



# Statement

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## Current Hospital Issues in the Medicare Program

*submitted for the record to the*

Committee on Ways & Means  
Subcommittee on Health  
U.S. House of Representatives

*by the*

Association of American Medical Colleges

May 20, 2014

The Association of American Medical Colleges (AAMC) is pleased to submit this statement to the record for the May 20, 2014, hearing, “Current Hospital Issues in the Medicare Program,” of the House Ways & Means Committee’s Subcommittee on Health.

AAMC is a not-for-profit association representing all 141 accredited U.S. medical schools; nearly 400 major teaching hospitals and health systems, including 51 Department of Veterans Affairs medical centers; and nearly 90 academic and scientific societies. Through these institutions and organizations, the AAMC represents 128,000 faculty members, 83,000 medical students, and 110,000 resident physicians.

The AAMC applauds Subcommittee Chairman Kevin Brady and Ranking Member Jim McDermott for their continued attention to the Medicare payment issues affecting our nation’s hospitals and the patients they serve. We welcome this opportunity to share with the Subcommittee our concerns with the Centers for Medicare and Medicaid Services’ (CMS) new policy for determining the appropriateness of inpatient hospital care, commonly referred to as the “two-midnights” policy, as well as the ongoing challenges faced by our member institutions in responding to aggressive audits by Recovery Audit Contractors (RACs).

Effective October 1, 2013, CMS established a new time-based standard for determining whether a hospitalization should be considered inpatient or outpatient care for the purposes of Medicare reimbursement. Eschewing the long-used clinical criteria to determine the most medically appropriate setting for care, CMS’s new policy draws a bright line based on expected length of stay. Simply put, hospitalizations expected to last longer than two midnights are classified as inpatient and, with few exceptions, those stays expected to be shorter must be billed as outpatient.

While we recognize CMS’s intention to clarify Medicare’s hospital inpatient admission criteria, the two-midnights policy as written adds a new layer of complexity that subverts CMS’s stated objective of clarity, creates confusion and financial burden for patients, and inappropriately places clinical judgment at odds with adequate reimbursement for hospitals.

In response to the vehement outcry from the AAMC and the rest of the hospital community, as well as vocal concern from Members of Congress, CMS delayed one aspect of enforcement of the two-midnights policy. Under this partial delay, hospitals must still follow the two-midnights rule in their claims submission, but should they happen to make errors, RACs may not retroactively deny payment on the basis of the two-midnights rule alone. In passing the *Protecting Access to Medicare Act of 2014*, Congress extended this suspension of RAC audits related to the two-midnights policy until March 31, 2015. The AAMC is grateful for the work of the House Ways & Means Committee and other Congressional champions to pass this important provision.

While the AAMC values this modest relief from RAC audits directed at these stays, the underlying two-midnights policy is still very much in effect and is negatively affecting providers and patients every day, as hospitals are still expected to be in full compliance with the flawed rule. This present and ongoing impact makes today's hearing particularly timely, as does the open comment period on CMS's FY15 IPPS proposed rule. We hope today's hearing, and accompanying testimony from outside stakeholders such as the AAMC, will inspire Members of the Subcommittee and their colleagues to formally urge CMS to use its rulemaking authority to immediately undo the most harmful aspects of the two-midnights policy and focus instead on sensible reforms to the RAC process.

### **The Two-Midnights Policy Arbitrarily Disregards the Medical Judgment of Physicians**

Academic medical centers care for many patients with high-acuity and complex medical issues. The physicians and other medical professionals at these premier institutions are committed to delivering the highest quality medical care, in the most appropriate settings, to every patient – without exception. In making decisions whether to admit patients to the hospital, these highly-trained clinicians rely on their best medical judgment and established clinical protocols, rather than a stopwatch. With the benefit of hindsight one could likely identify a portion of short inpatient hospitalizations that could have been treated in outpatient settings, but identifying such cases in the moment of treatment is far more complex.

CMS has established a brief and concrete list of procedures, which, if conducted during a short hospital stay, would qualify the admission as inpatient. There are many other circumstances in which a short inpatient hospitalization is medically necessary, but are challenging to encapsulate on an 'exceptions' list as they are highly dependent on many factors such as a patient's overall condition, age, and co-morbidities. These include, but are certainly not limited to:

- *Congestive Heart Failure (CHF)*: A patient may come to the hospital experiencing symptoms related to CHF and require short-term but intensive monitoring in an inpatient setting that includes interventions to reduce fluid on their lungs. These patients may have underlying cardiac and pulmonary disease (such as emphysema) that makes diagnosis and treatment more complex. In otherwise stable, healthy patients, fluid and electrolytes can be brought back into balance relatively quickly with aggressive treatment. Many patients can switch quickly from an intravenous to oral regimen and go home in short order without having to stay "two midnights." However, many CHF patients also suffer from renal disease requiring closer monitoring and careful fluid balancing to avoid having treatment for one disease (CHF) negatively affect another (renal disease). In such cases, patients may still fare well and be discharged before 'two midnights' have elapsed but must be treated in an inpatient hospital setting. Not providing that level of care would endanger patient safety.

- *Acute Exacerbation of Asthma*: Some patients presenting with particularly acute asthma attacks may respond relatively quickly to IV steroids and nebulized inhaled medicines, yet it is difficult to predict who will suffer respiratory failure before the medications stabilize them. Often, these patients may be able to transition to home inhalers and oral steroids in under ‘two midnights’ but not all will – and they may require intubation, use of a ventilator, and an extended hospital stay. Careful monitoring, in a setting equipped to respond quickly should the patient’s status worsen, is often essential since it is impossible to always predict accurately which patients will recover quickly and which will remain critically ill.
- *Myocardial Infarction (MI or Heart Attack)*: Similarly, patients experiencing symptoms of chest pain may have underlying cardiac and lung disease that make a diagnosis of acute MI (a potentially fatal event) important to rule out. When a diagnosis is confirmed, this will require a brief inpatient stay that consists of management *with anti-coagulants, beta blockers, aspirin, statins, coronary angiography, and other immediate and intensive interventions*. After a short period of careful inpatient monitoring and assessment, patients in this category are sometimes able to return home without having to stay more than one night, but this discharge time does not diminish the necessity of their hospital care. Our advances in our ability to treat heart attack patients safely and effectively in shorter periods of time does not mean that those patients are in any less danger; or that the intensity of care required to treatment them has decreased.

In academic medical centers, where patients are much more likely to have complicated medical conditions or behavioral health issues, physicians often see cases that require inpatient treatment because of their sheer complexity. Seemingly simple presenting 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— 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.

No one would argue that every asthma or chest pain case warrants an inpatient level of care, but it is undeniable that some of these cases require brief hospitalizations and aggressive care and monitoring during that stay. The factors in distinguishing such instances are numerous, nuanced, and necessarily unique to each patient. It is for this reason that a policy based solely on length of time and a limited set of procedure-based exceptions will never provide a safe or adequate rubric for determining appropriateness of inpatient care.

## **The Two-Midnights Policy Results in Unsustainable Payment Cuts to Hospitals and Discourages Efficiency**

In hospitals across the country, physicians continue use their best medical judgment in making treatment and site of care decisions –risking their payments, instead of their patients. This means that patients continue to be hospitalized for stays shorter than two-midnights, for all of the reasons illustrated above and many others, but now hospitals are receiving dramatically reduced reimbursements for those medically necessary short stays. At Johns Hopkins, the number of patients admitted to the hospital but reimbursed only at outpatient rates has increased by 33 percent since the implementation of the two-midnight policy. At University of Texas Southwestern, the shift to re-classifying clinically required inpatient hospitalizations as outpatient claims has led to over \$3 million in lost reimbursement across three specialties alone, with the true impact likely far greater. This experience is typical among AAMC members, and results in a dramatic payment cut for medically necessary hospital services delivered to patients.

The very fact that these medically necessary intensive stays can occur in such a relatively brief period of time is a testament to the innovation and achievement of high-performing institutions. 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. In the past, these patients would have been expected to stay longer and, therefore, would be considered inpatients under the two-midnights policy. This is the very medical efficiency CMS should be encouraging but, instead, hospitals are seeing dramatic reimbursement cuts as these gains in efficiency result in denials of inpatient claims.

The two-midnights policy is also responsible for another, even more direct, cut to hospital reimbursement. When finalizing its new time-based standard for distinguishing between appropriate inpatient and outpatient care, CMS assumed that the net effect would be more claims – previously classified as outpatient –reimbursed as inpatient hospitalizations. Based on this assumption, CMS predicted a net revenue increase in hospital payments and in order to maintain budget neutrality, slashed hospital reimbursement by \$220M for FY2014. Unless reversed, this payment cut remains in hospitals’ base payment rate in perpetuity – resulting in over \$2 billion in cuts during the current 10-year budget window.

Independent reviewers have not been able to replicate CMS’s findings. In fact, outside research confirms the recent experiences reported by our individual member institutions: the two-midnights policy results in fewer cases being classified as inpatient, not more. In a peer-reviewed article in *The Journal of Hospital Medicine*, University of Wisconsin School of Medicine and Public Health researchers stated, “*Although CMS predicts that more patients will be classified as inpatients under the new rule, we determined the opposite.*”<sup>1</sup> In their study applying both methodologies to the same set of historic claims, the Wisconsin researchers found that the two-

midnights rule would decrease the number of cases classified as inpatient by 7.4 percent.<sup>2</sup> These results are consistent with those reported by the Department of Health and Human Services' Office of Inspector General (OIG), which found that the new two-midnights methodology would "significantly reduce" the number of cases classified as inpatient.<sup>3</sup>

CMS's faulty assumption that hospitals would see an increase in inpatient cases means hospitals are now taking a double hit: their volume of inpatient cases is declining (even without any change in services delivered) and CMS has cut their underlying payment rate for each remaining inpatient case. This is gravely concerning and unsustainable. Any alternative to the two-midnights policy must proactively reverse the cuts to hospital payment rates implemented in the FY2014 IPPS Final Rule, as these cuts were meant to offset increases in inpatient volume which we know did not, and will not, occur as a result of the two-midnights policy.

### **The Two-Midnights Payment Cuts Disproportionately Harm Teaching Hospitals & Safety Net Providers**

The two-midnights policy is particularly devastating to academic medical centers and safety-net hospitals. AAMC member institutions are dedicated to core social missions, in addition to providing the highest quality clinical care. These missions include serving the uninsured, maintaining costly trauma centers and burn units, conducting ground-breaking research, and training the next generation of medical professionals. Our hospitals' commitment to meeting these community needs does not diminish simply because CMS arbitrarily decides that only some hospital care will be reimbursed as "inpatient," and neither do the costs these hospitals incur to keep training programs running, their doors open to all comers, and their lifesaving research underway.

And yet, when CMS's two-midnight policy shifts payment for necessary hospital care into the outpatient system, these hospitals lose their add-on payments for indirect medical education (IME) and disproportionate share (DSH) payments and see decreases in their Direct Graduate Medical Education (DGME) payments. These funding streams were established by Congress to support specific missions that remain national priorities. We cannot afford for the draconian cuts imposed by the two-midnights policy to limit access to care for the most vulnerable, delay lifesaving cures, and undermine efforts to train the workforce we need to meet the demands of those newly insured by the Affordable Care Act.

### **The Two-Midnights Policy Unfairly Shifts Costs to Patients**

As illustrated above, policies that arbitrarily cut hospital payments affect patients in indirect but real and harmful ways. In the case of the two-midnights rule, there is also a direct financial impact on Medicare beneficiaries.

If a patient's hospitalization is arbitrarily classified as "outpatient" based on her length of stay, Medicare will cover the care through Part B (instead of Part A used for inpatient hospital care). This means that she will be billed separately for each procedure and test, and be responsible for up to 20 percent of the costs for each service – bills that can mount into the hundreds of thousands of dollars. Additionally, a patient's "outpatient" hospitalization will not count toward the three-day inpatient stay needed for eligibility for Medicare coverage of a skilled nursing facility or rehab facility after leaving the hospital, further exacerbating her potential financial liability.

In addition to placing new and unpredictable financial burdens on patients, the two-midnights policy creates confusion and threatens the doctor-patient relationship. Patients unaware of the policy are blindsided by unexpected costs. Those who are informed about the possibility of substantial cost-sharing if their hospital stay happens to be short are resisting necessary diagnostic tests and treatments for fear of the possible expense. Physicians and hospital administrative staff – themselves perplexed by CMS's policy – can offer little clarity about likely financial obligations for patients, eroding the trust essential to delivering the highest quality care.

### **Implementing the Two Midnights Rule Adds Significant Administrative Burden**

Though the AAMC believes the two-midnights policy to be deeply flawed, we have been working closely with our members to help them come into compliance with the new rule. Across the country, our members are having to retrain staff at every level – from residents and physicians, administrative billing staff, compliance officers, and others – to shift from assessments of medical necessity to evaluations of predicted time estimates. Hospitals are making significant investments in reprogramming electronic medical records and claims processing systems comply with the new rule. And still, these same institutions each continue to invest hundreds of thousands of dollars annually to responding to RAC audits – the issue the two-midnights policy was intended to alleviate.

Adding an entirely unnecessary element of confusion and disruption for teaching hospitals, the CMS guidance implementing the two-midnights policy excludes most residents from the list of medical professionals who can certify that an admission is expected to last longer than two midnights. Teaching hospital by-laws allow residents to write orders on behalf of the attending physicians who supervise them, and rarely have their own admitting privileges as they are not considered to be part of the medical staff. CMS's strict requirement that only those with admitting privileges are able to certify an expected length of stay, and that such a certification must happen prior to discharge, means that the supervisors must be tracked down prior to patient discharge for the sole purpose of ensuring that the paperwork is correct – disrupting hospital workflows and distracting from patient care. CMS's inability to address this seemingly easy fix

has been discouraging, and highlights that the problem with the current rule is both in its underlying policy and in its implementation.

### **An Alternative Policy Must Prioritize Medical Judgment and Appropriate Reimbursement**

The AAMC appreciates that the two-midnights policy originated as an attempt to provide clarity about the appropriate site of care, which has been the source of many RAC audits. Though we believe the flaws in this policy are numerous and its effects damaging, we support CMS's stated intention would hope to see a revised policy that still includes this added clarity – but without sacrificing the critical role of medical judgment and adequate reimbursement for medically necessary short hospitalizations.

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. The AAMC advocates for simply returning to the policy in place for short stays prior to Oct. 1, 2013, along with simple reforms to the RAC process, as a sufficient “alternative short stay policy.” This is a straightforward solution that would provide much needed relief and could be achieved immediately.

Among these much-needed and straightforward RAC reforms is a reversal of the CMS policy requiring that a denied inpatient claim may only be re-billed under Part B within 12 months of the date of service. Given the length of time involved in appealing a RAC denial, this limit effectively leaves hospitals with no recourse for payment. At a minimum, the 12-month time limit for re-billing under Part B should be suspended during an ongoing RAC appeals process.

Were a more complicated approach to short-stay reimbursement to be pursued, we would urge policymakers to begin with the change described above as an essential first step, and to proceed beyond that only with caution and significant input from stakeholders. The policy directions for alternative payments for short stays suggested in CMS's FY15 IPPS proposed rule have the potential to undermine the very basis of the diagnosis-related group (MS-DRG) system. We also remain concerned that any “alternative short stay policy” that creates a claims classification other than inpatient would put at risk essential policy add-on payments such as DSH and IME. Even if an alternative short stay policy were developed carefully over time, hospitals need relief from the two-midnights policy immediately. The AAMC urges CMS to revert its approach to stays lasting fewer than two midnights to a reliance on medical judgment, accompanied by basic RAC reforms.

## Conclusion

The AAMC recognizes the imperative to ensure that hospitals accurately bill for the services they provide, and seriousness of making wise and efficient use of Medicare funds. As currently drafted, the two-midnights policy supports neither of these goals, and places unnecessary burden on hospitals and the patients they serve. We stand ready to work with policymakers to develop a simple, and much-needed, alternative.

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<sup>1</sup> Sheehy, A. M., Caponi, B., Gangireddy, S., Hamedani, A. G., Pothof, J. J., Siegal, E. and Graf, B. K. (2014), Observation and inpatient status: Clinical impact of the 2-midnight rule. *Journal of Hospital Medicine*. 9: 203–209, February, 2014.

<sup>2</sup> Ibid.

<sup>3</sup> Department of Health and Human Services Office of Inspector General. Hospitals' use of observation stays and short inpatient stays for Medicare Beneficiaries, OEI-02–12-00040. *Issued July 29, 2013. Available at: <http://oig.hhs.gov/oei/reports/oei-02–12-00040.asp>. Accessed May 18, 2014.*