

**Testimony of
Jyotirmaya Nanda, M.D.
on behalf of the
American Hospital Association
before the
Special Committee on Aging
of the
United States Senate**

“Challenging the Status Quo: Solutions to the Hospital Observation Stay Crisis”

May 20, 2015

On behalf of the American Hospital Association’s (AHA) nearly 5,000 member hospitals, health systems and other health care organizations, and its 43,000 individual members, I thank you for the opportunity to testify on the increase in the use of observation stays.

I am Jyotirmaya Nanda, M.D., system medical director for informatics and physician compliance at the Center for Clinical Excellence and Corporate Responsibility at St. Louis-based SSM Health Care. SSM Health is a Catholic, not-for-profit health system serving the comprehensive health needs of communities across the Midwest through one of the largest integrated delivery systems in the nation. SSM Health was founded in 1872 by the Franciscan Sisters of Mary and includes 19 hospitals, more than 60 outpatient care sites, a pharmacy benefit company, an insurance company, two nursing homes, comprehensive home care and hospice services, a telehealth and technology company and two accountable care organizations (ACOs) across Illinois, Missouri, Oklahoma and Wisconsin. With more than 1,300 employed physicians and nearly 30,000 employees in four states, SSM Health is one of the largest employers in the communities it serves.

Hospitals seek to deliver the right care at the right time in the right setting. While a complex issue, observation services ultimately reflect high standards of care and quality regulations to which hospitals adhere. The use of observation services has expanded due to many factors, including: evolution of medical practice patterns; changes in Medicare payment policy; activities of Medicare audit contractors; and hospitals’ legitimate concerns about enforcement actions.



Traditionally, the decision to admit a patient as an inpatient has been up to the judgment of the treating physician, with oversight from the hospital and input from the patient. However, Medicare audit contractors continuously second guess physician judgment, sometimes years after a patient was seen and often with additional retrospective information on the patient's condition, undermining the physician's medical judgment at the time. This has led the Centers for Medicare & Medicaid Services (CMS) to adopt a new "time-stamp" inpatient payment policy called the "Two-Midnight Rule." Today, most inpatient admissions are based on whether or not a patient will stay two midnights in a hospital, regardless of what time the patient presented.

Below, I outline how we got to where we are today, and offer suggestions for clarifying and improving Medicare payment policy to reduce the reliance on observation care. Ultimately, it is important to remember, whether a patient is in observation status, an outpatient or an inpatient, they will receive the best care possible.

BACKGROUND

CMS defines observation as:

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 or another area of the hospital.ⁱ

It is important to note that the distinction between inpatient and observation services is a payment distinction set forth by CMS, **not a clinical distinction**. According to CMS payment policy, Medicare beneficiaries who remain at the hospital under observation status are considered outpatients, with coverage under Medicare Part B. As a result, observation patients may be subject to higher out-of-pocket costs due to copays and pharmacy charges, and they do not qualify for skilled nursing facility care at discharge, even if they stay three days. In contrast, Medicare beneficiaries expected to stay at the hospital for more than two midnights are considered by CMS to be inpatients; since their care is reimbursed under Medicare Part A, they are eligible for post-discharge skilled nursing facility care after a three-day inpatient stay.

Despite this payment distinction, Medicare beneficiaries who receive observation services while their physician and care team determine a course of treatment, commonly receive care in the same hospital rooms as inpatients and the care delivered is often indistinguishable from inpatient care. Notably, the care team provides the same standard of care for a patient in observation as if the patient was admitted as an inpatient. As a result, observation status can be confusing for patients, who are physically in the hospital, many times overnight, and receive tests, procedures, medications and nursing care that could never happen in the outpatient clinical setting.

Hospitals are doing their best, both to comply with Medicare payment policies and to address the confusing and difficult issue of patient status with patients and their families. SSM has hired dedicated patient access nurses and case managers that comb through all the hospital admissions, identify Medicare and Medicaid beneficiaries and give them printed materials and explanation of what an observation stay is. This is then documented in the flow sheet rows for case management

that were specifically built for this in the electronic health record system. In order to provide this information to patients, we hired three full-time equivalent employees (FTEs) for our smallest hospitals and up to six FTEs in our larger hospitals. This is a recurrent annual expense that could otherwise be used for improvements in patient care delivery. We also have dedicated physician advisors in each of our hospitals; 80 percent of their time is spent determining whether a patient meets the requirements for inpatient admission.

HOW MEDICARE AUDIT CONTRACTORS CONTRIBUTE TO OBSERVATION STAYS

The decision to admit a patient as an inpatient is a complex medical judgment that involves the consideration of many factors, such as the patient’s medical history and medical needs, the types of facilities available to inpatients and outpatients, the hospital’s bylaws and admission policies, the relative appropriateness of treatment in each setting, the patient risk of an adverse event and other factors. CMS itself notes that the decision to admit a patient is a “complex medical decision.”

Hospitals base admission decisions on these clinical considerations and the information available at the time the patient is seen, relying on the medical judgment of the treating physician. However, all too often their judgment is now second-guessed by auditors, including Recovery Audit Contractors (RACs), months or even years after the fact. Hospitals risk loss of reimbursement, monetary damages and penalties from auditors when they admit patients for short, inpatient stays, even when that admission was made with the best medical judgment of the treating physician at the time the patient was seen and the care was indisputably medically necessary. Faced with the prospect of ongoing and numerous claim denials by RACs, hospitals and physicians seem to have become more wary about admitting patients for what could be short inpatient stays.

At the same time, some Department of Justice (DoJ) attorneys have started using the False Claims Act (FCA) to challenge physicians’ inpatient admission decisions. In their view, many Medicare beneficiaries who have been admitted as inpatients should be placed in observation status. When the treating physician instead determines that such a beneficiary should be admitted as an inpatient, these attorneys contend that the resulting services are not “reasonable and necessary for the diagnosis or treatment of illness or injury,” and therefore are not covered by Medicare. They therefore contend that every claim submitted to Medicare for these “unnecessary” inpatient stays amounts to a fraud against the government, punishable under the FCA. FCA violations carry stiff penalties – treble damages plus a substantial per-claim penalty.

The auditors and prosecutors have made it clear that they believe observation status can serve as a substitute for inpatient admission in many cases. As a result of these inappropriate denials and actions, hospitals are left in an untenable position. On the one hand, they risk loss of reimbursement, monetary damages and penalties from auditors and prosecutors when they admit patients for short, medically necessary, inpatient stays. On the other hand, they face criticism from certain patients and CMS over the perceived use of observation services instead of inpatient

admission. Hospitals must comply with the rules and regulations set forth by the government and their contractors.

REFORM NEEDED

Fundamental Reform of the RAC Program. Perhaps the largest driver of the increase in observation stays has been the RACs. Congress authorized the RAC program to identify improper Medicare fee-for-service payments – both overpayments and underpayments. However, the current structure of the RAC program has led to an overwhelming number of inappropriate denials, with contractors often denying claims for indisputable medically necessary care. RACs are paid on a contingency fee basis, receiving a commission of 9 to 12.5 percent of the value of the claims they deny. The more claims they deny, the more they profit. Furthermore, RACs are not financially penalized for inappropriate denials that are later overturned in the Medicare appeals system.

Providers are able to contest claims denials through the Medicare appeals system, and they appeals denials because they stand behind the medical judgment of the treating physician. But the appeals process is a lengthy and costly process, and providers must evaluate carefully claim denials to determine whether to invest the substantial time and significant resources required for filing an appeal. The appeals system consists of five sequential levels of appeal. If a provider disagrees with the decision it receives at one level, it may appeal the decision to the next level. Appeals at the first two levels are reviewed by CMS contractors. The reviews consist solely of a desk audit of the cold paper record and are largely considered by those who take the appeals – both beneficiaries and providers alike – to be biased toward upholding the original denial. Third- and fourth-level appeals are reviewed by entities independent of CMS and are viewed as more objective reviews. In particular, hospitals generally have received favorable decisions at the third-level of appeals or the administrative law judge (ALJ) level. The ALJ level affords hospitals the first opportunity to present testimony based on clinical factors that are critical to accurate decisions in denials of complex hospital claims in a hearing and to receive an independent review of all evidence. The fifth-level of appeal is federal court, and it frequently is unavailable because of the expense of taking a case to federal court even when the case meets the amount in controversy required for a hearing in federal court.

Hospitals appeal 78 percent of denied RAC determinations, according to a September 2014 AHA surveyⁱⁱ, while data from the Department of Health and Human Services (HHS) Office of Inspector General show that 72 percent of hospital appeals that go to the third level of the Medicare appeals system are overturned in favor of the hospital.ⁱⁱⁱ The high percentage of claims that are appealed by hospitals and later overturned in the appeals process indicates that RACs often deny claims that are appropriate. Due to the high volume of denied RAC determinations, hospitals now must wait more than two years for an appeal to be assigned to an impartial ALJ. In the meantime, hospitals are not paid for the cost of providing medically necessary care to Medicare patients, and they are never reimbursed for the costly appeals process.

In December 2014, CMS announced changes to the RAC program that will take effect upon commencement of new multi-year RAC contracts, which CMS is in the process of awarding. The

future changes include providing more time for hospitals to contest appeals directly with RACs through a pre-appeal discussion period; requiring RACs to complete audits and provide results to hospitals within 30 days; reducing the number of records RACs can pull from hospitals with lower error rates (while potentially increasing the number from hospitals with higher error rates); and limiting the RAC lookback period to six months when reviewing the medical necessity of an inpatient admission. In addition, in April, the Medicare Payment Advisory Commission put forth a package of recommendations designed to address its concerns about the RAC program, including tying a RAC's contingency fee to its denial overturn rate. While these are steps in the right direction, they fall far short of critical fundamental RAC reform.

The Medicare Audit Improvement Act of 2015 (H.R. 2156), introduced by Reps. Sam Graves (R-MO) and Adam Schiff (D-CA), would make fundamental changes to the RAC program. Specifically, the bill would:

- Eliminate the contingency fee structure; instead, it would pay RACs a flat fee, as every other Medicare contractor is paid, to reduce the financial incentive for overzealous auditing practices.
- Reduce payments to RACs that are inaccurate in their audit determinations and have high appeals overturn rates.
- Fix CMS's unfair rebilling rules by allowing hospitals to rebill claims when appropriate.
- Require RACs to make their inpatient claims decisions using the same information the physician had when treating the patient, not information that becomes available after the patient leaves the hospital.

These reforms would go a long way toward ensuring the program is more accurate and fair for the Medicare program, providers and beneficiaries.

Waivers for Coordinated Care. CMS has acknowledged that the three-day stay requirement itself is a barrier to recent efforts to better coordinate and manage care delivered to Medicare beneficiaries. New payment models, such as ACOs, are intended to provide incentives to providers to coordinate care, improve quality and health outcomes for patients and reduce costs for the Medicare program. However, more flexibility – including a relaxing of restrictive Medicare payment rules – is needed for providers as health care shifts from the traditional fee-for-service model to one focused more on quality and efficiency. For example, the Center for Medicare and Medicaid Innovation (CMMI) has waived the skilled-nursing facility three-day stay rule for some Pioneer ACOs, as well as those that participate in its new Next Generation ACO initiative. For Next Generation ACOs, CMS also will waive the geographic and practice setting limitations on the provision of telehealth – so that beneficiaries could receive telehealth services in their residences, regardless of geographic location; and the homebound requirement for home health visits. Further, HHS has allowed Pioneer ACOs and those in Medicare's Shared Savings Program (MSSP) to continue operating outside of federal anti-kickback and physician self-referral laws at least through fiscal year 2015. Such laws, as well as other Medicare payment rules, act as barriers to incentivizing the kind of performance and behavior we are trying to achieve – the re-design of patient care.

The AHA urges additional waivers of hospital discharge planning requirements that prohibit hospitals from specifying or otherwise limiting the providers who may provide post-hospital services and the two-midnight rule. The AHA suggests that CMS waive the two-midnight inpatient admission criteria for hospitals that participate in an MSSP ACO. Waiver of the two-midnight rule for hospitals that are ACO participants would allow those hospitals to provide care in the most appropriate setting without regard to the rule's arbitrary time-based criteria. Such a waiver would be appropriate since the ACO would ultimately bear financial responsibility for the cost of an inpatient stay that may have been reimbursed as outpatient under the two-midnight rule.

Waiving these payment regulations is essential so that ACOs may coordinate care and ensure that it is provided in the right place at the right time. These waivers could provide ACOs with valuable tools to increase quality and reduce unnecessary costs; as such, they should be available to advance the success of all ACOs that provide care for Medicare beneficiaries, not just those that accept advanced risk. Further, CMS should implement the waivers in a manner that is not prohibitively burdensome to ACOs that wish to take advantage of them. For example, AHA members that participated in the Pioneer ACO program and have applied for waiver of the skilled nursing facility three-day requirement reported an overly burdensome application and reporting process. Instead, CMS should ensure that the waivers are easily accessible to ACOs and should rely on the Medicare ACO programs' existing cost and quality metrics to ensure that ACOs continue to provide high-quality, appropriate care to their ACO populations.

CONCLUSION

Hospitals strive to provide the right care in the right setting for each and every patient they see. However, CMS payment rules and overzealous auditors, such as RACs, and prosecutors are second-guessing physicians' clinical judgment, placing hospitals and physicians in the difficult position of placing patients in observation status. Further, restrictive Medicare payment rules serve as a barrier to hospitals striving to better coordinate care and improve quality and health outcomes for Medicare beneficiaries by exploring new payment and delivery system models. The AHA stands ready to work with the committee to help develop clear federal policy on observation status, reform the RAC program and address payment regulations that inhibit reform efforts.

ⁱ Centers for Medicare & Medicaid Services. "Are You a Hospital Inpatient or Outpatient?" Revised May 2014. Retrieved from: <https://www.medicare.gov/Pubs/pdf/11435.pdf>.

ⁱⁱ American Hospital Association. "The Real Cost of the Inefficient Medicare RAC Program." May 2015. Available at: <http://www.aha.org/content/15/hospsurveyreport.pdf>.

ⁱⁱⁱ HHS Office of the Inspector General. "Improvements are Needed at the Administrative Law Judge Level of Medicare Appeals." November 2012. Retrieved from: <http://oig.hhs.gov/oei/reports/oei-02-10-00340.pdf>.