

Lee Sacks, M.D.  
Chief Medical Officer  
Advocate Health Care  
Chief Executive Officer  
Advocate Physician Partners

Written Testimony for the Record  
House Ways & Means Health Subcommittee  
Hearing on Current Hospital Issues in the  
Medicare Program

Submitted June 3, 2014

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On behalf of Advocate Health Care (Advocate), thank you for holding the May 20th hearing, titled “Current Hospital Issues in the Medicare Program.” We very much appreciate the Subcommittee’s leadership on – and attention to – some of the most pressing issues facing hospitals and health systems and the patients we serve. From our perspective, there are three issues in particular – the current inefficiencies and problems with the recovery audit contractor (RAC) program, the Centers for Medicare and Medicaid Services’ (CMS) two-midnight policy, and the current Medicare requirement that a beneficiary have a three-day stay in a hospital before qualifying for skilled nursing facility (SNF) care – which necessitate Congressional attention and prompt action. We thank you for addressing these issues during the May 20th hearing.

Advocate, named among the nation’s Top 5 largest health systems based on quality by Truven Analytics, is the largest health system in Illinois and one of the largest health care providers in the Midwest. Advocate operates more than 250 sites of care, including 12 hospitals that encompass 11 acute care hospitals, the state’s largest integrated children’s network, five Level I trauma centers (the state’s highest designation in trauma care), three Level II trauma centers, one of the area’s largest home health care companies and one of the region’s largest medical groups. We are proud to contribute to the development of Illinois’ and the nation’s health care workforce by training more primary care physicians and residents at our four teaching hospitals than any other health system in the state.

Advocate is leading the nation in health system delivery innovation and is eager to bring our experiences forward to the benefit of helping transform the federal government and the nation’s health care system. We have established the largest accountable care organization (ACO) in the country, which includes a commercial insurance contract, a Medicare Shared Savings Program (MSSP), and a Medicaid Accountable Care Entity. Using the Advocate Physician Partners’ Clinical Integration Program and care coordination efforts as a model, AdvocateCare, Advocate’s commercial ACO, has achieved savings of an estimated two percent below the Chicagoland market costs and has successfully performed in all quality measures.<sup>1</sup> We are proud to be a national leader in innovative payment and care delivery models, and we seek to enhance and expand such efforts to the benefit of more patients and communities.

Advocate embraces the values of compassion, equality, excellence, partnership, and stewardship. In service of its healing mission, Advocate supports – and seeks to advance – policies and programs that ensure access to quality health care for all in need without compromising health care providers’ ability to deliver such care. Advocate stands ready to work with policymakers at all levels to promote and preserve the health of the individuals, families, and communities of Illinois and to advance innovation in health care delivery to ensure quality and improve outcomes for all who are served by the nation’s health care system. In that spirit, we submit this written testimony for your consideration as you develop policy solutions to address the challenges discussed by you, your colleagues, and the witnesses during the hearing.

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<sup>1</sup> To learn more about AdvocateCare visit <http://amgdoctors.com/patients-and-families/advocatecare>.

**RAC Program**

Reducing payment inaccuracies and minimizing fraudulent activity maximize Medicare resources available for patient care. As such, Advocate supports and fully complies with the federal government's myriad efforts to reduce improper Medicare payments; however, we face numerous challenges with respect to the fashion in which the Medicare RAC program operates as it is tipped in favor of the RACs. Despite Advocate's record of payment accuracy, Advocate's hospitals experienced a 58 percent increase in RAC record requests between calendar years 2011 and 2012. We are concerned with this significant increase in the number of Medicare RAC audit requests as we feel strongly that the time and resources being expended to process and respond to Medicare RAC audit requests can be better spent on improving the quality of care and outcomes for the patients we serve.

Since 2010, due to the sheer volume of requests, Advocate has hired seven full time employees solely to receive, log, and initially process Medicare RAC requests. This staff is in addition to the approximately 20 personnel who are responsible for substantively responding to Medicare RAC audits and appeals. Throughout the Advocate system, there are approximately 30 full time employees who are working each day to address some aspect of the Medicare RAC audit process. In total, since January 2010, Advocate has received 19,334 record requests worth \$149,752,591 in Medicare claims, resulting in \$19,321,090 returned to the federal government, of which \$2,415,136 or 12.5% was paid to the RAC Auditor and \$16,905,953 was paid to the U.S. Treasury/Medicare program.

**Advocate estimated RAC compliance expenses 2010-January 2014:**

<b>Expense</b>	<b>Cost</b>
Staff	\$ 8,400,000
Executive Health Resources, Inc.	\$ 14,400,000
Milliman	\$1,000,000
Audit-tracking database	\$ 500,000
<b>Total Expenses</b>	<b>\$24,300,000</b>

According to the American Hospital Association (AHA), 40% of claims are denied by RACs nationally; of those denied claims, 44% are appealed and 72% of appealed Medicare Part A denials are fully overturned at the third level of appeal. The following summarizes Advocate's experience to-date:

*Advocate Health Care  
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<b>Year</b>	<b>Appeal Rate</b>	<b>Overturn Rate</b>
2010	23%	68%
2011	48%	60%
2012	57%	65%
2013	40%	72%
<b>Average</b>	<b>42%</b>	<b>66%</b>

Advocate has serious concerns with respect to the length of time between the initial RAC audit records request and the final adjudication. The RAC audit period can be up to three years and the RAC appeals process can take up to two years – stretching the timeframe from when a claim is first filed for services to concluding adjudication to as long as five years. AHA reports that 75% of RAC appeals are caught in the Medicare appeals process. This protracted timeline often precludes hospitals from securing full payment for needed patient care. Since many denials are for inpatient care (Part A) that was medically necessary, but RACs contend the care could have been provided in the hospital outpatient (Part B) setting, these claims often fall outside the 1-year filing window under which a provider can seek Medicare reimbursement. Medicare rules prohibit hospitals from rebilling services under Part B if they are older than one year.

- CMS found that 75% of RAC-denied claims fall outside the filing window and cannot be rebilled, despite the agency’s requirement to pay for all reasonable and necessary care.
- As the Medicare program moves from a “pay and chase” system to a pre-payment model, providers will incur a significant financial burden as RACs will be able to hold monies until the issue reaches its final adjudication.

Currently most of the Medicare RAC audit requests are sent via paper through the U.S. mail system. Providers are given a limited number of days in which to respond to RAC audit requests; as such, use of this slow mode of communication significantly limits our response timeframe. Moreover, as the U.S. mail system can be somewhat unreliable, it is not uncommon for requests to fail to reach providers. Advocate urges Congress to require that all Medicare RAC audit requests be conducted via electronic means. Such efforts will allow providers the maximum amount of time in which to respond to requests and will help to improve the efficiency of the overall process.

Medicare RACs are slow to respond to providers’ appeals requests. In Advocate’s experience, our average response to an appeal request is between 18 and 24 months after the appeal is filed. Advocate urges Congress to significantly reduce the timeframe by which RACs must respond to appeals and to limit the number of records requests.

The *Medicare Audit Improvement Act of 2013* (HR 1250) would establish a limit for record requests, impose financial penalties on RACs that fail to comply with program requirements, make RAC performance evaluations publicly available, and allow denied inpatient claims to be billed as outpatient where appropriate. We believe this legislation will provide greater accountability and transparency to RAC operations, improve program functioning for all parties, and more appropriately identify the payments and providers that need adjudication. We respectfully encourage you to move this important legislation, as a standalone measure or as part of a larger package; this important bill will help level the playing field between RACs and health care providers.

### **Two-Midnight Policy**

Since it was first announced in the fiscal year 2014 proposed Inpatient Prospective Payment System rule, the two-midnight policy has posed serious concerns to our physicians. While we appreciate CMS' efforts to provide additional clarity regarding the rule, Advocate is troubled by CMS' presumption that stays spanning less than two midnights generally should be classified as outpatient. Our physicians tell us that, in many instances, it is not always known – or expected – at the point of admission whether a beneficiary will require a stay spanning two midnights or more. Moreover, this policy can be confusing to Medicare beneficiaries who may not view an overnight stay in the hospital as anything other than an inpatient stay, and reclassification of a stay as outpatient impacts beneficiary out-of-pocket costs and eligibility for Medicare-covered skilled nursing care.

We are pleased Congress recently enacted, as part of the most recent Sustainable Growth Rate (SGR) “patch” legislation, a partial-enforcement delay of the two-midnight rule during which RACs are prohibited from conducting post-payment patient status reviews for inpatient stays with dates of admission from October 1, 2013, through March 31, 2015, unless there is “evidence of systematic gaming, fraud, abuse, or delays in the provision of care by a service provider.” However, the legislation continues to authorize through June 2015 other medical review activities related to the two-midnight policy. As such, we are very concerned that these recent actions do not go far enough to correct this flawed policy and therefore, continue to urge enactment of HR 3698, the *Two-Midnight Rule Delay Act of 2013*, introduced by Representative Jim Gerlach (R-PA). This important measure bans enforcement of the rule, prohibits an increase in the sample of claims selected for prepayment review under the Medicare Probe and Educate program, and directs the Secretary of Health and Human Services to develop a much-needed, new payment methodology appropriate for short inpatient stays. Taken together, the provisions of HR 3698 should help ensure that patients receive the right care in the right setting at the right time and give providers the clarity they need to comply with all payment and administrative requirements of the Medicare program with respect to short inpatient stays. We hope you will move this proposal through the subcommittee and advance its enactment this year.

### **Three-Day Stay**

Under current policy, Medicare fee-for-service beneficiaries must have at least a three-day inpatient hospital stay before they qualify for Medicare-covered care in a SNF. While we appreciate the intent behind the policy is to help ensure that those beneficiaries who are referred to a SNF truly need that level and type of care, we believe the policy unintentionally precludes certain beneficiaries from receiving the SNF care their health care providers believe they require. We have heard from our physicians and nurses across our system that the Medicare three-day policy stands in the way of patients receiving the type of care they need at the time they need it because for some cohorts of Medicare beneficiaries it forces the institution to admit a beneficiary for expensive inpatient care, when SNF care may be more medically appropriate for the individual patient. Clinicians have explained to us that the policy is not grounded in evidence-based medicine or clinical guidelines for the particular condition the patient has, and does not allow for a physician's clinical judgment to be applied to each individual patient's particular circumstance. Rather, the policy is a "one-size-fits-all" approach, which does not allow patients who do not need a three-day hospital stay but do need SNF care to access SNF care in a timely or direct fashion – increasing costs to Medicare and the beneficiary.

Nationally, approximately one quarter of Medicare beneficiaries are admitted to SNFs from hospitals and readmitted to the hospital within 30 days.<sup>2</sup> In a six month period November 1, 2012, to April 20, 2013, Advocate hospitals treated 2,756 beneficiaries who were admitted from and returned to a SNF. While not all of these patients are readmitted as an inpatient to the hospital in order to qualify for Medicare coverage, anecdotal evidence suggests a significant number of patients use this mechanism in order to subsequently obtain SNF coverage. Such care transitions – which are potentially disruptive to the patient and can negatively impact their quality of care – result in an unnecessary increase in health care costs.

In addition, Advocate hospitals have seen an increase in the number of Medicare beneficiaries who are treated in their emergency departments for care that could be better provided in a SNF but for the imposition of the three-day rule. As a result, Medicare pays for high-cost health care delivered in the emergency department, when lower-cost, more appropriate care at a SNF may be more aligned with the beneficiary's particular health care needs.

Further complicating the situation is that for a different cohort of beneficiaries, the use of observation services is increasing. According to Medicare, "observation services are hospital outpatient services given to help the doctor decide if the patient needs to be admitted as an inpatient or can be discharged. Observation services may be given in the Emergency Department (ED) or another area of the hospital."<sup>3</sup> Patients under observation may indeed spend one or more nights in the hospital; however, since observation status is considered "outpatient

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<sup>2</sup> Mor V., Intrator O., Feng Z., & Grabowski D.C., The Revolving Door of Rehospitalization from Skilled Nursing Facilities, Health Affairs, 2010 Jan. 29(1); 57-64.

<sup>3</sup> "Are You a Hospital Inpatient or Outpatient? If You Have Medicare – Ask!" Published by the Centers for Medicare and Medicaid Services, available at <http://www.medicare.gov/pubs/pdf/11435.pdf>.

*Advocate Health Care  
Written Testimony for the Record  
Ways & Means Health Subcommittee  
Hearing on Current Hospital Issues in the Medicare Program  
Submitted June 3, 2014*

care” it does not “count” toward meeting the current requirements of the three-day rule.<sup>4</sup> As such, a number of beneficiaries who spend three days under observation status at the hospital who indeed may need SNF care, do not qualify for it to be covered by the Medicare program.

The three-day rule only applies to beneficiaries who are enrolled in the traditional Medicare fee-for-service program. Medicare Advantage plans may provide SNF coverage without the prerequisite three-day rule inpatient stay, but are not required to do so. Medicare Advantage’s direct access to SNF care suggests that waiving the three-day rule may help reduce overall costs for many beneficiaries and the Medicare program, given that Medicare pays more for inpatient care than it does for care provided at a SNF. Advocate’s Medicare Advantage plan – which, consistent with many other Medicare Advantage plans, does not impose the three-day rule requirement – maintains an average length of stay (ALOS) of 3.5 days in the hospital for its beneficiaries, in comparison with Medicare fee-for-service ALOS which is 4.53 days. National guidelines by Milliman note the ALOS in the hospital for Medicare age patients in moderately managed programs should be 4.90 days. Our ability to maintain the lower ALOS for Medicare Advantage patients suggest waiving the three-day rule may help reduce overall costs for many beneficiaries and the Medicare program. Most importantly, a lower ALOS reduces the likelihood of complications such as nosocomial infection and adverse safety events, which can significantly drive up costs and negatively impact patient outcomes.

In 2012, approximately 10 percent of the Advocate Medicare Advantage SNF admissions were direct admits with no inpatient stay. Because Advocate’s Medicare Advantage plan is not bound by the three-day rule requirement, enrollees are able to more readily access site-appropriate care, which saves valuable health care resources, and can ensure the enrollee avoids unnecessary exposure to the acute care environment. In 2012, of the Advocate Medicare Advantage enrollees who were admitted from an Advocate hospital to a SNF:

- 36% of patients were admitted to a SNF in less than three days of inpatient care; (20% admitted to a SNF after 2 days, 16.4% after one day inpatient hospital).
- The remaining 64% of enrollees had a length of stay of 3 or more acute hospital days prior to moving to a SNF.

As you heard from CMS Deputy Administrator Sean Cavanaugh, a significant number of hospitals and health systems – such as Advocate – are helping to transform the delivery of health care and have illustrated this commitment to improving care while bending the cost curve by becoming partners with Medicare through numerous initiatives, including the ACO Pioneer program, the Advance Payment ACO initiative, the MSSP, and other alternative payment models. During the hearing, Deputy Administrator Cavanaugh twice mentioned that CMS has granted the Pioneer ACOs and a group of hospitals and post-acute providers testing bundled

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<sup>4</sup> According to the Medicare Payment Advisory Commission (MedPAC), nationally, the use of Medicare observation care has increased significantly to more than 31 million hours in 2008, up from 23 million hours in 2006 (an increase of 33 percent). MedPAC, *Recent Growth in Hospital Observation Care*, MedPAC presentation, Sept. 13, 2010, at page 6, available at <http://www.medpac.gov/transcripts/observation%20sept%202010.pdf>.

*Advocate Health Care  
Written Testimony for the Record  
Ways & Means Health Subcommittee  
Hearing on Current Hospital Issues in the Medicare Program  
Submitted June 3, 2014*

payment models a waiver from the Medicare three-day rule to test the impact of allowing beneficiaries “direct access” to SNFs.

We believe eliminating the three-day rule for institutions participating in the MSSP should improve the quality of care for Medicare beneficiaries and help to ensure they receive the right care, in the right setting, at the right time. Advocate’s experience with Medicare Advantage’s direct access to SNF care suggests that waiving the three-day rule for institutions like ours may help reduce overall costs for many beneficiaries and the Medicare program, given that Medicare pays more for inpatient care than it does for care provided at a SNF. Advocate respectfully urges the Subcommittee to encourage CMS to expand the scope of its three-day rule waivers to include MSSP participants, such as Advocate.

**Conclusion**

Again, thank you for holding this important hearing and for your attention to these critical policy issues. Advocate stands ready to work with all members of the Ways and Means Health Subcommittee, and your other colleagues, to advance policies, programs, and practices that will help improve quality of care and outcomes, reduce spending, minimize improper payments, and otherwise help ensure that Medicare beneficiaries receive the right care, at the right time, in the specific care setting appropriate for their medical needs and health status. Specifically, we hope you and your colleagues will take action to reform the RAC program, ban implementation of the two-midnight rule, and eliminate the three-day rule for a broader group of hospitals and health systems who have demonstrated – to the federal government and the nation – a commitment to delivery system reform and the testing of alternative payment models. If we can be of any assistance, please do not hesitate to call upon us – we are eager to be a resource to you as you tackle these pressing Medicare payment and policy issues.