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**Testimony before the United States Committee on Ways and Means
Subcommittee on Health**

Current Hospital Issues in the Medicare Program

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Chairman Brady, Ranking Member McDermott, and members of the Committee, thank you for the opportunity to discuss observation status and the implications observation policies have on hospitals, physicians, and Medicare beneficiaries. My name is Ann Sheehy, and I am a physician at the University of Wisconsin School of Medicine and Public Health in Madison, Wisconsin. I am a hospitalist, which is a physician who cares for patients primarily in the acute care hospital setting. I am also a member of the Public Policy Committee of the Society of Hospital Medicine (SHM), an association that represents the nation's more than 44,000 hospitalists. As inpatient-based physicians, hospitalists contribute to improving the quality of care, reducing length of stay and generally helping to control healthcare costs by providing focused medical care to hospitalized patients. Because of our clinical work and extensive experience in the hospital setting, hospitalists have a first-hand view of what observation care looks like to patients, physicians, and hospitals.

Observation Care is Problematic for Medicare Beneficiaries and Hospitals

Inpatient hospital care is paid for under Medicare Part A, and Medicare beneficiaries who stay 3 midnights or more as inpatients are also eligible for skilled nursing facility coverage at discharge. Observation care is often provided in the same hospital beds as inpatient care, but is considered outpatient and therefore paid for under Part B. As a result, patients under observation are not covered by Part A hospital insurance, leaving them vulnerable to higher out-of-pocket charges, including copays and hospital pharmacy charges. They also do not qualify for skilled nursing facility care, even if they stay 3 midnights. Observation care also presents a financial burden for

hospitals. At the University of Wisconsin, observation care is delivered at a nearly \$240 loss per patient day.

Calling Hospitalized Patients “Outpatients” Does Not Make Clinical Sense and is Vastly Different from the CMS Observation Definition

The distinction between observation and inpatient is one that does not make sense to providers and patients. Observation care is provided physically within the hospital and the services provided are often indistinguishable from inpatient care, yet we are forced to label these hospitalized patients as outpatients.

To provide a typical example, consider an elderly woman who falls at home and breaks her hand. Several days of diarrhea left her dehydrated and lightheaded, likely a reason for her fall. Already unsteady on her feet, she uses a walker to get around. I treat her dehydration with intravenous fluids, but her new cast now prevents her from gripping her walker properly, and the pain medicines she needs make her confused. She now requires help getting to the bathroom, and it is clearly not safe for her to be at home. Yet, without regard for her condition, Medicare may view her as an outpatient based purely on time in the hospital, as if she were in a clinic.

The Centers for Medicare & Medicaid Services (CMS) describes observation as, “a well-defined set of specific, clinically appropriate services”...so “a decision can be made regarding whether patients will require further treatment as hospital inpatients or if they are able to be discharged from the hospital,” and that the decision to admit the patient should be made “in less than 48 hours, usually in less than 24 hours. In only rare and exceptional cases do...outpatient observation services span more than 48 hours.”¹

¹ Department of Health and Human Services and Centers for Medicare and Medicaid services. Medicare Benefit policy manual. Available at: <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R42BP.pdf>

We published our University of Wisconsin Hospital data in JAMA Internal Medicine last summer.² Of 43,853 hospital encounters between July 2010 and December 2011, 4,578 (10.4%) were observation. The average length of stay was 33.3 hours, and 16.5% of our observation patients stayed longer 48 hours. We also had 1,141 distinct observation ICD-9 codes. We concluded that observation status for hospitalized patients was markedly different from the CMS length of stay definition for observation, given that our mean length of stay was longer than 24 hours, and 1 in 6 patients stayed longer than 48 hours. We also determined that observation was not well defined, given our finding of over 1,000 distinct observation diagnoses coded. These findings are important, because current policy does not reflect what is happening in real clinical practice. Any attempt to reform observation policy must consider how far observation care in clinical practice has strayed from what observation was intended to be, as described by Medicare's own observation definition.

Observation Status Harms the Physician-Patient Relationship

One of the hardest things as a provider is when a patient asks me what observation means. Patients do not understand that being in a hospital bed, staying overnight, getting tests and procedures and frequent nursing care can still mean they are an outpatient, as if they were in a clinic. Many of these patients ask me to change them to inpatient, even though I am hamstrung by this payment policy. As a physician, I may not even know a patient is under observation if it were not for the observation flag in our electronic health record.

Medicare Beneficiaries Are Increasingly Classified As Observation

The Medicare Payment Advisory Commission (MedPAC) March report to Congress documented a 28.5% increase in outpatient services per FFS part B beneficiary from 2006 to 2012, with a

² Sheehy, A, Graf B, Gangireddy S, et al. Hospitalized but not admitted: characteristics of patients with "observation status" at an academic medical center. JAMA Intern Med. 2013;173(21):1991-8.

12.6% decrease in inpatient discharges per Part A beneficiary over this same time period.³

Therefore, the observation burden is increasing nationwide, with more beneficiaries disadvantaged by observation hospitalization each year.

It is for this reason that SHM is actively supporting the bipartisan "Improving Access to Medicare Coverage Act" (H.R. 1179) introduced by Representatives Courtney and Latham. This legislation amends the Medicare statute's definition of "post-hospital extended care services" to clarify that Medicare beneficiaries in observation are deemed inpatients for the purposes of meeting the three- day stay requirement for Medicare-covered SNF care.

Hospitalists see first-hand how the current policies negatively impact patients and the Medicare system overall. Patients who are admitted with observation status often choose to return home rather than paying out-of-pocket for a SNF stay. The resultant lack of appropriate post-acute SNF care can result in additional problems such as dehydration, falls and many other avoidable complications. These complications can not only lead to otherwise preventable readmissions but also increase costs to Medicare for the treatment of conditions that were not present at the time of the original hospital stay.

The "2-Midnight Rule" and Short Stay Hospitalizations

As the Committee is aware, in the fiscal year 2014 Inpatient Prospective Payment System (IPPS) final regulation, CMS established a new policy to determine observation and inpatient status⁴.

Previously, clinical criteria, guided by such clinical decision tools as Interqual® or Milliman®,

³ MedPAC 2014 Report to Congress. Chapter 3: Hospital inpatient and observation services. Available at: http://www.medpac.gov/documents/Mar14_entirereport.pdf.

⁴ The Centers for Medicare and Medicaid Services Inpatient Prospective Payment System (IPPS) 1599-F. Available at: <http://www.gpo.gov/fdsys/pkg/FR-2013-08-19/pdf/2013-18956.pdf>

directed observation or inpatient status decisions. As of the new rule that went into effect on October 1, 2013, patients staying < 2 midnights, with some exceptions were to be observation, and those staying ≥ 2 midnights would be inpatient. Full enforcement and auditing of the rule has been delayed through March 31, 2015, initially by CMS, and subsequently by P.L. 113-93, The Protecting Access to Medicare Act of 2014. The “2-midnight” rule presents new problems in observation care.

Under The 2-Midnight Rule, Time of Day A Patient Becomes Ill May Determine Status and Insurance Benefits

To provide an example, a Medicare beneficiary may be hospitalized with pneumonia, needing intravenous antibiotics, a chest x-ray, some respiratory treatments, and oxygen. The patient improves enough to leave the hospital after 40 hours of care. If that patient happens to get sick and present to our hospital Tuesday at 1:00 am, this means I would discharge them at 5:00 pm Wednesday--a 1 midnight stay. But if this same patient becomes ill at 10:00 pm on Tuesday and needs the exact same 40 hours of care, I would discharge them at 2:00 pm on Thursday. This is a 2 midnight stay. Thus the time of day a patient gets sick, not different clinical needs, may determine a patient’s hospital status and insurance benefits.

This is not just a theoretical finding. In a second JAMA Internal Medicine publication last year, we found that almost half (46.9%) of our University of Wisconsin Hospital < 2 midnight encounters would have been assigned observation status instead of inpatient by virtue of time of day of presentation.⁵ Last month, we published a paper in the Journal of Hospital Medicine

⁵ Sheehy A, Graf B, Gangireddy S, et al. “Observation Status” for hospitalized patients: implications of a proposed Medicare rules change. JAMA Intern Med. 2013;173(21):2004-2006.

showing that 13.6% of our institution's observation patients presenting for care before 8:00 am would stay 2 midnights, compared to 31.2% of patients arriving after 4:00 pm.⁶

2-Midnights Is an Arbitrary Cut Point That Does Not Distinguish Distinct Clinical Populations

The 2-midnight rule does not distinguish between clinical populations because it is a time-based policy with no basis in sound clinical judgment. At the University of Wisconsin we retrospectively applied the two midnight rule to 14 months of prior observation encounters and found that 4 out of 5 top ICD-9 codes were the same whether the length of stay was < 2-midnights or ≥ 2-midnights, again confirming that patients with the exact same clinical problem would receive different insurance benefits by virtue of whether their stay crossed 2 midnights or not.⁷ From my perspective as a physician, their care will be indistinguishable, but as patients they will experience variable financial burdens merely as a result of time of presentation and not the amount of care they require.

The 2-Midnight Rule Disadvantages Short Stay, Acutely Ill Patients

Clinically, the 2-midnight rule hurts a new population of patients—those staying < 2 midnights. As an example, a patient with diabetic ketoacidosis (DKA) may be sick enough to require intensive care unit (ICU) admission and an intensive level of services that involves an insulin infusion, glucose checks every hour, chemistry laboratory tests every 2-6 hours, intensive 1 to 1, or 2 to 1 nursing care, and intravenous hydration. This can be a lifesaving treatment for patients, and requires a level of care that could not be delivered as an outpatient. Yet, these patients can improve quickly, sometimes in 24-48 hours. Prior to the 2-midnight rule, these patients would have always been inpatient. Now a short stay, even in the ICU, can be considered outpatient.

⁶ Sheehy A, Caponi B, Gangireddy S, et al. Observation and inpatient status: clinical impact of the 2-midnight rule. *J Hosp Med.* 2014;9:203-209.

⁷ *Ibid.*

The 2-midnight rule unfairly hurts such patients by classifying them as outpatients under observation status, and leaves physicians, nurses, and case managers with the unfortunate task of explaining this illogical scenario to patients and their families.

The 2-Midnight Rule May Add Cost and Waste to the System

In real clinical practice, discharge criteria are subjective. The 2-midnight rule creates incentives that are misaligned with efficient care delivery, and may add costs to the system. For the patient with diabetic ketoacidosis described above, if she is improved by 5:00 pm the night leading up to what would be a second midnight, but not 100% better, some providers might consider keeping her one more night for more intravenous fluids, which may not be absolutely essential but would almost certainly make the patient stronger. Providers, under pressure from patients aware of the rule, may respond to such incentives created by the 2-midnight rule.

Determining Length of Stay At Admission is Challenging For Providers

When a patient is hospitalized, a physician must make a written determination as to whether the patient will need to stay 2-midnights or more. This attestation must occur before important tests and procedures are performed or test results received, and so often this statement is no more than guesswork. A Medicare beneficiary presenting with fever might have a serious bloodstream infection or they may have a self-limited virus. The treatment and time needed for appropriate care are markedly different between these two conditions, yet diagnostic tests to distinguish between these two conditions take some time before results are available. At the time of hospitalization, physicians are now forced to guess how many midnights a Medicare beneficiary will need to be in the hospital while the specific condition and requisite treatment plan to get the patient better may still be unknown.

Audits and Appeals

Established under the Tax Relief and Health Care Act of 2006, the Recovery Audit Contractor (RAC) program gives private contractors the authority to audit patient records to determine if observation or inpatient status was appropriate. The RAC program was well-intentioned.

Medicare fraud and abuse cannot be tolerated and true overpayments to hospitals and physicians should be recouped, but the current system tends to question clinical nuance and my judgment as a physician rather than rooting out real problems.

Concerns about the RAC Program

The RAC auditors are paid exclusively on contingency as a percent of the Medicare dollars they recover for the federal government on cases audited. Unfortunately, these contingency incentives favor aggressive auditing, without transparency, accountability or repercussions for cases that should never have been audited.

While RACs receive no direct payments from the federal government, the reality is the RAC program costs all of us. Hospitals spend an enormous amount of resources on determining patient status, and then preparing cases for audit and appeal, for very little benefit. Some hospitals even pay private companies to do this for them. For patients hospitalized between 10/1/2012-9/30/2013, the RAC requested 299 charts from University of Wisconsin Hospital for medical necessity concerns, and are still well within their rights to request more. Of these 299 charts, the RAC determined that 63 (21%) had improper payments. Our hospital has appealed 92% (58/63) of these audits, and has won every single appeal that has been adjudicated as of May 14, 2014 (34/58, 59%), while the remaining 24 cases are still in Level 1 or 2 of the appeals process. Essentially, our hospital pays to prepare these cases in order to prove we were correct to begin with, but the RACs pay no penalty for generating this work. These are Medicare dollars that

hospitals spend not on direct Medicare beneficiary care, but on a process of defending themselves against RAC auditors.

In addition, the federal government ultimately pays for unchecked RAC activity in the appeals process. As the Committee is aware, the appeals process has 5 levels, and cases reaching Level 3 are heard by the Department of Health and Human Services' Office of Medicare Hearings and Appeals (OMHA) administrative law judges (ALJ). Recently, the OMHA temporarily suspended new requests for ALJ hearings, citing a nearly 357,000 case backlog.⁸ The weekly case receipt at OMHA has grown from 1,250 a week in January of 2012 to 15,000 per week at the end of 2013. While these numbers are not exclusively RAC payment denials, there is no question that the RAC system generates a large number of these requests, at no consequence to the RACs, but at a direct administrative cost to the federal government.

Provider Judgment and Autonomy Can Be Trumped By the RAC System

To again consider the patient needing brief, less than 2 midnights of intensive care unit services for diabetic ketoacidosis, why would a physician not just claim inpatient status? Because this case runs counter to the current observation rule of 2 midnights, it is highly vulnerable to audit. This means an auditor who never met the patient in question, a year or so after the patient discharges home, may decide to question my judgment and care as a physician, and put this case through an auditing process. Both audits and the threat of audits create workflow pressures in day-to-day practice, ranging from changes status determination to extensive documentation requirements to defend my decisions. To avoid audits, in a survey conducted this year by the Society of Hospital Medicine, hospitalists report they are asked to change the status of their patients from inpatient to observation status, or vice versa, for 16% of the cases they see in an average day of clinical

⁸ Office of Medicare Hearings and Appeals letter to appellants. Available at: http://www.hhs.gov/omha/letter_to_medicare_appellants_from_the_calj.pdf

service, adding a great deal of administrative work and time away from actually caring for patients.

Summary

Observation status merits significant reform, and the 2-midnight rule is not the answer. The 2-midnight rule and observation status in general negatively impact the delivery of good patient care. These policies require attention to find simple, common-sense solutions, that most importantly consider the original intent of observation policy, as defined by the Medicare program. Medicare policy should be aligned with clinical realities and should also be rooted in allowing physicians to provide the care patients need. I would caution, however, that observation reform, whether it is legislative or regulatory, will not be successful unless there is concurrent reform of the federal auditing programs that enforce observation rules.

The Society of Hospital Medicine looks forward to working with the Committee on identifying workable solutions to problems associated with observation care and the 2-midnight rule. We stand ready to help craft policies that are not only easier for physicians and hospitals to understand, but are also clinically appropriate for patients.