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S. HRG. 113–905

ADMITTED OR NOT? THE IMPACT OF MEDICARE OBSERVATION STATUS ON SENIORS

HEARING

BEFORE THE

SPECIAL COMMITTEE ON AGING

UNITED STATES SENATE

ONE HUNDRED THIRTEENTH CONGRESS

SECOND SESSION

WASHINGTON, DC

JULY 30, 2014

Serial No. 113–27

Printed for the use of the Special Committee on Aging

Available via the World Wide Web: http://www.govinfo.gov

U.S. GOVERNMENT PUBLISHING OFFICE

46–917 PDF WASHINGTON : 2023

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C O N T E N T S

ADMITTED OR NOT?
THE IMPACT OF MEDICARE OBSERVATION STATUS ON SENIORS

WEDNESDAY, JULY 30, 2014

U.S. SENATE,
SPECIAL COMMITTEE ON AGING,
Washington, DC.

The Committee met, pursuant to notice, at 1:57 p.m., Room 418, Russell Senate Office Building, Hon. Bill Nelson, Chairman of the Committee, presiding.

Present: Senators Nelson, Whitehouse, Blumenthal, Baldwin, Warren, and Collins.

Also Present: Senator Brown.

OPENING STATEMENT OF SENATOR BILL NELSON, CHAIRMAN

The CHAIRMAN. Good afternoon.

Forty-nine years ago today, President Johnson signed the Medicare bill into law. Times have changed, but we are constantly trying to strengthen and improve this important program so that seniors and folks with disabilities get the care they deserve, and, as part of that process of continuing to improve Medicare, today's topic impacts a lot of Medicare beneficiaries financially, more than we realize, and that is the impact of Medicare's hospital observation status.

Now, most folks, after spending the night in the hospital, would say that they had been admitted to the hospital, but, now we find out that they really have not been admitted, that they were there under observation, even though everything, save for the two words' difference, "admitted" and "observation," everything else is the same.

In observation status, it can cost less than Medicare's inpatient deductible, even when a beneficiary has copayments for outpatient services, but, the real problem comes when a senior citizen learns that they are the one that after their observation status in the hospital, they need nursing home coverage, and, despite staying in the hospital for the required three days or more, Medicare will not cover that nursing home stay because the beneficiary was never admitted, instead, was under observation, and, it is a coding change in Medicare that can add up to big out-of-pocket expenses.

Well, we ought to do better by our Medicare beneficiaries. They deserve better than being in this back and forth rigmarole of terminology.

Senator Brown, one of our colleagues, has introduced a bill that Senator Collins and I support to count any three days a beneficiary stays in the hospital as eligible for nursing home coverage. That is one way to get at this problem.

Medicare officials are at a critical juncture right now to determine payment rules for both inpatient and outpatient services for the coming year, and so we need to shine a spotlight on the importance of this issue to the beneficiaries around the nation, and that is the essence of the discussion today.

Senator Collins is going to take over the Committee when I have to go to a classified briefing on the Ukraine, of which I am headed to the Ukraine in another week and a half. Senator Collins, thank you for offering to do that.

Senator Collins.

OPENING STATEMENT OF SENATOR SUSAN M. COLLINS, RANKING MEMBER

Senator COLLINS. Thank you very much, Mr. Chairman.

I appreciate you calling this hearing to highlight the increasing use of hospital observation stays and the financial implications for Medicare patients and their families.

Medicare originally intended observation stays as a way to give hospital physicians more time to run tests or do lab work in order to decide whether or not a patient should be admitted to the hospital or is stable enough to go home. These observation stays, which Medicare considers to be outpatient care, usually lasted between 24 and 48 hours. Hospitals, however, are increasing their use of observation stays and they are also keeping Medicare patients in observation status longer.

The number of seniors entering the hospital for observation increased by nearly 70 percent over five years, to 1.6 million in 2011. Moreover, eight percent of Medicare patients had observation stays longer than 48 hours in 2011, up from three percent in 2006.

According to the HHS Inspector General, in 2012, Medicare beneficiaries had more than 600,000 observation stays that lasted three nights or more. Many of these patients find themselves in kind of a Medicare twilight zone, where they may be in a hospital bed for days, receiving care and treatment from doctors and nurses, but still have not been officially admitted to the hospital as an inpatient.

The financial consequences can be severe for seniors. For example, they are held responsible for outpatient copayments and prescription drug costs that they would not have incurred as an inpatient. There also is no out-of-pocket cap on these costs.

More important, as the Chairman has mentioned, if a Medicare patient is not formally admitted as an inpatient, Medicare will not pay for any subsequent skilled nursing or rehabilitation care. A Medicare patient must spend three consecutive midnights in the hospital as an admitted patient in order to qualify for coverage for care in a skilled nursing facility. As a consequence, if a patient who has been on observation status needs follow-up nursing home care, they must pay the entire cost themselves, even if they have spent the last three midnights in a hospital bed being cared for by the hospital's doctors and nurses. How confusing is that.

Many patients on observation stays may not even realize that they have never been admitted officially as an inpatient. They just know that they are in the hospital. If they are admitted later to a skilled nursing facility for follow-up care, they may be shocked to learn that they will be liable for out-of-pocket costs totaling thousands of dollars.

I recently heard from a woman from Portland, Maine, whose mother-in-law went to the ER complaining of chest pain. She was put in the hospital on observation status, where she remained for five days. During that time, she became very weak, had difficulty swallowing, and lost 20 pounds. She was discharged to a nursing facility, where she stayed for nearly a month for follow-up care. Her family had been told that she was being observed while she was in the hospital, but they had no idea what that meant. They were, therefore, stunned to learn that they would have to pay more than $9,000 because Medicare would not cover the skilled nursing care. This imposed a huge financial burden for this family.

Mr. Chairman, I am also concerned that many beneficiaries may be foregoing needed skilled nursing or rehabilitation care simply because they cannot afford the out-of-pocket costs, and, as you mentioned, you and I have both cosponsored a bill to resolve this situation by deeming time spent in hospitalization observation status as inpatient care for the purpose of Medicare's three-day prior hospital stay requirement.

In closing, I also want to take this opportunity to welcome Bob Armstrong from Maine, who will be testifying on our panel this afternoon. Bob and I happen to be from the same hometown in Maine, Caribou, Maine, and he has a long and stellar career in long-term care administration and advocacy. He currently serves as Vice President of Elder Care Services for St. Mary's Health Care Systems in Lewiston, Maine, and I look forward to hearing his perspective as well as that of the remainder of our excellent panel of witnesses.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Collins.

Senator Blumenthal, would you do the honors of introducing Ms. Borgstrom.

OPENING STATEMENT OF SENATOR RICHARD BLUMENTHAL, COMMITTEE MEMBER

Senator BLUMENTHAL. I would be delighted, Mr. Chairman, and I very much appreciate your giving me that honor.

Before I do so, just let me join in thanking you for having this hearing. The issues that are going to be addressed by our panel today and by your questions, I think, are profoundly important to the future of health care in America.

I apologize that I have to leave to chair a hearing of another committee that we share, the Commerce Committee, on some important consumer issues, so, I just want to say to our entire panel of experts, thank you for being here.

Thank you especially to Marna Borgstrom, who has ably led the Yale-New Haven Health System. It is really a tribute to her work that she is here today. I have read her testimony. Her observations about the harm and the costs of the so-called "two-midnight" policy,

I think, are a very instructive set of information for this hearing to consider.

As President and CEO of Yale-New Haven Health System, whose flagship is the Yale-New Haven Hospital, she has been a leader not only in that hugely important institution, but also for our entire State and, indeed, the nation. Just to give you some idea of the scope of Yale-New Haven, it deals with about 18,000 employees and a medical staff of 5,675, with more than 90,000 discharges in 2012 alone and $2.6 billion in revenue, so, it has examples and lessons for us in this here and many, many others, and, she has been a leader in health care delivery reform, reducing costs, improving the quality of health care in a way that has set a model for the nation and certainly for our State.

I welcome her here, and thank you for being here.

The CHAIRMAN. Senator Warren, I will give Harvard equal time.

Senator BLUMENTHAL. Wait a minute. If I had known that, I would have gone on——

The CHAIRMAN. Do you want to introduce Mrs. Engler?

OPENING STATEMENT OF SENATOR ELIZABETH WARREN, COMMITTEE MEMBER

Senator WARREN. I am very pleased to have Mrs. Engler here today and to say thank you very much for being here. We welcome hearing from you and hearing the personal story that you have to tell. You know, it is powerfully important here.

I want to thank the Chairman and the Ranking member for holding this hearing. This is a serious problem and it is a problem that is getting worse. According to a 2012 study published in Health Affairs, the number of Medicare patients who are in the hospital for more than three days under observation status increased by 88 percent just from 2007 to 2009, and, the Inspector General reported that over a quarter of the 1.5 million Medicare observation stays in 2012 lasted for more than two nights.

The reasons for this increase are complex, and this afternoon, we are going to talk a lot, I know, about billing and coding and admissions and prospective payments systems and audits and all the ways that we can fix every one of those, but, while we talk about those things, I know that we are going to work hard to stay focused on what is really important here, and it is making sure that seniors get the care they need and can afford that care. That is the promise of Medicare, and if we are letting some of our seniors down, then we need to fix it.

Thank you all very much for being here. Thank you, Mrs. Engler, for being here. We very much appreciate it. It is so important to hear personal stories about how this affects people.

Thank you, Mr. Chairman.

The CHAIRMAN. Mrs. Engler is accompanied by Toby Edelman from the Center for Medicare Advocacy. Thank you for coming.

All right. Senator Baldwin, to introduce our final panelist. Please, do the honors for Dr. Sheehy.

Senator Baldwin.

OPENING STATEMENT OF SENATOR TAMMY BALDWIN, COMMITTEE MEMBER

Senator BALDWIN. Thank you, Chairman Nelson, Ranking Member Collins, for holding this incredibly important hearing on such an important and timely issue.

I am honored to get the opportunity to introduce Dr. Ann Marie Sheehy, head of the Division of Hospital Medicine at the University of Wisconsin School of Medicine and Public Health.

With a strong background in academic medicine, Dr. Sheehy conducts research on health care disparities and the effect of health care policy on patient care in the hospital, and, as a practicing hospitalist, she experiences firsthand the impact of observation status on Wisconsin's seniors and physicians. She received her M.D, and a Master's in Clinical Research from the Mayo Medical School and Graduate School and completed her residency at Johns Hopkins Hospital.

Dr. Sheehy, welcome to the Committee and thank you for joining us here today to share your experience. We very much appreciate it.

The CHAIRMAN. We will go in the order of Mrs. Engler, Ms. Borgstrom, Mr. Armstrong, and Dr. Sheehy.

Mrs. Engler.

STATEMENT OF SYLVIA C. ENGLER, MEDICARE BENEFICIARY, (ACCOMPANIED BY TOBY EDELMAN), SENIOR POLICY ATTORNEY, CENTER FOR MEDICARE ADVOCACY, FRAMINGHAM, MASSACHUSETTS

Mrs. ENGLER. Committee Chairman Nelson, Ranking Member Collins, and members of the Committee, thank you for the opportunity to tell you the story of my family and the Medicare observation rules.

My name is Sylvia C. Engler, age 83. I am still employed in the medical field and still working. I live in Framingham, Massachusetts. My husband, Harold, age 92, and I have been married for 60 years. He was Vice President of Sales and Marketing for the Convention and Traveling Industry. He worked until age 90.

For most of his life, the only medical conditions Harold had was COPD and asthma, which have been controlled for years. Five years ago, at age 87, Harold had a heart triple-bypass, went back to work in three months. Three months later, he had urgent hernia surgery. The doctor told him that it was required. He was in the hospital for only two-and-a-half days and was classified as inpatient. There was no problem with that. He recovered and then continued to work.

Last year, on March 28, 2013, at age 91, he again urgently needed hernia surgery. This time, it was a double hernia. His doctor told me to take him to the emergency room at Beth Israel Hospital in Boston. He had emergency surgery, stayed in the hospital for five days as complications set in. He was bleeding, passing clots in his urine. For the first time, he had to have a catheter. Five days later, on April 2, 2013, he was discharged home with the catheter still in place.

He was only home for two days when he had to return to the hospital. On April 4th, he woke up vomiting bile, with diarrhea,

and had a high temperature. He was sent back to the same Boston hospital by ambulance. He had fluid in his lungs, a temperature of 101, and possible pneumonia. Again, he had blood in his urine. I was told that he had contracted a virus in the hospital. They had to tap fluid from his lungs. He stayed in this hospital for another five days.

On April 10th, 2013, he was sent home again, unable to walk or stand alone. The Foley catheter was still in place. He could not get out of the automobile. My daughter and I actually had to try to pull him from the car, as he could not walk by himself. Harold had to use a walker while I helped balance him. He sat down on our bed and collapsed. His complexion turned gray. He had chest pains, shortness of breath, and severe pain from the catheter. Thinking it was his heart, I gave him a nitroglycerin pill, which made his condition worse.

I called the local ambulance and he was taken to the local hospital. The ER doctor stated that, "If he was my patient, he never would have been sent home in this condition." Harold could not walk or stand up on the same day that he was released from the Boston hospital the second time. After a total of ten days in the hospital, he was sent from the local ER to a local nursing home for rehab.

I thought Medicare would pay for Harold's nursing home care because he had been in the hospital for ten days and he needed rehab. I learned from the nursing home that Harold had never been admitted to the hospital as an inpatient. The nursing home told me that Harold was "medical observation" when he was in the hospital. This did not make sense to me, because Harold was on a floor with other inpatients and received care just like an inpatient in a hospital. The hospital never told me that he was medical observation. They said nothing about it. Harold remained in the nursing home six weeks for rehab.

The administrator told me that we had to pay the nursing home $7,859 immediately upon leaving or the bill would be put into collection for the full amount of $15,000, or my house would have been attached for the full amount. We paid the $7,859, but I had to cash a money market account to pay the bill.

I looked for someone who could help us fight this and found a wonderful lawyer, Diane Paulson of the Medicare Advocacy Project at Greater Boston Legal Services. Diane has been working with me for over a year to try to get Medicare to cover the nursing home bill. She keeps appealing, but Medicare keeps telling us that we cannot appeal the hospital's decision to call my husband "medical observation," that since he was not an inpatient, Medicare will not cover his nursing home bill. I later found out that the hospital had to pay back millions of dollars to Medicare because they called some patients inpatients instead of outpatients. I think this is why my husband was called observation.

Harold was able to remain at home for several months after he was discharged from the rehab, but then he had to go to a nursing home for patients with dementia, where he remains to this day. I am still fighting this battle with the help of my lawyer.

Thank you for listening to my unfortunate situation. I hope you will make changes so this will not happen to anyone else. Thank you.

The CHAIRMAN. Well, there you have it stated quite clearly. We thank you. We want to thank Senator Whitehouse and Senator Brown. I have already uttered your name, Senator Brown, as the sponsor of the legislation which we, Senator Collins and I, have co-sponsored.

Let me just take care of a delightful little administrative item here. Would our summer interns please stand up, Hannah Berner, Allison Gottman, Danielle Spiegelman, Selena Qian, Michael Watson, and Al Haidar. We want to thank you. This is the last time, since we are going into the August "go back home" time period, and so we want to thank you for your good work on our Committee. We appreciate it very much.

Ms. Borgstrom.

STATEMENT OF MARNA PARKE BORGSTROM, CHIEF EXECUTIVE OFFICER, YALE-NEW HAVEN HOSPITAL, PRESIDENT AND CHIEF EXECUTIVE OFFICER, YALE–NEW HAVEN HEALTH SYSTEM, NEW HAVEN, CONNECTICUT

Ms. BORGSTROM. Thank you, Chairman Nelson, Ranking Member Collins, and distinguished members of the Committee, and thank you for inviting me to testify. I am Marna Borgstrom, the President and CEO of the Yale-New Haven Health System. I also served as the Chair of the Association of American Medical Colleges, Council of Teaching Hospitals and Health Systems.

As Senator Blumenthal said, our system is large. We have over 20,000 employees, 6,000 medical staff members. The flagship hospital is Yale-New Haven, which is a 1,541-bed academic medical center, which, in affiliation with the Yale University School of Medicine, includes a mission of educating tomorrow's health care professionals and advancing medical care.

My remarks today are going to focus on CMS's "two-midnight" policy rule related to inpatient care. As you know, under this policy, hospital admissions spanning two midnights are considered inpatient care for purposes of Medicare payment. In contrast, hospital stays of less than two midnights are considered outpatient care, regardless of clinical severity or a doctor's judgment on whether inpatient care is needed.

A primary concern regarding the two-midnight policy is the financial impact and confusion it creates for patients. I would like to—when a patient is deemed outpatient, as my colleague noted, she is responsible for 20 percent of a copay. Also, her outpatient time does not count toward the three-day stay requirement for nursing home care.

I would like to share one example of the two-midnight rule very recently in our hospital. On July 5th, an 88-year-old frail female with known breast cancer metastatic to her bones and lungs came in with chest pain and difficulty breathing. She needed to be hospitalized and was appropriately predicted to require less than two midnights in the hospital. She was placed in observation and was discharged late the next day. 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 was upset because she could not, due to her observation status.

She saw her doctors over the next two weeks, but continued to get weak. Her family brought her back to the hospital on July 21st. She was dizzy, not eating well, and could not care for herself during the day. Again, a review was done and the patient did not meet the inpatient criteria, so she was again placed in observation. The family wanted her to go to a skilled nursing facility, but could not afford $250 a day, nor $20 at home for a home health aide. They had no choice but to take her home with the limited services they can afford.

We have little doubt that we will be seeing this patient again, and all of her care providers secretly hope that when she comes back, she will be sick enough to meet the inpatient criteria so that she can get into a facility and be cared for in a loving and dignified way.

Beyond the direct impact on patients, the two-midnight policy penalizes hospitals like ours that, with improved technology, can evaluate, treat, and transition certain patients to an appropriate care setting in less than the two-midnight time frame. This is the very medical efficiency that CMS should be encouraging, but instead, hospitals are seeing dramatic reimbursement cuts. In addition, the two-midnight policy ignores physicians' clinical judgment on medical necessity and instead relies on a rigid and arbitrary time-based approach.

The two-midnight policy disproportionately impacts academic medical centers and safety net hospitals, as it shifts payment for necessary hospital care to the outpatient setting. As a result, teaching and safety net hospitals experience decreases in their direct Graduate Medical Education payments and lose altogether their payments for indirect medical education and disproportionate share. These mission-related payments are intended to support the delivery of care to vulnerable patients and those who require services that are unique to teaching hospitals, including trauma centers and burn units. We cannot afford for these social missions to be jeopardized at a time when medical education for new practitioners is critical to meet the demands of the United States aging population.

My colleagues across the country and I believe that CMS's policy must change for stays lasting fewer than two midnights. We should return to the policy in place prior for short stays before October 13th that defers to a clinician's judgment, understanding that the decision to admit a patient to the hospital is not made lightly.

Additionally, we support your recommendation that Congress eliminate the three-day inpatient stay requirement for Medicare coverage of nursing home care and provide some sort of cap to patient copays.

Yale-New Haven and hospitals across the country stand ready to work with policy makers on these important efforts, and I thank you for the opportunity to testify today.

The CHAIRMAN. Thank you, Ms. Borgstrom.

Senator Brown, I know you have to leave. Did you want to say something about your bill?

Senator BROWN. Thank you. Only to say thank you to you, as the Chair of this Committee, and Ranking Member Collins, for holding this hearing and for this discussion and for your cosponsorship of the legislation that a number of us have been working on, the Improving Access to Medicare Coverage Act.

I think, when I heard the last two-thirds of Mrs. Engler's testimony, and we have all in our own States heard a number of these stories, that our case workers tell us about, that people on the street tell us about—a woman in Cleveland came to me. She had a 90-year-old mother taken to the emergency room. The same thing happened. She was stuck with this huge bill, and, we know the kind of anxiety and fear inflicted on the individual patient and inflicted on the family that comes from this quirk in the Medicare law, and I just wanted to say how appreciative I am that the Committee is taking it up and hopeful that we can move on this legislation.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Brown.

Mr. Armstrong.

STATEMENT OF BOB ARMSTRONG, VICE PRESIDENT, ELDER CARE SERVICES, ST. MARY'S HEALTH SYSTEM, LEWISTON, MAINE

Mr. ARMSTRONG. Good afternoon, Chairman Nelson, Ranking Member Collins, and distinguished members of the Committee. I would like to thank you for holding this important hearing to examine the impact of Medicare observation status on seniors. I especially appreciate the opportunity to appear before you here today.

My name is Bob Armstrong and I am the Vice President of Elder Care Services for St. Mary's Health System in Lewiston, Maine. Our nursing home, St. Mary's d'Youville Pavilion, is one of the largest nursing homes north of Boston and a flagship component of the elder care services offered through St. Mary's Health System, which, by the way, also includes St. Mary's Medical Center, so, we actually deal with this issue on both the hospital and the nursing home side.

With our state-of-the-art rehab center, we have a specialized dementia care unit, skilled and long-term care, and we provide our residents with the most advanced technology and skilled nursing care in the region. More importantly, we offer, hopefully, respect, care, and compassion to every one of our residents.

The St. Mary's Health System is proud to be a member of the Maine Health Care Association and the American Health Care Association. The Maine Health Care Association represents over 200 nursing homes and assisted living facilities in Maine, including for-profit and not-for-profit facilities. The most recent Statewide occupancy report indicates that Maine nursing homes care for over 6,300 residents every day. Sixty-five percent are in long-term care being paid for by Medicaid, 23 percent are paid for by private pay, and 12 percent are covered by Medicare, usually a Medicare Part A skilled benefit.

The American Health Care Association is the nation's largest association of long-term care and post-acute care providers. Our Association advocates for quality of care and services for the frail elder-

ly and those with disabilities. Our members provide essential care to millions of individuals in more than 12,000 not-for-profit and for-profit member facilities.

Our Association and its affiliates, including the Maine Health Care Association and member providers, advocate continuing vitality of long-term care provider community. The Association is committed to developing and advocating for public policies, such as the one being addressed today, that support quality of care and quality of life for our nation's most vulnerable population that I, as an administrator, deal with every day. We also would like to state that the support of the American Health Care Association and the Maine Health Care Association is in strong support of the policies that address the observation stays issue. I thank you, Senators Nelson and Collins, for bringing this critical issue to the forefront.

As a long-term care administrator, which I have been for 29 years, I have seen the last several years firsthand the impact the observation stays issue has had on residents and their families. For example, one resident, a sixty-six year-old gentleman, was admitted to my facility for short-term rehab care after a hospital stay and care for the treatment of a left humerus fracture and two broken ribs and some other injuries accompanying his fall.

According to the discharge documentation sent to us from the hospital, the resident was admitted to the hospital on November 9th, 2013, and was discharged on November 14th, 2013. The paperwork clearly gave an admitting hospital diagnosis with the fall injuries, including the left humerus fracture, which indicated the resident qualified under Medicare for post-hospital skilled rehab care. The paperwork also clearly indicated that we received that he was an inpatient in the hospital.

We provided appropriate skilled rehab care to this resident, who then successfully returned home. We believed, as the family did, that the resident's stay would be covered by Medicare Part A because the hospital discharge paperwork clearly showed that the resident was admitted to the hospital, and then they stayed in the hospital for at least the required three days.

My facility then appropriately billed Medicare for the resident and was told that the resident was, by the way, not really admitted to the hospital as an inpatient, similar to the case of our panelist today. The resident was in the hospital for five days under observation, even though, again, I say that the paperwork I have clearly stated that he was an inpatient as well as being admitted. My facility lost thousands of dollars for providing care for this resident in need with no payment from Medicare, even though this resident clearly should have received their Medicare Part A skilled nursing care benefit.

Now, in our case, because of our mission, we did not charge the family or attempt to recover the funds from the family because it was not their fault. They were under the assumption that the Medicare benefit would cover them. We were all under the assumption the Medicare benefit would cover them, and we did not feel it appropriate to burden the family with the bill, so we absorbed the thousands of dollars as a bad debt and took it that way.

This is just one, as we have heard today, of the countless heart wrenching stories from across the country.

We all—this is why we are having the hearing here today—must do more to ensure our nation's most vulnerable have access to their Medicare benefit they have earned and so rightly deserve. I am asking, along with the American Health Care Association, that Congress pass and sign into law bipartisan legislation that Representatives Joe Courtney and Tom Latham, along with Senator Brown, introduced, the Improving Access to Medicare Coverage Act of 2013, S. 569, H.R. 1179, which many on the Committee, including Senator Nelson and Senator Collins—thank you—are cosponsors of. It seems to count all hospital days spent in observation towards the three-day inpatient required for Medicare coverage of Part A skilled nursing care benefits.

Our Association also supports legislation eliminating the three-day requirement, which effectively solves the related issue of observation stays. Representative Jim Renacci's bipartisan Creating Access to Rehabilitation for Every Senior, called the CARES Act of 2013, or H.R. 3531, eliminates the three-day inpatient stay requirement by allowing all seniors that meet particular criteria to automatically qualify to waive the prior hospitalization requirement. The criteria are based on the CMS Nursing Home Compare Program.

In addition, we also back a similar bill introduced by Representative Jim McDermott, the Fairness for Beneficiaries Act of 2013, called H.R. 3144, which also seeks to eliminate the three-day stay requirement.

It is important to note that several national patient and provider organizations have written to CMS and advocated on the Hill in support of addressing this observation stays issue. In fact, the American Health Care Association is part of an Observation Stays Coalition, which consists of 30 provider and beneficiary organizations working to address this issue. It is simply not right, and I think the members of the Committee understand it is certainly not fair, to limit the access to the quality of care for those who are most in need.

Hopefully, now is time for Congress to pass this legislation to solve this problem, and again, I thank you for the opportunity to weigh in on this important matter, and I and the members of the Maine Health Care Association and the American Health Care Association look forward to working with the members of Congress in both chambers on this issue as it goes forward, and I would be more than happy to answer any of your questions. Thank you.

The CHAIRMAN. Thank you, Mr. Armstrong.

Those of you standing in the back, we have some seats available up here on the side walls, so avail yourself of that, please.

Dr. Sheehy.

STATEMENT OF ANN M. SHEEHY, M.D., CHIEF, DIVISION OF HOSPITAL MEDICINE, UNIVERSITY OF WISCONSIN SCHOOL OF MEDICINE AND PUBLIC HEALTH, AND MEMBER, PUBLIC POLICY COMMITTEE, SOCIETY OF HOSPITAL MEDICINE, MADISON, WISCONSIN

Dr. SHEEHY. Thank you, Chairman Nelson, Ranking Member Collins, and members of the Committee. Thank you for the opportunity to discuss observation policy today, and thank you, Senator Baldwin, for the kind introduction.

I am a physician at the University of Wisconsin Hospital in Madison, Wisconsin. I am a hospitalist, which is a physician who cares for patients primarily in the acute care hospital setting. I also conduct research on how observation impacts hospitals and patients, and I am a member of the Society of Hospital Medicine, an association that represents the nation's more than 44,000 hospitalists.

I would like to make three points today. First, observation status is problematic for Medicare beneficiaries and it needs reform.

I became interested in researching observation about four years ago because I was concerned about what was happening to patients under observation. As the Committee is aware, patients hospitalized under observation are considered outpatients, so are covered under Medicare Part B, subject to copays and pharmacy charges with no cumulative limit, and do not qualify for skilled nursing facility care as inpatients do, even if they stay three midnights. What I see as a physician are patients who stay overnight in a hospital and receive care that is often indistinguishable from inpatient care, yet Medicare views them as outpatients, as if they were in a clinic.

I will never forget the patient who first opened my eyes to the problem of observation. Of limited financial means, this woman had a new diagnosis of cancer. 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 her hospital stay 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 was not eligible.

What should observation really be? Most physicians recognize a role for observation in providing a few additional hours of care for low-complexity patients immediately following an emergency department visit to decide whether a patient needs admission as an inpatient or can discharge home. In fact, that is exactly what the CMS Benefit Manual says, that observation should be used for a well-defined subset of patients and should last less than 24 hours. In only rare and exceptional cases do outpatient observation services span more than 48 hours.

Unfortunately, this is no longer what observation looks like in clinical practice. We published our University of Wisconsin data in JAMA Internal Medicine last year. Of more than 43,000 hospital encounters, we found that over half of our observation patients stayed longer than 24 hours, and one in six stayed longer than 48 hours, indicating that stays longer than 48 hours were no longer rare and exceptional. Any attempt to reform observation status must recognize how far observation status in clinical practice has drifted from CMS's original intent, and, more patients are being hospitalized under observation, as documented by MedPAC and others.

The second point I would like to make is that the new two-midnight rule is not a fix for the observation problem.

As the Committee is aware, CMS recently established a new rule to determine observation. Effective October 21, 2013, most patients hospitalized less than two midnights were to be considered observation, and those staying two midnights or more would be consid-

ered inpatient, although full enforcement of this rule has been delayed through March 31, 2015.

There are several problems with this rule. First, time of day a patient becomes ill, not different clinical needs, determine insurance benefits. Say a patient requires 40 hours of hospital care before they are safe to go home. If this patient is hospitalized at 9:00 p.m. on Wednesday, they will discharge at 1:00 p.m. on Friday, a two-night stay, so they are inpatient, but, if this exact same patient needing the exact same clinical care is hospitalized at 1:00 a.m. on Thursday morning, they will discharge at 5:00 p.m. on Friday, a one-midnight stay, and will be considered observation.

This is not just theoretical. At the University of Wisconsin Hospital, in a second publication last year, we retrospectively determined that nearly half of our less than two-midnight encounters would have been considered observation instead of inpatient solely based on time of day they became sick, not different clinical needs.

The two-midnight rule also hurts a new population of patients, those requiring less than two midnights of care. A patient with diabetic ketoacidosis may present to the hospital acutely ill and need intensive care unit admission, a level of care that could never safely be delivered in an outpatient clinic setting. Yet, these patients can also improve quickly, sometimes in less than 48 hours. Now, short stays, even in an intensive care unit, can be considered outpatient.

Finally, as the Committee is aware, the Recovery Audit Contractor Program charged with enforcing observation determinations needs major reform. Given the recent roundtable this Committee hosted earlier this month, I will not spend more time here other than to state that no plan to reform observation will be successful without concomitant reform of the RAC system.

Thank you for conducting this hearing today. The Society of Hospital Medicine looks forward to working with the Committee to improve observation care for Medicare patients, and I appreciate Senator Brown and all of the members of this Committee who have supposed S. 569, the bill that counts time spent in observation towards the two-midnight requirement for skilled nursing facility care, which SHM also strongly supports.

Senator COLLINS. [Presiding.] Thank you very much for your testimony.

Let me start by thanking Mrs. Engler for being with us today and putting a human face on the consequences of this very complex and troubling problem.

I want to start my questioning with Dr. Sheehy and Ms. Borgstrom. There has been, as both of you have referenced, an increase in the number of observation stays that hospitals are doing, and I am wondering why that is. We see it in the Inspector General's report, that there has been measurable and substantial increase in the number of observation stays. Why are we hearing these stories where hospitals are keeping people for fairly substantial amounts of time and not admitting them as inpatients? What incentives are there that are driving the decision to keep someone in observation status rather than just admitting them as an inpatient patient?

Dr. SHEEHY. Thank you for that question. I think the simple answer is there is increased auditing pressure from the Recovery Audit Contractors that have increased scrutiny and increased surveillance of our admission and observation determinations. At the University of Wisconsin Hospital, we have seen a marked escalation in our audits, on the several-hundredfold increase over the last four years. Hospitals are very fearful of mislabeling a patient. We do not want to commit Medicare fraud. We want to follow the rule of the land and that is what we have been doing.

I will also say there is a marked fear of the length and the cumbersome nature of these audits. Our audits at the University of Wisconsin that are still in appeals since 2010 have been in the appeals process for over 500 days, and so a hospital is also looking at that as a decision about whether they are willing to put a case through a very lengthy appeals process.

Senator COLLINS. Ms. Borgstrom.

Ms. BORGSTROM. I cannot add a lot, because I agree completely. You know, we have read the rules, we understand them, and we want to follow them, and, I think, frankly, as a non-clinician, but talking with a lot of our clinicians, they feel that the criteria for making a patient inpatient are quite clear, and when they do not honestly believe that a patient meets that criteria, they do not feel that they have the ability to use their judgment to override the regulation and instead admit those patients to observation status.

Senator COLLINS. Well, I learned a lot attending the roundtable that we had at which the Recovery Audits were discussed at length. It is clear that they are producing unintended consequences because of the way the incentive structure is set up, where they get a percentage of whatever they recover, and yet, if you look at the success that hospitals, home health care agencies, nursing homes, other providers, doctors, dentists, et cetera, have when they appeal the decision of the Recovery Audit, it really shows you that there is something wrong with the system, so, it is interesting that that is playing into this problem, as well.

Ms. Borgstrom, do hospitals use observation status with individuals with other forms of insurance, or just with Medicare? As a related question, do non-Medicare plans have similar policies or limitations with regard to follow-up nursing home care? Mr. Armstrong, that might be a question for you, as well.

Ms. BORGSTROM. You know, I cannot speak uniformly to them, but we do admit patients other than Medicare patients to observation status. Each contract that we have with a third-party payer is different in terms of what they pay and how they determine the appropriate location for a patient. To the best of my knowledge, Medicare Advantage and the commercial policies do not have the three-day requirement before skilled nursing is paid for.

Senator COLLINS. Mr. Armstrong, is that your experience, as well?

Mr. ARMSTRONG. Yes, Senator. In our hospital, we admit, and we actually in our hospital are trying to limit, because of the cause and effect of this issue, the number of observation days that our hospital actually utilizes, but, it usually just generally affects negatively the Medicare recipients. Where the insurance payers do not have the same limitations in their contracts with us, they do not

require the three-day midnight. They do not require some of these things. They just require that a person need the skilled care, so it really does not affect them as it would a Medicare recipient. This falls mostly on Medicare recipients for skilled care.

Ms. EDELMAN. Excuse me, Senator, if I could say something about——

Senator COLLINS. Yes, Ms. Edelman.

Ms. EDELMAN. [continuing.] About the Recovery Auditors. There are a lot of programs that the Federal Government has to prevent fraud, to make sure that Medicare payments are appropriate. What is unique about Recovery Auditors is if they come in and look at the hospital's decisions and decide that a patient should have been called an outpatient instead of an inpatient, the hospital is basically required to repay to Medicare everything that it got. It gets zero payments for medically necessary care. Nobody is disputing that the care is medically necessary and appropriate, but because the wrong term was used—a person was called inpatient instead of outpatient—hospitals do not get paid.

It is understandable that they want to err on the side of calling people outpatients. At least, then, they get Part B payments from Medicare, the Part B copayments from the patient, and they can also bill the patient for the prescription drugs in the hospital, but, if they make a mistake and call them inpatient, they get nothing.

Senator COLLINS. That is an excellent point. What we really need to do with the Medicare program to reduce improper payments, whether it is fraud or mistakes, is to have better controls up front and more collaboration with stakeholders up front rather than doing the pay-and-chase model, which is what we have now.

I am going to turn to my colleagues and then I will have some additional questions. Senator Warren.

Senator WARREN. Thank you very much, Chairman.

Some seniors need additional care at a skilled nursing facility after leaving the hospital before they can return home safely, as Mrs. Engler so eloquently pointed out, and, that is the reason that I am also a cosponsor of Senator Brown's bill, along with Senator Collins and Chairman Nelson and Senator Baldwin, but, I see that as a good start, but we also recognize that some seniors still need skilled nursing facilities without spending any time in the hospital.

In 2010, as part of a CMS Care Management Pilot Program, Massachusetts General Hospital allowed patients to be sent directly to a skilled nursing facility after evaluation by a doctor. These were patients who needed rehab after a fall or needed some extra care to recover from an illness. Compared to similarly situated patients who were sent home instead of being directly admitted from the hospital to the nursing facility, patients in the pilot experienced fewer subsequent admissions to the hospital and cost Medicare less money over the subsequent 60 days.

I understand that the three-day rule was put in place to try to protect against over-utilization of highly specialized care, but I also understand that we are trying to move toward a payment system that rewards for value and not for providing unnecessary services. Today, almost all of the Pioneer ACOs, including Massachusetts General Hospital, waive the three-day rule.

Given the results from pilot programs like the one at MGH and the ongoing experience of our ACOs across the country, do you think that a three-day rule is still the most appropriate measure of the need for a skilled nursing facility? I thought I might start with you, Ms. Borgstrom.

Ms. BORGSTROM. I have a little bit of familiarity with the Massachusetts General experience, and again, I will say, as a non-clinician, no, I do not think that the three-day stay as a preparatory requirement for skilled nursing facility makes sense, and, in addition to what the Pioneer ACOs permit, which is direct admission to skilled nursing, also, in CMS's experience with bundled payments—we are participating in 11 of the bundled payments—you can admit patients directly to skilled nursing if you want.

I think it gets down to the economic issue versus clinical judgment, because clinical judgment in the case of the Massachusetts General experience said these patients will do better and we will bypass the inpatient environment, and for older Americans, not go through the confusion of being moved on two occasion. I think that that is—there is real opportunity for reform.

Senator WARREN. Right. I just want to be clear when you say the clinical versus the economic. In fact, relying on clinical judgment, according to our best evidence, saved money. It did not cost money.

Ms. BORGSTROM. Right.

Senator WARREN. These two things were not in tension with each other. When used appropriately, they seem to reinforce each other.

Ms. BORGSTROM. I absolutely agree with you, but the prevailing CMS payment methodology is currently DRGs.

Senator WARREN. Well, so that is why we are talking about——

Ms. BORGSTROM. Right.

Senator WARREN. [continuing.] Alternative ways to do this, and, I thought, perhaps, you would like to weigh in on this, Mr. Armstrong.

Mr. ARMSTRONG. Yes. I think, as stated in the opening remarks, the three-day requirement was implemented years and years and years ago and it just continues to be on the books.

As my colleague on the panel just spoke to, in Bangor, we have Eastern Maine Medical Center, which is a Pioneer ACO and they are not required to do this. Other programs, like the PACE program, or Program for All-Inclusive Care for the Elderly that operates very successfully in 29 States, including successfully in Massachusetts and Rhode Island in the New England area, they do not require the three-day hospitalization because they have a capitated payment for Medicare and Medicaid for the residents that cover a whole host of services, that keep people at home, or if they have to go to a nursing home, like I say, directly without going to the hospital, the PACE program pays for that, so, there are currently other CMS programs that do not require the three-day hospitalization at all.

Senator WARREN. As you rightly point out, and within that, there are other ways to manage the access question.

Mr. ARMSTRONG. Yes.

Senator WARREN. We understand we do not want to have over-utilization. We want to get appropriate utilization.

Mr. ARMSTRONG. For example, the three-day hospitalization stay is just one of the triggers now that qualifies for someone. They still have to meet the need for skilled nursing care or skilled therapy care or a combination of those to qualify for skilled care in our facility, so, if you waive the three-day requirement altogether, they would still have to meet that criteria to need the service, and that is currently already in the CMS requirements for Medicare reimbursement, so, if you just did away with the three-day requirement, they would still be required to meet the need for the service before we could provide it.

Senator WARREN. Good. Well, thank you very much. I have more questions on this, but I will wait for the next round. Thank you, Madam Chairman.

Senator COLLINS. Thank you.

Senator Baldwin.

Senator BALDWIN. Thank you. I wanted to add the voice of another patient experience to what we have heard today, and thank you, Mrs. Engler, for being here to put a face and a story behind the issues that we are dealing with today.

I heard this from a constituent in Port Washington, Wisconsin. This gentleman had heart surgery to treat atrial fibrillation at a Wisconsin hospital. He stayed overnight, but was discharged the following day with a catheter and further instructions from his doctor. He was shocked to find out that his treatment was billed under observation status, requiring him to shoulder 20 percent of the cost, and, he was also so frustrated that he called another area hospital and was told that the same procedure there would have been billed under Part A as an inpatient at their facility, which, of course, only added to his substantial confusion about what was going on, so, I thank all of you for being here today to shed additional light and help us as we move forward.

Although full enforcement of the two-midnight rule has been delayed, hospitals and physicians across the country have already made, it seems, significant administrative changes in anticipation of compliance with the policy, and these changes are exposing the consequences of using observation status when it is not based on clinical needs.

Dr. Sheehy, I wonder if you could describe the experience and challenge faced by the University of Wisconsin Hospital in preparing for enforcement of the two-midnight rule and additional information on how it has impacted you and your fellow hospitalists in their practice.

Dr. SHEEHY. Thank you for that question. We had very little time to prepare for the two-midnight rule. The final rule was posted in the Federal Register on August 19th and the rule went into effect on October 1st. This was a major, major change in all hospitals. We had changed from looking at clinical decision tools, such as InterQual and Milliman, to make our observation determinations to one based on time. Further, we had to interpret the rule and understand what kind of documentation CMS was going to be looking for, what their auditors would be looking for to enforce this rule. At the time, we did not know there were going to be delays, so we—every possible prepared for the rule as if it was going to be,

and it is still the law of the land. Although enforcement is delayed, we are trying to comply.

I think this has impacted physicians negatively. I think we feel that our clinical judgment has really been overridden by kind of a time-based rule which will be enforced by auditors. When I see a patient, say, in the emergency department—and I was working this weekend—I am looking at a patient and I am trying to determine when I first see them whether they are going to need two midnights or not, and sometimes a Medicare beneficiary will come in with something simple like a fever, which can be a very self-limited virus or it could be a life-threatening bloodstream infection, and I cannot know that up front and I have to make that decision right away and my determination is going to be subject to scrutiny down the road.

Senator BALDWIN. I thank you, and particularly that your answer helps shed some light for us on sort of who is in the decision making position, the fact that you need to predict the future without having perfect clarity about the future.

I guess I am interested, also, in the role that you and your colleagues play in the necessity to improve the conversation and communication with the patients about what it means to be under observation rather than as an inpatient. Obviously, you are providing the care, but this function is also very important so that they are as informed consumers of health care as they possibly can be, and talking about these issues before they perhaps decide to forego further care. Tell me a little bit about what role you and your fellow hospitalists play in that regard.

Dr. SHEEHY. Well, I completely agree that patients need to be informed about what their status is. One of the tricky parts of this is, sometimes, I will not know right away, so a patient who may decide whether or not they want to agree to the care I am proposing does not have that information in front of them. They may be admitted to the hospital, and then the next day it may look like they are actually going to get better quicker and they are going to be observation based on length of stay, so, patients really are not equipped with that information at the right time.

We have—at the University of Wisconsin, our case managers inform all of our patients who are under observation. We feel it is very important, and we field a lot of questions on that. One of the downsides, which is part of this process, is that, like I mentioned in my oral testimony, once patients find out they are under observation, a lot of them are very concerned, and, when they only should be focusing on getting themselves better and worrying about their health, now they are worrying about observation. That said, patients still need to know and we need to deal with those questions that come.

Senator BALDWIN. Thank you.

Senator COLLINS. Senator Whitehouse.

Senator WHITEHOUSE. Thank you, Chairman, and thank you to the witnesses.

The Rhode Island Governor's Advisory Commission on Aging has written to formally express to me its concern over the severe impact of the designation of an observational status upon Medicare patients when seeking health services at a hospital upon the onset

of an injury or illness, and they go on to say that the significant lack of information, although available in, quote, "the fine print," and the enormous unexpected financial responsibility consequences which this designation unloads upon an unsuspecting Medicare-eligible participant cannot be overstated.

Health Affairs published back in 2012 a study by Brown University researchers, including a guy named Dr. Vincent Moore, who we work with a lot on these issues, that reviewed the outpatient Medicare claims data from 2007 to 2009 on these observation stays and they found that the number of observation stays increased by 34 percent and inpatient admissions decreased, suggesting a shift by the hospitals, and, whether they are doing it for their own accounts or whether they are doing it because they are afraid of audits and it is a response to pressure, would be my first question. Do you think that they have changed their behavior in response to this, and is it self-interested in the sense that this is somehow beneficial for the hospitals, or is it simply trying to duck the risk of CMS audits?

Ms. Borgstrom, you seem—or Dr. Sheehy, whichever.

Dr. SHEEHY. I think that is a wonderful question, and MedPAC also has data looking from 2006 to 2012 that show about a 28.5 percent increase in observation—actually, outpatient stays, and a decrease in inpatient stays of about 12 percent over that time.

I think it is important to point out that, financially, at the University of Wisconsin, we have looked at our data pretty carefully and our hospital loses money on observation stays, so, there is no incentive for a hospital, other than to avoid an audit, to put a patient in observation. I truly feel this is hospitals trying to comply with Medicare rules and accepting the consequences of that.

Senator WHITEHOUSE. Got you. I am not sure I understand the two-midnight rule exactly.

Senator COLLINS. That is because no one understands the two-midnight rule exactly.

Senator WHITEHOUSE. Is it actually two midnights? Because, if it actually is two midnights——

Senator COLLINS. It is not 48 hours.

Senator WHITEHOUSE. [continuing.] Then it seems to me that if you are taken ill at 11:00 p.m.——

Senator COLLINS. Exactly.

Senator WHITEHOUSE. [continuing.] You can be in the hospital for 25 hours and pass the two-midnight rule and be on your way, whereas if you are slow in the ambulance and got in after midnight, you could be 47 hours in the hospital and fail the two-midnight rule, and, I am getting nods that that is, indeed, correct, so, 25 could be enough to make it and 47 too little to make it, even though 25 is less than 47. It does not seem to make mathematical sense.

Of course, Senators dabbling in mathematics is a dangerous thing, so I will leave it at that, but, I appreciate very much the testimony that you all have brought, and particularly, Mrs. Engler, the personal story that you, unfortunately, had to bring here, and, to our Chairman and to Ranking Member Collins, thank you to you both.

Senator COLLINS. Thank you.

Ms. EDELMAN. There are actually two two-midnight rules, Senator.

Senator WHITEHOUSE. Oh, it gets better.

Ms. EDELMAN. I mean, one is what the doctor is supposed to—well, the doctor is supposed to predict, and as Dr. Sheehy said, that is not how doctors think. It is not what they are doing, so, they are supposed to decide, this person should be an inpatient because I believe this patient will be here for two midnights.

The second two midnight is what the auditors do, so, if the doctor is not sure or thinks the person may not be in the hospital for two midnights, what CMS says is the physician should say this patient is an outpatient, and then the next day, if the person is still there and still needs to be there, maybe that person should become an inpatient, so, the second two-midnight rule is what the auditors do. If they see somebody was an outpatient for a day and then an inpatient for a day, they are not going to review those cases. It is extremely confusing.

Senator WHITEHOUSE. Have you ever——

Ms. EDELMAN. If you think it is confusing, I mean, the patients have no idea, because they think—they have come from the emergency room, and the doctor says, you need to stay. We are not done. We need to figure out what is wrong, and, you are upstairs in a bed and getting care, and as Dr. Sheehy says, indistinguishable if you are an inpatient or an outpatient.

Senator WHITEHOUSE. Have you ever come across a patient who came into the emergency room, was directed by their doctor that they had to be, I guess "admitted" is probably not the precise word in this, but, in any event, taken to a room upstairs and treated as if admitted, that they were somehow in outpatient status? Does anybody think that?

Ms. EDELMAN. Do patients think that they are outpatients?

Senator WHITEHOUSE. Yes.

Ms. EDELMAN. No. People think they are——

Senator WHITEHOUSE. Because they are not. They are in.

Ms. EDELMAN. [continuing.] They think—they are in a bed. They are——

Senator WHITEHOUSE. In is in. Out is out.

Ms. EDELMAN. Right.

Senator WHITEHOUSE. Yes.

Thank you.

Senator COLLINS. Ms. Edelman, we have heard all these stories that Mrs. Engler and Mr. Armstrong have told about the confusion that Senator Whitehouse has just referred to, and I just cannot imagine anyone who is ill and has been put into a hospital bed making a distinction or even realizing there is a distinction between being in inpatient status or in observation status.

My question—and we have also heard Mr. Armstrong talk about how his nursing home, to its great credit and to St. Mary's Health System's great credit, absorbed the cost of treating a patient because of this lack of clarity so that it did not fall on the patient's family, but, not every nursing home is going to do that. They did not in the case of Mrs. Engler's husband, for example.

My question to you is this. How does CMS respond to complaints from beneficiaries or their families about the lack of clarity in what their status was which leads to tremendous financial penalties for them? Is there an established appeals process for beneficiaries dealing with this issue?

Ms. EDELMAN. There is no established appeals process. Medicare does not consider outpatient status a denial of Medicare. It is just payment under Part B instead of Part A, and, in fact, CMS does not require hospitals to inform people that they are outpatients. If somebody goes from the hospital—from the emergency room to a bed and is an outpatient, there is no requirement that the patient be told.

The only time CMS says that there needs to be information is if the physician says, my patient is an inpatient and that decision gets reversed. Then, CMS says, okay, hospital, under those circumstances, you must tell the patient your status has changed from inpatient to outpatient.

There is no right of appeal at that point. There is no due process. Usually, in due process, you get notice and an opportunity for a hearing. There is no opportunity for a hearing.

CMS tells people all kinds of things. Sometimes, they tell patients, call the Quality Improvement Organization, but they say—QIOs say, we only handle Part A, not Part B, so we do not handle those cases. Increasingly, we hear from people that they are being told by CMS that there is no appeal. There is just nothing they can do about it.

We came up with a system on our own to say, appeal from the Medicare Summary Notice, but that is after the fact. That is only if people have actually gone to the skilled nursing facility, paid out-of-pocket, gotten a Medicare covered level of care, and then try to fight with CMS and try to get the payment back, which is what Mrs. Engler described. They are appealing. This happened over a year ago. They have lost at the first two levels of appeal. Now, the next level is the Administrative Law Judge. Maybe that is a year in the future, but, sometimes people win those cases and frequently they lose those administrative appeals, and CMS is not making it clear.

Senator COLLINS. You know, when I think of all the confusion that already exists over whether or not Medicare pays for nursing home care and under what circumstances, to expect a beneficiary to understand whether or not they have been in a hospital bed as an inpatient versus in observation status is just absurd. I just cannot imagine that the vast majority of patients would know there was any difference at all. Is that your experience in trying to help people?

Ms. EDELMAN. People have no idea of what has happened and they do not hear frequently until they are about to be discharged, when they are told, you know, bring your checkbook to the nursing home because you are going to have to pay for it, so, people have no idea of what to do.

That is why the legislation you are all supporting is so important. It just says—it is so simple. It is one sentence. If you are in the hospital for three midnights, you have met that requirement, and, as Mr. Armstrong said, there are many other requirements,

still, which would still continue to exist, but, if you have been in the hospital for three nights, they count.

I would just say in response to what Senator Warren said before, when Medicare was enacted in 1965, that is where the three-midnight rule came in. The average length of stay for people 65 and older in an acute care hospital was 13-plus days. As of a couple of years ago, it was five-plus days, so, it is a huge reduction in the time people spend in a hospital, and people assume if they are in a bed, they are really in the hospital.

Senator COLLINS. A very logical assumption to make.

Mr. Armstrong, have you seen elderly beneficiaries with Medicare forego care because they are—they become aware that it is not going to be covered under the Medicare program? Have you seen cases where seniors actually do not get the follow-up nursing home care or rehabilitation services that they need because of the cost?

Mr. ARMSTRONG. Yes, Senator, and unfortunately, I have seen cases where—in many cases, they do not know they are in an observation status. There are cases where they sort of discover it in some fashion and they do not then want to go in and get the rehab care they need because they are then realizing they have to pay thousands of dollars to get this care.

There are cases where we have seen people not get the care they need go home and return to us through the hospital, and eventually to us again because they did not get the care they needed properly the first time, and those cases are the saddest cases because, because they did not get rehab properly the first time, then Medicare also, from a cost perspective, pays for another hospital visit which ends up being covered by Medicare, and then they go to a nursing home again anyway and then end up being taken care of, but, this poor person in the meantime did not get the care they should have gotten up front, and those are the saddest cases, really, because they go home and they are not properly rehabbed and then they fall and they break a hip and they start the whole cycle over again. It is worse than if they just got the proper care in the beginning.

Senator COLLINS. Those are terrible cases, because not only is there unnecessary suffering, but there is greater expense to the system in the long run, so, it reminds me of the therapy caps that are put on, which, in my view, prevent people from regaining full function in some cases where someone has had, for example, a severe stroke, and it just makes no sense and it ends up costing the system more plus causing suffering that could be avoided.

Senator Warren.

Senator WARREN. Thank you.

You know, as we have been talking about, the two-midnight rule was put in place to try to deal with the issue of long observation stays by saying, anyone who is in the hospital for two midnights should be an inpatient, but, I just want to make sure we get a couple of questions on the record here that we are able to build, and the first one is a fact question, and that is, in your experience, has the two-midnight rule decreased or increased the number of long observation stays? Dr. Sheehy.

Dr. SHEEHY. Yes. Thank you for that question. I think the one benefit of the two-midnight rule is likely a decrease in those long observation stays.

However, if I could speak to the—we are currently under the probe and educate period under the MACs, the Medicare Administrative Contractors, while the RACs are on hiatus, and at University of Wisconsin Hospital, we had nine cases that were pulled and looked at in the probe and educate period. Three of those were determined to be overpayments. All three of those cases were cases we tried to claim two-midnight inpatient stays for. The MACs—which we thought would be honored because the physician's determination was that that patient needed two midnights. We went through the appeals process. We watched their webinars, did not get further information, requested a consult, and just days before our consult occurred, we got notification from the MACs that all cases would be paid.

I think the point of that is, is we are vulnerable. Even those two-midnight cases that we think are going to hold as two midnights and we would see a reduction in long-stay observation, if hospitals start getting audited on cases they claim two midnights for, we are going to see that long observation stay rate increase.

Senator WARREN. That is a very interesting point.

Would you like to weigh in on that, Mr. Armstrong.

Mr. ARMSTRONG. Yes. I mean, I think it is interesting. I picked a case in my oral testimony on purpose because of the timing of the so-called implementation of the rule. My case was actually following the implementation of the two-midnight rule time-wise. I actually picked it specifically for that reason, that it did not seem to affect that particular case at all, so, if it was supposed to be in place, it was supposed to be policy, the hospital who referred the person to us did not follow the policy, you know, that is supposedly in case, because it actually followed in the time frame when it was supposed to be implemented, so, I actually picked that case on purpose for this question, because in our case, the person still was in the hospital for five days——

Senator WARREN. Right. I get it.

Mr. ARMSTRONG. [continuing.] You know, I mean, it is——

Senator WARREN. Let me ask, then, another part of this, and that is that the hospitals in Massachusetts, and, I think, around the country, have asked for a way to define and pay for hospital stays that are less than two days where inpatient care is appropriate, and, in this year's inpatient Prospective Payment System proposed rule, CMS asked for feedback on the policy options to address these short stays, and I am very glad that the agency is working on it, but I want to ask about this, and that is, again, this question about the impact on seniors.

Ms. Borgstrom, I would like to start with you. Will a well-designed short stay policy greatly reduce or even eliminate long hospital stays under observation status? If not, what else do you think needs to happen?

Ms. BORGSTROM. It is hard to answer that question because the caveat is in well designed.

Senator WARREN. Fair enough.

Ms. BORGSTROM. I think it is—you know, I believe that it——

Senator WARREN. I do not want this to be, "and then a miracle occurred."

Ms. BORGSTROM. No, but I believe that it is possible to create a rational short stay payment plan that would decrease long-stay observation patient stays.

Senator WARREN. Let me just ask you the same question. Dr. Sheehy, do you agree with that?

Dr. SHEEHY. I think you could. I think you could come up with some sort of a short stay modifier or some short stay DRGs that would accomplish that goal. It would need to be accompanied by some check on the auditing of the process, and hopefully, these would be paid under Medicare Part A so the vulnerability that the Medicare beneficiary feels currently would not be felt.

Senator WARREN. I recognize, there is going to be some complexity to this. I mean, we cannot get away from that, but, the question is, on balance, whether that is a better approach than using the two-midnight rule as a way to try, as you rightly point out, Mr. Armstrong, to sometimes corral the problem of long observation stays.

Mr. Armstrong.

Mr. ARMSTRONG. Well, I think, to give CMS some credit, they have come up with the ACO concept and the concept of bundled payment, which sort of takes that three midnight and this whole observation and all this—and the two midnight—all off the table by, you know, having to take care of these people in a bundled payment, and we are entering in our system into a bundled payment agreement as we speak with CMS for several bundles which we will not have to deal with some of these requirements, because under the bundled payment, we will have a settled bundled payment from CMS for the whole continuum of care, including the physician practice, including the operation, say, for a hip, the inpatient stay for the hip fracture or replacement, as well as for the skilled stay in our skilled facility will all be covered under the bundle and we will not have to deal with, really, any of these issues.

Senator WARREN. Basically, just to underline your point, that means we do not need the complexity in the system. We do not need the complexity and the resources spent in the monitoring, and most importantly, to go back to Ms. Borgstrom's point, we are really relying on clinical judgment at that point which aligns with the financial incentives, and financial responsibility, I should say.

Mr. ARMSTRONG. Yes.

Senator WARREN. Is that a fair description, Mr. Armstrong?

Mr. ARMSTRONG. Yes, Senator. Yes.

Senator WARREN. Good. Ms. Borgstrom.

Ms. BORGSTROM. Just adding to that, because I think your question and your point is really important, and to Mr. Armstrong's point, CMS is trying to support some experimentation with the ACOs, with bundled payments, to determine a way that allows clinical judgment to determine how patients are cared for and create more rational economic incentives.

I think the problem here is we are not giving those time to work and we are overlaying it with another policy that, you know, as this hearing is demonstrating, very few people understand and find rational. It is almost that we are trying to do too much without let-

ting some things play out and determine what is really going to optimize the delivery of patient care and the payment requirements or expectations.

Senator WARREN. Good. Thank you. I think that is at least a hopeful sign, so thank you very much, and, again, thank you so much for being here, Mrs. Engler, and getting us started in the right direction. I am sorry for the need for it, but welcome your coming here to talk about it to try to do some good for others, so, thank you.

Senator COLLINS. Senator Baldwin.

Senator BALDWIN. Thank you.

There is existing policy and emerging policy discussions and pressure to reduce unnecessary hospital readmissions, and I am wondering about any observations you might have about the interaction between use of observation status versus inpatient status and that other whole set of policies. It looks like, Mr. Armstrong, you are eager to kick it off.

Mr. ARMSTRONG. Well, yes. It is a wonderful question, Senator, because if a person is never admitted to the hospital, then they go home and have other problems, the hospital then cannot be punished for a hospital readmission because they were never admitted in the first place, so, these policies, you know, when implemented, have the interesting consequences in the real world when they get implemented, where it is an incentive, again, for the hospitals now to use observations even more because then the person was never ever admitted, so, if they get readmitted, it never happened.

Senator BALDWIN. Dr. Sheehy.

Dr. SHEEHY. I would say, as kind of a—in my clinical practice, that the readmission penalty and reclassification of patients as inpatient or observation really does not cross our mind. It is one of so many things that are out there. We are really trying to determine what the patient's clinical needs are, what their diagnosis is, how to start their care. A lot of times—most of the time, I can see that a patient has been in the hospital within 30 days, but I do not know if that hospitalization was observation or inpatient or not. It just really does not—and my colleagues, I think, at the University of Wisconsin, would agree. It just is not a part of our decision making to make a patient inpatient or observation.

We do know that observation is a detriment to patients. It is a detriment to our hospital, so, for us to try to make a patient observation instead of inpatient for the readmission penalty reason just really would not make a lot of sense, either.

Senator BALDWIN. Thank you. Any other comments? Thank you.

Senator COLLINS. Thank you. Senator Whitehouse, it is my understanding that you are all set?

Senator WHITEHOUSE. All set.

Senator COLLINS. Thank you.

I want to thank our witnesses for being with us today. One of the advantages of our Committee is that we are able to take the time to delve into very complex issues that have very significant impacts on our seniors, and I think we have seen an example of that here today. Your testimony has been extremely helpful in allowing us to better understand these complex issues and the very real life consequences that they have for seniors, for nursing

homes, for hospitals, for practitioners, for advocates, and we very much appreciate your being here.

I am sure that Senator Nelson is going to have some additional questions for the record, and other members who were unable to be here today may, as well, so the hearing record will remain open for ten days for the submission of any additional testimony, questions, and we would appreciate your cooperation in answering them.

Again, thank you so much for being with us today, and this hearing is now adjourned.

[Whereupon, at 3:23 p.m., the Committee was adjourned.]

APPENDIX

Prepared Witness Statements

Admitted or Not? The Impact of Medicare Observation on Seniors

U.S. Senate Special Committee on Aging

Testimony of Sylvia C. Engler
Framingham, Massachusetts

July 30, 2014

Committee Chairman Nelson, Ranking Member Collins, and members of the Committee, thank you for the opportunity to tell you the story of my family and the Medicare "observation" rules.

My name is Sylvia C. Engler, age 83. I am still employed in the medical field and still working. I live in Framingham, Massachusetts. My husband Harold, age 92, and I have been married for 60 years. He was Vice President of Sales and Marketing for the Convention and Traveling Industry. He worked till age 90. For most of his life, the only medical conditions Harold had were COPD and asthma which have been controlled for years. Five years ago, at age 87, Harold had a heart triple bypass and went back to work in three months. Three months later he had urgent hernia surgery. The doctor told him that it was required. He was in the hospital for only 2 1/2 days and was classified as an "inpatient." There was no problem with that. He recovered, and then continued to work.

Last year on March 28, 2013, at age 91, he again urgently needed hernia surgery. This time it was a double hernia. His doctor told me to take him to the emergency room at Beth Israel

Hospital in Boston. He had emergency surgery and stayed in the hospital for 5 days as complications set in. He was bleeding and passing blood clots in his urine. For the first time, he had to have a catheter. Five days later, on April 2, 2013, he was discharged home with the catheter still in place. He was only home for two days when he had to return to the hospital. On April 4th, he woke up vomiting bile, with diarrhea, and had a high temperature. He was sent back to the same Boston hospital by ambulance. He had fluid in his lungs, a temperature of 101, and possible pneumonia. Again he had blood in his urine. I was told that he had contacted a virus in the hospital. They had to tap fluid from his lungs. He stayed in this hospital for another 5 days.

On April 10, 2013 he was sent home again, unable to walk or stand alone. The Foley catheter was still in place. He could not get out of the automobile. My daughter and I actually had to try to pull him from the car as he could not walk by himself. Harold had to use a walker while I helped balance him. He sat down on our bed and collapsed. His complexion turned grey. He had chest pains, shortness of breath, and severe pain from the catheter. Thinking it was his heart, I gave him a nitroglycercin pill which made his condition worse. I called the local ambulance and he was taken to the local hospital. The ER doctor stated that if he was my patient he never would have been sent home in this condition. Harold could not walk or stand up. On the same day that he was released from the Boston hospital the second time, after a total of 10 days in the hospital, he was sent from the local ER to a local nursing home for rehab.

I thought Medicare would pay for Harold's nursing home care because he had been in the hospital for 10 days and he needed rehab. I learned from the nursing home that Harold had never been admitted to the hospital as an inpatient. The nursing home told me that Harold was "medical observation" when he was in the hospital. This did not make sense to me because

Harold was on a floor with other inpatients and received care just like an inpatient in a hospital. The hospital never told me that he was "medical observation"; they said nothing about it. Harold remained in the nursing home 6 weeks for rehab. The administrator told me that we had to pay the nursing home $7,859.00 immediately upon leaving, or the bill would be put into collection for the full amount of $15,000 or my house would have been attached for the full amount. We paid the $7859.00, but I had to cash a money market account to pay the bill.

I looked for someone who could help us fight this and found a wonderful lawyer, Diane Paulson, of the Medicare Advocacy Project at Greater Boston Legal Services. Diane has been working with me for over a year to try to get Medicare to cover the nursing home bill. She keeps appealing, but Medicare keeps telling us that we can't appeal the hospital's decision to call my husband "medical observation" and that since he was not an inpatient, Medicare won't cover his nursing home bill. I later found out that the hospital had to pay back millions of dollars to Medicare because they called some patients inpatients instead of outpatients. I think this is why my husband was called observation. Harold was able to remain at home for several months after he was discharged from the rehab. But then he had to go to a nursing home for patients with dementia, where he remains to this day. I am still fighting this battle with the help of my lawyer.

Thank you for listening to my unfortunate situation. I hope you will make changes so that this won't happen to anyone else.

Statement of Marna Borgstrom

President and Chief Executive Officer of Yale-New Haven Health System

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.
>
> 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.

TESTIMONY OF
Bob Armstrong
Vice President of Elder Care Services for
St. Mary's Health System, Lewiston Maine.
BEFORE THE U.S. SENATE AGING COMMITTEE:
Admitted or Not? The Impact of Medicare Observation Status on Seniors
JULY 30, 2014

Good afternoon, Chairman Nelson, Ranking Member Collins, and distinguished members of the Committee. I'd like to thank you for holding this important hearing to examine the impact of Medicare Observation Status on seniors. I especially appreciate the opportunity to appear before you here today. My name is Bob Armstrong, and I am the Vice President of Elder Care Services for St. Mary's Health System in Lewiston Maine. St. Mary's d'Youville Pavilion is one of the largest nursing homes north of Boston and the flagship component of the elder care services offered through St. Mary's Health System. With our state-of-the-art rehab center, specialized dementia care unit, skilled and long term care, we provide our residents with the most advanced technology and skilled nursing care in the region. More importantly, we offer respect, care, and compassion to every resident.

d'Youville Pavilion offers three distinct care options. At its core is a 42-bed private room rehab center, which provides rehabilitation care principally for Medicare beneficiaries recovering from surgery, an illness, or injury. Marguerite's Garden, which is the Memory Care Unit, is our 42-bed Alzheimer's Secure Unit offering specialized care for people suffering with dementia and related forms of illness. The 126 dually certified beds in our Nursing Facility offers compassionate and friendly long-term care to our community's residents. Everyone living at St. Mary's d'Youville Pavilion, whether for a short transitional stay or as part of a long-term plan, may take part in a broad range of social activities and personal care services.

St. Mary's Health System is proud to be a member of the Maine Health Care Association (MHCA) and the American Health Care Association/National Center for Assisted Living (AHCA/NCAL). MHCA represents over 200 nursing homes and assisted living facilities, including for profit and not for profit facilities. The most recent statewide occupancy report indicates that Maine's nursing homes care for over 6,300 residents. Sixty five percent were paid for through Medicaid, 23% were private pay, and 12% were covered by Medicare.

AHCA/NCAL is the nation's largest association of long term and post-acute care providers. The association advocates for quality care and services for the frail, elderly, and individuals with disabilities. Our members provide essential care to millions of individuals in more than 12,000 not for profit and for profit member facilities.

AHCA/NCAL, its affiliates – including MHCA, and member providers advocate for the continuing vitality of the long-term care provider community. The association is committed to developing and advocating for public policies that support quality care and quality of life for our nation's most vulnerable. Therefore, AHCA/NCAL is in support of policies that address the observation stays issue. I thank you, Senators Nelson and Collins for bringing this critical issue to the forefront.

As a long term care administrator for over 29 years, I have seen firsthand the impact the observation stays issue has had on residents and their families. For example, one resident, a 66 year old gentleman was admitted to my facility for short term rehab care after a hospital stay for the care and treatment of a left humerus fracture. According to the discharge documentation from the hospital, the resident was admitted to the hospital on November 9, 2013, and was discharged on November 14, 2013. The paper work clearly gave an admitting hospital diagnoses: Fall with the following injuries; including the left humerus fracture, which indicated the resident qualified under Medicare for post-hospital skilled rehab care.

We provided appropriate skilled rehab care to the resident who then successfully returned home. We believed that the resident's stay would be covered by Medicare Part A because the hospital discharge paper work clearly showed that the resident was admitted to the hospital and that they stayed in the hospital for at least three days. My facility then appropriately billed Medicare for payment, and was then told that the resident was not admitted to the hospital as an inpatient. The resident was in the hospital for five days under observation. My facility lost thousands of dollars for providing care for this resident in need with no payment from Medicare, even though this resident clearly should have received their Medicare Part A skilled nursing care benefit.

This is just one of the countless heart wrenching stories from across the country. The facts are there that the observation stays issue continues to remain a problem. In fact, in July 2013, the Office of the Inspector General reported that hospitals varied widely in their use of observation stays and, in calendar year 2012, that beneficiaries had 617,702 hospital stays that lasted at least three nights, but that did not include three inpatient nights. As a result these beneficiaries would not qualify for SNF Part A services under Medicare. The report supported counting observation days towards the three-day inpatient stay minimum requirement. In addition, according to an AARP report from last year, the use of Medicare hospital observation services grew by over 100 percent from 2001 to 2009. Finally, in September 2013, the Long Term Care Commission recommended that the Centers for Medicare and Medicaid Services (CMS) count time spent in observation status toward meeting the prior three-day stay requirement.

We must do more to ensure our nation's most vulnerable have access to the Medicare benefit they have earned and so rightly deserve. I am asking, along with AHCA/NCAL, that Congress pass and sign into law bipartisan legislation that Representatives Joe Courtney and Tom Latham, along with Senator Sherrod Brown introduced. The Improving Access to Medicare Coverage Act of 2013 (S. 569/H.R. 1179), which many on the Committee – including Senators Nelson and Collins – are cosponsors of, seeks to count all hospital days spent in observation towards the three-day inpatient stay required for Medicare coverage of Part A skilled nursing care benefits.

The association also supports legislation eliminating the three-day stay requirement, which effectively solves the related issue of observation stays. Representative Jim Renacci's bipartisan Creating Access to Rehabilitation for Every Senior (CARES) Act of 2013 (H.R. 3531) eliminates the three-day inpatient stay requirement by allowing centers that meet particular criteria to automatically qualify to waive the prior hospitalization requirement. The criteria are based on the CMS Nursing Home Compare program. In addition, we back a similar bill introduced by Representative Jim McDermott, the Fairness for Beneficiaries Act of 2013 (H.R. 3144), which also seeks to eliminate the three-day stay requirement.

It is important to note that several national patient and provider organizations have written CMS and advocated on the Hill in support of addressing the observation stays issue. In fact, AHCA/NCAL is part of the observation stays Coalition, which consists of 30 provider and beneficiary organizations working to address this issue. It is simply not right to limit access to quality care for those most in need. Now is the time for Congress to pass legislation that solves the problem. Thank you again for the opportunity to weigh in on this important matter. AHCA/NCAL looks forward to working with Members of Congress in both chambers on the observation stays issue.

Testimony before the United States Senate
Special Committee on Aging

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

July 30, 2014

Ann M. Sheehy, MD, MS
Member, Public Policy Committee
Society of Hospital Medicine
Chief, Division of Hospital Medicine
University of Wisconsin School of Medicine and Public Health

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

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[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

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[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

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[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.

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[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 thought they do not yet know the diagnosis or treatment plan.

Although hospitalists admit patients daily, in the SHM survey[15], 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 than2 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

[15]Society 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 system[16].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.

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[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.

Statements for the Record

ADMITTED OR NOT? THE IMPACT OF OBSERVATION STATUS ON SENIORS

Senate Special Committee on Aging
Hearing

Statement by
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Washington, DC
July 30, 2014

Six years ago, a woman in Wisconsin called the Center for Medicare Advocacy with a Medicare problem. She had spent some time in a skilled nursing facility (SNF), but the facility told her that Medicare Part A would not pay for her stay because she had not been an inpatient in an acute care hospital for three days. The woman asked how that could possibly be true. After all, she had been hospitalized for 13 days. It turned out that the hospital had called her an outpatient for all 13 days.

The Wisconsin woman had no way of knowing that she was an outpatient in observation status. She was in a bed in the hospital, had diagnostic tests, received physician and nursing care, medications, treatment, food, and a wrist band. Her care was indistinguishable from the medically necessary care she would have received if she had been formally admitted as an inpatient. As in most hospitals, she was likely intermingled with inpatients so that even the physicians and nurses treating her did not know whether she was an inpatient or an outpatient. And the hospital was not required to inform her that she was an outpatient or the consequences of that status. But, solely because she was **called** an outpatient in observation status, Medicare Part A would not pay for her post-hospital care in the SNF. Medicare limits payments to SNFs for beneficiaries who are formally admitted to an acute care hospital as inpatients. As discussed below, the primary reason hospitals classify their patients as outpatients is their concern that they will be required to repay to Medicare all reimbursement for the medically necessary care they provided if Recovery Auditors determine, years later, that the patients should have been called outpatients instead of inpatients.

Since talking with and representing the Wisconsin woman six years ago, the Center for Medicare Advocacy has spoken with hundreds, if not thousands, of families with similar experiences. Patients are hospitalized, receiving medically necessary care for multiple days, but they are called outpatients. Medicare pays for outpatients' care in the hospital under Part B, for inpatients' care, under Part A. Sometimes, when acute care hospitals bill Medicare Part B for observation hours, outpatients are said to be in "observation status."

This hearing is the first hearing to focus of the impact of observation status on Medicare beneficiaries. Prior hearings by the Senate Finance Committee and the House Ways and Means Committee focused, entirely or primarily, on the impact of the Recovery Auditor program on acute care hospitals, not on the impact on Medicare beneficiaries.[1]

Congress is grappling with a broad range of important and complex policy issues related to observation status, including how to classify hospital stays and the proper role of the Recovery Audit program. The issue for Medicare beneficiaries is simple and the solution for most beneficiaries is straightforward. Congress can fix the major problem[2] that outpatient status and observation status create for Medicare patients – the loss of Medicare coverage of their post-hospital care in the SNF – by enacting H.R. 1179 and S. 569, the Improving Access to Medicare Coverage Act of 2013. The identical bipartisan bills, in essentially a single sentence, count all time in the hospital for purposes of satisfying the three-midnight rule.[3] Other Medicare coverage requirements for SNF care remain unchanged by the legislation.[4] As of July 29, 2014, the House bill, introduced by Congressman Joseph Courtney, has 157 co-sponsors in the House, and the Senate bill, introduced by Senator Sherrod Brown, has 25 co-sponsors in the Senate. Several Members of this Committee, including Senators Nelson and Collins, are co-sponsors of the legislation.

An *ad hoc* coalition of 30 organizations – including the American Medical Association, the Society for Hospital Medicine, AARP, the National Committee to Preserve Social Security and Medicare, the Alliance for Retired Americans, the American Health Care Association, LeadingAge, the American Case Management Association, the Leadership Council of Aging Organizations, the National Council on Aging, the Catholic Health Association, the National Hispanic Council on Aging, and many others – supports the legislation. Our joint Fact Sheet is attached to this Statement. We are not aware of any opposition to the bills.

The Long-Term Care Commission, mandated by §642 of the American Taxpayer Relief Act of 2012, P.L. 112-240, endorsed the legislation in its final report in 2014[5] as did the Alternative Report written by five members of the Commission.[6]

Use of outpatient status for patients in a hospital bed is common and increasing

A study by Brown University reviewed 100% of outpatient Medicare claims data between 2007 and 2009 in order to identify observation stays in the hospital. Researchers found that the *number* of observation stays increased by 34% and inpatient admissions decreased, suggesting "a substitution of outpatient observation services for inpatient admissions."[7] They also found that the average *length of stay* in observation increased by more than 7% and that the number of patients in observation status for 72 hours or more increased by 88% between 2007 and 2009 (from 23,841 patients in 2007 to 44,843 patients in 2009). Brown University researchers identified the Recovery Audit Contractor (RAC) program and Condition Code 44 as the primary causes of hospitals' extensive and increasing use of outpatient status to classify their patients.

The RAC (now called Recovery Auditors), begun as a demonstration in 2003 by the Medicare Modernization Act and made permanent in 2006 by the Tax Relief and Health Care Act, is

intended to identify and correct improper payments in the traditional Medicare program.[8] However, if Auditors conclude that a patient should have been treated as an outpatient, not an inpatient, the hospital must refund all of the Medicare reimbursement it received for the patient's care, even though the care was medically necessary. Under Condition Code 44, a hospital's utilization review committee has authority to reverse an attending physician's decision to admit a patient to inpatient status, with the concurrence of the practitioner responsible for the patient's care.[9]

Hospitals' use of observation status has continued to increase since the Brown University study. An analysis by the Department of Health and Human Services's Office of Inspector General looked at Medicare patients' hospital stays in calendar year 2012.[10] The Inspector General described three categories of patient classifications: observation stays (outpatient stays where the hospital billed Medicare for observation hours), long outpatient stays (outpatient stays where the hospital did not bill Medicare for observation hours), and short inpatient stays. In 2012, the Inspector General found that 1.5 million stays were classified as observation stays and that 1.4 million were classified as long outpatient stays. More than 600,000 hospital stays were three or more midnights, but they did not include three inpatient midnights (that is, some or all of the time was called outpatient). The Inspector General recommended that the Centers for Medicare & Medicaid Services (CMS) consider how to ensure that Medicare beneficiaries with similar post-acute care needs have the same access to, and cost-sharing obligations for, their SNF care. The Office recognized that federal legislation might be necessary to achieve this result.

Outpatient status and its consequences for patients

A typical situation is that a patient in an emergency room is told by the emergency room physician that she must stay in the hospital for additional diagnostic tests and treatments. Only much later, often not until the patient is about to leave for the SNF, is she told that she was classified as an outpatient and that Medicare Part A will not pay for her stay in the SNF. Patients in outpatient or observation status have gone to the hospital, and been diagnosed and given medically necessary treatment, for a broad variety of acute problems – falls, broken bones and fractures, chest pains. Many have had surgery.

However, when patients are classified as "outpatients," they face enormous financial consequences. The most significant is that the Medicare program, Part A, will not pay for medically necessary post-acute care in a SNF unless patients are admitted as *inpatients* for at least three consecutive days.[11] Patients who are called *outpatients* do not qualify for Medicare Part A coverage of their SNF stay. They must pay out-of-pocket – often hundreds of dollars a day just for room and board. In addition, they must pay Medicare Part B copayments for any therapies they receive plus the cost of their medications. Sometimes, under these circumstances, the adult children pay for their parents' SNF stay; sometimes nieces and nephews pay; sometimes patients cash in their life insurance policies to pay for their SNF stay. Patients who cannot afford to pay private out-of-pocket rates may go home, often to be rehospitalized a day or two later.

Over the past six years, the Center for Medicare Advocacy has heard from Medicare beneficiaries and their families across the country about lengthy hospital stays where the patients

were labeled outpatients, sometimes outpatients in observation status. One recent call was from the daughter of a 90 year old man who had been living at home with his wife. Following a fall, he went to the Urgent Care center. The physician there advised him to go immediately to the emergency room for care of the hematoma on his leg, which was increasing in size. On the way into the operating room, the hematoma burst. The man had emergency surgery to evacuate the hematoma and remained in the hospital for four midnights, all called outpatient. From the hospital, he went to a SNF for skilled nursing care and rehabilitation. His care in the SNF would have been covered in its entirety by Medicare Part A if he had been formally admitted to the hospital as an inpatient. As an outpatient in the hospital, however, he did not qualify for Part A coverage of his stay at the SNF. The bill for his 18-day stay at the SNF was $4573, which he paid out-of-pocket. An Administrative Law Judge (ALJ) found that the man's primary care physician supported an inpatient admission. She also found, as had a CMS investigation, that the patient was not informed of his outpatient status until he was discharged from the hospital. Nevertheless, the ALJ upheld denial of Medicare Part A coverage of his SNF stay solely because the patient was "hospitalized . . . as an outpatient," not admitted as an inpatient.

CMS has repeatedly expressed concern about the impact of long outpatient stays on Medicare beneficiaries

CMS has expressed concern about outpatient stays since at least 2005, when it asked (in the proposed annual update for Medicare reimbursement for SNFs) if observation time should be counted towards meeting the qualifying three-day inpatient stay.[12] In August 2010, CMS held a public Listening Session to hear concerns about increasingly frequent and long outpatient stays.[13] In July 2012, CMS again asked for public comment on possible changes to observation status.[14] In August 2013, CMS as part of final rules for inpatient hospital reimbursement, CMS established time-based definitions of inpatient care – the so-called two-midnight rule.[15] While not changing the three-day inpatient requirement for Medicare coverage of a SNF stay, the two-midnight rule directs physicians to write inpatient admission orders if they believe their patients will remain hospitalized for two or more midnights. Enforcement of these rules is now subject to a Congressional moratorium through March 2015.[16] However, a retrospective study of the application of the two-midnight rule for patients at the University of Wisconsin, conducted by Dr. Ann Sheehy and others, found that the rule would increase, not decrease, use of observation status.[17] In the Center for Medicare Advocacy's experience, hospital practice does not appear to have changed all. Since the October 2013 effective date of the new rules, the Center has continued to hear from families about patients who have been hospitalized for multiple days as outpatients. A recent call involved an 81-year old woman hospitalized for six days in April 2014 as an outpatient in observation status. Medicare is not paying for her subsequent SNF stay.

Why outpatient status for hospitalized patients must be fixed

First and most importantly, calling a patient an outpatient makes no sense to patients and their families. Patients do not understand why they are called outpatients when they are in a hospital undergoing diagnosis and treatment for acute conditions for multiple days and nights. When the hospital care is identical, regardless of whether patients are called inpatients or outpatients, it is arbitrary to call some patients inpatients and others, outpatients. Moreover, since CMS does not require that outpatients be notified of their status as outpatients, unless the hospital reverses their

inpatient status to outpatient under Condition Code 44, patients and their families often have no way of knowing about their status or its consequences. Patients often receive the first notice of their status in the hospital at the time of their discharge, and sometimes not until later, at the SNF. Observation status, as used today, makes no sense to patients or their families.

Outpatient status for hospitalized patients also makes no sense for physicians, whose medical training does not include time-based notions and who do not think about midnights when they are deciding how to diagnose what is wrong with their patients and how to treat them. Nor does observation status make sense for hospitals, which have difficult and time-consuming conversations with their patients when they learn they are outpatients and the consequences of outpatient status. Hospitals have more difficulty identifying a SNF for post-hospital care when Medicare coverage is not available.

Second, despite the fact that the hospital care is the same regardless of whether a patient is called an inpatient or an outpatient, hospitals are forced to spend a considerable amount of money trying to make the "right" decision and pass (or avoid) review by Recovery Auditors. Hospitals spend Medicare reimbursement on outpatient status in three ways. 1. Hospitals buy the proprietary system InterQual® because the system is used by Recovery Auditors when they review inpatient/ outpatient decisions. When hospitals' admissions decisions are evaluated based on InterQual® criteria, it is understandable that hospitals buy and use the same program to make decisions. 2. Hospitals increase staffing in their utilization review committees, which oversee and review physicians' inpatient decisions and, depending on their application of InterQual® criteria, may reverse inpatient admission decisions and reclassify inpatients as outpatients.[18] 3. Hospitals hire outside consulting firms to help them make decisions about inpatient/outpatient status. The main consulting firm we hear about makes physicians available to hospitals 24 hours a day/seven days a week to help them make "medical necessity" decisions and determine whether patients should be admitted as inpatients or called outpatients. Since 1997, the firm has handled millions of cases. Hospitals should be spending Medicare reimbursement on care for patients, not on making arbitrary inpatient/outpatient classifications of patient status.

Third, when outpatient status is used to describe hospitalized patients, it skews hospitals' readmission data. Federal law imposes financial penalties on hospitals that readmit patients (with certain diagnoses) within 30 days of discharge.[19] However, penalties are applied only to inpatient admissions. If *outpatients* return to the hospital within 30 days, their return is not a readmission because they were originally labeled outpatients, not inpatients. Similarly, if *inpatients* return to the hospital within 30 days as outpatients, their return also does not count as a readmission. Clearly, some portion of the reported decline in hospital readmission reflects the fact that many patients are called outpatients, even though they are receiving medically necessary care, and are occupying a bed, in the hospital.

Conclusion

In invited commentary on Dr. Sheehy's analysis of observation status at the University of Wisconsin Hospital,[20] Dr. Robert M. Wachter, Department of Medicine, University of California, San Francisco described observation status as having "morphed into madness."[21] He wrote: "[I]n fact, if one was charged with coming up with a policy whose purpose was to confuse

and enrage physicians and nearly everyone else, one could hardly have done better than Observation Status."

Dr. Wachter is right. Congress can fix the major problem that observation status creates for Medicare patients – the loss of Medicare coverage of their post-hospital care in the SNF care – by enacting the Improving Access to Medicare Coverage Act of 2013, H.R. 1179 and S. 569. While Congress considers broader policy issues of how to classify hospital stays, the proper role of the Recovery Audit program, and how to update criteria for Medicare coverage of SNF care, it should enact H.R. 1179 and S.569 to resolve the problem of outpatient status for patients and their families.

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[1] Senate Finance Committee, "Program Integrity: Oversight of Recovery Audit Contractors" (June 25, 2013), http://www.finance.senate.gov/hearings/hearing/?id=7b79eddd-5056-a032-52de-e9f0d4ce8ed0; House Ways and Means Committee, Subcommittee on Health, "Current Hospital Issues in the Medicare Program" (May 20, 2014), http://waysandmeans.house.gov/calendar/eventsingle.aspx?EventID=379825.

[2] Outpatient status also creates financial burdens for patients who do not have Medicare Part B; they are considered uninsured and are charged hospitals' "sticker" prices. Patients are also concerned about high medication charges in the hospital while they are in outpatient status.

[3] Section 2, entitled "Counting a period of receipt of outpatient observation services in a hospital toward the 3-day inpatient hospital requirement for coverage of skilled nursing facility services under Medicare," says simply, "`For purposes of this subsection, an individual receiving outpatient observation services shall be deemed to be an inpatient during such period, and the date such individual ceases receiving such services shall be deemed the hospital discharge date (unless such individual is admitted as a hospital inpatient at the end of such period)."

[4] A patient must require, and a physician must order, skilled services on a daily basis (skilled nursing services seven days a week or skilled rehabilitation services five days a week or a combination or both); the skilled care must be related to the condition for which the patient was hospitalized; the care must be required on an inpatient basis; and the transfer to the SNF must occur within 30 days of the hospital discharge. 42 U.S.C. §§1395x(i), 1395f(a)(2)(B).

[5] Long-Term Care Commission, *Report to the Congress,* page 71 (Sep. 30, 2013), http://www.gpo.gov/fdsys/pkg/GPO-LTCCOMMISSION/pdf/GPO-LTCCOMMISSION.pdf.

[6] *A Comprehensive Approach to Long-Term Services and Reports*, page 14 (Sep. 23, 2013), http://www.medicareadvocacy.org/wp-content/uploads/2013/10/LTCCAlternativeReport.pdf.

[7] Zhanlian Feng, et al, "Sharp Rise In Medicare Enrollees Being Held In Hospitals For Observation Raises Concerns About Causes And Consequences," *Health Affairs* 31, No. 6 (2012).

[8] http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Recovery-Audit-Program/index.html.

[9] Condition Code 44, Transmittal 299 (Sep. 2004), now at Medicare Claims Processing Manual, CMS Pub. No. 100-04, Ch. 1, §50.3, http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c01.pdf (scroll down to §50.3 at p. 152).

[10] Office of Inspector General, *Hospitals' Use of Observation Stays and Short Inpatient Stays for Medicare Beneficiaries*, OEI-02—12-00040 (July 29, 2013), http://oig.hhs.gov/oei/reports/oei-02-12-00040.pdf.

[11] 42 U.S.C. §1395x(i), 42 C.F.R. §409.30(a)(1).

[12] 70 Fed. Reg. 29,069, at 29,098 (May 19, 2005). In the final rules, CMS said it would continue reviewing the policy. 70 Fed. Reg. 45,025, at 45,050 (Aug. 2005).

[13] Transcript is available at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/downloads/94244031HosptialObservationBedsListeningSession082410.pdf
[14] 77 Fed. Reg. 45,061, at 45,155 (July 30, 2012). CMS declined to make any changes in 2012. 77 Fed. Reg. 68,209, at 68,433 (Nov. 15, 2012).
[15] 78 Fed. Reg., 50,495, at 50,906-954 (Aug. 19, 2013).
[16] Section 111 of the Protecting Access to Medicare Act of 2014 (H.R. 4302).
[17] Ann M. Sheehy, Bartho Caponi, Sreedevi Gangireddy, Azita G. Hamedani, Jeffrey J. Pothof, Eric Siegal, Ben K. Graf, "Observation and Inpatient Status: Clinical Impact of the 2-Midnight Rule," *J Hosp Med.* 2014; 9(4): 203-209.
[18] The American Case Management Association, the professional association of hospital discharge planners, conducted a survey of its members in 2012. Survey respondents reported that 71% of their hospitals added staff to make medical necessity determinations on admission; nearly one-third reported that their hospitals spent more than $150,000 for the new staff; nearly two-thirds used outside reviewers; and 79% reported that patients were spending more time in observation.
[19] Section 3025 of the Affordable Care Act, 42 U.S.C. §1886(q), established the Hospital Readmissions Reduction Program; 42 C.F.R Part 412. http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Readmissions-Reduction-Program.html.
[20] Ann M. Sheehy, MD, MS, et al., "Hospitalized but Not Admitted: Characteristics of Patients With 'Observation Status' at an Academic Medical Center," *JAMA Intern Med.* 2013;173(21):1991-1998
(concluding that "observation care in clinical practice is very different than what CMS initially envisioned and creates insurance loopholes that adversely affect patients, health care providers, and hospitals.").
[21] Robert M. Wachter, M.D., "Observation Status for Hospitalized Patients," *JAMA Intern Med.* 2013;173(21):1999-2000.

OBSERVATION STAYS DENY MEDICARE BENEFICIARIES ACCESS TO SKILLED NURSING FACILITY CARE

Medicare beneficiaries are being denied access to Medicare's skilled nursing facility (SNF) benefit because acute care hospitals are increasingly classifying their patients as "outpatients" receiving observation services, rather than admitting them as inpatients. Patients are called outpatients despite the fact that they may stay for many days and nights in hospital beds and receive medical and nursing care, diagnostic tests, treatments, medications, and food, just as they would if they were inpatients. Under the Medicare statute, however, patients must have an inpatient hospital stay of three or more consecutive days, not counting the day of discharge, in order to meet Medicare criteria for coverage of post-acute care in a SNF. As a result, although the care received by patients in observation status is indistinguishable from the care received by inpatients, outpatients in observation who need follow-up care in a SNF do not qualify for Medicare coverage. Hospital stays classified as observation, no matter how long and no matter the type or number of services provided, are considered outpatient. These hospital stays do not currently qualify patients for Medicare-covered care in a SNF.

Hospitals' use of observation status and the amount of time patients spend in observation status are both increasing. A study found a 34% increase in the ratio of observation stays to inpatient admissions between 2007 and 2009, leading the researchers to conclude that outpatient observation status was becoming a substitute for inpatient status. The same study also documented increases in long-stay outpatient status, including an 88% increase in observation stays exceeding 72 hours.

A primary motivation for hospitals' increasing use of observation status has been concern about the Recovery Audit Contractor (RAC) program, now renamed Recovery Auditors. If the RAC or another Medicare reviewer determines that a patient has been incorrectly classified as an inpatient, the hospital is denied reimbursement for most services provided to the patient, despite the fact that the services were medically necessary and coverable by Medicare. In addition, readmission penalties imposed against hospitals may increase the incentives for hospitals to label patients as outpatients. Patients who are called outpatients do not trigger any readmission penalty when they return to the hospital. Likewise, patients who have been inpatients do not trigger a readmission penalty if they return to the hospital as outpatients.

Support for counting time spent in observation status toward the three-day prior inpatient stay continues to grow. In July 2013, the Office of the Inspector General reported that hospitals varied widely in their use of observation stays and, in calendar year 2012, that beneficiaries had 617,702 hospital stays that lasted at least three nights, but that did not include three inpatient nights. These beneficiaries did not qualify for SNF services under Medicare. The report was supportive of counting observation days towards the three-day inpatient stay minimum requirement. In addition, in September 2013, the Long Term Care Commission recommended that CMS count time spent in observation status toward meeting the prior three-day stay requirement.

In August 2013, CMS released its FY 2014 inpatient payment rule. This final rule does not solve the problem because it explicitly states that days spent in observation do not count for purposes of satisfying the three-day inpatient stay requirement.

There is bipartisan support in both the House and Senate to fix this problem. Representatives Joseph Courtney (D-CT) and Tom Latham (R-IA) have introduced the ***Improving Access to Medicare Coverage Act of 2013*** (H.R.1179) to help Medicare beneficiaries who are hospitalized in observation status. This bill would require that time spent in observation be counted towards meeting the three-day prior inpatient stay that is necessary to qualify for Medicare coverage of SNF care. Senator Sherrod Brown (D-OH) has introduced a companion bill, S.569, cosponsored by Senator Susan Collins (R-ME).

Statement for the Hearing Record:

Office of Inspector General
U.S. Department of Health and Human Services

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

United States Senate
Special Committee on Aging

July 30, 2014
216 Hart Senate Office Building
2:15 PM

Statement for the Hearing Record:

Office of Inspector General
U.S. Department of Health and Human Services
Hearing Title: "Admitted or Not? The Impact of Medicare Observation Status on Seniors"
United States Senate
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Good morning, Chairman Nelson, Ranking Member Collins, and other distinguished Members of the Committee. Thank you for inviting the U.S. Department of Health and Human Services (the Department) Office of Inspector General (OIG) to submit a statement for the hearing record about our work in an important area of hospital policy that affects beneficiaries, providers, and taxpayers.

In July 2013, we published a report about hospital observation and short inpatient stays. The Centers for Medicare & Medicaid Services (CMS) subsequently implemented the two-midnight hospital policy. The key takeaways today are: 1) significant issues existed with observation and short inpatient stays in 2012, 2) policymakers must ensure that beneficiaries with similar post-hospital care needs have the same access to and cost-sharing for skilled nursing facility (SNF) services, and 3) careful evaluation of the two-midnight policy and possible alternatives is essential.

Many Had Expressed Concerns About Observation and Short Inpatient Stays

When Medicare beneficiaries enter the hospital, hospital physicians often need to decide whether to admit them as inpatients or to provide observation services. Observation services are short-term treatments and assessments provided to outpatients to determine whether beneficiaries require further treatment as inpatients or can be discharged.

CMS, Members of Congress, industry groups and the public raised concerns about hospitals' use of observation stays and short inpatient stays. They were concerned about beneficiaries spending long periods in observation stays without being admitted as inpatients. In particular, they were concerned that beneficiaries may pay more as outpatients than if they were admitted as inpatients. Moreover, beneficiaries who were not admitted as inpatients may not qualify under Medicare for needed SNF services following discharge from the hospital. Beneficiaries who did not qualify for SNF services under Medicare may have independently chosen to receive them, but were then responsible for all SNF charges. In addition, CMS was concerned about improper payments for short inpatient hospital stays when the beneficiaries should have been treated as outpatients.

Some of these issues may have arisen because Medicare pays for inpatient and outpatient stays very differently. Inpatient hospital stays are paid under Medicare Part A according to the Inpatient Prospective Payment System (IPPS). The IPPS is designed to reflect the cost of caring

for an average beneficiary, so payments to hospitals generally do not depend on the number of services provided or the beneficiary's length of stay.

Observation and other outpatient stays are paid under Medicare Part B according to the Outpatient Prospective Payment System (OPPS). The OPPS is a hybrid of a prospective payment system and a fee schedule, so payments to hospitals tend to increase as the number of services provided increases.

Significant Issues Existed With Observation and Short Inpatient Stays Prior to the Two-Midnight Hospital Policy

OIG evaluated hospitals' use of observation stays and short inpatient stays in 2012, before the implementation of CMS's new hospital policy.[1] Our findings highlight important issues that require continued attention. They are summarized below.

Beneficiaries in observation stays commonly spent 1 night or more in the hospital

Beneficiaries had 1.5 million observation stays in 2012. Beneficiaries in these stays were most often treated for chest pain, and the majority of these stays began in the emergency department. In 92 percent of observation stays, beneficiaries spent at least 1 night in the hospital. In 26 percent of stays, beneficiaries spent 2 nights; in 11 percent of stays, beneficiaries spent at least 3 nights.

Short inpatient stays were often for the same reason as observation stays, but Medicare paid nearly three times more for a short inpatient stay than for an observation stay, on average

Beneficiaries had 1.1 million short inpatient stays in 2012. Similar to beneficiaries in observation stays, those in short inpatient stays were most commonly treated for chest pain. Additionally, 6 of the 10 most common reasons for short inpatient stays were among the 10 most common reasons for observation stays. The areas of overlap were chest pain, digestive disorders, fainting, nutritional disorders, irregular heartbeat, and circulatory disorders.

However, short inpatient stays were far more costly to Medicare than observation stays. Medicare paid an average of $5,142 per short inpatient stay, but it paid an average of $1,741 per observation stay. For each of the most common reasons a beneficiary was in the hospital, the average Medicare payment was always higher for short inpatient stays than for observation stays.

Beneficiaries also paid far more for short inpatient stays than for observation stays, on average

Beneficiaries paid almost two times more for short inpatient stays than for observation stays on average—that is, $725 per short inpatient stay compared to $401 per observation stay. For all

[1] *Hospitals' Use of Observation Stays and Short Inpatient Stays for Medicare Beneficiaries*, OEI-02-12-00040, July 2013, available at http://oig.hhs.gov/oei/reports/oei-02-12-00040.asp. Short inpatient stays are inpatient stays that lasted 1 night or less.

but two of the most common reasons for treatment, beneficiaries paid more, on average, for short inpatient stays than for observation stays. The two exceptions were stays for circulatory disorders and for coronary stent insertions. In addition, 6 percent of beneficiaries in observation stays paid more than they would have paid had they been in an inpatient stay.

Hospitals varied widely in their use of short inpatient and observation stays

Some hospitals were far more likely to use short inpatient stays while others were far more likely to use observation stays.[2] Nationally, just over one-quarter of these stays were short inpatient stays. However, some hospitals used short inpatient stays for less than 10 percent of their stays, while others used them for over 70 percent of their stays.

A clearer policy was needed

Our report showed that though observation and short inpatient stays were for similar reasons, reimbursement was very different. The variation in the use of these stays across hospitals suggested that the policy in place at the time was not being implemented consistently. Given that the inpatient-versus-outpatient decision affects how much Medicare pays and how much the beneficiary pays, a clearer policy was needed.

Beneficiaries with Similar Post-Hospital Care Needs Should Have the Same Access To and Cost-sharing for SNF Services

We also found that beneficiaries had almost 618,000 hospital stays that lasted 3 nights or more, but did not include 3 inpatient nights. Because their stays did not include 3 inpatient nights, these beneficiaries did not qualify for SNF services under Medicare. For about 25,000 of the 618,000 hospital stays, beneficiaries received SNF services following discharge from the hospital. Medicare nearly always paid (inappropriately) for these SNF services. However, for about 2,000 of the hospital stays, Medicare did not pay for the SNF services, and the beneficiary was charged an average of about $11,000.

This result raised concerns about SNF services for beneficiaries. It is important to ensure that beneficiaries with similar post-hospital care needs have the same access to and cost-sharing for SNF services. Allowing nights spent as an outpatient to count toward the 3 nights needed to qualify for SNF services may require additional statutory authority.

Careful Evaluation of the Two-Midnight Policy and Possible Alternatives is Essential

In response to ongoing concerns, CMS implemented a hospital policy—known as the two-midnight policy—in October 2013 to address the issues with observation and short inpatient stays. The new policy provides guidelines for when hospitals should bill for inpatient stays and

[2] This analysis includes outpatient stays that lasted at least 1 night, but were not coded as observation stays. For some of these stays, hospitals may have provided observation services without coding the claims as observation stays. Hospitals are not always paid a separate amount for coding claims as observation stays.

when they should bill for outpatient services, such as observation. Specifically, the rule states that a hospital stay is appropriately inpatient when the physician admits a beneficiary with the expectation of the stay lasting at least two midnights. CMS expects this policy to reduce the numbers of short inpatient stays and of observation stays lasting 2 nights or longer.

However, the policy has not been evaluated to ensure that it is working effectively. This policy will affect hospitals' use of observation stays and short inpatient stays, which in turn will affect Medicare and beneficiary payments to hospitals. The new policy may also affect beneficiaries' access to SNF services. Because providers have been vocal in their opposition to the two-midnight policy and because CMS and Congress are considering alternatives, a careful evaluation of the two-midnight policy and possible alternatives is essential.

As policymakers move forward, the issues that we highlighted in our prior report continue to be relevant. Information about the impact of the new policy is needed to ensure that policymakers take these issues into account as they move forward.

Further Action Is Needed To Ensure that Hospital Payment Policies Are Efficient and Effective

Ensuring that Medicare's hospital payment policies are effective and efficient for beneficiaries, providers, and taxpayers is of paramount importance. A number of factors must be carefully considered, including clear guidelines for hospitals and contractors; similar payments for similar care; and the overall impact on Medicare payments, hospitals, and beneficiaries. This will continue to require a concerted effort by a number of key players, including CMS, CMS's contractors, providers, OIG, and Congress. Such actions are essential for fighting fraud, waste, and abuse and for protecting Medicare beneficiaries and the Medicare Trust Fund.

New and changing Department programs, including hospital payment policy, offer opportunities to prevent waste and fraud and increase the value realized from prudent Federal investments. They also raise challenges for efficient and effective implementation; therefore, close oversight is essential. Full funding of OIG's fiscal year 2015 budget request would enable us to continue and enhance our focus on hospital payment policy, as well as the Department's other public health and human service programs, the marketplaces, and Medicare.[3]

Thank you for your leadership and interest in these important issues and for the opportunity to discuss some of our work.

[3] For more details on OIG's impact, the essential work we have planned, and the resources needed to fulfill these mission-critical activities, see OIG's fiscal year 2015 Congressional budget justification, available online at http://oig.hhs.gov/reports-and-publications/index.asp.

AARP
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August 6, 2014

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

The Honorable Susan Collins
Ranking Member
Special Committee on Aging
U.S. Senate
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

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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.

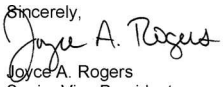
Prescription Drug Coverage during Observation Status

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
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Government Affairs

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