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Special Committee on Aging

United States Senate

"Admitted or Not? The Impact of Medicare Observation Status on Seniors"

July 30, 2014

Chairman Nelson, Ranking Member Collins, and distinguished members of the Committee, thank you for the opportunity to testify today and share Yale New Haven's perspective on important issues affecting hospitals in the Medicare program and the beneficiaries they serve.

I am Marna Borgstrom, President and CEO of Yale-New Haven Health System (YNHHS). Yale New Haven Health System, through its Yale-New Haven, Bridgeport, Greenwich, and Northeast Medical Group Delivery Networks, provides comprehensive, cost effective, advanced patient care characterized by safety and clinical and service quality. In affiliation with the Yale School of Medicine and other universities and colleges, YNHHS educates health professionals and advances clinical care. In all of its work, YNHHS is committed to innovation and excellence in patient care, teaching, research, and service to our communities it has the privilege of serving. With more than 18,000 employees and a medical staff of 5,675, Yale New Haven Health had more than 90,000 discharges in 2012, generated more than $2.6 billion in revenue and accumulated total assets of approximately $3.6 billion.

The flagship hospital for YNHHS is Yale-New Haven Hospital (YNHH), a non-profit, 1,541-bed tertiary academic medical center receiving national and international referrals. Yale-New Haven Hospital includes Smilow Cancer Hospital, Yale-New Haven Children's Hospital, and Yale-New Haven Psychiatric Hospital. Relying on the skill and expertise of more than 4,500 university and community physicians and advanced practitioners, including more than 600 resident physicians, YNHH provides comprehensive, multidisciplinary, family-focused care in more than 100 medical specialty areas.

In recent years, the environment for hospitals has changed drastically, particularly in the financing of research, education, and patient care – our core missions. Sequestration of the federal budget and subsequent fiscal pressures have flat-lined federal research funding and resulted in reductions in reimbursement for patient care from federal, state, and private payers. My remarks today focus on one problematic policy in particular – the Centers for Medicare & Medicaid Services' (CMS) "two-midnight" policy for inpatient admission and medical review criteria, which disregards physicians' clinical judgment and exacerbates the existing challenges that hospitals face when having to explain to beneficiaries a policy that causes beneficiary confusion. Beneficiaries are unlikely to understand why, when they believe they are in a hospital, the stay is treated as an outpatient service by Medicare and they are therefore responsible for co-

pays and perhaps a deductible, or why this stay will mean that they do not meet the three-day inpatient stay requirement for coverage of skilled nursing care and the reimbursement. I will share with you examples of the two-midnight policy's impact on patient care, the doctor-patient relationship, and financial sustainability of the hospitals treating the underserved and the most complex cases. In short, this policy undermines the goals of the Affordable Care Act (ACA) to provide high-quality care more efficiently and, most importantly, affordably for patients.

THE TWO-MIDNIGHTS 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 or a doctor's determination that a patient requires hospitalization. The policy took effect Oct. 1, 2013, but thanks to an act of Congress, enforcement has been delayed through March 31, 2015, although hospitals are nonetheless required to comply with the policy. Though retroactive enforcement by auditors has been suspended, Yale New Haven, like all other responsible Medicare providers, has come into compliance with the law as currently in place. This means that all of the impacts I describe are very real day-to-day challenges for our clinicians, patients, and bottom line right now.

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 creates confusion and financial burden for patients and inappropriately puts decisions of medical necessity at odds with sustainable reimbursement.

CONFUSION AND HUGE BILLS STRAIN THE DOCTOR / PATIENT RELATIONSHIP

At Yale-New Haven, our primary issue with the two-midnight policy is the confusion it creates for patients, their families, and their clinicians. Worse, the harm to patients often goes far beyond misunderstanding – being classified as an outpatient, simply because their hospital stay didn't happen at quite the right time of day or last long enough, has serious financial consequences. When a patient is considered an outpatient she is responsible for the 20 percent copay required under Medicare Part B. Further, her outpatient time in the hospital does not count toward her three-day stay eligibility requirement for skilled nursing care. An example of how difficult this can be for families comes to mind:

> An 88 year old frail female patient with known breast cancer metastatic to her bones and lungs came in with chest pain and difficulty breathing on July 5th and was evaluated. She needed to be hospitalized for some additional tests and treatments that were appropriately predicted to require less than 2 midnights in the hospital. She was placed in Observation and went home late the next day with visiting nurse services. She lives with her son who works full time and the patient is frequently home alone. The family wanted her to go to a skilled nursing facility and were visibly upset and angry that she could not because of her placement into Observation status. The recommendation from the hospital was to increase the services and support she had at home to keep her safe.

> She saw her doctors over the next 2 weeks but was continuing to get weak. Her family was forced to bring her back to the hospital on July 21st as she now was dizzy, not eating well, and couldn't care for herself during the day. Again a review was done and the patient did not meet Inpatient criteria so she was placed once again into Observation. The family desperately wanted her in a skilled nursing facility but could not afford $250 per day at the facility nor the $20 per hour home health aide. The family had no choice but to take her home with the limited services that they could afford. The son was hopeful friends and family could check in on her during the day and that she would be ok but was clearly worried about his mom given the progression over the previous few weeks.
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> We have little doubt that we will be seeing this patient again in our Emergency Department – all of her care providers secretly hoping that she is "sick enough" at that time to meet Inpatient criteria just so that she can get into a facility and be cared for in a loving and dignified way.

The arbitrary and unpredictable nature of these financial obligations is particularly confusing for patients and their families. A patient can stay overnight in the hospital, in the same room, get the same care, eat the same meals as inpatients – and yet under the two-midnights policy still be considered an observation patient expected to pay 20 percent of the costs. Though we at Yale-New Haven do all we can to predict these financial outcomes and communicate them to patients, CMS's insistence that a patient's designation hinge on time rather than clinical judgment means that the outcomes are often out of our hands. Our inability to reliably tell patients something as basic as whether they're an inpatient or not undermines the trust between a doctor and a patient that is fundamental to so many aspects of the care relationship.

Regrettably for all involved, these bills can be quite high. Even for a hospital stay that seems relatively short, 20 percent of every line item for every service, device, and procedure quickly adds up. In addition to these bills, patients who require rehabilitative skilled nursing care after their hospital stay may find themselves ineligible for any Medicare coverage for any of it if a portion of their hospital stay was as an observation patient. As care providers helping patients and their families plan for their post-acute care, we see heartbreaking choices between financial hardship and insufficient care at home. This leads to preventable injuries and readmissions to the hospital.

Most alarming to me are the reports I've received from doctors throughout our system, but particularly those in the emergency department, who tell me about patients who – upon hearing that they're being admitted for 'observation' – choose to leave the hospital entirely, rather than risk the significant financial burden of an observation outpatient stay. As an example:

> A 67 year old man without a doctor who had untreated high blood pressure, high cholesterol and a very strong family history of heart attacks, including a brother who died at age 52, came in with a very concerning story of increasing chest pain. This was worrisome for acute coronary syndrome. He rarely sees doctors because he does not like them and has avoided coming into the hospital, but noted the pain was getting much worse and he was worried. His initial evaluation in the Emergency Department revealed normal labs and electrocardiogram results. The Emergency Department appropriately recommended the patient stay in the hospital for further evaluation by Cardiology that would include a stress test and possibly a cardiac catheterization. The patient

> noted that he just lost his job and insisted that he cannot afford the copays if placed in observation status. The case was reviewed and unfortunately he did not meet Inpatient criteria. Despite multiple physician and nurse pleas to stay for further evaluation the patient left the Emergency Department because of his assigned patient status. We do not know what the ultimate outcome was for this patient.

These are patients who require hospitalization but who leave because of financial concerns. This is not one or two patients, but upwards of twenty in the several months since this policy has been enacted. I'm confident it would be an even greater number if more patients knew about the potential burden of being deemed an outpatient.

THE TWO-MIDNIGHTS POLICY SUBVERTS EFFICIENCY AND THREATENS THE SAFETY NET

The two-midnight policy now requires physicians to abandon the clinical assessment of medical necessity when determining the appropriate setting of care, and instead imposes a rigid time-based approach. Under the 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 experienced use of complex clinical judgment to assess the short-term risk of adverse outcomes.

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 significantly.

Yale-New Haven Health System, which is anchored by a 1,541 bed, tertiary referral center – YNHH, treats many high acuity patients with complex medical issues. 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 efficiently 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 in the moment, 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, as is the case for many of our patients at Yale-New Haven. Though some chest pain cases may be handled appropriately 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 disproportionately impacts academic medical centers and safety-net hospitals. Hospitals like Yale-New Haven continue to provide the same essential community services – serving the uninsured, maintaining trauma centers, 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 Hospital (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 of new health care consumers under the ACA.

IMMEDIATE CHANGE IS NECESSARY: PROPOSALS FOR REFORM

As stated earlier, we appreciate that the origin of the two-midnight policy was an attempt to clarify when patients should be placed in outpatient observation status and when an inpatient admission is appropriate. Unfortunately, this policy has done nothing to improve this situation for patients: they are confused; they are negatively impacted financially; and their observation status is all the more divorced from their true clinical needs. Clinicians become entangled in reimbursement details and struggle to maintain the trust of their patients, and hospitals are receiving inadequate funding for critical research and teaching missions. Speaking on behalf of a medical community concerned about Medicare and the beneficiaries it serves, I urge you to support immediate relief from the two-midnight policy and to clarify the complex rules regarding observation stays that confound beneficiaries and lead to unnecessary audits.

As Chair of the Association of American Medical College's Council of Teaching Hospitals and Health Systems, I have had the opportunity to speak with my colleagues around the country about this policy issue, and we believe practical and straightforward reform is possible. 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 unnecessary audits and most egregious problems for patients. 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. This policy defers to a physician's clinical judgment, understanding that the decision to admit a patient to the hospital is not made lightly.

Additionally, Congress should eliminate the three day inpatient stay requirement for Medicare coverage of Skilled Nursing Facility (SNF) care and provide some sort of cap to patient co-pays, perhaps not to exceed the inpatient deductible, which can be eclipsed during stays that require testing, consultation, and medications. Beyond this immediate relief, I look forward to working

with hospital leaders around the country, Congress, and the Administration to identify reimbursement policies for hospital stays that make sense to patients and adequately cover the costs of care for the institutions that serve them.

CONCLUSION

Yale-New Haven Health System takes very seriously its obligation to determine the appropriate setting for patients and 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 observation stay reimbursement – that drain precious time, resources, and attention that could more effectively be focused on patient care. Yale-New Haven and hospitals across the country stand ready to work with policymakers to support these efforts.