



520 Eighth Avenue, North Wing, 3rd Floor

New York, NY 10018

212.869.3850/Fax: 212.869.3532

**United States House of Representatives
Committee on Ways & Means, Subcommittee on Health
Hearing on Current Hospital Issues in the Medicare Program
May 20, 2014**

Chairman Brady, Ranking Member McDermott, and distinguished members of the Subcommittee on Health, I am Joe Baker, President of the Medicare Rights Center (Medicare Rights). Medicare Rights is a national, non-profit organization that works to ensure access to affordable health care for older adults and people with disabilities through counseling and advocacy, educational programs, and policy initiatives. Thank you for the opportunity to testify on current hospital issues in the Medicare program.

Medicare Rights answers 15,000 questions on our national helpline each year, serving older adults, people with disabilities, and those that help them—family caregivers, social workers, attorneys, and other service providers. Through our educational initiatives, we touch the lives of another 140,000 people with Medicare and their families. Additionally, Medicare Interactive, our online learning tool, receives approximately 1.1 million visits annually.

Problems presented by callers to the Medicare Rights helpline are varied and complex. In 2012, the most common questions heard on our helpline centered on three themes: affording basic health care costs, appealing denials of coverage, and enrolling in Medicare. In all of these areas, we see that people with Medicare lack needed support.¹

We find that navigating a complex array of Medicare coverage rules for hospital stays can be taxing for seniors and people with disabilities. Not only are these rules confusing, their application can create real, and even catastrophic, cost burdens for people with Medicare. Our statement concerns the beneficiary impact of three policies pertaining to Medicare hospital stays, including: the growing use of observation status, allowable hospital rebilling practices, and the currently delayed “two midnights” policy.

Our Clients Are Often Burdened and Confused by Medicare’s Hospital Coverage Policies:

Even some of the simpler cases we hear on the Medicare Rights helpline make clear the challenges that Medicare beneficiaries face when staying in a hospital under observation status, cases like Ms. N’s.

¹ Sutton, C., Bennett, R., Sanders, S., and F. Riccardi, “Medicare Trends and Recommendations: An Analysis of 2012 Call Data from the Medicare Rights Center’s National Helpline,” (Medicare Rights Center: January 2014), available at: <http://www.medicarerights.org/policy/priorities/2012-medicare-trends/>.

Ms. N—a 68 year-old Nebraskan who lives with Multiple Sclerosis—called our helpline upon receipt of a hospital bill. In January, she had a short, two-day hospital stay. Although Ms. N was initially told she would be admitted, she was later informed that her stay would be categorized as an outpatient stay for observation. Still, Ms. N continued to receive the very same care that she would have as an inpatient, including services and tests, medications, food, and so forth. During this stay, she was not permitted to take her routine medications from the supplies she brought from home, but was given her prescriptions from the hospital pharmacy.

Several months later, Ms. N received a \$200 bill for the two days of routine medication she received while in the hospital. Normally, Ms. N pays only \$10 per month for the exact same prescriptions. Ms. N submitted the bill to her Part D plan, but coverage was denied because the hospital pharmacy is out-of-network. To obtain only partial recovery of her costs, she must now pursue an appeal.

Ms. N reports being deeply frustrated and confused by this situation, and she expressed feeling “taken advantage of” by the hospital, her Part D plan, and Medicare. Had Ms. N been treated as an inpatient, her prescriptions would have been covered under Part A, and the entirety of Ms. N’s cost sharing would have been paid by her Medigap supplemental plan. In other words, Ms. N’s hospital bills—including the 20-fold increase in costs for her routine prescriptions—resulted solely because the hospital deemed Ms. N an outpatient as opposed to an inpatient.

Ms. N’s experience was frustrating and burdensome; yet, her case includes some positive elements. First, unlike many beneficiaries that we assist, the hospital informed Ms. N of her outpatient status in a timely manner. Second, Ms. N did not need care from a Skilled Nursing Facility (SNF) following her hospital stay. To receive coverage for SNF care under Medicare, a beneficiary must have spent three days as a hospital inpatient, not including the day of discharge. Had Ms. N needed SNF care, her time under observation would not have counted towards this requirement.

Indeed, some of the most distressing cases heard on our helpline come from beneficiaries unable to secure Medicare coverage for post-acute SNF care. Callers to our helpline feel confused, distressed and powerless in the face of significant costs. Under federal guidelines, beneficiaries have no right to learn that they are not inpatients, no avenue to challenge the non-admission, and no control over the decision.

A Needed Coverage Fix: Counting Observation Status Towards Medicare’s Three-Day Rule

Unlike Ms. N, many people with Medicare receive SNF care following a hospital stay. As noted above, days spent in a hospital under observation (essentially as an outpatient) do not count towards Medicare’s three-day inpatient rule to qualify for SNF coverage. As a result, beneficiaries who spend three or more days in the hospital under observation may spend thousands of dollars on subsequent rehabilitative care.

Typically a beneficiary is placed in observation following an emergency room stay. While observation may be an appropriate clinical tool in some instances, recent studies suggest that misuse of observation

status is on the rise. Under previous Medicare guidelines, observation stays were to span more than 48 hours in only rare exceptions, but stays increasingly last longer.²

According to a 2012 study, the ratio of observation/outpatient to inpatient stays increased by 34 percent from 2007 to 2009—leading researchers to conclude that observation stays were being used in place of inpatient admissions. At the same time, the study concluded that observation stays of more than three days increased by 88 percent.³ A July 2013 Office of the Inspector General (OIG) report determined that almost 618,000 beneficiaries had observation stays that lasted three nights or more in 2012.⁴

Finally, a recent AARP study concluded that the use of observation status among Medicare beneficiaries more than doubled over a nine-year period, and the duration of observation stays increased. According to AARP, “Between 2001 and 2009, median time spent under observation for all beneficiaries who received OS [observation status] increased by 29 percent, from 17 hours to 22 hours.”⁵

Evidence suggests a multitude of factors contribute to hospitals’ increased use of observation status and the lengthened duration of observation stays, such as changes in Medicare payment policies, heightened pressure on hospitals to reduce inpatient stays and readmissions, greater efficiencies related to how emergency departments triage care, and more.⁶ While Congress and the Administration should examine and address these factors where necessary, immediate solutions are needed to mitigate the harmful impact of lengthy observation stays on people with Medicare.

Toward this end, we urge members of Congress to pass the Improving Access to Medicare Coverage Act of 2013 (H.R. 1179 and S. 569). This bipartisan bill would credit time spent in observation towards the three-day requirement for Medicare-covered skilled nursing care. The legislation would significantly lessen the severe financial consequences facing Medicare beneficiaries and families who lack Medicare coverage for needed skilled care following a hospital stay of three days or more.

Additionally, we continue to urge that hospitals be required to inform beneficiaries about their outpatient/observation status. To date, there is no such requirement. In 2013, New York State—home to the Medicare Rights Center—passed legislation to require hospitals to provide written notice to all

² Zao, L., Schur, C., Kowlessar, N. and K.D. Lind, “Rapid Growth in Medicare Hospital Observation Services: What’s Going On?” (AARP Public Policy Institute: September 2013), available at: http://www.aarp.org/content/dam/aarp/research/public_policy_institute/health/2013/rapid-growth-in-medicare-hospital-observation-services-AARP-ppi-health.pdf.

³ Zhanlian, F. Wright, B. and V. Mor, “Sharp Rise In Medicare Enrollees Being Held In Hospitals For Observation Raises Concerns About Causes And Consequences,” *Health Affairs* 31, No. 6 (2012)

⁴ Office of the Inspector General (OIG), “Hospitals’ Use of Observation Stays and Short Inpatient Stays for Medicare Beneficiaries,” (July 2013), available at: <http://oig.hhs.gov/oei/reports/oei-02-12-00040.asp>.

⁵ Zao, L., Schur, C., Kowlessar, N. and K.D. Lind, “Rapid Growth in Medicare Hospital Observation Services: What’s Going On?” (AARP Public Policy Institute: September 2013), available at: http://www.aarp.org/content/dam/aarp/research/public_policy_institute/health/2013/rapid-growth-in-medicare-hospital-observation-services-AARP-ppi-health.pdf.

⁶ Ibid.

patients placed under observation.⁷ While this serves as an important model for other states, we believe that beneficiaries would be best served if the Medicare program implemented a similar requirement.

Similarly, there is no mechanism to allow beneficiaries to appeal or challenge a hospital's determination of their status. In essence, beneficiaries deemed outpatients who then face significant SNF costs lack appropriate recourse. Beneficiaries requiring SNF care may appeal Medicare's decision to deny payment for their rehabilitative, post-acute care, but these cases are rarely successful because they ultimately hinge on a hospital's initial determination of inpatient versus outpatient status.

Finally, we believe that CMS should take action to mitigate the use of observation services on beneficiaries' drug costs. To date, payment of outpatient hospital care does not include coverage for chronic medications. As such, coverage of routine medications falls to the beneficiary's Part D plan. As demonstrated by Ms. N's case, these prescriptions may be denied or come at a higher cost, as most hospital pharmacies are not within Part D plan networks.

At a minimum, CMS should implement rules to ensure that patients are not responsible for cost sharing above what they would pay at a regular, preferred, and in-network pharmacy. Additionally, CMS should devise a system to require Part D plans to pay hospital pharmacy claims seamlessly, without the additional paperwork, burden, and delay patients now face. We also encourage CMS to explore aligning outpatient hospital coverage rules (Part B) for chronic medications with those currently in place for inpatient care (Part A). Under Part A, routine medications are covered as part of a patient's hospital care.

Rebilling Policies Pose Financial Risks to People with Medicare:

In 2013, CMS finalized a proposal to allow hospitals to bill Part B when a Part A claim is denied because an inpatient stay was not determined to be reasonable or necessary.⁸ According to CMS, this policy is intended to lessen inappropriate use of observation stays, essentially by mitigating financial risks to hospitals facing increased scrutiny with respect to inpatient (Part A) billing. While this is an important goal, we continue to believe that this policy inappropriately shifts the financial risk of denied Part A claims to the person with the least control over these costs—the beneficiary.

Under the current policy, beneficiaries will not be liable for costs incurred under a denied Part A claim. Yet, the same is not true for cost sharing associated with a hospital's subsequent billing for services under Part B. We believe there are two areas where beneficiary liability could be large, unpredictable and uncontrollable, including: (1) Part B costs and (2) Part D costs.

- **Increased Part B Costs:** Under the current policy, beneficiaries will be responsible for excluded services received in the hospital; for the difference between Part A and Part B cost sharing for covered services; and for services provided to beneficiaries who are not enrolled in Part B. This last

⁷ NY Pub Health L § 2805-W (2012)

⁸ Centers for Medicare & Medicaid Services (CMS), Inpatient Prospective Payment System (IPPS) 1599-F (August 2013), available at: <http://www.gpo.gov/fdsys/pkg/FR-2013-08-19/pdf/2013-18956.pdf>.

scenario is most dire, as we expect that these beneficiaries will be wholly liable for the cost of their hospital care. Beneficiaries in these situations should not be responsible for higher costs.

- **Increased Part D Costs.** Detailed above, Ms. N’s case clearly captures the risks posed to beneficiaries who are retroactively deemed outpatients in the event of a denied Part A claim. As an inpatient, most medications are covered under Part A. Ms. N was informed of her changed status (from inpatient to observation) during her stay; yet, she was still unprepared for and confused by the resulting increased cost sharing. We expect that beneficiaries whose claims are rebilled by the hospital at a later date will find this experience even more perplexing.

As acknowledged by CMS, most hospital pharmacies are out-of-network under most Part D plans, resulting in high cost sharing to patients. As noted above, we continue to urge that beneficiaries be shielded from higher prescription drug costs when placed under outpatient/observation status. We believe the same should be true in instances involving rebilling. We continue to urge that beneficiaries be held harmless from added costs; in particular, beneficiaries should not be denied coverage by their Part D plan, and should not be responsible for cost sharing above what they would pay at a regular, preferred and in-network pharmacy.

We acknowledge that there will be many instances where costs will be less for a beneficiary under a rebilled Part B claim than they would be under Part A, and we applaud CMS’ requirement that beneficiaries are refunded by hospitals in these circumstances. We also know that associated deductibles, coinsurances, and copayments will vary under rebilling circumstances depending on a beneficiary’s supplemental coverage. According to the OIG, in 2012, only six percent of beneficiaries under observation paid more than beneficiaries receiving comparable care as inpatients.⁹ Nevertheless, we continue to urge that Medicare beneficiaries be held harmless in instances where associated cost sharing for care received under Part B (and by extension, Part D) is higher than under a denied Part A claim.

CMS states the agency lacks the authority to implement a hold harmless provision.¹⁰ As such, we urge Congress to step in. At the same time, we continue to advocate for advance notice to beneficiaries about potential changes in cost sharing due to rebilling. We are grateful that CMS intends to conduct an educational campaign on this policy, but we do not believe this campaign will be sufficient. Retroactive increases in Part B or Part D—occurring many months after a hospital discharge—will not only be confusing and troubling for beneficiaries, but may also be unaffordable for many.

“Two Midnights” Policy is Arbitrarily Derived; A Clinical Solution is Needed:

Also in 2013, CMS finalized the “two midnights” standard, intended to alleviate the growing problem of the impact of observation status on Medicare beneficiaries. Under the final policy, beneficiaries staying

⁹ Office of the Inspector General (OIG), “Hospitals’ Use of Observation Stays and Short Inpatient Stays for Medicare Beneficiaries,” (July 2013), available at: <http://oig.hhs.gov/oei/reports/oei-02-12-00040.asp>.

¹⁰ Centers for Medicare & Medicaid Services (CMS), Inpatient Prospective Payment System (IPPS) 1599-F (August 2013), available at: <http://www.gpo.gov/fdsys/pkg/FR-2013-08-19/pdf/2013-18956.pdf>.

less than two midnights in a hospital (with some exceptions) are to be considered outpatients in observation status, and beneficiaries staying two midnights or more are to be considered inpatients.¹¹ Rather than basing patient status on health care needs and clinically determined standards, the rule makes time-based presumptions about needed care.

We remain concerned that the final policy fails to clarify coverage rules or improve care for people with Medicare. According to recent research, under the “two midnight” rule, a beneficiary’s status as an inpatient or outpatient will ultimately be determined by the time of day that a patient presents symptoms, as opposed to medical need.¹² As such, we do not believe the “two midnights” policy facilitates transparent communications by hospitals and health care providers to beneficiaries about their status and cost sharing responsibilities.

Select enforcement efforts related to the “two midnights” rule are delayed through March 31, 2015.¹³ In the interim, we continue to urge that CMS reach out to both beneficiaries and especially clinicians, who are experienced in emergency medicine, geriatrics, and inpatient hospital care, to advise on how policies related to observation status can be modified or altered to better address beneficiaries’ needs.

Conclusion:

In sum, as reflected by the experiences shared by callers to the Medicare Rights helpline, much can be done to improve policies concerning hospital stays for older adults and people with disabilities. First and foremost, we urge Congress to pass H.R. 1179 and S. 569—to count time spent in observation status towards post-acute Medicare coverage for skilled nursing care. In addition to this legislation, reforms are needed to improve beneficiary notice and appeals related to observation status as well as to ease the burden of higher cost sharing for routine medicines administered during outpatient hospital stays.

We also urge Congress and CMS to revisit the agency’s current policies related to beneficiary liability for hospital rebilling of denied Part A claims. We firmly believe that people with Medicare should be held harmless from higher cost sharing associated with hospital rebilling that occurs months following a hospital discharge. Last, we continue to believe that the time-based, arbitrarily defined “two midnights” rule for assessing patient status is flawed. We continue to hope that CMS will adopt a clinically relevant solution to facilitate patients’ best interests.

Thank you for the opportunity to testify.

¹¹ Ibid.

¹² Sheehy, A., “Testimony before the United States Committee on Ways and Means, Subcommittee on Health: Current Hospital Issues in the Medicare Program,” (Society of Hospital Medicine: May 2014), available at: http://waysandmeans.house.gov/uploadedfiles/052014_sheehy_testimony_final_hl.pdf.

¹³ Protecting Access to Medicare Act of 2014 §111, Pub. L. 113-93.