

STATEMENT OF

SEAN CAVANAUGH

**DEPUTY ADMINISTRATOR AND DIRECTOR,
CENTER FOR MEDICARE,
CENTERS FOR MEDICARE & MEDICAID SERVICES**

ON

MEDICARE PAYMENT POLICY ON SHORT HOSPITAL STAYS

BEFORE THE

U. S. SENATE SPECIAL COMMITTEE ON AGING

MAY 20, 2015

**Statement of Sean Cavanaugh on
Medicare Payment Policy on Short Hospital Stays
Senate Special Committee on Aging
May 20, 2015**

Chairman Collins, Ranking Member McCaskill, and members of the Committee, 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. Given the Administration's commitment to improving our nation's health delivery system, including delivering care in the most appropriate care setting and spending dollars more wisely, 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 and other program integrity initiatives, 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, most recently through the Medicare and CHIP Reauthorization Act of 2015, has extended the probe and education strategy and the limitation on the Recovery Auditors through September 30, 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 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. In a recent notice of proposed rulemaking published April 30, 2015,¹ we noted that hospitals and physicians continue to voice their concern with parts of the 2-midnight rule, and that we are considering this feedback carefully, as well as recent MedPAC recommendations, and expect to include a further discussion of the broader set

¹ <http://www.gpo.gov/fdsys/pkg/FR-2015-04-30/pdf/2015-09245.pdf>

of issues related to short inpatient hospital stays, long outpatient stays with observation services, and the related -0.2 percent IPPS payment adjustment in the CY 2016 hospital outpatient prospective payment system proposed rule that will be published this summer.

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, \$1,260 for 2015.

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: 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 the over 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 fourth quarter of FY 2013, the Recovery Auditors have returned over \$5.4 billion to the Medicare Trust Funds.

Recovery Audit Program Improvements

On December 30, 2014, CMS announced a number of changes to the Recovery Audit Program². Such modifications included changing the recovery auditor “look-back period” for patient status reviews to 6 months from the date of service in cases where a hospital submits the claim within 3 months of the date that it provides the service. Several other program improvements were included in this announcement. We have established limits on additional documentation requests (ADRs) that are based on a hospital's compliance with Medicare rules, incrementally applied ADR limits for providers that are new to recovery auditor reviews, and diversified ADR limits across all types of claims for a certain provider. We also have established a requirement that recovery auditors must complete complex reviews within 30 days, and failure to do so will result in the loss of the recovery auditor's contingency fee. In addition, we will require recovery auditors to wait 30 days before sending a claim to the MAC for adjustment. This 30-day period will allow the provider to submit a discussion period request before the MAC makes any payment adjustments. These changes will be effective with the next Recovery Audit Program contract awards. 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. However, due to protests, CMS is delayed in the awarding and commencement of work under the new contracts.

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 OPSS. 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.

² <https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Recovery-Audit-Program/Downloads/RAC-Program-Improvements.pdf>

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 stay did not span at least three days after being formally admitted to the hospital as an inpatient, even if their total length of stay spanned more than three 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 OPSS proposed rule on the definition of ‘inpatient,’ and in the CY 2013 OPSS

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 originally 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 continued to select a sample of claims for the probe review and education. CMS worked closely with the MACs to ensure the accuracy of claim reviews and identify recurrent provider errors.

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 Medicare and CHIP Reauthorization Act of 2015, and previous legislative actions, 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 September 30, 2015. CMS is closely monitoring the results of the reviews in order to focus future educational outreach efforts.

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. There was no consensus on the best way to achieve appropriate payment incentives and oversight of short stays.

Conclusion

The current limitation on Recovery Auditor patient status review now in place through September 30, 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 considering feedback, as well as recent MedPAC recommendations relating to the two midnight rule, carefully and expects to include a further discussion of the broader set of issues related to short inpatient hospital stays, long outpatient stays with observation services, and the related -0.2 percent IPPS payment adjustment in the proposed calendar year 2016 Hospital Outpatient Prospective Payment system 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 working with the Congress and others to find a path forward that achieves our shared goals.