LIST OF WITNESSES TO APPEAR BEFORE
THE COMMITTEE ON WAYS AND MEANS
SUBCOMMITTEE ON HEALTH

HEARING ON CURRENT HOSPITAL ISSUES IN THE MEDICARE PROGRAM

TUESDAY, MAY 20, 2014 - BEGINNING AT 9:30 A.M.

1100 LONGWORTH HOUSE OFFICE BUILDING

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STATEMENT OF

SEAN CAVANAUGH

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

ON

MEDICARE PAYMENT POLICY ON SHORT HOSPITAL STAYS

BEFORE THE

U. S. HOUSE COMMITTEE ON WAYS AND MEANS, SUBCOMMITTEE ON HEALTH

MAY 20, 2014

DEPARTMENT OF HEALTH & HUMAN SERVICES • USA

Statement of Sean Cavanaugh on
Medicare Payment Policy on Short Hospital Stays
House Committee on Ways and Means, Subcommittee on Health
May 20, 2014

Chairman Brady, Ranking Member McDermott, and members of the Subcommittee, thank you for this opportunity to discuss short hospital stay payment policy in the Medicare program. Because of statutory requirements, the Medicare payment rates for inpatient and outpatient hospital stays differ. It is important to recognize that not every patient who receives care in a hospital setting requires inpatient care. Therefore, when a Medicare beneficiary arrives at a hospital in need of medical or surgical care, the physician or other qualified practitioner must decide whether to admit the beneficiary for inpatient care or treat him or her as an outpatient. The inpatient admission decision is often a complex medical judgment. These decisions also have significant implications for provider reimbursement and beneficiary cost sharing.

Through the Recovery Audit program, we identified high rates of error for hospital services rendered in a medically-unnecessary setting (*i.e.*, inpatient rather than outpatient). At the same time, hospitals and other stakeholders have requested additional clarity regarding the definition of 'inpatient,' and expressed concern for beneficiaries experiencing extended outpatient stays, causing confusion about their eligibility for skilled nursing facility services. In 2012, we solicited feedback on possible criteria that could be used to determine when inpatient admission is reasonable and necessary for purposes of payment under Medicare Part A.

In response to this feedback, in 2013, the Centers for Medicare & Medicaid Services (CMS) finalized a proposal addressing Medicare payment policy regarding the benchmark criteria that should be used when determining whether inpatient admission is reasonable and necessary, a policy that has become known as the "two midnight" rule. CMS sought to balance principles that I believe are shared by all stakeholders, including beneficiaries, hospitals, physicians, and the Congress: the need for criteria that are clear, are consistent with sound clinical practice, reflect the beneficiaries' medical needs, respect a physician's judgment, and are consistent with the efficient delivery of care to protect the Trust Funds.

CMS has been conducting extensive outreach and education efforts to hospitals and other stakeholders on this new policy. In November 2013, CMS began a probe and educate strategy whereby Medicare Administrative Contractors (MACs) conducted pre-payment reviews on a sample of short stay inpatient claims from each hospital, for dates of admission between October 1, 2013 and March 31, 2014, to determine compliance with the two midnight rule. Claims for inpatient admissions that were determined not reasonable and necessary pursuant to the two midnight rule were denied, and the MACs provided further education regarding the rule. As part of this strategy, we also prohibited the Recovery Auditors from conducting any post-payment medical necessity inpatient status reviews of claims with dates of admission between October 1, 2013 and March 31, 2014. CMS used this opportunity to engage in a dialogue with stakeholders on the two midnight rule. As we began hearing from stakeholders that more time was needed to understand the policy, we extended the medical review probe and educate strategy through September 30, 2014. The Congress further extended the probe and education strategy and the limitation on the Recovery Auditors through March 31, 2015. We believe these extensions will allow hospitals and other stakeholders time to fully benefit from the probe and educate strategy. However, despite CMS' efforts to educate hospitals and other stakeholders on the two midnight rule, stakeholders have provided feedback that the rule introduced confusion for providers.

Therefore, we recently solicited feedback through a notice of proposed rulemaking published April 30, 2014, on an alternative payment methodology as CMS seeks to address the issue of Medicare payment policy for these short stays. We are interested in public comments on such a payment methodology; specifically, how to define short stays and how a more appropriate payment might be designed. We look forward to working with the Congress and others to find a path forward that achieves our shared goals.

Medicare Program Payment Policy

CMS pays acute-care hospitals (with a few exceptions specified in the law) for inpatient stays under the Hospital Inpatient Prospective Payment System (IPPS) in the Medicare Part A

program. CMS largely sets payment rates prospectively for inpatient stays based on the patient's diagnoses, procedures, and severity of illness. A hospital receives a single payment for the case based on the payment classification—Medicare Severity Diagnosis-Related Group (MS-DRGs) under the IPPS. The IPPS payment includes the operating costs for labor and supplies, and capital costs such as depreciation, rent, and taxes that efficient facilities are expected to incur when furnishing inpatient services. Adjustments or additional payments are made to the IPPS payment for area wage index, teaching hospitals, disproportionate share of low-income patients, hospitals in rural areas, and outliers. Beneficiaries pay an inpatient Part A deductible for each benefit period, $1,216 for 2014.

In contrast, the Hospital Outpatient Prospective Payment System (OPPS) is paid under the Medicare Part B program and is a hybrid of a prospective payment system and a fee schedule, with some payments representing costs packaged into a primary service and other payments representing the cost of a particular item, service, or procedure. Payment amounts vary according to the Ambulatory Payment Classification group to which a service is assigned. Adjustments are made to the OPPS payment for area wage index, outliers, certain cancer hospitals, and certain types of rural hospitals. Generally, OPPS payments reflect the number and type of items and services furnished to a beneficiary during an outpatient stay. Beneficiaries are responsible for the copayments for hospital outpatient services provided, after they meet the Part B deductible.

Roles of the Medicare Administrative Contractors & Recovery Auditors

Compliance with CMS payment rules is monitored primarily through two types of contractors: Medicare Administrative Contractors (MACs) and Recovery Auditors. These contractors work directly with health care providers on behalf of CMS: together, they process Medicare claims, educate providers, and address improper payments. Recovery Auditors primarily identify and correct Medicare improper payments.

Medicare Administrative Contractors

As required under the Medicare Prescription Drug Improvement, and Modernization Act of 2003, CMS reformed Medicare claims processing and established MACs

as multi-state, regional contractors responsible for administering both Medicare Part A and Medicare Part B claims. CMS relies on a network of MACs to process Medicare claims, and MACs serve as the primary operational contact between the Medicare Fee-For-Service program and approximately 1.5 million health care providers enrolled in the program. MACs enroll health care providers in the Medicare program and educate providers on Medicare billing requirements, in addition to answering provider and complex beneficiary inquiries. Collectively, the MACs and the other Medicare claims administration contractors process nearly 4.9 million Medicare claims each business day, and disburse more than $365 billion annually in program payments. MACs also conduct prepayment and post-payment review on Medicare claims to ensure proper Medicare payments.

Recovery Auditors

The Recovery Audit Program's mission is to identify and correct Medicare improper payments through the efficient detection and collection of overpayments made on claims of health care services provided to Medicare beneficiaries, and the identification of underpayments to providers. CMS uses the vulnerabilities identified by the Recovery Auditors to implement actions that will prevent future improper payments nationwide. Since full implementation in FY 2010 through the first quarter of FY 2014, the Recovery Auditors have returned over $7.4 billion to the Medicare Trust Fund.

Recovery Audit Program Improvements

CMS is currently in the procurement process for the next round of Recovery Audit Program contracts and plans to award these contracts this year. In February 2014, CMS announced a number of changes to the Recovery Audit Program that will take effect with the new contract awards as a result of stakeholder feedback. CMS believes that improvements to the RAC program will result in a more effective and efficient program, including improved accuracy, less provider burden, and more program transparency.

Admission and Medical Review Criteria for Inpatient Services

When a beneficiary arrives at a hospital, the physician must decide whether it is medically reasonable and necessary to admit the beneficiary as a hospital inpatient, or whether to treat the beneficiary as an outpatient. Services furnished to hospital inpatients are generally billed under the IPPS, while services furnished to outpatients are generally billed under the OPPS. Both the decision to keep the beneficiary at the hospital and the expectation of needed duration of the stay are multifactorial decisions, based on such complex medical factors as beneficiary medical history and comorbidities, the severity of signs and symptoms, current medical needs, and the need for prolonged nursing, diagnostic, and treatment services during the time period for which hospitalization is considered.

In some cases, when the physician admits the beneficiary as a hospital inpatient and the hospital provides inpatient care, a Medicare claims review contractor, such as the MACs or the Recovery Auditors, determines that inpatient care was not reasonable and necessary under section 1862(a)(1)(A) of the Act and denies the hospital inpatient claim for payment, or attempts to recover the payment. These reviews necessarily occur after care is furnished and the claim has been submitted, which presents challenges for all parties.

When a MAC or Recovery Auditor determines a payment was made that should not have been—for example, because it was made for an ineligible service—CMS considers the payment to be "improper." The majority of improper payments under Medicare Part A for short-stay inpatient hospital claims have been due to inappropriate patient status (that is, the services furnished were reasonable and necessary, but should have been furnished on a hospital outpatient, rather than hospital inpatient, basis).

These high rates of error for hospital services rendered in inpatient rather than outpatient settings suggested to CMS that greater clarity on the inpatient hospital admission criteria might be useful for stakeholders. Additionally, CMS heard from stakeholders that hospitals appeared to be responding to the financial risk of admitting Medicare beneficiaries for inpatient stays that may later be denied upon contractor review by electing to treat beneficiaries as outpatients receiving observation services, often for extended periods of time, rather than admitting them as hospital

inpatients. This practice created confusion and hardship for beneficiaries, who were liable for additional cost-sharing for post-hospital skilled nursing facility services if their hospital stays did not span three inpatient days. In addition to increased observation utilization, CMS also heard concerns from hospitals about Medicare Part A to Part B rebilling policies when a hospital inpatient claim was denied because the inpatient admission was not medically necessary.

In response to these concerns, CMS solicited stakeholder feedback in the Calendar Year (CY) 2013 OPPS proposed rule on the definition of 'inpatient,' and in the CY 2013 OPPS Final Rule, CMS discussed the stakeholder feedback received on criteria for inpatient services. Stakeholders suggested a variety of ways to determine when a patient is appropriately admitted to the hospital as an inpatient including, among other suggestions: (1) using a measure of time to determine inpatient status; (2) developing criteria-based tools for when a patient should be admitted as an inpatient; and (3) relying on physician judgment. There was no consensus among the public commenters on the best alternative to what was then a combination of physician judgment and an expectation that the patient would stay at least overnight or 24 hours in the hospital.

In the FY 2014 IPPS proposed rule, CMS proposed to establish a new benchmark for purposes of the physician or other qualified non-physician practitioner's decision to order an inpatient admission and asked for public comments on this new benchmark. On August 2, 2013, CMS issued the FY 2014 IPPS Final Rule, which finalized the "two midnight rule." The two midnight rule refined CMS' longstanding policy on how Medicare contractors review inpatient hospital admissions for payment purposes. Under this Final Rule, in addition to services designated as inpatient-only, surgical procedures, diagnostic tests and other treatments are generally appropriate for inpatient hospital admission and payment under Medicare Part A when the physician: (1) expects the beneficiary to require a stay that crosses at least two midnights; and (2) admits the beneficiary to the hospital based upon that expectation.

The Final Rule specifies that the timeframe used in determining the expectation of a stay surpassing two midnights begins when the beneficiary starts receiving services in the hospital. This includes outpatient observation services or services in an emergency department, operating

room or other treatment area. While the Final Rule emphasizes that the time a beneficiary spends as an outpatient before the formal inpatient admission order is not inpatient time, it also provides that the physician—and the Medicare review contractor—may consider this period when determining, as part of an admission decision, if it is reasonable to expect the patient to require care spanning at least two midnights. Documentation in the medical record must support a reasonable expectation that the beneficiary will require a medically necessary stay lasting at least two midnights.

In that Final Rule, CMS also recognized that there could be inpatient stays where the patient was reasonably expected to need two nights of care in the hospital but actually was discharged in less time due to unforeseen circumstance, such as beneficiary transfer, death, or departure against medical advice. In such instances, inpatient admission and Part A payment would still generally be appropriate, so long as the medical record supports the physician's reasonable expectation of the need for medically necessary hospital care spanning two or more midnights and documents the unforeseen, interrupting circumstance. CMS also provided exceptions to the two midnight rule for cases in which the physician expects the medically necessary hospital care to span less than two midnights but inpatient admission would nonetheless be appropriate. Exceptions to the rule include: (1) surgical procedures on the inpatient only list; and (2) other rare and unusual circumstances to be identified through subregulatory instruction. To date, newly initiated mechanical ventilation has been identified as a rare and unusual exception to the two midnight benchmark.

In addition, the FY 2014 IPPS Final Rule adopted provisions relating to the rebilling of services under Medicare Part B if a claim is denied under Part A because the inpatient admission was not medically necessary. The Final Rule permits such rebilling for a broader range of services than had been permitted under our prior policy. Under this Final Rule, a hospital can also bill and be paid for these inpatient services under Part B if—after the patient has been discharged—it determines through self-audit (utilization review) that the patient should not have been admitted as an inpatient.

Inpatient Hospital Reviews

Following implementation of the two midnight rule, CMS issued guidance on how it would review affected inpatient hospital claims. CMS instructed the MACs and Recovery Auditors not to review Part A claims spanning two or more midnights after formal admission for appropriateness of inpatient admission (*i.e.,* patient status reviews), absent evidence of systematic gaming, abuse, or delays in the provision of care in an attempt to qualify for the two midnight presumption. CMS specified that prepayment probe reviews would be conducted for inpatient claims spanning less than two midnights after formal admission for claims with dates of admission on or after October 1, 2013 but before April 1, 2014. Specifically, MACs would conduct patient status reviews using a probe and educate strategy for claims submitted by acute care inpatient hospital facilities, long-term care hospitals, and inpatient psychiatric facilities for dates of admission on or after October 1, 2013 but before April 1, 2014. That is, MACs would select a sample of 10 claims for prepayment review for most hospitals (25 claims for large hospitals). Based on the results of these initial reviews, MACs would deny claims that did not comply with the two midnight rule, conduct educational outreach efforts, and repeat the process where necessary.

CMS decided to extend the inpatient hospital prepayment review probe and educate review process for an additional 6 months, through September 30, 2014, to allow more time for CMS to provide continued education and for hospitals to understand and fully comply with the two midnight rule. During this period, MACs will continue to select a sample of claims for the probe review and education. CMS has been working closely with the MACs to ensure the accuracy of claim reviews and identify recurrent provider errors. The probe review and education process is well under way and results of the reviews are being closely monitored in order to focus future educational outreach efforts.

In addition, CMS postponed post-payment enforcement of the two midnight rule for FY 2014. Recovery Auditors were instructed not to conduct any post-payment patient status reviews for claims with dates of admission October 1, 2013 through September 30, 2014. Per the recently enacted "Protecting Access to Medicare Act of 2014," CMS will continue the probe and

education process while prohibiting the Recovery Auditors from conducting post-payment patient status reviews of inpatient claims with dates of admission through March 31, 2015.

Alternative Payment Approaches for Short Inpatient Stays

In the FY 2015 IPPS proposed rule, CMS solicited comments on the general concept of an alternative payment methodology under the Medicare program for short inpatient hospital stays and specifically, how such a methodology might be designed. One issue for consideration is how to define a short inpatient stay for determining appropriate Medicare payment. Another issue would be how to determine the appropriate payment once a short stay has been identified. Some have suggested a per diem amount, perhaps modelled after the existing transfer payment policy. We recognize that payment for similar short-stay cases would be very different under the OPPS and the IPPS depending upon whether the beneficiary has been formally admitted to the hospital as an inpatient. We also solicited comments regarding the circumstances under which the IPPS payment should be capped at, or higher than, the OPPS payment. We welcome input on these and other issues related to a potential alternative payment methodology for short inpatient hospital stays.

Conclusion

The current limitation on Recovery Auditor patient status review now in place through March 31, 2015, for inpatient claims provides an opportunity to revisit short hospital stay payment policy and to engage with stakeholders on how to address this issue. CMS is soliciting comments on alternative payment approaches for short inpatient stays and is working closely with stakeholders to explore the possibility of additional exceptions to the two midnight rule. Concurrently, CMS believes that the improvements made to the next phase of the Recovery Auditor program will reduce provider burden and diversify the kinds of compliance issues Recovery Auditors investigate—improvements that will help ease the implementation of new payment policies. CMS looks forward to continuing to work with stakeholders and the Congress to address the complex question of how to further improve payment policy around the complex issues surrounding short hospital stay payment policy.

U.S. Department of Health & Human Services

Office of Inspector General

Testimony of:
Jodi D. Nudelman
Regional Inspector General for
Office of Evaluation and Inspections
Office of Inspector General
U.S. Department of Health and Human Services

Hearing:
"Current Hospital Issues in the Medicare Program"

House Committee on Ways and Means
Subcommittee on Health

May 20, 2014
1100 Longworth House Office Building
9:30 AM

Testimony of:
Jodi D. Nudelman
Regional Inspector General for
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Hearing Title: "Current Hospital Issues in the Medicare Program"
House Ways and Means Committee
Subcommittee on Health

Good morning, Chairman Brady, Ranking Member McDermott, and other distinguished Members of the Subcommittee. Thank you for the opportunity to testify about the U.S. Department of Health and Human Services (the Department) Office of Inspector General's (OIG) work to improve Medicare oversight and reduce waste, fraud, and abuse. Fighting waste, fraud, and abuse in Medicare is a top goal for OIG.

OIG has recommended numerous actions to advance this goal. The Department has implemented many of OIG's recommendations, resulting in cost savings, improved program operations, and enhanced protections for beneficiaries. In fiscal year (FY) 2013, OIG reported estimated savings of more than $19 billion resulting from legislative and regulatory actions supported by OIG recommendations. However, more remains to be done. In March 2014, OIG issued its *Compendium of Priority Recommendations*,[1] which highlights additional opportunities for cost savings and program and quality improvements. Implementing these recommendations could result in billions of dollars saved and more efficient and effective programs.

As you requested, my testimony today summarizes OIG's work in three areas that are key to improving the Medicare program for taxpayers and beneficiaries. They are: hospital observation and short inpatient stays; Recovery Audit Contractors (RACs); and the Medicare appeals process. In each of these areas, we identified significant issues and made recommendations to address them. The key takeaways from my testimony today are: 1) the two-midnight hospital policy must be carefully evaluated, 2) the Centers for Medicare & Medicaid Services (CMS) should enhance its oversight of RACs and follow through on program vulnerabilities that lead to improper payments, and 3) fundamental changes are needed in the Medicare appeals system.

The Two-Midnight Hospital Policy Must Be Carefully Evaluated

Last October, CMS implemented a new hospital policy. The new policy provides guidelines for when hospitals should bill for inpatient stays and when hospitals should bill for outpatient services, such as observation. These inpatient-versus-outpatient decisions significantly affect

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[1] Office of Inspector General's *Compendium of Priority Recommendations*, available online at http://oig.hhs.gov/reports-and-publications/compendium/index.asp.

how much Medicare pays the hospital, how much the beneficiary must pay, and the beneficiary's eligibility for skilled nursing facility (SNF) services when he or she leaves the hospital.

We evaluated hospitals' use of observation stays and short inpatient stays before the implementation of the new hospital policy.[2] Our findings highlight important issues that require continued attention. They are summarized below.

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 an observation stay, on average

We found that beneficiaries in both short inpatient and observation stays were most commonly treated for chest pain. Additionally, 6 of the 10 most common reasons for short inpatient stays were also among the 10 most common reasons for observation stays. 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 the 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 a short inpatient stay than an observation stay on average—that is, $725 per short inpatient stay compared to $401 per observation stay. For all 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. Only 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.[3] 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.

Some beneficiaries had hospital stays that lasted three nights or more but did not qualify for SNF services under Medicare

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 three inpatient nights, these beneficiaries

[2] OIG, *Hospitals' Use of Observation Stays and Short Inpatient Stays for Medicare Beneficiaries*, OEI-02-12-00040, July 2013. Short inpatient stays are inpatient stays that lasted one night or less.

[3] This analysis includes outpatient stays that lasted at least one 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.

did not qualify for SNF services under Medicare. For about 25,000 of the 618,000 hospital stays, beneficiaries received SNF services following their 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.

The new hospital policy must be evaluated

The issues that we highlighted in the July 2013 report continue to be relevant. CMS's new 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. Information about the impact of the new policy is needed to ensure that policymakers take these issues into account as they move forward.

CMS Should Strengthen its Oversight of RACs and Follow through on Vulnerabilities That Lead to Improper Payments

Recovery Audit Contractors (RACs) play a critical role in identifying improper payments and protecting the fiscal integrity of Medicare. An OIG review found that RACs identified improper payments totaling $1.3 billion in FYs 2010 and 2011.[4] While most of these improper payments were overpayments and resulted in dollars returned to the Medicare Trust Funds, some were underpayments and resulted in dollars returned to providers. Approximately 88 percent of the recovered and returned improper payments came from inpatient hospital claims. Medical services delivered in inappropriate facilities accounted for about a third of the improper payments. This includes claims in which the RAC found that services provided to a beneficiary in an inpatient setting could have been provided in an outpatient setting.

Providers did not appeal RAC decisions for about 94 percent of claims identified as overpayments. Of the 6 percent that were appealed, almost half were decided in favor of the appellant.

CMS should enhance its follow-through on improper payment vulnerabilities identified through RAC audits

CMS uses RAC audits to identify vulnerabilities and develop corrective action plans to prevent future improper payments. CMS identified 46 program vulnerabilities in FYs 2010 and 2011. These included vulnerabilities such as indicating the incorrect place of service on claims or billing for services or supplies for deceased beneficiaries. By June 2012, CMS had taken corrective actions to address the majority of these vulnerabilities. These corrective actions were not considered closed, however, because CMS had not yet evaluated their effectiveness, an

[4] OIG, *Medicare Recovery Audit Contractors and CMS's Actions To Address Improper Payments, Referrals of Potential Fraud, and Performance,* OEI-04-11-00680, August 2013.

important step in its process. Thus, it is not clear to what extent these corrective actions have prevented improper payments from recurring.

CMS performance evaluations of RACs lacked some key metrics

Although CMS completed performance evaluations for all of its RACs in 2010 and 2011, these evaluations lacked metrics related to some key contract requirements. Most notably, CMS did not evaluate RACs on the extent to which they identified improper payments. In addition, four of eight performance evaluations did not include information on the RAC's ability, accuracy, or effectiveness in identifying overpayments. In response to our report, CMS noted that it has revised its RAC evaluations to incorporate metrics on identification of improper payments and accuracy rates.

Key recommendations to CMS include:

- Evaluate the effectiveness of corrective actions to prevent Medicare overpayments.
- Strengthen performance evaluation metrics and better ensure that contractors meet performance standards.

The Medicare Appeals System Needs Fundamental Changes

The administrative appeals system is an essential component of the Medicare program. Appeals decisions affect providers, beneficiaries, and the Medicare program as a whole. It is imperative that the appeals system be efficient, effective, and fair.

The system has experienced an unprecedented surge of appeals over the past two years. According to the Office of Medicare Hearings and Appeals (OMHA), the number of appeals reaching Administrative Law Judges (ALJ)—the third level of appeals—doubled from FY 2012 to 2013.[5] Further, OMHA estimates that its backlog will reach a million claims by the end of this fiscal year. A concerted effort by all key players—including OIG, CMS, OMHA, and Congress—is needed to address this issue and to maintain the integrity of the appeals system.

Before the recent surge, OIG completed work that focused on the ALJ level of appeals.[6] Although the work covered FY 2010, many of the findings and recommendations are relevant to understanding and addressing the current challenges.

A small percentage of providers account for a large number of appeals

Medicare providers make up the vast majority—85 percent—of appellants at the ALJ level of appeal. Beneficiaries filed 11 percent and State Medicaid agencies filed 3 percent of appeals. Moreover, only 2 percent of these providers accounted for nearly one-third of all ALJ appeals.

[5] Department, *Justification of Estimates for Appropriations Committees, Fiscal Year 2015, OMHA.*
[6] OIG, *Improvements Are Needed at the Administrative Law Judge Level of Medicare Appeals*, OEI-02-10-00340, November 2012.

Specifically, 96 providers filed at least 50 appeals each with 1 provider filing over 1,000 appeals. These providers were twice as likely as others to file appeals regarding medical supplies, such as wheelchairs. During interviews, ALJ staff raised concerns that some providers appeal every payment denial and may have incentives to appeal because a favorable decision is likely.

For over half of appeals, ALJs decided fully in favor of appellants

In FY 2010, ALJs reversed prior-level decisions and decided fully in favor of appellants for 56 percent of appeals. In comparison, Qualified Independent Contractors (QICs)—the second level of appeals—decided fully in favor of appellants for only 20 percent of appeals. At the ALJ level, appellants were most likely to receive favorable decisions for Part A hospital appeals (72 percent) and least likely for Parts C and D appeals (18 percent and 19 percent, respectively).

Differences between ALJ and prior-level decisions were due to different interpretations of Medicare policies and other factors

Several factors led to ALJs reaching different decisions than those in the prior level of appeals. We found that ALJs tended to interpret Medicare policies less strictly than did QICs. In addition, ALJ and QIC staff commonly noted that some Medicare policies are unclear. Many noted that unclear policies lead to more fully favorable decisions for appellants and to more variation among adjudicators.

ALJs and QICs also differed in the degree to which they specialized in Medicare program areas and in their use of clinical experts. In contrast to QICs, ALJs do not have medical directors and clinicians on staff. Several ALJ staff said ALJs tended to rely on testimony and other evidence from treating physicians.

In addition to variation between the two levels of appeals, we also found variation among ALJs. In particular, the fully favorable rate for appellants ranged from 18 to 85 percent among the 66 ALJs. According to many ALJ staff, different philosophies among ALJs contribute to the variation in fully favorable rates. They said that given the same facts and the same applicable Medicare policy, some ALJs would make decisions that are favorable to appellants, while others would not.

CMS participation in ALJ appeals affects the outcome

CMS participated in 10 percent of ALJ appeals in FY 2010. When CMS participated, the ALJs were less likely to decide fully in favor of the appellant. The role of CMS participation was most striking with appeals involving medical supplies; the appellant was about half as likely to receive a fully favorable decision when CMS participated.

Current practices regarding appeals documents are highly inefficient

Both CMS and ALJ staff identified problems with case files. They reported that a case file at the ALJ level often differed in content, organization, and format compared to the same appeal's case

file at the QIC level, creating inefficiencies in the appeals system. Because the QICs' case files are almost entirely electronic and ALJs primarily accept only paper case files, the QICs must convert the files to paper format before sending to the ALJs. Most staff noted that this process is resource intensive and prone to error.

Key recommendations to OMHA and CMS include:

- Identify and clarify Medicare policies that are unclear and interpreted differently.
- Develop and coordinate training on Medicare policies.
- Standardize case files and make them electronic.
- Continue to increase CMS participation in ALJ appeals.
- Implement a quality assurance process to review ALJ decisions.

Further Action Is Needed To Ensure that Hospital Payment Policies, RACs, and the Medicare Appeals Process Work Efficiently and Effectively

Ensuring that the Medicare program works effectively and efficiently for beneficiaries, taxpayers, and providers is of paramount importance. Clear policies, strong oversight of contractors, and an appeals system that is effective, efficient, and fair are critical to accomplishing this goal. This requires a concerted effort by a number of key players, including CMS, CMS contractors, providers, OIG, and Congress. It also requires a commitment to evaluating and implementing smart policy, exercising vigilant oversight of contractors, and implementing innovative solutions to improve the appeals process. Such actions are essential for fighting fraud, waste, and abuse and for protecting Medicare beneficiaries and the Medicare Trust Funds.

OIG is committed to continuing its strong oversight. At stake are billions of dollars, the solvency of the program, and the health and well-being of beneficiaries. We will continue to audit and evaluate these critical program areas and recommend solutions to improve efficiency and effectiveness. We are challenged in meeting this mission by declining resources for Medicare and Medicaid oversight at a time when these programs and our responsibilities are growing. By the end of this fiscal year, we expect to reduce Medicare and Medicaid oversight by about 20 percent. Full funding of our 2015 budget request would enable us to provide more robust oversight and advance solutions to protect programs, beneficiaries, and taxpayers.

Thank you for your interest and support and for the opportunity to discuss some of our work. I am happy to answer any questions you may have.

FOR THE RECORD

American Orthotic & Prosthetic Association

Statement of the American Orthotic and Prosthetic Association on Short Stays and Unintended Consequences of RAC Audits and the Massive Backlog of Medicare Appeals on May 20, 2014 Before the Health Subcommittee of the House Ways and Means Committee

The American Orthotic and Prosthetic Association (AOPA), founded in 1917, is the largest national trade association for providers and suppliers of orthotics and prosthetics representing more than 2,000 patient care locations and one hundred and fifty suppliers and manufacturers. The field of providing artificial limbs or customized bracing for those Medicare beneficiaries with limb loss or limb impairment is a highly specialized area representing a small, roughly one-third of one percent, slice of Medicare spending but has a huge impact on restoring mobility to those patients served. A replacement limb may mean the difference between returning to work and a former life quality and remaining an active and contributing member of society. Customized bracing solutions may have a similar long range impact.

That's why AOPA was pleased that this hearing announcement referenced orthotics and prosthetics by noting, "Importantly, short stays are not the only area of concern when addressing RAC audits, appeals and an increase in observations stays. For example there are a number of durable medical equipment and prosthetic/orthotic cases that are also held up at the ALJ appeal level."

AOPA submitted a statement for this Subcommittee's hearings on April 30, 2014 on ideas to improve Medicare oversight to reduce waste, fraud and abuse in which we outlined suggestions that would assist in this endeavor. We respectfully request that our statement of April 30, 2014 also be incorporated by reference, together with this statement, into the record of this hearing.

In that earlier statement AOPA referenced the consequences RAC audits are having on delivering timely patient care and the disruption of service brought on by these audits and the lack of due process in the heavily backlogged appeals process. Our members were stunned when the Office of Medicare Hearings and Appeals announced a suspension in the scheduling of hearings before the Administrative Law Judge which has been the only remaining recourse our members have successfully utilized to fight unfair audit claim denials.

AOPA still believes that the best and surest way to combat fraud in the orthotics and prosthetics sector is to prevent fraud in the first place. There are constructive ways to fight fraud without punishing an entire healthcare sector, such as hospitals and orthotic and prosthetic (O&P) patient care providers, as we have seen these past three years.

H.R. 3112 Is a Strong Positive Step in Fighting Fraud; Surety Bonds Are Not an Answer to Fraud—They Punish All Legitimate Medicare Providers, Without Posing Any Significant Impediment to Unscrupulous Actors Who Perpetrate Medicare Fraud

Effectively fighting Medicare fraud requires implementing truly effective measures aimed at stopping unscrupulous actors and saving Medicare dollars, as in H. R. 3112, the Medicare Orthotics and Prosthetics improvement Act of 2013, which avoids pointless or misdirected steps like RAC and Pre-

payment audits about paperwork "gotchas" that have little or no relationship to preventing actual fraud. One such misdirected effort has been CMS' imposition of surety bond requirements on all providers. These bonds add substantial costs to all legitimate providers, including substantial new financial burdens on small business O&P facilities, but do nothing to distinguish legitimate from fraudulent providers—a fraudulent provider who pays the surety "toll" to support its enterprise of bilking Medicare then continues to receive Medicare payments unabated. It is a small, insignificant barrier to Medicare scammers, but it is another financial setback for honest providers.

Legislative Efforts Relating to Limiting the In-Office Ancillary Care Exception to Stark Self-Referral Rules

AOPA has noted that W&M Ranking Minority Member, Rep. McDermott has introduced a bill aimed at eliminating the exception from the Stark self-referral provisions for in-office ancillary services. AOPA supports this new legislation in principle. The Orthotic & Prosthetic Alliance in recent months has communicated concerns to OIG about how, in the context of physician-owned distributorships (PODs), the in-office ancillary services rule sometimes operates and results, at least as it relates to O&P, in increases of the number and value of services which the patient does not need, thus costing Medicare taxpayer dollars. However, no substantive action was taken. This provision has also prompted state legislative issues in states like Texas where it has been used by special interests to try to expand the prospects for payments to unqualified or under-qualified providers.

Prior Authorization is Not an Answer for Massive Non-Fraud RAC and Prepayment Audits That Have Hit Part B Medicare Claims for Artificial Limbs

The topic of prior authorization in terms of Medicare is a complex one. The BIG hitch is that in Medicare Prior Authorization, and at least most commercial plans, is NOT a promise of payment, and therefore AOPA and the vast majority of its patient care facility members oppose it as any kind of 'solution' to audits. CMS would be severely challenged to implement prior authorization as to the cost and timely responses.

CMS has unfortunately seen cookie-cutter solutions for RAC audits. Therefore, two years ago CMS said—"If a demonstration project in prior authorization was acceptable for power wheelchairs (PME) in DME, let's solve the O&P audit issues the same way." A major problem is that, in reality, the PME demo project resulted in longer delays for patients. CMS insists the numbers are shorter, but reliable reports estimate that it takes between 70-100 days from the date the physician orders a power wheelchair until the prior authorization goes through and the power wheelchair reaches the beneficiary. That kind of delay simply doesn't work for the care of amputees--who, even in the delays of the RAC environment, get their replacement limbs much faster. And again, prior authorization may have worked for a few limited cases in the private sector if, and only if, it is a absolute guarantee of payment) where it is an irreversible promise of payment (otherwise, it creates its own cash flow problems). That is not true in Medicare.

Concepts That Will Work in Restoring Sanity to RAC and Pre-Payment Audits of Claims for Part B Artificial Limbs for Medicare Amputees

While the prior authorization route is not a solution, we wish to highlight particularly the proposal from the Orthotic & Prosthetic Alliance, which has developed a working draft for a legislative solution, detailed below. These are steps that definitely would assist in greatly reducing the devastation RAC and prepayment audits of Part B claims for artificial limbs by CMS contractors have caused for Medicare amputees. A quick summary of key elements includes:

A. Establish the prosthetist/orthotist's notes as a legitimate component of the patient medical record, comparable to a therapist;
B. Establish the prosthetist/orthotist as a recognized Medicare provider of care, distinguished from treatment as a DME supplier;
C. Skip the QIC audit stage in review, since it takes time and virtually never results in a favorable decision for the O&P provider;
D. Advance the audit more expeditiously to the ALJ for final action;
E. Mandate that CMS compile data on audits separate from DME needed to track both the very high rate O&P RACs audit appeals and high overturn rate on appeal (CMS has consistently refused to track such data);
F. Establish financial penalties for RACs if an established percentage of appeal overturns occur; and
G. Address the need for more ALJs to mitigate the current backlog, either by direction to the Office of Medicare Hearings and Appeals (OMHA), which is the arm of HHS, as opposed to CMS, which is responsible for funding for ALJs, or a statutory change to allow CMS to fund ALJ appeals for RAC determinations.

Unlike Part A, There Has Been No Pause or Any Relief Whatsoever from CMS as to Part B RACs.

Chairman Brady's observation in announcing these hearings noted that, "The Ways and Means Committee fought hard to ensure that patients are getting the care they need, and that Medicare is properly paying hospitals for the care they provide. While we were able to provide some relief last March, it was only a temporary fix. We must work on a permanent solution. We don't want providers unnecessarily looking over their shoulder for auditors. We want hospitals to be accurately reimbursed so that they can focus all of their time on providing the right type of care for patients."

AOPA applauds the search for a longer terms solution for hospitals as those solutions in part will help address or inspire solutions for the similar audit problems facing O&P providers. An additional longer term solution for O&P through the enactment of H.R. 3112 would simply require CMS to implement section 427 of the Medicare, Medicaid and SCHIP Benefit Improvement and Protection Act of 2000 (BIPA), which requires CMS to only make payments to "qualified providers," as those professionals certified by the two main certification organizations, or their equivalent, in the field of O&P or properly licensed in those states requiring licensure.

Another long term solution provided by H.R. 3112 is that eligibility for payment would be linked to the qualification of the providers and the complexity of the device the patient needs. Patient quality of care then would be improved. Additionally taxpayer dollars would be saved through a reduction in poor outcomes and repeated charges for follow up O&P care that would not be necessary if a qualified provider had served the patient in the first place.

Many suppliers affected by RAC audits are small businesses like our members. They do not have the financial wherewithal to sustain their business when RAC audits or other questionable tactics to fight fraud and abuse continue unabated. It would be our hope that the focus of these hearings on the needs of our nation's hospitals under Part A becomes the clarion call for expanding solutions to relieve the threatening disasters that will befall small business providers under Part B if early and significant relief is not forthcoming.

As we indicated in our statement for the April 30 Ways & Means Health Subcommittee hearing, **many, including members of Congress, see the Part A relief for hospitals in terms of the "pause" for about a year relating to RACs under the two midnight rule, and think there has been similar relief under Part B for O&P RACs--the truth is that there has been no pause or any relief whatsoever from CMS as to Part B RACs.**

Conclusion

In conclusion, AOPA wants to continue to work with Congress and CMS to ensure that those who prey on Medicare beneficiaries do not find the orthotics and prosthetics sector an easy place to establish and operate a fraud scheme. We offer our support for developing more effective means to fight Medicare fraud that does not punish legitimate suppliers who are playing by the rules. We believe that the fairest and most effective system is one that prevents fraud before it starts, and we hope that Congress will direct CMS to develop a system taking the pathways outlined in both Section 427 of BIPA 2000 and H.R. 3112 to deter fraud, promote program integrity, and protect the due process rights of legitimate orthotics and prosthetics suppliers.

AOPA appreciates the efforts of the Chairman of the Committee and of the Subcommittee on Health for working with us to find ways to better regulate our payments. We hope to continue to work with you to improve the quality of care we deliver to patients who need orthotic and prosthetic services, and to protect the integrity of the Medicare program.

Statement of Amy Deutschendorf, MS, RN ACNS-BC
Senior Director Utilization/Clinical Resource Management
at the
Johns Hopkins Health System
before the
Subcommittee on Health
of the
Committee on Ways & Means
of the
U.S. House of Representatives

"Hearing on Current Hospital Issues in the Medicare Program"

May 20, 2014

Chairman Brady, Ranking Member McDermott and distinguished members of the Subcommittee, thank you for the opportunity to testify today and share Johns Hopkins' perspective on important issues affecting hospitals in the Medicare program.

I am Amy Deutschendorf, senior director of utilization and clinical resource management for the Johns Hopkins Health System, in Baltimore, Md. In this capacity, I am responsible for utilization management, which includes admission and concurrent review, regulatory audits, denials and appeals, care coordination (including case management and social work), and our readmissions reduction initiative.

Johns Hopkins is an integrated network of six academic and community hospitals, four suburban health care and surgery centers, more than 30 primary health care outpatient sites, and numerous international partnerships. For more than a century, Johns Hopkins has been a recognized leader in patient care, medical research and teaching. Today, Johns Hopkins is known for its excellent faculty, nurses and staff specializing in every aspect of medical care.

Over the past decade, our environment has changed drastically, particularly in the financing of research, education and patient care – our core missions. The federal budget sequestration and related fiscal pressures have flattened federal research funding in recent years and resulted in reductions in reimbursement for patient care from federal, state and private payers. My remarks today focus on two major changes – the Centers for Medicare & Medicaid Services' (CMS) two-midnight policy for inpatient admission and medical review criteria, and the agency's Recovery Audit Contractor (RAC) program. I will share with you examples of the administrative and direct financial burdens borne by hospitals in implementing these policies and responding to audit requests. In short, they are draining precious hospital resources that should be focused on patient care.

THE TWO-MIDNIGHT 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. The policy took effect Oct. 1, 2013, but thanks to an act of Congress, enforcement has been partially delayed through March 31, 2015.

NEGATIVE IMPACT ON HOSPITALS AND PATIENTS

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 adds a new layer of complexity that subverts CMS's stated objective of clarity, creates confusion and stress for patients, and inappropriately puts decisions of medical necessity at odds with adequate reimbursement.

As a large tertiary referral center, Johns Hopkins Hospital treats many patients with high-acuity and complex medical issues. Our physicians make admission decisions very carefully based on the unique circumstances of each patient, including their current medical needs, risks of adverse events, medical history and comorbidities, and severity of signs and symptoms. 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 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, 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. Though some chest pain cases may be appropriately handled 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 now requires physicians to abandon the medical assessment of medical necessity when determining the appropriate setting of care, and instead imposes a rigid time-based approach. Under the two-midnight 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 use of experienced, complex clinical judgment to assess the short-term risk of adverse outcomes. This puts patients at risk, as adequate reimbursement is placed at odds with medical judgment and imposes new financial burdens on Medicare beneficiaries, as they face new Part B cost-sharing for hospital care. **Medicare should encourage our efficient evaluation and treatment of these high-risk, complex patients in the appropriate medical setting to avoid adverse outcomes rather than create payment guidelines that arbitrarily**

assign an ambulatory (or outpatient) level of care. The new policy serves as a disincentive for hospitals to be innovative and further improve care efficiency.

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 by 33 percent. Since Oct. 1, 2013, we have seen a three-fold increase in the number of patients our physicians cautiously predicted would only stay only one-midnight (and thus began as outpatients) but later had to admit for longer stays, demonstrating the complexity of anticipating length of stay based on a patient's initial presenting symptoms.

The two-midnight policy is particularly devastating to academic medical centers and safety-net hospitals. Hospitals like Johns Hopkins continue to provide the same essential community services – serving the uninsured, maintaining trauma centers and burn units, 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 (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 for the infusion of new health care consumers under the Affordable Care Act.

CHANGES TO THE TWO-MIDNIGHT POLICY

As stated earlier, we appreciate that the genesis of the two-midnight policy was an attempt to provide clarity about the appropriate site of care, which is so often the target of RAC audits. Though the flaws in this policy are numerous and its effects damaging, we would hope to see a revised policy that still includes added clarity – but without sacrificing the critical role of medical judgment and adequate reimbursement for medically necessary short stays.

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 burden of RAC review. 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, were simple reforms to the RAC process (described below) implemented as well. Were a more complicated approach to short-stay reimbursement pursued, as suggested by CMS

in its most recent inpatient proposed rule, we would urge policymakers to ensure that the fundamental basis of the diagnosis-related group (MS-DRG) system remains intact and that policy-based add-on payments such as DSH and IME be included in short-stay reimbursement. Eighteen members of this Committee and 137 members of Congress have cosponsored H.R. 3698, a bill supported by the American Hospital Association (AHA), and we thank Congressman Gerlach and Congressman Crowley for being the sponsors of this bill, which highlights the need for a payment policy solution for these patients.

THE RECOVERY AUDIT CONTRACTOR (RAC) PROGRAM

Hospitals take seriously their obligation to properly bill for the services they provide to Medicare and Medicaid beneficiaries and are committed to working with CMS to ensure the accuracy of Medicare and Medicaid payments. We recognize the need for auditors to identify billing errors; however, redundant government auditors, unmanageable medical record requests and inappropriate payment denials are wasting hospital resources and contributing to growing health care costs. Fundamental reform of the RAC program is needed to prevent inaccurate payment denials and to make the overall auditing effort more transparent, timely, accurate and administratively reasonable.

BURDEN OF INCREASED AUDIT ACTIVITY

In recent years, CMS has drastically increased the number of program integrity auditors that review hospital payments to identify improper payments. These audit contractors include both RACs and Medicare Administrative Contractors (MACs). RACs are charged with identifying improper Medicare and Medicaid fee-for-service payments – both overpayments and underpayments. They are paid on a contingency fee basis, receiving 9 to 12.5 percent of the improper payments they identify and collect. Due to this incentive structure, RACs frequently target high-dollar inpatient claims. MACs conduct pre-payment and post-payment audits and also serve as providers' primary point-of-contact for enrollment and training on Medicare coverage, billing and claims processing.

No one questions the need for auditors to identify billing mistakes; however, responding to the increasing number of audits and challenging inappropriate denials drains hospitals' time, funding and attention that could more effectively be focused on patient care. For example, according to the AHA's RAC*Trac* survey of 2,400 participating hospitals, there was a 60 percent increase in the number of records requested for RAC audits during 2013. These Medicare claims now collectively represent nearly $10 billion in Medicare payments, a 56 percent increase from the claims requested for RAC audits through 2012.

INAPPROPRIATE DENIALS BY RACS

In addition to the financial burden of complying with RAC audits, hospitals are experiencing a significant number of erroneous RAC denials, which total millions of dollars. Of the medical records submitted for Johns Hopkins Hospital, 50 percent were automatically denied as being billed at the wrong level of care. We presented 239 cases for discussion and had ***favorable*** determinations in 135 (over fifty percent) of the cases. The rest of these cases are in the appeal process. It is important to note that our commercial payer denials (including Medicaid) for

medical necessity prior to appeal are approximately 2.5 percent of our commercial inpatient days.

Physicians who treat Medicare patients do not have the benefit of knowing in advance the health outcome of the patient; therefore, they treat patients in the setting they determine to be medically appropriate. We should, of course, expect hospitals to accurately bill for care deemed medically necessary due to the information available at the time of the patient's case. RAC auditors, however, view cases through the lens of their 20/20 hindsight and second-guess physicians by evaluating medical records with information that was not available to the physician when the patient presented. Exacerbating this biased approach is the subjective nature of these denials, with which hospitals often disagree because of the reviewers' lack of relevant clinical training. In our experience with the RAC discussion process, medical necessity determination was made using proprietary guidelines and medical judgment by practitioners who were not specialists or even generalists in the clinical area the patient needed. RACs are not penalized for their inaccuracy, and the burden falls completely to the hospital to appeal each claim that is inappropriately denied.

Despite being charged with ensuring the accuracy of Medicare payments, and despite a purported expertise in identifying inaccuracies, RACs do not have a strong record finding errors in hospital claims. For example, according to a report from the Department of Health and Human Services' (HHS) Office of Inspector General, 72 percent of RAC denials that were appealed were overturned in favor of the hospital at the third level of appeal. In fact, some hospitals have appeal success rates above 95 percent. Unfortunately, not all hospitals have the resources to appeal denials because it is costly and time consuming. RACs receive their commission of 9 to12.5 percent for each inappropriately denied claim that hospitals don't appeal.

UNEVEN PLAYING FIELD FOR APPEALS

RACs have a significant focus on reviewing short inpatient stays, and they deny these types of claims sometimes up to three years after the patient was treated. Hospitals are successful in their appeals even though they face a highly uneven playing field when they appeal an erroneous RAC denial. To recapture full payment for reasonable and necessary care, hospitals must separately appeal each RAC denial through an appeals process that can take years and years. A single auditor can produce dozens of denials per day, while a hospital must appeal every incorrect denial through a one-claim-at-a-time appeal process. The latest AHA survey indicates that about 70 percent of all appealed claims are still in the appeals process.

Meanwhile, the need for fundamental RAC reform has become even more apparent and urgent since the HHS Office of Medicare Hearings and Appeals (OMHA) announced in December 2013 that it will take at least two years for hospital appeals to be assigned to an administrative law judge because OMHA currently has 375,000 claims to assign and it doesn't want to add any more claims to its backlog. Additionally, OMHA expects posted assignment hearing wait times will continue to exceed six months. **During this 30-month period in the appeals process, hospitals are not paid for the care they provided to Medicare beneficiaries.**

Hospital resources should be spent on patient care, not fighting erroneous RAC denials for years on end. Additionally, Medicare beneficiaries are hurt when their inpatient stay is inaccurately

denied by a RAC, resulting in higher out-of-pocket expenses and, in some instances, bills that otherwise would have been covered by Medicare. Without fundamental reform, the RAC program will continue to improperly harm Medicare beneficiaries and hospitals.

Alternatives to the Current RAC Process

It is time for a thoughtful and coherent approach to Medicare audits, one that will achieve the goals of CMS: ensuring hospital compliance with policies that support appropriate care for our Medicare beneficiaries, rewarding innovation in the safe reduction of acute care utilization, and actually reducing unnecessary administrative costs to both acute care hospitals and the Medicare program. This could be achieved in a variety or combination of ways, for example:

- Implement a concurrent review process to partner with hospitals and other providers;
- Use data-mining techniques to find outliers and conduct sample audits to detect true errors; and/or
- Audit compliance programs for comprehensive practices to assure medical necessity of admissions and continued stays for Medicare patients. (Our health system utilization departments review every day of every inpatient stay for medical necessity and have a rigorous process for self-denial prior to the claim being billed to Medicare.)

The complexity of the current regulations distracts providers from focusing on the real goals for our patients: the provision of safe and quality care. One solution is the Medicare Audit Improvement Act (H.R. 1250/S. 1012), currently supported by 214 Members of Congress in the House. Another possible solution is the formation of a stakeholder group to work with CMS to comprehensively address these compliance issues and develop collaborative and rational solutions that will facilitate rather than further complicate hospitals' ability to care for patients.

CONCLUSION

Johns Hopkins takes seriously its obligation 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 the RAC program as currently administered – that drain precious time, resources and attention that could more effectively be focused on patient care. Johns Hopkins and hospitals across the country stand ready to work with policymakers to support these efforts.

Statement

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Current Hospital Issues in the Medicare Program

submitted for the record to the

For the Record

Committee on Ways & Means
Subcommittee on Health
U.S. House of Representatives

by the

Association of American Medical Colleges

May 20, 2014

The Association of American Medical Colleges (AAMC) is pleased to submit this statement to the record for the May 20, 2014, hearing, "Current Hospital Issues in the Medicare Program," of the House Ways & Means Committee's Subcommittee on Health.

AAMC is a not-for-profit association representing all 141 accredited U.S. medical schools; nearly 400 major teaching hospitals and health systems, including 51 Department of Veterans Affairs medical centers; and nearly 90 academic and scientific societies. Through these institutions and organizations, the AAMC represents 128,000 faculty members, 83,000 medical students, and 110,000 resident physicians.

The AAMC applauds Subcommittee Chairman Kevin Brady and Ranking Member Jim McDermott for their continued attention to the Medicare payment issues affecting our nation's hospitals and the patients they serve. We welcome this opportunity to share with the Subcommittee our concerns with the Centers for Medicare and Medicaid Services' (CMS) new policy for determining the appropriateness of inpatient hospital care, commonly referred to as the "two-midnights" policy, as well as the ongoing challenges faced by our member institutions in responding to aggressive audits by Recovery Audit Contractors (RACs).

Effective October 1, 2013, CMS established a new time-based standard for determining whether a hospitalization should be considered inpatient or outpatient care for the purposes of Medicare reimbursement. Eschewing the long-used clinical criteria to determine the most medically appropriate setting for care, CMS's new policy draws a bright line based on expected length of stay. Simply put, hospitalizations expected to last longer than two midnights are classified as inpatient and, with few exceptions, those stays expected to be shorter must be billed as outpatient.

While we recognize CMS's intention to clarify Medicare's hospital inpatient admission criteria, the two-midnights policy as written adds a new layer of complexity that subverts CMS's stated objective of clarity, creates confusion and financial burden for patients, and inappropriately places clinical judgment at odds with adequate reimbursement for hospitals.

In response to the vehement outcry from the AAMC and the rest of the hospital community, as well as vocal concern from Members of Congress, CMS delayed one aspect of enforcement of the two-midnights policy. Under this partial delay, hospitals must still follow the two-midnights rule in their claims submission, but should they happen to make errors, RACs may not retroactively deny payment on the basis of the two-midnights rule alone. In passing the *Protecting Access to Medicare Act of 2014*, Congress extended this suspension of RAC audits related to the two-midnights policy until March 31, 2015. The AAMC is grateful for the work of the House Ways & Means Committee and other Congressional champions to pass this important provision.

While the AAMC values this modest relief from RAC audits directed at these stays, the underlying two-midnights policy is still very much in effect and is negatively affecting providers and patients every day, as hospitals are still expected to be in full compliance with the flawed rule. This present and ongoing impact makes today's hearing particularly timely, as does the open comment period on CMS's FY15 IPPS proposed rule. We hope today's hearing, and accompanying testimony from outside stakeholders such as the AAMC, will inspire Members of the Subcommittee and their colleagues to formally urge CMS to use its rulemaking authority to immediately undo the most harmful aspects of the two-midnights policy and focus instead on sensible reforms to the RAC process.

The Two-Midnights Policy Arbitrarily Disregards the Medical Judgment of Physicians

Academic medical centers care for many patients with high-acuity and complex medical issues. The physicians and other medical professionals at these premier institutions are committed to delivering the highest quality medical care, in the most appropriate settings, to every patient – without exception. In making decisions whether to admit patients to the hospital, these highly-trained clinicians rely on their best medical judgment and established clinical protocols, rather than a stopwatch. With the benefit of hindsight one could likely identify a portion of short inpatient hospitalizations that could have been treated in outpatient settings, but identifying such cases in the moment of treatment is far more complex.

CMS has established a brief and concrete list of procedures, which, if conducted during a short hospital stay, would qualify the admission as inpatient. There are many other circumstances in which a short inpatient hospitalization is medically necessary, but are challenging to encapsulate on an 'exceptions' list as they are highly dependent on many factors such as a patient's overall condition, age, and co-morbidities. These include, but are certainly not limited to:

- *Congestive Heart Failure (CHF)*: A patient may come to the hospital experiencing symptoms related to CHF and require short-term but intensive monitoring in an inpatient setting that includes interventions to reduce fluid on their lungs. These patients may have underlying cardiac and pulmonary disease (such as emphysema) that makes diagnosis and treatment more complex. In otherwise stable, healthy patients, fluid and electrolytes can be brought back into balance relatively quickly with aggressive treatment. Many patients can switch quickly from an intravenous to oral regimen and go home in short order without having to stay "two midnights." However, many CHF patients also suffer from renal disease requiring closer monitoring and careful fluid balancing to avoid having treatment for one disease (CHF) negatively affect another (renal disease). In such cases, patients may still fare well and be discharged before 'two midnights' have elapsed but must be treated in an inpatient hospital setting. Not providing that level of care would endanger patient safety.

- *Acute Exacerbation of Asthma:* Some patients presenting with particularly acute asthma attacks may respond relatively quickly to IV steroids and nebulized inhaled medicines, yet it is difficult to predict who will suffer respiratory failure before the medications stabilize them. Often, these patients may be able to transition to home inhalers and oral steroids in under 'two midnights' but not all will – and they may require intubation, use of a ventilator, and an extended hospital stay. Careful monitoring, in a setting equipped to respond quickly should the patient's status worsen, is often essential since it is impossible to always predict accurately which patients will recover quickly and which will remain critically ill.

- *Myocardial Infarction (MI or Heart Attack)*: Similarly, patients experiencing symptoms of chest pain may have underlying cardiac and lung disease that make a diagnosis of acute MI (a potentially fatal event) important to rule out. When a diagnosis is confirmed, this will require a brief inpatient stay that consists of management w*ith anti-coagulants, beta bl*ockers, aspirin, statins, coronary angiography, and other immediate and intensive interventions. After a short period of careful inpatient monitoring and assessment, patients in this category are sometimes able to return home without having to stay more than one night, but this discharge time does not diminish the necessity of their hospital care. Our advances in our ability to treat heart attack patients safely and effectively in shorter periods of time does not mean that those patients are in any less danger; or that the intensity of care required to treatment them has decreased.

In academic medical centers, where patients are much more likely to have complicated medical conditions or behavioral health issues, physicians often see cases that require inpatient treatment because of their sheer complexity. Seemingly simple presenting conditions, such as chest pain, are often not so simple in patients who suffer from multiple comorbidities. Though some chest pain cases may be appropriately handled in observation units, very sick patients— 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.

No one would argue that every asthma or chest pain case warrants an inpatient level of care, but it is undeniable that some of these cases require brief hospitalizations and aggressive care and monitoring during that stay. The factors in distinguishing such instances are numerous, nuanced, and necessarily unique to each patient. It is for this reason that a policy based solely on length of time and a limited set of procedure-based exceptions will never provide a safe or adequate rubric for determining appropriateness of inpatient care.

The Two-Midnights Policy Results in Unsustainable Payment Cuts to Hospitals and Discourages Efficiency

In hospitals across the country, physicians continue use their best medical judgment in making treatment and site of care decisions –risking their payments, instead of their patients. This means that patients continue to be hospitalized for stays shorter than two-midnights, for all of the reasons illustrated above and many others, but now hospitals are receiving dramatically reduced reimbursements for those medically necessary short stays. At Johns Hopkins, the number of patients admitted to the hospital but reimbursed only at outpatient rates has increased by 33 percent since the implementation of the two-midnight policy. At University of Texas Southwestern, the shift to re-classifying clinically required inpatient hospitalizations as outpatient claims has led to over $3 million in lost reimbursement across three specialties alone, with the true impact likely far greater. This experience is typical among AAMC members, and results in a dramatic payment cut for medically necessary hospital services delivered to patients.

The very fact that these medically necessary intensive stays can occur in such a relatively brief period of time is a testament to the innovation and achievement of high-performing institutions. 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. In the past, these patients would have been expected to stay longer and, therefore, would be considered inpatients under the two-midnights policy. This is the very medical efficiency CMS should be encouraging but, instead, hospitals are seeing dramatic reimbursement cuts as these gains in efficiency result in denials of inpatient claims.

The two-midnights policy is also responsible for another, even more direct, cut to hospital reimbursement. When finalizing its new time-based standard for distinguishing between appropriate inpatient and outpatient care, CMS assumed that the net effect would be more claims – previously classified as outpatient –reimbursed as inpatient hospitalizations. Based on this assumption, CMS predicted a net revenue increase in hospital payments and in order to maintain budget neutrality, slashed hospital reimbursement by $220M for FY2014. Unless reversed, this payment cut remains in hospitals' base payment rate in perpetuity – resulting in over $2 billion in cuts during the current 10-year budget window.

Independent reviewers have not been able to replicate CMS's findings. In fact, outside research confirms the recent experiences reported by our individual member institutions: the two-midnights policy results in fewer cases being classified as inpatient, not more. In a peer-reviewed article in *The Journal of Hospital Medicine*, University of Wisconsin School of Medicine and Public Health researchers stated, "*Although CMS predicts that more patients will be classified as inpatients under the new rule, we determined the opposite.*"[1] In their study applying both methodologies to the same set of historic claims, the Wisconsin researchers found that the two-

midnights rule would decrease the number of cases classified as inpatient by 7.4 percent.[2] These results are consistent with those reported by the Department of Health and Human Services' Office of Inspector General (OIG), which found that the new two-midnights methodology would "significantly reduce" the number of cases classified as inpatient.[3]

CMS's faulty assumption that hospitals would see an increase in inpatient cases means hospitals are now taking a double hit: their volume of inpatient cases is declining (even without any change in services delivered) and CMS has cut their underlying payment rate for each remaining inpatient case. This is gravely concerning and unsustainable. Any alternative to the two-midnights policy must proactively reverse the cuts to hospital payment rates implemented in the FY2014 IPPS Final Rule, as these cuts were meant to offset increases in inpatient volume which we know did not, and will not, occur as a result of the two-midnights policy.

The Two-Midnights Payment Cuts Disproportionately Harm Teaching Hospitals & Safety Net Providers

The two-midnights policy is particularly devastating to academic medical centers and safety-net hospitals. AAMC member institutions are dedicated to core social missions, in addition to providing the highest quality clinical care. These missions include serving the uninsured, maintaining costly trauma centers and burn units, conducting ground-breaking research, and training the next generation of medical professionals. Our hospitals' commitment to meeting these community needs does not diminish simply because CMS arbitrarily decides that only some hospital care will be reimbursed as "inpatient," and neither do the costs these hospitals incur to keep training programs running, their doors open to all comers, and their lifesaving research underway.

And yet, when CMS's two-midnight policy shifts payment for necessary hospital care into the outpatient system, these hospitals lose their add-on payments for indirect medical education (IME) and disproportionate share (DSH) payments and see decreases in their Direct Graduate Medical Education (DGME) payments. These funding streams were established by Congress to support specific missions that remain national priorities. We cannot afford for the draconian cuts imposed by the two-midnights policy to limit access to care for the most vulnerable, delay lifesaving cures, and undermine efforts to train the workforce we need to meet the demands of those newly insured by the Affordable Care Act.

The Two-Midnights Policy Unfairly Shifts Costs to Patients

As illustrated above, policies that arbitrarily cut hospital payments affect patients in indirect but real and harmful ways. In the case of the two-midnights rule, there is also a direct financial impact on Medicare beneficiaries.

If a patient's hospitalization is arbitrarily classified as "outpatient" based on her length of stay, Medicare will cover the care through Part B (instead of Part A used for inpatient hospital care). This means that she will be billed separately for each procedure and test, and be responsible for up to 20 percent of the costs for each service – bills that can mount into the hundreds of thousands of dollars. Additionally, a patient's "outpatient" hospitalization will not count toward the three-day inpatient stay needed for eligibility for Medicare coverage of a skilled nursing facility or rehab facility after leaving the hospital, further exacerbating her potential financial liability.

In addition to placing new and unpredictable financial burdens on patients, the two-midnights policy creates confusion and threatens the doctor-patient relationship. Patients unaware of the policy are blindsided by unexpected costs. Those who are informed about the possibility of substantial cost-sharing if their hospital stay happens to be short are resisting necessary diagnostic tests and treatments for fear of the possible expense. Physicians and hospital administrative staff – themselves perplexed by CMS's policy – can offer little clarity about likely financial obligations for patients, eroding the trust essential to delivering the highest quality care.

Implementing the Two Midnights Rule Adds Significant Administrative Burden

Though the AAMC believes the two-midnights policy to be deeply flawed, we have been working closely with our members to help them come into compliance with the new rule. Across the country, our members are having to retrain staff at every level – from residents and physicians, administrative billing staff, compliance officers, and others – to shift from assessments of medical necessity to evaluations of predicted time estimates. Hospitals are making significant investments in reprogramming electronic medical records and claims processing systems comply with the new rule. And still, these same institutions each continue to invest hundreds of thousands of dollars annually to responding to RAC audits – the issue the two-midnights policy was intended to alleviate.

Adding an entirely unnecessary element of confusion and disruption for teaching hospitals, the CMS guidance implementing the two-midnights policy excludes most residents from the list of medical professionals who can certify that an admission is expected to last longer than two midnights. Teaching hospital by-laws allow residents to write orders on behalf of the attending physicians who supervise them, and rarely have their own admitting privileges as they are not considered to be part of the medical staff. CMS's strict requirement that only those with admitting privileges are able to certify an expected length of stay, and that such a certification must happen prior to discharge, means that the supervisors must be tracked down prior to patient discharge for the sole purpose of ensuring that the paperwork is correct – disrupting hospital workflows and distracting from patient care. CMS's inability to address this seemingly easy fix

has been discouraging, and highlights that the problem with the current rule is both in its underlying policy and in its implementation.

An Alternative Policy Must Prioritize Medical Judgment and Appropriate Reimbursement

The AAMC appreciates that the two-midnights policy originated as an attempt to provide clarity about the appropriate site of care, which has been the source of many RAC audits. Though we believe the flaws in this policy are numerous and its effects damaging, we support CMS's stated intention would hope to see a revised policy that still includes this added clarity – but without sacrificing the critical role of medical judgment and adequate reimbursement for medically necessary short hospitalizations.

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 burden of RAC review. But for stays lasting fewer than two midnights, CMS's policy must change. An alternative solution need not be complex. The AAMC advocates for simply returning to the policy in place for short stays prior to Oct. 1, 2013, along with simple reforms to the RAC process, as a sufficient "alternative short stay policy." This is a straightforward solution that would provide much needed relief and could be achieved immediately.

Among these much-needed and straightforward RAC reforms is a reversal of the CMS policy requiring that a denied inpatient claim may only be re-billed under Part B within 12 months of the date of service. Given the length of time involved in appealing a RAC denial, this limit effectively leaves hospitals with no recourse for payment. At a minimum, the 12-month time limit for re-billing under Part B should be suspended during an ongoing RAC appeals process.

Were a more complicated approach to short-stay reimbursement to be pursued, we would urge policymakers to begin with the change described above as an essential first step, and to proceed beyond that only with caution and significant input from stakeholders. The policy directions for alternative payments for short stays suggested in CMS's FY15 IPPS proposed rule have the potential to undermine the very basis of the diagnosis-related group (MS-DRG) system. We also remain concerned that any "alternative short stay policy" that creates a claims classification other than inpatient would put at risk essential policy add-on payments such as DSH and IME. Even if an alternative short stay policy were developed carefully over time, hospitals need relief from the two-midnights policy immediately. The AAMC urges CMS to revert its approach to stays lasting fewer than two midnights to a reliance on medical judgment, accompanied by basic RAC reforms.

Conclusion

The AAMC recognizes the imperative to ensure that hospitals accurately bill for the services they provide, and seriousness of making wise and efficient use of Medicare funds. As currently drafted, the two-midnights policy supports neither of these goals, and places unnecessary burden on hospitals and the patients they serve. We stand ready to work with policymakers to develop a simple, and much-needed, alternative.

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[1] Sheehy, A. M., Caponi, B., Gangireddy, S., Hamedani, A. G., Pothof, J. J., Siegal, E. and Graf, B. K. (2014), Observation and inpatient status: Clinical impact of the 2-midnight rule. *Journal of Hospital Medicine*. 9: 203–209, February, 2014.

[2] Ibid.

[3] Department of Health and Human Services Office of Inspector General. Hospitals' use of observation stays and short inpatient stays for Medicare Beneficiaries, OEI-02–12-00040. *Issued July 29, 2013. Available at:* http://oig.hhs.gov/oei/reports/oei-02–12-00040.asp. *Accessed May 18, 2014.*

FOR THE RECORD

STATEMENT

of the

American Medical Association

to the

Committee on Ways and Means
Subcommittee on Health
United States House of Representatives

RE: Current Hospital Issues in the Medicare Program

May 20, 2014

Division of Legislative Counsel
(202) 789-7481

Statement

of the

American Medical Association

to the

Committee on Ways & Means
Subcommittee on Health

RE: Current Hospital Issues in the Medicare Program

May 20, 2014

The American Medical Association (AMA) is pleased to provide the Subcommittee on Health of the Committee on Ways & Means with our views on Medicare's two-midnight policy, short inpatient stays, outpatient observation stays, auditing, and appeals. As a threshold matter, we urge the Subcommittee to consider that these issues significantly affect physicians as well as hospitals. These issues have raised considerable interest among our members and state and specialty medical societies. We look forward to continuing to provide the physician perspective as the Subcommittee examines these important issues.

Two-Midnight Policy

The AMA opposes Medicare's two-midnight policy and believes it should be rescinded in its entirety.[1] Under the policy, Medicare contractors presume that hospital inpatient admissions are reasonable and necessary for beneficiaries who exceed the two-midnight benchmark. In addition, Medicare contractors must now presume that hospital services spanning less than two midnights should have been provided on an outpatient basis. While stays for less than two midnights may be deemed properly inpatient if there is clear documentation in the medical record to support the physician's inpatient stay order, such determinations necessitate contractor review and audit. Therefore, hospitals have a disincentive to permit such orders.

[1] AMA Letter to CMS on the Medicare Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long Term Care Hospital Prospective Payment System and Proposed Fiscal Year 2014 Rates; Quality Reporting Requirements for Specific Providers; Hospital Conditions of Participation; Medicare Program; FY 2014 Hospice Wage Index and Payment Rate Update; Hospice Quality Reporting Requirements; and Updates on Payment Reform; Proposed Rules. June 25, 2013. Available at https://download.ama-assn.org/resources/doc/washington/x-pub/inpatient-prospective-payment-systems-comment-letter-25june2013.pdf

While we understand that the Centers for Medicare & Medicaid Services (CMS) intended to provide greater clarity regarding what constitutes an inpatient stay by instituting this policy, the effect has been quite the opposite. The policy has led to much confusion for physicians who are now faced with estimating the length of stay for their patients and determining whether they would fit within the arbitrary rubric of a two-midnight stay. For example, under the policy, the visit of a patient who comes to the hospital at 1:00 a.m. on a Monday, and stays through 11:00 p.m. on Tuesday—a total of 46 hours—would be presumed by Medicare review contractors to have been properly categorized as an outpatient stay. Incongruously, the visit of a patient who comes to the hospital at 11:00 p.m. on a Monday, and stays through 1:00 a.m. on a Wednesday—a total of 26 hours—would be presumed by a Medicare review contractor to have been properly categorized as an inpatient stay.

Adding to the complexity of the two-midnight policy is the inconsistency between when a hospital stay is considered to be inpatient for purposes of hospital reimbursement versus when a patient is considered an inpatient for purposes of coverage. The policy allows Medicare contractors to count the entire length of stay, including the time prior to the inpatient order, toward meeting the two-midnight benchmark for hospital reimbursement purposes. In contrast, the patient status does not change from "outpatient" to "inpatient" until the physician inpatient order is entered. This can alter the overall cost of the stay to the patient, and can significantly affect patient coverage for services like skilled nursing facility (SNF) care, for example. Physicians who are managing the overall care of their patients while also responding to institutional concerns about audits are left trying to navigate multiple interests and divergent rules.

We also have serious concerns about the administrative burden that this policy is having on physicians. While the authority to determine whether a patient requires an inpatient level of care should remain with the physician, the numerous inpatient order and certification requirements issued by CMS via sub-regulatory guidance and multiple addenda have resulted in a tremendous amount of new, confusing rules for physicians. We have advocated that, at a minimum, CMS should actively educate physicians and hospitals in regard to compliance with these requirements. Such education should go beyond CMS open door forums and national provider calls; education is needed "on the ground" to help physicians understand the litany of these requirements and their complexity.

Short Inpatient Stays

We are pleased that CMS adopted our recommendation in its 2015 Inpatient Prospective Payment Systems (IPPS) proposed rule to explore whether the use of a short stay payment adjustment might be a vehicle to remedy the problem of increased observation care and the

related issues that this trend has caused for physicians and patients.[2] We believe that a short stay payment methodology may more appropriately reimburse services that fall below the two-midnight benchmark, lessening the pressure on hospitals to either admit a patient or place the patient in observation care.

The short stay outlier is utilized by CMS as an adjustment to the payment rate for long-term care hospital (LTCH) stays that are generally much shorter than the average length of stay for a Medicare severity long-term care diagnosis-related group. Our impression is that the use of a short stay outlier affords LTCHs the flexibility to tailor patient stays for the amount of time to most appropriately address patients' clinical needs. We will be developing more detailed recommendations on this topic over the next several months, and will share our work with the Subcommittee at that time.

Outpatient Observation Stays

There can be wide differences in cost to the patient for time spent as an outpatient under observation. For example, self-administered drugs can cost significantly more for the patient under observation than to an inpatient. In addition, there may be repercussions related to post-acute coverage. Patients who require post-hospitalization SNF care must have a prior three-day inpatient stay to qualify for Medicare coverage. While CMS has asserted that the two-midnight benchmark addresses this issue, we think that the new two-midnight policy may have exacerbated the problem, as noted earlier in this testimony.

Consider the following hypothetical: a patient presents to the hospital at 1:00 a.m. on Monday and is placed under observation. By 2:00 a.m. on Wednesday, the patient is still in need of care, and is admitted to the hospital as an inpatient. The patient does not leave the hospital until 9:00 a.m. on Thursday, and is discharged to a SNF. Since the patient was there for more than two-midnights, she will be presumed by Medicare contractors to have been properly admitted as an inpatient for purposes of hospital reimbursement. But, because she was only an inpatient from 2:00 a.m. on Wednesday until 9:00 a.m. on Thursday, it is our understanding that she will not qualify for SNF care, even though she has been in the hospital for four days.

Because of the inequity for patients of the three-day inpatient stay requirement for coverage of SNF care, we have long advocated that CMS should either rescind that policy or allow outpatient observation care days to count toward the three-day stay requirement. In that vein, we strongly support S. 569 / H.R. 1179, the "Improving Access to Medicare Coverage Act of 2013," and urge the Subcommittee to act on this important legislation.

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[2] AMA and American Hospital Association Letter to CMS regarding Inpatient Admission and Review Criteria set forth in the FY 2014 Hospital Inpatient Prospective Payment System Final Rule. November 8, 2013. Available at https://download.ama-assn.org/resources/doc/washington/x-pub/two-midnight-suspension-letter-08nov2013.pdf

Audits

Physicians are firmly committed to eradicating fraud and abuse from the federal health care programs. Monies that inappropriately flow from federal health care programs divert vital resources that should be devoted to patient care. The AMA has long believed that the most efficient way to combat fraud is to employ targeted, streamlined methods of fraud identification and enforcement, rather than overly burdensome requirements for all physicians, the majority of whom strive to comply with the rules and regulations governing participation in the Medicare program. Through this lens, we have generally been supportive of the stated goal of CMS' Center for Program Integrity to employ data analytics and targeted fraud enforcement, rather than burdensome rules and methods, to efficiently target true fraud.

We continue to have serious concerns, however, about CMS' Recovery Audit Contractor (RAC) program. RACs audit physicians in private practice and in the hospital setting, and such audits are often very disruptive and resource-intensive. They are also often erroneous: the 2011 RAC report to Congress stated that provider-appealed overpayment determinations were decided in favor of the provider 43.6 percent of the time.[3] The 2012 RAC report to Congress, which was released earlier this year, cited a figure of 26.7 percent of appeals decided in providers' favor.[4] We think this number may not be representative of RACs' accuracy because, as we discuss later in our testimony, the number of appeals at the Administrative Law Judge (ALJ) level increased dramatically during that year and were not all fully adjudicated.[5] Importantly, physicians and other providers are most likely to have decisions overturned at this level of appeal.

Because of the litany of problems with the RAC program to date, we have engaged with CMS as they revise and renew their RAC contracts for the next contract period. **In particular, we sent formal recommendations on improvements to the RAC Statement of Work (SOW) to CMS last year, such as penalties for RACs that have a high error rate or that fail to meet administrative deadlines.**[6] We were pleased that CMS recently announced some positive changes to the forthcoming SOW, such as guidelines for when RACs can receive contingency

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[3] CMS. Recovery Auditing in Medicare and Medicaid for Fiscal Year 2011. Available at http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Recovery-Audit-Program/Downloads/FY2011-Report-To-Congress.pdf pg. 33.

[4] CMS. Recovery Auditing in Medicare and Medicaid for Fiscal Year 2012. March 2014. 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 pg. 42.

[5] HHS. Office of Medicare Hearings and Appeals. Medicare Appellant Forum. February 12, 2014. Available at http://www.hhs.gov/omha/omha_medicare_appellant_forum_presentations.pdf (slides 15-16).

[6] AMA. Letter to CMS on the Revised RAC SOW. August 30, 2013. Available at https://download.ama-assn.org/resources/doc/washington/x-pub/rac-program-letter-30august2013.pdf

fees for appealed claims and deadlines for provider discussion periods.[7] Many of our other recommendations, however, have not been announced by CMS as adopted in the new SOW. We are continuing our work on these issues, and welcome further dialogue with the Subcommittee on the problems our members have encountered with the RACs and legislative means by which they may be addressed.

Appeals

We are very concerned about the two-year backlog at the Office of Medicare Hearings and Appeals (OMHA), and recently sent a letter with 97 state and specialty medical societies requesting action on this issue.[8] As you are likely aware, OMHA hosted a hearing on this topic in February. During that hearing, it was apparent that OMHA is being tasked with adjudicating a record number of appeals, largely because of problems with the RAC program. Many physicians believe that they must appeal erroneous overpayment recoupments to the administrative law judges at OMHA to receive equitable and fair determinations. While OMHA laid out plans to improve processes and protocols on their end, the problem clearly lies with the RAC and other audit programs themselves. We strongly believe that CMS should take a bottom-up approach to solving this problem and revise the RAC and other audit programs as we have recommended throughout this testimony to give the requisite relief to both physician appellants and OMHA staff.

Conclusion

Thank you for giving the AMA the opportunity to share our views on these important issues. We look forward to continuing to work with the Subcommittee as you formulate your next steps.

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[7] CMS. RAC Program Improvements. Available at http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Recovery-Audit-Program/Downloads/RAC-Program-Improvements.pdf. Accessed May 15, 2014.

[8] AMA, State and Specialty Societies. Letter to OMHA regarding Appeal Backlog. February 12, 2014. Available at https://download.ama-assn.org/resources/doc/washington/x-pub/medicare-appeals-backlog-sign-on-12feb2014.pdf