS participated. In contrast, 60 percent of ALJ decisions were fully favorable when CMS did not participate. As shown in Table 4, this difference was greatest for DMEPOS appeals.

Table 4: Fully Favorable Rates When CMS Participated and When CMS Did Not Participate, by Medicare Program Area, FY 2010

Medicare Program Area	Percentage of Appeals Fully Favorable to Appellants		Percentage Point Difference*
	When CMS Participated	When CMS Did Not Participate	
Part A	59%	62%	4
Part B	48%	59%	12
DMEPOS	30%	58%	28
All Appeals	**44%**	**60%**	**16**

Source: OIG analysis of MAS data and CMS participation data, 2012.

* Rows do not subtract to percentage point differences because of rounding.

CMS and ALJ staff noted several benefits of CMS participation. Most CMS staff cited an improved relationship between the two agencies, and many ALJ staff

[33] The analysis for this finding was limited to Part A, Part B, and DMEPOS appeals. CMS does not participate in Parts C and D appeals, which typically involve disputes between appellants and their private plans.

noted that CMS often provided needed information. Most CMS staff further noted that their participation in ALJ appeals has taught them to include more specific information in their decisions and position papers to make them more useful to ALJs.

Citing these benefits, nearly all CMS staff reported plans to increase participation in ALJ appeals, especially by the contractors that originally denied the claims or recouped the claim payments. A few staff noted that these contractors are often in the best position to defend their decisions. In FY 2010, only one of these contractors participated regularly, with QICs accounting for nearly all of the remaining participation.[34] CMS staff also reported plans to become a party, rather than a participant, more often, stating that this will allow the agency to better present its position.

Staff raised concerns about the acceptance of new evidence and the organization of case files

Most CMS and ALJ staff noted that the requirements for accepting new evidence at the ALJ level are open to wide interpretation. Starting in 2005, ALJs may accept new evidence only if they determine that appellants had good cause for waiting until the appeals reached the ALJ level to submit it. Most ALJ staff said that they typically accepted new evidence when submitted. As one ALJ explained, an ALJ's role "is to make a determined effort to find out all of the relevant information to make the best determination…. Maybe I let that color my determination of letting in new evidence."

Nearly all CMS staff reported that the ALJs' acceptance of new evidence reduced the efficiency of the appeals system. Most of them noted that appellants are required, and have many opportunities, to submit evidence prior to the ALJ level. According to one CMS staff member, when ALJs accept new evidence without good cause, it "eliminates the value of the two previous levels of appeal."

Nearly all CMS and ALJ staff also identified problems with case files. They reported that a case file at the ALJ level often differed in content, organization, and format compared to the same appeal's case file at the QIC level. Staff noted that these differences created inefficiencies in the appeals process. Most ALJ staff reported that incomplete or disorganized case files caused them to spend time requesting information from QICs or appellants, remanding appeals back to QICs, or reorganizing case files. Many ALJ and CMS staff noted that the two agencies need to reach an agreement regarding how QICs should organize the case files before sending them to the ALJ level.

[34] CMS funded a demonstration project to increase participation by one of the DMEPOS contractors that make the initial decisions to pay or deny claims.

In addition, problems arise because the QICs' case files are almost entirely electronic, while ALJs accept only paper case files. The QICs convert the electronic case files to paper format before sending them to the ALJs; most staff noted that this process is resource intensive and prone to error. In a February 2011 report to Congress, the Chief ALJ acknowledged that her agency had "a critical need to transform its case file process from paper to a fully electronic environment."[35]

ALJ staff handled suspicions of fraud inconsistently

When deciding an appeal, ALJ staff may come across evidence that suggests an appellant engaged in Medicare fraud. For example, evidence may suggest that the Medicare services were not furnished or were not furnished as billed. Nearly all ALJ staff reported having suspected appellants of Medicare fraud; however, they were inconsistent in how they handled their suspicions. In addition, the agency does not have written policies about how ALJ staff should handle suspected fraud.

Notably, ALJ staff differed in the extent to which they referred suspected fraud to their supervisors or to law enforcement. While many staff had made at least one fraud referral, many others did not make referrals based on their suspicions. Several of those who did not refer stated that the evidence of fraud was limited and a referral would not have been appropriate. Several others, however, indicated that making fraud referrals is not part of their job. For example, one staff member said, "[I] never referred and don't want to refer anything … [it is] not our business here;" another said "there is an unspoken rule not to report [fraud]."

When deciding an appeal, ALJ staff also differed in whether they sought additional information when they suspected fraud. A few staff reported that they sought additional information by reviewing licensing databases, searching the Internet, or calling investigators. Several staff also were in favor of more communication between law enforcement and ALJs regarding fraud investigations. In contrast, other staff were opposed to having any additional information when deciding an appeal.

ALJ staff also differed in how they made decisions when they suspected fraud. Several ALJs explained that they decide against appellants if the evidence lacks credibility and they suspect fraud. For example, one ALJ reported that he denied a group of claims because all the medical records looked suspiciously similar. In contrast, a few ALJs suggested that they assume the evidence is factual and do not assess whether it may have been falsified.

Further, a few ALJ and CMS staff noted that having an appellant simultaneously in the appeals system and under investigation for fraud presented challenges. In

[35] OMHA, FY 2012 Justification of Estimates for Appropriations Committees, p. 4.

particular, CMS expressed concern that an appellant may manipulate the appeals system to influence the fraud investigation. For example, appellants may selectively appeal claims to obtain favorable ALJ decisions. Staff reported that favorable ALJ decisions may compromise law enforcement's ability to get a conviction from a fraud investigation.

CONCLUSION AND RECOMMENDATIONS

ALJs decide tens of thousands of appeals each year. Because these decisions are critical to providers and beneficiaries and affect the Medicare program as a whole, it is imperative that the appeals process be efficient, effective, and fair.

Our review found that the vast majority of ALJ appeals in FY 2010 were filed by providers, with a small number of providers accounting for nearly one-third of all appeals. For 56 percent of appeals, ALJs reversed prior-level decisions by QICs and decided fully in favor of appellants. Differences between ALJ and QIC decisions were due to different interpretations of Medicare policies and other factors. These differences may provide appellants an incentive to appeal to the ALJ level, where they are likely to receive favorable decisions.

Additionally, the favorable rate varied widely by ALJ. Further, when CMS participated in appeals, ALJ decisions were less likely to be favorable to appellants. In addition, ALJ and CMS staff raised concerns that the acceptance of new evidence and the organization of case files reduced the efficiency of the appeals system. Lastly, ALJ staff handled suspicions of fraud inconsistently.

Our findings highlight a number of inconsistencies and inefficiencies in the Medicare appeals process. Together, they demonstrate that OMHA and CMS must take action to improve the appeals system, while maintaining ALJs' independence.

Therefore, we recommend that OMHA and CMS:

Develop and Provide Coordinated Training on Medicare Policies to ALJs and QICs

OMHA and CMS should work together to develop and provide training on Medicare policies to ALJ and QIC staff. By coordinating training, OMHA and CMS will help ensure that knowledge of Medicare policies is consistent at the second and third levels of appeal. OMHA and CMS should provide training at least annually and focus on policies that tend to be interpreted differently by ALJs and QICs or among ALJs. For example, one area of focus should be Part A hospital appeals in which ALJs reversed prior-level decisions for nearly three-quarters of appeals. The agencies should identify training topics by analyzing appeals data and surveying staff.

Identify and Clarify Medicare Policies That Are Unclear and Interpreted Differently

Unclear policies can lead to inconsistencies between ALJs and QICs and among ALJs. At least annually, CMS and OMHA should identify policies that are unclear and interpreted differently by soliciting input from CMS contractors and ALJ staff and by analyzing appeals data. The agencies should focus on policies with vague definitions, such as beneficiaries who are "declining," and on program

areas with particularly high favorable rates, such as Medicare Part A. CMS should then work to develop or clarify these policies, as needed.

Standardize Case Files and Make Them Electronic

To improve the efficiency of the appeals process, OMHA and CMS should make case files more consistent across the various levels of appeal. Finalizing and enforcing a Memorandum of Understanding should be a first step toward standardizing the content and organization of case files. As well as specifying how the documents in the case file should be organized, the memorandum should define a method, such as a checklist, for easily identifying which documents are in the case file. OMHA and CMS should train staff on the memorandum requirements.

In addition, OMHA should accelerate its Electronic Records Initiative to transition from paper to electronic files. OMHA and CMS must coordinate this effort closely and should take other measures in the interim to reduce formatting differences in case files. The agencies may require additional funding to complete the transition to electronic case files.

Revise Regulations To Provide More Guidance to ALJs Regarding the Acceptance of New Evidence

Current regulations regarding the acceptance of new evidence provide little guidance and only one example of good cause—when the QIC raises a new issue not discussed at the first level of appeal. OMHA and CMS should revise these regulations to include additional examples as well as factors for ALJs to consider when determining good cause. In particular, the regulations should specify that ALJs consider whether the appellant could have obtained the evidence earlier.

Improve the Handling of Appeals From Appellants Who Are Also Under Fraud Investigation and Seek Statutory Authority To Postpone These Appeals When Necessary

When Medicare providers are simultaneously in the appeals system and under investigation for fraud, both the appeals process and the investigations may be compromised. OMHA and CMS should improve how these cases are handled. CMS should work with its contractors and law enforcement to identify and monitor the appeals of providers that are under investigation. This information should be used to inform decisions about administrative and law enforcement actions and about whether CMS should participate at the ALJ level of appeal.

Additionally, OMHA and CMS should seek statutory authority to postpone appeals at the levels they administer. The agencies should make decisions to postpone appeals only after receiving a request from law enforcement and should work with law enforcement to define the circumstances under which appeals may be postponed. Postponement decisions should be made by OMHA and CMS staff who are not directly responsible for deciding appeals.

We recommend that OMHA:

Seek Statutory Authority To Establish a Filing Fee
Given the concerns raised about appellants who filed frequently, OMHA should seek statutory authority to implement a modest filing fee. Such a fee would only nominally affect the average appellant, but would encourage frequent filers to more carefully assess their appeals before filing. The fee should not apply to beneficiaries. OMHA should consider various options for making the fee effective and fair, such as scaling the fee to the dollar amount at issue.

Implement a Quality Assurance Process To Review ALJ Decisions
The range of fully favorable rates among ALJs raises concerns about whether all ALJs are applying Medicare policies in accordance with regulations. Medicare regulations state that ALJs are bound by Medicare laws, regulations, and National Coverage Determinations and must give substantial deference to Local Coverage Determinations and CMS program guidance. OMHA should implement a quality assurance process to review ALJ decisions. OMHA could, for example, review a sample of ALJ decisions and, when needed, provide ALJs with additional training. OMHA may want to focus its efforts on certain types of appeals, such as those concerned with policies that tend to be interpreted differently among ALJs. OMHA should also assess ALJs' use of on-the-record reviews to make decisions.

Determine Whether Specialization Among ALJs Would Improve Efficiency
OMHA should determine whether specialization among ALJs would improve the efficiency of the appeals process. Any specialization would need to be consistent with the statutory requirement to randomly assign appeals. If OMHA decides to implement specialization, it should develop policies and procedures describing the manner and extent to which ALJs will specialize.

Develop Policies To Handle Suspicions of Fraud Appropriately and Consistently and Train Staff Accordingly
OMHA should develop policies and provide training to ALJ staff regarding how to handle suspicions of fraud. These policies and training should be developed in collaboration with CMS and OIG and should inform staff about when and how to refer suspicions of fraud. The policies and training should also instruct staff to base decisions only on evidence in the case files and hearing testimony, as required by Federal regulation, and to consider the credibility of the evidence when making decisions. OMHA should work with CMS and OIG periodically to keep informed about emerging fraud trends.

We recommend that CMS:

Continue To Increase CMS Participation in ALJ Appeals
Given the benefits cited by both agencies, CMS should continue to increase its participation in ALJ appeals. Building upon its current efforts, CMS should make

strategic decisions about which contractors are in the best position to represent CMS and which appeals most warrant CMS participation, such as Part A hospital appeals or those from frequent filers. CMS should establish participation guidelines and incentives for each type of contractor and should track the results of their participation. The guidelines should indicate the circumstances in which a contractor should consider becoming a party, rather than a participant.

AGENCIES' COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

OMHA and CMS concurred fully or in part with all 10 of our recommendations. With regard to the first recommendation, OMHA stated that it instituted, and CMS participated in, an annual symposium that offers ALJs training on a wide range of Medicare policies and emerging issues. CMS added that it has invited OMHA to participate in its annual conference for contractor medical directors and that it will continue working with OMHA to identify new opportunities for collaboration.

With regard to the second recommendation, OMHA noted that while it is beyond the scope of its mission to participate in Medicare policy development, it supports efforts to clarify unclear policies and increased communication with CMS when decisional trends reveal differing policy interpretations. CMS noted the value of tracking appeals to determine which Medicare policies are most often at issue and stated that in some instances, it might be beneficial to clarify a particular policy.

With regard to the third recommendation, OMHA stated that it is working with CMS to develop a Memorandum of Understanding regarding standardizing case files and to determine whether MAS can accommodate the electronic folder or whether a new operating system must be developed. CMS added that it will continue to discuss with OMHA options to fully develop an electronic system.

With regard to the fourth recommendation, OMHA stated that it will review regulations regarding acceptance of new evidence and will develop guidance and provide training to address ALJs' concerns raised in the report. CMS added that it will explore options for providing additional guidance regarding accepting new evidence at the ALJ level.

With regard to the fifth recommendation, OMHA stated that it did not concur with staff"s issuing determinations regarding postponement of ALJ decisions because of due process concerns. CMS raised the same concerns and further noted that postponing appeals could compromise fraud investigations. At the same time, OMHA stated that it supports CMS's developing a mechanism to limit appeals to the ALJ level, and CMS proposed discussing concerns with OMHA to determine the best approach for handling these appeals. In response, we recognize the seriousness of the due process and other concerns and emphasize that postponement should be considered only after weighing these concerns together with the potential impact of fraudulent activities on beneficiaries and the Medicare Trust Funds. We further emphasize that the agencies should make decisions to postpone appeals only after receiving a request from law enforcement and that these postponement decisions should not be made by ALJs or others who are directly responsible for deciding appeals.

With regard to the sixth through ninth recommendations, OMHA stated that it will evaluate whether or not filing fee authority is appropriate and, if so, seek authority to collect such fees. It further noted that it has instituted a Quality Assurance Program based upon peer review of ALJ decisions. OMHA also stated that although it is not convinced that ALJ specialization would improve case processing, it will conduct further evaluation. Lastly, it stated that it has conducted training and continues to develop policies with respect to handling suspicions of fraud.

With regard to the tenth recommendation, CMS stated that it plans to increase participation in ALJ appeals by the agency's contractors. It will also enhance participation guidelines for contractors and monitor the results of participation to determine the most effective and efficient use of the resources currently available.

The full text of OMHA's comments is provided in Appendix D, and the full text of CMS's comments is provided in Appendix E.

APPENDIX A

Administrative Law Judge Appeals Filed by Each Type of Appellant, Fiscal Year 2010

Medicare Program Area	Percentage of Provider Appeals	Percentage of Beneficiary Appeals	Percentage of State Medicaid Agency Appeals
Part A	40%	16%	90%
Hospitals	9%	4%	<1%
Home Health/ Hospice Agencies	13%	1%	48%
Other Part A	14%	8%	3%
Skilled Nursing Facilities	4%	4%	39%
Part B	34%	16%	<1%
Transportation	5%	7%	<1%
Diagnostic Testing	7%	1%	0%
Practitioner Services	13%	3%	0%
Other Part B	9%	5%	<1%
Durable Medical Equipment, Prosthetics, Orthotics, and Supplies	25%	5%	0%
Part C	1%	47%	10%
Part D	<1%	8%	0%
Other*	<1%	8%	0%
Total**	**100%**	**100%**	**100%**

Source: Office of Inspector General analysis of Medicare Appeals System data, 2012.

* This category includes appeals about beneficiary premiums and entitlement to Medicare.

** Total may not sum to 100 percent because of rounding.

APPENDIX B

Percentage of Administrative Law Judge Appeals That Were Fully Favorable to Appellants, Fiscal Year 2010

Table B-1: Percentage of Administrative Law Judge Appeals That Were Fully Favorable to Appellants by Type of Appellant, Fiscal Year 2010

Medicare Program Area	Percentage of Appeals Fully Favorable to Appellants**		
	Providers	Beneficiaries	State Medicaid Agencies
Part A	67%	36%	24%
Part B	59%	46%	n/a
Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS)	53%	40%	n/a
Part C	15%	19%	7%
Part D	15%	20%	n/a
Other*	n/a	26%	n/a
Total	**61%**	**28%**	**22%**

Source: Office of Inspector General (OIG) analysis of Medicare Appeals System (MAS) data, 2012.

* This category includes appeals about beneficiary premiums and entitlement to Medicare.

** The percentage of appeals with fully favorable decisions was calculated only if there were 50 or more appeals for that Medicare program area.

Table B-2: Percentage of Administrative Law Judge Appeals That Were Fully Favorable to Appellants by Frequent Filer Status, Fiscal Year 2010

Medicare Program Area	Percentage of Appeals Fully Favorable to Appellants**	
	Providers Who Were Frequent Filers***	Providers Who Were Not Frequent Filers
Part A	67%	67%
Part B	70%	54%
DMEPOS	50%	58%
Part C	n/a	15%
Part D	n/a	15%
Other*	n/a	n/a
Total	**61%**	**60%**

Source: OIG analysis of MAS data, 2012.

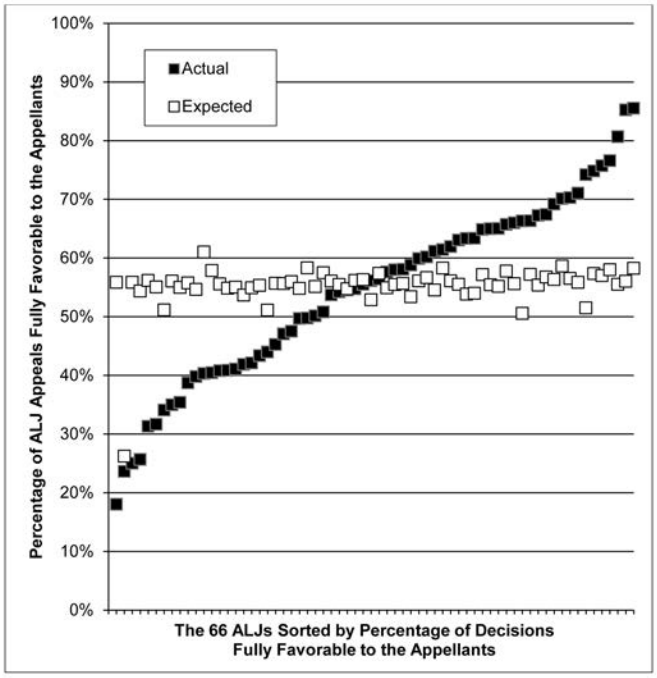
* This category includes appeals about beneficiary premiums and entitlement to Medicare.

** The percentage of appeals with fully favorable decisions was calculated only if there were 50 or more appeals for that Medicare program area.

*** A frequent filer is an appellant that had 50 or more appeals decided in fiscal year 2010.

APPENDIX C

Actual Fully Favorable Rates Compared to Expected Fully Favorable Rates by Administrative Law Judge,* Fiscal Year 2010



Source: Office of Inspector General analysis of Medicare Appeals System data, 2012.

Note: To calculate each ALJ's expected rate, we first determined the fully favorable rate among all ALJs for each Medicare program area; next, we multiplied these rates by the proportion of appeals the ALJ had in that program area and summed the results.

*ALJ.

APPENDIX D

Office of Medicare Hearings and Appeals Comments

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Office of the Secretary

Office of Medicare Hearings and Appeals
Office of the Chief Judge
1700 North Moore Street, Suite 1800
Arlington, VA 22209
(703) 235-0535 Main Line
(703) 235-0700 Facsimile

MEMORANDUM

Date: September 14, 2012

To: Daniel R. Levinson
Inspector General

/S/

From: Nancy J. Griswold
Chief Administrative Law Judge

Subject: Office of Inspector General Draft Report: *Improvements are needed at The Administrative Law Judge Level of Medicare Appeals*, OEI-02-10-00340

Thank you for the opportunity to review and comment on the Office of Inspector General's (OIG) draft report on Medicare appeals at the Administrative Law Judge (ALJ) level. The Office of Medicare Hearings and Appeals (OMHA) appreciates the thoroughness of the report and concurs with many of the suggested recommendations which are based on the evaluation of ALJ appeals during fiscal year 2010.

We are happy to report that a number of recommendations are already being addressed through OMHA's continuing efforts to review and improve operations. However, with respect to a few recommendations, we believe that more evaluation is necessary. Our response to the recommendations is set forth below.

RECOMMENDATION: *Develop and Provide Coordinated Training on Medicare Policies to ALJs and QICs*

RESPONSE: CONCUR

Beginning in fiscal year 2010, OMHA instituted an annual Judicial Education Symposium (JES) for all OMHA ALJs. JES is conducted in three phases throughout the calendar year and offers training on a wide range of Medicare policies and emerging OMHA issues. The symposium presenters include Centers for Medicare and Medicaid Services (CMS) subject matter experts, Medicare Appeals Council (MAC) judges and OMHA's most experienced ALJs. OMHA seeks input from ALJs and CMS in identifying topics for presentation based on new policies or

emerging trends. For the 2012 JES series, nine hours are being devoted to CMS policy issues. OMHA and CMS conduct bi-weekly conference calls to discuss policy and processing matters.

In addition to the JES, OMHA instituted a Substantive Law Training program in fiscal year 2011. The Substantive Law Training program provides standarized high-quality training to recently hired attorneys and ALJs on Medicare law and policy. A cadre composed of experienced OMHA Attorney-Advisors and ALJs developed the written and oral presentations. OMHA has also developed specialized training for paralegals and is in the process of developing a comprehensive legal assistant training program. Finally, OMHA is working with CMS to provide quarterly policy updates to adjudicators and staff.

RECOMMENDATION: *Identify and Clarify Medicare Policies That are Unclear and Interpreted Differently*

RESPONSE: CONCUR WITH COMMENTS

CMS is charged by the Secretary with administering the Medicare program; OMHA's mission is to process Medicare appeals within the existing policy framework established by CMS on behalf of the Secretary. It is beyond the scope of OMHA's mission to participate in Medicare policy development, including policy clarification. Policy clarification is, and should remain, the responsibility of CMS as it is the administrator of the Medicare program. Nevertheless, OMHA supports all efforts to improve the Medicare program, including clarification of unclear policies and increased communication between OMHA and CMS when decisional trends reveal differing policy interpretations. OMHA has opened the dialogue with CMS.

Although clarification of Medicare policies is not within OMHA's program mission, OMHA wishes to point out that clarification of procedural policies governing the hearing process is within OMHA's responsibilities. This position is consistent with our response to the fourth recommendations regarding the admission of new evidence.

RECOMMENDATION: *Standardize Case Files and Make Them Electronic*

RESPONSE: CONCUR

Regarding standardizing case files, OMHA is working with CMS to develop a Memorandum of Understanding (MOU) with respect to the standardized order in which the Qualified Independent Contractor (QIC) furnishes Medicare Part B case files to OMHA. OMHA will also look to update its current Medicare Part A MOU with CMS and the QICs, consistent with the Medicare Part B MOU regarding case file standardization and organization.

We also agree that an electronic case processing system would increase efficiency within OMHA. We have developed requirements to be used in development of an electronic case processing system. OMHA and CMS are currently working cooperatively to determine whether the existing platform, the Medicare Appeals System (MAS), can accommodate the electronic folder or whether a new operating system must be developed. As the OIG noted, the development and institution of an electronic case processing system is dependent on funding.

RECOMMENDATION: *Revise Regulations to Provide More Guidance to ALJs regarding the Acceptance of New Evidence*

RESPONSE: CONCUR WITH COMMENTS

OMHA has identified several regulations which it is currently evaluating for future changes. OMHA will review regulation(s) regarding acceptance of new evidence and determine whether any future revisions are warranted. Additionally, OMHA will develop policy guidance and provide training to address the concerns raised by ALJs interviewed for this report.

RECOMMENDATION: *Improve the Handling of Appeals that are also under Fraud Investigation and Seek Statutory Authority to Postpone These Appeals when Necessary.*

RESPONSE: CONCUR IN PART, WITH COMMENTS

OMHA agrees there is a need for additional internal policy guidance with respect to the handling of referrals for investigation when an ALJ, or ALJ team member, believes a file contains evidence of fraud. OMHA will formalize its guidance in an upcoming Chief Judge Bulletin.

The OIG suggests OMHA and CMS work with law enforcement to define the circumstances under which appeals can be postponed. OMHA does not concur with the OIG's recommendation that OMHA and CMS staff issue determinations regarding postponement of ALJ decisions when appellants are under investigation for fraud. Suspending hearings, and possible payments, for appellants who have not been found in an adjudicatory proceeding to be in violation of fraud statutes raises due process concerns.

Moreover, OMHA is also concerned that the OIG's recommendation may be inconsistent with the Federal Administrative Procedure Act (APA) requirement that ALJs decide cases based on evidence in the record and that ALJs not be subject to the direction of an employee or agent engaged in the investigative function of an agency. *See,* 5 U.S.C. § 554. Currently, the only legal authority that would allow OMHA to suspend appeals simultaneously being investigated by law enforcement authorities is a stay issued by a Federal court.

Generally, ALJs have no knowledge of criminal investigations involving appellants at the time cases are received. In fact, such cases have already passed through two levels of appeals before reaching OMHA. OMHA supports CMS developing a mechanism to limit appeals to the ALJ level by identifying potential fraud cases before they are allowed into the appeals system. Further, an ALJ does have the option to reopen his or her decision in light of any new evidence.

RECOMMENDATION: *Seek Statutory Authority to Establish a Filing Fee*

RESPONSE: CONCUR WITH COMMENTS

OMHA will evaluate whether or not filing fee authority is appropriate for the ALJ appeals process, and if so, seek statutory authority to collect filing fees. The benefit of a filing fee requirement must be weighed against the potential financial burden imposed on beneficiaries.

RECOMMENDATION: *Implement a Quality Assurance Process to Review ALJ Decisions*

RESPONSE: CONCUR

OMHA concurs with this recommendation. OMHA has instituted a Quality Assurance Program (QAP) based upon peer review of a random sample of ALJ decisions using standard guidelines. OMHA began development of the program in 2011 and began weekly peer review of ALJ decisions in August of 2012.

RECOMMENDATION: *Determine Whether Specialization among ALJs Would Improve Efficiency*

RESPONSE: CONCUR WITH COMMENTS

OMHA is not convinced that ALJ specialization would actually improve case processing efficiency or accuracy. Further, as mentioned in the OIG's recommendation, federal law requires all ALJ appeals are assigned in a random rotation. *See* 5 U.S.C. § 3105 (2011). Notwithstanding the above, OMHA will conduct further evaluation to determine whether this recommendation would improve case processing efficiency in a manner which does not violate federal law.

RECOMMENDATION: *Develop Policies and Train Staff to Handle Suspicions of Fraud Appropriately and Consistently*

RESPONSE: CONCUR

OMHA has conducted anti-fraud training sessions in conjunction with the OIG and CMS. OMHA staff has been informed how to report suspicions of fraud regarding an appeal. OMHA continues to develop policies aimed at providing guidance to ALJs and their staff with respect to handling suspicions of fraud. As stated earlier, OMHA maintains frequent contact with a designated OIG Office of Investigations contact at the national level and has made several fraud referrals.

Further, OMHA training of ALJs and Attorney-Advisors has reiterated that decisions must always be based on evidence in the case file and hearing testimony. Such decisions must also be made in accordance with existing Medicare law, regulations, and policy.

Once again, we do appreciate the opportunity to review and comment on this report. Please contact me if you have any questions regarding our comments.

APPENDIX E

Centers for Medicare & Medicaid Services Comments

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

DATE: SEP 1 8 2012

TO: Daniel R. Levinson
Inspector General

FROM: Marilyn Tavenner /S/
Acting Administrator

SUBJECT: Office of Inspector General (OIG) Draft Report: "Improvements Are Needed at the Administrative Law Judge Level of Medicare Appeals" (OEI-02-10-00340)

Thank you for the opportunity to review and comment on the OIG draft report, "Improvements Are Needed at the Administrative Law Judge Level of Medicare Appeals." In the draft report, the OIG examined the characteristics of appeals decided by Medicare administrative law judges (ALJs) in fiscal year (FY) 2010; the differences between ALJ and prior-level decisions and differences among ALJs; and the extent to which the Centers for Medicare & Medicaid Services (CMS) participated in ALJ appeals in FY 2010. We appreciate the OIG's time and effort in reviewing our processes. Our responses to the OIG's recommendations are below.

Recommendations to CMS and the Office of Medicare Hearings and Appeals (OMHA):

OIG Recommendation

The OIG recommends CMS and OMHA develop and provide coordinated training on Medicare policies to Administrative Law Judges (ALJs) and Qualified Independent Contractors (QICs).

CMS Response

The CMS concurs with this recommendation. In 2011 and 2012, CMS staff participated in OMHA's annual Judicial Education Symposium, and conducted training on a variety of Medicare policy issues. The symposia afford ALJs and their staffs an opportunity to discuss general policy and procedural issues with CMS. This training is mutually beneficial, and we would welcome the opportunity to include the QICs in future sessions. Similarly, in recent years, CMS has invited OMHA leadership to participate in our annual Contractor Medical Director conference attended by CMS staff and staff from our Medicare Administrative Contractors (MACs), QICs, Recovery Auditors (RAs), and Zone Program Integrity Contractors (ZPICs). Like the Judicial Education Symposia, this conference provides an opportunity for our contractor staff to interact with and ask questions of OMHA staff and senior leadership about policy and procedural issues. Finally, our QICs also have access to training and educational

opportunities on Medicare policies, procedures and initiatives via monthly meetings organized by CMS' Administrative QIC (AdQIC), and monthly policy updates issued by the AdQIC to all QICs.

Going forward, CMS will continue working with OMHA and the AdQIC to identify new opportunities for collaboration on trainings for our appeals adjudicators, and where possible, provide joint training sessions for the QICs and ALJs. Additionally, CMS will continue evaluating appeals decisions to help identify policies that are being interpreted inconsistently by QICs and ALJs, and use this information to develop future appeals training programs.

OIG Recommendation

The OIG recommends CMS and OMHA identify and clarify Medicare policies that are unclear and interpreted differently.

CMS Response

The CMS concurs with this recommendation. We agree with the OIG that there is value in tracking appeals so we can evaluate the cases that are being reversed and determine which Medicare policies are most often at issue in these cases. Similarly, we agree that in some instances, as a result of reversals at higher adjudicative levels, it might be beneficial to clarify a particular Medicare policy. Currently, the AdQIC identifies and reports to CMS, on an annual basis, policies and procedures that seem to be unclear, based on appeals outcomes, and provides recommendations for revisions.

The CMS also believes that appeals outcomes at the ALJ level should be used by lower level adjudicators to evaluate their review strategies. Thus, CMS intends to look at ways to help ensure that all contractors (MACs, RAs, ZPICs, and QICs) are evaluating the outcomes of their appeals at the ALJ level and appropriately considering the applicable ALJ reversal rates in developing any future review strategies. This approach will help ensure that resources at all levels of the appeals process are being used most effectively.

OIG Recommendation

The OIG recommends CMS and OMHA standardize case files and make them electronic.

CMS Response

The CMS concurs with this recommendation and notes that together with OMHA, we have been exploring a number of process improvements, such as electronic records from the QICs, to help expedite the appeals process for both parties and adjudicators. Currently, the Medicare Appeals System (MAS) stores some electronic appeals case files, and promotes them to OMHA through the MAS. However, the MAS functionality to support manipulation of the electronic files is limited. Nevertheless, OMHA has made substantial progress in implementing the needed electronic case file functionality and is conducting a gap analysis to determine any additional steps that may be needed in order to fully implement an electronic case file system. We will

continue to discuss with OMHA options to fully develop an electronic appeals case file processing environment.

Similar efforts are also underway to implement the transfer of appeal case files electronically between the QICs and MACs. Some of the MACs have already initiated an electronic case file transfer process with the QICs. We are currently working on the requirements phase of implementing the MAS for the MACs. Implementation is dependent on funding, but our goal is to have all MACs utilizing MAS for Part A appeals by 2014. This initiative will facilitate an electronic appeals process and realize operational efficiencies by using one consolidated appeals system.

OIG Recommendation

The OIG recommends CMS and OMHA revise regulations to provide more guidance to ALJs regarding the acceptance of new evidence.

CMS Response

The CMS concurs in part with this recommendation. As part of our on-going discussions with OMHA, CMS will explore options for providing additional guidance regarding accepting new evidence for the first time at the ALJ level, including possible revisions to the fee-for-service regulations at 42 CFR Part 405.

OIG Recommendation

The OIG recommends CMS and OMHA improve the handling of appeals that are also under fraud investigation and seek statutory authority to postpone these appeals when necessary.

CMS Response

The CMS concurs in part with this recommendation. We agree that CMS and OMHA can improve and better coordinate their processes for handling appeals that are also under fraud investigation. Also, when the same claims are part of both a fraud investigation and an administrative appeal, it may be beneficial to delay either the appeals process or the fraud investigation to avoid inconsistent decisions in two parallel proceedings involving the same facts. However, we note that suspending appeals may impact the due process rights guaranteed to appellants. Additionally, given our current policy to not suspend appeals in such cases, we believe that implementing a delay might tip-off providers about the fraud investigation. Thus, prior to undertaking the OIG's recommendation to seek statutory authority to delay appeals, we propose to first discuss our concerns with OMHA, so that we can determine the best approach for handling appeals that are also under fraud investigation, and ensure that our approach maintains the due process rights of all appellants, is not detrimental to Medicare beneficiaries and does not have the potential to compromise the resolution of a pending criminal matter.

Page 4 – Daniel R. Levinson

Recommendation to CMS:

OIG Recommendation

The OIG recommends CMS continue to increase CMS participation in ALJ appeals.

CMS Response

The CMS concurs in part with this recommendation. We agree with the OIG's assessment that participation in ALJ hearings provides an opportunity for contractors to explain Medicare policies and the reason(s) for claim denials in more detail, educate adjudicators at all levels of the appeals process, and increase the ALJ uphold rate. The QICs have participated in ALJ hearings since their inception in 2005. Starting in 2009, CMS expanded contractor participation, to include one Durable Medical Equipment Medicare Administrative Contractor (DME MAC). After evaluating the results of this participation and securing additional funding, it was expanded to include all the DME MACs in 2011. In addition, pending available funding, CMS plans to continue increasing participation requirements in the MAC Statements of Work. In addition, RAs and ZPICs have also begun increasing their participation in ALJ hearings.

Going forward, to help facilitate contractor participation in ALJ hearings, CMS intends to continue developing requirements aimed at streamlining the communication process for coordinating participation in ALJ hearings. Consistent with OIG's recommendations, CMS will work to enhance participation guidelines for contractors, and will explore establishing guidance on electing party status for ALJ hearings. We will also continue monitoring the results of contractor participation to determine the most effective and efficient use of the resources currently available for this activity. We believe these efforts will increase contractor participation in cases where participation is most needed. OIG also recommended CMS include incentives related to participation in ALJ hearings. We believe, based on CMS' current and future efforts to increase effective and efficient participation, it will not be necessary to include contractual incentives for contractor participation. However, we will explore the possibility of building such incentives into contractors' Statements of Work.

Thank you for the opportunity to review and comment on the draft report.

ACKNOWLEDGMENTS

This report was prepared under the direction of Jodi Nudelman, Regional Inspector General for Evaluation and Inspections in the New York regional office, and Nancy Harrison and Meridith Seife, Deputy Regional Inspectors General.

Judy Bartlett served as the team leader for this study. Other Office of Evaluation and Inspections staff from the New York regional office who conducted the study include Rachel Bryan, Christine Moundas, Liz Osius, and Michael Rubin. Central office staff who provided support include Scott Manley and Debra Roush.

Office of Inspector General

http://oig.hhs.gov

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The Office of Audit Services (OAS) provides auditing services for HHS, either by conducting audits with its own audit resources or by overseeing audit work done by others. Audits examine the performance of HHS programs and/or its grantees and contractors in carrying out their respective responsibilities and are intended to provide independent assessments of HHS programs and operations. These assessments help reduce waste, abuse, and mismanagement and promote economy and efficiency throughout HHS.

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Ms. JENKINS. This letter details the hospital's problem with CMS' final OPPS rule for 2014 regarding outpatient therapeutic services at critical access hospitals and supports legislation that I have introduced to delay enforcement of the rule until the end of 2014. This rule, while well intentioned, is creating a regulatory hardship in rule setting. So the letter notes that CMS has disallowed physicians at a hospital based rural health clinic from meeting the direct supervision requirements, which makes it very difficult for Anderson County Hospital to be reimbursed by Medicare for services rendered.

The most troubling part of the letter is that the hospital notes, that the physician supervision requirements have no impact on the quality of care and that the hospital will administer the outpatient therapy even without the Medicare reimbursement. This is a tale-tell sign of a misguided rule that has missed the point.

So, Mr. Cavanaugh, is it your opinion that requirements on physician's supervision of outpatient therapy services at critical access hospitals are feasible and would CMS benefit from a delay in enforcement in order to revisit this rule?

Mr. CAVANAUGH. First of all, thank you for telling us about the experience of these two hospitals.

I don't have an opinion on the delay, but I am interested in the issue, and I am happy to look into it further outside of this hearing if you are willing to share that experience with me.

Ms. JENKINS. Okay. We will follow up with you and would like to work with you to give these folks some relief and better care for Kansans.

Mr. CAVANAUGH. I am more than happy to look further into it.

Ms. JENKINS. Okay.

Thank you, Mr. Chairman. I yield back.

Chairman BRADY. Thank you, Ms. Jenkins.

And before we dismiss the witnesses, Dr. McDermott and I would love to have both of you give us more perspective by letter of the 6 percent that are appealed for overpayments, the value of them relative to the other base of them, which are related to the two payment, Two Midnights Rule, any other insight you can give us on those. The numbers seem very low compared to what we have heard anecdotally, and we really would like to have more light shined on those areas if you don't mind. We'll follow up with you by letter, but we would love to have, I think the members would love to have that perspective.

Mr. CAVANAUGH. We would be happy to do that.

[The information follows: The Honorable Lynn Jenkins]

Anderson
County Hospital
SAINT LUKE'S HEALTH SYSTEM

May 18, 2014

The Honorable Lynn Jenkins
1027 Longworth HOB
Washington, DC 20515

Dear Representative Jenkins:

As you know, I have communicated with you in the past about the consequences of the physician supervision requirements that were included in the Outpatient Prospective Payment Final Rule (OPPS) for 2014, as published in the *Federal Register* on December 10, 2013. These rules will have an unintended impact on the provision of outpatient therapeutic services in Critical Access Hospitals and to patient care in rural settings.

Anderson County Hospital (ACH) is a Critical Access Hospital (CAH) located in Anderson County, Kansas. Since 1994, we have operated a hospital-based rural health clinical staff by employed physicians and mid-levels, the only primary care clinic currently operating in our county. Additionally, our emergency room is staffed with physicians and mid-level practitioners 24/7. For the past two years, ACH has continued to struggle with how to meet the supervision requirements. Initially, it was that we would use a combination of ER and primary care providers to provide the direct supervision; if one of them was not immediately available, we would provide the service and not bill for it. Please keep in mind that while direct supervision does not require the provider to be in the room with the patient, they do need to be immediately available. The location of both our clinic and ER providers meet this requirement.

In a clarification received from CMS in January, they further instructed us that hospital employed practitioners in hospital-based rural health clinics, even those that are located on the same campus and adjacent to the hospital, cannot meet the direct supervision requirement for outpatient therapeutic services. This makes it nearly impossible for us to meet the supervision requirements. Although we have a full complement of staff that could provide direct supervision, the ability to use them to provide services is not in question.

Anderson County Hospital
SAINT LUKE'S HEALTH SYSTEM

These requirements present a significant hardship and expense to rural hospitals and is in direct conflict to the Conditions of Participation for CAHs. It will limit the ability to provide our outpatients with basic therapeutic services such as IV infusions, initial antibiotic therapy, emergency cardiac drugs and blood transfusions. These are services that have been provided in rural communities safely throughout the years, and will ultimately impact access to important services for the patients and communities we serve.

For those CAHs who have emergency room coverage provided by their own employed physicians, the requirements are even more difficult to meet. Since CAH conditions of participation say that the physician does not need to be in the ER, must respond to the emergency room within 30 minutes, most hospitals have protocols that allow a registered nurse to begin life saving IV therapy on a verbal order from the provider. The physician supervision requirements seem to contradict this.

The strangest part of the interpretation of these rules is that they only impact payment, not the actual provision of the services, so this is not really an issue of quality or patient safety. We are told that we are able to provide the services when needed, but unless there is documented direct supervision, we are not able to bill or be paid for the services provided.

Because of the implications of these rules and their interpretation on the provision of outpatient therapeutic services at our hospital and many others in rural settings, I ask for your support of H.R. 4067, which would put a hold on enforcement of the supervision requirements through 2014. This additional time would hopefully allow the opportunity to re-visit the many issues raised by these rules and would go a long way in alleviating the consequences of the policy that I've outlined in this letter. We must keep in mind that the intent of the CAH program was to provide access to quality patient care in rural communities. A delay in enforcement would help us refocus on that goal.

Sincerely,

Dennis A. Hachenberg, FACHE
Chief Executive Officer
Anderson County Hospital

421 S. Maple Street, P.O. Box 309, Garnett, KS 66032 • Phone (785) 448-3131

Chairman BRADY. With that, thank you very much, both of you, for testifying, and let's line up for a second panel.

Thank you very much. I made the introductions earlier, so we will, for the sake of time, go right into testimony.

Ms. Deutschendorf, you are recognized for 5 minutes, and welcome to all the second panel.

STATEMENT OF AMY DEUTSCHENDORF, SENIOR DIRECTOR OF CLINICAL RESOURCE MANAGEMENT, JOHNS HOPKINS HOSPITAL AND HEALTH SYSTEM

Ms. DEUTSCHENDORF. Chairman Brady, Ranking Member McDermott, and distinguished Members of the Subcommittee, thank you so much for this opportunity to testify today and share the Johns Hopkins experience on these important issues affecting hospitals in the Medicare program.

I am Amy Deutschendorf. I am a nurse. I am responsible for assuring the appropriate utilization of clinical resources for our patients in the right care setting, and that includes care coordination in the readmissions reductions initiative. My remarks today focus on two major changes, the CMS definition of an inpatient the Two Midnight Rule, and also the agency's recovery audit contractor program, both of which are draining precious hospital resources which need to be redirected to quality patient care delivery.

We know that the Two Midnight Rule was spawned out of an attempt to limit lengthy observation stays and add clarity to the definition of an inpatient, but unfortunately, the rule adds a new layer of complexity that not only does not meet that CMS objective but has created confusion and stress for our providers and our patients and has been operationally extremely difficult to implement.

Our observation rate has increased by 33 percent as a result of the Two Midnight Rule. It has taken away physician judgment in the determination of hospitalization as an inpatient and has instead required our physicians to become soothsayers as they try to project whether or not a patient who presents to the emergency department with a myriad of symptoms and comorbidities and determine if they are going to require a greater than a Two Midnight stay.

More importantly, under the Two Midnight Rule, we have patients who require the services that only a hospital can provide, sometimes in the intensive care setting, yet we are calling them outpatients in this new world. This concept belies any rationality and has created safety and quality of care concerns.

Medicare patients are being billed differently than other patients for equivalent services. They are subject to paying deductibles and copays associated with Part A benefits which could be up to 20 percent of their hospitalization. They think they are coming in for hospital care and their Part A benefit covers that. We have had patients who have actually left and refused important diagnostic studies and medications as a result of increased financial risk.

The Two Midnight Rule is especially devastating for academic and safety net hospitals. There has been a reduction in inpatient volumes as a result of the Two Midnight Policy which has redirected dollars for necessary hospital care to the outpatient system, causing a loss of payments for critical community programs, indi-

rect medical education, general medical education, and disproportionate share payments at a time we need them the most.

Since its inception, RAC has created enormous financial and administrative burden on hospitals as we struggle to respond to the plethora of medical record requests and to the denials and mount appeal processes. RAC has targeted short stays, again, the assumption that these stays are medically unnecessary. In truth, short hospital stays are good and reflect the efficient and appropriate management of care, some of which can be very intensive.

Even though Hopkins has a rigorous compliance process for which we review every day of every single Medicare patient stay for medical necessity, RAC denied 50 percent of the medical records that were requested. We took 239 of these to discussion and immediately 135, almost 60 percent, were overturned at discussion even before the first level of appeal. The rest of our 92 percent are in the appeal process.

The RAC program is costing American hospital millions of dollars in the administrative burden to manage the RAC requests, denials, and appeals processes, as well as the financial hit for revenue losses for care that was provided to patients.

There are a lot of smart and committed legislators and policymakers who have put their heads around these issues to come up with solutions that are workable. Unfortunately, with each iteration and layer of new ideas come complexities and unintended consequences that seem to yield the opposite result. In the case of the Two Midnight Rule, Congress and CMS should consider reverting to an earlier time, that before October 1st, 2013, and should reinstate the determination of inpatient hospitalization based on physician judgment with one caveat, the patients who are hospitalized for greater than two midnights for medical necessity and medically necessary hospital services should be presumed to be inpatients. If we are thoughtful about RAC reform, the short stay problem goes away and alternative short stay payment policies become unnecessary.

Congress should consider the formation of a multi-stakeholder collaborative working group to develop a sound alternative to the current Medicare audit program. We appreciate Congressman Gerlach's and Congressman Crowley's leadership as the lead sponsors of H.R. 3698 and Chairman Brady, thank you for your attention to this issue and holding a hearing on it. Having nearly half the members of this committee support this needed reform sends an important message to your hospitals and to CMS that this issue must be addressed.

The Two Midnight Rule and the RAC program are draining precious time, resources, and attention that need to be more effectively focused on patient care. Johns Hopkins and hospitals around the country stand ready to work with Congress and CMS to support these efforts.

Thank you so much for allowing me to testify.

[The prepared statement of Ms. Deutschendorf follows:]

Statement of Amy Deutschendorf, MS, RN ACNS-BC
Senior Director Utilization/Clinical Resource Management
at the
Johns Hopkins Health System
before the
Subcommittee on Health
of the
Committee on Ways & Means
of the
U.S. House of Representatives

"Hearing on Current Hospital Issues in the Medicare Program"

May 20, 2014

Chairman Brady, Ranking Member McDermott and distinguished members of the Subcommittee, thank you for the opportunity to testify today and share Johns Hopkins' perspective on important issues affecting hospitals in the Medicare program.

I am Amy Deutschendorf, senior director of utilization and clinical resource management for the Johns Hopkins Health System, in Baltimore, Md. In this capacity, I am responsible for utilization management, which includes admission and concurrent review, regulatory audits, denials and appeals, care coordination (including case management and social work), and our readmissions reduction initiative.

Johns Hopkins is an integrated network of six academic and community hospitals, four suburban health care and surgery centers, more than 30 primary health care outpatient sites, and numerous international partnerships. For more than a century, Johns Hopkins has been a recognized leader in patient care, medical research and teaching. Today, Johns Hopkins is known for its excellent faculty, nurses and staff specializing in every aspect of medical care.

Over the past decade, our environment has changed drastically, particularly in the financing of research, education and patient care – our core missions. The federal budget sequestration and related fiscal pressures have flattened federal research funding in recent years and resulted in reductions in reimbursement for patient care from federal, state and private payers. My remarks today focus on two major changes – the Centers for Medicare & Medicaid Services' (CMS) two-midnight policy for inpatient admission and medical review criteria, and the agency's Recovery Audit Contractor (RAC) program. I will share with you examples of the administrative and direct financial burdens borne by hospitals in implementing these policies and responding to audit requests. In short, they are draining precious hospital resources that should be focused on patient care.

THE TWO-MIDNIGHT POLICY

On Aug. 2, 2013, CMS finalized its "two-midnight" policy whereby the agency will generally consider hospital admissions spanning two midnights as appropriate for payment under the inpatient prospective payment system; however, hospital stays of less than two midnights will generally be considered outpatient cases, regardless of clinical severity. The policy took effect Oct. 1, 2013, but thanks to an act of Congress, enforcement has been partially delayed through March 31, 2015.

NEGATIVE IMPACT ON HOSPITALS AND PATIENTS

While we appreciate CMS's efforts to address the clarity and appropriateness of Medicare's hospital inpatient admission criteria, the two-midnight policy as written adds a new layer of complexity that subverts CMS's stated objective of clarity, creates confusion and stress for patients, and inappropriately puts decisions of medical necessity at odds with adequate reimbursement.

As a large tertiary referral center, Johns Hopkins Hospital treats many patients with high-acuity and complex medical issues. Our physicians make admission decisions very carefully based on the unique circumstances of each patient, including their current medical needs, risks of adverse events, medical history and comorbidities, and severity of signs and symptoms. Without exception, each physician's goal is to ensure the highest quality medical care for each and every patient. In some of these complex cases, high intensity services – available only in an inpatient setting – are necessary but can be completed in a relatively short period of time. For example, some acute exacerbations of asthma may be easily resolved with IV steroids and a nebulizer, while others may require intubation and use of a ventilator. Though the hindsight of the auditable claim is 20/20, the treating physician must trust his or her best medical judgment, and err on the side of protecting patients from risk.

Further, seemingly simple conditions, such as chest pain, are often not so simple in patients who suffer from multiple comorbidities. Though some chest pain cases may be appropriately handled in observation units, very sick patients—often with underlying cardiac, lung, and other diseases— require more intensive monitoring and treatment, especially because the risk of fatality is high if a heart attack does occur. In these cases, inpatient care is medically necessary – even if the patient is deemed fit to return home without further diagnosis after less than 'two midnights' of careful monitoring.

The two-midnight policy now requires physicians to abandon the medical assessment of medical necessity when determining the appropriate setting of care, and instead imposes a rigid time-based approach. Under the two-midnight policy, hospitals are expected to care for high-complexity, high-acuity patients with considerable hospital care needs in an outpatient setting solely because Medicare has redefined the definition of an inpatient stay, removing from the calculation the physician's use of experienced, complex clinical judgment to assess the short-term risk of adverse outcomes. This puts patients at risk, as adequate reimbursement is placed at odds with medical judgment and imposes new financial burdens on Medicare beneficiaries, as they face new Part B cost-sharing for hospital care. **Medicare should encourage our efficient evaluation and treatment of these high-risk, complex patients in the appropriate medical setting to avoid adverse outcomes rather than create payment guidelines that arbitrarily**

assign an ambulatory (or outpatient) level of care. The new policy serves as a disincentive for hospitals to be innovative and further improve care efficiency.

We also are concerned that the two-midnight policy penalizes hospitals like ours that provide innovative, efficient care. With improved technology and efficiency, more patients are being evaluated, treated, and transitioned to an appropriate care setting in less than the two-midnight timeframe. These are the same patients who in the past would have been expected to have a longer stay and, therefore, considered to be an inpatient under the two-midnight policy. This is the very medical efficiency CMS should be encouraging but, instead, hospitals are seeing dramatic reimbursement cuts as these gains in efficiency are "rewarded" by denials of inpatient claims. As a result of the two-midnight policy, the number of patients admitted to the hospital but reimbursed only at outpatient rates has increased by 33 percent. Since Oct. 1, 2013, we have seen a three-fold increase in the number of patients our physicians cautiously predicted would only stay only one-midnight (and thus began as outpatients) but later had to admit for longer stays, demonstrating the complexity of anticipating length of stay based on a patient's initial presenting symptoms.

The two-midnight policy is particularly devastating to academic medical centers and safety-net hospitals. Hospitals like Johns Hopkins continue to provide the same essential community services – serving the uninsured, maintaining trauma centers and burn units, conducting research and training the next generation of physicians – even if CMS arbitrarily decides that some hospital care should no longer be reimbursed as inpatient care. Yet when CMS's two-midnight policy shifts payment for necessary hospital care into the outpatient system, these hospitals experience decreases in their Direct Graduate Medical Education (DGME) payments and lose their payments for indirect medical education (IME) and disproportionate share (DSH) payments. These payments were intended to support the delivery of care to vulnerable patients and those who may require the services unique to teaching hospitals. We cannot afford for these social missions to be jeopardized at a time when medical education for new practitioners is critical to meet the demand for the infusion of new health care consumers under the Affordable Care Act.

CHANGES TO THE TWO-MIDNIGHT POLICY

As stated earlier, we appreciate that the genesis of the two-midnight policy was an attempt to provide clarity about the appropriate site of care, which is so often the target of RAC audits. Though the flaws in this policy are numerous and its effects damaging, we would hope to see a revised policy that still includes added clarity – but without sacrificing the critical role of medical judgment and adequate reimbursement for medically necessary short stays.

To that end, we support the premise that patients who are hospitalized for medically necessary services lasting longer than two midnights should generally be considered inpatients. Maintaining this portion of the two-midnight policy will eliminate excessive hospital stays under observation status and reduce some of the burden of RAC review. But for stays lasting fewer than two midnights, CMS's policy must change. An alternative solution need not be complex; in fact, simply returning to the policy in place for short stays prior to Oct. 1, 2013 may be a good place to start, were simple reforms to the RAC process (described below) implemented as well. Were a more complicated approach to short-stay reimbursement pursued, as suggested by CMS

in its most recent inpatient proposed rule, we would urge policymakers to ensure that the fundamental basis of the diagnosis-related group (MS-DRG) system remains intact and that policy-based add-on payments such as DSH and IME be included in short-stay reimbursement. Eighteen members of this Committee and 137 members of Congress have cosponsored H.R. 3698, a bill supported by the American Hospital Association (AHA), and we thank Congressman Gerlach and Congressman Crowley for being the sponsors of this bill, which highlights the need for a payment policy solution for these patients.

THE RECOVERY AUDIT CONTRACTOR (RAC) PROGRAM

Hospitals take seriously their obligation to properly bill for the services they provide to Medicare and Medicaid beneficiaries and are committed to working with CMS to ensure the accuracy of Medicare and Medicaid payments. We recognize the need for auditors to identify billing errors; however, redundant government auditors, unmanageable medical record requests and inappropriate payment denials are wasting hospital resources and contributing to growing health care costs. Fundamental reform of the RAC program is needed to prevent inaccurate payment denials and to make the overall auditing effort more transparent, timely, accurate and administratively reasonable.

BURDEN OF INCREASED AUDIT ACTIVITY

In recent years, CMS has drastically increased the number of program integrity auditors that review hospital payments to identify improper payments. These audit contractors include both RACs and Medicare Administrative Contractors (MACs). RACs are charged with identifying improper Medicare and Medicaid fee-for-service payments – both overpayments and underpayments. They are paid on a contingency fee basis, receiving 9 to 12.5 percent of the improper payments they identify and collect. Due to this incentive structure, RACs frequently target high-dollar inpatient claims. MACs conduct pre-payment and post-payment audits and also serve as providers' primary point-of-contact for enrollment and training on Medicare coverage, billing and claims processing.

No one questions the need for auditors to identify billing mistakes; however, responding to the increasing number of audits and challenging inappropriate denials drains hospitals' time, funding and attention that could more effectively be focused on patient care. For example, according to the AHA's RAC*Trac* survey of 2,400 participating hospitals, there was a 60 percent increase in the number of records requested for RAC audits during 2013. These Medicare claims now collectively represent nearly $10 billion in Medicare payments, a 56 percent increase from the claims requested for RAC audits through 2012.

INAPPROPRIATE DENIALS BY RACS

In addition to the financial burden of complying with RAC audits, hospitals are experiencing a significant number of erroneous RAC denials, which total millions of dollars. Of the medical records submitted for Johns Hopkins Hospital, 50 percent were automatically denied as being billed at the wrong level of care. We presented 239 cases for discussion and had ***favorable*** determinations in 135 (over fifty percent) of the cases. The rest of these cases are in the appeal process. It is important to note that our commercial payer denials (including Medicaid) for

medical necessity prior to appeal are approximately 2.5 percent of our commercial inpatient days.

Physicians who treat Medicare patients do not have the benefit of knowing in advance the health outcome of the patient; therefore, they treat patients in the setting they determine to be medically appropriate. We should, of course, expect hospitals to accurately bill for care deemed medically necessary due to the information available at the time of the patient's case. RAC auditors, however, view cases through the lens of their 20/20 hindsight and second-guess physicians by evaluating medical records with information that was not available to the physician when the patient presented. Exacerbating this biased approach is the subjective nature of these denials, with which hospitals often disagree because of the reviewers' lack of relevant clinical training. In our experience with the RAC discussion process, medical necessity determination was made using proprietary guidelines and medical judgment by practitioners who were not specialists or even generalists in the clinical area the patient needed. RACs are not penalized for their inaccuracy, and the burden falls completely to the hospital to appeal each claim that is inappropriately denied.

Despite being charged with ensuring the accuracy of Medicare payments, and despite a purported expertise in identifying inaccuracies, RACs do not have a strong record finding errors in hospital claims. For example, 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 at the third level of appeal. In fact, some hospitals have appeal success rates above 95 percent. Unfortunately, not all hospitals have the resources to appeal denials because it is costly and time consuming. RACs receive their commission of 9 to12.5 percent for each inappropriately denied claim that hospitals don't appeal.

UNEVEN PLAYING FIELD FOR APPEALS

RACs have a significant focus on reviewing short inpatient stays, and they deny these types of claims sometimes up to three years after the patient was treated. Hospitals are successful in their appeals even though they face a highly uneven playing field when they appeal an erroneous RAC denial. To recapture full payment for reasonable and necessary care, hospitals must separately appeal each RAC denial through an appeals process that can take years and years. A single auditor can produce dozens of denials per day, while a hospital must appeal every incorrect denial through a one-claim-at-a-time appeal process. The latest AHA survey indicates that about 70 percent of all appealed claims are still in the appeals process.

Meanwhile, the need for fundamental RAC reform has become even more apparent and urgent since the HHS Office of Medicare Hearings and Appeals (OMHA) announced in December 2013 that it will take at least two years for hospital appeals to be assigned to an administrative law judge because OMHA currently has 375,000 claims to assign and it doesn't want to add any more claims to its backlog. Additionally, OMHA expects posted assignment hearing wait times will continue to exceed six months. **During this 30-month period in the appeals process, hospitals are not paid for the care they provided to Medicare beneficiaries.**

Hospital resources should be spent on patient care, not fighting erroneous RAC denials for years on end. Additionally, Medicare beneficiaries are hurt when their inpatient stay is inaccurately

denied by a RAC, resulting in higher out-of-pocket expenses and, in some instances, bills that otherwise would have been covered by Medicare. Without fundamental reform, the RAC program will continue to improperly harm Medicare beneficiaries and hospitals.

ALTERNATIVES TO THE CURRENT RAC PROCESS

It is time for a thoughtful and coherent approach to Medicare audits, one that will achieve the goals of CMS: ensuring hospital compliance with policies that support appropriate care for our Medicare beneficiaries, rewarding innovation in the safe reduction of acute care utilization, and actually reducing unnecessary administrative costs to both acute care hospitals and the Medicare program. This could be achieved in a variety or combination of ways, for example:

- Implement a concurrent review process to partner with hospitals and other providers;
- Use data-mining techniques to find outliers and conduct sample audits to detect true errors; and/or
- Audit compliance programs for comprehensive practices to assure medical necessity of admissions and continued stays for Medicare patients. (Our health system utilization departments review every day of every inpatient stay for medical necessity and have a rigorous process for self-denial prior to the claim being billed to Medicare.)

The complexity of the current regulations distracts providers from focusing on the real goals for our patients: the provision of safe and quality care. One solution is the Medicare Audit Improvement Act (H.R. 1250/S. 1012), currently supported by 214 Members of Congress in the House. Another possible solution is the formation of a stakeholder group to work with CMS to comprehensively address these compliance issues and develop collaborative and rational solutions that will facilitate rather than further complicate hospitals' ability to care for patients.

CONCLUSION

Johns Hopkins takes seriously its obligation to properly bill for the services we provide. Our mission of caring for our communities depends on fulfilling this obligation.

Hospitals need reform of confusing and harmful policies – such as the two-midnight policy and the RAC program as currently administered – that drain precious time, resources and attention that could more effectively be focused on patient care. Johns Hopkins and hospitals across the country stand ready to work with policymakers to support these efforts.

Chairman BRADY. Thank you.
Dr. Evans.

STATEMENT OF ELLEN EVANS, MD, CORPORATE MEDICAL DIRECTOR, HEALTHDATAINSIGHTS

Dr. EVANS. Chairman Brady, Ranking Member Dr. McDermott, Members of the Committee, thank you very much for this opportunity to testify before you today.

I am Dr. Ellen Evans, lead physician with HealthDataInsights, the Region D CMS recovery auditor. I am a proud graduate of the University of Texas Medical School, residency trained, board certified licensed family physician, with a certificate of added qualifications in geriatric medicine. I joined HDI during the RAC demonstration program. At HDI, I oversee all of our medical and clinical recovery audit activities.

The recovery audit program is not focused on fraudulent payments. We review claims to ensure compliance with Medicare practices and also identify underpayments that are returned to the providers. This program is a critical component of Medicare operations because over $30 billion are improperly paid by Medicare every year. Since the recovery audit program was passed and implemented in a bipartisan fashion in 2006, over 8 billion improperly paid Medicare dollars have been recovered, as well as over $700 million in underpayments returned to providers.

Recovery auditors identify the types of claims that are most at risk of improper payment by employing vast auditor experience and using Federal publications such as HHS, OIG, GAO, and CERT reports. Every issue a recovery auditor seeks to review is submitted first to CMS for a rigorous evaluation and approval process. Issues that are approved are posted to the recovery auditor's provider portal in advance of any activity.

CMS has limited the recovery audit medical record request to 2 percent of Medicare claims for any given provider. All medical reviews are conducted by licensed and experienced clinicians who undergo extensive screening and comprehensive training. When a provider disagrees with an audit finding, the provider can initiate a discussion period before formally appealing the denial. This is in addition to the usual CMS appeals process.

Though the program has proven to be cost effective, recent constraints have caused a significant decrease in recovery audit reviews. First, as part of the implementation of the Two Midnight Rule, a moratorium was placed on recovery auditors preventing auditing of short stay hospitals for 18 months. Second, CMS announced the program would be suspended until new contracts are in place. The award date is currently unknown. These two changes will result in over $5 billion of improper payments not being restored to the Medicare trust fund.

Now, let me provide you some facts about the program. First, a recovery auditor is required to return all of its fee when a refinding is reversed upon any level of provider appeal. This means recovery auditors are incentivized to work accurately and precisely. Second, according to the most recent CMS report to Congress, only 7 percent of all recovery audit determinations have been overturned on appeal. Third, recovery auditors are accurate. An independent CMS validation contractor gave recovery auditors a cumulative accuracy score of over 95 percent. Finally, recovery auditors target improp-

erly paid claims of all types, yet Medicare data has noted consistent high dollar errors for inpatient short stays.

Based on this data, it is imperative to the longevity of the Medicare trust fund to correct inpatient short stays. That being said, we understand the frustration expressed by the hospital community surrounding the Two Midnight Rule. We want to work with CMS and the providers to bring clarity to the rules. As the committee moves forward on this important issue, I offer the following recommendations for the program.

First, we support the ALJ appeal reforms outlined in the November 2012 HHS Office of the Inspector General report. Second, we support continued effort by CMS to offer providers front end education to increase provider knowledge of Medicare policies, and lastly, we support increased dialogue among recovery auditors, providers, policymakers, to improve the direction of the program. We are pleased to be a part of the dialogue today.

The recovery audit program must continue to play a role in the Medicare program, especially in light of the recent increases in an improper payment rate. I appreciate the opportunity to appear before you all today and would be pleased to answer any questions that you may have.

Chairman BRADY. Thank you.

[The prepared statement of Dr. Evans follows:]

Chairman Brady, Ranking Member McDermott, Members of the Committee, thank you very much for the opportunity to testify before you today. My name is Dr. Ellen Evans and I serve as the Corporate Medical Officer for Health DataInsights (HDI), a technology driven healthcare services company that specializes in claims integrity and the correction of improper payments for the Medicare Trust Fund, government and private payors. HDI currently serves as the CMS Recovery Auditor for Region D which is comprised of 17 western states and 3 US territories.

As background, I am a graduate of the University of Texas Medical School at Houston and a residency-trained, Board-certified licensed Family Physician with a Certification of Added Qualifications in Geriatric Medicine. My clinical practice experience has included hospital care and geriatric inpatient and outpatient consultation services as well as rehab, nursing home, home care, and Critical Access Hospital coverage. Leading the Creighton University Geriatric Education Program and Geriatric Consultation Services in Omaha, Nebraska, I served as the Medical Director of community and hospital-based Skilled Nursing Facilities (SNFs) and Long Term Care facilities. A past President of the Nebraska Medical Directors Association, I joined HDI after serving as the Contractor Medical Director for the Medicare Division of Mutual of Omaha—one of the largest Medicare fiscal intermediaries. In my current role, as Corporate Medical Officer of HDI, I oversee all of our medical and clinical activities, which include clinically-intelligent claim selection, well-documented new issue submission, accurate and precise medical record review, and quality assurance throughout every clinical aspect of HDI's recovery audit work.

Evolution of the Recovery Audit Program

The Recovery Audit program is an innovative approach to recovering improperly paid Medicare claims. Unlike other contractors in the Medicare program integrity field, our work is not focused on fraudulent payments, but instead we review paid claims to ensure that providers who participate in the Medicare program are complying with Medicare billing policies and guidelines. These are the most prevalent types of Medicare improper payments: payment made for services that do not meet Medicare's coverage and medical necessity criteria; payment made for services that are incorrectly coded; and payment made for services where the submitted documentation does not support the services as billed. The funds we recoup from improperly paid Medicare payments are returned directly back to the Medicare Trust Fund. In addition to identifying overpayments, Recovery Auditors also identify underpayments that are returned to providers.

I joined HDI during the Medicare Recovery Audit Demonstration Program. Unlike many other Federal healthcare program integrity contracts, the Recovery Audit program was first piloted in three states—New York, Florida and California, with a few additional states added mid pilot. During this three year period, over $1 billion of improper payments were corrected for the Medicare Trust Fund. As a result of the success of the program, in 2006, Congress mandated that the Department of Health and Human Services institute a permanent and national Recovery Audit program.

The Recovery Audit demonstration served as an important tool to help CMS prepare and shape the permanent Recovery Audit Program that is in place today. As a result of lessons learned and feedback from Medicare providers and suppliers during and after the demonstration period, CMS adopted numerous changes to improve the permanent Recovery Audit program. These changes included:

- Limiting the number of medical records that are requested for review;
- Requiring each Recovery Auditor to employ a full-time medical director who is a licensed physician, as well as licensed RNs and certified coders to ensure the reviews are completed accurately;
- Requiring the Recovery Auditor to return its contingency fee if a provider contests an audit and the Recovery Auditor loses at any level of the appeal;
- Posting new issues targeted by the audits on the Recovery Auditor's website to provide more transparency;
- Changing the look back period from four years to three years; and
- Accepting imaged medical records from providers on CD/DVDs in lieu of paper records.

In addition to general contract oversight, CMS has specific requirements that include:

1. Complying with an established approval process for all new review issues,
2. Requiring approved new issues are posted to the Recovery Auditor's website,
3. Requiring the specific audit issue is detailed in each request for medical records,
4. Following the CMS established medical record request limits,
5. Reimbursing certain providers for medical records,
6. Applying restrictions on findings of improper payment for minor omissions that other CMS review contractors deny,
7. Providing written notification to providers on all determinations, finding or not,
8. Affording providers opportunity to have a discussion with a Recovery Auditor's physician,
9. Affording providers a discussion period with the Recovery Auditor prior to initiating a formal appeal with the Medicare Administrative Contractors (MAC), and
10. Comply with monthly accuracy sampling conducted by an independent CMS contractor to confirm Recovery Audit findings.

These CMS requirements are unique to Recovery Auditors when compared to other Medicare Program Integrity contractors. The result is to ensure enviable accuracy and precision of Recovery Audit work.

CMS Requirements on Postpayment Reviews Unique to Recovery Auditors, Compared to Other Contractor Types, as of May 7, 2013

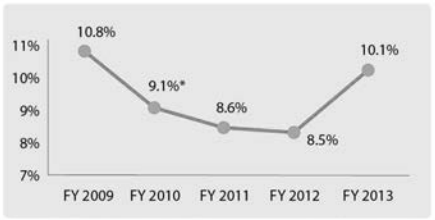
Requirement	Contractor Type			
	Medicare Administrative Contractors (MAC)	Zone Programs Integrity Contractors (ZPIC)	Comprehensive Error Rate Testing (CERT) Contractor	Recovery Auditors (RA)
Selection of claims for postpayment review				
CMS approval of criteria for selecting billing issues prior to widespread use	No	No	n/a	Yes
Provider notice of issues targeted for review				
Provider notice (on website) of billing issues targeted for postpayment review	No	No	n/a	Yes
Additional documentation requests (ADR)				
Provider reimbursement for copies of medical records	No	No	No	In some cases
Limits on number of ADRs contractor can request from provider	No	No	No	Yes
Reviews				
Authority to deny claim for minor omissions	Yes	Yes	Yes	No
Provider communication				
Provider notification regardless of review outcome	No	No	No	Yes
Reviewer's credentials available upon provider request	No	No	No	Yes
Access to contractor's medical director to discuss claim denials upon request	No	No	No	Yes
40 days to discuss any revision to initial determination informally prior to having to file an appeal	No	No	No	Yes
Quality assurance				
External validation of randomly selected claims by independent contractor	No	No	No	Yes

Source: GAO: Medicare Program Integrity: Increasing Consistency of Contractor Requirements May Improve Administrative Efficiency, July 2013

The Recovery Audit Program Today

Billions of Medicare dollars are paid improperly by the Medicare program every year. The improper payment rate for Medicare recently increased from 8.5% in FY2012 to 10.1% in FY2013. Medicare pays over $300 billion in claims each year, which means that over $30 billion in taxpayer dollars is lost to waste and billing errors each year.

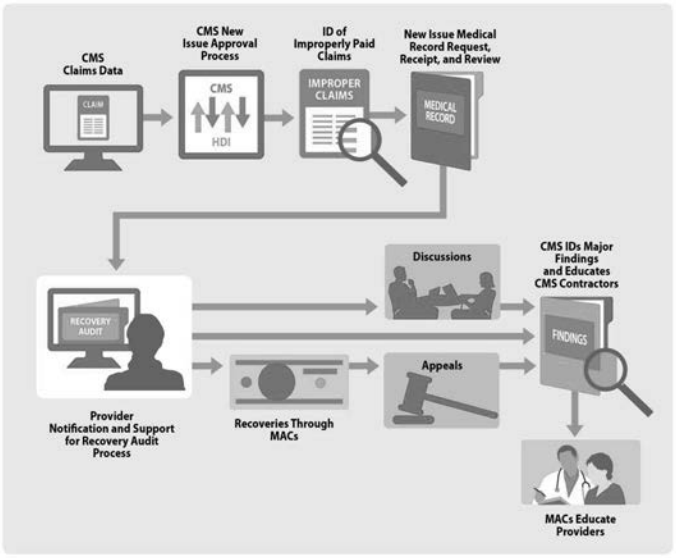
Percentage of Improper Payments Made Under the Medicare Fee-for-Service Program



Source: HHS FY 2013 Agency Financial Report * results exceeded target

Recovery Auditors serve an important role in correcting improper Medicare payments. Over $8 billion of improperly paid Medicare dollars have been recovered under the Recovery Audit program since 2006.

How Recovery Auditors Identify Improper Payments



CMS designed the Recovery Audit program to identify improper payments and return funds to the Medicare Trust Fund. Recovery Auditors identify the types of claims that are most at risk for improper payment by employing vast auditor experience, data mining, and use of Federal publications such as HHS OIG, GAO and CERT reports. In order to ensure Recovery Auditors are making accurate claim determinations, every issue that a Recovery Auditor seeks to review must be submitted first to CMS for a rigorous evaluation and approval process. In submitting new issues, the Recovery Auditor must describe the CMS rationale for identification of the improper payment including federal reports, statutory references and CMS rules and regulations. Furthermore, new issue submissions must provide methodology for claim selection and identification of medical record review guidelines based on identified medical record elements in support of a submitted claim. Issues which are approved are then posted to the Recovery Auditor's Provider Portal in advance of any audit activity.

Recovery Auditors use three methods to review claims:

- Automated – improper payments identified based on claims payment data
- Semi-Automated – Improper payments based on claims payment data and provider has opportunity to submit record prior to improper payment determination
- Complex – review of medical records with higher probability of improper payment

Medical records are only requested for complex review claims and CMS has limited the amount of medical records (ADRs) a Recovery Auditor can request to less than 2% of Medicare claims for any given provider.

Medical reviews are conducted by licensed and experienced clinicians who undergo extensive screening and comprehensive training, and meet specific education requirements. HDI's team includes licensed physicians, licensed RNs, certified coders and registered pharmacists with oversight of all provided by the Medical Director. In addition, HDI has established Quality Review and Assessment programs that drive audit review accuracy and precision in real time to generate the most accurate and precise provider audit results possible.

HDI's goal is to generate quality determinations that are accurate, precise and well documented. These determinations are clearly and concisely communicated to the provider. Within the provider communication, Recovery Auditors cite the specific sections of CMS manuals, guidelines, rules and regulations which are associated with the audit finding. CMS appeal instructions are also included in the provider communication should the provider disagree with the review determination.

How the Appeals Process Works for Audited Claims

In cases in which a provider disagrees with a finding by the Recovery Auditor, the provider has an opportunity to initiate a "discussion period" before formally appealing the denial. This offers providers an opportunity to submit supporting documentation for their original billing. It is also an additional opportunity for the Recovery Auditor to explain the rationale behind an

overpayment decision. Upon review of all provider information, the Recovery Auditor notifies the provider of its final determination.

The provider also can utilize the normal CMS appeals process, the five-level Medicare claims appeal process through which fee-for-service providers appeal reimbursement decisions.

There are five levels of appeal –note that appeals rarely reach the last two levels These are as follows:

1. Redetermination by the Fiscal Intermediary (ie Medicare Administrative Contractor)
2. Reconsideration by a Qualified Independent Contractor;
3. Administrative Law Judge Hearing;
4. Medicare Appeals Council Review; and
5. Judicial Review in U.S. District Court.

In November 2012, HHS OIG reported that certain improvements could be employed at the Administrative Law Judge (ALJ) level of Medicare Appeals. Currently, there is a large backlog of cases at the Administrative Law Judge level that is causing concern for all stakeholders. It has been documented that a number of factors have driven the backlog. This includes increased numbers of appeals by providers and limited ALJ resources. I will speak to the appeals process later in my testimony, but I think all stakeholders agree that this stage of the Recovery Audit process needs closer attention. We look forward to collaborating with stakeholders to focus on long term reforms to the Recovery Audit appeals process which will allow the ALJ's to effectively manage incoming appeals.

Beyond the correction of improper Medicare payments, Recovery Auditors also work together with CMS to evaluate recovery audit results and identify major findings and possible corrective action steps. CMS corrective actions include installing national claims edits, generating provider education materials, refining billing and medical necessity requirements to improve improper payment rates, and clarifying or changing policy. Regular Major Finding discussions among CMS and its contractors are held to understand Recovery Audit findings and identify corrective interventions with MACs and CMS, including the identification of provider outreach, education opportunities and instruction.

Success of the Recovery Audit Program

From FY 2012 to FY 2013, the Recovery Auditors returned more money to the Medicare Trust Fund than any other healthcare integrity initiative, earning the distinction by the HHS OIG as the "most improved" program. Since 2006, the Recovery Auditors have recovered over $8.9 billion in improper payments to the Medicare Trust Fund as well as returned over $700 million in underpayments to providers. Based on the return on investment that the Recovery Audit program yields, the program is a cost effective means of identifying underpayments and overpayments in the Medicare fee-for-service program. Because of the program's success, the projected life of the Medicare Trust Fund has been extended by two additional years.

This high level of recovery has occurred notwithstanding the fact that Recovery Auditors are limited to reviewing less than two percent of providers' Medicare claims volume. In fact, in 2012, the OIG report stated that despite all of CMS' program integrity programs, the Agency still reviews less than 1% of the over one billion fee-for-service claims paid annually. Controls such as these have been put into place to ensure there is a balance between oversight of Medicare spending and provider burden. As outlined earlier, these types of safeguards along with efforts to maximize transparency and provide vital data to the Medicare Administrative Contractors for provider education are unique to the Recovery Audit program and have played a part in the overall success of the program.

New Changes to the Recovery Audit Program

CMS has played an integral role in the Recovery Audit program since the demo began in 2006. The agency has made continual advancements to enhance the program and ensure minimal provider burden, high levels of accuracy, and transparency. The Medicare provider community and the Recovery Auditors played a distinct role in developing and encouraging the numerous changes made to the Recovery Audit program after the demonstration. Additionally, in February 2014, CMS announced it would be making a number of new changes to the Recovery Audit program, which would be effective with the new contractor awards. These changes were made to enhance the program, as well as address provider concerns.

Concern	Program Change
Upon notification of an appeal by a provider, the Recovery Auditor is required to stop the discussion period.	Recovery Auditors must wait 30 days to allow for a discussion before sending the claim to the MAC for adjustment. Providers will not have to choose between initiating a discussion and an appeal.
Providers do not receive confirmation that their discussion request has been received.	Recovery Auditors must confirm receipt of a discussion request within three days.
Recovery Auditors are paid their contingency fee after recoupment of improper payments, even if the provider chooses to appeal.	Recovery Auditors must wait until the second level of appeal is exhausted before they receive their contingency fee.
Additional documentation request (ADR) limits are based on the entire facility, without regard to the differences in department within the facility.	CMS is establishing revised ADR limits that will be diversified across different claim types (e.g., inpatient, outpatient).
ADR limits are the same for all providers of similar size and are not adjusted based on a provider's compliance with Medicare rules.	CMS will require Recovery Auditors to adjust the ADR limits in accordance with a provider's denial rate. Providers with low denial rates will have lower ADR limits while providers with high denial rates will have higher ADR limits.

Source: CMS

Current Status

Even though the Recovery Audit program has proven to be a success, the program has recently been subject to external constraints that have resulted in a significant decrease in recovery audit reviews.

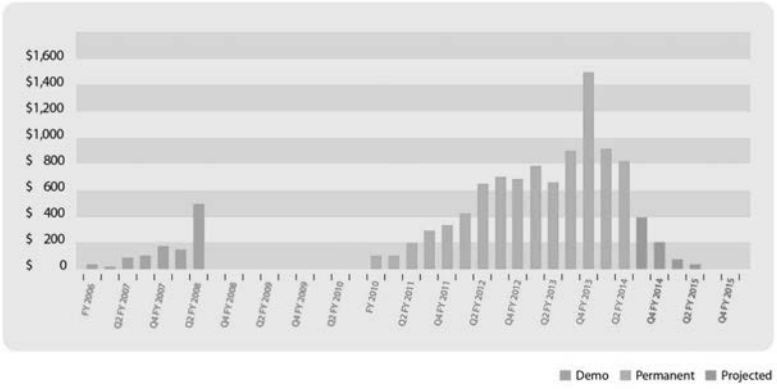
First, as part of the implementation of the 2 midnight rule, a moratorium was placed on the Recovery Auditors, preventing auditing of short-stay hospital claims from October 2013-March 2015. As of now, these short-stay claims will never be subject to review by a Recovery Auditor. CERT reports have documented that short-stay inpatient claims historically have a high probability of improper payment. As such, Members of Congress and taxpayers should be concerned that Medicare providers will be shielded from Recovery Audit review of these types of claims for 18 months. Based on years of historical Recovery Audit data, it is estimated that the audit moratorium will result in over $5 billion in lost savings to the Medicare Trust fund.

The second significant change to the program is the current program "pause" until the new Recovery Auditor contracts are finalized. In February 2013, CMS began the procurement process for the next round of Recovery Audit contracts. At that time, CMS announced the Recovery Audit program would continue during the transition, with some decline in the number of audits allowed. As of today, the new Recovery Audit contracts have not been awarded. In February 2014, CMS announced the Recovery Audit program would be suspended until the new contracts are in place, but it is currently unknown when the awards will occur.

The audit moratorium and the program "pause" have scaled back the essential scope and effectiveness of the Recovery Audit program. The result is billions of dollars of improper

payments are not being recovered and restored to the Medicare Trust Fund, contributing to Medicare's long term solvency challenges. Recent Recovery Audit corrections quarterly reports already show that recoveries have declined significantly over the past two quarters.

Recovery Audit Collection by Quarter



Recovery Audit Program Myths: Setting the Record Straight

Despite the success of the Recovery Audit program, misconceptions about how the program works and how Recovery Auditors carry out their audits remain. The Recovery Audit program administered by CMS is relatively simple and is very similar in its scope and structure to audit programs carried out in other government programs, such as Medicaid and TRICARE, and in the commercial sector by insurers and other payers. However, because the program is relatively new, some confusion about the program remains. I would like to take this opportunity to dispel some common myths about the program:

Myth #1: Recovery Auditors are Bounty Hunters because they receive a fee on every claim they deny. A Recovery Auditor is required to return all of its fees when a finding is reversed at any level of provider appeal. This means Recovery Auditors are incentivized to work accurately and precisely. In actuality, Recovery Auditors are paid through performance-based contracts in which they are only paid for overpayments and underpayments that are accurately identified and corrected. This type of fee structure requires Recovery Auditors to absorb the front end cost of auditing. Unlike cost-plus contractors, the federal government does not provide any funding for hiring and training of experienced clinicians, claims analysts, and other experts to run the program. This incentivizes Recovery Audit contractors only to pursue claims which are

improperly paid. Contingency-based contracting protects taxpayer dollars by only paying for results.

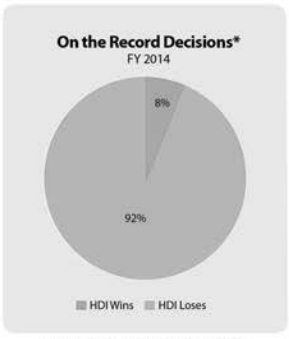
Myth #2: Over 70% of appeals before an ALJ are overturned in favor of the hospital.

According to CMS' most recent Recovery Audit program Report to Congress, in FY 2012, only seven percent of all Recovery Auditors' determinations have been challenged and later overturned on appeal. Specifically, Medicare providers appealed 373,259 claims, which constitute 26.3 percent of all Medicare claims with overpayment collections. Of those claims appealed to the ALJ, 99,476 claims were overturned with decisions in the provider's favor (26.7 percent). For HDI specifically, we can report that in FY 2014 when HDI attends a hearing, 77.3% of our improper payment denials have been upheld at the ALJ level.

In its March 2014 Recovery Audit report to Congress, CMS notes that "the receipt and an appeal and the reversal of a Recovery Auditor decision does not necessarily mean the Recovery Auditor was wrong in its determination." For example, providers are often given the opportunity to reopen their claims to correct their billing during the appeals process. Additionally, the report notes inconsistencies also occur between the Recovery Auditor decision and ALJ decision due to the fact that Recovery Auditors are required to make their claims decision based on all CMS policies including manuals and Local Coverage Determinations (LCDS), while ALJs provide deference to but are not bound by these same CMS requirements.

There also has been an increasing number of ALJs appeal decisions occurring "on the record," which are decisions based solely on the review of relevant documents without a hearing. Decisions made on the record do not afford Medicare Recovery Audit Contractors an

*HDI receives only 11% of notices to attend hearings



*HDI has no opportunity to participate for CMS

opportunity to participate, providing legal arguments and clinical testimony discussing the merits of the review and the Medicare regulations that resulted in the claim denial. Our data support the fact that when decisions are made by ALJ's on the record and HDI does not participate in a hearing, the overturn rate significantly increases.

Myth #3: Recovery Auditors are often inaccurate and inflict avoidable legal and administrative costs on hospitals. Another program safeguard that is unique to the Recovery Audit program is the use of an independent validation contractor to review random samples of claims of which a Recovery Auditor has made an improper payment determination. These samples are collected on a monthly basis and scored on an annual basis to produce an accuracy score for each Recovery Auditor. This score represents how often Recovery Auditors are accurate in their overpayment and underpayment determinations. CMS' most recent report to Congress cites that in FY 2012 all Recovery Auditors have a cumulative accuracy score of 95.5%. I am also proud to report that in the March 2014 report, HDI's cumulative accuracy rate was reported as 97.25%.

Cumulative Accuracy Score by Recovery Auditor

Region	% of Accuracy
Region A	96.3%
Region B	96.3%
Region C	92.5%
Region D	97.2%
Average Accuracy Score	**95.5%**

Source: CMS Recovery Auditing in Medicare and Medicaid for FY 2012 Report to Congress, March 2014

Myth #4: Recovery Auditors lack clinical expertise. CMS regulations, instructions and statements of work for its contractors require every medical review be performed by a licensed clinician. Those include medical doctors, licensed RNs, certified coders, and registered pharmacists. CMS requires a licensed physician to serve full time as a Medical Director for every Recovery Audit contractor. I am pleased to tell you HDI meets or exceeds these requirements. Every medical record review completed by HDI is performed by a qualified clinician in accordance with CMS requirements. HDI employs a full-time Corporate Medical Director, a full-time Senior Medical Director, and a team of Physician Reviewers, while our parent company maintains a staff of physicians and other clinicians across every specialty who are available for consultation as needed. It is also important to note HDI's clinicians are recruited based on solid credentials backed by experience in the practice of their field and with utilization management and/ or medical review expertise. Our recruitment and hiring process brings quality clinicians to our team. The HDI training and mentoring process ensures complete familiarity with CMS Medicare manuals, guidelines, rules, regulations, and coverage resulting in demonstrated clinical expertise before any audit determinations are released.

Myth #5: Recovery Auditors impact beneficiary care. It is important to understand that Recovery Audit Contractors do not deny care, impact clinical decisions made by providers, or impact the quality of services to beneficiaries. Recovery Audit Contractors review claims after care has been provided to patients. Hospitals have already received their Medicare payments by the time a review is conducted.

Additionally, the CMS statement of work precludes recovery of claims where a beneficiary would be liable for an improperly paid claim. This means that Medicare beneficiaries are never affected financially by any recovery audit work.

Myth #6: Recovery Auditors Target Short Inpatient Stays. As already discussed here today, it is often pointed out that Recovery Auditors have focused on Short Inpatient hospital stays. There is a very compelling reason why Recovery Auditors focus on Short Inpatient hospital stays. Medicare data, such as CERT measurements, HHS OIG and PEPPER/Fathom reports have consistently noted high dollar error rates for these types of hospital claims. With persistent billing error rates for Hospital Care driven by high dollar hospital short stays, an HHS OIG study last year (2013) reported both Medicare and its Beneficiaries pay more for Hospital Care billed as Inpatient care than they pay for Hospital Care billed as Outpatient care. Based on this data, it is imperative to the longevity of the Trust Fund that Recovery Auditors focus on short inpatient stays.

That being said, as has already been indicated, we understand the frustration expressed by the hospital community surrounding the 2 midnight rule, and we want to work with CMS and the provider community to bring clarity to the rules regarding short inpatient stays. Clarity, combined with effective education and outreach, will help the system move forward in a way that addresses the legitimate concerns of providers while respecting the importance of program integrity and the interests of the taxpayers in protecting the Trust Funds. In fact, recovery audit helps bring clarity to the rules and regulations of the Medicare system by offering corrective feedback to the submission of improper claims. Without correction, the errors of improper billing are perpetuated and become entrenched.

Recovery Audit Program Recommendations

As the Committee looks to move forward on this important issue, I would like to offer the following recommendations for the Recovery Audit Program.

1. Appeals Reform as documented in the 2012 HHS OIG Report

The ALJ process, under the executive branch, is the third level of appeal for providers and has presented the CMS contractors and the Recovery Audit program with significant difficulties leading to results that are inconsistent with the goals of the Medicare program. For example, The HHS OIG documented serious issues with the ALJ process contained in their 2012 report, including:

- Medicare Regulations, Policies and Manuals are not being followed by the ALJs
- ALJ decisions are inconsistent with MAC and QIC rulings that uphold the audit approximately 90% of the time
- Many ALJ judges rule against CMS audit findings regardless of the issue presented
- Many ALJs do not have clinical expertise for reviewing clinical cases and require additional training
- An overwhelming number of ALJ decisions favorable to providers provides an incentive for providers to continue appealing
- Certain providers are "serial appellants" and are committed to appealing 100% of audits, thereby clogging the system and creating financial burden on the program

Appeals Reform would include:

- Increasing the number of ALJ judges to allow for effective management of the work load
- Implement ALJ training on Medicare policy for consistent application of CMS policy and rulings
- Review the increased use of "on the record" decisions by ALJs
- Review ALJ policy of "complete individual independence"

2. Continue to empower MACs to offer Provider Education that increases provider knowledge of Medicare policies

Consistent reinforcement of CMS policies, rules and regulations by effective educational outreach, goes a long way toward addressing many of the issues we are discussing here today. When providers fully understand Medicare rules and how to abide by them, the whole system benefits. We believe this should be an important priority for CMS and for this Committee.

3. Collaboration amongst stakeholders

Increase the dialogue between Recovery Auditors, providers, policymakers and other stakeholders to move forward in improving the direction of Recovery Audit program and protecting Medicare program and tax dollars from improper payments

4. Continuous, consistent program integrity oversight by CMS

The Recovery Auditors recommend that in order to reduce error rate where over $30billion in claims are improperly paid each year, CMS should continue to provide oversight of claim payments through continuous, consistent program integrity efforts to ensure accurate payment of claims, clear payment policies and recoupment of improper payments. We recommend that more reviews are shifted to pre-payment review for more immediate feedback to the providers.

Conclusion

In summary, we at HDI are pleased to be a part of the dialogue that is occurring today around balancing Medicare oversight with managing provider impact. The Recovery Audit program

seeks to strike this balance though its evolution from a demonstration program to a permanent program. Our quality measures have shown that we perform our workload with a high level of reproducible effectiveness and efficiency that is based in sound and experienced clinical expertise among licensed professionals with physician oversight and medical direction. Recovery Auditors maintain high accuracy; low appeals overturn rates; and steady recoveries of monies to providers and to the federal government. This success was noted by naming Recovery Audit program the "most improved" program distinction from the HHS OIG.

We believe the Recovery Audit program must continue to play a role in the Medicare program—especially in light of the recent increase in improper payments. The program is a proven success in meeting its mission to identify and correct Medicare improper payments, and return overpayments back to the Medicare Trust Fund.

Chairman BRADY. Dr. Sheehy.

STATEMENT OF ANN SHEEHY, MD, MEMBER, PUBLIC POLICY COMMITTEE, SOCIETY OF HOSPITAL MEDICINE

Dr. SHEEHY. Chairman Brady, Ranking Member McDermott, and Members of the Committee, thank you for the opportunity to testify today on observation status, the Two Midnight Rule, and related issues.

My name is Ann Sheehy. I am a physician at the University of Wisconsin Hospital in Madison, Wisconsin. I am a hospitalist, which is a physician who cares for patients primarily in an acute care hospital setting. I am also a member of the public policy committee of the Society of Hospital Medicine, an association that represents the Nation's more than 44,000 hospitalists.

Observation care is often provided in the same hospital beds as inpatient care, and to a physician and a patient, the care provider is indistinguishable but is considered outpatient not covered by Medicare Part A. Many Medicare beneficiaries ask how they could be outpatients when they are staying overnight in a hospital. Many ask me to change them to inpatient, which is something I cannot do under current policy. The centers for Medicare and Medicaid services describes observation as a well defined set of services that should last less than 24 hours, and in only rare and exceptional cases, spend more than 48 hours.

We published our University of Wisconsin Hospital data in JAMA Internal Medicine last summer. The average observation length of stay at our hospital was 33 hours, and almost 1 in 6 of our observation patients lasted longer than 48 hours. We also had 1,141 distinct observation codes. We concluded that observation status for hospitalized patients was markedly different from the CMS definition I just stated as mean length of stay was longer than 24 hours, observation stays beyond 48 hours were common, and the number of diagnoses codes showed that this was not well defined.

These numbers demonstrate that observation care in real clinical practice is vastly different than how CMS intended observation to be. Any attempt to reform observation policy must recognize how far observation status has strayed from what observation should truly mean, and this problem is getting worse with more beneficiaries disadvantaged by observation. The most recent MedPAC report documented 28.5 percent increase in outpatient services from 2006 to 2012 with a 12.6 decrease in inpatient discharges over the same time period.

As the committee is aware, CMS recently established a new policy to determine observation and inpatient status. As of October 1, patients staying less than two midnights with some exceptions were to be observation, and those two or more midnights would be inpatient, although full enforcement has been delayed through March 31st of 2015.

The Two Midnight Rule has presented new challenges in observation care. For example, a Medicare beneficiary may be hospitalized with pneumonia and is improved enough to leave the hospital after 40 hours of care. If that patient happens to get sick and present to our hospital Tuesday at 1:00 a.m., this means I would

discharge them at 5:00 p.m. on Wednesday, a one midnight stay, but if the same patient becomes ill at 10:00 p.m. on Tuesday and needs the exact same 40 hours of care, I would discharge him at 2:00 p.m. on Thursday, a two midnight stay. Thus the time a patient gets sick, not different clinical needs, may determine the patient's hospital status and insurance benefits.

This is not just a theoretical finding. In a second JAMA Internal Medicine publication last year, we found that almost half of our University of Wisconsin Hospital less than two midnight encounters would have been assigned observation status instead of inpatient by virtue of time of day of presentation.

Clinically, the Two Midnight Rule hurts the new population of patients, those staying less than two midnights. As an example, a patient with diabetic ketoacidosis may be sick enough to require intensive care unit admission and an extraordinary amount of services that can be lifesaving, certainly a level of care that cannot be delivered safely as an outpatient. Yet these patients can improve quickly, sometimes in 24 to 48 hours. Now a short stay, even in the intensive care unit, can be considered outpatient.

The RAC program was well-intentioned, and Medicare fraud and abuse cannot be tolerated, yet we need more transparency and oversight of Medicare's current auditing programs. The reality is the RAC program costs all of us. In a recent 1-year period at the University of Wisconsin Hospital from October of 2012 to September of 2013, we appealed 92 percent of RAC audits for medical necessity, and we have won every single appeal that has been cited as of May 14 of 2014, which is already two-thirds of these cases.

Essentially, our hospital pays to repair these cases in order to prove we were right the first time, but the RAC pays no penalty for generating this work. These are Medicare dollars that hospitals spend not on direct Medicare beneficiary care, but on a process of defending themselves against RAC auditors.

In addition, the Federal Government ultimately pays for unchecked RAC activity in the appeals process as evidenced by the current OMHA case backlog. The RAC system generates a large number of these payment denials at no consequence to the RACs but at a direct cost to the Federal Government.

To again consider the patient with diabetic ketoacidosis needing intensive care for less than two midnights, why would I not just claim inpatient status? Because this case is counter to the current observation rule of two midnights and is highly vulnerable to audit. This means an auditor who never met the patient in question, a year or more after the patient discharges home, may decide to question my judgment as a physician and audit. Provider autonomy and ability to do what is right can be trumped by the RAC system.

In conclusion, observation status certainly merits reform and the Two Midnight Rule is not the answer. The Two Midnight Rule and observation status in general negatively impacts the delivery of good patient care. We need common sense solutions that most importantly consider the original intent of observation policy. I would caution, however, that observation reform will not be successful unless there is concrete reform of the Federal auditing programs that enforce observation rules. The Society of Hospital Medicine looks forward to working with the committee on identifying workable so-

lutions to problems associated with observation care and the Two Midnight Rule.

[The prepared statement of Dr. Sheehy follows:]

Current Hospital Issues in the Medicare Program

Committee on Ways and Means

Subcommittee on Health

May 20, 2014

Chairman Brady, Ranking Member McDermott, and members of the Committee, thank you for the opportunity to discuss observation status and the implications observation policies have on hospitals, physicians, and Medicare beneficiaries. My name is Ann Sheehy, and I am a physician at the University of Wisconsin School of Medicine and Public Health in Madison, Wisconsin. I am a hospitalist, which is a physician who cares for patients primarily in the acute care hospital setting. I am also a member of the Public Policy Committee of the Society of Hospital Medicine (SHM), an association that represents the nation's more than 44,000 hospitalists. As inpatient-based physicians, hospitalists contribute to improving the quality of care, reducing length of stay and generally helping to control healthcare costs by providing focused medical care to hospitalized patients. Because of our clinical work and extensive experience in the hospital setting, hospitalists have a first-hand view of what observation care looks like to patients, physicians, and hospitals.

Observation Care is Problematic for Medicare Beneficiaries and Hospitals

Inpatient hospital care is paid for under Medicare Part A, and Medicare beneficiaries who stay 3 midnights or more as inpatients are also eligible for skilled nursing facility coverage at discharge. Observation care is often provided in the same hospital beds as inpatient care, but is considered outpatient and therefore paid for under Part B. As a result, patients under observation are not covered by Part A hospital insurance, leaving them vulnerable to higher out-of-pocket charges, including copays and hospital pharmacy charges. They also do not qualify for skilled nursing facility care, even if they stay 3 midnights. Observation care also presents a financial burden for

hospitals. At the University of Wisconsin, observation care is delivered at a nearly $240 loss per patient day.

Calling Hospitalized Patients "Outpatients" Does Not Make Clinical Sense and is Vastly Different from the CMS Observation Definition

The distinction between observation and inpatient is one that does not make sense to providers and patients. Observation care is provided physically within the hospital and the services provided are often indistinguishable from inpatient care, yet we are forced to label these hospitalized patients as outpatients.

To provide a typical example, consider an elderly woman who falls at home and breaks her hand. Several days of diarrhea left her dehydrated and lightheaded, likely a reason for her fall. Already unsteady on her feet, she uses a walker to get around. I treat her dehydration with intravenous fluids, but her new cast now prevents her from gripping her walker properly, and the pain medicines she needs make her confused. She now requires help getting to the bathroom, and it is clearly not safe for her to be at home. Yet, without regard for her condition, Medicare may view her as an outpatient based purely on time in the hospital, as if she were in a clinic.

The Centers for Medicare & Medicaid Services (CMS) describes observation as, "a well-defined set of specific, clinically appropriate services"…so "a decision can be made regarding whether patients will require further treatment as hospital inpatients or if they are able to be discharged from the hospital," and that the decision to admit the patient should be made "in less than 48 hours, usually in less than 24 hours. In only rare and exceptional cases do…outpatient observation services span more than 48 hours."[1]

[1] Department of Health and Human Services and Centers for Medicare and Medicaid services. Medicare Benefit policy manual. Available at: http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R42BP.pdf

We published our University of Wisconsin Hospital data in JAMA Internal Medicine last summer.[2] Of 43,853 hospital encounters between July 2010 and December 2011, 4,578 (10.4%) were observation. The average length of stay was 33.3 hours, and 16.5% of our observation patients stayed longer 48 hours. We also had 1,141 distinct observation ICD-9 codes. We concluded that observation status for hospitalized patients was markedly different from the CMS length of stay definition for observation, given that our mean length of stay was longer than 24 hours, and 1 in 6 patients stayed longer than 48 hours. We also determined that observation was not well defined, given our finding of over 1,000 distinct observation diagnoses coded. These findings are important, because current policy does not reflect what is happening in real clinical practice. Any attempt to reform observation policy must consider how far observation care in clinical practice has strayed from what observation was intended to be, as described by Medicare's own observation definition.

Observation Status Harms the Physician-Patient Relationship

One of the hardest things as a provider is when a patient asks me what observation means. Patients do not understand that being in a hospital bed, staying overnight, getting tests and procedures and frequent nursing care can still mean they are an outpatient, as if they were in a clinic. Many of these patients ask me to change them to inpatient, even though I am hamstrung by this payment policy. As a physician, I may not even know a patient is under observation if it were not for the observation flag in our electronic health record.

Medicare Beneficiaries Are Increasingly Classified As Observation

The Medicare Payment Advisory Commission (MedPAC) March report to Congress documented a 28.5% increase in outpatient services per FFS part B beneficiary from 2006 to 2012, with a

[2] Sheehy, A, Graf B, Gangireddy S, et al. Hospitalized but not admitted: characteristics of patients with "observation status" at an academic medical center. JAMA Intern Med. 2013;173(21):1991-8.

12.6% decrease in inpatient discharges per Part A beneficiary over this same time period.[3] Therefore, the observation burden is increasing nationwide, with more beneficiaries disadvantaged by observation hospitalization each year.

It is for this reason that SHM is actively supporting the bipartisan "Improving Access to Medicare Coverage Act" (H.R. 1179) introduced by Representatives Courtney and Latham. This legislation amends the Medicare statute's definition of "post-hospital extended care services" to clarify that Medicare beneficiaries in observation are deemed inpatients for the purposes of meeting the three- day stay requirement for Medicare-covered SNF care.

Hospitalists see first-hand how the current policies negatively impact patients and the Medicare system overall. Patients who are admitted with observation status often choose to return home rather than paying out-of-pocket for a SNF stay. The resultant lack of appropriate post-acute SNF care can result in additional problems such as dehydration, falls and many other avoidable complications. These complications can not only lead to otherwise preventable readmissions but also increase costs to Medicare for the treatment of conditions that were not present at the time of the original hospital stay.

The "2-Midnight Rule" and Short Stay Hospitalizations

As the Committee is aware, in the fiscal year 2014 Inpatient Prospective Payment System (IPPS) final regulation, CMS established a new policy to determine observation and inpatient status[4]. Previously, clinical criteria, guided by such clinical decision tools as Interqual® or Milliman®,

[3] MedPAC 2014 Report to Congress. Chapter 3: Hospital inpatient and observation services. Available at: http://www.medpac.gov/documents/Mar14_entirereport.pdf.

[4] The Centers for Medicare and Medicaid Services Inpatient Prospective Payment System (IPPS) 1599-F. Available at: http://www.gpo.gov/fdsys/pkg/FR-2013-08-19/pdf/2013-18956.pdf

directed observation or inpatient status decisions. As of the new rule that went into effect on October 1, 2013, patients staying < 2 midnights, with some exceptions were to be observation, and those staying ≥2 midnights would be inpatient. Full enforcement and auditing of the rule has been delayed through March 31, 2015, initially by CMS, and subsequently by P.L. 113-93, The Protecting Access to Medicare Act of 2014. The "2-midnight" rule presents new problems in observation care.

Under The 2-Midnight Rule, Time of Day A Patient Becomes Ill May Determine Status and Insurance Benefits

To provide an example, a Medicare beneficiary may be hospitalized with pneumonia, needing intravenous antibiotics, a chest x-ray, some respiratory treatments, and oxygen. The patient improves enough to leave the hospital after 40 hours of care. If that patient happens to get sick and present to our hospital Tuesday at 1:00 am, this means I would discharge them at 5:00 pm Wednesday--a 1 midnight stay. But if this same patient becomes ill at 10:00 pm on Tuesday and needs the exact same 40 hours of care, I would discharge them at 2:00 pm on Thursday. This is a 2 midnight stay. Thus the time of day a patient gets sick, not different clinical needs, may determine a patient's hospital status and insurance benefits.

This is not just a theoretical finding. In a second JAMA Internal Medicine publication last year, we found that almost half (46.9%) of our University of Wisconsin Hospital < 2 midnight encounters would have been assigned observation status instead of inpatient by virtue of time of day of presentation.[5] Last month, we published a paper in the Journal of Hospital Medicine

[5] Sheehy A, Graf B, Gangireddy S, et al. "Observation Status" for hospitalized patients: implications of a proposed Medicare rules change. JAMA Intern Med. 2013;173(21):2004-2006.

showing that 13.6% of our institution's observation patients presenting for care before 8:00 am would stay 2 midnights, compared to 31.2% of patients arriving after 4:00 pm.[6]

2-Midnights Is an Arbitrary Cut Point That Does Not Distinguish Distinct Clinical Populations

The 2-midnight rule does not distinguish between clinical populations because it is a time-based policy with no basis in sound clinical judgment. At the University of Wisconsin we retrospectively applied the two midnight rule to 14 months of prior observation encounters and found that 4 out 5 top ICD-9 codes were the same whether the length of stay was < 2-midnights or ≥ 2-midnights, again confirming that patients with the exact same clinical problem would receive different insurance benefits by virtue of whether their stay crossed 2 midnights or not.[7] From my perspective as a physician, their care will be indistinguishable, but as patients they will experience variable financial burdens merely as a result of time of presentation and not the amount of care they require.

The 2-Midnight Rule Disadvantages Short Stay, Acutely Ill Patients

Clinically, the 2-midnight rule hurts a new population of patients—those staying < 2 midnights. As an example, a patient with diabetic ketoacidosis (DKA) may be sick enough to require intensive care unit (ICU) admission and an intensive level of services that involves an insulin infusion, glucose checks every hour, chemistry laboratory tests every 2-6 hours, intensive 1 to 1, or 2 to 1 nursing care, and intravenous hydration. This can be a lifesaving treatment for patients, and requires a level of care that could not be delivered as an outpatient. Yet, these patients can improve quickly, sometimes in 24-48 hours. Prior to the 2-midnight rule, these patients would have always been inpatient. Now a short stay, even in the ICU, can be considered outpatient.

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[6] Sheehy A, Caponi B, Gangireddy S, et al. Observation and inpatient status: clinical impact of the 2-midnight rule. J Hosp Med. 2014;9:203-209.

[7] *Ibid.*

The 2-midnight rule unfairly hurts such patients by classifying them as outpatients under observation status, and leaves physicians, nurses, and case managers with the unfortunate task of explaining this illogical scenario to patients and their families.

The 2-Midnight Rule May Add Cost and Waste to the System

In real clinical practice, discharge criteria are subjective. The 2-midnight rule creates incentives that are misaligned with efficient care delivery, and may add costs to the system. For the patient with diabetic ketoacidosis described above, if she is improved by 5:00 pm the night leading up to what would be a second midnight, but not 100% better, some providers might consider keeping her one more night for more intravenous fluids, which may not be absolutely essential but would almost certainly make the patient stronger. Providers, under pressure from patients aware of the rule, may respond to such incentives created by the 2-midnight rule.

Determining Length of Stay At Admission is Challenging For Providers

When a patient is hospitalized, a physician must make a written determination as to whether the patient will need to stay 2-midnights or more. This attestation must occur before important tests and procedures are performed or test results received, and so often this statement is no more than guesswork. A Medicare beneficiary presenting with fever might have a serious bloodstream infection or they may have a self-limited virus. The treatment and time needed for appropriate care are markedly different between these two conditions, yet diagnostic tests to distinguish between these two conditions take some time before results are available. At the time of hospitalization, physicians are now forced to guess how many midnights a Medicare beneficiary will need to be in the hospital while the specific condition and requisite treatment plan to get the patient better may still be unknown.

Audits and Appeals

Established under the Tax Relief and Health Care Act of 2006, the Recovery Audit Contractor (RAC) program gives private contractors the authority to audit patient records to determine if observation or inpatient status was appropriate. The RAC program was well-intentioned. Medicare fraud and abuse cannot be tolerated and true overpayments to hospitals and physicians should be recouped, but the current system tends to question clinical nuance and my judgment as a physician rather than rooting out real problems.

Concerns about the RAC Program

The RAC auditors are paid exclusively on contingency as a percent of the Medicare dollars they recover for the federal government on cases audited. Unfortunately, these contingency incentives favor aggressive auditing, without transparency, accountability or repercussions for cases that should never have been audited.

While RACs receive no direct payments from the federal government, the reality is the RAC program costs all of us. Hospitals spend an enormous amount of resources on determining patient status, and then preparing cases for audit and appeal, for very little benefit. Some hospitals even pay private companies to do this for them. For patients hospitalized between 10/1/2012-9/30/2013, the RAC requested 299 charts from University of Wisconsin Hospital for medical necessity concerns, and are still well within their rights to request more. Of these 299 charts, the RAC determined that 63 (21%) had improper payments. Our hospital has appealed 92% (58/63) of these audits, and has won every single appeal that has been adjudicated as of May 14, 2014 (34/58, 59%), while the remaining 24 cases are still in Level 1 or 2 of the appeals process. Essentially, our hospital pays to prepare these cases in order to prove we were correct to begin with, but the RACs pay no penalty for generating this work. These are Medicare dollars that

hospitals spend not on direct Medicare beneficiary care, but on a process of defending themselves against RAC auditors.

In addition, the federal government ultimately pays for unchecked RAC activity in the appeals process. As the Committee is aware, the appeals process has 5 levels, and cases reaching Level 3 are heard by the Department of Health and Human Services' Office of Medicare Hearings and Appeals (OMHA) administrative law judges (ALJ). Recently, the OMHA temporarily suspended new requests for ALJ hearings, citing a nearly 357,000 case backlog.[8] The weekly case receipt at OMHA has grown from 1,250 a week in January of 2012 to 15,000 per week at the end of 2013. While these numbers are not exclusively RAC payment denials, there is no question that the RAC system generates a large number of these requests, at no consequence to the RACs, but at a direct administrative cost to the federal government.

Provider Judgment and Autonomy Can Be Trumped By the RAC System

To again consider the patient needing brief, less than 2 midnights of intensive care unit services for diabetic ketoacidosis, why would a physician not just claim inpatient status? Because this case runs counter to the current observation rule of 2 midnights, it is highly vulnerable to audit. This means an auditor who never met the patient in question, a year or so after the patient discharges home, may decide to question my judgment and care as a physician, and put this case through an auditing process. Both audits and the threat of audits create workflow pressures in day-to-day practice, ranging from changes status determination to extensive documentation requirements to defend my decisions. To avoid audits, in a survey conducted this year by the Society of Hospital Medicine, hospitalists report they are asked to change the status of their patients from inpatient to observation status, or vice versa, for 16% of the cases they see in an average day of clinical

[8] Office of Medicare Hearings and Appeals letter to appellants. Available at: http://www.hhs.gov/omha/letter_to_medicare_appellants_from_the_calj.pdf

service, adding a great deal of administrative work and time away from actually caring for patients.

Summary

Observation status merits significant reform, and the 2-midnight rule is not the answer. The 2-midnight rule and observation status in general negatively impact the delivery of good patient care. These policies require attention to find simple, common-sense solutions, that most importantly consider the original intent of observation policy, as defined by the Medicare program. Medicare policy should be aligned with clinical realities and should also be rooted in allowing physicians to provide the care patients need. I would caution, however, that observation reform, whether it is legislative or regulatory, will not be successful unless there is concurrent reform of the federal auditing programs that enforce observation rules.

The Society of Hospital Medicine looks forward to working with the Committee on identifying workable solutions to problems associated with observation care and the 2-midnight rule. We stand ready to help craft policies that are not only easier for physicians and hospitals to understand, but are also clinically appropriate for patients.

Chairman BRADY. Thank you.
Ms. Edelman.

STATEMENT OF TOBY S. EDELMAN, SENIOR POLICY ATTORNEY, CENTER FOR MEDICARE ADVOCACY, INC.

Ms. EDELMAN. Mr. Chairman and Members of the Committee, my name is Toby Edelman. I am a senior policy attorney with the Washington, D.C. office of the Center for Medicare Advocacy. The center is a not-for-profit, nonpartisan public interest law firm based in Connecticut that provides education advocacy and legal assistance to Medicare beneficiaries.

We are very pleased to be invited to testify today about the impact on Medicare patients of outpatient status and observation status. Six years ago, a woman called our office with a Medicare problem. She had spent some time in the skilled nursing facility, but the facility told her that Medicare Part A would not pay for her stay because she had not been an inpatient in an acute care hospital for 3 days. She asked how that could possibly be true, after all she had been in the hospital for 13 days. It turned out that the hospital had called her an outpatient for all 13 days.

The Wisconsin woman had no way of knowing she was an outpatient in observation status. She was in a bed in the hospital for 13 nights, she had diagnostics tests, received physician and nursing care, medications, treatment, food, a wristband. Her care was indistinguishable from the medically necessary care she would have received if she had been formally admitted as an inpatient.

As in most hospitals, she was intermingled with inpatient, so even the physicians and nurses providing care to her didn't know whether she was an inpatient or an outpatient, and the hospital was not required by CMS rules to inform her that she was an outpatient or the consequences of that status. But solely because she was called an outpatient in observation status, Medicare Part A did not pay for her post-hospital care. Medicare limits payments to SNFs who are hospital patients, who are called inpatients for 3 consecutive days, not counting the day of discharge, what we call the Three Midnight Rule.

In the past 6 years, the center has spoken with literally hundreds of families from all over the country with similar experiences. It is a very rare day that goes by that we don't hear from at least one person and usually more. I would like to describe the more recent case and the consequences. A 90-year old man living at home with his wife had a fall. He went to the urgent care center and the physician there advised him to immediately go to the hospital because of a hematoma on his leg, was growing rapidly. The daughter who called me told me that as her father was being wheeled into the operating room, the hematoma burst. He had emergency surgery to evacuate the hematoma and remained in the hospital for four midnights, all outpatient. From the hospital, he went to the skilled nursing facility for rehabilitation, stayed for 18 days, and went home.

If the man had been formally admitted to the hospital as an inpatient, Medicare Part A would have paid the entire bill for his 18-day stay. Medicare Part A payment is comprehensive and pays for room and board, nursing care therapy, drugs, everything that the patient needs during that stay. Medicare pays 100 percent of the cost for the first 20 days in the SNF, and beginning on Day 21, the resident pays the copayment, up to 100-day maximum number of

days in the benefit period, but because her father that been called an outpatient during his entire four day stay, Medicare did not pay, Medicare Part A did not pay. The man had to pay out of pocket the SNF charges. For room and board, the charges were 4,573 days, $73 for the 18-day stay. In addition, he had to pay Medicare Part B copayments for all of the therapy he received daily, and he had to pay for his prescription drugs.

An administrative law judge found that the man's primary care physician supported an inpatient admission, and she also found that he had not been informed of his outpatient status; nevertheless, she upheld denial of Part A payment for his SNF stay solely because he was, as she described him, hospitalized as an outpatient. Obviously, from the perspective of patients and their families, what is happening makes no sense. When patients need to be in the hospital for the diagnosis and treatment of acute care conditions and when they are getting medically necessary care they need in the hospital for multiple days and nights, they do not understand why they are called outpatients and why their care in the SNF will not be covered.

You have heard from physicians and hospitals this morning about why calling hospitalized patients outpatients is causing hardship for them, and some of the issues that we have been discussing this morning are very complex, but the solution for Medicare patients is simple and straightforward. H.R. 1179 counts all the time in the hospital for purposes of satisfying the Three Midnight Rule. As of last week, there were 144 cosponsors. There is a companion bill in the Senate, and the bills are bipartisan.

The legislation is supported by a broad ad hoc coalition of 30 organizations, and I have attached our comment fact sheet to the end of my testimony with all of our logos on top.

We urge the committee to quickly move on this legislation as you consider these other far more complicated issues.

Thank you.

Chairman BRADY. Thanks, Ms. Edelman.

[The prepared statement of Ms. Edelman follows:]

CURRENT HOSPITAL ISSUES IN THE MEDICARE PROGRAM

Subcommittee on Health
House Committee on Ways and Means
Hearing

Testimony by
Toby S. Edelman
Senior Policy Attorney
Center for Medicare Advocacy, Inc.
Washington, DC
May 20, 2014

Six years ago, a woman in Wisconsin called our office with a Medicare problem. She had spent some time in a skilled nursing facility (SNF), but the facility told her that Medicare Part A would not pay for her stay because she had not been an inpatient in an acute care hospital for three days. The woman asked how that could possibly be true – after all, she had been hospitalized for 13 days. It turned out that the hospital had called her an outpatient for all 13 days.

The Wisconsin woman had no way of knowing that she was an outpatient in observation status. She was in a bed in the hospital, had diagnostic tests, received physician and nursing care, medications, treatment, food, and a wrist band. Her care was indistinguishable from the medically necessary care she would have received if she had been formally admitted as an inpatient. As in most hospitals, she was likely intermingled with inpatients so that even the physicians and nurses treating her did not know whether she was an inpatient or an outpatient. And the hospital was not required to inform her that she was an outpatient or the consequences of that status. But, solely because she was **called** an outpatient in observation status, Medicare Part A would not pay for her post-hospital care in the SNF. Medicare limits payments to SNFs for hospital patients who are **called** inpatients.

Since talking with and representing the Wisconsin woman six years ago, the Center for Medicare Advocacy has spoken with hundreds of families with similar experiences. Patients are hospitalized, receiving medically necessary care for multiple days, but they are called outpatients. Medicare pays for outpatients' care in the hospital under Part B, for inpatients' care, under Part A. Sometimes, when acute care hospitals bill Medicare Part B for observation hours, outpatients are said to be in "observation status."

This hearing is considering a broad range of important and complex policy issues including how to classify hospital stays and the proper role of the Recovery Audit program. The issue I am addressing is simple and has a straightforward solution. Congress can fix the major problem[1] that outpatient status and observation status create for Medicare patients – the loss of Medicare

coverage of their post-hospital care in the SNF – by enacting H.R. 1179 and S. 569, the Improving Access to Medicare Coverage Act of 2013. The identical bipartisan bills, in essentially a single sentence, count all time in the hospital for purposes of satisfying the three-midnight rule.[2] Other Medicare coverage requirements for SNF care remain unchanged.[3] As of May 16, 2014, the House bill, introduced by Congressman Joseph Courtney, has 144 co-sponsors in the House, and the Senate bill, introduced by Senator Sherrod Brown, has 25 co-sponsors in the Senate. Several Members of this Subcommittee are co-sponsors of the legislation.

An *ad hoc* coalition of 30 organizations – including the American Medical Association, the Society for Hospital Medicine, AARP, the National Committee to Preserve Social Security and Medicare, the Alliance for Retired Americans, the American Health Care Association, LeadingAge, the American Case Management Association, the Leadership Council of Aging Organizations, and many others – supports the legislation. Our joint Fact Sheet is attached to my testimony. We are not aware of any opposition to the bills.

The Long-Term Care Commission, mandated by §642 of the American Taxpayer Relief Act of 2012, P.L. 112-240, endorsed the legislation in its final report in 2014[4] as did the Alternative Report written by five members of the Commission.[5]

Use of outpatient status for patients in a hospital bed is common and increasing

A study by Brown University reviewed 100% of outpatient Medicare claims data between 2007 and 2009 in order to identify observation stays in the hospital. Researchers found that the *number* of observation stays increased by 34% and inpatient admissions decreased, suggesting "a substitution of outpatient observation services for inpatient admissions."[6] They also found that the average *length of stay* in observation increased by more than 7% and that the number of patients in observation status for 72 hours or more increased by 88% between 2007 and 2009 (from 23,841 patients in 2007 to 44,843 patients in 2009). Brown University researchers identified the Recovery Audit Contractor (RAC) program and Condition Code 44 as the primary causes of hospitals' extensive and increasing use of outpatient status to classify their patients. The RAC (now called Recovery Auditors), begun as a demonstration in 2003 by the Medicare Modernization Act and made permanent in 2006 by the Tax Relief and Health Care Act, is intended to identify and correct improper payments in the traditional Medicare program.[7] However, if Auditors conclude that a patient should have been treated as an outpatient, not an inpatient, the hospital must refund all of its Medicare reimbursement for the patient's care, even though the care was medically necessary. Under Condition Code 44, a hospital's utilization review committee can reverse an attending physician's decision to admit a patient to inpatient status, with the concurrence of the practitioner responsible for the patient's care.[8]

Hospitals' use of observation status has continued to increase since the Brown University study. A recent analysis by the Department of Health and Human Services's Office of Inspector General looked at Medicare patients' hospital stays in calendar year 2012.[9] The Inspector General described three categories of patient classifications: observation stays (outpatient stays where the hospital billed Medicare for observation hours), long outpatient stays (outpatient stays where the hospital did not bill Medicare for observation hours), and short inpatient stays. In 2012, the Inspector General found that 1.5 million stays were classified as observation and that

1.4 million were classified as long outpatient stays. More than 600,000 hospital stays were three or more midnights, but they did not include three inpatient midnights (that is, some or all of the time was called outpatient). The Inspector General recommended that the Centers for Medicare & Medicaid Services (CMS) consider how to ensure that Medicare beneficiaries with similar post-acute care needs have the same access to, and cost-sharing obligations for, their SNF care. The Office recognized that federal legislation might be necessary to achieve this result.

Outpatient status and its consequences for patients

A typical situation is that a patient in an emergency room is told by the emergency room physician that she must stay in the hospital for additional diagnostic tests and treatment. Only much later, often not until the patient is about to leave for the SNF, is she told that she was an outpatient and that Medicare will not pay for her stay in the SNF. Patients in outpatient or observation status have gone to the hospital, and been diagnosed and given medically necessary treatment, for a broad variety of acute problems – falls, broken bones and fractures, chest pains.

However, when patients are classified as "outpatients," they face enormous financial consequences. The most significant is that the Medicare program will not pay for medically necessary post-acute care in a SNF unless patients are admitted as *inpatients* for at least three consecutive days.[10] Patients who are called *outpatients* do not qualify for Medicare coverage of their SNF stay. They must pay out-of-pocket – often hundreds of dollars a day just for room and board plus Medicare Part B copayments for any therapies they receive plus the cost of their medications. Sometimes the adult children pay for their parents' SNF stay; sometimes nieces and nephews pay; sometimes patients cash in their life insurance policies to pay for their SNF stay. Patients who cannot afford to pay private out-of-pocket rates may go home, often to be rehospitalized a day or two later.

Over the past six years, the Center for Medicare Advocacy has heard from hundreds of Medicare beneficiaries and their families across the country about lengthy hospital stays where the patients were labeled outpatients, sometimes outpatients in observation status. One recent call was from the daughter of a 90 year old man who had been living at home with his wife. Following a fall, he went to the Urgent Care center. The physician there advised him to go immediately to the emergency room for care of the hematoma on his leg, which was increasing in size. On the way into the operating room, the hematoma burst. The man had emergency surgery to evacuate the hematoma and remained in the hospital for four midnights, all called outpatient. From the hospital, he went to a SNF for skilled nursing care and rehabilitation, care that would have been covered by Medicare Part A if he had been formally admitted to the hospital as an inpatient. The bill for his 18-day stay at the SNF was $4573, which he paid out-of-pocket. An Administrative Law Judge (ALJ) found that the man's primary care physician supported an inpatient admission. She also found, as had a CMS investigation, that the patient was not informed of his outpatient status until he was discharged from the hospital. Nevertheless, the ALJ upheld denial of Medicare coverage of his SNF stay solely because the patient was "hospitalized . . . as an outpatient," not admitted as an inpatient.

CMS has repeatedly expressed concern about the impact of long outpatient stays on Medicare beneficiaries

CMS has expressed concern about outpatient stays since at least 2005, when it asked (in the proposed annual update for Medicare reimbursement for SNFs) if observation time should be counted towards meeting the qualifying three-day inpatient stay.[11] In August 2010, CMS held a public Listening Session to hear concerns about increasingly frequent and long outpatient stays.[12] In July 2012, CMS again asked for public comment on possible changes to observation status.[13] In August 2013, CMS as part of final rules for inpatient hospital reimbursement, CMS established time-based definitions of inpatient care – the so-called two-midnight rule.[14] While not changing the three-day inpatient requirement for Medicare coverage of a SNF stay, the new rule directs physicians to write inpatient admission orders if they believe their patients will remain hospitalized for two or more midnights. Enforcement of these rules is now subject to a Congressional moratorium through March 2015.[15] However, a retrospective study of the application of the two-midnight rule for patients at the University of Wisconsin, conducted by Dr. Ann Sheehy, found that the rule would increase, not decrease, use of observation status.[16] In the Center for Medicare Advocacy's experience, hospital practice does not appear to have changed all. Since the October 2013 effective date of the new rules, the Center continues to hear from families about patients who have been hospitalized for multiple days as outpatients. A call last week involved an 81-year old woman hospitalized for six days in April 2014 as an outpatient in observation. Medicare is not paying for her subsequent SNF stay.

Why outpatient status for hospitalized patients must be fixed

First and most importantly, calling a patient an outpatient makes no sense to patients and their families. Patients do not understand why they are called outpatients when they are in a hospital undergoing diagnosis and treatment for acute conditions for multiple days and nights. When the hospital care is identical whether patients are called inpatients or outpatients, it is arbitrary to call some patients inpatients and others, outpatients. Moreover, since CMS does not require that outpatients be notified of their status as outpatients, unless the hospital reverses their inpatient status to outpatient under Condition Code 44, patients and their families often have no way of knowing about their status or its consequences until they are discharged. Observation status, as used today, makes no sense to patients or their families.

Outpatient status for hospitalized patients also makes no sense for physicians, whose medical training does not include time-based notions and who do not think about midnights when they are deciding how to diagnose what is wrong with their patients and how to treat them. Nor does observation status make sense for hospitals, which have difficult and time-consuming conversations with their patients when they learn they are outpatients and the consequences of outpatient status. Hospitals have more difficulty identifying a SNF for post-hospital care when Medicare coverage is not available.

Second, despite the fact that the hospital care is the same regardless of whether a patient is called an inpatient or an outpatient, hospitals are forced to spend a considerable amount of money trying to make the "right" decision and pass review by Recovery Auditors. Hospitals spend Medicare reimbursement on outpatient status in three ways. 1. Hospitals buy the proprietary

system InterQual because the system is used by Recovery Auditors when they review inpatient/ outpatient decisions. When hospitals' admissions decisions are evaluated based on InterQual criteria, it is understandable that hospitals buy and use the same program. 2. Hospitals increase staffing in their utilization review committees, which oversee and review physicians' inpatient decisions and, depending on their application of InterQual criteria, may reverse inpatient admission decisions and reclassify inpatients as outpatients.[17] 3. Hospitals hire outside consulting firms to help them make decisions about inpatient/outpatient status. The main consulting firm we hear about makes physicians available to hospitals 24 hours a day/seven days a week to help them make "medical necessity" decisions and determine whether patients should be admitted as inpatients or called outpatients. Since 1997, the firm has handled millions of cases. Hospitals should be spending Medicare reimbursement on care for patients, not on making arbitrary inpatient/outpatient classifications of patient status.

Third, when outpatient status is used to describe hospitalized patients, it skews hospitals' readmission data. Federal law imposes financial penalties on hospitals that readmit patients (with certain diagnoses) within 30 days of discharge.[18] However, the penalty applies only to inpatients. If *outpatients* return to the hospital within 30 days, their return is not a readmission because they were originally labeled outpatients, not inpatients. Similarly, if *inpatients* return to the hospital within 30 days as outpatients, their return also does not count as a readmission. Clearly, some portion of the reported decline in hospital readmission reflects the fact that many patients are called outpatients.

Conclusion

In invited commentary on Dr. Sheehy's analysis of observation status at the University of Wisconsin Hospital,[19] Dr. Robert M. Wachter, Department of Medicine, University of California, San Francisco described observation status as having "morphed into madness."[20] He wrote: "[I]n fact, if one was charged with coming up with a policy whose purpose was to confuse and enrage physicians and nearly everyone else, one could hardly have done better than Observation Status."

Dr. Wachter is right. Congress can fix the major problem that observation status creates for Medicare patients – the loss of Medicare coverage of their post-hospital care in the SNF care – by enacting the Improving Access to Medicare Coverage Act of 2013, H.R. 1179 and S. 569. While Congress considers broader policy issues of how to classify hospital stays, the proper role of the Recovery Audit program, and how to update criteria for Medicare coverage of SNF care, it should enact H.R. 1179 and S.569 to resolve the problem of outpatient status for patients and their families.

Thank you.

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[1] Outpatient status also creates financial burdens for patients who do not have Medicare Part B; they are considered uninsured and are charged hospitals' "sticker" prices. Patients are also concerned about high medication charges in the hospital while they are in outpatient status.

[2] Section 2, entitled "Counting a period of receipt of outpatient observation services in a hospital toward the 3-day inpatient hospital requirement for coverage of skilled nursing facility services under Medicare," says simply, "'For

purposes of this subsection, an individual receiving outpatient observation services shall be deemed to be an inpatient during such period, and the date such individual ceases receiving such services shall be deemed the hospital discharge date (unless such individual is admitted as a hospital inpatient at the end of such period)."

[3] A patient must require, and a physician must order, skilled services on a daily basis (skilled nursing services seven days a week or skilled rehabilitation services five days a week or a combination or both); the skilled care must be related to the condition for which the patient was hospitalized; the care must be required on an inpatient basis; and the transfer to the SNF must occur within 30 days of the hospital discharge. 42 U.S.C. §§1395x(i), 1395f(a)(2)(B).

[4] Long-Term Care Commission, *Report to the Congress,* page 71 *(*Sep. 30, 2013), http://www.gpo.gov/fdsys/pkg/GPO-LTCCOMMISSION/pdf/GPO-LTCCOMMISSION.pdf.

[5] *A Comprehensive Approach to Long-Term Services and Reports*, page 14 (Sep. 23, 2013), http://www.medicareadvocacy.org/wp-content/uploads/2013/10/LTCCAlternativeReport.pdf.

[6] Zhanlian Feng, et al, "Sharp Rise In Medicare Enrollees Being Held In Hospitals For Observation Raises Concerns About Causes And Consequences," *Health Affairs* 31, No. 6 (2012).

[7] http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Recovery-Audit-Program/index.html.

[8] Condition Code 44, Transmittal 299 (Sep. 2004), now at Medicare Claims Processing Manual, CMS Pub. No. 100-04, Ch. 1, §50.3, http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c01.pdf (scroll down to §50.3 at p. 152).

[9] Office of Inspector General, *Hospitals' Use of Observation Stays and Short Inpatient Stays for Medicare Beneficiaries*, OEI-02—12-00040 (July 29, 2013), http://oig.hhs.gov/oei/reports/oei-02-12-00040.pdf.

[10] 42 U.S.C. §1395x(i), 42 C.F.R. §409.30(a)(1).

[11] 70 Fed. Reg. 29,069, at 29,098 (May 19, 2005). In the final rules, CMS said it would continue reviewing the policy. 70 Fed. Reg. 45,025, at 45,050 (Aug. 2005).

[12] Transcript is available at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/downloads/94244031HosptialObservationBedsListeningSession082410.pdf

[13] 77 Fed. Reg. 45,061, at 45,155 (July 30, 2012). CMS declined to make any changes in 2012. 77 Fed. Reg. 68,209, at 68,433 (Nov. 15, 2012).

[14] 78 Fed. Reg., 50,495, at 50,906-954 (Aug. 19, 2013).

[15] Section 111 of the Protecting Access to Medicare Act of 2014 (H.R. 4302).

[16] Ann M. Sheehy, Bartho Caponi, Sreedevi Gangireddy, Azita G. Hamedani, Jeffrey J. Pothof, Eric Siegal, Ben K. Graf, "Observation and Inpatient Status: Clinical Impact of the 2-Midnight Rule," *J Hosp Med.* 2014; 9(4): 203-209.

[17] The American Case Management Association, the professional association of hospital discharge planners, conducted a survey of its members in 2012. Survey respondents reported that 71% of their hospitals added staff to make medical necessity determinations on admission; nearly one-third reported that their hospitals spent more than $150,000 for the new staff; nearly two-thirds used outside reviewers; and 79% reported that patients were spending more time in observation.

[18] Section 3025 of the Affordable Care Act, 42 U.S.C. §1886(q), established the Hospital Readmissions Reduction Program; 42 C.F.R Part 412. http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Readmissions-Reduction-Program.html.

[19] Ann M. Sheehy, MD, MS, et al., "Hospitalized but Not Admitted: Characteristics of Patients With 'Observation Status' at an Academic Medical Center," *JAMA Intern Med.* 2013;173(21):1991-1998 (concluding that "observation care in clinical practice is very different than what CMS initially envisioned and creates insurance loopholes that adversely affect patients, health care providers, and hospitals.").

[20] Robert M. Wachter, M.D., "Observation Status for Hospitalized Patients," *JAMA Intern Med.* 2013;173(21):1999-2000.

Chairman BRADY. Thank you all for your testimony.

Ms. Deutschendorf and Dr. Sheehy, do you think RACs disproportionately target high value inpatient claims?

Ms. DEUTSCHENDORF. Yes.

Dr. SHEEHY. Yes.

Chairman BRADY. In the appeals of those, could you give us what you think is the true cost of appeal. My assumption is, high value claims are more complex, there is more of the files reviewed. You are obviously bringing in medical professionals as well as appeals processing. In a case like that for a hospital, what is the true cost of that appeal roughly? I am sure it varies, but——

Ms. DEUTSCHENDORF. So we actually when RAC was proposed several years ago as a permanent part of the program, we actually went through a process to estimate the cost of an individual appeal. You have to add into that, all of the costs associated with the medical record requests, the issues in terms of loading this into software because of the mountain, and for a hospital like Hopkins it could be 600.

And then you have got 50 percent of those that may be denied, so then the tracking and everything that goes along with that. So there is all of that prior work, then there is the estimation of time it is for our nurses to review the cases, our physicians to review the cases.

Chairman BRADY. What do you think that cost is overall?

Ms. DEUTSCHENDORF. So we estimated it was about $2,000 an appeal at the first and second level, but then when you get up to the ALJ level that requires another add on because you need attorney support with that as well as physician advisor support during that time.

Chairman BRADY. What do you think that cost is?

Ms. DEUTSCHENDORF. I could probably get back to you, but I would say it is a couple of thousand dollars per, at the ALJ level.

Chairman BRADY. In addition?

Ms. DEUTSCHENDORF. In addition.

Chairman BRADY. After the first two steps; and the third step?

Ms. DEUTSCHENDORF. We as a health system spent about $4 million just gearing up for the RAC process to add on the additional personnel it would take to manage that process.

Chairman BRADY. Is that compliance and appeal?

Ms. DEUTSCHENDORF. Compliance, appeals and medical records and just managing and tracking the whole process as well as software.

Chairman BRADY. Thank you.

Dr. Sheehy, do you have an estimate on the cost of an appeal on a high value claim.

Dr. SHEEHY. Yeah. I don't have an estimate on a single appeal, but I can say the resources our hospital puts forth in the whole auditing process, we have multiple nurse case managers that their entire job is to determine status and assist physicians in helping to determine the proper status.

Once an appeal is made, we have a team of lawyers, our CMO, two utilization review physicians, and multiple other nurse case managers staff, whose job is to fight the appeals process, so anyone

looking at those numbers of staff can calculate that this is a costly endeavor to our hospital.

Chairman BRADY. Okay. Did both of you hear Mr. Cavanaugh describe one solution as short stay outlier approach? Do you have a view on whether that helps, hurts, doesn't solve the problem?

Dr. SHEEHY. I think you know, we have been talking about different solutions, and obviously I think CMS did intend the Two Midnight Rule to fix a problem in observation status. They recognized there were issues with the current observation policy. I think now we have seen the Two Midnight Rule also has issues, and we would hope that the there would be more consideration of policies going forward, thinking about the true definition of what observation truly means, a very short stay, a patient, a very well-defined subset of clinical needs prior to going forward and coming up with a new plan.

We would also strongly advocate for a pilot. I think with the Two Midnight Rule is evidence of rolling out a policy across the country with unintended consequences. I think a pilot would be of great benefit.

Ms. DEUTSCHENDORF. I would agree with that, with everything Dr. Sheehy said. One of the statements that was made earlier was there was disparity between the cost of observation stays, and I would submit that one of the reasons for that is the true definition of what observation used to be, and that was a period of time to help determine whether or not the patient needed hospitalization as an inpatient or could be sent home.

Those short stays in observation would be very less costly. By the time they need to be admitted, those are patients that require extensive diagnostic studies and extensive treatment, and sometimes those patients turn around in less than two days, and so we should not be penalized for being efficient in our ability to manage those patients as an inpatient.

Chairman BRADY. Thank you.

Ms. Edelman, you made a point that drew my attention. You were making the case that if outpatients return to the hospitals within 30 days their return isn't a readmission because they were originally labeled as outpatient, and some portion of the report at the client hospital readmissions reflects the fact that many patients are called outpatients. Any idea how frequent that is, what percentage of the reported decline that might represent?

Ms. EDELMAN. We don't have data that would indicate what portion of the readmitted patients are not called readmitted because of observation, but actually the only reason that we have ever heard from families told by the hospitals that they are using observation status is the Recovery Audit Program.

Nobody has ever actually brought up the hospital readmissions issue, but we know that is now in effect, so it obviously has some impact because if somebody returns to the hospital as an outpatient, that does not count as an inpatient, and a penalty would not be applied.

Chairman BRADY. Dr. Evans, when there are costs associated with the hospital appealing, especially in high value inpatient claims and they are overturned, the RAC returns the commission. Is that correct?

Dr. EVANS. That is correct.

Chairman BRADY. Do they share in the cost of that appeal at all?

Dr. EVANS. Well, the cost of our work doing that appeal and the work doing the review initially.

Chairman BRADY. But having lost that claim, does the RAC reimburse some portion of the cost?

Dr. EVANS. Well, we are paying back all of the funds that were used on our part to do the work.

Chairman BRADY. Right. That was because it was an improper determination up front, but do you share in the cost? So you don't receive your commission.

Dr. EVANS. There is a financial penalty that occurs. There is not a payment for any of the costs of the hospital, so I am not aware of the——

Chairman BRADY. So, the impact is you return the commission, but you don't share in the cost of the lost appeal?

Dr. EVANS. We pay our portion of attending the appeal, and the provider pays their portion.

Chairman BRADY. Say that again.

Dr. EVANS. We pay our portion of attending the appeal, and the provider pays their portion of attending the appeal.

Chairman BRADY. Okay. Win or lose, that is how it is divided?

Dr. EVANS. That is correct. So when we win there is not any difference either.

Chairman BRADY. Okay, I will finish with this. Listening to testimony today, there are an isolated number of short stay DRGs that may be problematic that was discussed earlier. In the oversight of the RAC program, did CMS ever intervene to stop audits so they could insert a targeted payment approach to quickly and easily solve the problem of the short stay DRGs?

Dr. EVANS. And you said a targeted DRG approach?

Chairman BRADY. Yeah.

Dr. EVANS. They haven't intervened. The intervention has been to stop the short-stay reviews with the Two Midnight Rule, but there has not been an intervention and I think what we have heard said today is there is a lot of variety, a lot of difference across providers in the rate of improper payment, for outpatient versus inpatient care, and I think we have also seen discussion that we need to look at where we go forward.

So for instance, CMS is proposing in the new contract, that we have a variation in the amount of medical records that are reviewed based on the providers' outcomes. So if we have a provider who has a very low rate of improper payment, we would expect to decrease as we go forward their number of records looked at. If we have a provider who has a higher rate, we would expect to increase that going forward. So CMS is looking at that, and so I think what I would say is we want to collaborate with you, and I think this opportunity to share information is very good; and I look forward to be involved in continuing this sort of information exchange.

Chairman BRADY. Okay, thank you.

Dr. McDermott.

Mr. MCDERMOTT. Thank you, Mr. Chairman.

There was a Senator by the name of Daniel Patrick Moynihan who said there are a lot of simple answers around but we need a great complexifier and the fact is that we have a very complex question here, and the next level is going to be, it seems to me, even more complex because you have all agreed that the patients get treated the same whether they are observation or inpatient. The patient gets what they are supposed to get. So what we are discussing here is who pays how much to whom, and it is a question of whether the beneficiaries get charged more or the hospitals get less money. That seems to be where we are.

And one of the issues that has come up here, Ms. Edelman, is one that I would like to hear your thoughts about. There has been a talk about the different cost sharing between Part A and Part B, and people are suggesting that we roll Part A and Part B together, and that, that somehow will eliminate or alleviate or something in this whole process. I would like to hear from you as a patient advocate what you think will happen to beneficiaries if we roll the A and B together generally but also specifically in this outpatient observation status, because I think we don't want to make another step that makes it even worse. I mean, we were trying to fix a problem with what we did, so give me your ideas.

Ms. EDELMAN. Thank you for that question.

Simplifying the program, a complex Medicare program would be helpful. The problem with the Medicare redesign proposals that we have seen that combine Part A cost-sharing obligations, is that they also prohibit other insurance like Medigap policies that provide first dollar coverage and so the consequence is that these combined Part A–Part B cost-sharing obligations would shift costs to the patients. The idea of that is, in fact, to make people pay more out of pocket on the assumption that they will be more careful healthcare consumers, but what we know will happen is that people will avoid medically necessary care because they won't be able to afford it.

Medicare beneficiaries already spend a much higher proportion of their income on healthcare than younger people, and half of the Medicare beneficiaries have incomes of $23,500 a year. They really cannot afford to pay more out of pocket, which would happen as a result of a number of these redesign proposals that we have seen.

Our program with a couple of other programs, Medicare Rights Center and California Health Advocate submitted a statement to this committee a year ago about concerns, about the Medicare redesign proposals. I would be happy to submit that for the record.

Mr. MCDERMOTT. How would the rolling of the two together affect this whole question of observation versus—or would it just be there would be no question anymore. It would just be a patient in the system?

Ms. EDELMAN. Well, it would depend upon how the specifics of the redesign worked and how people would have to pay. Right now if people are in-patient, they pay the inpatient deductible. If they are outpatients, they pay the full cost out of pocket for the nursing home care and Part B copayments and medications and it is not clear what would happen with a combination of those two.

Mr. MCDERMOTT. Does the three day stay that has to be there to go into the nursing home, what happens to that?

Ms. EDELMAN. That is still in the statute unless that gets repealed. That has been in the Medicare statute from the beginning.

Mr. MCDERMOTT. So if they are in the hospital and the hospital calls it an observation, they do not get the credit for going into the nursing home?

Ms. EDELMAN. They do not get, the three midnights do not stay, so the woman in Wisconsin who was in the hospital for 13 days, consecutive days, as an outpatient did not have a three day qualifying inpatient stay.

Mr. MCDERMOTT. And rolling the Part A and Part B together would not change that?

Ms. EDELMAN. Wouldn't change the three midnight rule. That is still there.

Mr. MCDERMOTT. You know what we are trying to do. How would you design what we should do at this point?

Everybody's saying we should call a committee together or something, but I would like somebody to put something on the table and say, if anybody has an idea what we should do in this situation, I would like to hear it.

Ms. EDELMAN. Well, for the simple issue of qualifying for skilled nursing facility care, the H.R. 1179 does it by just counting all the time. It doesn't deal with whether observation makes sense or doesn't make sense. It doesn't deal with recovery auditors. It doesn't deal with all of these much more complicated issues. It just says if you have been in the hospital for three nights, the time should count.

And I would just say when Medicare was enacted in 1965; the average length of stay in an acute-care hospital for people age 65 and over was 12 plus days. The average length of stay now in the acute care hospitals for people 65 and over is 5 plus days. The three midnight rule is a problem considering how medicine is practiced today.

Mr. MCDERMOTT. Thank you.

Chairman BRADY. Thank you.

Mr. Gerlach.

Mr. GERLACH. Thank you, Mr. Chairman.

Ms. Deutschendorf, in your testimony you basically say that the Two Midnight Policy now requires physicians to abandon the medical assessment component of the medical necessity test when determining the appropriate setting of care and instead imposes a rigid time-based approach. Can you elaborate or expand on that a bit?

Ms. DEUTSCHENDORF. So for our providers what happens now is the patient presents to the emergency department, and now they are faced with this question, do you expect that the time this patient will require hospital services will be greater than two midnights, which to Dr. Sheehy's point, could be depending on whether that patient arrives one minute before midnight on the first midnight and then stays 24 hours and one minute in the second midnight, or whether they would need to be hospitalized for up to 48 hours.

A lot can happen in 48 hours, and what we have found since October 1, is that we have tripled the amount of patients who have started out as an outpatient and has been converted to an inpa-

tient after or just before the second midnight because, in fact, we got it wrong. Because we really don't know. Patients present to the emergency department with a myriad of problems, some of which are going to respond rapidly, some of which will not respond rapidly, and there is no way of knowing that, and we are doing the right things.

We do have an army of case managers and utilization management nurses who now have to run around the hospital looking for patients who have crossed the first midnight to see if these patients will require medically necessary services beyond the second midnight so that we can get than converted. We have been instructed by CMS that if the patient is going to cross the second midnight, they want them to be converted, even if they are going to go home in the next twelve hours. It is logistically a very difficult policy to implement and has required a lot of financial increases as a result of that.

Mr. GERLACH. H.R. 3698 would require the Secretary of HHS to establish a new methodology for utilization in situations involving the shorter stays in hospitals. We got some idea from Ms. Edelman about what she'd like to see relative to that kind of new methodology.

Could I have quickly the other three of you, please give us your thoughts as a follow-up to Mr. McDermott's question, what specifically change-wise and what kind of new methodology ought to be employed so that there is a fairness, an equity in terms of how hospitals are reimbursed for those that come in in a very short-stay kind of situation. Dr. Sheehy, can we start with you?

Dr. SHEEHY. Thank you for that question.

I think it is a very complicated topic, and I think a simple answer is probably difficult to give. I think getting back to the principles of observation being a triaging definition, it was always meant to be a definition where someone needed a few additional hours to determine whether they should be fully admitted as an inpatient or discharged home.

I think we need to get back to the principles of that definition and come up with a methodology that respects that definition. I think we also need to think about the difficulty as a provider I have telling a patient who is staying overnight in a hospital, getting inpatient nursing care, getting intravenous medications and tests in a hospital setting, how I could explain that to that patient that they are an outpatient. I think getting back to the heart of what observation really means, I think is what we need to focus on coming up with a new policy.

Mr. GERLACH. And then you added that you thought that should be done on a pilot basis first to really test the idea to see if it really in a practical way is working before you expand it to the entire system?

Dr. SHEEHY. That is correct. I think we will see the unintended consequences in any policy. I think we will understand better how a policy should be audited and do it on a smaller scale so hospitals across the country are not investing a lot of money on a whole new plan that has a lot of issues. We can figure out those issues and tweak the plan before it is implemented nationwide.

Mr. GERLACH. Dr. Evans, do you have a quick answer to that even though you look at it from the RAC perspective?

Dr. EVANS. Well, first from the RAC perspective, again, I have said I think the collaboration and discussion is very good, and I think that the idea that there is some changes that can be made are good. If there were a pilot we would be willing to be involved in that. I would say I am here for the recovery audit work, but I am very interested in this personally. If after the meeting or something you wanted to talk to me as a taxpayer, I am a physician——

Mr. GERLACH. You are not having heart palpitations right now or anything?

Dr. EVANS. No, I am not. I love this. I think it is really excellent to have this discussion. It is what I am doing my work for so that this would sort of happen. I am running over, okay.

I just wanted to say I have been medical director of skilled nursing facilities and worked at the MAC and now at the HDI, and I have got a lot of ideas, but I think we would support this type of reform, and we could offer discussion and support afterwards.

Thank you.

Mr. GERLACH. Thank you.

Chairman BRADY. Thank you.

Mr. Kind.

Mr. KIND. Thank you, Mr. Chairman.

And I want to thank our panelists for an excellent presentation today and Dr. Sheehy, a special welcome to you. I have had the opportunity back home to visit UW Hospital System and the clinics, and I have always been very impressed with the quality of care, the outcome, the measurements that are being established back home. But you are probably sensing a source of frustration coming from this dais. This is some tough, complicated stuff, and we are trying to wrap our head around it and we are listening to you try to thread the needle on different statuses on observation, inpatient, outpatient.

As policymakers, we are going to have a hard time being able to provide direction at this level of expertise or knowledge that is required of it. It is really kind of a source of frustration that we have with the overall healthcare payment system that we have in our country today. This is fee for service. It is this coding. It is this payment based on how much is done, not how well it is being done, and there are tools in place right now; and many of us have been pushing hard and been very inpatient to move to a more value, quality outcome-based reimbursement system. If we can get those financial systems I think aligned right, we are going to unleash a heck of a lot of innovation in the health care system. Knowing what those benchmarks need to be, where those measurements are, and then figuring out how to meet them.

Because the truth is we don't have so much a budget deficit problem here in Washington as we have a healthcare spending problem, and that is what we are wrestling with. There are only a few options that we can go down the road with. One is greater cost shifting, you know, having patients bear more of the risk of higher costs. We see that with voucher proposals or what have you, or you are going to have some indiscriminate provider cuts being made, and the provider community obviously isn't going to be very happy

with that. We see this with sequestration and pushing those hospital cuts out for infinity it seems at this point.

Or we need to be working with the provider community to establish those quality measurements and then align the financial incentives so it is value based and no longer observational status or all these technical definitions that just weigh us down, and it is just exhausting having these conversations and getting the feedback from patients and providers alike.

So, I guess it is just a general question. Dr. Sheehy, I can start with you. If anyone else wants to chime in. Ideally where do we need to be going with the healthcare payment system of this country right now so that we are not having hearings like this talking about inpatient or outpatient or observational status and trying to figure out what the best policy is in addressing it?

Dr. SHEEHY. Well, thank you for the question, and thank you for all the work you do for the State of Wisconsin on healthcare.

I would be more than happy to work with you in the future on these issues going forward. I think it is very complicated, I think there is certainly a role for quality measures in physician payment, and I think as hospitalists we are trying to figure out exactly how we fit into that payment model.

Going forward, though, I think, you know, I am from a small town in Wisconsin as well, I grew up near Madison where I work, and what I do on a daily basis is take care of patients in the hospital. Some of these patients might have been my neighbors or maybe a middle school teacher, and I think if we can get back to thinking about these are Medicare patients, they have worked their whole lives, and what is the right thing to do for them, I think we are going to find those solutions.

Mr. KIND. Ms. Edelman, I am concerned about the impact on the beneficiaries, the patients out there. It seems like they are getting caught and often not to their knowledge and just based on definitions that are applied to them and then the increased out-of-pocket expenses which they experience which creates a tremendous hardship and yet within the Medicare system itself, we have seen beneficiary payments come down dramatically in recent years, and hopefully that is sustainable, and hopefully that is due to some of the reforms that are taking place in the delivery system but also some of the new payment models out there.

How much concern do you have right now in regards to the cost shift that you are seeing with the beneficiary community?

Ms. EDELMAN. The cost shifting in the observation status is considerable, and we know that some people really do not have the money to pay for the nursing home care out of pocket when they are told what the cost is, and they go home and then what we hear is a couple of days later they have another fall, they break a hip, they are back in the hospital. So the costs to the system are very intense.

We know families are contributing huge amounts of money to pay for out-of-pocket costs because Medicare is not paying for the nursing home. So we have heard of a nephew being asked to bring a check to the nursing home today for $7,000 for his aunt to get care. People are doing that, families are kicking in money that they may not really have. We have heard of families cashing in life in-

surance policies that were intended for burials because they need to get the nursing home care. So it is having a tremendous impact on Medicare beneficiaries and their families trying to pay these high costs.

The average private rates are like $250 a day, but I was in the nursing home in Boston last month, and the private rates were 450 to 480 a day. Most people can't pay that.

Mr. KIND. Thank you.

Thank you, Mr. Chairman.

Chairman BRADY. Thank you.

Mr. Smith.

Mr. SMITH. Thank you, Mr. Chairman.

Ms. Deutschendorf, in your written testimony you referenced the Medicare Audit Improvement Act, H.R. 1250, obviously supported by numerous members of the House. I am wondering if you could reflect a bit on an alternative that I happened to introduce, H.R. 2329, the Administrative Relief and Accurate Medicare Payments Act. Have you reviewed that bill, and could you reflect on that at all?

Ms. DEUTSCHENDORF. I have not, but I would be happy to respond in writing.

Mr. SMITH. All right. You bet. Thank you very much.

Mr. SMITH. Ms. Edelman, what do you believe is the cost—well, first of all, do you believe that Medicare beneficiaries are very familiar with the financing or the various—I mean, we have heard a lot of technical things. I started to keep a list here, and I lost it amidst the paperwork here of just terminology and funding strategies and schedules of payments and so forth. How familiar are seniors with that type of thing?

Ms. EDELMAN. I think most people have no idea of what the terminology is or what it means.

Mr. SMITH. And do you believe that there is a cost to that, given the existence of that disconnect with patients and, I mean, I don't believe we could really expect them to be familiar with all of these intricate details of a funding system. Is there any possible way just to have a system to where seniors are more familiar with what is going on with the funding, so not that it has to be out of pocket, but so that they can perhaps know more what their options are?

As you pointed out in your testimony, that they were considered an outpatient, but yet they were in the hospital for so long and certainly thought that they were an inpatient; what do you think the alternatives should be?

Ms. EDELMAN. Well, there are some bills that would suggest giving information to people to tell them, at least give them information that they are outpatients and a couple of states have passed laws, Maryland and New York, requiring that people should be informed that they are outpatients and what the consequence is.

But unlike other Medicare systems, they don't have an opportunity to contest their outpatient status. Generally if somebody goes into the hospital as an inpatient, the person immediately gets a form Your Rights As a Medicare Patient and if the hospital wants to discharge the person, and the person thinks I am really not ready to go, there is an immediate appeal to a representative of the Medicare program to make a decision.

In observation status there is no due process right for the Medicare patients. There is nothing they can do, so giving them information is helpful, but we also need to give them an opportunity to say I should be called an inpatient, not an outpatient.

Mr. SMITH. Would you agree that the more the government has gotten involved, that the more expensive healthcare has become?

Ms. EDELMAN. Well, I don't know if the cost of the Government has been the cause of health care becoming expensive. Certainly before the Government was involved a lot of people didn't get health care, so it has been critically important. Medicare is a very important program for older people, and most older people love their Medicare program. Without it they wouldn't get the health care they need.

Mr. SMITH. Okay, thank you, Mr. Chairman. I yield back.

Chairman BRADY. Mr. Pascrell.

Mr. PASCRELL. Mr. Chairman, I would just like to make a couple of points in response to my friend, Mr. Roskam's comments in the last panel about state budget neutrality, which is interesting to define, and how it affects what we are talking about.

New Jersey is in a unique position because my state is an all-urban state with no rural or critical access hospitals. I would like to point out that the permanent adjustments have always been based on the national budget neutrality, always. So this includes adjustments for critical access hospitals and there ironically are 53 critical access hospitals in Mr. Roskam's state of Illinois. I think we need to make that clear.

Now, Ms. Edelman, your organization has done a significant amount of work in the area of observation stays, and you worked directly with a number of beneficiaries who have run into problems with the way they were classified. I think you have defined that. In your experience, do beneficiaries generally know whether they are classified as inpatients or under observation status, in your experience?

Ms. EDELMAN. Most patients do not know that they are in observation, and the Medicare program does not require hospitals to tell them. The only time——

Mr. PASCRELL. Do they have a right to know that?

Ms. EDELMAN. Well, they should have a right to know it. Yes, they should. They should know and the consequence.

Mr. PASCRELL. When do patients generally find out what their status is?

Ms. EDELMAN. Usually at the time of discharge.

Mr. PASCRELL. When they pay their bills?

Ms. EDELMAN. Bring the checkbook to the nursing home because Medicare——

Mr. PASCRELL. That's what I figured.

Ms. EDELMAN [continuing]. Will not be paying.

Mr. PASCRELL. You mentioned earlier observation status is particularly problematic when Medicare beneficiaries need care in a skilled nursing facility after leaving the hospital. Because Medicare won't cover these services unless, unless, a patient has been classified as an inpatient for at least three days. Am I right so far?

Ms. EDELMAN. Yes.

Mr. PASCRELL. Ms. Edelman, in the cases your organization has handled, what is happening to observation status patients in need of care at a skilled nursing facility after leaving the hospital?

Ms. EDELMAN. Some are not going because they can't afford it. Some are going and paying out of pocket and trying to appeal later through the Medicare summary notice form that they get, trying to appeal through the administrative process. But many of the people that I have spoken to do not pursue the appeals. They give up. It is just too complicated and too time consuming, and they give up.

Mr. PASCRELL. Are many of these seniors paying out of pocket?

Ms. EDELMAN. Yes, they are paying out of pocket, and their families are as well.

Mr. PASCRELL. So, Mr. Chairman, in conclusion if we don't identify and respect the right to know, and we had a Patients Bill of Rights, which is part of the reform process that we are now going through, then we defeat the purpose of what we are doing.

Seniors, anybody, has a right to know what status they are in, what that implies, and how much it is going to cost them eventually if they don't get out of that status or if they don't cross over. I think that this is serious business, I ask you to bring us to attend to it, and there is legislation here which is bipartisan, and I hope that you will do that, and thank you for the hearing.

Chairman BRADY. Thank you.

Mr. Renacci.

Mr. RENACCI. Thank you, Mr. Chairman, and I thank the panel for being here.

It is interesting because I think we are really talking about the problem, and then there's the symptoms of the problem. The problem is the hospital readmission reduction program, and quite frankly the policy that was written was probably, the thought was good, the outcomes are becoming bad because when a patient enters the hospital, they are either classified as observation. They are not admitted. There's all kind of things. They are outpatients. We are putting them in classifications. Why? Because we don't want to be penalized for the reduction program if you are in the hospital.

And again, I am not blaming the hospitals in that sense. They are trying to survive, too. But, quite frankly, who is getting hurt here but the patient? So let's look at the unintended consequences. We have patients that go into a hospital. They are the sickest of sick, we know they are coming back, and we have an issue there. It is one of the reasons why I introduced H.R. 4188, a bill that requires the Secretary of HHS to adjust the payment methodology to account for certain disparities really in patient population. This adjustment will really make a huge difference to hospitals across the country and the 9 million duly eligible beneficiaries that rely on these hospitals for critical care needs. We need to make sure. There are patients that are going to come into a hospital that are going to go back to the hospital, and those hospitals are being penalized. This bill would at least help that issue.

Now, on the other side, I still have a problem when you take a patient who quite frankly doesn't need to go to a hospital, should be going directly to the nursing home, but we have another policy that says you have to go to the hospital first, and you have to spend three days in that hospital and then that patient goes to

that hospital and, of course, they spend three days. They don't know whether they are observation, they don't know whether they are inpatient.

Then they come out, they go to a nursing home, and then they are penalized because in many cases they ended up as an observation status. That is a problem, too. That is why we talked earlier about the bill I introduced to eliminate the three-day stay. Let's face it, there are some patients that have to go in the hospital, but there are some that could go directly to the nursing home, and I question why we would ever be paying you know, up to $11,000 to have someone stay in a hospital for three days versus going into a nursing home where my statistics show the average stay is around 27 days. Quite frankly it doesn't make sense. We are spending money that is not necessary.

Ms. Edelman, I would ask you, you know, do you think the elimination of the three-day hospital stay is good policy?

Ms. EDELMAN. Well, I think it ultimately is what makes sense because as I said, the length of stay in hospitals has gone down so much that the three days is a very large portion of what time people actually do spend in the hospital.

The long-term care commission endorsed elimination of the three-day stay and so this is where I think as Congress is considering post-acute care reforms, which is a topic of discussion now, this should certainly be part of the discussion. We want to make sure that people are, that there is not a lot of gaming in nursing homes, so we want to be careful of that possibility; but this is where it needs to go to eliminate it. It doesn't make sense with the way medicine is practiced today.

Mr. RENACCI. And I don't know if there is anyone else on the panel that when we talk about H.R. 4188, which is a bill that really takes a look at these hospitals where there are readmissions for the sickest of sick, the poorest of poor, if we shouldn't have an adjustment for those. Is there anyone?

Ms. DEUTSCHENDORF. So, as I stated in my opening comments, and thank you for asking, I am responsible for the readmission reduction program for the Johns Hopkins Health system and our hospital. We have been at this for 4 years, and we are working really, really hard to implement all of the strategies that were suggested in the demonstration projects and at an academic center such as ours where we take care of some of the sickest patients in the country who are transplants, who are duly eligible, et cetera, we have not been able to move that ball.

And, in fact, it is all about numerators and denominators, but as you take out the short stays out of the denominator, and your patients are sicker, your readmission rates go up. Despite what we are doing, and we do have some successes, but we have not been able to move that. So having that bill with taking out transplants, end stage renal disease, substance abuse, and psychoses and some of the other things, would certainly help us. The other thing that we have really learned about this has to do with patient's values, beliefs and preferences, so it is very important that we share this responsibility not just with the providers but also the patients.

Mr. RENACCI. Thank you.

Mr. Chairman, I yield back.

Chairman BRADY. Thank you.

Mr. Reed.

Mr. REED. Thank you, Mr. Chairman.

I am way over here, so I appreciate, I will give you a different angle here to look at. I wanted to come today, and thank you Mr. Chairman, for holding this hearing, and thank you to the panelists.

This is something I am very concerned about coming from a rural section of the State of New York. My rural hospitals in particular are struggling to deal with these issues as well as many others, and I wanted to just read for the record a letter I received from one of our hospital directors at Jones Memorial Hospital in Wellsville, New York. She wrote, Dear Tom, Jones Memorial is a sole community hospital in rural upstate Western New York. Jones has an average daily census of 20 patients. As many rural New York state hospitals, Jones has limited resources and actively trying to keep costs down to the overall healthcare system. Then she goes on. She writes in 2012 Jones began receiving draft program audit notices. The cases dated back to 2009, they received a total of 240 inpatient claim denials. To date Jones have appealed and won approximately 197 of those claims. Of the 240 claims, 18 were not successful on appeal.

The rest of the cases are still pending, so pretty good outcome in regards to challenging these requests. But this is what she said that really stuck out to me in the letter. Jones Memorial with an average daily census of 20 has to employ three full-time RN case managers to make sure that someone is here the majority of the time to ensure compliance with the Two Midnight Rule. These same case managers spend a lot of their time working on appeals for the RAC audits. We also have three billing and medical records staff that spend 30 percent of their time on RAC audits and appeals. The dollars being expended for a small hospital are unsustainable.

Now when I hear Eva write me that letter, and I know Eva very well, Eva Benedict, does a great job there at Jones Memorial, my concern is this. How are these rural hospitals going to sustain themselves if they have to take on those administrative cost burdens that we just articulated there and keep the doors open and comply with this complexity coming out of Washington, D.C.? Does anyone on the panel disagree with me that in particular our rural hospitals are at a distinct threat as a result of the burdens that are coming out of this ambiguity? Dr. Sheehy.

Dr. SHEEHY. I can answer that question. My primary practice location is a University of Wisconsin Hospital which is a tertiary care referral hospital, but I also am privileged at one of our community hospitals and practice there. It is a small hospital and I agree with you. I think that the burden on smaller hospitals is enormous. I also think a lot of these smaller hospitals have contracted with, there are private companies now who will actually do what your hospital has described. Instead of hiring their own nurse case managers to do this, they will hire a private company now and pay them a lot of money to look at these claims for them and I think the cost is enormous. The cost to fight this process and to kind of learn how to do these audits and appeals, it is staggering.

Mr. REED. Anyone else share that sentiment or oppose that sentiment? Because I agree with you, those are dollars that otherwise could be going to the community in regards to servicing their healthcare needs as opposed to complying with the administrative burdens. Do you have any idea, here's a hospital with 20 average daily census, and they have got essentially five full-time workers focused on filling out paperwork. How can we do better? Yeah, ma'am.

Ms. EDELMAN. I just want to say one thing about that. That hospitals are spending an enormous amount of time and money trying to make these inpatient-outpatient decisions.

The first thing they do is buy InterQual, which is a proprietary computer program. Then they are hiring staff just to make these decisions, and the American Case Management Association, which is part of our ad hoc coalition supporting H.R. 1179, did a survey of their members. These are the hospital discharge planners. Three quarters of the hospitals reported hiring staff just to be making inpatient-outpatient medical necessity decisions. A third of them had spent more than $150,000 and this is a couple of years ago, on that staff.

Then they are also using an outside secondary reviewer. The company that we know of used to report on its Web site how many medical necessity cases they had done. Since 1997, they had done 4 million. If they are charging we think maybe $200, $250 a case, that is a lot of money to go out of the Medicare system which should be designed for providing care to people, but it is only to make the decision whether people should be admitted as inpatients or called outpatients, and the care is identical. It really makes no sense.

Mr. REED. Thank you.

My balance has expired, and I thank you for that input.

Chairman BRADY. Thank you.

Ms. Black.

Mrs. BLACK. Thank you, Mr. Chairman.

Again thank you for allowing me to sit here with the committee and ask questions.

I want to go back to the issue of the ALJs and the amount of overturned cases and we just hear—I know this is a complex situation, and we hear these numbers that keep floating around, and there is a report that I want to submit for the record, and it is from the Inspector General. The improvements are needed at the Administrative Law Judge level of Medicare appeals.

Chairman BRADY. Without objection.

Mrs. BLACK. Because there are some good pieces in here as well. But, Dr. Evans, I want to start with you on this question because our members are hearing at least 70 percent number that the providers win these appeals at the ALJ level. I understand that there are two different ways that the ALJ adjudicates cases, and can you please explain how the RAC's view of the overturn rate and how these numbers can deceive when looked at out of context?

Dr. EVANS. Yes. The report you refer to, the data that is in there is from 2010, and that was early on in the Recovery Audit Program. Now, I haven't done the analysis, and I would say that I think it is good that this has been brought up here, and I think

there is some further investigation of the data that can be done among the different experts like OIG, et cetera.

But that data is from 2010, and at that time we were getting no information about any kind of ALJ hearings. We have attended a few in the demonstration, but we weren't hearing, and we were asking about those. What we found out was that they were 89, 90 percent. You know, the add quick has that information, but they were huge numbers. They were on the record. The on the record in general is a high overturn rate. It is pretty much they are all overturned. All of the contractors across CMS have data that shows that, and in fact CMS had done a study with one of the contractors, where the attendance of CMS at the hearing makes a difference in the outcome of those hearings where the Medicare rules and regulations and the medical record compared to the claim is reviewed.

So I think it is an area that can be looked at, but I think that is part of the difficulty. If you look at the last study, the 7 percent overturn across the board is the most current data that we have.

Mrs. BLACK. Could those who are providers weigh in on this from your perspective as well, of your cases that get to the ALJ level? Dr. Sheehy, let me go with you first.

Dr. SHEEHY. Thank you for that question. We have little data on our ALJ Level 3 appeals at this time. The majority of our appeals are turned over in Level 1 or Level 2. I will just comment that I think the 2010 data, I think the RAC process and observation care has evolved so enormously in the last four years that I think it is worth looking at a new set of data and a new set of numbers.

We know that the RAC recovery rate, the recovery rate for back to the Government has increased. We know that the number of RAC audits have increased. This is why the OMHA has now put a hold on further audits and appeals. We know this is a lot due to RAC denials and so I think we really do need to look at a fresh set of numbers before we start thinking about a 7 percent number.

I can speak on behalf of our hospital. We appeal almost everything, and we win almost everything. The number that I cited in my testimony we appealed in our last one year, we appealed 92 percent of the audits that the RACs made, and we have already won two-thirds of them. The rest are in Level 1 or Level 2 of appeals, so our history is that we will win almost 100 percent of our appeals. I think there are a lot of hospitals out there that are similar.

Mrs. BLACK. That is a good piece of information. Thank you so much.

Others want to weigh in on that? Yes?

Ms. DEUTSCHENDORF. We just have 10 cases at the ALJ level that have just made it there, and part of that has to do with the delay in the actual recoupment, so we were able to take 239 cases of our 430-some denials directly for discussion, and we spent a lot of time preparing with legal and also with our physician advisors and went straight to the medical directors of our RAC, and 135 of those cases were overturned just at the discussion; and the remainder of those are in the appeal process now. So that is a 50 percent, or a 55 percent overturn rate just at the discussion level.

I just want to say one other thing. We had 108 cases denied for intensity modified radiation therapy. All 108 of those cases were overturned at the discussion level, again because these were medically necessary services that the RAC really was not able to really understand why these cases were brought forward.

Mrs. BLACK. Thank you.

And, Mr. Chairman, thank you so much for this hearing. It just seems to me that one of the things that I have learned from this hearing is that this certainly needs to have more oversight, more investigation to find out just how the program is working, because I am so concerned as being a nurse for over 40 years, that the care that we are giving and, Dr. Sheehy, please every time you give a testimony, use that example of a diabetic ketoacidosis because it is so compelling to make the case for how you just don't know what that patient is going to need when you receive them into the hospital.

Thank you so much, Mr. Chairman. I will look forward to more hearings.

Chairman BRADY. Thank you, Ms. Black.

I just have an inquiry, again, thank for all the witnesses, in the first panel again from Dr. Evans we heard repeatedly that RAC audits aren't a problem. 94 percent are not appealed. Of those who are only about half are returned. Percentage-wise this is a very small amount. Not a big problem. That is at odds with what we hear from our local hospitals in a major way.

And what I think I just heard from Dr. Sheehy and Ms. Deutschendorf is that is old data, that current appeals are much greater than that, and the overturn rate is substantial as well; and, while they may be a small percentage, these are more of the high-value claims, so proportionately more important, probably more expensive to appeal. Is that correct, in a nutshell? Well, what other perspective should we bring to this?

Dr. SHEEHY. I think that is a correct assessment. Just another data point, in the OMHA letter to hospitals, one of the numbers they cited, which I think this is why I think this is old data, they said in January of 2012, the OMHA was hearing about 1,250 appeals a week and at the end of 2013, they were getting 15,000, so I think the rate has just accelerated over two years; and I think that number tells you how audits have changed, how our practice has changed.

Chairman BRADY. Because the Inspector General's report was from 2010 and 2011, you are saying. Ms. Deutschendorf.

Ms. DEUTSCHENDORF. So I would agree with that, that the appeals have mounted as hospitals have been able to change their processes and also that they have rigorous utilization processes that they are also ensuring that they are meeting the compliance and meeting the regulatory requirements for Medicare review of inpatient stays.

We in our compliance program, we self deny almost $4 million a year in Medicare days that we feel we cannot justify for medical necessity. So we feel that anything that we appeal is justifiable. So anything that is denied by RAC, we will appeal.

Chairman BRADY. Got it.

Dr. McDermott.

Mr. MCDERMOTT. I am like you, a little by confused by what I am hearing here, but it seems like what you are saying is that the RACs operate like the fishermen in my district. They go out and throw a great big net, and that is where the 12,000, you jump from 1,500 at the end of one year to 12,000 in the next. You will say, you have got a lot of stuff in there, most of which turns out to be not justified because they are going on volume. You are saying that the RACs are going on volume, and they got a lot of bycatch, and they have to throw it back because it doesn't work.

Ms. DEUTSCHENDORF. That is exactly right. They cast a very broad net, and then what is really considered improper, we would respectfully disagree that those are not improper payments, and we are appealing all of them. So, we are appealing 92 percent. It is almost exactly the same as what Dr. Sheehy has said.

Mr. MCDERMOTT. Thank you.

Ms. EDELMAN. If I could just say one thing, if it is so complicated for hospitals to do these appeals, you can imagine what it is like for beneficiaries doing it on their own. There is one gentleman from Chicago that I talk to every couple of months, and he is in his 80s. He is homebound. The last conversation we had he was describing his cancer and the therapy he is having, and he is trying to do this appeal for his wife. It is very difficult for beneficiaries if they even get to that stage to appeal their outpatient status.

Chairman BRADY. Yeah. Thank you.

On behalf of Dr. McDermott, I would like to thank our witnesses for their testimony today, and I appreciate the continued assistance getting answers to the questions that were asked by the committee. These are challenging issues, interrelated, facing CMS, this committee, and our hospital providers.

My view is we have to address them head on in order to ensure seniors are treated fairly and do not face unnecessary charges, and it is equally important for providers and taxpayers to get these issues straightened out, so I look forward to working with all the witnesses and Members of the Committee to do just this.

As a reminder, any member wishing to submit a question to the record will have 14 days to do so; and if any questions are submitted to the witnesses, I ask that the witnesses respond in a timely manner. With that, the subcommittee is adjourned.

[Whereupon, at 12:32 p.m., the subcommittee was adjourned.]

[Submissions for the record follow:]

Wisconsin Hospital Association, Statement

WISCONSIN HOSPITAL ASSOCIATION, INC.

Statement For The Record

By Stephen Brenton, President, Wisconsin Hospital Association

Submitted to the U.S. House Ways & Means Committee Subcommittee on Health

Hearing on Current Hospital Issues in the Medicare Program

To Accompany the Hearing Record for Tuesday May 20, 2014

Thank you Chair Brady, Ranking Member McDermott and Wisconsin Committee Members Ryan and Kind for the opportunity to provide this statement for the record for the subcommittee's May 20, 2014 hearing on issues facing hospitals and health systems with respect to the Medicare program.

The Wisconsin Hospital Association is proud to represent Wisconsin hospitals and integrated health care systems which are constantly driven towards delivering better results for patients and improved health care value for all consumers and payers in Wisconsin, including the Medicare program. Our national leadership on delivering value has been validated by entities like the Dartmouth Atlas, The Commonwealth Fund and the Agency for Healthcare Research & Quality among others. At the same time, our hospitals and health systems, as are those in all other states, are in the midst of massive health care changes, including moving forward with electronic medical records, implementing major care delivery reforms, testing new payment models, adjusting to substantial upheaval in the health care insurance market, managing significant regulatory policy shifts while all the while absorbing billions of dollars in reduced federal payments for hospital care provided to Medicaid and Medicare patients.

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We believe our hospitals have been excellent partners with the Medicare program in their collective efforts to deliver high quality, cost efficient care to Medicare beneficiaries throughout urban, suburban and rural Wisconsin. Yet, our providers are forced to divert scarce health care dollars and resources to comply with a redundant, ill-targeted and burdensome Recovery Audit Contractor (RAC) program. That is why we encourage Congress to better focus the RAC program by passing legislation to address RAC program processes and unintended consequences.

Recovery Audit Contractors, Wisconsin Experience

Hospitals are one of the most highly regulated industries and are also covered by numerous government programs charged with ensuring Medicare and Medicaid payment accuracy. The current audit landscape for hospitals includes any number of these oversight programs and contractors such as the: Comprehensive Error Rate Testing (CERT) program, Office of Inspector General (OIG), Medicaid Integrity Contractors (MIC), Medicaid Integrity Program (MIP), Payment Error Rate Measurement Program (PERM), Medicare Administrative Contractor (MAC), Zone Program Integrity Contractors (ZPIC), and the Recovery Audit Contractors (RAC) to name a few. **While WHA and our providers support fighting "waste, fraud and abuse" in government health care programs, we believe it is important to understand that there is a cost borne by the health care delivery system when those programs are overly complex, poorly structured or redundant.**

To gauge Wisconsin hospital experiences with the impact of the RAC program on hospital operations and resources, we recently surveyed our hospitals. Seventy-four hospitals responded (57%), representing all size hospital and all geographic locations throughout Wisconsin. The following three survey responses provide a striking look at the RAC program's impact to date in our state:

- ***Wisconsin hospitals indicate the RAC finds nothing wrong with the overwhelming majority of records it requests.***

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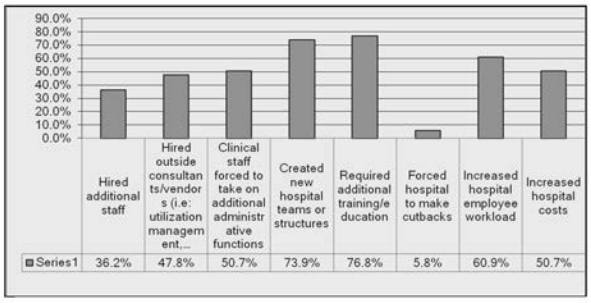
- ***All responding hospitals indicate the RAC program has diverted valuable resources (see graph)***



The above represents the percent of responding hospitals that selected a particular option. All hospitals selected at least one burden.

- ***Of the claims that were denied by the RAC, virtually all Wisconsin hospitals indicate appealing some of those denials while the vast majority of hospitals (84%) appeal at least 50% of all denied claims.***

With respect to this last bullet point, it demonstrates that hospitals believe the RACs are inappropriately denying a significant number of claims, forcing hospitals to appeal. One deleterious downstream impact of the volume of denied claims nationally is a massive backlog in the Medicare appeals process. In fact, the backlog is so bad at the Administrative Law Judge level that the Office of Medicare Hearings and Appeals recently announced a minimum *two year delay* for claims to be heard. This is unacceptable for the Medicare program, for hospitals and other providers, and for beneficiaries who have legitimate claims to be resolved.

Bipartisan Legislative Solutions

We believe our hospitals' experiences are mirrored across the nation and demonstrate the need for reform. **That is why WHA supports, as do 213 bipartisan Members in the House of Representatives, the Medicare Audit Improvement Act, H.R. 1250. This legislation will establish a more structured and defined framework around Medicare audit-related programs, including important provisions to address ongoing problems. Among the provisions, H.R. 1250 would:**

- Establish a consolidated limit for medical record requests from various contractors;

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- Improve auditor performance and transparency;
- Target medical necessity audits on widespread payment errors; and,
- Allow accurate payment for rebilled claims.

In addition to H.R. 1250, WHA supports additional legislation to address other unintended consequences of the RACs, one of which revolves around the issue of observation versus inpatient stays. This issue is the direct result of the RACs' particular focus on denying Medicare payment for shorter inpatient stays because the RAC deems, up to three years post-fact, that care should have been provided in the outpatient setting instead (regardless of the fact care was medically necessary).

Unfortunately, the fix put forth by the Centers for Medicare & Medicaid Services (CMS) in its FY 2014 Inpatient Prospective Payment System Rule, over objections from the hospital field, has caused even more confusion. While we appreciate CMS' attempt to address this RAC-caused problem, WHA does not believe the CMS "two midnight" policy is a workable solution. **Concerns continue to be expressed that the policy is flawed, overly complex and works to undermine the medical judgment of the treating physician by establishing an arbitrary time-based policy for inpatient admissions. WHA appreciates the delay in enforcement of this policy, including an additional six month delay recently passed by Congress earlier this year. However, we believe more needs to be done and would ask Congress to support H.R. 3698 which pulls the policy back altogether in order to replace it with a better vetted approach.**

Finally, in the sub-regulatory guidance stemming from this two midnights policy, CMS stated that, as a *condition of payment*, physicians at critical access hospitals (CAHs) must certify that a beneficiary may reasonably be expected to be discharged or transferred within 96 hours after admission to the CAH. If a physician cannot certify the reasonable expectation that a Medicare beneficiary will be discharged or transferred within 96 hours (barring unforeseen circumstances), then Medicare Part A payment is inappropriate. CMS appears to have brought to light a long-standing drafting error stemming back to the 1999 Balanced Budget Refinement Act (BBRA). It was in the BBRA that important improvements to the CAH program were made, including

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establishing the 96 hour *annual average for the conditions of participation* in the Medicare program. It seems the BBRA did not appropriately cross-reference the corollary payment statute, leaving these two conflicting 96 hour statutes.

No one knows why CMS elected to bring this particular provision into the two midnight guidance or why it elected to do so at this point in time, well over a decade after the BBRA's original enactment. **What we do know is that failing to correct this drafting error jeopardizes beneficiary choice and access to care in rural communities across the country. That is why WHA asks Congress to quickly pass bipartisan legislation known as the Critical Access Hospital Relief Act, H.R. 3991. Passing H.R. 3991 will help ensure CAHs can provide care to Medicare beneficiaries close to home.**

In closing, WHA and our hospitals and integrated health care systems support fighting "waste, fraud and abuse" in government health care programs, but those programs must be more effectively deployed and take into account the downstream impacts they have which are ultimately borne by the health care delivery system, payers and patients. **Congress can do much to ensure a more effective approach by passing the following three bipartisan bills:**

- **Medicare Audit Improvement Act, HR 1250,** ***to provide program improvements with Medicare audit-related activities;***
- **Two Midnight Rule Delay Act, HR 3698,** ***to roll back and replace Medicare's two midnight policy with an effective, workable solution;*** **and, the**
- **Critical Access Hospital Relief Act, HR 3991,** ***to ensure Medicare beneficiary choice and local access to care in rural communities.***

Thank you again for this opportunity to submit comments for the record.

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Watertown Regional Medical, Letter

Chairman Brady and members of the Committee,

Thank you very much for the opportunity to submit this testimony to the Health Subcommittee of the House Ways and Means Committee.

My name is John Kosanovich and I am President and CEO of the Watertown Regional Medical Center, Watertown, WI. We are a progressive regional health system serving south central Wisconsin with a main campus in Watertown Wisconsin and five other locations. We are a partner with the UW system.

We face two vexing problems--uncertainty and regulatory complexity -- that create a barrier for us to provide the best services to the citizens of our region.

The uncertainty, frankly, is largely a result of the action of this Subcommittee, Full Committee, and Congress. It is difficult to plan our future when we have no idea what drastic changes you may have in store for us as soon as March 2015. It is impossible to plan rationally for our future because this Congress -- both House and Senate -- have created a lurching, gyrating environment in which decisions are made at the last minute and presumably on the fly that dramatically impact the payments by our largest singe customer -- the Medicare program.

Let me illustrate. Everyone agrees that the current SGR system needs to be radically changed. But no one can agree how to pay for it. Early this year there was a bicameral, bipartisan repeal bill but it did not include so called "pay fors." As a result for at least the 8th time there was a "patch" to fully pay physicians and the necessary revenue through Medicare savings to pay for it was found. The current patch lasts until March 2015. None of us--least of all them--know how the Congressional Budget Office will score the cost of either permanently or temporarily fixing the system. The various CBO estimates over time is one of the most obvious examples of gyrations in the system.

Furthermore, there are a number of payments such as Medicare Dependent Hospitals (MDH) that are extended on a patch to patch basis. How do we plan our future and make sure we are giving the best care to our patients if we don't know if a program will exist or whether or not we will be eligible for it?

Eligibility of MDH is an interesting case in point. We were told by our fiscal intermediary that we were eligible for MDH and received the payment for several years. Then, the fiscal intermediary decided we were not eligible. Loss of the $1.6 million from MDH payments plus the loss of $1.5 million resulting from the Sequestration and other Medicare payment changes created a fiscal crisis for us. The crisis and our difficulty in planning continue because we don't know year to year if the MDH program will exist.

MDH should be made permanent. In addition, the law needs to be clarified that hospitals like ours which are known as “Lugar” hospitals are eligible for MDH which is far from clear in current law and regulations and needs statutory clarification.

Now let me turn to complexity which the MDH case illustrates. We have been advised that we have at least six options of how we can be paid. Our community is located between the Milwaukee and Madison Metropolitan Statistical Areas (MSA) in a rural county. There are various options which we might have, each one of which is treated differently by CMS. We may be Urban Milwaukee, Urban Madison, rural, Lugar, or "out migration". Confusing. You bet it is. The complexity of the regulatory environment makes it very difficult to make wise decisions. Layered on top is the uncertainty if any one of these categories will exist for us and whether or not special programs like MDH will continue to exist.

Much of the responsibility falls on CMS which issues the regulations, sets the rules, and then at a "sub-regulatory" basis picks winners and losers. Let me illustrate again.

> Buried deep in the federal register (8/18/11 p. 51599) is a discussion of the status of "Lugar" hospitals. In response to a comment, CMS in effect makes law by declaring that a Luger Hospital that waives it status to obtain re-designation to receive an out-migration adjustment is now no longer an urban hospital but is a rural hospital. There is nothing in statute or legislative history that justifies this distinction but CMS has decided that is the case.

It may be impossible to avoid much complexity but what I would urge the Committee to do three things:

1. Renew and enhance its oversight of CMS to reduce complexity.

2. Eliminate uncertainly by setting up a system that gives us all certainty in what our fiscal future will be.

3. Clarify the statue to permit Luger hospitals to receive MDH payments.

Thank you.

John P. Kosanovich
President & CEO

Walter F. O'Keefe, Letter

On August 12, 2011, my mother, Frances E. O'Keefe, fell at the retirement community in Hingham, MA. where she lived independently. She was taken by ambulance to the South Shore Hospital Emergency Room. She was badly bruised, but x-rays showed nothing was broken so she was discharged that same day and returned to her apartment in the retirement community.

Unfortunately, over the next few weeks her conditioned deteriorated to the point where she could not walk and was in excruciating pain. On September 4, 2011 she was transported back to the South Shore Hospital Emergency Room (ER) via ambulance. I was present in the ER when she was examined by a physical therapist and physician. The physical therapist rated her pain level as a 10 on a 1 to 10 scale and indicated it was unsafe for her to be discharged. The physician was concerned that she her condition had deteriorated since the fall and that she was experiencing a tingling sensation in her feet. The physician order an MRI and strong pain medications, including intravenous (IV) morphine. (IV morphine cannot be administered at a nursing home or rehab facility.) The physician told me she would be admitted to the hospital under the care of the "hospitalist" physician. She was admitted to the hospital and transferred out of the ER to a patient floor within a few hours after entering the ER.

Later that same evening they attempted to complete the MRI but my mother was still in such pain and so anxious, she could not tolerate the procedure. The following day, after the medications had reduced her pain, and she was given an anti-anxiety medication, the MRI was completed. The Hospitalist physician ordered a neurological consult which was completed on September 7, 2011. The MRI did not show any fractures or breaks, and the neurologist determined that my mother could be discharged to a skilled nursing facility to receive physical and occupational therapy. The Hospitalist physician determined it was medical necessary for my mother to be transported to the facility via ambulance.

My mother received the therapy and continued pain management medications she required including Percocet, an oral narcotic medication. Unfortunately during the time she was at the rehab center, she developed dementia and was unable to return to her independent living situation. She died a few months later on February 8, 2012. I was appointed executor to her estate by the Plymouth County Probate Court.

My mother's hospital stay in September for 4 days and 3 nights was paid under Medicare Part B. The physical and occupational therapy she received at the rehab facility was paid for by Medicare; however the room and board charges, which amounted to over $28,000 were not paid. After extensive investigation I learned that the rehab room and board charges were not paid because Medicare had determined that my mother did not have a 3 day pre-qualifying hospital admission prior to going into the rehab facility. Despite the fact that the hospital records clearly indicate that my mother was admitted to the hospital for 3 days as an "inpatient", (see enclosed hospital admission record) the hospital billed Medicare as if she was an "outpatient" and the bill was paid under Medicare part B, instead of part A.

As executor to her estate, I initiated the 5-step Medicare appeals process. The appeals process is very time consuming and complicated. I had to consult with a few attorneys to completely understand what had to be done. Then I had some logistical problems which required me to get the Medicare

Ombudsman's Office involved to rectify. The situation actually involved two appeals. I would have to appeal the decision that my mother's September hospital stay that was paid under Medicare part B and get that changed so that was paid under Medicare part A, and I would have to appeal the Medicare refusal to pay for the rehab room and board charges which were denied because of the hospital stay being paid as if my mother was an "outpatient" under Medicare Part B instead of part A.

To further complicate matters two different companies were involved with the two different bills. NHIC Corp. had processed the hospital stay claim, while Novitas Solutions handled the rehab facility claim. Obviously, successfully appealing the refusal to pay the rehab bill was dependent on my successfully appealing the NHIC decision to pay the hospital bill under Medicare part B, instead of part A. There were more logistical problems as Novitas could not find my appeal despite the fact I sent everything Return Receipt Requested.

NHIC indicated they could not find my appeal as well, and indicated that, in fact, they did not handle such appeals despite the fact that the Medicare Summary Notice states that appeals should be sent to them. NHIC indicated that they send any such appeal to Mass Pro. Working with Pat P of the Medicare Ombudsman's Office, I got the address of Mass Pro and was asked to send my appeal to them. I sent the appeal Return Receipt Requested, but it was returned as the address was old and incorrect. I obtained the new address and resent the appeal to their correct address (Return Receipt Requested), however, when I followed up with Mass Pro a few months later they stated they never received my appeal (I have the signed Return Receipt green card) and they did not handle such appeals anyway???

I tried to contact Pat Pierorazio at the Ombudsman's Office several times and left several messages but she has never returned my calls. At this point my right to appeal the Medicare decisions has, in a de facto sense, been completely blocked and I am only at step one of the five step process. The appeals bureaucracy is absurd.

The 3 day pre-qualifying hospital stay Medicare requirement is arbitrary and ridiculous. While the records indicate that my mother had a 3 day pre-qualifying "inpatient" hospital stay prior to entering the rehab facility, whether she had stayed 1 day or 5 days either as an "inpatient" or an "outpatient", my 89 year old mother could not walk when she left the hospital and had to be placed in a skilled nursing facility and Medicare should have paid for her room and board at that facility.

It is my understanding that there are some 62,000 cases similar to mine regarding this absurd regulation. Indeed, when I became eligible for Medicare none of the supplemental private Medicare insurers I looked at required the 3 day pre-qualifying hospital stay. It is time for congress to act and get rid of this ridiculous regulation and pay the backlogged 62,000 claims.

Thank you for your time and consideration.

Very truly yours,

Walter F. O'Keefe

Thomas M. Horiagon, MD MOccH, Letter

Dear Colleagues,

Many of you who are hospitalists, and some of you in other fields, have probably received calls from Executive Health Resources over the years about whether your patient should be in observation status or inpatient status. I can share some details about the company, their current predicament, and some tips for advocating on behalf of your patient when you take these calls.

Executive Health Resources (EHR) was formed in the 1990's as a side business of a eastern Pennsylvania hospitalist group that provided second level reviews of medical necessity for hospital services. You have probably encountered utilization review nurses or case managers who tell you from time to time that a particular patient doesn't "meet criteria" for some hospital service. The set of criteria to which they refer are either the InterQual or Milliman guidelines, which are proprietary decision support tools, that now have an enormous misclassification rate in assigning patients to inpatient, observation, or other categories of hospital-based care. The misclassification rate in these systems led to the need for second-level reviews to amend the recommendations of the first level software. In-house physician reviewers, Accretive, and EHR all work to provide these second level reviews using their own internal guidelines.

EHR grew over the years since inception into a company valued at a billion dollars when it was acquired by United Health Group about three years ago. Beyond concurrent reviews of hospital stays, it has moved into services lines addressing insurance denials, appeals, and post-discharge reviews. The company has its own legal team to stand behind its hospital stay classification recommendations in cases appealing RAC recovery attempts before an administrative law judge and the outcomes of those contests were used, along with medical literature of varying degrees of quality, to create clinical guidelines used by EHR Physician Advisors (the company physicians who call you) in arguing for an assignment to inpatient, observation, outpatient, or other level of care classifications.

What difference does it make when a patient is assigned to observation versus inpatient status? Well, the reimbursement to the hospital is roughly triple for patients receiving the same services depending on whether they receive these services as observation patients or inpatients. Moreover, the patient responsibility charges to Medicare patients treated in the observation classification are much higher, pharmacy charges in the hospital are not covered, and access to SNF's or swing beds after discharge are not covered by CMS.

So far, so good. EHR has a business model that looks to have the foundations for sustainability and growth. The more contests before administrative law judges, the more informed its recommendations became, and the value of its "business intelligence" increased. EHR developed a system of recommendations to greatly reduce the likelihood that RAC's (an enforcement contractor of CMS, incentivized like bounty hunters) would be able to take back hospital billing receipts under CMS's "pay and chase" strategy. However, since the basis for the recommendations was proprietary, front-line clinicians were no longer able to discern whether inpatient status or observation status was more appropriate. Both CMS payment enforcement actions and defense of these actions became the province of private contractors, using their own rules that were not transparent.

There were some bumps in the road. An enormous backlog of RAC audit appeals developed and the time to get a hearing before an ALJ jumped to about 200 days. Interestingly, the arguments used by RAC's in seeking to deny improper payments on medical necessity grounds were not about whether a service may or may not have been needed or appropriate but whether it might have been provided on an outpatient basis. There was a disproportionate impact on smaller hospitals that may not be able to muster the financial means to pursue lengthy appeals and that may also have more limitations in the spectrum of outpatient service offerings.

There was some backlash from CMS beneficiaries who began to realize that assignment to observation status greatly reduced their Medicare hospitalization benefits especially as they had no standing to challenge the assignment to observation or inpatient status which had substantial financial impact on the Medicare population. The decision logic was secret and could not be challenged.

A business cataclysm in the second level review industry occurred in May 2013 when CMS announced the FY2014 Inpatient Prospective Payment System (IPPS) guidelines. The guidelines introduced the now-famous "two-midnight" rule. Briefly, the rule can be summarized as follows: Inpatient services are generally appropriate for CMS beneficiaries if they have a need for a service that can only be reasonably and immediately provided in a hospital setting for a period of time from start of service to discharge that spans 2 consecutive midnights or is a surgical service that is mentioned on the CMS Inpatient Only list irrespective of time spent in hospital. The good faith estimate of the admitting physician that a course of care from start of service (e.g. ER triage time) to discharge would more probably than not span 2 midnights was grounds for classifying a patient as an inpatient. Considerations such as the patient's history and the course of similarly-situated patients at that institution were all fair bases for such an estimate. This rule was disruptive for EHR because the decision to assign patients to inpatient or observation status was no longer the sole province of proprietary expert system guidelines but was now within the grasp of ordinary well-intentioned physicians using a simple rule of thumb. The acuity of the patient or the rate of hospital resource consumption were not the primary determinants of correct classification of level of care. The market foundations for the first level and second level review systems were now much shakier. Since the implementation of the CMS two-midnight rule, the demand for EHR services has contracted greatly, its workforce in concurrent reviews is down about 40-50%, executive leadership has undergone a change, and the company is literally asking for suggestions as to how it might revive its concurrent second-level review system. Large hospital chains, such as Columbia/HCA have dropped their EHR contracts and some hospitals have stopped doing first and second level necessity reviews altogether.

Besides EHR, who comprises the other losers and winners under the two-midnight rule? Since expected duration of care rather than intensity of care is now the benchmark for classifying a hospital stay as inpatient or observation, high-intensity, short duration hospital stays (for example, scheduled cardiac ablations) were now classified as outpatient services. Depending on the hospital, such admissions may account for a large or small number of total hospital admissions (ranging from 10-70%) and there was a much bigger impact on larger hospitals that provided many of these short duration, high-intensity services. This was also a "have's" vs. "have-not's" disparity in the effect of this rule, but this time, more well-heeled institutions bore the most adverse impact. Predictably, the American Hospital Association

has been joined by others in filing a lawsuit against CMS challenging the two-midnight rule. Overall, hospital admissions of CMS beneficiaries classified as inpatient declined about 15% since the two-midnight rule was implemented on October 1, 2013. However, some patients may stand to benefit from the rule. Fragile geriatric patients with a variety of painful or disabling conditions at presentation who were previously assigned to in-hospital observation level of care classifications for periods exceeding a week on average for some diagnostic groups might now receive these services as inpatients if the good faith estimate of the duration of need for in-hospital services was 2 midnights or more at the time of admission.

How did EHR respond to this challenge? One way was to shed labor costs as quickly as possible. Another was to specifically instruct its physician advisors to refrain from using level of care classifications based on the two-midnight logic (except if there was documentation of an expected length of stay less than 2 midnights) or the Inpatient only list but rather to rely on its proprietary decision tools. So, while EHR will admit that it can do little to upgrade to inpatient classification short stay, higher-acuity services, it will continue to say that longer duration, lower intensity hospital stays are still classified as observation or not appropriate for in-hospital services. EHR has continued to give these recommendations since October 1, 2013 even though it has not participated in a single appeal since the 2 midnight rule implementation. EHR will still claim expertise in correct assignment of level of care even though the regulatory foundations for this claim have changed fundamentally.

So, what if EHR calls you about a patient's level of care? My recommendation is to stand your ground and to defend your patient's best interests. The playing field for level of care classification has been levelled. You know your patient. You are in a position to estimate how long this patient will likely be in the hospital, or for the surgeons, you know which HPHCS code applies to the services you provide. The EHR physician advisors have never seen your patient and their recommendations rely on proprietary guidelines that have not been subjected to public scrutiny. EHR's interests and that of their clients have now diverged. EHR is desperately trying to preserve the value of their intellectual capital even if their clients suffer. Moreover, while CMS may enjoy immunity from beneficiary lawsuits, EHR and United Health Group who continue to recommend level of care classifications at variance with the two-midnight rule since October 1, 2013 have no such protections.

Thomas M. Horiagon, MD MOccH

Texas Organization of Rural & Community Hospitals, Statement

TESTIMONY SUBMISSION FOR HOUSE WAYS AND MEANS SUBCOMMITTEE ON HEALTH
Hearing on Current Hospital Issues in the Medicare Program
May 20, 2014

Submitted by:
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The Texas Organization of Rural & Community Hospitals is a trade organization of the approximately 180 rural hospitals in Texas. Our organization appreciates the opportunity to offer written testimony to the House Ways and Means Subcommittee on Health.

RECOVERY AUDIT CONTRACTOR PROGRAM

Our organization would like to go on record as strongly supporting efforts by the federal government and the Centers for Medicare and Medicaid Services (CMS) to prevent, detect and counter fraud in the health care industry. Those who intentionally steal from the system should be aggressively punished. The problem at times, however, is that the Medicare and health care financial and billing systems have become extremely complicated over the years and very much subjective. Any given patient visit to the doctor can result in a billing code marked from a long list of potential billing codes, all of which may be medically correct. We have all experienced this in our personal physician's office where a number on a sheet of paper is quickly circled which will mean something to somebody later. The most appropriate billing code can often be subject to second guessing and different opinions – none of which constitute fraud.

The Recovery Audit Contractor (RAC) program has been an effort to make sure the health care system circles the correct number and doesn't intentionally circle the wrong number, especially when it means a higher payment. The program was needed and has done some good work. Unfortunately, the design of the program has also created problems in the health care industry and has resulted in payments being yanked away from health providers who provided legitimate services.

The overarching problem that the rural hospitals of Texas see is the method of payment for RAC auditors. To pay based on mere allegations has resulted in a "bounty hunter" environment. Congress must change this system. Auditors should not receive gain nor be incentivized to make allegations without a sound medical basis. They should be paid for their work and their efforts, independent of the outcome and any final recovery by the government. They should feel pressured to be fair and do the right thing – not to make a recovery no matter what. We would never consider paying IRS agents based their audit findings. We would never pay the police solely based on how many people they can pull over. Why do we treat health providers this way?

A second readjustment that Congress must provide is the huge inequity in how far auditors can go back versus the period for a hospital or other providers to make a correction or adjustment in billing. Medicare only allows providers to bill, rebill, or otherwise adjust billing for one year after the services are rendered. Yet auditors can go back and look at five (5) years (referred to as a four year look back

plus the billing year). The problem with this inequity is that if the auditor questions billing in years 2 through 5 (which is usually the case); the provider is beyond the one year billing window and cannot send in corrected or adjusted billing. The auditors then recoup or take back 100% of the payment. The providers get nothing.

The real inequity of this system is there are actual cases where a billing code is questioned, the auditors and the government took back all of the payment, but appropriate services were performed. Maybe a different billing number should have been used, but the hospital or provider provided services and ended up getting paid nothing. Further aggravating is the fact that in some cases, the provider should have been paid more and still gets nothing.

Congress must act to allow providers to rebill or adjust their billing for the same period of time that RAC auditors can look back and question their billing.

Admittedly, there is an appeal process that one would think would negate any inequities. Unfortunately, the RAC audit appeal process is not practical and tends to impede hospitals and other providers from receiving their grievance process. An indirect barrier for rural hospitals is that they do not have large internal financial and legal resources to fight this battle. Rather, because of their limited resources, they are often forced to turn to outside financial and legal consultants. The outcome for these hospitals – even when they win – is a loss as recovered funds end up being used to pay for the outside consultants. This is a shame as so many of the appeals are ultimately overturned. So, why take on that agony when the financial outcome for the hospital will be the same either way – you end up treating a patient for free.

In closing with regard to the RAC issue, Texas rural hospitals appreciate that this subcommittee has a growing awareness that there are problems with the RAC effort. And, hopefully many of these problems will be fixed with a proper balance of fairness to health providers yet allowing the government to continue with its efforts to seek out legitimate fraud. There are a number of bills pending related to RAC auditors. We believe that HR 1250 addresses the majority of the problems, yet does not limit appropriate efforts to go after fraud.

TWO MIDNIGHT RULE

A second issue before this committee which we would like to also comment on is the so called "Two Midnight" rule. We believe to arbitrarily predetermine that a patient stay in a hospital will be outpatient if it spans less than two midnights and will be inpatient if it spans more than two midnights is not based on any known medical science. The first question we continue to have is where does "midnight" come into play? At the very least, shouldn't it be a span over 24 hours and less than 24 hours? And, how does 24 hours separate outpatient and inpatient.

We agree that if a patient's diagnosis is one that only requires a treatment plan on an outpatient status, it should be billed and paid as such. But, there are many other factors in play, especially in rural hospitals. It is not uncommon for rural physicians treating a patient to find themselves with very limited resources and ancillary support. Labs tests and radiology may have to be sent off elsewhere delaying the physician's ability to completely diagnose, prescribe a treatment plan, and implement it. Should those physicians simply say "take two aspirin and call me in the morning after I get the test results back?" We don't think so and we don't think Congress thinks that either. Those physicians need sound and appropriate medical information to properly treat and they may feel they must admit a patient to the

hospital in the meantime. Physicians know that with the patient already hospitalized (even if a so called observation stay), should the condition unexpectedly decline, the patient is where they need to be.

The "Two Midnight" rule takes the physician's independent medical decision out of play and certainly does not factor in the variations in staff and medical resources at any given hospital. We are not sure what the appropriate timeframe may be, but we are certain you cannot draw a medical line between one midnight and two.

The "Two Midnight" must be reevaluated in a manner that takes into accounts appropriate patient treatment and not an arbitrary line based solely on saving money.

Sherry Smith, LCSW, Letter

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Congressman Kevin Brady
Committee on Ways and Means Health Subcommittee, via http://waysandmeans.house.gov
Hearing on Current Hospital Issues in the Medicare Program

To the Honorable members of the House Committee on Ways and Means Health Subcommittee:

My complaints are about Observation Status, something that doesn't exist, as far as I'm aware, except in Medicare. For the past two years, I have represented my aunt in her Medicare appeal about Observation Status at a hospital that led to an approximately $19,732.50 bill for rehabilitation at a Skilled Nursing Facility. During this time, I've filed appeals and also written letters to Congressmen, Senators, and President Obama about what I believe are violations of my aunt's due process rights (42 CFR sections 405.1205 et seq; Fifth and Fourteenth Amendments of the Constitution).

On March 30, 2012, my 92 year-old aunt fell and fractured her pelvis and left olecranon. An ambulance transported her to the local hospital because she could not stand or walk. At the ER, the physician admitted my aunt to the hospital as an inpatient. However the next day a different doctor reversed that decision to Observation Status. On April 1, 2012, orthopedic surgeons repaired my aunt's elbow. The hospital then placed my aunt on inpatient status until her transfer to a rehabilitation facility on April 3, 2012. She remained in the same hospital room throughout her stay. Thus, she had two inpatient days of stay and two observation status days prior to her transfer directly to the SNF where she remained until about June 25, 2012. My aunt received excellent care from doctors, nurses, and therapists.

Medicare initially denied payment for the ambulance but later granted our appeal. However, the appeals over the $20,000 SNF bills are currently sitting at the ALJ level. During the appeals, I believe that Medicare, and its contractors, Maximus and Palmetto, violated my aunt's due process rights. On July of 2012, I sent Palmetto my appeals via certified mail. They failed to issue a decision or denial letter on the first level appeal. I literally begged via numerous phone calls and certified letters asking them to send us a denial letter so that we could appeal to the next level. After contacting Congressman Sam Farr for his assistance, Mary K. Lucas, Congressional Specialist with Palmetto GBA wrote that: "On November 27, 2012, I requested that the Palmetto GBA Redeterminations Unit review Mrs. ____ Part A appeal. On November 29, 2012, Mrs. ___ appeal was dismissed. Her hospital claim was paid in full, so there was nothing to dispute about the way it was processed."

On February 19, 2013, Hadiya Green, Appeals Coordinator at Palmetto GBA, wrote to me and stated that: "This is in response to a request for redetermination of a claim for services provided to ____. We are unable to evaluate your request, as the claim(s) or dates of service identified in

your request have not been denied by the Intermediary. The only non-covered charges on this claim may be the coinsurance and deductible which are not appealable. Therefore we cannot take any further action and must dismiss your request."

Essentially, Palmetto and Maximus claimed that my aunt can't appeal the Observation Status that led to a $20,000 SNF bill. And the Second level of appeal was denied because Palmetto and Maximus failed to issue us denial letters on my aunt's first level appeal. Thus, the appeal is now before an ALJ. This appeal process has taken two years.

According to the Medicare.gov website, "all people with Medicare have the right to…Request an appeal of health coverage or payment decisions." Furthermore, the website states that beneficiaries have the right to "be protected from discrimination" and "Get information in a way you understand from Medicare, health care providers…" Medicare treats seniors differently than everyone under the age of 65. Because I have a PPO health insurance, if I remain at a hospital for more than 24 hours, they will admit me as an inpatient. Although my aunt was in the hospital for four days, the utilization committee, and one doctor, decided she would be Observation Status for 2 days and inpatient for 2 days. Thus, Medicare has essentially discriminated against my aunt and other seniors who rely on these federal health care benefits. By denying my aunt the right to appeal Observation Status, Medicare and the QIC's have also denied her due process rights under the Constitution, federal law, and regulations.

The Office of Medicare Hearings and Appeals held a forum on February 12, 2014 about the delays in Medicare hearings. Although a notice was sent to some organizations, I don't believe the notice was sent to beneficiaries or their representatives. I wrote to Ms. Nancy J. Griswald, Chief Administrative Law Judge, concerning this as well as to ask her about how many beneficiaries currently wait for a hearing. According to an April 1, 2014 letter written by Eileen McDaniel, Director, Office of Programs, "For beneficiary-initiated appeals received in June 2013, the average case processing time is currently 140 days, with 28% of beneficiary-initiated appeals received during that time still pending a decision. For beneficiary-initiated appeals received in August 2013, the average case processing time is currently 112 days, with 33% of beneficiary-initiated appeals received during that time still pending decision."

I sent Ms. McDaniel a follow-up letter since she failed to give me the number of beneficiaries awaiting appeals. She replied that "as of April 22, 2014, we have 2,537 pending appeals that were initiated by beneficiaries or representatives…She also explained that with my type of appeal, i.e. where the QIC dismissed my appeal, "the 90-day adjudication period does not apply. See 42 C.F.R. section 405.1016(a)…." I filed the appeal via certified mail to the Office of Hearings on July 22, 2013. It's now been ten months since I requested the hearing.

I hope you will investigate what I believe are injustices against seniors in the way Medicare dictates hospital stays as well as the many obstacles placed in the way of beneficiaries who appeal Observation Status to Medicare and the QIC's.

Sincerely,
Sherry Smith, LCSW

Pocono Medical Center, Statement

Testimony Submitted to the House Ways and Means Committee
by
Pocono Medical Center
About Current Hospital Issues in the Medicare Program
May 20, 2014

Pocono Medical Center appreciates the opportunity to submit this written testimony to the House Ways and Means Committee to supplement the oral testimony delivered to the committee about current hospital issues in the Medicare program.

Pocono Medical Center supports the American Hospital Association's position on Medicare's proposed two-midnight rule and appreciates the attention the committee is giving to that rule, and views on it, today.

At the same time, Pocono Medical Center has additional concerns about the Centers for Medicare & Medicaid Services' proposed inpatient prospective payments system regulation for FY 2015 and changes that proposed regulation calls for in Medicare area wage index system. We present those concerns today.

Introducing Pocono Medical Center

The Pocono Medical Center is a 235-bed, non-profit community hospital located in East Stroudsburg, Pennsylvania. It is the only hospital in Monroe County and has been designated a sole-community provider by the Centers for Medicare & Medicaid Services (CMS). Pocono Medical Center serves both Monroe and Pike counties, two of the fastest-growing counties in Pennsylvania. The hospital employs more than 1900 people and has over 235 physicians on the medical staff who work in more than 30 medical specialties. Its emergency room serves approximately 80,000 patients a year, it's Mother/Baby Unit welcomed over 800 newborns into the world in 2013, and last year the hospital provided more than $25 million in community benefit and investment to the community which includes uncompensated care to uninsured patients.

The Issue at Hand Today

CMS recently proposed a major update of the labor markets used to determine hospitals' Medicare area wage index adjustments. This update is based on the most recent labor market delineations developed by the Office of Management and Budget (OMB) based on 2010 census data – the first such use of 2010 census data for this purpose – and results in proposed changes in Medicare wage index adjustments for thousands of hospitals across the country, including Pocono Medical Center.

Among the proposed changes, Monroe County, where the Pocono Medical Center is located, has been reclassified from the rural area it has long been to an urban area.

The Challenge Pocono Medical Center Now Faces

Pocono Medical Center has long been classified by Medicare as a sole-community hospital because it has been located in a rural area and meets other formal Medicare criteria for this classification. This status is important to the hospital and the community it serves because it confers financial benefits to support the hospital's delivery of services that in many cases it would not provide if it made such decisions on a purely financial basis. The rationale for these benefits is that sole-community hospitals need to be able to provide a wide range of services – wider than financial prudence justifies – because of their relative geographic isolation and their communities' lack of acute-care options. The value of these benefits is more than $10 million a year, and without them, it is not clear if the hospital could survive.

For Pocono Medical Center to retain this vital sole-community hospital status and these essential benefits, it will need to seek to reclassify as a rural hospital – a move that would enable it retain its sole-community hospital status but that also would result in changes that would cost the hospital about $1.3 million a year in lost Medicare revenue.

This would be be a significant loss for the hospital, and CMS acknowledged in its announcement of the new labor market areas that it recognized that these changes could result in significant losses of Medicare revenue for some hospitals. For this reason, it extended grace periods for some hospitals: transition periods of up to three years during which selected hospitals would not suffer immediate losses of Medicare revenue and would instead have an opportunity to consider their options and make any adjustments in their operations needed to accommodate such a major loss of Medicare revenue. Among those granted transition periods are hospitals that would suffer a cut in their wage index because of the new labor market areas (one year); critical access hospitals located in counties that previously were designated rural but that would be urban under the new OMB labor market areas (two years); and hospitals currently located in urban counties that the new delineations reclassify as rural counties (three years).

Pocono Medical Center believes its situation closely mirrors that of critical access hospitals located in counties that previously were rural but that are now considered urban under the new OMB labor markets. For this reason, it believes that it – and other sole-community hospitals like it that have seen their rural designation changed to urban – should be given the same two-year transition period as those critical access hospitals.

Pocono Medical Center is far from alone in facing this difficult challenge. In all, 14 hospitals in 11 states – Alabama, Arizona, Hawaii, Michigan, New York, North Carolina, Pennsylvania, South Carolina, Tennessee, Texas, and Virginia – find themselves in the same situation today: facing a significant loss of Medicare revenue and without the relief from this sudden loss that CMS proposes extending to many similar hospitals facing a similar problem.

Conclusion

Pocono Medical Center understands and accepts the labor market changes OMB has proposed and that CMS intends to employ. The hospital also appreciates CMS's sensitivity to the problems sudden losses of Medicare reimbursement can cause and respects the agency's decision to offer affected hospitals a transition period to adjust to those changes. At the same time, however, Pocono Medical Center believes that because of the special role sole-community hospitals play and the special financial obligations they undertake as part of fulfilling that role, these hospitals, too, should be extended a transition period to ensure their ability to adjust to the proposed changes without jeopardizing their ability to serve their communities.

For this reason, Pocono Medical Center respectfully asks Congress to prevail upon the Secretary of the Department of Health and Human Services and the CMS administrator to extend a two-year transition period to the Pocono Medical Center and other sole-community hospitals that have seen their labor market lose its rural designation and be categorized as urban instead. If they reject this request, the hospital asks Congress to enact legislation imposing this much-needed solution on the administration.

Pocono Medical Center appreciates this opportunity to provide testimony to the Ways and Means Committee and welcomes any questions committee members or staff may have about the situation and tl hospital's request.

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Patricia Windle, Letter

Current Hospital Issues in the Medicare Program

To whom it may concern:

My mother, Anne Butler, was a resident of the Perry County Nursing and Rehab Center in Perryville, AR from June 27, 2011 to Feb. 24, 2012. Except for a few days when I was seriously ill (10 days) or had to be out of town on business (10 days), I was at the nursing home daily to feed Mother a meal and to help the staff with her care. I was keenly aware of her day to day status and since I had been her caregiver for the previous 12 years, I knew what her every nod, blink and grunt meant.

At 11pm on January 21, 2012 I received a call from the nursing home telling me that Mother's vitals were not good, they had placed her on oxygen, she was lethargic and they had called the nursing home physician. Her vital signs had apparently gotten so poor that one of the nurses exclaimed to me that "I thought your Mother was going to **code,** i.e. die**,** on us". An ambulance was called and she was rushed to Conway Regional Hospital in Conway, AR. By the time the paperwork was ready for me to sign, it was 12:11am Jan. 22, 2012. By making sure the paperwork wasn't done until after midnight, Mother lost what would have been considered day one on the hospital records.

Upon examination in the emergency room and blood work tested and then re-tested, Mother was found to be extremely anemic with her platelet count as 4. Normally, 35 to 40 would be considered acceptable. Immediately 2 units of blood was ordered. Keep in mind that in all the years I've taken Mother to her doctors she had never been diagnosed with anemia. The emergency room staff also mentioned that they had found some blood in Mother's stool sample.

When Mother was first placed in her room the floor nurse exclaimed to the family, "you mean this woman is still alive, most die from a stroke or heart attack when their blood level is 5 or 6. Your Mothers was a 4". She knew Mother was in critical condition as did the emergency room staff.

Mother received a chest x-ray which the physician noted 'possible concern for pneumonia' on his report. Urine and another blood test were done. In total Mother received 4 units of blood. Mother's condition was far past "the observation status".

On the same day Mother was admitted to the hospital, her records were examined by case management worker, Susan, who approved Mother for INPATIENT STATUS **that day**. I also have other hospital records showing that Mother was approved for inpatient status for that first day and was to be admitted as such. Dr. Gary Stewart was assigned to Mother as her physician. He was not on duty that day but was called. He gave the order for her to be "admitted" to the hospital. I have his signed letter stating that she should have been admitted "inpatient status".

Unfortunately, the doctor on duty at the hospital had already made his rounds and none of the hospital staff would call him to come sign the order or would get another physician to sign it. . I believe this was deliberate. Thus, Mother's inpatient status papers were not signed for an entire day, thus, she was apparently considered observation status even though she was in critical condition and being treated aggressively to save her life. (At this point in time no one had mentioned anything about such a thing as observation status and we had no idea what it was. It was not until after Mother was returned to the nursing home did we know anything about it). This is a dirty little secret the hospital keeps from families.

Mother's inpatient form was **signed** the next morning, Jan. 23, 2012. Mother received a total of 4 units of blood while at the hospital. By Jan. 25, 2012, Mother's platelet count had only reached 11.1 (as I mentioned earlier, 35 to 40 was normal according to what I was told). I could tell there was something else going on with her and we expressed our concerns to Dr. Stewart and also the hospital staff. Our concerns were swept under the rug and Mother was discharged on Jan. 25, 2012 despite our objections. Upon discharge, Mother was "officially" an observation patient for one day (Jan. 22) and an inpatient for two days (Jan. 23 & 24) thus, she did not qualify for a Medicare bed when returned to the nursing home. Mother was rushed out of the hospital, I believe to keep her from qualifying for a Medicare bed and as a cost saving procedure even though her blood count was less than 1/3 of what it should have been.

Dr. Stewart gave the order for Mother to have regular blood tests so he could monitor her. On Feb. 21st it had not been done. On Feb. 24th Mother was once again rushed to the Conway Regional Hospital in critical condition. Tragically, she coded once in the ambulance, was revived, but she passed away on Feb. 26, 2012. I believe this adequately proves she was more than an "observation" patient. Her death certificate lists cause of death as**: ACUTE GASTROINTESTINAL HEMORRHAGE.** For a solid month my Mother laid in the nursing home bleeding to death and suffering unimaginable pain all because the hospitals are apparently told to keep their inpatient admissions of the elderly down or their Medicare payments would be reduced. I believe they are being told to…admit them observation, do minimal testing and get them out before they can qualify for a Medicare bed.

How in the world can anyone, even Medicare, allow these poor, helpless, sick, old people, who have done so much for our country, to spend their last days on earth **tortured** to death all because of the almighty dollar and it's all perfectly acceptable by the government. Given the outcry over the waterboarding of terrorists, why isn't there an outcry for our Mothers and Fathers who are left to die in agony because "we have to keep our inpatient admissions low and costs down or the government will cut off hospital reimbursement payments".

Mother was admitted to the nursing home on Medicaid. Even though Mother qualified for all kinds of government "freebies" we never accepted any of it. Our family took care of her needs. Unfortunately, none of us could afford nursing home care and we had to turn to Medicaid for help. Now that Mother has passed away, Medicaid is demanding repayment of Mother's expenses at the nursing home. Our options; either borrow the money to repay Medicaid or sell her home which has been in our family for many generations. If Mother had qualified for a Medicare bed, a sizable chunk of the Medicaid bill would not be there.

I was told by two Conway Regional Hospital case management supervisors that we could appeal this observation status to Medicare and that we were a 'slam dunk' to win this on appeal. I appealed to Medicare, I've done everything I've been asked to do. I have two 10 ream size paper boxes full of letters and forms that I've submitted over the past 2+ years trying to appeal this observation vs inpatient status. I've been referred to dozens of people. I've been given the run-around so many times it makes me dizzy. So, what has me spending over two years of my life to get this appealed done? Absolutely NOTHING! The classic response is 'send us a letter and we'll see what we can do'.

Now, Medicare stated that they will no longer talk to our family because Mother's Will has not been probated nor an official representative been appointed by a judge. For two years they talked and corresponded with me, asking for this or that…which I supplied, but suddenly, they refuse any further communication. Mother's Will plainly states that her heirs, i.e. me, are representatives of her estate, yet, Medicare will not honor that status.

Sir or Madam, I have so many side stories related to this case that would make your blood boil but I've tried in my feeble way to relate a portion of my Mother's story to you. No one disputes that Mother was old but did she deserve to die in agony – bleeding to death – simply because it wasn't cost effective because of her age!!!

There's been much talk about the so-called death panels, Sir, I've experienced it within my own family. Mother was tried and judged not be worthy of living any longer based on her dollar value. She was denied 'THE RIGHT TO LIFE' as guaranteed in the Declaration of Independence. What she **was** given by all this is DEBT. The only material blessing she had left in this world was her old home-place. Because of one signature, on one little form, and this insane Observation status and cost cutting procedures, my Mother died in agony and her family is about to lose her home to estate recovery. PLEASE, do something to stop this observation status immediately and give our seniors the care they've worked their entire lives for. Do we not protect and defend our babies who are so helpless….then why on Earth can we not do the same for our helpless elderly. But, perhaps I can answer my own question by what I've learned about observation vs inpatient care – YOU'RE NOT COST EFFECTIVE!

I realize my letter is a bit harsh and blunt but, Sirs, let's not kid ourselves here, we all know what's going on with these seniors and it's difficult to believe some people in high places have become so hardened that they allow this to continue. When I started down this road of protesting observation vs inpatient status, I had no idea what I was getting myself in for. I trust people, I speak the truth and I expect others to do the same. But, I can tell you from experience in dealing with our bureaucratic system, trust and truth have long since been pronounced dead and buried just like the thousands of our most helpless and sickest. My tact and diplomacy have long since been worn thin by this endless stalling, delaying and I believe, outright lying by our government system. I'm not skilled in word manipulation so in my feeble way, I'm giving you my opinion of this deadly observation status you have now literally buried our mothers, fathers and grandparents under. Please, can you do something to change this observation status, NOW, before thousands of other Americans are tortured to death!

Thank you for your time.

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May 31, 2014

Patricia Klaiber, Letter

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June 15, 2014

www.waysandmeanscommittee.gov
Ways and Means Health Subcommittee
1102 Longworth House Office Building
Washington, DC 20515

Re: Public Submission ~ Current Hospital Issues in the Medicare Program
Observation v. Inpatient
Date of Hearing: May 20, 2014

Ladies and Gentlemen:

In 2011, my 92-year-old mother was hospitalized for three days/three nights at Hendricks Hospital in Indiana. Though she met all of Medicare's criteria listed under "Inpatient Hospital Services Covered Under Part A" (*Medicare Benefit Policy Manual,* Chapter 1, §10), she was denied coverage for physician-ordered physical therapy at a skilled nursing facility (SNF). Why? Because (and only because) Hendricks kept her in "**observation**" throughout the *three-day, three-night* hospitalization.

Hendricks Hospital contends that she was dismissed in an "improved condition. She was not. She was taken to the hospital by her daughter via automobile; three days later, she left in an emergency medical van, strapped to a gurney.

She was physically ineligible to return to her assisted-living apartment. She remained at the SNF for eighty-one (81) days. Because Medicare excluded her from coverage, her bill at the SNF was $24,190.

I have told my mother's story to family and friends. Not one understands how this could happen. Likewise, they are dismayed that it could happen to their parent … and to them. So, why is it happening? Susan Jaffe, *Kaiser Health News*, reports the following:

> "Medicare has strict criteria for hospital admissions and usually won't pay anything for admitted patients who should have been observation patients. In response to these rules, hospitals in recent years have increased their share of observation patients."
>
> "Hospitals have another incentive for keeping patients in observation status: If patients return within 30 days, they don't count as readmissions since they were not admitted in

the first place. Medicare withholds a percentage of payment from hospitals with high readmission rates."

"More Medicare beneficiaries are entering hospitals as observation patients every year. The number rose 69 percent in five years, to 1.6 million nationally in 2011, according to the most recent federal statistics. At the same time, Medicare hospital admissions have declined slightly."

"The over-classification of observation status is an increasingly pervasive problem: the number of seniors entering the hospital for observation increased 69 percent over five years, to 1.6 million in 2011."

Excerpts from *Kaiser Health News,* Susan Jaffe, "Hospital Observation Care …' (www.kaiserhealthnews.org) (September 4, 2013)

I pray for each of you as you work toward correcting this wrong.

Very truly,
Patricia Klaiber

New York StateWide Senior Action Council, Statement

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Statement by Maria Alvarez, Executive Director
New York StateWide Senior Action Council, Inc.
To the House Ways and Means Committee
For consideration and inclusion in the printed record for
Hearing: Current Hospital Issues in the Medicare Program.
June 3, 2014

The New York StateWide Senior Action Council, Inc. is a 41 year-old organization that works toward improving the quality of life of senior citizens and families in New York State.

Through our Medicare Consumer Counseling Assistance Project and Patient's Rights Helpline, we assist thousands of clients annually to make the best informed decisions regarding their healthcare and Medicare health insurance coverage.

We have been receiving calls on our Patient's Rights Helpline from distressed seniors with tens of thousands of dollars worth of hospital bills that they had assumed would be paid by Medicare. Application of Observations Status related rules have created financial chaos for many seniors who – no matter what their economic status – are often one nursing home admission short of impoverishment.

We believe that the massive increase in the placement of Medicare beneficiaries into observation status over the last few years has more to do with federal efforts to shift more of the costs of care to older persons and for hospitals' need to protect themselves against penalties for high readmission rates than with any reasons related to clear clinical need or quality of care.

Since its enactment in 1965, Medicare Part A has covered the costs of stays in a hospital and rehabilitation care thus enabling sick older persons to obtain critical care without fear of financial hardship. This core purpose needs to be clearly reaffirmed and maintained.

The rules related to Observation Status need to be fixed to benefit Medicare beneficiaries. Right now attempts to address the problem are piecemeal and ineffective. Individual states are offering possible fixes. CMS has proposed and finalized rules to attempt a partial fix in requiring that beneficiaries in a hospital bed for more than 48 hours need to be admitted. However, the legislative changes are still needed to assure that stays overnight in a hospital count toward the three night minimum for Part A to cover rehab care in a Skilled Nursing Facility (SNF).

We agree with the testimony given by Toby S. Edelman, Senior Policy Attorney at the Center for Medicare Advocacy presented to the House Ways and Means Committee Hearing on May 20, 2014. There has been

a rapid growth in the use of Observation Status (OS), uncertainty regarding the appropriateness of its use, and its potential financial impact on Medicare beneficiaries. Congress must act speedily to rectify the conundrum of observation status and its impact on the ability of Medicare beneficiaries to receive necessary SNF care.

We offer the following recommendations:

- **Establish easier and speedier access to the Observation Status appeals' process for Medicare beneficiaries.**

  The current OS appeals process is a fragmented, labor intensive, time-consuming pursuit for Medicare beneficiaries.

  In New York State, the federally designated Quality Improvement Organization, IPRO, only addresses quality of care and inappropriate discharge issues. Under the current system they do not directly handle OS issues and no effective access to appeal exists. OS problems are left unresolved at the beginning levels of the Medicare Appeals Process. IPRO should be charged with accepting OS appeals in order to make OS appeal decisions enforceable at the very beginning of the Appeals Process. *The Medicare Appeals Processes should be consistent and enforceable at all levels of Appeal.*

- ***To that end, a sick beneficiary and caregiver should not have to deal with OS issues on their own. Community based organizations should receive funding to provide education and assistance to Medicare beneficiaries regarding all aspects of Observation Status***

CMS should authorize their Quality Improvement Organizations (QIOs) (in New York State this would be the IPRO), to provide toll free access to appeals in the same way that discharge and quality of care complaints are now handled.

The current system for appealing observation status is extremely burdensome for the sick older person. It appears to be intentional by CMS with the desired outcome being that people will find it too difficult to appeal or give up. Two sample cases we have worked with illustrate this.

- A 93 year old woman received head injuries and broke her pelvis after a fall. She received an inappropriate assessment and treatment, was prematurely discharged and had to be readmitted because of the severity of her injuries. During her five days of care at the hospital she was placed into Observation Status for all but her last day. She was then discharged from the hospital and immediately admitted to a Skilled Nursing Facility (SNF) where she remained for 43 days for rehabilitation of her many problems.
  She was denied Medicare coverage under Part A for this 43 day SNF stay because she had not been an "admitted" hospital inpatient for three days prior to her stay at the SNF. She owed $18,932.55 to the nursing home for her rehabilitation.

Her caregiver contacted us for help. Through the assistance of IPRO she was able have the hospital cited for several quality of care problems. The IPRO noted, "It is unclear why this patient was admitted to observation services when and inpatient admission would have been fully justified due to the multiplicity of medical conditions treated." In addition, they noted that in this case, "Medical decisions overrule standardized and general criteria for admission."

It was clear that the hospital should have admitted her rather than placing her in observation status. In other words they should have billed Part A for her care. However, when the family appealed the denial

of the nursing home coverage charges, the Administrative Law Judge (ALJ) (it took nine months from the time of the incident to obtain a ruling), said that they were ineligible for coverage because they did not meet the three midnight rule and they couldn't rule on improperly billed care. A classic Catch-22. The Law Judge indicated that they could try to get the hospital to resubmit the bills as a Part A claim and then maybe they could request that the appeal be reopened. How is an already stressed patient or caregiver supposed to accomplish such a feat? In this case, the individual and her caregivers gave up and paid the cost of the nursing home care even though Medicare Part A clearly should have covered it. Thus shifting cost to the consumer.

CMS needs to provide such consumers with coordinated assistance so that when one part of CMS finds a quality problem, the other part of CMS helps them get reimbursed rather than finding loopholes to hide from covering such care through Part A.

- An eighty-eight year old decorated veteran of World War Two broke his pelvis as the result of a fall. He spent the next four days in a hospital bed and was eventually transferred via an ambulance to a Skilled Nursing Facility where he needed three weeks of rehabilitative care. He assumed he had been admitted to the hospital since he could not move from his bed; he did not understand that he had been placed into Observation Status; and would later find out that $6,000 for the costs of his SNF care were not covered by Part A.

  He went through a lengthy and time consuming process to appeal the denial of Medicare coverage of his subsequent stay in a SNF. However, the ALJ indicated that while he had been physically in a hospital bed for four days, since he was not "admitted" for three midnights, he was held financially responsible for the full amount he incurred while in the SNF for rehabilitation. At that stage the family through up their hands and gave up appealing further. Once again the system wore down the victim and transferred the cost of care to the consumer. (for further information see: http://www.timesunion.com/local/article/Observation-status-and-a-nasty-surprise-4106789.php)

These cases are not untypical of the current state of affairs that Medicare beneficiaries face when appealing such findings. The appeals process for Observation Status must be made a way to provide checks and balances rather than as a way to wear down consumers, transfer costs, and shirk responsibility for Part A coverage of post hospital rehab care in a SNF.

New York StateWide Senior Action Council also agrees with the policy recommendations set forth in the AARP Public Policy Institute September 2013 report to:

- **Require hospitals to provide notification to Medicare beneficiaries when they are placed under observation during their hospital stay and explain how Observation Status may affect their health insurance coverage and their out-of-pocket costs associated with outpatient care and post-acute SNF coverage.**

  The New York State Chapter 397 Observation Status Law enacted in 2013, requires hospitals to provide oral and written notice within 24 hours to Medicare beneficiaries placed under observation during their hospital stay, and explain how Observation Status may affect the patient's health insurance coverage. We applaud New York State taking this first step forward and recommend that this become a requirement in all of the States.

Written notice of OS status when it first occurs might reduce later beneficiary confusion about whether SNF care will be covered by Medicare. This required notification may spur beneficiaries to ask more questions about OS and seek assistance from local community groups.

- **Eliminate Medicare's 3-day prior stay requirement for Part A SNF coverage.**

  Medicare does not require a prior inpatient stay for coverage of services by other post-acute care providers, such as home health agencies, inpatient rehabilitation facilities, or long-term care hospitals. Medicare requirements should be consistent.

- **As long as the 3-day prior stay requirement remains in place, count all time spent in OS, as well as time as an inpatient, toward time required to qualify for SNF coverage.**

  There are identical bills (H.R. 1179 and S. 569, the Improving Access to Medicare Coverage Act of 2013) passage of which would require that all time spent in the hospital – whether called observation or inpatient – be included in calculating the three-day inpatient qualifying hospital stay.

- **Cap the total beneficiary liability for OS use at the inpatient deductible amount.**

  This proposal would limit the maximum financial burden for OS use to the amount that beneficiaries would incur for inpatient admission

- **Count OS use as an inpatient admission for purposes of the readmission reduction program.**

  This change would strengthen provider incentives to reduce avoidable readmissions and reduce potential gaming by closing a loophole that may encourage the inappropriate use of OS to avoid readmission penalties.

- **Clarify Medicare criteria for OS and inpatient admission**.

  Such clarification could reduce provider confusion and potential misuse of OS that may be associated with nonclinical considerations. As indicated in the results of a study by Dr. Sheedy, et al of observation status patients in the University of Wisconsin Hospital and Clinics that was published in the November edition of JAMA, many patients studied did not meet the guidelines for observation status. Further, that article notes, "It is uncertain what role, if any, observation status for hospitalized patients should have in the era of health care reform."

Thank you for the opportunity to comment on this important issue.

Respectfully submitted,
Maria Alvarez, Executive Director
New York StateWide Senior Action Council, Inc.

National Senior Citizens Law Center, Statement

NSCLC
National Senior Citizens Law Center
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Statement for the Record
United States House of Representatives Ways and Means Committee
Subcommittee on Health
Hearing on Current Hospital Issues in the Medicare Program
May 20, 2014

The National Senior Citizens Law Center (NSCLC) joins others in raising concerns about the impact on Medicare beneficiaries of an alarmingly common practice known as observation status. Observation status is depriving many older patients of their right to hospital coverage under Medicare Part A.[1]

Our attorneys hear from some of the over 600,000 Medicare beneficiaries[2] who receive hospital inpatient services, but are improperly classified as outpatients in observation status and, as a result, are forced to absorb hospital costs that otherwise would have been paid under Medicare Part A. In our experience, families and individuals face severe financial problems as a result of this practice.

This practice is particularly damaging to lower income older adults who are already saddled with high health care costs and should be able to trust that Medicare will cover a hospital stay. Although Medicare Part A pays for "inpatient" hospital care, Medicare beneficiaries face significantly larger co-insurance obligations under Part B which pays for outpatient medical care, including observation status care.

As importantly, in order to qualify for Medicare-covered skilled nursing facility (SNF) care, one must first have at least three days of "inpatient" Part A hospital care. Increasingly, however, hospitals are allowing patients to stay under Part B "observation status" without formally admitting them—in some cases up to 1-2 weeks. Without a formal admission, the patient is on the hook for the cost of nursing facility care. Unfortunately, the patient often does not realize the scope of his or her financial liability until months later.

Misguided payment incentives drive hospitals to observation status to avoid audits and prosecution because the federal government seeks to limit short stays in the hospital. However, observation status is only supposed to be used to assess whether a patient should receive more treatment and only for very short periods of time. NSCLC commends the bipartisan effort to protect consumers from the harm caused by this often arbitrary and overused practice, and supports the efforts of Representatives Joseph Courtney (D-CT) and Tom Latham (R-IA), and Senators Susan Collins (R-ME) and Sherrod Brown (D-OH) in sponsoring the *Improving Access to Medicare Coverage Act of 2013* (H.R.1179/S. 569).

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[1] Sharp Rise in Medicare Enrollees Being Held in Hospitals for Observation Raises Concerns about Causes and Consequences, *Health Affairs,* June 2012 31: 61251-1259.
[2] OIG, *Hospitals' Use of Observation Stays and Short Inpatient Stays for Medicare Beneficiaries,* OEI-02-12-00040, page 15 (July 29, 2013), http://oig.hhs.gov/oei/reports/oei-02-12-00040.pdf.

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National Kidney Foundation, Statement

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Testimony Submitted for the Record

National Kidney Foundation

To the House Ways and Means Committee
Subcommittee on Health

Hearing on Current Hospital Issues in the Medicare Program

May 30, 2014

Chairman Brady and Ranking Member McDermott, the National Kidney Foundation appreciates the opportunity to submit comments on H.R 4188 the "Establishing Beneficiary Equity in the Hospital Readmission Program Act," introduced by Representative Renacci as mentioned at the subcommittee hearing on May 20, 2014. NKF is America's largest and oldest health organization dedicated to the awareness, prevention, and treatment of kidney disease for hundreds of thousands of healthcare professionals, millions of patients and their families, and tens of millions of people at risk. In addition, NKF has provided evidence-based clinical practice guidelines for all stages of chronic kidney disease (CKD), since 1997 through the NKF Kidney Disease Outcomes Quality Initiative (NKF KDOQI).

This bill would exclude certain complex patients, including dialysis patients, from the Medicare hospital readmissions reduction program. People with end-stage renal disease, specifically those needing dialysis, are not an appropriate exclusion for the hospital readmissions reduction program. In fact, the hospital readmission reduction program, which currently focuses on readmissions for people with Heart Failure (HF), Acute Myocardial Infarction (AMI), pneumonia, congestive obstructive pulmonary disease (COPD), elective total hip arthroplasty (THA),and total knee arthroplasty (TKA), has spurred greater care coordination between hospitals and dialysis facilities, which can lead to improved outcomes for patients. This is particularly important for cardiovascular outcomes and infections, which are the two leading causes of hospitalizations in dialysis patents.[1] A recent study- showed that the risk of readmissions for hemodialysis patients could be reduced by 3.5 percent with just one additional, meaningful visit with their nephrology practitioners during the

[1] U.S. Renal Data System, USRDS 2013 Annual Data Report: Atlas of Chronic Kidney Disease and End-Stage Renal Disease in the United States, National Institutes of Health, National Institute of Diabetes and Digestive and Kidney Diseases, Bethesda, MD, 2013.

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month of discharge.[2] However, in order to act on this the practitioner needs to receive accurate and complete discharge information from the hospital in a timely manner.

The United States Renal Data Systems (USRDS), which is the nation's leading database of ESRD information, shows over 430,000 people with ESRD rely on dialysis to continue living. USRDS reports that on average dialysis patients are hospitalized nearly two times per year for a total stay of 11.7 days. All cause 30-day hospital readmissions for hemodialysis patients, age over 65, is around 35%, which declines after age 75 because of the increase in mortality.

In hemodialysis patients admitted to the hospital with AMI and HF the 30-day readmissions rate was 38% in 2011 (this includes patients age 0-75+, and is likely slightly lower for patients 65 and older due to the higher mortality rate). Among those readmitted after an initial cardiovascular related admit, 16.4% are readmitted for another cardiovascular issue. The percentage of hemodialysis patients admitted for pneumonia is 22.5%, and has nearly doubled in the past 20 years. These figures take into account both the primary and secondary codes listed at discharge.

Hospital readmissions are a shared responsibility. For dialysis patients, this responsibility is shared between the nephrology practitioner and the hospital. At the nephrology practitioner's disposal are also the resources of the dialysis facility. Both parties need to be accountable for acting to reduce readmissions. The practitioner must receive timely and accurate discharge information so they are aware of any medication adjustments or changes in patients' dialysis prescription that occurred while the patient was in the hospital. Since most readmissions for hemodialysis patients occur within the first seven days it is important that the nephrology practitioner receive the relevant discharge information and see the patient within the first few days of discharge to reduce the risk of readmissions. The hospital conditions of participation require that hospitals share discharge information with the patient's physician and dialysis facility. However, the required information may not encompass everything that a nephrology practitioner needs to know.[3] For example, a patient admitted for heart failure may be discharged and given a new target dry-weight that affects the patient's dialysis prescription. The nephrology practitioner and the dialysis facility need this information before the patient comes in for their dialysis treatment, otherwise they will rely on the most recent prescription they have, which can have dangerous consequences for the patient. Most hemodialysis patients will go in for their dialysis treatment within three days of their hospital

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[2] Erickson, Kevin F., et al. Physician Visits and 30-Day Hospital Readmissions in Patients Receiving Hemodialysis, JASN, 25: 2014.

[3] U.S. Centers for Medicare & Medicaid Services, Conditions of Participation: Interpretive Guidelines for 42 CFR 482.43. Discharge Planning, 2013 http://www.cms.gov/medicare/provider-enrollment-and-certification/surveycertificationgeninfo/downloads/survey-and-cert-letter-13-32.pdf.

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discharge. Under the conditions of participation the patient is permitted to take the discharge information to the dialysis facility and practitioner if it cannot be received electronically before the patient's first appointment. Not every patient will remember to give this information to their healthcare providers, so it is not as effective as a direct communication between the hospital and practitioner or facility.

The readmissions reduction program takes the requirement under the conditions of participation to the next level of care coordination by creating an additional incentive for hospitals to better coordinate with other health care providers like nephrology practitioners. As the Medicare Payment Advisory Committee stated in its June 2013 Report to Congress "… the readmission policy has pushed hospitals to look beyond their walls and improve care coordination across providers to reduce readmissions." In fact this program has spurred agreements and processes for communication between dialysis facilities, nephrology practitioners and hospitals in some areas of the country.[4] In addition, the Centers for Medicare & Medicaid Services (CMS) are already piloting a readmissions measure for dialysis facilities that is likely to be part of the ESRD Quality Incentive Program (QIP) in the near future. With both parties accountable for readmissions for dialysis patients it is likely more coordination will occur and dialysis patients will benefit dramatically. Conversely, by excluding dialysis patients from the program hospitals are likely to divert their focus and resources on care coordination from this population to other areas.

While dialysis patients are a challenging population because of multiple comorbidities, and often low socioeconomic status, action can be taken to reduce readmissions and mortality. Lives can be saved as well as dollars. One additional visit by a nephrology practitioner post hospital discharge can save an estimated $240 million per year.[5] We should not give up on these patients just because they require extra effort. We recommend rather than excluding dialysis patients from the hospital readmissions reduction program that proper risk adjustment be included in the program. Using individual hospital improvement, as is considered in the Hospital Value Based Purchasing program and in the ESRD QIP, or comparing hospitals with similar patient populations against one another would help ensure that hospitals that take care of more complex patients are not unfairly disadvantaged. This recommendation echoes that made by MEDPAC in its June 2013 report.

Thank you for your consideration of our concerns.

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[4] Discussions and presentations from the ESRD Networks Quality Conference, September 2012, presentations can be found at http://www.esrdnetworks.org/quality-conference-september-2012.
[5] Erickson, Kevin F., et al. Physician Visits and 30-Day Hospital Readmissions in Patients Receiving Hemodialysis, JASN, 25: 2014.

National Association of Urban Hospitals, Statement

NAUH
NATIONAL ASSOCIATION OF URBAN HOSPITALS

Testimony Submitted to the House Ways and Means Committee
by the
National Association of Urban Hospitals
About Current Hospital Issues in the Medicare Program
May 20, 2014

The National Association of Urban Hospitals (NAUH) appreciates the Ways and Means Committee's interest in examining perspectives about a number of hospital issues in the Medicare program, including the proposed two-midnight rule, short inpatient stays, outpatient observation stays, and audits and appeals. The nation's private, non-profit urban safety-net hospitals have special interest in another Medicare issue – Medicare DSH cuts – and appreciate the opportunity to share our perspectives on this matter with the committee today.

About the National Association of Urban Hospitals

The National Association of Urban Hospitals advocates for adequate recognition and financing of private, non- profit, urban safety-net hospitals that serve America's needy urban communities. These urban safety-net hospitals differ from other hospitals in a number of key ways: they serve communities whose residents are much older and poorer; they are far more dependent on Medicare and Medicaid for revenue; they provide far more uncompensated care; and unlike public safety-net hospitals, they have no statutory entitlement to local or state funds to underwrite their costs. NAUH's role is to ensure that when federal officials make policy decisions, they understand the implications of those decisions for these distinctive urban safety-net hospitals. NAUH pursues its mission through a combination of vigorous, informed advocacy, data-driven positions, and an energetic membership with a clear stake in the outcome of public policy debates.

The Issue: Medicare DSH Payments

Medicare disproportionate share hospital payments (Medicare DSH) are supplemental payments made only to hospitals that care for especially large numbers of low-income and uninsured patients. These hospitals suffer significant financial losses caring for these patients and Medicare DSH helps lessen those losses.

The Affordable Care Act calls for significant reductions of future Medicare DSH payments. The underlying rationale for these cuts is that because the reform law will result in millions of more Americans having health insurance, hospitals will care for fewer uninsured patients, which in turn will decrease their need for Medicare DSH.

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During the current fiscal year, Medicare has reduced Medicare DSH payments more than $500 million. Last month, the Centers for Medicare & Medicaid Services (CMS) proposed reducing them $2.1 billion in FY 2015.

Medicare DSH Cuts: Too Much, Too Soon

By definition, hospitals that qualify for Medicare DSH payments are the very providers that care for the greatest numbers of low-income, low-income elderly, and uninsured patients. Among them are the nation's private, non-profit urban safety-net hospitals, and these and other Medicare DSH recipients are ill-equipped to shoulder further Medicare DSH cuts at this time. In recent years, these hospitals have incurred, or about to incur, approximately $270 billion in reductions of their Medicare payments. These cuts include reductions in their annual cost-of-living adjustments and reduced Medicare bad debt reimbursement. They also include financial penalties through Medicare's hospital readmissions reductions and value-based purchasing programs – cuts that are now being questioned in numerous studies that suggest they are unfair to urban safety-net hospitals and others like them that care for especially large numbers of low-income patients. Finally, they continue to face across-the-board, two percent cuts in all of their Medicare payments as a result of sequestration – cuts that will last well into the next decade.

Urban safety-net hospitals and others like them are already struggling to accommodate these enormous cuts. Asking them to absorb more, in the form of further Medicare DSH cuts, could jeopardize their continued ability to provide the health care safety net their communities need and deserve.

Precedent for Delaying DSH Cuts

We believe Congress has already established a precedent for delaying reductions in DSH payments.

Specifically, twice in the past year it has voted to delay the implementation of similar Medicaid DSH cuts for a total of three years. These decisions, in our view, reflected Congress's collective judgment that these cuts were too much, too soon and that moving forward with them could jeopardize access to care in communities across the country.

NAUH believes the same is true of Medicare DSH cuts and that they, too, should be delayed to ensure that Americans have appropriate access to health care if and when they need it and to ensure that the fabric of the American health care safety net does not fray beyond repair.

Delay also is necessary because many Americans remain uninsured and will remain uninsured in the near future. A study published recently in the journal *Health Affairs*, in fact, noted that as many as 30 million people will remain uninsured and that providers' annual uncompensated care costs amounted to nearly $85 billion last year. The study also suggested that plans to reduce funding for uncompensated care by cutting Medicare DSH and Medicaid DSH payments would compromise the future ability of these providers to care for their patients regardless of those patients' ability to pay for their care.

Conclusion

Today, millions of Americans remain uninsured, and as a result, moving forward with the proposed cuts in the Medicare DSH program could hinder access to care for those who need it most – including residents of the predominantly low-income communities served by the nation's private, non-profit urban

safety-net hospitals. In hurting the hospitals that serve these patients, moreover, Medicare DSH cuts also could hurt the other patients these same hospitals serve – those covered by private insurance and those covered by Medicare.

For these reasons, the National Association of Urban Hospitals urges Congress to work in a timely manner to delay the implementation of cuts in Medicare DSH payments by supporting legislation to achieve that end.

The National Association of Urban Hospitals appreciates this opportunity to convey our views on this vital issue to the Ways and Means Committee and welcomes any questions committee members or staff may have about the issue and those views.

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Nathan Marra, Statement

Current Hospital Issues in the Medicare Program

Submitted by Nathan Marra

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My Grandfather worked his entire life to support his family. Part of his criteria when securing a job was securing healthcare for his family—including retirement healthcare for him and my Grandmother. He put in his time, retiring well after 60 years old. He paid into Medicare, and his years of service earned him retirement benefits.

Not too long after retirement, my Grandmother had a stroke. She was brought to the hospital only to have another stroke, because of inexperience on behalf of the staff working that day. More than 10 years have passed since that fateful day, and my Grandmother has been left wheelchair bound and has a difficult time with cognition.

My Grandparents are very humble, yet proud. They do not ask for help, and have a belief system that they take care of their kids, and not the other way around. My Grandfather is well into his 80's and still cares daily for my Grandmother with limited outside help. The required copayments and premiums he has been paying in retirement are not exactly cheap, but he pays them without question.

Recently, my Grandmother fell and fractured her leg, rendering her completely immobile. This same fracture would not immobilize a healthy individual, but due to her stroke and limited mobility, she cannot get into her wheelchair or bed without one hundred percent help. My Grandfather, at this stage in his life, cannot lift her whole body weight. The hospital realized this and placed her in a room on "Observation Status." Little did we know that this word would reach deep into my Grandfather's pocket. She has been in the hospital for over a month costing my Grandfather thousands of dollars. He uttered a sentence to me that nearly brought a tear to my eye. He said, "Why did I work all these years for healthcare coverage?"

It is really sad that one word, despite each individual's circumstances, can be the difference in coverage or no coverage. I just ask that the representatives of the citizens of the United States can overcome this dilemma with good common-sense action!

Thank you.

MRC, Statement

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United States House of Representatives
Committee on Ways & Means, Subcommittee on Health
Hearing on Current Hospital Issues in the Medicare Program
May 20, 2014

Chairman Brady, Ranking Member McDermott, and distinguished members of the Subcommittee on Health, I am Joe Baker, President of the Medicare Rights Center (Medicare Rights). Medicare Rights is a national, non-profit organization that works to ensure access to affordable health care for older adults and people with disabilities through counseling and advocacy, educational programs, and policy initiatives. Thank you for the opportunity to testify on current hospital issues in the Medicare program.

Medicare Rights answers 15,000 questions on our national helpline each year, serving older adults, people with disabilities, and those that help them—family caregivers, social workers, attorneys, and other service providers. Through our educational initiatives, we touch the lives of another 140,000 people with Medicare and their families. Additionally, Medicare Interactive, our online learning tool, receives approximately 1.1 million visits annually.

Problems presented by callers to the Medicare Rights helpline are varied and complex. In 2012, the most common questions heard on our helpline centered on three themes: affording basic health care costs, appealing denials of coverage, and enrolling in Medicare. In all of these areas, we see that people with Medicare lack needed support.[1]

We find that navigating a complex array of Medicare coverage rules for hospital stays can be taxing for seniors and people with disabilities. Not only are these rules confusing, their application can create real, and even catastrophic, cost burdens for people with Medicare. Our statement concerns the beneficiary impact of three policies pertaining to Medicare hospital stays, including: the growing use of observation status, allowable hospital rebilling practices, and the currently delayed "two midnights" policy.

Our Clients Are Often Burdened and Confused by Medicare's Hospital Coverage Policies:

Even some of the simpler cases we hear on the Medicare Rights helpline make clear the challenges that Medicare beneficiaries face when staying in a hospital under observation status, cases like Ms. N's.

[1] Sutton, C., Bennett, R., Sanders, S., and F. Riccardi, "Medicare Trends and Recommendations: An Analysis of 2012 Call Data from the Medicare Rights Center's National Helpline," (Medicare Rights Center: January 2014), available at: http://www.medicarerights.org/policy/priorities/2012-medicare-trends/.

Ms. N—a 68 year-old Nebraskan who lives with Multiple Sclerosis—called our helpline upon receipt of a hospital bill. In January, she had a short, two-day hospital stay. Although Ms. N was initially told she would be admitted, she was later informed that her stay would be categorized as an outpatient stay for observation. Still, Ms. N continued to receive the very same care that she would have as an inpatient, including services and tests, medications, food, and so forth. During this stay, she was not permitted to take her routine medications from the supplies she brought from home, but was given her prescriptions from the hospital pharmacy.

Several months later, Ms. N received a $200 bill for the two days of routine medication she received while in the hospital. Normally, Ms. N pays only $10 per month for the exact same prescriptions. Ms. N submitted the bill to her Part D plan, but coverage was denied because the hospital pharmacy is out-of-network. To obtain only partial recovery of her costs, she must now pursue an appeal.

Ms. N reports being deeply frustrated and confused by this situation, and she expressed feeling "taken advantage of" by the hospital, her Part D plan, and Medicare. Had Ms. N been treated as an inpatient, her prescriptions would have been covered under Part A, and the entirety of Ms. N's cost sharing would have been paid by her Medigap supplemental plan. In other words, Ms. N's hospitals bills—including the 20-fold increase in costs for her routine prescriptions—resulted solely because the hospital deemed Ms. N an outpatient as opposed to an inpatient.

Ms. N's experience was frustrating and burdensome; yet, her case includes some positive elements. First, unlike many beneficiaries that we assist, the hospital informed Ms. N of her outpatient status in a timely manner. Second, Ms. N did not did not need care from a Skilled Nursing Facility (SNF) following her hospital stay. To receive coverage for SNF care under Medicare, a beneficiary must have spent three days as a hospital inpatient, not including the day of discharge. Had Ms. N needed SNF care, her time under observation would not have counted towards this requirement.

Indeed, some of the most distressing cases heard on our helpline come from beneficiaries unable to secure Medicare coverage for post-acute SNF care. Callers to our helpline feel confused, distressed and powerless in the face of significant costs. Under federal guidelines, beneficiaries have no right to learn that they are not inpatients, no avenue to challenge the non-admission, and no control over the decision.

A Needed Coverage Fix: Counting Observation Status Towards Medicare's Three-Day Rule

Unlike Ms. N, many people with Medicare receive SNF care following a hospital stay. As noted above, days spent in a hospital under observation (essentially as an outpatient) do not count towards Medicare's three-day inpatient rule to qualify for SNF coverage. As a result, beneficiaries who spend three or more days in the hospital under observation may spend thousands of dollars on subsequent rehabilitative care.

Typically a beneficiary is placed in observation following an emergency room stay. While observation may be an appropriate clinical tool in some instances, recent studies suggest that misuse of observation

status is on the rise. Under previous Medicare guidelines, observation stays were to span more than 48 hours in only rare exceptions, but stays increasingly last longer.[2]

According to a 2012 study, the ratio of observation/outpatient to inpatient stays increased by 34 percent from 2007 to 2009—leading researchers to conclude that observation stays were being used in place of inpatient admissions. At the same time, the study concluded that observation stays of more than three days increased by 88 percent.[3] A July 2013 Office of the Inspector General (OIG) report determined that almost 618,000 beneficiaries had observation stays that lasted three nights or more in 2012.[4]

Finally, a recent AARP study concluded that the use of observation status among Medicare beneficiaries more than doubled over a nine-year period, and the duration of observation stays increased. According to AARP, "Between 2001 and 2009, median time spent under observation for all beneficiaries who received OS [observation status] increased by 29 percent, from 17 hours to 22 hours."[5]

Evidence suggests a multitude of factors contribute to hospitals' increased use of observation status and the lengthened duration of observation stays, such as changes in Medicare payment policies, heightened pressure on hospitals to reduce inpatient stays and readmissions, greater efficiencies related to how emergency departments triage care, and more.[6] While Congress and the Administration should examine and address these factors where necessary, immediate solutions are needed to mitigate the harmful impact of lengthy observation stays on people with Medicare.

Toward this end, we urge members of Congress to pass the Improving Access to Medicare Coverage Act of 2013 (H.R. 1179 and S. 569). This bipartisan bill would credit time spent in observation towards the three-day requirement for Medicare-covered skilled nursing care. The legislation would significantly lessen the severe financial consequences facing Medicare beneficiaries and families who lack Medicare coverage for needed skilled care following a hospital stay of three days or more.

Additionally, we continue to urge that hospitals be required to inform beneficiaries about their outpatient/observation status. To date, there is no such requirement. In 2013, New York State—home to the Medicare Rights Center—passed legislation to require hospitals to provide written notice to all

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[2] Zao, L., Schur, C., Kowlessar, N. and K.D. Lind, "Rapid Growth in Medicare Hospital Observation Services: What's Going On?" (AARP Public Policy Institute: September 2013), available at: http://www.aarp.org/content/dam/aarp/research/public_policy_institute/health/2013/rapid-growth-in-medicare-hospital-observation-services-AARP-ppi-health.pdf.

[3] Zhanlian, F. Wright, B. and V. Mor, "Sharp Rise In Medicare Enrollees Being Held In Hospitals For Observation Raises Concerns About Causes And Consequences," *Health Affairs* 31, No. 6 (2012)

[4] Office of the Inspector General (OIG), "Hospitals' Use of Observation Stays and Short Inpatient Stays for Medicare Beneficiaries," (July 2013), available at: http://oig.hhs.gov/oei/reports/oei-02-12-00040.asp.

[5] Zao, L., Schur, C., Kowlessar, N. and K.D. Lind, "Rapid Growth in Medicare Hospital Observation Services: What's Going On?" (AARP Public Policy Institute: September 2013), available at: http://www.aarp.org/content/dam/aarp/research/public_policy_institute/health/2013/rapid-growth-in-medicare-hospital-observation-services-AARP-ppi-health.pdf.

[6] Ibid.

patients placed under observation.[7] While this serves as an important model for other states, we believe that beneficiaries would be best served if the Medicare program implemented a similar requirement.

Similarly, there is no mechanism to allow beneficiaries to appeal or challenge a hospital's determination of their status. In essence, beneficiaries deemed outpatients who then face significant SNF costs lack appropriate recourse. Beneficiaries requiring SNF care may appeal Medicare's decision to deny payment for their rehabilitative, post-acute care, but these cases are rarely successful because they ultimately hinge on a hospital's initial determination of inpatient versus outpatient status.

Finally, we believe that CMS should take action to mitigate the use of observation services on beneficiaries' drug costs. To date, payment of outpatient hospital care does not include coverage for chronic medications. As such, coverage of routine medications falls to the beneficiary's Part D plan. As demonstrated by Ms. N's case, these prescriptions may be denied or come at a higher cost, as most hospital pharmacies are not within Part D plan networks.

At a minimum, CMS should implement rules to ensure that patients are not responsible for cost sharing above what they would pay at a regular, preferred, and in-network pharmacy. Additionally, CMS should devise a system to require Part D plans to pay hospital pharmacy claims seamlessly, without the additional paperwork, burden, and delay patients now face. We also encourage CMS to explore aligning outpatient hospital coverage rules (Part B) for chronic medications with those currently in place for inpatient care (Part A). Under Part A, routine medications are covered as part of a patient's hospital care.

Rebilling Policies Pose Financial Risks to People with Medicare:

In 2013, CMS finalized a proposal to allow hospitals to bill Part B when a Part A claim is denied because an inpatient stay was not determined to be reasonable or necessary.[8] According to CMS, this policy is intended to lessen inappropriate use of observation stays, essentially by mitigating financial risks to hospitals facing increased scrutiny with respect to inpatient (Part A) billing. While this is an important goal, we continue to believe that this policy inappropriately shifts the financial risk of denied Part A claims to the person with the least control over these costs—the beneficiary.

Under the current policy, beneficiaries will not be liable for costs incurred under a denied Part A claim. Yet, the same is not true for cost sharing associated with a hospital's subsequent billing for services under Part B. We believe there are two areas where beneficiary liability could be large, unpredictable and uncontrollable, including: (1) Part B costs and (2) Part D costs.

- **Increased Part B Costs:** Under the current policy, beneficiaries will be responsible for excluded services received in the hospital; for the difference between Part A and Part B cost sharing for covered services; and for services provided to beneficiaries who are not enrolled in Part B. This last

[7] NY Pub Health L § 2805-W (2012)
[8] Centers for Medicare & Medicaid Services (CMS), Inpatient Prospective Payment System (IPPS) 1599-F (August 2013), available at: http://www.gpo.gov/fdsys/pkg/FR-2013-08-19/pdf/2013-18956.pdf.

scenario is most dire, as we expect that these beneficiaries will be wholly liable for the cost of their hospital care. Beneficiaries in these situations should not be responsible for higher costs.

- **Increased Part D Costs.** Detailed above, Ms. N's case clearly captures the risks posed to beneficiaries who are retroactively deemed outpatients in the event of a denied Part A claim. As an inpatient, most medications are covered under Part A. Ms. N was informed of her changed status (from inpatient to observation) during her stay; yet, she was still unprepared for and confused by the resulting increased cost sharing. We expect that beneficiaries whose claims are rebilled by the hospital at a later date will find this experience even more perplexing.

  As acknowledged by CMS, most hospital pharmacies are out-of-network under most Part D plans, resulting in high cost sharing to patients. As noted above, we continue to urge that beneficiaries be shielded from higher prescription drug costs when placed under outpatient/observation status. We believe the same should be true in instances involving rebilling. We continue to urge that beneficiaries be held harmless from added costs; in particular, beneficiaries should not be denied coverage by their Part D plan, and should not be responsible for cost sharing above what they would pay at a regular, preferred and in-network pharmacy.

We acknowledge that there will be many instances where costs will be less for a beneficiary under a rebilled Part B claim than they would be under Part A, and we applaud CMS' requirement that beneficiaries are refunded by hospitals in these circumstances. We also know that associated deductibles, coinsurances, and copayments will vary under rebilling circumstances depending on a beneficiary's supplemental coverage. According to the OIG, in 2012, only six percent of beneficiaries under observation paid more than beneficiaries receiving comparable care as inpatients.[9] Nevertheless, we continue to urge that Medicare beneficiaries be held harmless in instances where associated cost sharing for care received under Part B (and by extension, Part D) is higher than under a denied Part A claim.

CMS states the agency lacks the authority to implement a hold harmless provision.[10] As such, we urge Congress to step in. At the same time, we continue to advocate for advance notice to beneficiaries about potential changes in cost sharing due to rebilling. We are grateful that CMS intends to conduct an educational campaign on this policy, but we do not believe this campaign will be sufficient. Retroactive increases in Part B or Part D—occurring many months after a hospital discharge—will not only be confusing and troubling for beneficiaries, but may also be unaffordable for many.

"Two Midnights" Policy is Arbitrarily Derived; A Clinical Solution is Needed:

Also in 2013, CMS finalized the "two midnights" standard, intended to alleviate the growing problem of the impact of observation status on Medicare beneficiaries. Under the final policy, beneficiaries staying

[9] Office of the Inspector General (OIG), "Hospitals' Use of Observation Stays and Short Inpatient Stays for Medicare Beneficiaries," (July 2013), available at: http://oig.hhs.gov/oei/reports/oei-02-12-00040.asp.
[10] Centers for Medicare & Medicaid Services (CMS), Inpatient Prospective Payment System (IPPS) 1599-F (August 2013), available at: http://www.gpo.gov/fdsys/pkg/FR-2013-08-19/pdf/2013-18956.pdf.

less than two midnights in a hospital (with some exceptions) are to be considered outpatients in observation status, and beneficiaries staying two midnights or more are to be considered inpatients.[11] Rather than basing patient status on health care needs and clinically determined standards, the rule makes time-based presumptions about needed care.

We remain concerned that the final policy fails to clarify coverage rules or improve care for people with Medicare. According to recent research, under the "two midnight" rule, a beneficiary's status as an inpatient or outpatient will ultimately be determined by the time of day that a patient presents symptoms, as opposed to medical need.[12] As such, we do not believe the "two midnights" policy facilitates transparent communications by hospitals and health care providers to beneficiaries about their status and cost sharing responsibilities.

Select enforcement efforts related to the "two midnights" rule are delayed through March 31, 2015.[13] In the interim, we continue to urge that CMS reach out to both beneficiaries and especially clinicians, who are experienced in emergency medicine, geriatrics, and inpatient hospital care, to advise on how policies related to observation status can be modified or altered to better address beneficiaries' needs.

Conclusion:

In sum, as reflected by the experiences shared by callers to the Medicare Rights helpline, much can be done to improve policies concerning hospital stays for older adults and people with disabilities. First and foremost, we urge Congress to pass H.R. 1179 and S. 569—to count time spent in observation status towards post-acute Medicare coverage for skilled nursing care. In addition to this legislation, reforms are needed to improve beneficiary notice and appeals related to observation status as well as to ease the burden of higher cost sharing for routine medicines administered during outpatient hospital stays.

We also urge Congress and CMS to revisit the agency's current policies related to beneficiary liability for hospital rebilling of denied Part A claims. We firmly believe that people with Medicare should be held harmless from higher cost sharing associated with hospital rebilling that occurs months following a hospital discharge. Last, we continue to believe that the time-based, arbitrarily defined "two midnights" rule for assessing patient status is flawed. We continue to hope that CMS will adopt a clinically relevant solution to facilitate patients' best interests.

Thank you for the opportunity to testify.

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[11] Ibid.
[12] Sheehy, A., "Testimony before the United States Committee on Ways and Means, Subcommittee on Health: Current Hospital Issues in the Medicare Program," (Society of Hospital Medicine: May 2014), available at: http://waysandmeans.house.gov/uploadedfiles/052014_sheehy_testimony_final_hl.pdf.
[13] Protecting Access to Medicare Act of 2014 §111, Pub. L. 113-93.

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Missouri Hospital Association, Letter

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June 3, 2014

Subcommittee on Health
House Ways and Means Committee
1100 Longworth House Office Building
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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

dl/cml

Meridian Health, Letter

May 30, 2014

Dear Honorable Chairman Brady:

Meridian Health welcomes this opportunity to advance our thoughts on how a short stay payment methodology could be designed. Meridian Health is a leading not-for-profit health care organization in New Jersey, comprised of Jersey Shore University Medical Center and K. Hovnanian Children's Hospital in Neptune, Ocean Medical Center in Brick, Riverview Medical Center in Red Bank, Southern Ocean Medical Center in Manahawkin and Bayshore Community Hospital in Holmdel.

As we have all come to experience, the inpatient short stay admission and observation patient classifications have created great difficulties among all key stakeholders including CMS, hospital providers, and most importantly, our senior citizens. The administrative burden placed on healthcare providers and CMS to administer this new "observation patient" status has been significant. The subsequent audit of these cases by the Recovery Audit Contractors (RAC) has proven to be expensive and has added an additional layer of overhead on healthcare providers to satisfy the audit requirements and to successfully appeal many of the audit determinations. The clinical decision by a physician as to what is best for a patient has become secondary to the length of time a patient spends in an acute care bed.

The additional cost burden on beneficiaries is also significant. We are learning that an increasing number of Medicare beneficiaries are requesting not to be placed in observation because of the potential for them to be responsible for more of the costs as opposed to an inpatient stay. The arbitrary determination of what constitutes an inpatient stay from an observation does not make sense to Medicare beneficiaries and only serves to confuse and concern them as to how care will be administered and what the cost of that care will be to them. It's time to redesign the regulations and payment methodologies to protect our seniors before this problem escalates and creates a patient safety issue.

We recommend eliminating in its entirety the observation payment category and replace it with a brand new reimbursement category called "*Inpatient Short Stay*". There could be a number of ways to calculate and implement a short stay payment category. We suggest designing a payment system similar to the existing Transfer Diagnostic Related Group (DRG) payment methodology, which should have minimal administrative burden to establish since the methodology is already being utilized by CMS. Although Transfer cases and the proposed Inpatient Short Stay are unique topics, the mechanics utilized to calculate the reimbursement for a Transfer DRG could easily be employed in determining the reimbursement for an Inpatient Short Stay.

In short, we recommend the following guiding principles:

- Patients staying less than 48 hours will be considered an "*Inpatient Short Stay*", with the exception of cases resulting in death, against medical advice, and cases categorized on the Medicare "inpatient only" list.

- An Inpatient Short Stay Payment System should utilize the existing inpatient Diagnostic Related Group (DRG) structure to place a patient into a classification.

- The payment will be determined by dividing the appropriate IPPS full rate by the geometric mean length of stay for the specific DRG under which the patient was treated.

- Enhance the value of day one's per diem similar to the payment methodology used for Transfer DRGs, which is two times the straight calculated per diem rate. The first day of any stay, whether it is a long or short stay, is always the most intensive in terms of the utilization of resources consumed.

- Example Calculation:
  - DRG 103: "Headaches without a MCC"
  - Assigned Geometric Mean for DRG 103 is 2.3 Days.
  - IPPS calculated full inpatient rate is $5,356.31 (this will be different for each hospital)
  - Straight Line Per Diem Based on the Geometric Mean = $2,328.83
  - First Day of Stay needs to be a graduated per diem rate from straight line to account for the resources consumed.

- A patient staying greater than 48 hours will be categorized as a regular inpatient stay and the full DRG reimbursement rate would be applied.

We strongly believe this new proposed system will increase patient satisfaction scores, reduce the administrative burdens on both CMS and healthcare providers and create a more consistent and improved reimbursement system for all Medicare beneficiaries. In addition, tax payer dollars spent on Recovery Audit Contractors (RACs) should be significantly reduced and can be redirected to support the *"Inpatient Short Stay"* program.

We would welcome any questions or the opportunity to discuss any additional information that you may need to set this course. We are committed to working with you to create a better system for the well being of all stakeholders. Thank you.

Sincerely yours,

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Medicare Advocacy Project, Statement

Medicare Advocacy Project
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June 2, 2014

Committee on Ways and Means

Re: Current Hospital Issues in the Medicare Program

The Medicare Advocacy Project (MAP) of Greater Boston Legal Services represents Massachusetts Medicare beneficiaries to insure that they receive the Medicare and Medicare-related health insurance coverage to which they are entitled. On behalf of our clients, most of whom have low incomes, we appreciate the opportunity to submit comments to your committee on current hospital issues in the Medicare program, specifically regarding the ongoing problem of observation status.

Many Massachusetts Medicare beneficiaries have sought our assistance due to the adverse impact they have experienced from having their time spent in hospitals classified as receiving observation, rather than inpatient, services. We are well aware of the increasing utilization of observation and of its adverse impact on Medicare beneficiaries. From the standpoint of our clients, attention to this problem has been long awaited and is long overdue. Classification as an outpatient precludes meeting the three day hospital admission prerequisite for Medicare skilled nursing facility coverage and costs many beneficiaries the full costs of skilled nursing facility care which can be thousands of dollars.

Unfortunately, because of the lack of due process rights afforded these hospitalized beneficiaries, who do not receive written notice about their categorization and have no appeal route for challenging this status, we have so far not been successful in obtaining for these beneficiaries the Medicare coverage to which they would otherwise be entitled. We have tried to appeal the Part B coverage awarded for their hospital services, saying the services should have been covered by Part A, but most of the contractors refuse to consider such an appeal.

Detailed below are examples of some of the Massachusetts Medicare beneficiaries the Medicare Advocacy Project is attempting to assist in challenging their hospitalization characterization as outpatient observation rather than as inpatient. Each of these beneficiaries was in a hospital room for at least three consecutive nights and received care that appeared to merit inpatient

hospitalization followed by inpatient skilled care.

Harold E, age 91, was admitted to Beth Israel Deaconess (BID) Medical Center on March 28, 2013, for open repair of recurrent left inguinal hernia. Prior to entering the hospital, he had been working part-time. Mr. E's medical history included prostate cancer, complicated by radiation proctitis. According to the hospital discharge summary, following surgery, he was admitted to the Acute Care service for pain management. A Foley catheter had been inserted during surgery, Mr. E had difficulty urinating after it was discontinued, and a Foley was reinserted after an unsuccessful trial of Lomax. On March 31, 2013, he experienced hematuria, most likely secondary to Foley placement. There was also concern about a possible blood clot obstruction. An April 1, 2013, Case Management Continued Stay review stated that per rounds that morning, it had been projected that he would likely be medically cleared to discharge on April 2 and no longer require acute care hospitalization and also stated, without any notification to Mr. E, that he was currently in observation level of care. However, April 1, 2013, Patient Notes report increasingly red urine and discharge plans were placed on hold. On April 2, 2013, Case Management Continued Stay review stated that Mr. E had been medically cleared that day to be discharged from the acute care setting. The Foley catheter was still in place at discharge. Throughout his hospitalization he received physical therapy services and he was discharged home on April 2, 2013, with a referral for Visiting Nurse Association skilled nursing and physical therapy services. Throughout the hospitalization, as well as on discharge, Mr. E had difficulty ambulating and was considered to be at risk for falling. His mental status was impaired and he underestimated or forgot his limitations. On April 4, 2013, Mr. E returned to BID Medical Center due to nausea and vomiting. His Foley catheter was still in place. His previous BID Medical Center hospital course was characterized in the record as complicated by urinary retention, with traumatic Foley placement resulting in hematuria with clots. Admission to medicine was recommended, fluid was administered through his veins and medication to treat his nausea was provided. An admission chest x-ray revealed fluid retention in the left lower lung. The fluid was drained through a tube on April 6, 2013, but re-accumulated and the possibility of pneumonia could not be ruled out. Blood was noted in the Foley on April 8, 2013; and Mr. E experienced difficulty voiding. In fact, the April 8, 2013, Progress Notes expresses a need for close monitoring to see if clots form or hematuria worsen and transfusion and/or a urology consult are needed. In total, Mr. E's diagnoses for this hospitalization included viral gastritis, pleural effusion, urinary retention and pneumonia, a hospital stay that was complicated by a loculated pleural effusion necessitating treatment with a chest tube and bloody urine. Mr. E was also seen by physical therapy during this hospitalization. On April 10, 2013, Foley catheter still in place, he was discharged from the hospital and admitted to a skilled nursing and rehabilitation facility where he remained until June 6, 2013, and received daily skilled care. However, because both his admissions were billed as observation, he was denied Medicare coverage for his $266/day April 10 to June 6, 2013, nursing home stay, totaling $17,556.

Ann G, age 83, who lives alone, fell inside her home and bumped her head on Friday morning, February 8, 2013, and was taken by ambulance to the BID Hospital/Milton Emergency Room (ER). She arrived at the ER at approximately 11:00 a.m. Hospital personnel ordered a CT scan, which came back clean, followed by a pelvic x-ray, which revealed fractures in two places. They then brought her to a room on the second floor and as far as she knew she had been admitted to the hospital. Not until just prior to her discharge did she learn that although she had been "admitted," the admission was for observation/outpatient, rather than inpatient, status. She was neither informed about nor aware of the distinction nor its ramifications. It is possible,

given that the assessment of Ms. G's admission status was done by a physician consulting from a remote site, (Executive Health Resources in Pennsylvania.) the fact that the CT scan was read first and came back showing no apparent head, neck or spine injury led the physician, on seeing only that image, to make his "outpatient/observation" determination, unaware that subsequent images revealed two pelvic fractures. While the record indicates that the pelvic fractures might have been old injuries, in fact Ms. G has never previously had a fractured pelvis, and any injuries showing on the x-ray were new injuries in need of immediate attention. Ms. G was not only told, however, that surgery for her fractured pelvis was not an option, but also that her pain medication options were Percocet, Ultram, and Tylenol, all in pill form. This was despite the fact that the orthopedic surgeon called in for consultation while Ms. G was in the ER, had ordered IV pain medication (Tramadol) to be administered, as needed. Ms. G would have accepted this medication if it had been offered and would have requested it had she had known it had been ordered. Although she did report being comfortable when lying perfectly still, straight, and flat; she consistently described her pain level as 8 or 9 on a scale of 1-10 with even the slightest movement of her lower body; and she never reported her pain level as 4, as the record incorrectly indicates. Ms. G's medical history includes asthma, a lobectomy and radiation due to lung cancer in 2007 with a resulting diagnosis of bronchiectasis, a paralyzed vocal cord which was treated surgically in May 2012 in a (failed) attempt to restore her ability to speak, a tracheostomy in 2012, and diabetes. Because of the fractured pelvis, physical and/or occupational therapists visited Ms. G at least twice during her hospitalization. The services they provided, which included monitoring, supervising and actively facilitating getting her out of bed safely, walking her a few steps, and then safely returning her to bed, are outside the realm of care provided under observation. In addition, Ms. G has diabetes which she treats with glipizide in pill form on a daily basis to control her blood sugar. While in the hospital, her diabetes control regimen was changed, however, to include multiple daily insulin injections. This was not a medical treatment she was trained to provide on her own at home and was also outside the realm of care provided under observation. Ms. G remained in the same hospital bed during her entire 5-day (Friday to Tuesday) stay. The first time a social worker mentioned her status being observation versus inpatient was on Monday afternoon, February 11, when orally informing her that "Because you're observation and not inpatient, Medicare will not cover the room and board charge" at the selected rehabilitation facility. In the context of and prior to the provision of her actual medical care she was never so informed. Neither did she ever receive anything in writing. After arriving at the BID Hospital/Milton ER on Friday, February 8, 2013, subsequent to falling at home, she clearly required more intervention than mere observation and was not ready to be transported to a rehabilitation facility until Tuesday, February 12th, the fifth day after she was brought to the ER. She remained at the rehabilitation facility until February 28, 2013, where she received daily skilled care. However, because her admission was billed as observation, she was denied Medicare coverage for her $418/day February 12-28, 2013, nursing home stay, totaling $7,106.

Sylvia G, age 87, who lives alone, entered North Shore Medical Center on 10/29/12 via the emergency room after falling at home due to dizziness that she reported to the examining physicians in the Emergency Department. An X-ray was taken and she was found to have a fracture of her Left shoulder as a result of this fall. The emergency department physician noted in his report that there was a need for further work-up and treatment in the hospital; that the reason for her dizziness should be evaluated. He also wrote that her condition was new, serious, that she should be admitted to the hospital, and he wrote in her record that "she is a full admission" and she remained hospitalized until 11/01/2012. During her stay she was given IV fluids, a Foley

catheter was inserted, and one of her medications, Amlodipine, was discontinued because it was thought that it lowered her blood pressure too much and may have contributed to her dizziness. Ms. G's diagnoses included hypertension, hypercholesterolemia, mild pulmonary hypertension, and a mitral valve leak. Her past medical history included torticollis of her neck for which she receives Botox injections every four months to prevent her neck from twisting to the right; a left ankle fracture in June 1992 with ORIF; two incidences of breast cancer in her left breast which resulted in a November, 2005, mastectomy; spinal arthritis and sciatica pain; a hysterectomy; and complaints to her primary care physician of feeling "off balance" during windy weather. During her hospitalization, she was unable to get in and out of bed or ambulate independently. She received PT and OT evaluations while in the hospital and notes in the record state that she was only able to walk a distance of 10 feet and would "continue to benefit from skilled PT services to determine the most appropriate assistive device and increase functional mobility and safety". The occupational therapist recommended short term rehabilitation to address maximal independence with self-care and mobility. In accordance with these recommendations, Ms. G went from the hospital to a skilled nursing and rehabilitation facility where she required and received daily skilled care and where she remained until December 12, 2012. However, because her hospitalization had been characterized as outpatient observation, rather than inpatient, her stay was not covered by Medicare and she was required to pay $355/day, or $10,650.

James B, age 87, who lives alone, slipped at home and entered Beverly Hospital on November 26, 2013, via the emergency room. He has one paralyzed arm and fell on and injured the other arm and shoulder. His past medical history includes hypertension, hyperlipidemia, gout, macular degeneration, prostate issue, heard of hearing and balance disorder. The medical records reflect that he was experiencing significant discomfort and although x-rays did not show any obvious dislocation, a fracture could not be excluded. He was admitted to the hospital with a diagnosis of an acute shoulder injury with possible fracture and intractable pain. He remained in the hospital for three days where he received IV morphine and was evaluated for physical therapy and was then discharged to a skilled nursing and rehabilitation facility where he remained until January 28, 2014, and received daily skilled therapy. The admitting physician wrote that he would be admitted to observation and is expected to stay less than two midnights in the hospital He, in fact remained in the hospital more than two midnights, and was not discharged until November 29, 2013. However, because his admission had been classified as observation he was denied Medicare coverage for his $365/day November 29, 2013 to January 28, 2014, nursing home stay, totaling $21,900.

Richard S, age 78, arrived at the Newton Wellesley Hospital emergency room on May 6, 2013. He had fallen twice the previous night, was having visual hallucinations, was dizzy and, according to his spouse, was disoriented. He complained of diarrhea and urinary incontinence and was too unsteady to ambulate. His past medical history included coronary artery disease, hyperlipidemia and hypertension. He was "admitted" to the hospital where he remained until May 9, 2013. While there, a CT scan and IV therapy for hydration were performed and he was seen in consultation with neurology who was concerned about normal pressure hydrocephalus and recommended a large volume spinal tap to evaluate for gait disturbance. Because the spinal tap did not improve Mr. S's walking normal pressure hydrocephalus seemed less likely and that his symptoms were more related to Lewy body dementia with some Parkinsonism features. He was also evaluated for and received physical and occupational therapy services. The neurologist and therapists recommended transfer to a rehabilitation facility for further assessment and therapy services and on May 9, 2013, Mr. S transferred to a skilled nursing facility. He

remained at this facility, where he required and received daily skilled care, until May 23, 2013, where, because his admission had been categorized as outpatient observation, he was required to pay $266/day, or $5,852.

Ruth D, age 90, who lives at home with her elderly husband, entered North Shore Medical Center on April 15, 2012, after falling at home and hitting her head. She was in pain; was unable to ambulate, despite her use of a walker; and an x-ray done in the emergency room revealed a fractured shoulder. Her past medical history included diabetes, myocardial infarction, breast cancer, chronic acquired lymphedema, hyperlipidemia, hypertension, stasis dermatitis, A Fib on Coumadin, diabetic retinopathy, cellulitis, osteoarthritis, GI hemorrhage, pneumonia, diastolic CHF, cystitis, hypoglycemia, edema, and dehydration. The hospital plan was for admission to the medical service due to her need of rehab given her need to use a walker, admission was ordered on 4/15/2012, therapy services were ordered and provided, and she remained as a hospital inpatient until 4/19/2012. Following her hospitalization she went to a skilled nursing and rehabilitation facility where she remained until July 10, 2012, and received daily skilled therapy. Based on her fractured shoulder and need for a walker, the potential for an adverse event happening and her need for 24 hour access to a physician in case of a possible head fracture, inpatient hospitalization from April 15-19, 2012, was appropriate. However, because her admission was billed as observation, she was denied Medicare coverage for her $395/day April 19 to July 11, 2012, nursing home stay, totaling $32,390.

On behalf of the above described Medicare beneficiaries, as well as the multitude of other beneficiaries adversely impacted by the increasing practice of hospitals to admit Medicare beneficiaries to outpatient observation, rather than inpatient, status we therefore ask that congress ideally eliminate the three day prior inpatient prerequisite for obtaining Medicare skilled nursing facility coverage but, if not, pass H.R. 1179 and S. 569 which would allow days spent as "observation outpatients" to count towards this three-day prior hospitalization prerequisite. We also appreciate your consideration of this important issue and thank you again for providing us with an opportunity to submit comments.

Very truly yours,

Diane F. Paulson
Senior Attorney

Marion P. Cunningham, Statement

Marion P. Cunningham, age 99, fell in her bathroom at Callista Court (an assisted living facility) in the early morning hours of December 27, 2013. She was in extreme pain, was transported by ambulance to Winona Health Hospital in Winona, Minnesota and admitted and classified as "observational status." Ms. Cunningham was not discharged until December 30, 2013 remaining in the hospital for three plus days which included three midnight stays.

Resulting from the fall, Ms. Cunningham had a laceration over her right eye, heavy bruising over the right side of her face and severe right shoulder pain. Following diagnostic procedures, she was diagnosed as having a fracture of the proximal head of the right humerus (broken shoulder), soft tissue damage to the right side of her face and a laceration over her right eye.

The laceration required stitches, a sling was applied to the fractured arm/shoulder and pain medication was provided. In addition, Ms. Cunningham received intravenous fluid and a urinary indwelling catheter for the duration of time spent at the hospital. She was housed in a private room on a floor unit with patients who had an "admission status" and her care was indistinguishable from that of patients with "admission status."

Secondary to profound pain and inability to bear weight on her right arm, Ms. Cunningham had a significant change in her mobility status. She was no longer able to use her walker due to loss of her right hand/arm usage. She required maximum assistance from staff for turning in bed, transfers to wheelchair and all activities of daily living such as bathing, eating, and dressing.

Ms. Cunningham is a very frail woman with other health problems. In December 2012 she developed shingles on the right side of her face and head resulting in ongoing pain due to herpetic neuropathy. She has poor vision with macular degeneration, is hearing impaired and her dementia was exacerbated by the trauma, pain and pain medications.

She received the same services of "admissions status" due to many complex issues: severity of the trauma, her cognitive status, her complete immobility including moving herself in bed and her advanced age. Because of her advanced age, her case lacked medical predictability in that she had to be monitored closely for complications post trauma and for her response to new medications especially with regard to pain management.

At the time of hospital discharge, Ms. Cunningham needed, in addition to the order for Physical and Occupational therapy, skilled nursing care. A total picture of her co-morbidity needed to be taken into consideration for the care required necessary for her to return to pre-accident health status.

At discharge, "observation status" during her three day hospitalization did not qualify Ms. Cunningham for Medicare coverage of the needed post-acute care in a skilled nursing facility. This is a denial of an entitled Medicare benefit.

Knollwood Retirement Community, Statement

Knollwood Residents' Association

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Knollwood Retirement Community
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May 30, 2014

Statement for Hearing on
Current Hospital Issues in the Medicare Program
By the Health Subcommittee of the House Committee on Ways and Means

A major problem for senior residents who live in retirement communities and their families arises from the application of Medicare regulations to coverage of care in skilled nursing facilities.

When a patient is in a hospital, a doctor at the hospital determines whether he or she is there in either observation status or inpatient status. Although care provided for "outpatients" can be essentially the same as care for "inpatients," the implications of outpatient status for Medicare beneficiaries are significant. Outpatient costs are not covered by Medicare Part A. Most important, when a patient leaves a hospital after an outpatient stay, medically necessary follow-up care in a skilled nursing facility (SNF) is not covered. A patient must have three or more consecutive days as an inpatient for subsequent SNF care to be covered. If a patient's stay is classified outpatient, that status can continue, no matter what services are provided or how many days he or she remains hospitalized. If a patient's status is changed to inpatient, the three day requirement is counted from the date the status is changed and does not include the original days in outpatient status.

Seniors and their families have already been affected. At typical SNF daily costs of $200 or more, the effect can be catastrophic; and, yet, their gap in coverage is not widely understood.

If Medicare does not cover SNF care, neither will a Medigap policy. Those policies are designed to supplement authorized Medicare payments. Further, if a patient has private long term care coverage, the policy is likely to have an elimination period designed to take advantage of the 100 day Medicare coverage for SNF care. Even if the patient has purchased this kind of expensive private protection, 100 days of SNF will likely not be covered.

Previously, the status of a patient's stay was based on his own doctor's evaluation and the Medicare guideline that a stay must be 24 hours to have the inpatient status. The number of stays classified as outpatient has increased dramatically in recent years, likely under pressure for hospitals and other providers to reduce Medicare costs.

Medicare has implemented rule changes that require an admitting order for inpatient care. It must be furnished by a hospitalist, a doctor who is responsible for the patient's care at the hospital. That physician must determine that the patient is expected to be in the hospital for three days and must document the factors used to support that expectation. This presents increased uncertainties for patients:

- The new rule bases status on timing rather than medical necessity and increases the time required for a stay to be presumed inpatient.
- The physician's order will be given consideration by Medicare, but is not determinative. THE DETERMINATION MADE ON ADMITTANCE COULD THEN BE REVERSED BY MEDICARE REVIEWERS.
- The physician writing the order is not the patient's physician, who is familiar with the patient and his history, but instead is a hospitalist employed by the hospital.

The new rule has made a bad situation worse. **We urge you to adopt the Improving Access to Medicare Coverage Act of 2013 (House of Representatives H.R. 1179, Senate S. 569).** IT WOULD AMEND THE LAW TO SPECIFY THAT TIME RECEIVING HOSPITAL SERVICES IN OBSERVATION STATUS WILL COUNT TOWARD SATISFYING THE 3 DAYS OF INPATIENT SERVICES REQUIRED FOR MEDICARE COVERAGE OF SNF CARE.

Respectfully yours,,

Mary Popper, President
Knollwood Residents Association
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Kirkland Senior Council, Statement

CITY OF KIRKLAND
SENIOR COUNCIL

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June 2, 2014

To: Waysandmeans.submissions@mail.house.gov

Re: Hearing "Current Hospital Issues in the Medicare Program"

We are writing you on behalf of the Kirkland Senior Council and Bellevue Network on Aging regarding the critical problems and confusion created by the extensive use of Observation Status for our Medicare seniors. As advisory groups established by Kirkland and Bellevue, we study, review, evaluate, and make recommendations on matters affecting older adults in our respective jurisdictions.

We are concerned about the increasing use of observation status and the burden it places on Medicare beneficiaries. No matter the length of stay in the hospital, without a three night inpatient stay, frequently needed Skilled Nursing Facility (SNF) follow-up is the private pay responsibility of the individual. Moreover, a patient on observation status is assessed the co-pays for each procedure or test while in the hospital even though an inpatient in an adjacent bed receiving the same tests, will have them covered by Medicare. In addition, while Medicare generally pays for all medications of hospital inpatients, patients under observation status often face large bills due to lack of Part D coverage, rejection of coverage by their pharmacy plan, required co-pays and/or the high rate of medication charges by the hospital pharmacies.

Our area hospitals are expressing their frustration that patients are confused and angry at the hospitals. The hospitals believe in many cases they have no choice but to classify patients as observation status because of the possible accusation of fraudulent admissions, the extraordinary costs they face with the recovery audit contractor (RAC) system, and their desire and need to maintain patient care and patient satisfaction standards.

The Kirkland Senior Council and Bellevue Network on Aging have discovered numerous cases of hardship and confusion experienced in the observation system. We are seeing numerous incidents where patients return home after an observation stay only to be returned to the emergency department or require hospital readmission multiple times. One patient was recently sent to the Emergency Department six times and placed on observation for short stays before being admitted as an inpatient for three nights and then sent to a SNF.

The following are three recent cases that demonstrate some of the problems we have encountered:

1. On November 3, 2013 a 100 year old female fell and was admitted late evening to the hospital with a fractured pelvis. She was initially conservatively classified as observation status, awaiting assessment by the Utilization Review staff, who the next morning determined she qualified for inpatient status. After a three night stay at the hospital, a social worker arranged for Medicare-covered discharge to a SNF on November 6. Only after several days at the SNF was the patient advised the first night hospital admission was on observation status. By the time this confusion was discovered, she had incurred SNF expenses in excess of $20,000. Patient was then moved to a lesser cost setting. She has now applied for Medicaid coverage because of the extraordinary expenses draining her funds.

2. In May 2013 a 73 year old female went to the hospital with severe confusion. The medical team initially thought patient was psychotic but after testing determined she had a stroke causing right-sided weakness. She had a history of TIAs and diabetes. She had been hospitalized for five days when the hospital social worker discussed discharge plans recommending a SNF stay for PT, OT and speech therapies. At that time the patient was advised she had been in observation status the entire five days and would have to pay privately at the SNF. She was transferred to a local SNF where she exhausted her savings.

3. On October 25, 2013 an 89 year old female was transported by ambulance to an Emergency Department after a fall. When the daughter arrived at 11:30 p.m. the patient was in a treatment room. Medical staff advised she likely had a hip fracture and were waiting for X-rays. She was operated on the next morning and discharged to a SNF on Monday, October 28 after a three-night hospital stay. She was discharged from the SNF on January 2. At no time was any mention made at either the hospital or the SNF that she had not met the Medicare eligibility requirement. In February she was advised Medicare had denied coverage because her first late night treatment at the hospital was observation status. The hospital administration admitted errors were made but stated they were unable to make a change in the admission status. The patient's out-of-pocket expenses at the SNF exceeded $40,000. After exhausting all remedies with the hospital and SNF, an appeal was sent to Noridian.

We recommend passage of HR 1179/S 569 to allow all nights of an observation patient's hospital stay count toward SNF stay when necessary for safe patient care.. Elimination of the three day inpatient requirement in order to receive SNF care would also solve the problem. While these bills do not address all problems created by observation status, they certainly address a major need for appropriate medical care for our Medicare seniors.

Thank you for the opportunity to express our concern about the impact of observation status.

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Karen L. Buckley, Letter

Karen Buckley

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"Current Hospital Issues in Medicare Program"

Dear Members of The Committee on Ways and Means,

In June of 2013 my mother, Jean Buckley, was placed under observation during two separate acute care hospital encounters at Barnes-Jewish Hospital in St. Louis, MO. Prior to these experiences, our family had no knowledge of the practice of placing Medicare beneficiaries on observation status, we simply trusted Barnes Hospital and their mission.

My mother is a senior citizen on Medicare, who suffers from debilitating Rheumatoid Arthritis and has a history of contracting stubborn bacterial infections. Many of these infections have been treated at Barnes and are documented in her EMR (dating back to 2009). She is classified as a high risk patient due to the nature of her disease. I have been alongside my mother during her illnesses and know the signs and symptoms well – June of 2013 was no different. During the first hospitalization we were informed of her switch to observation status on the fourth day of her fifth day stay. Up to that point we were talking with the social workers about which SNF to send her to for skilled nursing care and rehab following her UTI that had led to septicemia. Now we were panicking about how to take care of her at home as she would not qualify for a SNF stay due to the change in status. My mother was not well enough or strong enough to go home, yet that is what happened. She was discharged with antibiotics and an order for home care.

Less than 72 hours after being released my mother's condition had gotten so bad we had her taken back to Barnes ER. She had a fever of 104.5 and numerous other symptoms all related to septicemia. She was admitted on Friday for round two of her stay at Barnes – Jewish Hospital. This time our family was better prepared. I found the Medicare Advocacy Group online and was put in touch with Toby Edelman. With her guidance, my family thwarted the hospital administration's attempt to put my mother under observation after 5 days in acute care. Social workers and their supervisors used all kinds of tactics in an attempt to have my mother sign discharge papers – cajoling, frequent visits, even threats. We never left my mother alone during administration hours and refused to leave the hospital – it was a vigil. She was still in fragile health. The stress that the administration staff was putting my mother through certainly did not help the situation or my mother's health. I remember one particular social worker yelling at my mother, "You will not get access to your Medicare Part A and you will not go to a skilled nursing facility for care!" I kicked her out of the room after that! Thank goodness for the seasoned and compassionate medical team attending to my mother, especially her attending physician and second shift nurse; they were completely supportive. The entire time I kept in mind Toby Edelman's words, "Nothing should interfere with delivery of healthcare to the Medicare Beneficiary". Our family stayed on course and on the seventh day a social worker informed us my mother had been switched to inpatient status. A few days later she was discharged to a SNF where she stayed for over a 5 weeks of medical care and rehab following septicemia.

Had we not been there to protect and advocate for my mother I don't know how she would have survived. I am very thankful to The Medicare Advocacy Group and the wonderful medical team during her second encounter at Barnes. Please tell me how a sick senior citizen in the hospital would be able to navigate the crazy system that Barnes-Jewish Hospital puts its patients through. And where in all of this mess is their mission statement as an organization – "To take exceptional care of all people". We will never bring her or any family member there again for medical care.

I urge you to examine the way observation status is being over used and against its intended purpose by hospitals across the country. Medicare Beneficiaries are suffering as hospitals dodge accountability in relation to readmission rates and their financial reimbursements. Please limit the use of observation status to a more defined meaning and have hospitals follow better guidelines. Our Medicare Beneficiaries have earned the right to healthcare and they deserve access to it.

Respectfully,

Karen L. Buckley

Gundersen Health System, Letter

GUNDERSEN
HEALTH SYSTEM®

June 3, 2014

The Honorable Kevin Brady
Chair, House Ways and Means Subcommittee on Health
United States House of Representatives
1100 Longworth House Office Building
Washington, DC 20515-4903

Re: Hearing on Current Hospital Issues in the Medicare Program

Dear Chairman Brady and members of the House Ways and Means Subcommittee on Health:

On behalf of Gundersen Health System, we appreciate this opportunity to provide comments on current issues facing hospitals in the Medicare program. Specifically, our comments will focus on the time-based presumption policy, the Medicare Recovery Audit Contractor (RAC) program. We would also like to offer comments regarding proposed policies released on December 6, 2013 relating to Medicare Part D and Hospice covered medications. We are concerned about changes affecting our terminally ill patients and the scenarios we will need to present to them and their families that should not be a factor in their decisions on whether to utilize hospice services.

Gundersen Health System provides integrated care for patients along the rural Mississippi River stretches in western Wisconsin, northeast Iowa, and southeast Minnesota. As the largest employer in the La Crosse, Wisconsin region, Gundersen provides clinical services, level II trauma care, medical education along with ground ambulance services, med link air transport, and a five-star rated Medicare Advantage insurance plan for the past three years. We are also the largest regional employer with over 6,000 employees. Moreover, Gundersen has consistently achieved top national rankings in many areas of clinical excellence including named as a Healthgrades Top 100 hospital in overall care and many specialty areas.

Our approach to care is value-based. Gundersen Health System strongly supports public policies that moves away from volume-based care to one that rewards value-based care—high quality at low cost. In supporting this approach, a Medicare Payment and Advisory Commission (MedPAC) study found the La Crosse, Wisconsin region to have the *lowest utilization* of Medicare services per beneficiary *in the nation*. This demonstrates our efficiency in caring for our Medicare patients, coupled with our quality outcomes, makes us a provider of high value care.

Time-based presumption policy

Although the Centers for Medicare and Medicaid Services (CMS) issued and finalized a "time-based presumption" policy aimed at clarifying the necessity of inpatient stays for Medicare Part A reimbursement, they have yet to enforce this measure. This has resulted in hospitals, including Gundersen Health System, to be unclear in the extent to which this policy is law, or just not being

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enforced. Nonetheless, this policy does not reflect current hospital care standards and places hospitals in a precarious position as we are committed to our due diligence in compliance, even with an unenforced mandate. We urge lawmakers to instead provide more accountability in the Recovery Audit Contractor (RAC) program and discontinue the two-midnight policy while improved standards of care for inpatient stays are developed by clinical experts.

Although CMS has instructed RAC auditors to not enforce this policy, the provisions allow review contractors to presume an inpatient hospital admission is deemed reasonable and medically necessary if a beneficiary requires more than one Medicare utilization day, defined as an encounter crossing two midnights, regardless of time initially admitted. This presumption standard is arbitrary, and unreflective of how hospitals and medical providers care for patients. We urge lawmakers to ask CMS to abandon this policy and to solicit comments from hospitals on new standards rather than simply crossing two midnights for an inpatient stay.

Additionally, Gundersen Health System opposes this time parameter and instead supports the recommendations made by the American Hospital Association by instituting three changes to the RAC program:

1. Limit RAC review to only the information in the medical record that was known to the physician at the time of the decision to admit.
2. Instruct RACs to focus audits on other factors the agency has noted are relevant to the admission decision, instead of only factors like the patient's length of stay.
3. Provide accountability metrics for "incorrectly denying an inpatient stay – not just to recoup their contingency fee – to provide some check on the strong financial incentive RACs have to conclude that beneficiaries should not have been admitted."

RAC program

Payment integrity and auditing are very important in maintaining the viability of taxpayer funded programs. We recognize this, and for more than a decade Gundersen Health System has maintained a voluntary and robust compliance program modeled after the Office of Inspector General's Compliance Program guidance and the Federal Sentencing Guidelines. However, in recent years, we have experienced a significant increase in medical record requests from Medicare Recovery Audit Contractors (RAC). Medical claim requests by government auditors in general have increased over 200% from 2010 through the end of 2012. If payment for service is denied, Gundersen participates in the appeals process that can take months, even years to complete, and consumes numerous resources. In fact, we currently have nearly 90 appeals pending review from Qualified Independent Contractors (QIC).

As a solution to reducing costs of care while maintaining integrity in the program, we recommend lawmakers enact House Resolution 1250—the Medicare Audit Improvement Act. Currently, there lacks sufficient performance-based metrics for auditors; for example, there are no limits on the number of audit requests that can be made to hospitals. H.R. 1250 would establish performance-based measures to increase integrity and transparency. Specifically, the bill would limit the number of medical record requests, instill transparency in the audit process, and improve auditor performance. Although payment integrity measures are important for us as providers, under the new provisions, improvements would be made to the Medicare auditor activities.

Gundersen Health System continues to greatly appreciate the support of the Ways and Means Subcommittee on Health for value-based healthcare reform policies. We were very pleased over the past several months to advance meaningful value-based policy via repeal and replace of the Medicare

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Sustainable Growth Rate. Just as measurements of cost and quality on providers in a value driven system, performance-based measures should also apply to the auditing process. Enactment of H.R. 1250 will increase efficiency, implement performance-based measures, and increase transparency in the Medicare auditing process.

Medicare Hospice and Part D Benefit

CMS states overlapping situations involving Medicare Part D and the hospice benefit in administering the services for palliation and management of terminal prognosis should be "very minimal." In other words, medications provided under Medicare Part D would be presumably covered under hospice, and rarely involve prescription drugs for conditions not related to the hospice diagnosis. This assumption is not rare, and has negatively impacted terminally ill patients at our organization.

In prior comments on the proposed rule, we believed this policy would be shortsighted because there are often conditions unrelated to the hospice diagnosis, especially when the hospice diagnosis is cancer-related. Patients may often have underlying lung disease, diabetes, heart disease, kidney disease that is unrelated to kidney cancer, brain tumors, ovarian cancer, or even to other conditions such as Amyotrophic Lateral Sclerosis and Parkinson's disease. At times, patients may feel well with only 1-3 months to live and are enrolling in hospice, and may be reluctant to discontinue existing treatment for other underlying medical conditions they have become accustomed to as prescribed by their provider. Halting this treatment may cause significant symptoms and decline in function that would not be related to their primary hospice diagnosis. With reluctance to immediately stop existing medications, and understanding the gradual process to wean off medications, this policy would present challenges for our patients and providers. Also, we had stated the proposed policy changes may inadvertently limit the number of people who utilize hospice services, instead electing to continue under Medicare and Part D without the appropriate end-of-life services, compounding to increased costs with unnecessary hospitalizations.

As warned in comments to CMS, two negative outcomes occurred related to recent changes to the management of prescription coverage made by CMS for patients with Medicare Part D coverage who also enroll in the Medicare Hospice Benefit. In one example, a patient's Part D plan sponsor revoked continued coverage of viral medications for a patient entering hospice due to an end-stage respiratory disease because the virus was not the basis for the hospice admission. The appeals process ultimately distressed the patient, who died before Gundersen could advocate on their behalf during adjudication. In a second example, a patient revoked their hospice benefit when the patient learned their Part D plan sponsor might revoke continued coverage for prescriptions for a metabolic disease because it was not the basis for the patient's hospice stay, even though CMS has clearly stated that Part D plan sponsors must abide by the clinical determination made by the hospice physician or primary care physician as to whether a drug is unrelated to the terminal condition but still medically necessary.

Gundersen fully complies with the Conditions of Participation for hospice programs and we supply all medications for out hospice patients that are related to their terminal conditions. Halting of complicating treatments for non-hospice health conditions due to confusion over coverage determinations by Part D Plan Sponsors can cause distress, recurrence of disease symptoms and decline function. Gundersen believes the above examples illustrate the need for greater continuity in prescription coverage for drugs unrelated to the terminal condition. This will ensure patients have coverage for prescriptions they need to manage all of their health conditions, regardless of whether each health condition is the basis for the hospice stay. At Gundersen Health System, we are strong

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supporters of payment integrity and support CMS's efforts to work with Part D plans to provide controls against duplication of payment for drugs related to terminal conditions.

Conclusion

On behalf of Gundersen Health System, we appreciate this opportunity to provide comments on important issues facing hospitals in the Medicare program. We believe the issues we illustrated, along with proposed solutions noted, will the patients we serve and continue to provide high quality care for the communities we serve.

Sincerely,

Michael D. Richards
Executive Director of External Affairs
Gundersen Health System

External Affairs Department 1900 South Avenue, Mailstop: C01-011, La Crosse, WI 54601
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George L. Marra, Statement

05/29/2014
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Current Hospital Issues in the Medicare Program

My mother was taken to War Memorial Hospital when she fell at home. She was in the hospital under observation , because she had a broken leg. She was in a hospital bed receiving full care as if she was admitted, we didn't know until the 5th day she was in "under observation." When a person goes from the ER to a bed in the hospital, it has always meant you were admitted. No one mentioned anything about it being under observation. They kept her in 6 days, as my dad was unable to attend to her needs, because of the brace that was put on her. The hospital even stated that she needed to stay at the hospital as her needs could not be met at home. Because she was not admitted, Medicare would not pay for her stay in the rehab with skilled nursing while she received physical therapy.

My mother had a stroke about ten years ago and is paralyzed on one side. For this reason I believe Medicare should pick up the cost of room and board. I understand if she never had a stroke and had usage of her paralyzed side, she would be denied, as she could get some crutches and leave the hospital, but this is not possible. She has been wheelchair bound since the stroke. My dad is 83 years old and can no longer meet the needs for my mother in her currant condition.

Once she completes her therapy and her good leg has more strength, my dad will be able to take care of her with some assistance, in transferring her.
Both of my parents have worked hard all of their lives and just want to enjoy their so called "golden years", but paying $4000.00 every 2 weeks so she can get strong and return home is a real hardship on them. They would have been better off being deadbeats and never worked, as I'm told, if they had nothing, everything would be paid for, no questions asked.

I understand some things in life are not fair, but this situation needs to be corrected. Not just for my parents, but all hard working people who believe they are covered. Everything is not black and white, there are always situations that need to be reviewed to take all information into consideration, one being my mothers physical condition.

I just ask that the representatives of the citizens of the United States overcome this unjust policy with good common-sense. This is not much different then what

is happening to our Veteran's, who also serve us. My parents also served this county for many years in state government positions.
Thank you in advance for any help you can be to get this paid for.

Doreen Grossman, Letter

LETTER TO HOUSE WAYS AND MEANS COMMITTE FOR CURRENT HOSPITAL ISSUES IN THE MEDICARE PROGRAM

May 29, 2014

To Whom It May Concern,

I am writing this letter to relate how my mother, Sylvia Greenstein, was placed "under observation" when she was in the hospital back in October 2012 for a fractured shoulder. My mother fell on 10/29/12 at home due to dizziness that she reported to the physicians in the Emergency Dept. at North Shore Medical Center in Salem. She was examined by the physicians/nurses in the Emergency Dept at North Shore Medical Center at 19:39. An X-ray was taken and she was found to have a fracture of her left shoulder as a result of this fall. The emergency department physician noted in his report that there was a need for further work up and treatment in the hospital. The doctor felt that the reason for her dizziness should be evaluated. He also wrote in her medical record that her condition was new, serious and that she should be admitted to the hospital. My mother was admitted to an inpatient unit under observation status at 22:18 on 10/29/12 for a three day hospital stay. She was not admitted as a Medicare Part A patient, although another doctor on the inpatient unit wrote "she is a full admission. She remained on the inpatient unit until 11/01/12 at 10:00AM. During her stay she was given IV fluids and a Foley catheter was inserted. One of her blood pressure medications was discontinued as it was felt that it lowered her blood pressure too much and may have contributed to her dizziness.

When I went to visit her in the hospital, the case manager informed us that she was not admitted under Medicare Part A, but was admitted "under observation." The case manager told us that the Interqual Scale by McKesson was used to determine if she should be admitted or placed "under observation". She also said that she could see if my mother's stay might be able to be changed to inpatient status by the utilization review committee. A few hours later, I was informed that the utilization review committee agreed that my mother's admission "under observation" was appropriate. During her hospitalization, my mother was not able to get in and out of bed independently and was not able to ambulate independently. She was not safe to go home where she lived independently. Previous to this fall, my mother was independent in her ability to get dressed / undressed, take a shower, shop for groceries and household items. She frequently utilized a rollator walker to ambulate safely due to arthritis in her spine. She received PT and OT evaluations at the hospital which noted that my mother was only able to walk a distance of 10 feet and that my mother would "continue to benefit from skilled PT services to determine the most appropriate assistive device and increase functional mobility and safety. The occupational therapist recommended short term rehab to address maximal independence with self care and mobility.

My mother was then admitted to rehab center at a skilled nursing facility after three days in the hospital for a one month stay so that she could return to independent living. **She had to pay $10,000.00 out of her pocket** for her rehab stay since the hospital stay was not covered under Medicare Part A. My mother lives off of her social security check for her expenses and thus paying for rehab took away most of her savings.

Since I felt that my mother received medical care while on the inpatient unit, and had a three day hospital stay; I felt that her status should be changed to an inpatient status and be covered under Medicare Part A. I am trying to recover the money for my mother that she spent on her rehabilitation stay. I initiated an appeal with Medicare in February, 2013. A lawyer from the Boston Legal Aid Society has since taken over this appeal case for my mother in the fall of 2013.

Medicare Part A should pay for all hospitalizations that are three days and over. Many elderly live off their social security checks and cannot pay out of pocket for the 20% not covered by Medicare Part B and for necessary rehabilitation. I urge Congress to please consider changing the Medicare rules and cover all hospital stays that are three days or longer and to discontinue this "observation status" term that can cause financial devastation for senior citizens.

Respectfully,
Doreen Grossman

Diane Walter, Letter

May 16th, 2014

Current Hospital Issues in the Medicare Program

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Story previously submitted to CMA and HHS

August 28th, 2012
CMS
Department of Health and Human Services
Attn: CMS-1589-P
P.O. Box 8013
Baltimore, MD 21244-1850

I am writing to you today to enter a public comment in regard to observation status and our family experience with it. This newer practice is costing beneficiaries thousands of dollars because SNF care is not covered when a patient is discharged from a regular hospital bed to continued care and rehabilitation when in an "obs" status. It can be financially and emotionally devastating to a family.
My 81 year old father was admitted a total of three times under observation status in a local hospital in northern Wisconsin:

1. 3/16/2010 to 3/18/2010; diagnosis: severe weakness and dehydration and a fractured clavicle after a fall. My parents were not given the information he was being admitted under the observation status until discharge to a SNF for rehab and strengthening. During this stay, he received PT, OT, some intravenous fluids, tests and x-rays, just as a regular hospital admitted patient would receive. He was discharged to the SNF and my Mom paid $3500 to get him in the door with additional charges for medications and therapy co pays. He received PT/OT at least twice a day, sometimes three times a day. He stayed there from 3/18 until 3/30 and was released to go home. Total costs: about $4873.00 (OOP).

2. 12/15/2010 to 12/17/2010; diagnosis: severe weakness, low pulse oximetry and re-injury to his shoulder after another fall; also unable to walk. He did not meet the Milliman criteria for inpatient admission and observation status was used again. This time, my parents were informed of the status, but there was no way he could walk at that point so had to stay. Rehydration, (intravenous), PT and OT therapies, oxygen therapy, labs and tests were run. Dad was discharged to a SNF on 12/17/2010 where he received more PT/OT. (OOP costs about $4800) On 1/5/11, my father developed a delusional psychotic epidsode and became verbally

and physically combative. He was transferred to a hospital by local police and then to the only facility that would take him; the state mental hospital three hours south of their home. He was taken into custody under the Chapter 51.50, and transported via police escort to the mental hospital. They did a medication wash and in two days, Dad emerged exhausted, but his normal self. (Of note: all medical personnel were told not to give Dad narcotics over the past five years as he had several of these episodes in his history due to vascular dementia and the interaction with medications. He was given narcotics and anti-psycotic medication at the SNF and the first hospital to deal with pain issues.) He received excellent care at the mental hospital and the stigma of a place like that is no longer with our family. The driving distance was the only difficulty.

It took 45 days to find a facility that would accept him from a mental hospital. The group home was very nice and comfortable. He was admitted there 2/8/2011. It was so much safer than to take him home. The cost was $4000 a month plus medications.

3. 5/27/11- 6/10/2011; diagnosis: Spinal fractures after another fall, confusion. The fractures, severe pain, unable to walk and a little confusion were still not considered a reason for regular admission. Observation status was fully explained to my Mom this time. We had no choice. He was not in good shape and had so much pain. Dad received all the regular care; IV, CT scans, x-rays, lab work, etc. etc. A procedure called kyphoplasty was recommended and completed on about 6/4. When he woke up he was unable to swallow and changed to an inpatient status. Many, many tests were run to find out why he couldn't swallow. He developed a terrible thrush infection. They really could not give a definitive answer. We were given the choice of tube feeding via a nasogastric tube or a tube that goes through the abdominal wall directly to the stomach to feed him or palliative end of life care. I asked for other options such as TPN but they said those were more invasive and short term. The agonizing decision to choose palliative care was made and all treatments were discontinued on about 6/7/2011. Dad transferred back to the group home under hospice care about 5 P.M. 6/10/2011 and passed mid-afternoon on 6/11/2011.

We want to try and help others avoid all of this pain, frustration, expense, demoralization and terrible emotional stress if at all possible. That is why we want to tell Dad's story. I have worked in a major Milwaukee hospital ICU for 33 years and have seen the evolution of our healthcare system and our health insurance policies. I have a few thoughts and/or suggestions in regard to changes in the use of observation status:

Hospitals should not fear the RAC and the RAC employees all must be RN's or above.

Only MD's should be making the status decisions for a beneficiary, NO ONE ELSE.

Milliman admission criteria should be used as a guideline only. A doctor's assessment should be used for the final decision.

We all need to pause and think about the very vulnerable senior citizens, especially those without the financial resources to pay out of pocket for their care. Someday, we will be senior citizens.

Beneficiaries need to be fully informed about what their admission status is and have a mechanism in place to make appeals. (Current appeal processes do exist, but are lengthy to comply with: I have submitted all the Medicare requested reports as part of my current employment for patients being discharged from my unit.)

Mental and physical diagnoses need equal consideration.

Every hour as a patient in a hospital, no matter what the status, needs to count toward after hospital care. A patient should not be allowed in the observation status for more than twenty-four hours.

Dementia screenings and medication profiles need closer scrutiny for all patients, especially our senior citizens.

Thank you for this opportunity to express an opinion.

Diane Walter
Daughter of a proud American man and U.S. Army veteran

Denise Broccoli, Letter

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Dear Ways and Means Committee,

My experience with observation status started on a typically Sunday morning when I went to give my elderly father his daily medicine. A man who never complains to me about anything said his chest hurt. Being a concerned daughter I did what any of you would do and took him to the nearest hospital. At the hospital he was put in a room and given some tests to try and determine the cause of his chest pain. The doctor informed me that my father would be admitted into the hospital for additional testing and evaluation. After hours of waiting he was brought upstairs and put in a room.

While I was driving on my way to work a representative of the hospital called me and rattled of some sort of medical declaimer about observation status; when I specifically asked her what does that mean "his insurance is not going to pay for this" she offered me no further explanation in terms that someone who is not in the insurance business would understand. She just paused for a few seconds and said no…

On Monday night his doctors told me that they felt that my father should remain in the hospital and then go to a rehab. He was very unsteady on his feet from lying in bed, having difficulties getting in and out of chairs and going to the bathroom. He was also presenting signs of a respiratory infection. Tuesday afternoon his doctor called me and said that he was being admitted as an inpatient and would go to rehab in a few days. I no sooner hung the phone up from her and a social worker from the hospital called me and insisted I take my father home. When I questions her she said that the doctor was wrong!! (Do social worker go to medical school); and offer me no explanation or reasonable alternative, and said my father condition was not the hospitals problem! This social worker was calling my ninety year old mother and insisting she come get him as well…..

My father was very ill when the hospital told me to come and get him; he could not even lift his head to look at me..... He was sitting in a chair hunched over, his skin was grey, and he had a fever which he had been running off and on for a while and had become severely de-conditioned from this 4 day ordeal.. The hospital refuse to change my father's status, they discharged him without my signature even though there were some dedicated doctors and nurses who believe he was too ill to go home.

I had to put my father in rehab on private pay and was so grateful I could do that. He had a very dangerous upper respiratory infection which combined with his medical history could have ended his life. He was severely de-conditioned from being in a bed for days and basally in far worst condition then when I brought him to the hospital in the first place.

The wonderful nurse at the rehab, IMMEDIATELY look at my father and put him on antibiotics stating that there was nothing in my father's medical report from the hospital about his mucus and how it was a very obvious sign of infection. My father is at home now with us but he has not fully recovered to the condition he was in before I took him to the hospital. We are not sure he ever will. My family is blessed to have had the means to pay for his care. Please tell me what elderly people do who do not have any resources or family and friends to fight for them!!!!

My father is from the great generation that built this country somehow I feel that has been forgotten in Washington. While I understand the need to cut fraud and waste it felt like to me they are punishing the people who work for these benefits and allowing numbers guys to practice medicine without a license.

Members of the committee is this how you plan to cut waste, by putting elderly people who have earned their benefits at risk!!! Surely there must be a better way.

Regards,

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Connecticut's Legislative Commission on Aging, Statement

Connecticut's Legislative Commission on Aging

A nonpartisan policy and research office of the Connecticut General Assembly

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With 21 volunteer board members from across the state

CURRENT HOSPITAL ISSUES IN THE MEDICARE PROGRAM

Subcommittee on Health
House Committee on Ways and Means Hearing

Testimony by
Julia Evans Starr
Executive Director
Connecticut's Legislative Commission on Aging

June 2, 2014

We are very grateful to the House Way and Means Committee, Subcommittee on Health for closely examining current issues related to hospitals and Medicare, particularly the "two-midnight" rule and hospital observation status.

Connecticut's Legislative Commission on Aging is the non-partisan, public policy office of Connecticut's General Assembly devoted to preparing Connecticut for a significantly changed demographic and enhancing the lives of the present and future generations of older adults. For over twenty years, we have served as an effective leader in statewide efforts to promote choice, independence, empowerment and dignity for Connecticut's older adults and persons with disabilities.

CT's Legislative Commission on Aging has been following this issue closely, primarily through the work of our partners and national experts on this issue, The Center for Medicare Advocacy, who has filed a class-action lawsuit to challenge this practice.

As you are aware, increasingly hospital patients are finding they have been in the hospital under "Observation Status" even though they have been cared for in a hospital for many days. These patients have been treated in a regular hospital room, have been cared for by hospital doctors and nurses, just as you would expect of a stay in a hospital. However, they have not been officially "admitted". There are cases when an individual has been in hospital for as long as 14 days and yet was never officially admitted.

For Medicare beneficiaries the implications are especially jarring. According to Medicare benefit rules, these patients on observation status are considered "outpatient" and will not have access to the same Medicare benefits as someone who is considered "inpatient".

The patient on Medicare in observation status will have to pay co-pays for doctor visits and testing and also have to pay for routine drugs they may take for chronic conditions

(like high blood pressure and diabetes). Additionally, if the patient is discharged to a skilled nursing facility (SNF) for rehabilitation, the care they receive in the SNF will NOT be covered because they have not met the 3-day inpatient hospital stay requirement. The patient is then responsible for the cost of SNF care. According to Connecticut's Office of Policy and Management, in Connecticut, the average daily cost of nursing facility care is $390/day.

Further concerning is that this practice - of Medicare beneficiaries entering the hospitals as observation patients - is on the rise, according to Kaiser Health News. The number increased by 69% in five years, to 1.5 million people nationally in 2012.

Additionally, Medicare does not require hospitals to notify patients about their status. Many times, patients believe they are inpatient and do not realize the potential effects to the Medicare benefits. We are grateful to Connecticut's General Assembly for recently passing legislation requiring hospitals to provide written and oral notification to patients of their status within 24 hours of "admittance". Yet, more can and needs to be done.

This growing problem can be fixed by Congress by **enacting H.R. 1179 and S. 569, the Improving Access to Medicare Coverage Act of 2013.** Very simply, these identical bi-partisan bills would count all the time hospitalized toward the three-midnight rule allowing access to the Medicare Part A benefit.

Thank you *for this opportunity to provide this testimony and thank you for examining this critical issue to older adults in Connecticut and across the country.*

APTA, Letter

APTA
American Physical Therapy Association

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June 2, 2014

The Honorable Kevin Brady
Chairman
Ways and Means Committee
Health Subcommittee
1135 Longworth House Office Building
Washington, DC 20515

The Honorable Jim McDermott
Ranking Member
Ways and Means Committee
Health Subcommittee
1135 Longworth House Office Building
Washington, DC 20515

Dear Chairman Brady and Ranking Member McDermott:

On behalf of more than 88,000 physical therapists, physical therapist assistants, and students of physical therapy, the American Physical Therapy Association (APTA) thanks you and the members of the House Ways and Means Health Subcommittee for the opportunity to participate in the dialogue regarding the two-midnight policy, outpatient observation stays, and audits and appeals under Medicare. APTA commends your efforts to address these issues and we appreciate the opportunity to provide feedback on the impact these issues have on patients needing physical therapy services.

The Two-Midnight Rule

While the intention of the two mid-night rule was to provide further guidance and clarify the Medicare hospital inpatient admission criteria, the unintended consequences of the two-midnight policy are steep for patients and providers alike.

The two-midnight policy presumes that a hospital inpatient admission is appropriate for a Medicare beneficiary who requires a hospital stay that spans at least two midnights. Thus, a hospital stay that is less than two midnights should be considered outpatient and billed under Medicare Part B, with limited exceptions. APTA believes that the decision to admit a patient for an inpatient stay should be made by the physician and interdisciplinary team, including the physical therapist, and solely based on the clinical condition of the patient. Setting an arbitrary two-midnight rule can be harmful to patients, particularly those who are short stay with acute illnesses.

Recovery audit contractors (RACs) have been responsible for reviewing inpatient claims to determine whether an inpatient admission was necessary. If the RAC determines an inpatient admission should be denied, qualifying services that would have been considered reasonable and necessary had the patient been treated as an outpatient, including physical therapy, can be rebilled under Medicare Part B. While this policy appears to provide some relief for hospitals, it can have a harmful impact on a patient's access to

physical therapy services. Physical therapy services that are rebilled as outpatient services are subject to the Medicare therapy caps, manual medical review at $3,700, and functional limitation data reporting requirements. Since the vast majority of RAC denials do not occur until more than one year after a patient was treated, resubmitting outpatient therapy claims with the required functional limitation reporting data would be nearly impossible. Thus, rebilling under Part B is very difficult because inpatient billing requirements are not the same as the reporting requirements for outpatient therapy services.

Observation Status

Observation care is often provided in the same hospital beds as inpatient care but is considered outpatient care and thus billed under Part B instead of Part A. As the number of patients placed under observation status for more than 48 hours continues to grow, this impacts Medicare outpatient therapy utilization as well as the financial liability of the beneficiary and the provider. APTA encourages the Committee to set a timeframe for observation status of no more than 24 hours.

Due to the risk of denials when classifying patients for an inpatient stay, there are instances where a patient's entire stay in the hospital which can span as much as 16 days, is classified as "observation" and therefore considered an outpatient stay. When a Medicare patient is placed on observation status, any physical therapy services received during this period count towards the Medicare therapy caps. Therefore, all of the physical therapy services received during this period are counted toward the $1,920 therapy cap. Billing these services as outpatient therapy will limit patient access to physical therapy.

Observation status also has an impact on a patient's ability to enter skilled nursing facilities (SNFs) for a covered stay. In order to be eligible under Medicare Part A for the SNF benefit, a patient must have a qualifying 3-day hospital stay. Often times, SNFs find that a patient placed on observation status did not meet this requirement for SNF coverage. It is possible for therapy services in the SNF to be covered under the Part B program. However, the Medicare beneficiaries would then be responsible for the additional cost of coinsurance, leaving them vulnerable to higher out-of-pocket charges. This issue also affects home health agencies. Increasing the length of the observation period creates an administrative burden for post-acute care providers to comply with quality measurement programs relating to the prevalence of hospital readmissions for their patient population and other regulatory requirements such as functional reassessments in the home health setting.

Recovery Audit Contractors (RACs)
In addition to reviewing hospital billing claims, the RACs also manually review outpatient physical therapy services that exceed $3,700. Since implementation of the RAC review process, problems have persisted with the manual medical review process. The most common issues providers experience include: lost documentation, no process for confirming receipt of claims, non-compliance with the 10-day review period, lack of an electronic submission process, and inaccurate denials.

Furthermore, physical therapy providers are also subject to the same appeals process as the hospitals for claims that are denied by the RACs. Thus, providers who appeal denials for claims over $3,700 would go before an administrative law judge (ALJ) at the third level of appeal. As noted in the OMHA hearing on February 12, 2014, the backlog for hearing appeals at the ALJ level is significant and it can take several years before providers have an opportunity to have their appeal heard.

In order to address these issues, APTA believes that there needs to be standardization of the policies and procedures used by RACs to process manual medical review claims and a better opportunity to participate in "discussion" periods with the RACs before denials. This would allow providers to better prepare claims, and hopefully cut down on the backlog at the ALJ level. Additionally, as CMS is preparing to sign new contracts with the RACs in 2014, we encourage Congress to assist CMS in making this transition as smooth as possible in order to prevent further delays with claims processing.

APTA appreciates your work not only to address the above issues, but your continued efforts to reform the sustainable growth rate formula, the Medicare therapy caps, and the manual medical review process. We hope to work with you to find an appropriate solution to address the two-midnight policy, outpatient observation stays, and audits and appeals under Medicare. If the Subcommittee has questions or needs additional resources, please contact Mandy Frohlich, Senior Director of Government Affairs at mandyfrohlich@apta.org or 703-706-8548.

Sincerely,

Paul Rockar Jr.

Paul A. Rockar, Jr, PT, DPT, MS
President

PAR: las

AOPA, Statement

American Orthotic & Prosthetic Association

Statement of the American Orthotic and Prosthetic Association on Short Stays and Unintended Consequences of RAC Audits and the Massive Backlog of Medicare Appeals on May 20, 2014 Before the Health Subcommittee of the House Ways and Means Committee

Submitted by Thomas Fise, JD, Executive Director, American Orthotic and Prosthetic Association

The American Orthotic and Prosthetic Association (AOPA) is pleased to provide this statement concerning Medicare fraud and the delivery of care to Medicare beneficiaries who have suffered a loss of a limb or impaired use of a limb or the spine. AOPA, founded in 1917, is the largest orthotic and prosthetic (O&P) trade association, with a national membership that draws from all segments of the field of artificial limbs and customized bracing for the benefit of patients who have experienced limb loss or limb impairment. Members include patient care facilities, manufacturers and distributors of prostheses, orthoses, and related products, and educational and research institutions. The field of providing artificial limbs or customized bracing for those Medicare beneficiaries with limb loss or limb impairment is a highly specialized area representing a small, roughly one-third of 1 percent, slice of Medicare spending but has a huge impact on restoring mobility to those patients served. A replacement limb may mean the difference between returning to work and a former life quality and remaining an active and contributing member of society. Customized orthotic bracing solutions for chronic conditions may have a similar long range impact.

That is why AOPA was pleased that this hearing announcement referenced orthotics and prosthetics by noting, "Importantly, short stays are not the only area of concern when addressing RAC audits, appeals and an increase in observations stays. For example there are a number of durable medical equipment and prosthetic/orthotic cases that are also held up at the ALJ appeal level."
AOPA submitted a statement for this Subcommittee's hearing on April 30, 2014 on ideas to improve Medicare oversight to reduce waste, fraud and abuse in which we outlined suggestions that would assist in this endeavor. We respectfully request that our statement of April 30, 2014 also be incorporated by reference, together with this statement, into the record of this hearing.

In that earlier statement, AOPA referenced the effect RAC audits are having on delivering timely patient care, the disruption of service brought on by these audits, and the lack of due process in the heavily-backlogged appeals process. Our members were stunned when the Office of Medicare Hearings and Appeals announced a suspension in the scheduling of hearings before Administrative Law Judges, which has been the only remaining recourse our members have to fight unfair audit claim denials.

AOPA still believes that the best and surest way to combat fraud in the orthotics and prosthetics sector is to prevent fraud in the first place. There are constructive ways to fight fraud without punishing an entire healthcare sector, such as hospitals and orthotic and prosthetic (O&P) providers.

H.R. 3112 Is a Positive Step in Fighting Fraud; Surety Bonds Are Not an Answer to Fraud—They Punish All Legitimate Medicare Providers, Without Posing Any Significant Barrier to Unscrupulous Actors Who Perpetrate Medicare Fraud

Effectively fighting Medicare fraud requires implementing truly effective measures aimed at stopping unscrupulous actors and saving Medicare dollars. CMS's imposition of surety bond requirements on all

providers has been misdirected because it has little relationship to preventing fraud. These bonds burden all O&P suppliers, disproportionately affecting small O&P suppliers, but they do nothing to distinguish legitimate suppliers from fraudulent suppliers. Surety bond requirements are ineffective at preventing Medicare fraud and unnecessarily penalize legitimate providers.

Legislative Efforts Relating to Limiting the In-Office Ancillary Care Exception to Stark Self-Referral Rules

AOPA has noted that W&M Ranking Minority Member, Rep. McDermott has introduced a bill aimed at eliminating the exception from the Stark self-referral provisions for in-office ancillary services. AOPA supports this new legislation in principle. The Orthotic & Prosthetic Alliance in recent months has communicated concerns to OIG about how, in the context of physician-owned distributorships (PODs), the in-office ancillary services rule sometimes operates and results in an increase in the number and value of services that patients do not need. However, no substantive action was taken. This provision has also prompted state legislative issues in states like Texas where it has been used by special interests to try to expand the prospects for payments to unqualified or under-qualified providers.

Prior Authorization is Not an Answer for Massive Non-Fraud RAC and Prepayment Audits That Have Hit Part B Medicare Claims for Artificial Limbs

The topic of prior authorization in terms of Medicare is a complex one. The BIG hitch is that Medicare Prior Authorization is NOT a promise of payment, and therefore AOPA and the vast majority of its patient care facility members oppose it as any kind of 'solution' to audits. CMS would be severely challenged to implement prior authorization.

CMS has unfortunately seen cookie-cutter solutions for RAC audits. Therefore, two years ago CMS said—"If a demonstration project in prior authorization was acceptable for power wheelchairs (PME) in DME, let's solve the O&P audit issues the same way." A major problem is that, in reality, the PME demo project resulted in longer delays for patients. CMS insists the numbers are shorter, but reliable reports estimate that it takes between 70-100 days from the date the physician orders a power wheelchair until the prior authorization goes through and the power wheelchair reaches the beneficiary. That kind of delay simply doesn't work for the care of amputees--who, even in the delays of the RAC environment, get their replacement limbs much faster. Prior authorization may have worked for a few limited cases in the private sector if, and only if, it is an absolute guarantee of payment (otherwise, it creates its own cash flow problems). That is not true in Medicare.

Recommendations for Reasonable Reforms of RAC and Pre-Payment Audits of Claims for Artificial Limbs for Beneficiaries under Medicare Part B

Following are proposals from the Orthotic & Prosthetic Alliance to reform RAC and prepayment audits of Part B claims for artificial limbs. These are steps that definitely would assist in restoring fairness, transparency and due process as well as greatly reducing the devastation RAC and prepayment audits by CMS contractors has caused Part B claims for artificial limbs for Medicare amputees. They include:

a. Establish the prosthetist/orthotist's notes as a legitimate component of the patient medical record, comparable to a therapist;

b. Establish the prosthetist/orthotist as a recognized Medicare provider of care, distinguished from treatment as a DME supplier—the distinction between O&P and DME is clear both as O&P providers assume the role of lifetime mobility health professionals as well as being reflected in the much higher success rate when O&P appeals are decided at the ALJ level;

c. Remove the Qualified Independent Contractor (QIC) stage of the appeals process, since it takes time and virtually never results in a favorable decision for the O&P provider;

d. Advance the appeal more expeditiously to the ALJ for final action;

e. Mandate that CMS compile data on audit appeals for O&P only, separate from DME which is needed to track both the very high rate O&P RACs audit appeals and high overturn rate on appeal (CMS has consistently refused to track such data)*;

f. Establish financial penalties for RACs if an established percentage of appeal overturns occur, e.g. double interest penalties assessed against RAC, which funds along with savings from item C. above could be used to fund an increase in the number of ALJs; and

g. Address the need for more ALJs to mitigate the current backlog, either by direction to the Office of Medicare Hearings and Appeals (OMHA), which as an arm of HHS is responsible for funding for ALJs, or a statutory change to allow CMS to fund ALJ appeals for RAC determinations.

* It was underscored in the May 20 hearing before the Oversight and Government Reform Committee that overturn rates at the ALJ level run between 56% to 74% provider success in overturning RAC audit conclusions.

Unlike Part A, There Has Been No Pause or Any Relief Whatsoever from CMS as to Part B RACs.

Chairman Brady's observation in announcing these hearings noted that, "The Ways and Means Committee fought hard to ensure that patients are getting the care they need, and that Medicare is properly paying hospitals for the care they provide. While we were able to provide some relief last March, it was only a temporary fix. We must work on a permanent solution. We don't want providers unnecessarily looking over their shoulder for auditors. We want hospitals to be accurately reimbursed so that they can focus all of their time on providing the right type of care for patients."

AOPA applauds the search for a longer term solution for hospitals as those solutions in part will help address or inspire solutions for the similar audit problems facing O&P providers. An additional longer term solution for O&P through the enactment of H.R. 3112 would simply require CMS to implement section 427 of the Medicare, Medicaid and SCHIP Benefit Improvement and Protection Act of 2000 (BIPA), which requires CMS to only make payments to "qualified providers," as those professionals certified by the two main certification organizations, or their equivalent, in the field of O&P or properly licensed in those states requiring licensure.

Another long term solution provided by H.R. 3112 is that eligibility for payment would be linked to the qualification of the providers and the complexity of the device the patient needs. Patient quality of care then would be improved. Additionally, taxpayer dollars would be saved through a reduction in poor outcomes and repeated charges for follow up O&P care that would not be necessary if a qualified provider had served the patient in the first place.

As we indicated in our statement for the April 30 Ways & Means Health Subcommittee hearing, **many, including members of Congress, see the Part A relief for hospitals in terms of the "pause" for about a year relating to RACs under the two midnight rule, and think there has been similar relief under Part B for O&P RACs--the truth is that there has been no pause or any relief whatsoever from CMS as to Part B RACs.**

CMS Should Issue a Moratorium on Part B RAC Audits

Many suppliers affected by RAC audits are small businesses like our members. They do not have the financial wherewithal to sustain their business when RAC audits or other questionable tactics to fight fraud and abuse continue unabated. It would be our hope that the focus of these hearings on the needs of our nation's hospitals

under Part A becomes the clarion call for expanding solutions to relieve the threatening disasters that will befall small business providers under Part B if early and significant relief from Part B RAC audits is not forthcoming.

Conclusion

In conclusion, AOPA will continue to work with Congress and CMS to ensure that those who prey on Medicare beneficiaries do not find the O&P sector an easy place to establish and operate a fraud scheme. We offer our support for developing more effective means to fight Medicare fraud that does not punish legitimate suppliers who are playing by the rules. We believe that the fairest and most effective system is one that prevents fraud before it starts, and we hope that Congress will direct CMS to implement relevant provisions contained in Section 427 of BIPA and that it will pass H.R. 3112.

AOPA appreciates the Committee's efforts to work with us to find ways to better regulate our payments. We hope to continue to work with you to improve the quality of care we deliver to patients who need O&P services, and to protect the integrity of the Medicare program.

American Coalition for Healthcare Claims Integrity, Letter

May 19, 2014

The Honorable Kevin Brady
United States House of Representatives
Chairman, House Ways & Means Subcommittee on Health
1101 Longworth HOB,
Washington, D.C. 20515

Dear Chairman Brady,

Our coalition appreciates the opportunity to contribute recommendations on ways to improve Medicare oversight. In advance of the health subcommittee's hearing on this topic and in support of our mission to eliminate improper payments, I want to offer insight into the development and ongoing success of the Recovery Audit Contractor (RAC) program, as well as suggestions regarding how to strengthen the program in light of recent challenges.

Evolution of the Most Successful Integrity Initiative in Medicare History

According to the Department of Health and Human Services (HHS) FY2013 Agency Financial Report, Medicare loses more money to waste than any other federal program and, since 2011, the rate of improper payments has risen steadily from 8.6% to 10.1%.[i] In addition, in FY2013, providers overbilled Medicare by $45.6 billion.[ii]

In 2003, Congress mandated the creation of a program to combat Medicare waste. Over the course of a three-year pilot program, over $900 million in overpayments were returned to the Medicare Trust Fund and nearly $38 million in underpayments were returned to health care providers. As a result of the program's overwhelming success, in 2006, Congress mandated that the HHS institute a national Recovery Audit Contractor (RAC) program. In 2009, the Centers for Medicare and Medicaid Services (CMS) implemented the permanent RAC program to identify improper payments and recover misused taxpayer funds. Since then, **RACs have recovered over $8.9 billion**, while reviewing less than 2% of Medicare records from any given provider.

Ongoing Commitment to Provider Cooperation & Transparency

Since their inception, RACs have continually worked with CMS to minimize the administrative impact of auditing on providers. The Medicare provider community played a key role in adjusting elements of the RAC program after the demonstration. These included mandating a medical director to oversee all reviews, setting limits on medical record requests, and requiring auditors to pay back their contingency fee if a determination is overturned at any level of appeal, among several others.[iii] In February 2014, CMS introduced five new changes to the RAC program, effective with the new contractor awards. These changes were also made in support of providers.

CMS uses layered safeguards to ensure high levels of transparency among auditors and providers. From the FY2015 budget justification: "**CMS has several policies in place to oversee and limit Recovery Auditor actions.** Many of these requirements have been in place since the national program began. First, CMS approves all RAC review methodologies prior to allowing RACs to identify improper payments. […] Second, an independent validation contractor then selects a random sample of claims, from each RAC, on a monthly basis. The results of these validation reviews are compiled to create an annual "accuracy" score for each RAC, which is published in the Recovery Audit Programs' Report to Congress."[iv]

According to CMS, the existing RAC pay structure also promotes accuracy. As CMS explains: "If an improper payment determination is overturned at any level of appeal, the Recovery Auditor contingency fee must be returned to CMS. **This process helps ensure the accuracy of the Recovery Auditors' reviews**."[v] Furthermore, RACs invest significant front-end resources to ensure accuracy, including using teams of certified coders, nurses and other clinicians to review hundreds of medical records. As a result, **RACs have an average accuracy rating of 96%**.[vi]

Challenges to Medicare Oversight & Integrity

Today, the RAC program faces several challenges. In Fall 2013, to combat an uptick in hospital "observation" stays that lead to sicker patients and higher costs, CMS released a new rule, requiring patients to stay two midnights before the hospital can classify them as inpatient. CMS suspended the rules enforcement from Oct. 2013 to Oct. 2014. CMS also suspended nearly all RAC audits of inpatient hospitals, which account for 91% of over-billings recovered by RACs. Then, in March 2014, lawmakers included a provision to extend the RAC auditing suspension until March 31, 2015, a cumulative period of 18 months. **This oversight holiday absolves inpatient hospitals of oversight and will force the Medicare Trust Fund to forgo up to $6 billion in potential recoveries.**

In February, this suspension was complicated by CMS's decision to bar RACs from requesting medical records from providers, while the agency transitions to the new RAC program contracts, effectively halting all auditing. CMS anticipates that auditing will resume with the new RAC contracts are awarded. However, the status and start dates for the new contracts are unknown.

Delays in the Medicare appeals process have further compounded these issues. Providers can appeal RAC findings up to five times, with Administrative Law Judges (ALJs) overseeing the third level of appeals. In 2012, an investigation by the OIG found that due to "wide interpretation" of Medicare policy, overturn rates among ALJs ranged from 18-85%.[vii] In 2013, this inconsistency led to a surge in "frequent filers" – providers that appeal every single audit. According to the Office of Medicare Hearings and Appeals, this trend, along with an increase in Medicare beneficiaries and in state Medicaid agency activity resulted in a massive backlog of cases. In December 2013, officials suspended all ALJ assignments until the judges can work through the backlog, which will take approximately two years. Providers and integrity contractors agree that **these delays tie up critical resources, undermine Medicare integrity and threaten long-term access to care.**

In response to the appeals suspension, our coalition released recommendations for ALJ reform. These include opening more effective lines of communication across all levels of appeal, promoting case resolution at the lowest level,

and strictly and consistently enforcing Medicare policy. Taken together, these solutions would provide immediate relief to the appeals backlog and foster transparency among all Medicare stakeholders.

Get RACs Back to Work

CMS and the HHS Office of Inspector General continue to reinforce the effectiveness of RACs, despite the challenges mounted against this program. In its annual RAC report released March 25, 2014, CMS says, "In accordance with the President's initiative to eliminate waste and improper payments across Federal programs, the Medicare FFS **Recovery Audit Program has proven to be a valuable tool to reduce improper payments.**"[viii] In the recent budget justification, CMS explained that the RAC program's consistently low rates of appeal show the agency has been "effective in ensuring that only valid claims are denied by the Recovery Auditors."[ix] And in April 2014, the **OIG named the RAC program the 'most improved' healthcare integrity initiative** with a $1.4 billion increase in recoveries from FY2012 to FY2013.[x]

Improving Medicare integrity requires balance. In its five-year existence, the RAC program has been a critical partner to CMS in bolstering Medicare integrity and promoting program oversight. While our coalition supports ongoing improvements to integrity initiatives, we remain deeply concerned about the financial implications of the recent pause in Medicare oversight. Following this hearing, our coalition urges the committee to relay the importance of the RAC program back to program administrators and to help expedite the contract-awarding process. Furthermore, our coalition supports having an ongoing, open dialogue with all Medicare stakeholders about strategies to improve billing accuracy and Medicare integrity overall.

On behalf of program integrity contractors and the nearly 50 million seniors who rely on Medicare every day, thank you for your consideration and for your efforts to improve oversight of our nation's marquee healthcare program.

Sincerely,

Rebecca Reeves
The American Coalition for Healthcare Claims Integrity

[i] *The Department of Health and Human Services, FY2013 Agency Financial Report, December 2013, Page 15: http://www.hhs.gov/afr/2013-hhs-agency-financial-report.pdf*

[ii] *The Department of Health and Human Services, FY2013 Agency Financial Report, December 2013, Page 161: http://www.hhs.gov/afr/2013-hhs-agency-financial-report.pdf*

[iii] *The Medicare Recovery Audit Contractor (RAC) Program: An Evaluation of the 3-Year Demonstration, June 2008, Page 25:* http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/recovery-audit-program/downloads/RACEvaluationReport.pdf

[iv] *Centers for Medicare & Medicaid Services. Justification of Estimates for Appropriations Committees, March 2014, Page 338: http://www.cms.gov/About-CMS/Agency-Information/PerformanceBudget/Downloads/FY2015-CJ-Final.pdf*

[v] *Centers for Medicare & Medicaid Services, FY2010 RAC Report to Congress, Oct. 2012, Page 11: http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Recovery-Audit-Program/Downloads/FY2010ReportCongress.pdf*

[vi] *Centers for Medicare & Medicaid Services, FY2011 RAC Report to Congress, Oct. 2012, Page 32: http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Recovery-Audit-Program/Downloads/FY2011-Report-To-Congress.pdf*

[vii] *Department of Health and Human Services Office of Inspector General, Improvements are Needed at the Administrative Law Judge Level of Medicare Appeals, November 2012, Page 14. https://oig.hhs.gov/oei/reports/oei-02-10-00340.pdf*

[viii] *Centers for Medicare & Medicaid Services, FY2012 RAC Report to Congress, March 2014, Page 11: http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Recovery-Audit-Program/Downloads/Report-To-Congress-Recovery-Auditing-in-Medicare-and-Medicaid-for-Fiscal-Year-2012_013114.pdf*

[ix] *Centers for Medicare & Medicaid Services. Justification of Estimates for Appropriations Committees, March 2014, Page 219: http://www.cms.gov/About-CMS/Agency-Information/PerformanceBudget/Downloads/FY2015-CJ-Final.pdf*

[x] *Department of Health and Human Services Office of Inspector General, U.S. Department of Health and Human Services Met Many Requirements of the Improper Payments Information Act of 2002 But Did Not Fully Comply for Fiscal Year 2013, April 2014, Page 9: http://oig.hhs.gov/oas/reports/other/171452000.pdf*

America's Essential Hospitals, Statement

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Current Hospital Issues in the Medicare Program

America's Essential Hospitals appreciates the opportunity to submit comments to the House Committee on Ways and Means regarding hospital issues in the Medicare Program, particularly concerns around the Centers for Medicare & Medicaid Services (CMS) two-midnight policy/short inpatient stays, auditing, and appeals.

America's Essential Hospitals is the leading association and champion for hospitals and health systems dedicated to high-quality care for all, including the most vulnerable. Since 1981, America's Essential Hospitals has initiated, advanced, and preserved programs and policies that help these hospitals ensure access to care. It supports members with advocacy, policy development, research, and education.

Our more than 200 essential hospital members are vital to their communities, providing primary care through trauma care, disaster response, health professionals training, research, public health programs, and other services. They innovate and adapt to lead the broader health care community toward more effective and efficient care.

Two-Midnight Policy

America's Essential Hospitals is deeply concerned about the impact of the two-midnight policy on our member hospitals. Last November, we urged CMS to delay enforcement of the revised inpatient admission guidelines and medical review criteria until at least October 1, 2014. Since that time, enacted legislation has extended an enforcement ban by an additional six months, until April 1, 2015. This extension indicate congressional recognition that the agency, hospitals, and other stakeholders are not prepared to implement the two-midnight policy, which will require thorough hospital and staff training and will subject hospitals to review contractor audits of short inpatient stays.

Due to the clinical complexity of the patients treated at essential hospitals, it is of utmost important that physicians be allowed to make determinations on the appropriateness of care for a given patient based on the patient's specific needs and comorbidities instead of being bound by a rigid assessment of the projected length of stay. We believe CMS should continue to work with stakeholders to revise the two-midnight policy so physicians' judgment of the most appropriate

level of care for a patient is preserved and not overturned by the retrospective evaluation of review auditors. =

Since the association's November letter, we have solicited additional feedback from our members on examples of these short stays. The clinicians at our member hospitals tell us that certain services are best provided in the inpatient setting and should be added as exceptions to the two-midnight policy (see attached). We are not suggesting these services be added to the inpatient-only list, but rather that they be added only to the list of services considered exceptions to the two-midnight policy.

These exceptions are especially important in our member hospitals, where the type of high-acuity care provided to complex and vulnerable patient populations often necessitates short-term inpatient stays. The complexity observed in our hospitals' patient populations results from multiple factors, including patient comorbidities and social factors. For example, our hospitals treat a racially and ethnically diverse mix of patients. This diversity may predispose patients to specific conditions, such as sickle cell anemia and thalassemia, which expose them to greater risk when receiving certain procedures. Because these diseases may complicate a patient's care, physicians often will determine that a procedure is most appropriately performed in an inpatient setting to manage these complexities. Patients with underlying conditions or complications will frequently require the resources available only in the hospital inpatient setting, even if those patients ultimately require only a short stay that does not cross the two-midnight threshold.

Except in rare and unusual circumstances, the revised inpatient admission guidelines would not allow Medicare Part A reimbursement to providers for short stays such as these—even when the services provided are best administered in an inpatient setting. Previously, many of these procedures were reimbursed when performed as inpatient procedures. The revised policy will force practitioners to re-evaluate their long-standing practice of basing admission decisions on clinical judgment and instead force them to base such decisions on administrative criteria. This has the potential to adversely affect patient care. Because of the potential negative impact of the two-midnight policy on the physician-patient relationship, it is important that the types of short-stay procedures listed in this letter be added as exceptions to the two-midnight policy. This will ensure physicians can continue to provide the type of appropriate care their patients need without payment being overturned by a review contractor making a decision at a later stage, removed from the clinical considerations that warranted an admission order by the physician.

Observation Status

In our fiscal year 2014 Hospital Inpatient Prospective Payment System comment letter, America's Essential Hospitals encouraged CMS to deem patients in outpatient observation status to have been admitted after 72 hours of observation services and pay hospitals a diagnosis-related group (DRG) payment for these deemed-admitted patients. Hospitals provide observational services to patients based on a physician's clinical judgment that it is the most appropriate setting for the patient. In certain cases, a physician may decide that a patient's condition requires further treatment. To provide further clarity on the blurred line between payment for inpatient and

outpatient services, we believe CMS should consider a patient who has been receiving observation services for 72 hours as "deemed admitted" for payment purposes. Cases involving extended observational services are more akin to an inpatient admission in terms of the complexity and level of care required to treat the patient.

To ensure the hospital is being reimbursed appropriately for these cases, CMS would bundle the outpatient services provided during the 72 hours into the DRG payment. Then, through separate rulemaking, CMS should modify its requirement for skilled nursing facility coverage so the period of observation care is counted toward meeting the three-day requirement for patients who are subsequently admitted to the hospital, including these deemed-admitted patients.

Medicare Auditing and Appeals

We greatly appreciate the committee's interest in Medicare auditing and review contractors. We previously recommended that CMS allow Medicare review contractors to review inpatient admissions that last for more than one Medicare utilization day only in limited instances when there is a clear indication of fraud or abuse. Under CMS' proposed policy, a review contractor would presume that a stay that was ordered by a physician and surpasses two midnights was medically necessary and therefore qualifies for Medicare inpatient reimbursement. Although there is a presumption that the inpatient admission is reasonable and necessary when it spans at least two midnights, the contractor still maintains the authority to review the entire medical record in a case and reverse a physician's judgment, even where there is a physician order and certification. Specifically, CMS notes that review contractors still should evaluate all inpatient admission decisions to identify any stays that were inappropriately prolonged to meet the two-midnight requirement. Also, a physician's order would hold no presumptive weight regarding the medical necessity of an inpatient admission and would be evaluated in conjunction with the evidence in the medical record.

While the proposed policy provides more clarity by adding the length of stay element to the criteria for an inpatient admission, the Medicare review contractor still retains excessive authority to make decisions that contradict the clinical judgment of a licensed physician who issued a physician order. These decisions by review contractors, which are frequently erroneous and reversed on appeal, can result in inappropriate reimbursement for inpatient admissions in cases where the physician's initial judgment was correct. For essential hospitals already stretched thin, these inappropriate and inaccurate reviews are truly detrimental. Therefore, in cases where there is no indication of fraud or abuse, CMS should remove this excessive review authority and consider stays lasting more than one Medicare utilization day (i.e., crossing two midnights) reasonable and necessary inpatient admissions.

We appreciate the opportunity the Ways and Means Committee has afforded us to share the impact these Medicare policies have had on our more than 200 members nationwide. We are concerned that excessive auditing and faulty policies will burden essential hospitals committed

to providing high-quality care to all, including the most vulnerable. If the committee or any other interested party wishes to learn more about how these policies impact essential hospitals nationwide, please contact Shawn Gremminger, director of legislative affairs, at 202-585-0112 or sgremminger@essentialhospitals.org.

ATTACHMENT 1

This is the list of services recommended for exclusion to the two-midnight policy and, when available, their current procedural terminology (CPT) codes:

- **General procedures:**
  - **insertion of non-tunnel central venous catheter (CPT code 36556)**
  - **prostate surgeries, including transurethral resection of the prostate and prostatectomy (CPT code 52601)**
  - **tube thoracostomy (CPT code 32551)**
  - **incarcerated hernia (CPT code 49561)**
  - **modified radical mastectomy (CPT code 19307)**
  - **partial thyroidectomy (CPT codes 60210 and 60212)**
  - **total thyroidectomy (CPT code 60240)**
  - **drainage of hematoma/fluid (CPT code 10140)**
  - **laryngoscopy with tumor excision and scope (CPT code 31541)**
  - **laparoscopy appendectomy (CPT code 44970)**
  - **laparoscopic cholecystectomy (CPT code 47562)**
- **Cardiac procedures:**
  - **pacemaker, automatic implantable cardioverter defibrillators, and other implantable defibrillator placement/replacement/repositioning/removal, including removal of implantable cardioverter defibrillator (CPT code 33244) and biventricular cardiac defibrillator placement[1]**
  - **insert intracoronary stent (CPT code 92980)**
  - **left heart artery/ventricle angiography (CPT code 93458)**
  - **percutaneous aortic valvuloplasty (CPT code 92986)**
  - **percutaneous mitral valvuloplasty (CPT code 92987)**
  - **pericardiocentesis (CPT code 33010)**
- **Neurological procedures:**
  - **one-level cervical spine fusion (CPT 22554)[2]**
- **Oncological procedures:**
  - **hepatic transcatheter arterial chemoembolization[3]**
  - **elective chemotherapy cases for patients that have adverse effects**
  - **radioactive thyroid treatment, after which certain patients must be isolated due to high radiation levels**
  - **biopsy/removal of lymph nodes (CPT code 38525)**
- **Gynecological procedures:**

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[1]**Biventricular cardiac defibrillator placement requires an inpatient stay overnight to monitor complications, such as internal bleeding.**

[2]**Other comparable spine fusion procedures are on the inpatient-only list (e.g., CPT code 22585), and the one-level procedure requires care and treatment similar to these inpatient-only procedures.**

[3]**An inpatient stay is required to monitor when the tumor breaks down. There is a risk for kidney failure, and this is best treated in an inpatient setting.**

- closure of vagina (CPT code 57120)
- myomectomy vaginal method (CPT code 58145)
- vaginal hysterectomy (CPT code 58260)
- vaginal hysterectomy, including tube(s) and/or ovary(ies) (CPT code 58262)
- laparoscopy, surgical, with total hysterectomy, with tube(s) and ovary(ies) 250 g or less (CPT code 58571)

AMA, Statement

Statement

of the

American Medical Association

to the

Committee on Ways & Means
Subcommittee on Health

RE: Current Hospital Issues in the Medicare Program

May 20, 2014

The American Medical Association (AMA) is pleased to provide the Subcommittee on Health of the Committee on Ways & Means with our views on Medicare's two-midnight policy, short inpatient stays, outpatient observation stays, auditing, and appeals. As a threshold matter, we urge the Subcommittee to consider that these issues significantly affect physicians as well as hospitals. These issues have raised considerable interest among our members and state and specialty medical societies. We look forward to continuing to provide the physician perspective as the Subcommittee examines these important issues.

Two-Midnight Policy

The AMA opposes Medicare's two-midnight policy and believes it should be rescinded in its entirety.[1] Under the policy, Medicare contractors presume that hospital inpatient admissions are reasonable and necessary for beneficiaries who exceed the two-midnight benchmark. In addition, Medicare contractors must now presume that hospital services spanning less than two midnights should have been provided on an outpatient basis. While stays for less than two midnights may be deemed properly inpatient if there is clear documentation in the medical record to support the physician's inpatient stay order, such determinations necessitate contractor review and audit. Therefore, hospitals have a disincentive to permit such orders.

[1] AMA Letter to CMS on the Medicare Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long Term Care Hospital Prospective Payment System and Proposed Fiscal Year 2014 Rates; Quality Reporting Requirements for Specific Providers; Hospital Conditions of Participation; Medicare Program; FY 2014 Hospice Wage Index and Payment Rate Update; Hospice Quality Reporting Requirements; and Updates on Payment Reform; Proposed Rules. June 25, 2013. Available at https://download.ama-assn.org/resources/doc/washington/x-pub/inpatient-prospective-payment-systems-comment-letter-25june2013.pdf

While we understand that the Centers for Medicare & Medicaid Services (CMS) intended to provide greater clarity regarding what constitutes an inpatient stay by instituting this policy, the effect has been quite the opposite. The policy has led to much confusion for physicians who are now faced with estimating the length of stay for their patients and determining whether they would fit within the arbitrary rubric of a two-midnight stay. For example, under the policy, the visit of a patient who comes to the hospital at 1:00 a.m. on a Monday, and stays through 11:00 p.m. on Tuesday—a total of 46 hours—would be presumed by Medicare review contractors to have been properly categorized as an outpatient stay. Incongruously, the visit of a patient who comes to the hospital at 11:00 p.m. on a Monday, and stays through 1:00 a.m. on a Wednesday—a total of 26 hours—would be presumed by a Medicare review contractor to have been properly categorized as an inpatient stay.

Adding to the complexity of the two-midnight policy is the inconsistency between when a hospital stay is considered to be inpatient for purposes of hospital reimbursement versus when a patient is considered an inpatient for purposes of coverage. The policy allows Medicare contractors to count the entire length of stay, including the time prior to the inpatient order, toward meeting the two-midnight benchmark for hospital reimbursement purposes. In contrast, the patient status does not change from "outpatient" to "inpatient" until the physician inpatient order is entered. This can alter the overall cost of the stay to the patient, and can significantly affect patient coverage for services like skilled nursing facility (SNF) care, for example. Physicians who are managing the overall care of their patients while also responding to institutional concerns about audits are left trying to navigate multiple interests and divergent rules.

We also have serious concerns about the administrative burden that this policy is having on physicians. While the authority to determine whether a patient requires an inpatient level of care should remain with the physician, the numerous inpatient order and certification requirements issued by CMS via sub-regulatory guidance and multiple addenda have resulted in a tremendous amount of new, confusing rules for physicians. We have advocated that, at a minimum, CMS should actively educate physicians and hospitals in regard to compliance with these requirements. Such education should go beyond CMS open door forums and national provider calls; education is needed "on the ground" to help physicians understand the litany of these requirements and their complexity.

Short Inpatient Stays

We are pleased that CMS adopted our recommendation in its 2015 Inpatient Prospective Payment Systems (IPPS) proposed rule to explore whether the use of a short stay payment adjustment might be a vehicle to remedy the problem of increased observation care and the

related issues that this trend has caused for physicians and patients.[2] We believe that a short stay payment methodology may more appropriately reimburse services that fall below the two-midnight benchmark, lessening the pressure on hospitals to either admit a patient or place the patient in observation care.

The short stay outlier is utilized by CMS as an adjustment to the payment rate for long-term care hospital (LTCH) stays that are generally much shorter than the average length of stay for a Medicare severity long-term care diagnosis-related group. Our impression is that the use of a short stay outlier affords LTCHs the flexibility to tailor patient stays for the amount of time to most appropriately address patients' clinical needs. We will be developing more detailed recommendations on this topic over the next several months, and will share our work with the Subcommittee at that time.

Outpatient Observation Stays

There can be wide differences in cost to the patient for time spent as an outpatient under observation. For example, self-administered drugs can cost significantly more for the patient under observation than to an inpatient. In addition, there may be repercussions related to post-acute coverage. Patients who require post-hospitalization SNF care must have a prior three-day inpatient stay to qualify for Medicare coverage. While CMS has asserted that the two-midnight benchmark addresses this issue, we think that the new two-midnight policy may have exacerbated the problem, as noted earlier in this testimony.

Consider the following hypothetical: a patient presents to the hospital at 1:00 a.m. on Monday and is placed under observation. By 2:00 a.m. on Wednesday, the patient is still in need of care, and is admitted to the hospital as an inpatient. The patient does not leave the hospital until 9:00 a.m. on Thursday, and is discharged to a SNF. Since the patient was there for more than two-midnights, she will be presumed by Medicare contractors to have been properly admitted as an inpatient for purposes of hospital reimbursement. But, because she was only an inpatient from 2:00 a.m. on Wednesday until 9:00 a.m. on Thursday, it is our understanding that she will not qualify for SNF care, even though she has been in the hospital for four days.

Because of the inequity for patients of the three-day inpatient stay requirement for coverage of SNF care, we have long advocated that CMS should either rescind that policy or allow outpatient observation care days to count toward the three-day stay requirement. In that vein, we strongly support S. 569 / H.R. 1179, the "Improving Access to Medicare Coverage Act of 2013," and urge the Subcommittee to act on this important legislation.

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[2] AMA and American Hospital Association Letter to CMS regarding Inpatient Admission and Review Criteria set forth in the FY 2014 Hospital Inpatient Prospective Payment System Final Rule. November 8, 2013. Available at https://download.ama-assn.org/resources/doc/washington/x-pub/two-midnight-suspension-letter-08nov2013.pdf

Audits

Physicians are firmly committed to eradicating fraud and abuse from the federal health care programs. Monies that inappropriately flow from federal health care programs divert vital resources that should be devoted to patient care. The AMA has long believed that the most efficient way to combat fraud is to employ targeted, streamlined methods of fraud identification and enforcement, rather than overly burdensome requirements for all physicians, the majority of whom strive to comply with the rules and regulations governing participation in the Medicare program. Through this lens, we have generally been supportive of the stated goal of CMS' Center for Program Integrity to employ data analytics and targeted fraud enforcement, rather than burdensome rules and methods, to efficiently target true fraud.

We continue to have serious concerns, however, about CMS' Recovery Audit Contractor (RAC) program. RACs audit physicians in private practice and in the hospital setting, and such audits are often very disruptive and resource-intensive. They are also often erroneous: the 2011 RAC report to Congress stated that provider-appealed overpayment determinations were decided in favor of the provider 43.6 percent of the time.[3] The 2012 RAC report to Congress, which was released earlier this year, cited a figure of 26.7 percent of appeals decided in providers' favor.[4] We think this number may not be representative of RACs' accuracy because, as we discuss later in our testimony, the number of appeals at the Administrative Law Judge (ALJ) level increased dramatically during that year and were not all fully adjudicated.[5] Importantly, physicians and other providers are most likely to have decisions overturned at this level of appeal.

Because of the litany of problems with the RAC program to date, we have engaged with CMS as they revise and renew their RAC contracts for the next contract period. **In particular, we sent formal recommendations on improvements to the RAC Statement of Work (SOW) to CMS last year, such as penalties for RACs that have a high error rate or that fail to meet administrative deadlines.[6]** We were pleased that CMS recently announced some positive changes to the forthcoming SOW, such as guidelines for when RACs can receive contingency

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[3] CMS. Recovery Auditing in Medicare and Medicaid for Fiscal Year 2011. Available at http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Recovery-Audit-Program/Downloads/FY2011-Report-To-Congress.pdf pg. 33.

[4] CMS. Recovery Auditing in Medicare and Medicaid for Fiscal Year 2012. March 2014. Available at http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Recovery-Audit-Program/Downloads/Report-To-Congress-Recovery-Auditing-in-Medicare-and-Medicaid-for-Fiscal-Year-2012_013114.pdf pg. 42.

[5] HHS. Office of Medicare Hearings and Appeals. Medicare Appellant Forum. February 12, 2014. Available at http://www.hhs.gov/omha/omha_medicare_appellant_forum_presentations.pdf (slides 15-16).

[6] AMA. Letter to CMS on the Revised RAC SOW. August 30, 2013. Available at https://download.ama-assn.org/resources/doc/washington/x-pub/rac-program-letter-30august2013.pdf

fees for appealed claims and deadlines for provider discussion periods.[7] Many of our other recommendations, however, have not been announced by CMS as adopted in the new SOW. We are continuing our work on these issues, and welcome further dialogue with the Subcommittee on the problems our members have encountered with the RACs and legislative means by which they may be addressed.

Appeals

We are very concerned about the two-year backlog at the Office of Medicare Hearings and Appeals (OMHA), and recently sent a letter with 97 state and specialty medical societies requesting action on this issue.[8] As you are likely aware, OMHA hosted a hearing on this topic in February. During that hearing, it was apparent that OMHA is being tasked with adjudicating a record number of appeals, largely because of problems with the RAC program. Many physicians believe that they must appeal erroneous overpayment recoupments to the administrative law judges at OMHA to receive equitable and fair determinations. While OMHA laid out plans to improve processes and protocols on their end, the problem clearly lies with the RAC and other audit programs themselves. We strongly believe that CMS should take a bottom-up approach to solving this problem and revise the RAC and other audit programs as we have recommended throughout this testimony to give the requisite relief to both physician appellants and OMHA staff.

Conclusion

Thank you for giving the AMA the opportunity to share our views on these important issues. We look forward to continuing to work with the Subcommittee as you formulate your next steps.

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[7] CMS. RAC Program Improvements. Available at http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Recovery-Audit-Program/Downloads/RAC-Program-Improvements.pdf. Accessed May 15, 2014.

[8] AMA, State and Specialty Societies. Letter to OMHA regarding Appeal Backlog. February 12, 2014. Available at https://download.ama-assn.org/resources/doc/washington/x-pub/medicare-appeals-backlog-sign-on-12feb2014.pdf

Alliance for Retired Americans, Statement

The Alliance for Retired Americans appreciates the opportunity to submit comments to the Committee on Ways and Means, Subcommittee on Health for the hearing entitled "Current Hospital Issues in the Medicare Program," which focused on Medicare's two midnight rule. The Alliance is very concerned about the growing practice of hospitals keeping patients under "observation status", rather than admitting them as inpatients. We are hearing from more and more of our members who are being affected by the policy.

Founded in 2001, the Alliance is a grassroots organization representing more than 4 million retirees and seniors nationwide. Headquartered in Washington, D.C., the Alliance and its 33 state chapters work to advance public policy that strengthens the health and economic security of older Americans by teaching seniors how to make a difference through activism.

Observation status is a designation used by hospitals to bill Medicare. As a result of this designation, more and more seniors are experiencing difficulties getting Medicare coverage for admission to skilled nursing facility (SNF), along with other billing issues. In fact, Medicare estimates show that 1.6 million seniors were placed in "observation status" during a hospital stay in 2011. This is a 69 percent increase over the previous 5 years.

While Medicare manuals suggest hospitals may hold individuals up to 24 hours (and in some exceptional circumstances up to 48 hours) in "observation status" prior to being admitted, many seniors that spend numerous days in the hospital are deemed to be in "observation status." Care provided to patients who are placed in "observation status" is billed as outpatient rather than inpatient. This means that patients are responsible for the 20 percent copay. Also, patients are being billed for medications they take routinely and which are not a result of the hospital visit.

The most significant consequence is for seniors who upon discharge from the hospital require care at a skilled nursing facility. If these Medicare beneficiaries were deemed to be outpatients or in "observation status", they do not meet the three-day inpatient stay requirement necessary to receive Part A coverage for post-hospital care at a skilled nursing facility. These individuals find themselves having to cough up thousands of dollars for their care at these facilities or go without needed care altogether. Many seniors are having to mortgage their homes or ask their loved ones for money to cover their medical bills. While Medicare beneficiaries may try to appeal Medicare's decision, the appeals process is long and tedious with unknown outcomes, and this usually occurs after beneficiaries have spent considerably out of pocket to get care.

We are also hearing that in many states the state employees health care fund is paying for retired state employees who find themselves in "observation status." This is

placing a burden on the coffers of many state employees health funds. States should not have to pay the cost of what is clearly a covered service under the Medicare program.

Medicare beneficiaries who have played by the rules and contributed their entire working lives to the program so that they can have peace of mind and be covered for medically necessary services should not find themselves incurring unexpected costs and having to hire attorneys to get the coverage they already paid for.

One solution that would solve this situation is for Congress to pass the bipartisan bill Improving Access to Medicare Coverage Act of 2013, S.569 and H.R. 1179, introduced by Senators Sherrod Brown and Susan Collins and Representatives Joe Courtney and Tom Latham, which would amend Medicare law to count a beneficiary's time spent in the hospital on "observation status" towards the three-day hospital stay requirement for skilled nursing care. The measure would also establish a 90-day appeal period following passage for those that have a qualifying hospital stay and have been denied skilled nursing care after January 1, 2013.

The Alliance for Retired Americans is pleased to support the Improving Access to Medicare Coverage Act and urges its speedy adoption by Congress.

AHCA, Statement

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STATEMENT FOR THE RECORD

HOUSE WAYS AND MEANS HEALTH SUBCOMMITTEE HEARING
"CURRENT HOSPITAL ISSUES IN THE MEDICARE PROGRAM"
May 20, 2014

MARK PARKINSON
PRESIDENT AND CEO
AHCA/NCAL

Chairman Brady, Representative McDermott, and distinguished Members of the Health Subcommittee, thank you for the opportunity to share the perspectives of the American Health Care Association/National Center for Assisted Living (AHCA/NCAL) as the Subcommittee examines current hospital issues in the Medicare program, with an emphasis on the Centers for Medicare and Medicaid Services (CMS) two-midnights policy, short inpatient stays, outpatient observation stays, auditing and appeals.

I serve as the president and chief executive officer of AHCA/NCAL, the nation's largest association of long term and post-acute care providers. The association advocates for quality care and services for the frail, elderly, and individuals with disabilities. Our members provide essential care to millions of individuals in more than 12,000 not for profit and for profit member facilities.

AHCA/NCAL, its affiliates, and member providers advocate for the continuing vitality of the long term care provider community. We are committed to developing and advocating for public policies that support quality care and quality of life for our nation's most vulnerable. Therefore, we are in support of policies that address the observation stays issue.

AHCA/NCAL continues to strongly support Representatives Courtney and Latham, along with Senator Brown in the bipartisan legislation they introduced, the Improving Access to Medicare Coverage Act of 2013 (S. 569/H.R. 1179), which seeks to count all hospital days spent in observation towards the three-day inpatient stay required for Medicare coverage of Part A skilled nursing care benefits.

AHCA/NCAL also supports legislation eliminating the three-day stay requirement, which effectively solves the related issue of observation stays. Representative Renacci's bipartisan Creating Access to Rehabilitation for Every Senior (CARES) Act of 2013 (H.R. 3531) eliminates the three-day inpatient stay requirement by allowing centers that meet particular criteria to automatically qualify to waive the prior hospitalization requirement. The criteria are based on the CMS Nursing Home Compare program. In addition, the association supports a similar bill introduced by Representative McDermott, the Fairness for Beneficiaries Act of 2013 (H.R. 3144), which also seeks to eliminate the three-day stay requirement.

Several national patient and provider organizations have written CMS and advocated on the Hill in support of addressing the observation stays issue. Unfortunately, there have been countless heart-wrenching stories from seniors who have had to pay high out of pocket expenses since they were deemed to be on observation status, and Medicare did not cover their necessary skilled nursing facility care. Often times, these individuals didn't even know they were on observation status -- or know to ask.

It is simply not right to limit access to quality care for those most in need. Now is the time for Congress to pass legislation that addresses this issue once and for all. Thank you again for the opportunity to weigh in on this important matter. AHCA/NCAL looks forward to working with Members of Congress in both chambers on the observation stays issue.

Advocate Physician Partners, Statement

Advocate Health Care
Written Testimony for the Record
Ways & Means Health Subcommittee
Hearing on Current Hospital Issues in the Medicare Program
Submitted June 3, 2014

On behalf of Advocate Health Care (Advocate), thank you for holding the May 20th hearing, titled "Current Hospital Issues in the Medicare Program." We very much appreciate the Subcommittee's leadership on – and attention to – some of the most pressing issues facing hospitals and health systems and the patients we serve. From our perspective, there are three issues in particular – the current inefficiencies and problems with the recovery audit contractor (RAC) program, the Centers for Medicare and Medicaid Services' (CMS) two-midnight policy, and the current Medicare requirement that a beneficiary have a three-day stay in a hospital before qualifying for skilled nursing facility (SNF) care – which necessitate Congressional attention and prompt action. We thank you for addressing these issues during the May 20th hearing.

Advocate, named among the nation's Top 5 largest health systems based on quality by Truven Analytics, is the largest health system in Illinois and one of the largest health care providers in the Midwest. Advocate operates more than 250 sites of care, including 12 hospitals that encompass 11 acute care hospitals, the state's largest integrated children's network, five Level I trauma centers (the state's highest designation in trauma care), three Level II trauma centers, one of the area's largest home health care companies and one of the region's largest medical groups. We are proud to contribute to the development of Illinois' and the nation's health care workforce by training more primary care physicians and residents at our four teaching hospitals than any other health system in the state.

Advocate is leading the nation in health system delivery innovation and is eager to bring our experiences forward to the benefit of helping transform the federal government and the nation's health care system. We have established the largest accountable care organization (ACO) in the country, which includes a commercial insurance contract, a Medicare Shared Savings Program (MSSP), and a Medicaid Accountable Care Entity. Using the Advocate Physician Partners' Clinical Integration Program and care coordination efforts as a model, Advocate**Care,** Advocate's commercial ACO, has achieved savings of an estimated two percent below the Chicagoland market costs and has successfully performed in all quality measures.[1] We are proud to be a national leader in innovative payment and care delivery models, and we seek to enhance and expand such efforts to the benefit of more patients and communities.

Advocate embraces the values of compassion, equality, excellence, partnership, and stewardship. In service of its healing mission, Advocate supports – and seeks to advance – policies and programs that ensure access to quality health care for all in need without compromising health care providers' ability to deliver such care. Advocate stands ready to work with policymakers at all levels to promote and preserve the health of the individuals, families, and communities of Illinois and to advance innovation in health care delivery to ensure quality and improve outcomes for all who are served by the nation's health care system. In that spirit, we submit this written testimony for your consideration as you develop policy solutions to address the challenges discussed by you, your colleagues, and the witnesses during the hearing.

[1] To learn more about Advocate**Care** visit http://amgdoctors.com/patients-and-families/advocatecare.

Advocate Health Care
Written Testimony for the Record
Ways & Means Health Subcommittee
Hearing on Current Hospital Issues in the Medicare Program
Submitted June 3, 2014

RAC Program

Reducing payment inaccuracies and minimizing fraudulent activity maximize Medicare resources available for patient care. As such, Advocate supports and fully complies with the federal government's myriad efforts to reduce improper Medicare payments; however, we face numerous challenges with respect to the fashion in which the Medicare RAC program operates as it is tipped in favor of the RACs. Despite Advocate's record of payment accuracy, Advocate's hospitals experienced a 58 percent increase in RAC record requests between calendar years 2011 and 2012. We are concerned with this significant increase in the number of Medicare RAC audit requests as we feel strongly that the time and resources being expended to process and respond to Medicare RAC audit requests can be better spent on improving the quality of care and outcomes for the patients we serve.

Since 2010, due to the sheer volume of requests, Advocate has hired seven full time employees solely to receive, log, and initially process Medicare RAC requests. This staff is in addition to the approximately 20 personnel who are responsible for substantively responding to Medicare RAC audits and appeals. Throughout the Advocate system, there are approximately 30 full time employees who are working each day to address some aspect of the Medicare RAC audit process. In total, since January 2010, Advocate has received 19,334 record requests worth $149,752,591 in Medicare claims, resulting in $19,321,090 returned to the federal government, of which $2,415,136 or 12.5% was paid to the RAC Auditor and $16,905,953 was paid to the U.S. Treasury/Medicare program.

Advocate estimated RAC compliance expenses 2010-January 2014:

Expense	**Cost**
Staff	$ 8,400,000
Executive Health Resources, Inc.	$ 14,400,000
Milliman	$1,000,000
Audit-tracking database	$ 500,000
Total Expenses	**$24,300,000**

According to the American Hospital Association (AHA), 40% of claims are denied by RACs nationally; of those denied claims, 44% are appealed and 72% of appealed Medicare Part A denials are fully overturned at the third level of appeal. The following summarizes Advocate's experience to-date:

Year	Appeal Rate	Overturn Rate
2010	23%	68%
2011	48%	60%
2012	57%	65%
2013	40%	72%
Average	**42%**	**66%**

Advocate has serious concerns with respect to the length of time between the initial RAC audit records request and the final adjudication. The RAC audit period can be up to three years and the RAC appeals process can take up to two years – stretching the timeframe from when a claim is first filed for services to concluding adjudication to as long as five years. AHA reports that 75% of RAC appeals are caught in the Medicare appeals process. This protracted timeline often precludes hospitals from securing full payment for needed patient care. Since many denials are for inpatient care (Part A) that was medically necessary, but RACs contend the care could have been provided in the hospital outpatient (Part B) setting, these claims often fall outside the 1-year filing window under which a provider can seek Medicare reimbursement. Medicare rules prohibit hospitals from rebilling services under Part B if they are older than one year.

- CMS found that 75% of RAC-denied claims fall outside the filing window and cannot be rebilled, despite the agency's requirement to pay for all reasonable and necessary care.
- As the Medicare program moves from a "pay and chase" system to a pre-payment model, providers will incur a significant financial burden as RACs will be able to hold monies until the issue reaches its final adjudication.

Currently most of the Medicare RAC audit requests are sent via paper through the U.S. mail system. Providers are given a limited number of days in which to respond to RAC audit requests; as such, use of this slow mode of communication significantly limits our response timeframe. Moreover, as the U.S. mail system can be somewhat unreliable, it is not uncommon for requests to fail to reach providers. Advocate urges Congress to require that all Medicare RAC audit requests be conducted via electronic means. Such efforts will allow providers the maximum amount of time in which to respond to requests and will help to improve the efficiency of the overall process.

Medicare RACs are slow to respond to providers' appeals requests. In Advocate's experience, our average response to an appeal request is between 18 and 24 months after the appeal is filed. Advocate urges Congress to significantly reduce the timeframe by which RACs must respond to appeals and to limit the number of records requests.

The *Medicare Audit Improvement Act of 2013* (HR 1250) would establish a limit for record requests, impose financial penalties on RACs that fail to comply with program requirements, make RAC performance evaluations publicly available, and allow denied inpatient claims to be billed as outpatient where appropriate. We believe this legislation will provide greater accountability and transparency to RAC operations, improve program functioning for all parties, and more appropriately identify the payments and providers that need adjudication. We respectfully encourage you to move this important legislation, as a standalone measure or as part of a larger package; this important bill will help level the playing field between RACs and health care providers.

Two-Midnight Policy

Since it was first announced in the fiscal year 2014 proposed Inpatient Prospective Payment System rule, the two-midnight policy has posed serious concerns to our physicians. While we appreciate CMS' efforts to provide additional clarity regarding the rule, Advocate is troubled by CMS' presumption that stays spanning less than two midnights generally should be classified as outpatient. Our physicians tell us that, in many instances, it is not always known – or expected – at the point of admission whether a beneficiary will require a stay spanning two midnights or more. Moreover, this policy can be confusing to Medicare beneficiaries who may not view an overnight stay in the hospital as anything other than an inpatient stay, and reclassification of a stay as outpatient impacts beneficiary out-of-pocket costs and eligibility for Medicare-covered skilled nursing care.

We are pleased Congress recently enacted, as part of the most recent Sustainable Growth Rate (SGR) "patch" legislation, a partial-enforcement delay of the two-midnight rule during which RACs are prohibited from conducting post-payment patient status reviews for inpatient stays with dates of admission from October 1, 2013, through March 31, 2015, unless there is "evidence of systematic gaming, fraud, abuse, or delays in the provision of care by a service provider." However, the legislation continues to authorize through June 2015 other medical review activities related to the two-midnight policy. As such, we are very concerned that these recent actions do not go far enough to correct this flawed policy and therefore, continue to urge enactment of HR 3698, the *Two-Midnight Rule Delay Act of 2013*, introduced by Representative Jim Gerlach (R-PA). This important measure bans enforcement of the rule, prohibits an increase in the sample of claims selected for prepayment review under the Medicare Probe and Educate program, and directs the Secretary of Health and Human Services to develop a much-needed, new payment methodology appropriate for short inpatient stays. Taken together, the provisions of HR 3698 should help ensure that patients receive the right care in the right setting at the right time and give providers the clarity they need to comply with all payment and administrative requirements of the Medicare program with respect to short inpatient stays. We hope you will move this proposal through the subcommittee and advance its enactment this year.

Advocate Health Care
Written Testimony for the Record
Ways & Means Health Subcommittee
Hearing on Current Hospital Issues in the Medicare Program
Submitted June 3, 2014

Three-Day Stay

Under current policy, Medicare fee-for-service beneficiaries must have at least a three-day inpatient hospital stay before they qualify for Medicare-covered care in a SNF. While we appreciate the intent behind the policy is to help ensure that those beneficiaries who are referred to a SNF truly need that level and type of care, we believe the policy unintentionally precludes certain beneficiaries from receiving the SNF care their health care providers believe they require. We have heard from our physicians and nurses across our system that the Medicare three-day policy stands in the way of patients receiving the type of care they need at the time they need it because for some cohorts of Medicare beneficiaries it forces the institution to admit a beneficiary for expensive inpatient care, when SNF care may be more medically appropriate for the individual patient. Clinicians have explained to us that the policy is not grounded in evidence-based medicine or clinical guidelines for the particular condition the patient has, and does not allow for a physician's clinical judgment to be applied to each individual patient's particular circumstance. Rather, the policy is a "one-size-fits-all" approach, which does not allow patients who do not need a three-day hospital stay but do need SNF care to access SNF care in a timely or direct fashion – increasing costs to Medicare and the beneficiary.

Nationally, approximately one quarter of Medicare beneficiaries are admitted to SNFs from hospitals and readmitted to the hospital within 30 days.[2] In a six month period November 1, 2012, to April 20, 2013, Advocate hospitals treated 2,756 beneficiaries who were admitted from and returned to a SNF. While not all of these patients are readmitted as an inpatient to the hospital in order to qualify for Medicare coverage, anecdotal evidence suggests a significant number of patients use this mechanism in order to subsequently obtain SNF coverage. Such care transitions – which are potentially disruptive to the patient and can negatively impact their quality of care – result in an unnecessary increase in health care costs.

In addition, Advocate hospitals have seen an increase in the number of Medicare beneficiaries who are treated in their emergency departments for care that could be better provided in a SNF but for the imposition of the three-day rule. As a result, Medicare pays for high-cost health care delivered in the emergency department, when lower-cost, more appropriate care at a SNF may be more aligned with the beneficiary's particular health care needs.

Further complicating the situation is that for a different cohort of beneficiaries, the use of observation services is increasing. According to Medicare, "observation services are hospital outpatient services given to help the doctor decide if the patient needs to be admitted as an inpatient or can be discharged. Observation services may be given in the Emergency Department (ED) or another area of the hospital."[3] Patients under observation may indeed spend one or more nights in the hospital; however, since observation status is considered "outpatient

[2] Mor V., Intrator O., Feng Z., & Grabowski D.C., The Revolving Door of Rehospitalization from Skilled Nursing Facilities, Health Affairs, 2010 Jan. 29(1); 57-64.
[3] "Are You a Hospital Inpatient or Outpatient? If You Have Medicare – Ask!" Published by the Centers for Medicare and Medicaid Services, available at http://www.medicare.gov/pubs/pdf/11435.pdf.

care" it does not "count" toward meeting the current requirements of the three-day rule.[4] As such, a number of beneficiaries who spend three days under observation status at the hospital who indeed may need SNF care, do not qualify for it to be covered by the Medicare program.

The three-day rule only applies to beneficiaries who are enrolled in the traditional Medicare fee-for-service program. Medicare Advantage plans may provide SNF coverage without the prerequisite three-day rule inpatient stay, but are not required to do so. Medicare Advantage's direct access to SNF care suggests that waiving the three-day rule may help reduce overall costs for many beneficiaries and the Medicare program, given that Medicare pays more for inpatient care than it does for care provided at a SNF. Advocate's Medicare Advantage plan – which, consistent with many other Medicare Advantage plans, does not impose the three-day rule requirement – maintains an average length of stay (ALOS) of 3.5 days in the hospital for its beneficiaries, in comparison with Medicare fee-for-service ALOS which is 4.53 days. National guidelines by Milliman note the ALOS in the hospital for Medicare age patients in moderately managed programs should be 4.90 days. Our ability to maintain the lower ALOS for Medicare Advantage patients suggest waiving the three-day rule may help reduce overall costs for many beneficiaries and the Medicare program. Most importantly, a lower ALOS reduces the likelihood of complications such as nosocomial infection and adverse safety events, which can significantly drive up costs and negatively impact patient outcomes.

In 2012, approximately 10 percent of the Advocate Medicare Advantage SNF admissions were direct admits with no inpatient stay. Because Advocate's Medicare Advantage plan is not bound by the three-day rule requirement, enrollees are able to more readily access site-appropriate care, which saves valuable health care resources, and can ensure the enrollee avoids unnecessary exposure to the acute care environment. In 2012, of the Advocate Medicare Advantage enrollees who were admitted from an Advocate hospital to a SNF:

- 36% of patients were admitted to a SNF in less than three days of inpatient care; (20% admitted to a SNF after 2 days, 16.4% after one day inpatient hospital).
- The remaining 64% of enrollees had a length of stay of 3 or more acute hospital days prior to moving to a SNF.

As you heard from CMS Deputy Administrator Sean Cavanaugh, a significant number of hospitals and health systems – such as Advocate – are helping to transform the delivery of health care and have illustrated this commitment to improving care while bending the cost curve by becoming partners with Medicare through numerous initiatives, including the ACO Pioneer program, the Advance Payment ACO initiative, the MSSP, and other alternative payment models. During the hearing, Deputy Administrator Cavanaugh twice mentioned that CMS has granted the Pioneer ACOs and a group of hospitals and post-acute providers testing bundled

[4] According to the Medicare Payment Advisory Commission (MedPAC), nationally, the use of Medicare observation care has increased significantly to more than 31 million hours in 2008, up from 23 million hours in 2006 (an increase of 33 percent). MedPAC, Recent Growth in Hospital Observation Care, MedPAC presentation, Sept. 13, 2010, at page 6, available at http://www.medpac.gov/transcripts/observation%20sept%202010.pdf.

payment models a waiver from the Medicare three-day rule to test the impact of allowing beneficiaries "direct access" to SNFs.

We believe eliminating the three-day rule for institutions participating in the MSSP should improve the quality of care for Medicare beneficiaries and help to ensure they receive the right care, in the right setting, at the right time. Advocate's experience with Medicare Advantage's direct access to SNF care suggests that waiving the three-day rule for institutions like ours may help reduce overall costs for many beneficiaries and the Medicare program, given that Medicare pays more for inpatient care than it does for care provided at a SNF. Advocate respectfully urges the Subcommittee to encourage CMS to expand the scope of its three-day rule waivers to include MSSP participants, such as Advocate.

Conclusion

Again, thank you for holding this important hearing and for your attention to these critical policy issues. Advocate stands ready to work with all members of the Ways and Means Health Subcommittee, and your other colleagues, to advance policies, programs, and practices that will help improve quality of care and outcomes, reduce spending, minimize improper payments, and otherwise help ensure that Medicare beneficiaries receive the right care, at the right time, in the specific care setting appropriate for their medical needs and health status. Specifically, we hope you and your colleagues will take action to reform the RAC program, ban implementation of the two-midnight rule, and eliminate the three-day rule for a broader group of hospitals and health systems who have demonstrated – to the federal government and the nation – a commitment to delivery system reform and the testing of alternative payment models. If we can be of any assistance, please do not hesitate to call upon us – we are eager to be a resource to you as you tackle these pressing Medicare payment and policy issues.

ACMA, Letter

June 3, 2014

Submitted via e-mail (waysandmeans.submissions@mail.house.gov)

Chairman Brady, Ranking Member McDermott and Representatives Blumenauer, Buchanan, Gerlach, Johnson, Kind, Nunes, Pascrell, Price, Roskam, Ryan, Smith and Thompson
Ways and Means Subcommittee on Health
United States House of Representatives
Washington, DC 20515

RE: Current Hospital Issues in the Medicare Program

Dear Honorable Members:

On behalf of our more than 4,800 nurses, social workers, physicians, educators, administrators, and other professionals – representing approximately 985 U.S. hospitals, nearly 40% of all U.S. hospitals – responsible for providing case management services in hospitals or health systems, the American Case Management Association (ACMA) appreciates the opportunity to submit our concerns and recommendations related to observation services for consideration by the Committee and for inclusion in the printed record of the Committee's May 20, 2014 hearing.

As you know, hospital case managers are clinically-competent professionals responsible for managing health care transitions across multiple providers and throughout the continuum of care, a critical component in reducing preventable hospital readmissions and improving patient outcomes.

As an association representing professionals who daily serve as advocates on behalf of both patients and the hospital they serve, observation services is an issue that is of particular concern to our membership, and since 2012, ACMA has actively advocated to halt the inappropriate use of observation services.

Observation services and the three-day stay requirement are issues that adversely impact both patient and provider; creating barriers for case managers in providing appropriate care and facilitating safe transitions. In a survey of ACMA members, 78% of the 334 respondents said that they were experiencing longer length of stay (LOS) for patients receiving observation services.[1]

Medicare statutes and regulations do not define observation services. The only definition appears in various CMS manuals, where observation services are described as: [2]

> "a well-defined set of specific, clinically appropriate services, which include ongoing short term treatment, assessment, and reassessment, that are furnished while a decision is

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> being made regarding whether patients will require further treatment as hospital inpatients or if they are able to be discharged from the hospital."[3]

According to the CMS manuals, in most cases a beneficiary may not remain in observation services for more than 24 or 48 hours.[4] Unfortunately, under Medicare rules, time spent in outpatient observation services in a hospital does not satisfy the three-day inpatient hospital requirement which entitles the patient to Medicare coverage of any post-hospital extended care services in a skilled nursing facility (SNF). This means that Medicare beneficiaries are then charged directly for various services they receive in an acute care setting, including prescription medications, and for their SNF stay, rather than Medicare covering those costs. Patients who are medically qualified for SNF placement, but are unable to pay out-of-pocket, are often discharged to home because they did not satisfy the three-day stay requirement.[5]

However, the issues surrounding observation services have changed – it is no longer extended LOS in observation status that does not allow for SNF coverage. Now patients should be admitted if they require a second night in the hospital. Thus, five- and six-day observation stays should now be unheard of – but reports from hospitals indicate an increase in observation stays (a stated CMS concern), and patients are not qualifying for SNF care because their first night in the hospital was in observation status. In addition, patients are exposed to Part B costs, including the cost of self-administered medications. CMS has stated that there is no difference in "level of care" between observation and inpatient, but decided that all short stays should be outpatient. There is no logic to this position.

The issue of certification of admission should also be addressed. The Social Security Act requires certification of the medical necessity for inpatient admission but addresses only admissions "over time," and specifically mentions the timing of certification of outliers. The 2015 Inpatient Prospective Payment System (IPPS) rule adopted outlier certification rules for new inpatient admissions, which led to a number of inconsistencies. Ultimately, CMS stated that certification was no more than an admission order plus routine medical necessity documentation. This decision created a number of serious issues, because CMS requires that (a.) the certification be signed before discharge (an unnecessary requirement that leads to technical denials) and (b.) all elements of certification be signed by the time of discharge. Documentation supporting medical necessity for admission includes the admission history and physical (H&P), but we have recently heard of a Medicare Administrative Contractor (MAC) denying payment because the H&P had not been signed prior to discharge, which can be an impossibility for a short inpatient stay with a dictated H&P that requires transcription.

Outlined below are our association's recommendations regarding the various issues surrounding observation services. As health care professionals who are directly impacted by these issues, we ask that you please consider our feedback and concerns carefully as you evaluate current hospital issues in the Medicare program, specifically the ongoing problem of observation services.

Recommendations

- Amend Medicare law (Title XVIII of the Social Security Act) to allow for the time patients spend in the hospital under observation services to count toward the requisite

three-day hospital stay for coverage of skilled nursing care. This is the goal of H.R. 1179 and S.569 (Improving Access to Medicare Coverage Act of 2013).

- CMS should develop a "short stay DRG" to allow admission of any patient who requires hospital care beyond the emergency department (ED) and short observation stays, such as 12 hours (including time spent in the ED).
- Implement a change in regulations that would meet the statutory certification requirement by requiring the admitting physician to sign a simple, standardized certification statement such as, "I certify that this admission was medically necessary in compliance with current Medicare regulations." There would be no reduction in the required documentation for medical necessity for admission, but documentation would no longer be tied to certification. Furthermore, nothing prevents such a statement from being signed any time prior to billing.

We appreciate your willingness to consider the concerns of health care delivery system case management professionals. ACMA and its members would be glad to further discuss these concerns and recommendations. We would appreciate the opportunity to work with members of the Committee to improve upon current systems and efforts to rectify issues in the Medicare program.

Should you have any questions, please feel free to contact me at 501-907-2262 or lgregc@acmaweb.org.

Cordially,

/s/

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3. Medicare Benefit Policy Manual, CMS Pub. 100-02, Chapter 6, §20.6; same language in Medicare Claims Processing Manual, CMS Pub. 100-04, Chapter 4, §290.1.
4. *Id.*
5. *Id.*

AARP, Letter

AARP
Real Possibilities

June 3, 2014

The Honorable Kevin Brady
Chairman
Subcommittee on Health
Committee on Ways and Means
U.S. House of Representatives
Washington, DC 20515

The Honorable Jim McDermott
Ranking Member
Subcommittee on Health
Committee on Ways and Means
U.S. House of Representatives
Washington, DC 20515

Dear Chairman Brady and Ranking Member McDermott:

On behalf of nearly 38 million AARP members and the millions more Americans with Medicare, thank you for holding the May 20, 2014, hearing examining current hospital issues in the Medicare program. Decisions concerning inpatient admissions, observation status, and short inpatient hospitals stays have a tremendous impact on Medicare beneficiaries. Specifically, the decision to admit an individual, and the timing of that decision, greatly affects the beneficiary's out-of-pocket costs and the ability to receive skilled nursing facility (SNF) care covered by Medicare.

The use of "observation status" has become more prevalent in recent years. A study released last year by AARP's Public Policy Institute found the use of Medicare hospital observation services grew by over 100 percent from 2001 to 2009.[i] This rise in observation services has coincided with a decrease in inpatient admissions. Additionally, the duration of observation stays has grown longer. While there may be several reasons for these trends, it is clear that Medicare beneficiaries are spending more and more time in the hospital without being formally admitted. Admission as an inpatient activates Medicare Part A cost-sharing and a three-day stay requirement; as opposed to observation status, which is billed under Part B and can expose beneficiaries to unexpectedly high out-of-pocket costs that can amount to thousands of dollars.

Two-midnight Rule

The Centers for Medicare & Medicaid Services (CMS) attempted to reduce the number of long observation stays by establishing a presumption that stays spanning more than two midnights would be considered medically necessary. In theory, CMS expects that deeming an admission reasonable and necessary if the stay is expected to span two midnights encourages providers to move some patients from outpatient or observation status to inpatient status.

CMS subsequently clarified that the two-midnight benchmark is not the *sole* criteria for admission. CMS believes that the two-midnight benchmark should not preempt physician judgment regarding medical necessity. Some patients may require hospital

admissions for less than two midnights, and physicians should not be discouraged from admitting them due to confusion or misinterpretation of the rule.

Cost-sharing

The two-midnight rule, however, fails to address how observation status affects beneficiary cost-sharing and SNF coverage. CMS expects the physician's decision to admit will be based on the cumulative time spent at the hospital beginning with the initial outpatient service, thereby allowing the physician to consider the time already spent receiving those services in estimating the beneficiary's total expected length of stay.

Yet, later in the rule, CMS states: "While outpatient time may be accounted for in application of the two-midnight benchmark, it may not be retroactively included as inpatient care for skilled nursing care eligibility or other benefit purposes. Inpatient status begins with the admission based on a physician order." (78 Fed. Reg. 50950) This appears to be a significant inconsistency which will have a dramatic impact on beneficiary costs. If the entire time spent receiving care is deemed reasonable and necessary for admission, then the entirety of care should be billed under Part A. Otherwise, CMS and the hospital are effectively telling the patient: "Some of the time you were here was reasonable and necessary and billed under Part A; yet, at the same time, some of the stay wasn't reasonable and necessary and will be billed under Part B." We believe CMS cannot have it both ways.

Billing for physician services, laboratory tests, imaging, and hospital administered drugs under Part B subjects the beneficiary to the 20 percent coinsurance. In addition, because Part B does not cover the cost of self-administered drugs provided in the outpatient setting, beneficiaries are typically responsible for the full cost of hospital charges for these drugs, instead of having them covered as part of a Part A stay. These charges can quickly add up and exceed the Part A hospital deductible amount of $1,216 per benefit period, as well as be especially burdensome for those on fixed incomes. We urge Congress and the Administration to clarify beneficiary cost-sharing for observation stays should align with Part A cost sharing upon admission.

Three-day Stay Requirement, Observation Status, and Skilled Nursing Facility Coverage

Individuals in observation status or observation (receiving outpatient observation services) are classified as hospital outpatients, not as inpatients. However, in many hospitals, actual medical services provided in the inpatient and observation settings are virtually identical. Patients in observation status may stay in a hospital bed overnight or for periods of time as long as several days and receive care that may be indistinguishable from inpatient care.

Unfortunately, the financial impact for Medicare beneficiaries who spend time in observation can be burdensome and significant. Medicare requires a three-day inpatient hospital stay as a precondition for Medicare coverage of SNF services. However, time spent in observation does not count toward the three-day stay

requirement, so some beneficiaries may fail to qualify for Medicare coverage of SNF care, even though they have spent more than three days in a hospital setting. These beneficiaries may be faced with paying the full cost of their SNF care or being denied appropriate SNF care due to lack of Medicare coverage. The Office of the Inspector General of the U.S. Department of Health and Human Services found that in 2012, Medicare beneficiaries who did not qualify for Medicare coverage of SNF services were liable for SNF costs averaging $10,503.[ii] In some cases, Medicare beneficiaries may not even be aware that they are under observation and the financial implications of observation status until after they leave the hospital. And those who are made aware of their observation status may forego necessary follow-up SNF care.

AARP and many other groups have endorsed the bipartisan Improving Access to Medicare Coverage Act (H.R. 1179/S. 569) sponsored by Representatives Joe Courtney (D-CT) and Tom Latham (R-CT) and Senators Sherrod Brown (D-OH) and Susan Collins (R-ME) to help address the high costs that some Medicare beneficiaries pay for SNF care due to their time in observation. This legislation would count time spent receiving outpatient observation services (i.e. in observation status) toward the 3-day prior inpatient stay requirement for SNF coverage. This legislation would help some beneficiaries receive the SNF services they need and help reduce large out-of-pocket expenses for some Medicare beneficiaries who need SNF services. We urge the House and Senate to act on this legislation.

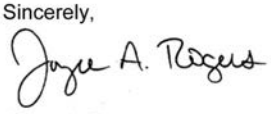
Prescription Drug Coverage during Observation Status

Many beneficiaries find themselves facing large hospital bills for drugs they received while in "outpatient" observation status. When an individual is in outpatient observation status at a hospital, Medicare Part B is billed, and pays for, 80 percent of the hospital services provided. However, some outpatient prescription drugs received in the hospital while a patient is in observation status, such as oral medications, are not billed to Part B. Beneficiaries who do not have Part D drug coverage must pay out-of-pocket for the full amount of hospital charges for these drugs. Beneficiaries who are fortunate enough to have Part D coverage must submit a claim to their Medicare Part D plan to receive reimbursement for these drugs. Part D plans are required to have a process in place to pay claims submitted by beneficiaries who received drugs from a hospital's out-of-network pharmacy. However, the burden falls on beneficiaries to get their drugs appropriately covered under Part D.

Beneficiaries must request an out-of-network pharmacy claim form from their Part D plan and submit the completed claim form with the bill for medications from the hospital as well as a letter explaining that they were in observation status at the hospital and could not get to an in-network pharmacy. If the beneficiary received drugs in the hospital that were off-formulary, they need to ask the Part D plan for an exception to have the drugs covered. Also, after the Part D plan covers the drugs, the beneficiary will be liable for co-pays which may be higher because the hospital pharmacy is out-of-network. In short, observation status is leading to higher drug costs for beneficiaries than they would otherwise incur if they received their drugs on an inpatient basis.

AARP appreciates the attention the Subcommittee is paying to observation stays and related issues. We look forward to working with the Committee as you address these issues and urge action on the Improving Access to Medicare Coverage Act. If you have any questions, please feel free to contact me or have your staff contact Andrew Scholnick or Rhonda Richards of our Government Affairs staff at 202-434-3770 or ascholnick@aarp.org or rrichards@aarp.org.

Sincerely,



Joyce A. Rogers
Senior Vice President
Government Affairs

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AAMC, Letter

The Association of American Medical Colleges (AAMC) is pleased to submit this statement to the record for the May 20, 2014, hearing, "Current Hospital Issues in the Medicare Program," of the House Ways & Means Committee's Subcommittee on Health.

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 128,000 faculty members, 83,000 medical students, and 110,000 resident physicians.

The AAMC applauds Subcommittee Chairman Kevin Brady and Ranking Member Jim McDermott for their continued attention to the Medicare payment issues affecting our nation's hospitals and the patients they serve. We welcome this opportunity to share with the Subcommittee our concerns with the Centers for Medicare and Medicaid Services' (CMS) new policy for determining the appropriateness of inpatient hospital care, commonly referred to as the "two-midnights" policy, as well as the ongoing challenges faced by our member institutions in responding to aggressive audits by Recovery Audit Contractors (RACs).

Effective October 1, 2013, CMS established a new time-based standard for determining whether a hospitalization should be considered inpatient or outpatient care for the purposes of Medicare reimbursement. Eschewing the long-used clinical criteria to determine the most medically appropriate setting for care, CMS's new policy draws a bright line based on expected length of stay. Simply put, hospitalizations expected to last longer than two midnights are classified as inpatient and, with few exceptions, those stays expected to be shorter must be billed as outpatient.

While we recognize CMS's intention to clarify Medicare's hospital inpatient admission criteria, the two-midnights policy as written adds a new layer of complexity that subverts CMS's stated objective of clarity, creates confusion and financial burden for patients, and inappropriately places clinical judgment at odds with adequate reimbursement for hospitals.

In response to the vehement outcry from the AAMC and the rest of the hospital community, as well as vocal concern from Members of Congress, CMS delayed one aspect of enforcement of the two-midnights policy. Under this partial delay, hospitals must still follow the two-midnights rule in their claims submission, but should they happen to make errors, RACs may not retroactively deny payment on the basis of the two-midnights rule alone. In passing the *Protecting Access to Medicare Act of 2014*, Congress extended this suspension of RAC audits related to the two-midnights policy until March 31, 2015. The AAMC is grateful for the work of the House Ways & Means Committee and other Congressional champions to pass this important provision.

While the AAMC values this modest relief from RAC audits directed at these stays, the underlying two-midnights policy is still very much in effect and is negatively affecting providers and patients every day, as hospitals are still expected to be in full compliance with the flawed rule. This present and ongoing impact makes today's hearing particularly timely, as does the open comment period on CMS's FY15 IPPS proposed rule. We hope today's hearing, and accompanying testimony from outside stakeholders such as the AAMC, will inspire Members of the Subcommittee and their colleagues to formally urge CMS to use its rulemaking authority to immediately undo the most harmful aspects of the two-midnights policy and focus instead on sensible reforms to the RAC process.

The Two-Midnights Policy Arbitrarily Disregards the Medical Judgment of Physicians

Academic medical centers care for many patients with high-acuity and complex medical issues. The physicians and other medical professionals at these premier institutions are committed to delivering the highest quality medical care, in the most appropriate settings, to every patient – without exception. In making decisions whether to admit patients to the hospital, these highly-trained clinicians rely on their best medical judgment and established clinical protocols, rather than a stopwatch. With the benefit of hindsight one could likely identify a portion of short inpatient hospitalizations that could have been treated in outpatient settings, but identifying such cases in the moment of treatment is far more complex.

CMS has established a brief and concrete list of procedures, which, if conducted during a short hospital stay, would qualify the admission as inpatient. There are many other circumstances in which a short inpatient hospitalization is medically necessary, but are challenging to encapsulate on an 'exceptions' list as they are highly dependent on many factors such as a patient's overall condition, age, and co-morbidities. These include, but are certainly not limited to:

- *Congestive Heart Failure (CHF)*: A patient may come to the hospital experiencing symptoms related to CHF and require short-term but intensive monitoring in an inpatient setting that includes interventions to reduce fluid on their lungs. These patients may have underlying cardiac and pulmonary disease (such as emphysema) that makes diagnosis and treatment more complex. In otherwise stable, healthy patients, fluid and electrolytes can be brought back into balance relatively quickly with aggressive treatment. Many patients can switch quickly from an intravenous to oral regimen and go home in short order without having to stay "two midnights." However, many CHF patients also suffer from renal disease requiring closer monitoring and careful fluid balancing to avoid having treatment for one disease (CHF) negatively affect another (renal disease). In such cases, patients may still fare well and be discharged before 'two midnights' have elapsed but must be treated in an inpatient hospital setting. Not providing that level of care would endanger patient safety.

- *Acute Exacerbation of Asthma:* Some patients presenting with particularly acute asthma attacks may respond relatively quickly to IV steroids and nebulized inhaled medicines, yet it is difficult to predict who will suffer respiratory failure before the medications stabilize them. Often, these patients may be able to transition to home inhalers and oral steroids in under 'two midnights' but not all will – and they may require intubation, use of a ventilator, and an extended hospital stay. Careful monitoring, in a setting equipped to respond quickly should the patient's status worsen, is often essential since it is impossible to always predict accurately which patients will recover quickly and which will remain critically ill.

- *Myocardial Infarction (MI or Heart Attack)*: Similarly, patients experiencing symptoms of chest pain may have underlying cardiac and lung disease that make a diagnosis of acute MI (a potentially fatal event) important to rule out. When a diagnosis is confirmed, this will require a brief inpatient stay that consists of management w*ith anti-coagulants, beta bl*ockers, aspirin, statins, coronary angiography, and other immediate and intensive interventions. After a short period of careful inpatient monitoring and assessment, patients in this category are sometimes able to return home without having to stay more than one night, but this discharge time does not diminish the necessity of their hospital care. Our advances in our ability to treat heart attack patients safely and effectively in shorter periods of time does not mean that those patients are in any less danger; or that the intensity of care required to treatment them has decreased.

In academic medical centers, where patients are much more likely to have complicated medical conditions or behavioral health issues, physicians often see cases that require inpatient treatment because of their sheer complexity. Seemingly simple presenting conditions, such as chest pain, are often not so simple in patients who suffer from multiple comorbidities. Though some chest pain cases may be appropriately handled in observation units, very sick patients— with underlying cardiac, lung, and other diseases— require more intensive monitoring and treatment, especially because the risk of fatality is high if a heart attack does occur. In these cases, inpatient care is medically necessary – even if the patient is deemed fit to return home without further diagnosis after less than 'two midnights' of careful monitoring.

No one would argue that every asthma or chest pain case warrants an inpatient level of care, but it is undeniable that some of these cases require brief hospitalizations and aggressive care and monitoring during that stay. The factors in distinguishing such instances are numerous, nuanced, and necessarily unique to each patient. It is for this reason that a policy based solely on length of time and a limited set of procedure-based exceptions will never provide a safe or adequate rubric for determining appropriateness of inpatient care.

The Two-Midnights Policy Results in Unsustainable Payment Cuts to Hospitals and Discourages Efficiency

In hospitals across the country, physicians continue use their best medical judgment in making treatment and site of care decisions –risking their payments, instead of their patients. This means that patients continue to be hospitalized for stays shorter than two-midnights, for all of the reasons illustrated above and many others, but now hospitals are receiving dramatically reduced reimbursements for those medically necessary short stays. At Johns Hopkins, the number of patients admitted to the hospital but reimbursed only at outpatient rates has increased by 33 percent since the implementation of the two-midnight policy. At University of Texas Southwestern, the shift to re-classifying clinically required inpatient hospitalizations as outpatient claims has led to over $3 million in lost reimbursement across three specialties alone, with the true impact likely far greater. This experience is typical among AAMC members, and results in a dramatic payment cut for medically necessary hospital services delivered to patients.

The very fact that these medically necessary intensive stays can occur in such a relatively brief period of time is a testament to the innovation and achievement of high-performing institutions. With improved technology and efficiency, more patients are being evaluated, treated, and transitioned to an appropriate care setting in less than the two-midnight timeframe. In the past, these patients would have been expected to stay longer and, therefore, would be considered inpatients under the two-midnights policy. This is the very medical efficiency CMS should be encouraging but, instead, hospitals are seeing dramatic reimbursement cuts as these gains in efficiency result in denials of inpatient claims.

The two-midnights policy is also responsible for another, even more direct, cut to hospital reimbursement. When finalizing its new time-based standard for distinguishing between appropriate inpatient and outpatient care, CMS assumed that the net effect would be more claims – previously classified as outpatient –reimbursed as inpatient hospitalizations. Based on this assumption, CMS predicted a net revenue increase in hospital payments and in order to maintain budget neutrality, slashed hospital reimbursement by $220M for FY2014. Unless reversed, this payment cut remains in hospitals' base payment rate in perpetuity – resulting in over $2 billion in cuts during the current 10-year budget window.

Independent reviewers have not been able to replicate CMS's findings. In fact, outside research confirms the recent experiences reported by our individual member institutions: the two-midnights policy results in fewer cases being classified as inpatient, not more. In a peer-reviewed article in *The Journal of Hospital Medicine*, University of Wisconsin School of Medicine and Public Health researchers stated, "*Although CMS predicts that more patients will be classified as inpatients under the new rule, we determined the opposite."*[1] In their study applying both methodologies to the same set of historic claims, the Wisconsin researchers found that the two-

midnights rule would decrease the number of cases classified as inpatient by 7.4 percent.[2] These results are consistent with those reported by the Department of Health and Human Services' Office of Inspector General (OIG), which found that the new two-midnights methodology would "significantly reduce" the number of cases classified as inpatient.[3]

CMS's faulty assumption that hospitals would see an increase in inpatient cases means hospitals are now taking a double hit: their volume of inpatient cases is declining (even without any change in services delivered) and CMS has cut their underlying payment rate for each remaining inpatient case. This is gravely concerning and unsustainable. Any alternative to the two-midnights policy must proactively reverse the cuts to hospital payment rates implemented in the FY2014 IPPS Final Rule, as these cuts were meant to offset increases in inpatient volume which we know did not, and will not, occur as a result of the two-midnights policy.

The Two-Midnights Payment Cuts Disproportionately Harm Teaching Hospitals & Safety Net Providers

The two-midnights policy is particularly devastating to academic medical centers and safety-net hospitals. 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, 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 CMS arbitrarily decides 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.

And yet, when CMS's two-midnight policy shifts payment for necessary hospital care into the outpatient system, these hospitals lose their add-on payments for indirect medical education (IME) and disproportionate share (DSH) payments and see decreases in their Direct Graduate Medical Education (DGME) payments. These funding streams were established by Congress to support specific missions that remain national priorities. We cannot afford for the draconian cuts imposed by the two-midnights policy to limit access to care for the most vulnerable, delay lifesaving cures, and undermine efforts to train the workforce we need to meet the demands of those newly insured by the Affordable Care Act.

The Two-Midnights Policy Unfairly Shifts Costs to Patients

As illustrated above, policies that arbitrarily cut hospital payments affect patients in indirect but real and harmful ways. In the case of the two-midnights rule, there is also a direct financial impact on Medicare beneficiaries.

If a patient's hospitalization is arbitrarily classified as "outpatient" based on her length of stay, Medicare will cover the care through Part B (instead of Part A used for inpatient hospital care). This means that she will be billed separately for each procedure and test, and be responsible for up to 20 percent of the costs for each service – bills that can mount into the hundreds of thousands of dollars. Additionally, a patient's "outpatient" hospitalization will not count toward the three-day inpatient stay needed for eligibility for Medicare coverage of a skilled nursing facility or rehab facility after leaving the hospital, further exacerbating her potential financial liability.

In addition to placing new and unpredictable financial burdens on patients, the two-midnights policy creates confusion and threatens the doctor-patient relationship. Patients unaware of the policy are blindsided by unexpected costs. Those who are informed about the possibility of substantial cost-sharing if their hospital stay happens to be short are resisting necessary diagnostic tests and treatments for fear of the possible expense. Physicians and hospital administrative staff – themselves perplexed by CMS's policy – can offer little clarity about likely financial obligations for patients, eroding the trust essential to delivering the highest quality care.

Implementing the Two Midnights Rule Adds Significant Administrative Burden

Though the AAMC believes the two-midnights policy to be deeply flawed, we have been working closely with our members to help them come into compliance with the new rule. Across the country, our members are having to retrain staff at every level – from residents and physicians, administrative billing staff, compliance officers, and others – to shift from assessments of medical necessity to evaluations of predicted time estimates. Hospitals are making significant investments in reprogramming electronic medical records and claims processing systems comply with the new rule. And still, these same institutions each continue to invest hundreds of thousands of dollars annually to responding to RAC audits – the issue the two-midnights policy was intended to alleviate.

Adding an entirely unnecessary element of confusion and disruption for teaching hospitals, the CMS guidance implementing the two-midnights policy excludes most residents from the list of medical professionals who can certify that an admission is expected to last longer than two midnights. Teaching hospital by-laws allow residents to write orders on behalf of the attending physicians who supervise them, and rarely have their own admitting privileges as they are not considered to be part of the medical staff. CMS's strict requirement that only those with admitting privileges are able to certify an expected length of stay, and that such a certification must happen prior to discharge, means that the supervisors must be tracked down prior to patient discharge for the sole purpose of ensuring that the paperwork is correct – disrupting hospital workflows and distracting from patient care. CMS's inability to address this seemingly easy fix

has been discouraging, and highlights that the problem with the current rule is both in its underlying policy and in its implementation.

An Alternative Policy Must Prioritize Medical Judgment and Appropriate Reimbursement

The AAMC appreciates that the two-midnights policy originated as an attempt to provide clarity about the appropriate site of care, which has been the source of many RAC audits. Though we believe the flaws in this policy are numerous and its effects damaging, we support CMS's stated intention would hope to see a revised policy that still includes this added clarity – but without sacrificing the critical role of medical judgment and adequate reimbursement for medically necessary short hospitalizations.

To that end, we support the premise that patients who are hospitalized for medically necessary services lasting longer than two midnights should generally be considered inpatients. Maintaining this portion of the two-midnight policy will eliminate excessive hospital stays under observation status and reduce some of the burden of RAC review. But for stays lasting fewer than two midnights, CMS's policy must change. An alternative solution need not be complex. The AAMC advocates for simply returning to the policy in place for short stays prior to Oct. 1, 2013, along with simple reforms to the RAC process, as a sufficient "alternative short stay policy." This is a straightforward solution that would provide much needed relief and could be achieved immediately.

Among these much-needed and straightforward RAC reforms is a reversal of the CMS policy requiring that a denied inpatient claim may only be re-billed under Part B within 12 months of the date of service. Given the length of time involved in appealing a RAC denial, this limit effectively leaves hospitals with no recourse for payment. At a minimum, the 12-month time limit for re-billing under Part B should be suspended during an ongoing RAC appeals process.

Were a more complicated approach to short-stay reimbursement to be pursued, we would urge policymakers to begin with the change described above as an essential first step, and to proceed beyond that only with caution and significant input from stakeholders. The policy directions for alternative payments for short stays suggested in CMS's FY15 IPPS proposed rule have the potential to undermine the very basis of the diagnosis-related group (MS-DRG) system. We also remain concerned that any "alternative short stay policy" that creates a claims classification other than inpatient would put at risk essential policy add-on payments such as DSH and IME. Even if an alternative short stay policy were developed carefully over time, hospitals need relief from the two-midnights policy immediately. The AAMC urges CMS to revert its approach to stays lasting fewer than two midnights to a reliance on medical judgment, accompanied by basic RAC reforms.

Conclusion

The AAMC recognizes the imperative to ensure that hospitals accurately bill for the services they provide, and seriousness of making wise and efficient use of Medicare funds. As currently drafted, the two-midnights policy supports neither of these goals, and places unnecessary burden on hospitals and the patients they serve. We stand ready to work with policymakers to develop a simple, and much-needed, alternative.

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[2] Ibid.

[3] Department of Health and Human Services Office of Inspector General. Hospitals' use of observation stays and short inpatient stays for Medicare Beneficiaries, OEI-02–12-00040. *Issued July 29, 2013. Available at:* http://oig.hhs.gov/oei/reports/oei-02–12-00040.asp. *Accessed May 18, 2014.*