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**Testimony before the United States Senate
Special Committee on Aging**

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

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Chairman Nelson, Ranking Member Collins, and members of the Committee, thank you for the opportunity to discuss observation status and the impact observation policies have on Medicare beneficiaries. My name is Ann Sheehy, and I am a physician at the University of Wisconsin School of Medicine and Public Health in Madison, Wisconsin. I am a hospitalist, which is a physician who cares for patients primarily in the acute care hospital setting. Because of our clinical work and extensive experience in the hospital setting, we have a front-line view of the impact observation care has on Medicare beneficiaries.

As a researcher, I have also explored how observation status impacts hospitals and patients, and our studies have appeared in *JAMA Internal Medicine*^{1,2} and *The Journal of Hospital Medicine*.³ I am a member of the Public Policy Committee of the Society of Hospital Medicine (SHM), an association that represents the nation's more than 44,000 hospitalists. In that role, I worked on the SHM committee that drafted our white paper on observation. This study, released today, is the first national report of physician views on how observation care impacts patients and clinical work in the hospital.⁴ In this study, 93% of respondents felt observation status was a critical policy issue for hospitalists and their patients. Thus it is very timely that this Committee is examining this issue today.

I would like to make three points on the issue of observation status:

- 1) Observation care is problematic for Medicare beneficiaries and is in need of broad reform;
- 2) The new "2-Midnight" rule that took effect October 1, 2013 is not a fix for the observation problem; and

¹ Sheehy, A, Graf B, Gangireddy S, et al. Hospitalized but not admitted: characteristics of patients with "observation status" at an academic medical center. *JAMA Intern Med.* 2013;173(21):1991-8.

² Sheehy A, Graf B, Gangireddy S, et al. "Observation Status" for hospitalized patients: implications of a proposed Medicare rules change. *JAMA Intern Med.* 2013;173(21):2004-2006.

³ Sheehy A, Caponi B, Gangireddy S, et al. Observation and inpatient status: clinical impact of the 2-midnight rule. *J Hosp Med.* 2014;9:203-209.

⁴ Society of Hospital Medicine. The Observation Status Problem: Impact and Recommendations for Change. Released July 30, 2014. Accessible via www.hospitalmedicine.org/advocacy.

- 3) The Recovery Audit Contractor (RAC) program charged with enforcing observation status is fraught with problems that negatively impact Medicare beneficiaries, a topic that I will only touch on given the Roundtable Discussion this Committee hosted on this topic July 9, 2014.

1). Observation Care is Problematic for Medicare Beneficiaries and Providers

As the Committee is aware, inpatient care is reimbursed under Medicare Part A, and patients hospitalized as inpatients are eligible for post-discharge skilled nursing facility care after a 3 midnight stay. Medicare beneficiaries hospitalized under observation 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 care at discharge, even if they stay 3 midnights.⁵

Outpatient Observation Care is Increasing

According to the Medicare Payment Advisory Commission's (MedPAC) March report, from 2006-2012, outpatient services increased 28.5% per Part B beneficiary, and inpatient discharges have decreased 12.6% per Part A beneficiary over these same years.⁶ Although assuredly some of the increase could be attributed to advances in efficiency in medicine, it is also clear that Medicare policies, including additional pressures from recovery audit contractors (RAC) on these decisions, are driving the shift of patients into observation status.

Observation is Far from What CMS Initially Intended

Most providers recognize a role for observation care in providing an additional few hours of care for low-complexity patients immediately following an emergency department visit in order to determine

⁵ Are you a hospital inpatient or outpatient? Available at: <https://www.medicare.gov/Pubs/pdf/11435.pdf>

⁶ MedPAC 2014 Report to Congress. Chapter 3: Hospital inpatient and observation services. Available at: http://www.medpac.gov/documents/Mar14_entirereport.pdf.

whether a patient may be discharged to home, or should be admitted to the hospital.⁷ In fact, CMS defines observation as:

a well-defined set of specific, clinically appropriate services...[so] a decision can be made regarding whether patients will require further treatment as hospital inpatients or if they are able to be discharged from the hospital,...[and the decision to admit the patient should be made] “in less than 48 hours, usually in less than 24 hours. In only rare and exceptional cases do...outpatient observation services span more than 48 hours.”⁸

Unfortunately, this is no longer what observation looks like in clinical practice. MedPAC documented an increase in observation average length of stay from 26 to 29 hours over the years 2006 to 2012.⁹ We also studied our 43,853 University of Wisconsin Hospital encounters between July 2010 and December 2011 and found that 1 in 10 patients (4,578) were hospitalized under observation, most stayed longer than 24 hours (mean 33.3 hours) and 1 in 6 stayed longer than 48 hours, indicating that stays longer than 2 days were not “rare and exceptional” as CMS had intended. Further, we had 1,141 unique ICD-9 diagnosis codes in our study, indicating that observation was not “well defined”¹⁰ Any attempt to reform observation status must recognize how far observation has drifted from its original intent, largely due to auditing pressures.

Observation care is often indistinguishable from inpatient care, denying Medicare beneficiaries inpatient coverage even when hospitalized on inpatient wards

Medicare patients hospitalized under observation commonly receive care in the same hospital rooms as

⁷ Observation status for hospitalized patients: A maddening policy begging for revision. Available at: <http://archinte.jamanetwork.com/article.aspx?articleid=1710118>

⁸ Department of Health and Human Services and Centers for Medicare and Medicaid services. Medicare Benefit policy manual. Available at: <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R42BP.pdf>

⁹ Medicare Payment Advisory Commission (MedPAC) 2014 Report to Congress. http://www.medpac.gov/documents/mar14_entirereport.pdf

¹⁰ Sheehy, A, Graf B, Gangireddy S, et al. Hospitalized but not admitted: characteristics of patients with “observation status” at an academic medical center. JAMA Intern Med. 2013;173(21):1991-8.

inpatients, and the care delivered is often indistinguishable from inpatient care. As a physician, when I walk into a room and meet a patient for the first time, I usually cannot tell if they are observation or inpatient. Worse, many seniors have never heard of observation. These are hardworking people who have paid into the Medicare program for years, only to be told that even though they need to stay overnight in the hospital, have tests, procedures, medications and nursing care that could never happen in an outpatient clinic setting, Medicare views them not as admitted hospital patients, but essentially as if they were clinic patients.

One of the hardest aspects of observation is when a Medicare patient realizes they are under observation and what that means. Suddenly the anxiety over what they will have to pay out of pocket for hospital and nursing home care becomes an even greater concern for them than the medical problem that brought them in. Some of these patients ask me to change them to inpatient, which I cannot do under current payment policies. At a time when they should rightfully be focused on their health and getting well, our seniors are facing the stress of incomprehensible status determinations and the associated consequences.

I will never forget the patient who first opened my eyes to the problem of observation. Of limited financial means, living alone in a small apartment, this woman had recently been diagnosed with cancer. Her appetite was poor, and she was admitted to the hospital with dehydration. After some intravenous fluids, she actually felt much better, but she was still weak and frail and the physical therapist recommended she go to a skilled nursing facility for a brief period of time to build her strength. Her only worry should have been her health, yet her main concern was what her hospital bill and skilled nursing facility bill were going to be, because she was on observation. Here was a patient who had paid into the Medicare program her whole life, only to realize when she needed it most, she wasn't eligible. This was echoed in the SHM survey, as one hospitalist described further concerns: "...I have had a number of people refuse to be

admitted for care they need due to concerns over status and what their bill will be.”¹¹

Summary

Observation care in clinical practice is vastly different than its original intent. Any attempt to reform observation must return observation to its original purpose so that hospitalized Medicare beneficiaries are cared for fairly whenever they need hospital based care. Medicare payment policy is currently taking precedence over the delivery of necessary care. This needs to change.

2). The new “2-Midnight” rule that took effect October 1, 2013 is not a fix for the observation problem

Until recently, observation determinations were made based on clinical criteria, commonly defined and determined by clinical decision tools such as Milliman® or InterQual®. CMS recently established a new rule to determine observation status in its fiscal year 2014 Inpatient Prospective Payment System (IPPS) final regulation.¹² Effective October 1, 2013, patients hospitalized less than 2 midnights, with few exceptions, were to be considered observation, and those staying 2 or more midnights would be considered inpatient. Initially postponed by CMS, and subsequently by Congress under P.L. 113-93, The Protecting Access to Medicare Act of 2014, full enforcement of the so-called “2-Midnight rule” has been delayed through March 31, 2015.

Time of day a patient becomes ill, not different clinical needs, determines insurance benefits under the “2-Midnight rule”

At the University of Wisconsin Hospital, we retrospectively applied the 2-Midnight rule to our patient

¹¹ Society of Hospital Medicine. The Observation Status Problem: Impact and Recommendations for Change. Released July 30, 2014. Accessible via www.hospitalmedicine.org/advocacy.

¹² The Centers for Medicare and Medicaid Services Inpatient Prospective Payment System (IPPS) 1599-F. Available at: <http://www.gpo.gov/fdsys/pkg/FR-2013-08-19/pdf/2013-18956.pdf>

encounters and determined that nearly half (46.9%) of our less-than-2 midnight encounters would have been considered observation instead of inpatient solely based on time of day they presented for care.¹³ Looked at another way, we found that time of day of presentation predicted whether a patient would cross 2 midnights or not. We found that 13.6% of our observation patients hospitalized prior to 8:00 am would stay 2 midnights, while 31.2% hospitalized after 4:00 pm will cross two midnights.¹⁴ This means that time of day a patient gets sick, not different clinical needs, will determine insurance coverage.

On the individual patient level, consider a Medicare patient who requires 40 hours of hospital care before they are safe to go home. If this patient is hospitalized at 9:00 pm Wednesday, they will discharge at 1:00 pm on Friday--a two night stay, so they are inpatient. But if this exact same patient is hospitalized at 1:00 am Thursday morning, they will discharge at 5:00 pm Friday--a one night stay, and will be considered observation. The same patient, with the same condition has an entirely different outcome when it comes to their Medicare benefit.

Counting midnights and determining length of stay at admission is challenging for providers and detracts from patient care

There is no time when the 2-Midnight rule is more difficult for a physician than when working in the middle of the night. Because the midnight time point is so important in determining benefits, physicians want to be sure they know whether the patient's "clock" started before or after midnight. Yet Medicare beneficiaries deserve to have their physicians focused on their medical care, not figuring out from notes and tests if care started before midnight or not prior to writing an inpatient order. Just this past weekend, I was working the night shift, and was reminded again of this problem.

¹³ Sheehy A, Graf B, Gangireddy S, et al. "Observation Status" for hospitalized patients: implications of a proposed Medicare rules change. *JAMA Intern Med.* 2013;173(21):2004-2006.

¹⁴ Sheehy A, Caponi B, Gangireddy S, et al. Observation and inpatient status: clinical impact of the 2-midnight rule. *J Hosp Med.* 2014;9:203-209.

In addition, at the time a patient is hospitalized, the physician must write an order as to whether they expect the patient will be an inpatient (needing 2 or more midnights) or not. Often, this decision needs to be made before key tests are performed or results known. For example, a Medicare patient may present with nausea and vomiting, which may indicate a 24 hour virus, or it may indicate a partial bowel obstruction that may take several days to improve. Physicians are now forced to guess how many midnights a Medicare beneficiary may need even though they do not yet know the diagnosis or treatment plan.

Although hospitalists admit patients daily, in the SHM survey¹⁵, 78% of hospitalists stated they needed assistance from case managers to determine patient status, and others reported use of external consultants to help them make the admission decision. Only 40.4% of hospitalists felt they could determine patient status without assistance. Further, hospitalists report that they are asked to change status for 1 out of every 6 patients under their care, highlighting the complexity of the inpatient versus observation decision. What should be a simple task—writing an admission order—now requires additional staff just to navigate complicated Medicare rules.

The 2-Midnight rule disadvantages short stay patients, even if they need an acute and intense level of care

While long observation stays may be reduced under the 2-Midnight rule, it hurts a new population of patients, those requiring less than 2 midnights of care. Even a patient who may be sick enough to require hospitalization in an intensive care unit (ICU) can be considered outpatient if their stay does not span 2 midnights. A patient with an unstable heart rhythm or a patient with diabetic ketoacidosis may present to the hospital acutely ill and need intensive nursing, intravenous medications, fluids, and frequent monitoring of blood tests and vital signs, a level of care that could never be safely delivered in an

¹⁵Society of Hospital Medicine. The Observation Status Problem: Impact and Recommendations for Change. Released July 30, 2014. Accessible via www.hospitalmedicine.org/advocacy.

outpatient clinic setting. Yet these patients can improve quickly, sometimes in less than 48 hours. Prior to the 2 midnight rule, no physician would have ever considered writing an outpatient observation order for such patients, but now short stays, even in the ICU, can be considered outpatient.

Summary

A new arbitrary definition for observation simply changes which Medicare patients are disadvantaged under observation policy. The 2-Midnight rule determines insurance coverage based on an arbitrary cut point, which hurts patients who might present for care just after midnight, or patients who might need a short period of intensive care. Such a rule based not on clinical need but on time of day a patient becomes ill, is not the right solution for the observation problem.

3). The Recovery Audit Contractor (RAC) program charged with enforcing observation status is fraught with problems that negatively impact Medicare beneficiaries

The RAC program is well intentioned, and Medicare fraud and abuse cannot be tolerated. However, as the Committee is aware from the July 9, 2014 roundtable discussion, the Recovery Audit Contractor (RAC) program is fraught with problems. Although the goal of the RAC program is to reduce improper payments, RACs are the only Medicare auditors paid on a contingency fee system¹⁶. This aligns their financial incentives not with reducing overpayments, but instead incentivizes the creation of more audits by questioning physicians' judgment.

The audit and appeals process is lengthy, of unclear benefit, and data evaluating the program is challenging to interpret

The Office of Inspector General (OIG) issued a report in August 2013 detailing RAC audit activity from

¹⁶ Department of Health and Human Services Office of Inspector General. Medicare Recovery Audit Contractors and CMS's actions to address improper payments, referrals of potential fraud, and performance. Available at: <http://oig.hhs.gov/oei/reports/oei-04-11-00680.pdf>

2010 and 2011 which indicated that providers appealed only 6% (65,198/1,067,011) of audits, although 44% (28,815) of appeals were successful.¹⁷ Given that the RAC program was established nationwide in 2010, it is important to understand those numbers in the context of current auditing practices. At the University of Wisconsin in 2010, RACs reviewed just 15 charts, alleged overpayments in 3 (20.0%) cases, only 1 (33.3%) of which we appealed. By 2013, RACs requested 960 charts, alleged overpayment in 164 (17.1%), of which we appealed 151 (92.1%). Thus we have experienced a marked increase in overpayment determinations by the RAC, despite the fact that we have consistently won almost all of our appeals with decisions. Cases that remain in appeals have now exceeded 500 days at our hospital, a clear denial of due process. The extensive wait time prior to adjudication impacts a hospital's decision to file an appeal. These decisions may hurt Medicare patients, as hospitals that are unable to have payments held in limbo for years or cannot afford a robust RAC audit and appeal preparation team may end up having to rebill Medicare Part B instead of entering the appeals process, therefore declaring observation on patients that might otherwise qualify as inpatient. This is very important to understand in the context of the so-called increase in improper payments seen in the Medicare program of 8.5% in FY 2012 compared to 10.1% in FY 2013, as reported in this Committee Staff Report from the July 9 roundtable discussion.¹⁸ Although impossible to quantify, at least some of these improper payments are logged as improper simply because a hospital or provider was financially or logistically unable to contest the decision.

In CMS's FY 2012 Report to Congress on Recovery Auditing,¹⁹ they note:

In FY 2012, only 7 percent of all Recovery Auditor determinations have been challenged and

¹⁷ Department of Health and Human Services Office of Inspector General. Medicare Recovery Audit Contractors and CMS's actions to address improper payments, referrals of potential fraud, and performance. Available at: <http://oig.hhs.gov/oei/reports/oei-04-11-00680.pdf>

¹⁸ Senate Special Committee on Aging. Committee staff report: Improving audits: How we can strengthen the Medicare program for future generations. Available at: <http://www.aging.senate.gov/imo/media/doc/Improving%20Audits%20-%20Improper%20Payments%20Report%20-%20FINAL.pdf>

¹⁹ Recovery Auditing in Medicare and Medicaid for fiscal year 2012: FY 2012 report to Congress as required by Section 1893 (h) of the Social Security Act and Section 6411 (c) of the Affordable Care Act. Available at: http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Recovery-Audit-Program/Downloads/Report-To-Congress-Recovery-Auditing-in-Medicare-and-Medicaid-for-Fiscal-Year-2012_013114.pdf

later overturned on appeal. Medicare providers appealed 373,259 claims, which constitute 26.3 percent of all claims with overpayment determinations. Of those claims appealed, 99,476 claims were overturned with decisions in the provider's favor (26.7 percent).

Yet the American Hospital Association RACTrac data from last quarter 2012 reported a 40% appeal rate, with a 72% success rate.²⁰ Clearly, these numbers differ, and unfortunately, the low level of detail contained in these reports does not allow for a definitive answer to explain the discrepancy. However, there are three important considerations: First, the CMS report contains decisions for FY 2012, yet clearly many audits and appeals are not resolved in single year. Thus outstanding appeals, if not excluded from the denominator in calculating success rates, may skew these numbers. Second, as stated above, many hospitals rebill Part B out of necessity, a reality that cannot easily be considered in these statistics. Finally, and perhaps most importantly, many "appeals" are overturned in favor of the hospital during the discussion period, a step just before the first 'official' level of appeals where a Recovery Auditor Medical Director reviews the case that the first line RAC employee decided was an overpayment. While CMS does not technically consider this an appeal, a hospital would certainly consider this an overpayment determination that was decided in their favor. This unofficial process involves a significant amount of work, preparation and cost, similar to an appeal, yet this number is unlikely to be reflected in the CMS report of appeal success rate.

Summary

The RAC program is begging for improved transparency and accountability. The RACS are not penalized for inaccuracies, nor are hospitals compensated for the staff they must pay to assist with patient status determinations and an auditing and appeals process that largely determines hospitals and providers were correct to begin with. These are Medicare dollars that hospitals can no longer spend on direct beneficiary care, which hurts all Medicare patients.

²⁰ American Hospital Association RACTrac. Available at: <http://www.aha.org/advocacy-issues/rac/ractracreportsarchive.shtml>

Summary and recommendations

Observation care remains a major problem in the Medicare program, and the 2-Midnight rule is not the right solution. The 2-Midnight rule and observation policy negatively impact Medicare beneficiaries, and unfortunately, as use of observation care for hospitalized patients has markedly expanded, its cost savings have become ingrained in the system, making it a much more difficult problem to overcome. However, this does not make maintenance of the status quo acceptable. Any reform must consider the original intent and purpose of observation status so that all Medicare beneficiaries are treated fairly and have both hospital and nursing home coverage, regardless of whether their hospital stay is classified as observation or inpatient.

In the FY 2015 proposed IPPS rule,²¹ CMS solicited input on an alternative payment methodology under the Medicare program for short inpatient stays. MedPAC is also exploring options on how to define short stays and establish proper payment for such stays.²² As SHM suggested in its comments on the proposed rule, a lower acuity modifier could be considered for most DRGs, or a system of short-stay inpatient DRGs could be created. Alternatively, observation could be eliminated and the payment system could be modified in a cost-neutral fashion. Any plan should consider Medicare beneficiaries as inpatients so that they have fair Medicare Part A coverage. Importantly, any observation reform, whether regulatory or legislative, will fail unless there is concurrent reform of the federal RAC programs that enforce observation and inpatient determinations.

The SHM white paper on observation status outlines a set of short-term and long-term solutions to observation, including more detail on the options mentioned above. SHM ultimately believes that a sustainable solution must be a significant departure from the status quo that does not just shift the pressures from one aspect of the admission decision to another. This view was perfectly characterized by

²¹ FY 2015 proposed IPPS rule. Available at: <http://www.gpo.gov/fdsys/pkg/FR-2014-05-15/pdf/2014-10067.pdf>

²² MedPAC commentary on CMS-1607-P. Available at: http://www.medpac.gov/documents/06132014_MedPAC_FY15_IPPS_comment.pdf

one of the respondents in the SHM survey who said, “stop [the] distinction on observation versus inpatient—it’s nearly impossible for physicians and patients to understand and get right. It’s an arbitrary distinction for medical patients.”

Further, SHM strongly supports S. 569, the “Improving Access to Medicare Coverage Act of 2013,” introduced by Sen. Sherrod Brown. S. 569 would count any midnight a Medicare beneficiary spends in the hospital towards the 3 day skilled nursing care qualifying stay, regardless of whether that night is observation or inpatient. Many members of this Committee have cosponsored this important legislation, and we appreciate your support.

The Society of Hospital Medicine looks forward to working with the Committee on observation issues so that all Medicare beneficiaries can have access to the care they need and deserve.