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August 6, 2014

The Honorable Bill Nelson	The Honorable Susan Collins
Chairman	Ranking Member
Special Committee on Aging	Special Committee on Aging
U.S. Senate	U.S. Senate
Washington, DC 20510	Washington, DC 20510

Dear Chairman Nelson and Ranking Member Collins:

On behalf of nearly 38 million AARP members and the millions of Americans with Medicare, thank you for holding the hearing regarding the impact of observation status on seniors on July 30, 2014, Medicare's 49th anniversary. Decisions concerning inpatient admissions and observation status 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. When Medicare was created in 1965, the average length of stay for beneficiaries 65 and older was about 13 days.[ii] By 2010, the average length of stay had decreased to 5.4 days.[iii] 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; in contrast, observation status 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. However, the evidence suggests the two-midnight rule has had the opposite of the intended effect; instead of encouraging hospitals to increase

admissions, they are shifting more care to outpatient settings, including observation status.[iv]

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.

However, AARP does not believe the two-midnight rule fully and adequately addresses the problem of short hospital stays and the increased use of observation care, especially from a beneficiary perspective. AARP suggested in comments to CMS that it institute a backstop trigger whereby any beneficiary in a hospital setting, including emergency room or observation, will automatically become an inpatient after a set point in time, such as 24-48 hours. Such a change would better protect beneficiaries from indefinite observation status.

Cost-sharing

The two-midnight rule 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 observation services, physician services, laboratory tests, imaging, and hospital administered drugs under Part B subjects the beneficiary to the 20 percent coinsurance for each service. 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, and are especially burdensome for those on fixed incomes. In fact, forthcoming research from AARP's Public Policy Institute found that 10 percent of all beneficiaries who spent time in

observation faced out-of-pocket costs that exceeded the hospital inpatient deductible of $1,068 in 2009.[v] We urge Congress and the Administration to clarify that beneficiary cost-sharing for observation stays should align with Part A cost sharing upon admission. In other words, we urge that total beneficiary liability for observation services be capped at the Medicare inpatient deductible amount.

Three-day Stay Requirement, Observation Status, and SNF Coverage

Individuals under observation 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. In some cases, Medicare beneficiaries may not even be aware that they are under observation, and many are unaware of the financial implications of observation status until after they leave the hospital. Those who are made aware of their observation status may, unfortunately, forgo necessary follow-up SNF care.

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. According to AARP's forthcoming report, beneficiaries who were held under observation and later admitted to a SNF-- those who did not have a prior three-day inpatient stay-- had higher out-of-pocket SNF costs than those who qualified for Medicare coverage. Moreover, 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.[vi]

AARP and many other groups have endorsed the bipartisan *Improving Access to Medicare Coverage Act* (S. 569/H.R. 1179)-- sponsored by Senators Sherrod Brown (D-OH) and Susan Collins (R-ME), and Representatives Tom Latham (R-IA) and Joe Courtney (D-CT) -- 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 three-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.

Notice of Status

Beneficiaries must be informed and made aware of how any changes to their status will affect them. CMS should proactively inform the public of policy changes through educational campaigns, updates to the Medicare & You handbook, and information on medicare.gov. Likewise, beneficiaries should be quickly notified if there is a specific change in the billing status of any recently received service. AARP has endorsed the bipartisan *Notice of Observation Treatment and Implication for Care Eligibility (NOTICE) Act of 2014* (H.R. 5232) sponsored by Representatives Todd Young (R-IN) and Lloyd Doggett (D-TX). The legislation would require hospitals to provide meaningful written and oral notification to patients who are in the hospital “under observation” for more than 24 hours. While this does not solve the problems regarding cost-sharing and access to SNF coverage, it is an important step to ensuring Medicare beneficiaries have access to information about their care.

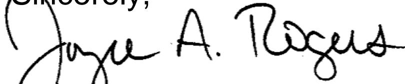
Prescription Drug Coverage during Observation Status

Many beneficiaries also 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 Committee is paying to this important issue. We look forward to working with the Committee to address this issue, 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 Ariel Gonzalez of our Government Affairs staff at 202-434-3770 or agonzalez@aarp.org.

Sincerely,



Joyce A. Rogers
Senior Vice President
Government Affairs

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[i] "Rapid Growth in Medicare Hospital Observation Services: What's Going On?" Social & Scientific Systems and AARP Public Policy Institute, Research Report Pub. 2013-10 (Sept. 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.*

[ii] M. R. Chassin, "Variations in Hospital Length of Stay: Their Relationship to Health Outcomes," Congressional Office of Technology Assessment (Aug. 1983).

[iii] Data Compendium, "Medicare Short-Stay Hospital Utilization", Tables V.1 and V.2, CMS (Dec. 2011). Accessed at: http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/DataCompendium/2011_Data_Compendium.html.

[iv] Moody's Investors Service, "Comment on Two-Midnight Rule" (March 12, 2014). Accessed at: http://www.scribd.com/doc/212860170/Moody-s-Investors-Service-Comment-on-Two-Midnight-Rule.

[v] "To Admit or Not To Admit: The Financial Impact of Hospital Observation Status on Medicare Beneficiaries", Social & Scientific Systems and AARP Public Policy Institute, Research Report; Pre-publication WORKING DRAFT, Under Review (July 2014).

[vi] Office of Inspector General, *Hospitals' Use of Observation Stays and Short Inpatient Stays for Medicare Beneficiaries," Memorandum Report OEI-02-12-00040* 15 (Office of Inspector General, Department of Health and Human Services, July 29, 2013), *available at* http://oig.hhs.gov/oei/reports/oei-02-12-00040.pdf.