

PROTECTING PATIENTS FROM SURPRISE MEDICAL BILLS

HOUSE WAYS AND MEANS COMMITTEE

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STATEMENT OF THE CENTER FOR MEDICARE ADVOCACY

One of the most significant and largest surprise medical bills that a Medicare beneficiary faces is a bill for a stay in a skilled nursing facility (SNF) when the Medicare patient’s prior medically necessary stay in the hospital was called “observation status,” rather than inpatient admission. Although the Medicare program confirms that a hospital physician can order whatever care, tests, medications, and treatments a patient needs, whether the patient is called an inpatient, an outpatient, or a patient in observation status,¹ Medicare Part A limits coverage for a SNF stay to a patient who was hospitalized as an inpatient for at least three consecutive days, not counting the day of discharge.² This Medicare billing issue – whether the hospital submits the bill for the patient’s stay to Medicare Part A (inpatient) or to Medicare Part B (outpatient) for medically necessary hospital care – is depriving hundreds of thousands of Medicare patients each year of their Part A SNF benefit. A 2016 report by the HHS Office of Inspector General documented the increasing numbers of outpatients, finding that 633,148 patients in Fiscal Year 2014 had spent three or more midnights in the hospital that did not include three inpatient midnights.³ There is nothing that patients can do about their status in the hospital. Although the Notice of Observation Treatment and Implication for Care Eligibility Act (NOTICE Act) requires hospitals to inform patients of their status as outpatients,⁴ Medicare regulations expressly prohibit patients from appealing observation status.⁵

For more than a decade, the Center for Medicare Advocacy has heard from Medicare patients and their families across the country about observation status.⁶ The recurring story is that a patient was hospitalized for three or more consecutive days, but the hospital called some or all of the days observation. Deprived of a three-day inpatient stay, although meeting all other requirements for Medicare Part A coverage of a post-hospital SNF stay, the patient had to pay the SNF out-of-pocket. SNFs often demand payment upfront for a full month.

A recent story from Indiana is typical. A Medicare patient was hospitalized for six nights, all classified as observation. When she went to the SNF, she was admitted as a private-pay patient and had to pay \$8000 out-of-pocket. Last year, National Public Radio reporter Alison Kodjak described her mother’s experience with observation status. Although hospitalized for four days, her mother was classified as an observation status patient for the first three days. The SNF that

¹ 80 Fed. Reg. 70297, 70539 (Nov. 13, 2015) (confirming that two-midnight benchmark “does not prevent the physician from ordering or providing any service at any hospital, regardless of the expected duration of the service”).

² 42 U.S.C. §1395x(i); 42 C.F.R. §409.30(a)(1).

³ OIG, *Vulnerabilities Remain Under Medicare’s 2-Midnight Hospital Policy*, 13, OEI-02-15-00020 (Dec. 2016), <https://oig.hhs.gov/oei/reports/oei-02-15-00020.pdf>.

⁴ 42 U.S.C. §1395cc(a)(1)(Y).

⁵ 42 C.F.R. §405.926(u).

⁶ The Center for Medicare Advocacy’s materials on observation status are available at <https://www.medicareadvocacy.org/?s=observation&op.x=0&op.y=0>.

agreed to admit Kodjak’s mother as a private-pay patient required an immediate upfront payment of \$12,000, which Kodjak borrowed from her home equity line of credit.⁷

There is a solution to the issue of observation status that could resolve this surprise medical bill issue for many Medicare patients. The Center for Medicare Advocacy is a founding member of an ad hoc coalition of more than 30 national organizations – including, among others, the American Association of Post-Acute Care Nursing, the American Case Management Association, the American Health Care Association, the American Medical Association, the Alliance of Retired Americans, AARP, The Hartford Institute for Geriatric Nursing, the Leadership Council of Aging Organizations, LeadingAge, and the Society of Hospital Medicine – who support the Improving Access to Medicare Act of 2019 (H.R. 1682/S. 753). This simple bipartisan, bicameral bill counts all time in the hospital, whether called inpatient or outpatient or observation, as satisfying Medicare’s requirement for a three-day inpatient hospital stay. A copy of the coalition’s Fact Sheet, which also identifies the supporting organizations, is attached.

The Inspector General’s 2016 report found that the reasons for the hospitalization of inpatients and outpatients, and the care and services they received in the hospital, were the same.⁸ Among its recommendations, the Inspector General suggested counting all time in the hospital “so that beneficiaries receiving similar hospital care have similar access to these [SNF] services”⁹ – essentially what the Improving Access to Medicare Act of 2019 would do.

The Center for Medicare Advocacy is a national, private, non-profit law organization, founded in 1986, that provides education, analysis, advocacy, and legal assistance to assist people nationwide, primarily the elderly and people with disabilities, to obtain necessary health care, therapy, and Medicare. The Center focuses on the needs of Medicare beneficiaries, people with chronic conditions, and those in need of long-term care and provides training regarding Medicare and health care rights throughout the country. It advocates on behalf of beneficiaries in administrative and legislative forums, and serves as legal counsel in litigation of importance to Medicare beneficiaries and others seeking health coverage. These comments are based on our experiences talking with and representing hundreds of Medicare beneficiaries and their families who have been caught in observation status.

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⁷ Alison Kodjak, “How Medicare’s Conflicting Hospitalization Rules Cost Me Thousands of Dollars” (Apr. 20, 2018), <https://www.npr.org/sections/health-shots/2018/04/20/583338114/how-medicare-conflicting-hospitalization-rules-cost-me-thousands-of-dollars>.

⁸ OIG, *Vulnerabilities Remain Under Medicare’s 2-Midnight Hospital Policy, 10-11*, OEI-02-15-00020 (Dec. 2016), <https://oig.hhs.gov/oei/reports/oei-02-15-00020.pdf>.

⁹ *Id.* 16-18.

Support the Improving Access to Medicare Coverage Act

Supported By

American Association of Healthcare Administrative Management (AAHAM)
American Association of Post-Acute Care Nursing (AAPACN)
AARP
American Case Management Association (ACMA)
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American Geriatrics Society (AGS)
American Health Care Association (AHCA)
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Alliance for Retired Americans
American College of Emergency Physicians
American Medical Association
AMDA - The Society for Post-Acute and Long-Term Care Medicine
American Physical Therapy Association (APTA)
The Catholic Health Association of the United States (CHA)
Center for Medicare Advocacy
The Hartford Institute for Geriatric Nursing
The Jewish Federations of North America
Justice in Aging
Leadership Council of Aging Organizations
LeadingAge
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Medicare Rights Center
National Association of Area Agencies on Aging (n4a)
National Academy of Elder Law Attorneys, Inc. (NAELA)
National Association of Health Care Assistants (NAHCA)
National Association of Health Underwriters (NAHU)
National Association for State Long-Term Care Ombudsman Programs (NASOP)
National Association for the Support of Long Term Care (NASL)
National Center for Assisted Living (NCAL)
National Committee to Preserve Social Security & Medicare
The National Consumer Voice for Quality Long-Term Care
Society of Hospital Medicine (SHM)
Special Needs Alliance

Medicare beneficiaries are being denied access to Medicare's skilled nursing facility (SNF) benefit because of the way hospital stays are classified.

Under Medicare law, patients must have an *inpatient* stay in a short-term acute care hospital spanning at least three consecutive days (not counting the day of discharge) in order for Medicare to pay for a subsequent stay in a SNF. However, acute care hospitals are increasingly identifying patients as in "observation," an *outpatient* designation, rather than admitting them as inpatients.

Outpatients may stay for multiple days and nights in hospital beds and receive medical and nursing care, diagnostic tests, treatments, medications, and food, just as inpatients do. However, although the care received by patients in observation status can often be similar to the medically necessary care received by inpatients, outpatients who need follow-up care do not qualify for Medicare coverage in a SNF. As a result, the Medicare beneficiary ends up being responsible for paying for the SNF stay, which places an unfair burden on the beneficiary through no fault of their own. Counting observation status toward the Medicare benefit is a common-sense policy that does not affect hospital care but does protect the ability of beneficiaries to receive needed post-acute nursing home care. That is why we support passage of the **Improving Access to Medicare Coverage Act (H.R. 1682/S. 753)**, which would do exactly that.

Hospitals' use of observation status and the amount of time patients spend in observation status are both increasing.

An early study¹ found a 34% increase in the ratio of observation stays to inpatient admissions between 2007 and 2009, leading the researchers to conclude that outpatient observation status was increasingly becoming a substitute for inpatient status. The same study also documented increases in long-stay outpatient status, including an 88% increase in observation stays exceeding 72 hours. A 2013 report by the Department of Health and Human Services Office of Inspector General (OIG) found that in 2012, beneficiaries had 617,702 hospital stays that lasted at least three days, but that did not include three *inpatient* days. The pattern continued. In December 2016, the Inspector General reported that 748,337 long hospital stays were called outpatient, including 633,148 outpatient stays of three or more days, in FY 2014. Between FYs 2013 and 2014, outpatient stays increased by 8.1%, despite implementation of the two-midnight rule (see reverse side of document) that was expected to decrease outpatient stays.

Support for counting time spent in observation status toward the three-day prior inpatient stay continues to grow:

- The Inspector General's 2013 report was supportive of counting observation days towards the three-day inpatient stay requirement.
- In September 2013, the Congressionally-created Long Term Care Commission recommended that the Centers for Medicare & Medicaid Services (CMS) count time spent in observation status toward meeting the three-day stay requirement.
- In 2015, the Medicare Payment Advisory Commission (MedPAC) explored various policy options for counting time spent in observation toward meeting the SNF 3-day requirement. The Commission unanimously recommended that CMS revise the SNF 3-day rule to allow for up to two outpatient observation days to count toward meeting the requirement, recognizing that beneficiaries are needlessly facing barriers to accessing needed post-acute care.²
- New payment models, such as the Next Generation Accountable Care Organization (ACO), have recognized the confusion and flawed logic of the observation status issue and have allowed a waiver for the 3-day stay requirement, including time spent in observation. Counting observation stays would therefore more closely align with newer models of care and reduce confusion for patients.

¹ Zhanlian Feng, Brad Wright and Vincent Mor, Sharp Rise In Medicare Enrollees Being Held In Hospitals For Observation Raises Concerns About Causes And Consequences, *Health Affairs*, 31, no. 6 (2012): 1251-1259.

² Medicare Payment Advisory Commission (MedPAC), June 2015 Report to Congress.

Recent efforts have focused on eliminating burden and unanticipated/surprise medical bills that are having a significant negative impact on out-of-pocket-costs and patient-provider relationship. The observation stays matter is one such area that should be seriously looked at when focusing on efforts to eliminate surprise medical bills.

The Improving Access to Medicare Coverage Act of 2019 counts the time Medicare beneficiaries spend in observation toward the three-day stay requirement, so that Medicare patients who spend three days in a hospital, regardless of inpatient/observation designation, are able to access post-acute care in a SNF when they need it.

As mentioned earlier, legislation that will be re-introduced this Congress in March with bipartisan support would create a full and permanent solution. The **Improving Access to Medicare Coverage Act (H.R. 1682/S. 753)**, sponsored by Representatives Joe Courtney (D-CT) and Glenn ‘GT’ Thompson (R-PA) and Senators Sherrod Brown (D-OH), Susan Collins (R-ME), Sheldon Whitehouse (D-RI), and Shelley Moore Capito (R-WV), would help Medicare beneficiaries who are hospitalized in observation by requiring that time spent in observation be counted towards meeting the three-day prior inpatient stay.

Recent efforts to address the problem of observation status have fallen far short of a comprehensive fix.

The NOTICE Act (P.L. 114-42), while a step in the right direction, does not go far enough to ensure patients have access to needed post-acute care services.

Since March 8, 2017, the NOTICE Act has required hospitals to inform patients who are receiving outpatient observation services for more than 24 hours that they are outpatients, not inpatients. Hospitals must use the Medicare Outpatient Observation Notice (MOON) and provide an oral explanation. While receiving notice informs patients of their status, the law – although a positive step forward – does not give patients hearing rights or count the time in the hospital for purposes of SNF coverage.

The “two-midnight” rule, which was intended to slow the growth in long outpatient stays does not eliminate, and in fact has exacerbated, the barriers beneficiaries face in accessing needed post-acute care services.

How the 2-Midnight Rule Works

In October 2013, CMS adopted the “two-midnight rule”, which establishes time-based criteria for physicians to use when deciding to admit a patient as an inpatient or keep them under outpatient observation. The rule states that for patients expected to require hospital services for at least two midnights, inpatient admission will be presumed appropriate for payment. Likewise, for patients expected not to require hospital services for at least two midnights, outpatient observation is presumed appropriate. The rule was intended to give admitting physicians additional assurance that their decision to admit would not be questioned by auditors, thereby reducing the incidence of long outpatient stays. CMS intended the two-midnight rule to decrease the number of long outpatient stays, and decrease the number of short inpatient admissions.

What the OIG Found

In a December 2016 report³, the OIG found that since the implementation of the two-midnight rule, total outpatient stays have increased and total inpatient stays have decreased – the opposite of CMS’ expectations – exacerbating an already challenging problem. It is now clear that while CMS intended to fix the problem through implementation of the two-midnight rule, it has inadvertently worsened the situation for thousands of beneficiaries who are unable to access needed post-acute care. The report recommends that CMS analyze the potential impacts of counting time spent as an outpatient toward meeting the SNF three-day requirement so that beneficiaries receiving similar hospital care have similar access to post-acute care services.

While the rule and its revision reflect CMS’ concerns about long outpatient stays, hospitals are unlikely to change their practices when CMS provides no meaningful guidance on when an inpatient stay of fewer than two midnights is appropriate. Physician decisions about patient status continue to be reviewed by hospitals under the same standards as before: short inpatient decisions are prioritized for review by Quality Improvement Organizations (QIOs); and the specter of audits by Recovery Auditors (still known as RACs) remains. The mission of the RACs is to identify and correct Medicare and Medicaid improper payments. A RAC’s determination that a patient has been incorrectly classified as an inpatient requires the hospital to return most of the Medicare reimbursement for the patient’s stay, despite the fact that the services were medically necessary and coverable by Medicare. Recently-imposed penalties for readmitting a hospital patient within 30 days increase hospitals’ motivation to classify patients as outpatients, rather than inpatients.

³ Department of Health and Human Services Office of Inspector General (OIG), December 2016 Report OEI-02-15-00020.