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CURRENT HOSPITAL ISSUES IN THE MEDICARE PROGRAM

Subcommittee on Health
House Committee on Ways and Means
Hearing

Testimony by
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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.