

**Statement of Amy Deutschendorf, MS, RN ACNS-BC
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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”

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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 RACTrac 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 to 12.5 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.