



June 3, 2014

Submitted via e-mail (waysandmeans.submissions@mail.house.gov)

Chairman Brady, Ranking Member McDermott and Representatives Blumenauer, Buchanan, Gerlach, Johnson, Kind, Nunes, Pascrell, Price, Roskam, Ryan, Smith and Thompson
Ways and Means Subcommittee on Health
United States House of Representatives
Washington, DC 20515

RE: Current Hospital Issues in the Medicare Program

Dear Honorable Members:

On behalf of our more than 4,800 nurses, social workers, physicians, educators, administrators, and other professionals – representing approximately 985 U.S. hospitals, nearly 40% of all U.S. hospitals – responsible for providing case management services in hospitals or health systems, the American Case Management Association (ACMA) appreciates the opportunity to submit our concerns and recommendations related to observation services for consideration by the Committee and for inclusion in the printed record of the Committee's May 20, 2014 hearing.

As you know, hospital case managers are clinically-competent professionals responsible for managing health care transitions across multiple providers and throughout the continuum of care, a critical component in reducing preventable hospital readmissions and improving patient outcomes.

As an association representing professionals who daily serve as advocates on behalf of both patients and the hospital they serve, observation services is an issue that is of particular concern to our membership, and since 2012, ACMA has actively advocated to halt the inappropriate use of observation services.

Observation services and the three-day stay requirement are issues that adversely impact both patient and provider; creating barriers for case managers in providing appropriate care and facilitating safe transitions. In a survey of ACMA members, 78% of the 334 respondents said that they were experiencing longer length of stay (LOS) for patients receiving observation services.¹

Medicare statutes and regulations do not define observation services. The only definition appears in various CMS manuals, where observation services are described as:²

"a well-defined set of specific, clinically appropriate services, which include ongoing short term treatment, assessment, and reassessment, that are furnished while a decision is

being made regarding whether patients will require further treatment as hospital inpatients or if they are able to be discharged from the hospital."³

According to the CMS manuals, in most cases a beneficiary may not remain in observation services for more than 24 or 48 hours.⁴ Unfortunately, under Medicare rules, time spent in outpatient observation services in a hospital does not satisfy the three-day inpatient hospital requirement which entitles the patient to Medicare coverage of any post-hospital extended care services in a skilled nursing facility (SNF). This means that Medicare beneficiaries are then charged directly for various services they receive in an acute care setting, including prescription medications, and for their SNF stay, rather than Medicare covering those costs. Patients who are medically qualified for SNF placement, but are unable to pay out-of-pocket, are often discharged to home because they did not satisfy the three-day stay requirement.⁵

However, the issues surrounding observation services have changed – it is no longer extended LOS in observation status that does not allow for SNF coverage. Now patients should be admitted if they require a second night in the hospital. Thus, five- and six-day observation stays should now be unheard of – but reports from hospitals indicate an increase in observation stays (a stated CMS concern), and patients are not qualifying for SNF care because their first night in the hospital was in observation status. In addition, patients are exposed to Part B costs, including the cost of self-administered medications. CMS has stated that there is no difference in “level of care” between observation and inpatient, but decided that all short stays should be outpatient. There is no logic to this position.

The issue of certification of admission should also be addressed. The Social Security Act requires certification of the medical necessity for inpatient admission but addresses only admissions “over time,” and specifically mentions the timing of certification of outliers. The 2015 Inpatient Prospective Payment System (IPPS) rule adopted outlier certification rules for new inpatient admissions, which led to a number of inconsistencies. Ultimately, CMS stated that certification was no more than an admission order plus routine medical necessity documentation. This decision created a number of serious issues, because CMS requires that (a.) the certification be signed before discharge (an unnecessary requirement that leads to technical denials) and (b.) all elements of certification be signed by the time of discharge. Documentation supporting medical necessity for admission includes the admission history and physical (H&P), but we have recently heard of a Medicare Administrative Contractor (MAC) denying payment because the H&P had not been signed prior to discharge, which can be an impossibility for a short inpatient stay with a dictated H&P that requires transcription.

Outlined below are our association’s recommendations regarding the various issues surrounding observation services. As health care professionals who are directly impacted by these issues, we ask that you please consider our feedback and concerns carefully as you evaluate current hospital issues in the Medicare program, specifically the ongoing problem of observation services.

Recommendations

- Amend Medicare law (Title XVIII of the Social Security Act) to allow for the time patients spend in the hospital under observation services to count toward the requisite

three-day hospital stay for coverage of skilled nursing care. This is the goal of H.R. 1179 and S.569 (Improving Access to Medicare Coverage Act of 2013).

- CMS should develop a “short stay DRG” to allow admission of any patient who requires hospital care beyond the emergency department (ED) and short observation stays, such as 12 hours (including time spent in the ED).
- Implement a change in regulations that would meet the statutory certification requirement by requiring the admitting physician to sign a simple, standardized certification statement such as, “I certify that this admission was medically necessary in compliance with current Medicare regulations.” There would be no reduction in the required documentation for medical necessity for admission, but documentation would no longer be tied to certification. Furthermore, nothing prevents such a statement from being signed any time prior to billing.

We appreciate your willingness to consider the concerns of health care delivery system case management professionals. ACMA and its members would be glad to further discuss these concerns and recommendations. We would appreciate the opportunity to work with members of the Committee to improve upon current systems and efforts to rectify issues in the Medicare program.

Should you have any questions, please feel free to contact me at 501-907-2262 or lgregc@acmaweb.org.

Cordially,

/s/

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References

1. American Case Management Association. "Observation Status and the 3-Day Stay Requirement." Survey. 19 April 2012.
2. "Observation Status: Lawsuit, Bagnall v. Sebelius (No. 3:11-cv-01703, D. Conn), filed on November 3, 2011." Center for Medicare Advocacy, Inc. 31 May 2012 <<http://www.medicareadvocacy.org/medicare-info/observation-status/>>.
3. Medicare Benefit Policy Manual, CMS Pub. 100-02, Chapter 6, §20.6; same language in Medicare Claims Processing Manual, CMS Pub. 100-04, Chapter 4, §290.1.
4. *Id.*
5. *Id.*