

Congress of the United States
Washington, DC 20515

September 6, 2019

The Honorable Alex Azar
Secretary of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

The Honorable Seema Verma
Administrator, Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

Dear Secretary Azar and Administrator Verma:

In a recent tweet, Administrator Verma acknowledged that sometimes, Medicare rules don't "always make sense." Specifically, she singled out the so-called "three-day requirement," Medicare law which requires that beneficiaries have an inpatient hospital stay of at least three days in order to qualify for coverage of subsequent post-hospital care in a skilled nursing facility. We agree that this rule is bureaucratic and harmful, and we have been working for many years to remove this barrier to care. At the start of the 116th Congress we again introduced the bipartisan "Improving Access to Medicare Coverage Act" which would ensure that all beneficiaries who are hospitalized for three days are eligible for covered, doctor-recommended SNF treatment, regardless of whether their hospital stay was as an inpatient or under observation status.

As you know, beneficiaries are routinely denied coverage of their necessary SNF care because of the arbitrary distinction between observation and inpatient status. Despite receiving the same care as beneficiaries considered "inpatients", patients who are coded as "under observation" are denied coverage of this doctor-recommended care. As a result of this rule, patients and their families find themselves facing thousands of dollars in surprise bills for skilled nursing care they believed would be covered.

In more than one report the HHS office of the Inspector General has acknowledged this inequity. In 2016 the OIG found that on average, patients hospitalized under observation were liable for \$10,503 in post-hospital surprise bills that would have been covered had they been considered inpatients. Most recently, in July 2019 the OIG listed this issue as their number one recommendation among their top suggestions for reducing fraud, waste, and abuse in HHS programs.

Administrator Verma's recent tweet acknowledging the inherent inequity with the current three-day requirement is a welcome indication of the Administration's willingness to consider regulatory action to remedy this bureaucratic and semantic problem. In a previous letter, we outlined CMS' existing authority to define inpatient in a way that ensures patients placed under observation status have access to the same coverage as inpatients. Specifically, federal appeals court has recognized that neither the statute nor the regulation surrounding this issue define the term "inpatient" and instead, the term is defined in the Medicare Benefit Policy Manual.

This year, we ask if you intend to use your authority to once and for all remove this inequitable, longstanding, and bureaucratic barrier to care.

Thank you for your attention to this important issue.

Sincerely,

Handwritten signature of Joe Courtney in blue ink.

Rep. Joe Courtney

Member of Congress

Handwritten signature of Glenn 'GT' Thompson in blue ink.

Rep. Glenn 'GT' Thompson

Member of Congress