PROGRAM INTEGRITY: OVERSIGHT OF RECOVERY AUDIT CONTRACTORS

United States Senate Committee on Finance
Hearing
June 25, 2013

Statement Submitted by the Center for Medicare Advocacy, Inc.

The Senate Finance Committee's June 25 hearing on the Recovery Audit Contractors (RACs) program highlights the high financial costs that the RAC program has imposed on acute care hospitals – costs related to hiring additional staff to make inpatient/outpatient decisions, hiring outside consultants to help hospitals make decisions about patients' status, responding to RACs' request for documents, and appealing denials (often successfully) through the administrative appeals process.

The Center for Medicare Advocacy, Inc. (Center) offers this statement about the significant impact of the RAC program on Medicare beneficiaries. The Center, established in 1986, is a national nonprofit, nonpartisan organization that provides education, advocacy, and legal assistance to help older people and people with disabilities obtain fair access to Medicare and necessary health care. The Center is headquartered in Connecticut and Washington, DC.

RACs, observation status, and the impact on Medicare beneficiaries

Acute care hospitals know that if they classify a patient as an inpatient and a RAC later decides that, in its view, the patient should have been classified as an outpatient, they will receive basically no Medicare reimbursement for any of the medically necessary care they provided to the patient. As a result of this concern and in efforts to avoid RAC reviews, many hospitals are increasingly labeling their patients "outpatients."

Patients in outpatient "observation status" generally receive care that is indistinguishable from the care they receive as inpatients. Often sent to a hospital bed from the emergency room, where the physician has told them that they need to remain in the hospital for further care, patients are placed in a hospital bed and receive nursing and medical care, diagnostic tests and

treatments, medications, and food. They may stay multiple days and even weeks.

The financial consequences for Medicare beneficiaries who are labeled "outpatient" are enormous. Because Medicare will pay for medically necessary post-acute care in a skilled nursing facility (SNF) only for patients who are called "inpatients" in the hospital, patients who are called outpatients do not qualify for Medicare coverage of their SNF care. They must pay privately for their care – often hundreds of dollars a day plus Medicare Part B copayments for the rehabilitation services they receive plus the costs of their medications. Sometimes the adult children pay for their parents' SNF stay; sometimes nieces and nephews pay; sometimes patients cash in life insurance policies to pay for their SNF stay. Patients who cannot afford to pay private-pay rates to the SNF may go home, often to be rehospitalized a day or two later.

The Center heard from hundreds of beneficiaries and their families across the country about hospital stays of five or six days, or even 13 or 22 days. The patients were labeled outpatients in observation status for their entire hospital stay. One recent call involved an 86-year old woman who was hospitalized with a broken shoulder. Initially admitted as an inpatient, the woman was reclassified by the hospital as an outpatient. She stayed three midnights and then went to a SNF for rehabilitation, where she paid, out-of-pocket, $7600 for the first month and was told she would be billed $10,000 for the second month. A second recent call involved an 87-year old woman who fractured her shoulder. Called an outpatient by the hospital for her entire four-day stay, she paid $10,650 for her subsequent one-month stay in the SNF. A third beneficiary, an 89 year old woman was hospitalized for three days with pneumonia and sent home. She returned to the hospital the next day, having fallen and broken her hip. She remained in the hospital for six days as an "outpatient in bed" and then went to a SNF, paying out-of-pocket for her care.

Researchers have documented that hospitals' use of outpatient observation status parallels the decline in inpatient stays. Reviewing 100% of Medicare claims data for 2007-2009, researchers found that the number of outpatient observation stays for Medicare beneficiaries increased over the three-year period, while inpatient admissions decreased, suggesting "a substitution of outpatient observation services for inpatient admissions."[1]

The Brown University researchers also reported that the average length of stay in observation increased during the 36 months by more than 7%. Significantly, they found that more than 10% of beneficiaries were placed on observation status for more than 48 hours (despite the fact that the Medicare Manual suggests that observation should generally not exceed 24 hours, may sometimes be up to 48 hours, and, in "only rare and exceptional cases," more than 48 hours.[2]

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[1] Zhanlian Feng, David B. 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).

[2] CMS, Medicare Benefit Policy Manual, CMS Pub. 100-02, Chapter 6, §20.6, http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c06.pdf (scroll down to §20.6 at p. 18); same language in Medicare Claims Processing Manual, CMS Pub. 100-04, Chapter 4,

With nearly one million beneficiaries held in observation status each year, the 10% figure meant that approximately 100,000 people were in observation for more than 48 hours. Finally, the researchers identified a sharp increase in beneficiaries held in observation status for 72 or more hours – 23,841 beneficiaries in 2007; 44,843 beneficiaries in 2009 – an 88% increase. The researchers confirmed that their counts of observation stays were conservative and might be too low.

The Brown University researchers recognized both hospitals' motivation to avoid RAC auditors and the significant harmful impact on Medicare beneficiaries of hospitals' increasing use of observation status:

> [I]t is reasonable to be concerned that observation services may create barriers for access to postacute skilled nursing facility care, especially for those having been held for observation for an extended period of time. The dual trends of increasing hospital observation services and declining inpatient admissions suggest that hospitals and physicians may be substituting observation services for inpatient admissions – perhaps to avoid unfavorable Medicare audits targeting hospital admissions.

The researchers predicted, correctly, that incentives in the Affordable Care Act to reduce inpatient hospitalizations[3] "may drive ev use of observation status has in fact increased dramatically in recent years.

In proposed rules published on May 10, 2013, the Centers for Medicare & Medicaid Services (CMS) reported that the percentage of patients in observation for more than 48 hours increased from 3% to 8% between 2006 and 2011.[4] Moreover, no observation nearly tripled, but the total number of observation stays of any duration also increased by nearly 50% over the same five-year period. In 2006, approximately 920,000 Medicare beneficiary hospitalizations were in observation status. In 2011, approximately 1.4 million Medicare beneficiary hospitalizations were in observation status. Between 2006 and 2011, there was a more than 400% increase in the number of patients in observation status for more than 48 hours (27,600 people in 2006; 112,000 people in 2011).

Pending bipartisan legislation would resolve beneficiaries' primarily concern with observation status

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[3] These provisions include, for example, Hospital Readmissions Reduction Program, §3025, 42 U.S.C. §1395ww(q); National Pilot Program on Payment Bundling, §3023, 42 U.S.C. §1866C; and Independence at Home Demonstration Program, §3024, 42 U.S.C. §1866D, all of which have reducing rehospitalizations as an explicit goal.

[4] 78 Fed. Reg. 27486, 27644 (May 10, 2013).

Bipartisan legislation pending in the Senate and House – S.569, H.R. 1179, the "Improving Access to Medicare Coverage Act of 2013" – would resolve beneficiaries' primary problem with observation status by counting all time in the hospital towards meeting the three-day qualifying inpatient stay.

Support for the legislation is broad. The attached Fact Sheet supporting the legislation is endorsed by 14 national organizations, representing physicians and other health care providers as well as advocates for Medicare beneficiaries. No national organization has announced opposition to the legislation.