

GUNDERSEN HEALTH SYSTEM®

June 3, 2014

The Honorable Kevin Brady
Chair, House Ways and Means Subcommittee on Health
United States House of Representatives
1100 Longworth House Office Building
Washington, DC 20515-4903

Re: Hearing on Current Hospital Issues in the Medicare Program

Dear Chairman Brady and members of the House Ways and Means Subcommittee on Health:

On behalf of Gundersen Health System, we appreciate this opportunity to provide comments on current issues facing hospitals in the Medicare program. Specifically, our comments will focus on the time-based presumption policy, the Medicare Recovery Audit Contractor (RAC) program. We would also like to offer comments regarding proposed policies released on December 6, 2013 relating to Medicare Part D and Hospice covered medications. We are concerned about changes affecting our terminally ill patients and the scenarios we will need to present to them and their families that should not be a factor in their decisions on whether to utilize hospice services.

Gundersen Health System provides integrated care for patients along the rural Mississippi River stretches in western Wisconsin, northeast Iowa, and southeast Minnesota. As the largest employer in the La Crosse, Wisconsin region, Gundersen provides clinical services, level II trauma care, medical education along with ground ambulance services, med link air transport, and a five-star rated Medicare Advantage insurance plan for the past three years. We are also the largest regional employer with over 6,000 employees. Moreover, Gundersen has consistently achieved top national rankings in many areas of clinical excellence including named as a Healthgrades Top 100 hospital in overall care and many specialty areas.

Our approach to care is value-based. Gundersen Health System strongly supports public policies that moves away from volume-based care to one that rewards value-based care—high quality at low cost. In supporting this approach, a Medicare Payment and Advisory Commission (MedPAC) study found the La Crosse, Wisconsin region to have the *lowest utilization* of Medicare services per beneficiary *in the nation*. This demonstrates our efficiency in caring for our Medicare patients, coupled with our quality outcomes, makes us a provider of high value care.

Time-based presumption policy

Although the Centers for Medicare and Medicaid Services (CMS) issued and finalized a “time-based presumption” policy aimed at clarifying the necessity of inpatient stays for Medicare Part A reimbursement, they have yet to enforce this measure. This has resulted in hospitals, including Gundersen Health System, to be unclear in the extent to which this policy is law, or just not being

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enforced. Nonetheless, this policy does not reflect current hospital care standards and places hospitals in a precarious position as we are committed to our due diligence in compliance, even with an unenforced mandate. We urge lawmakers to instead provide more accountability in the Recovery Audit Contractor (RAC) program and discontinue the two-midnight policy while improved standards of care for inpatient stays are developed by clinical experts.

Although CMS has instructed RAC auditors to not enforce this policy, the provisions allow review contractors to presume an inpatient hospital admission is deemed reasonable and medically necessary if a beneficiary requires more than one Medicare utilization day, defined as an encounter crossing two midnights, regardless of time initially admitted. This presumption standard is arbitrary, and unreflective of how hospitals and medical providers care for patients. We urge lawmakers to ask CMS to abandon this policy and to solicit comments from hospitals on new standards rather than simply crossing two midnights for an inpatient stay.

Additionally, Gundersen Health System opposes this time parameter and instead supports the recommendations made by the American Hospital Association by instituting three changes to the RAC program:

1. Limit RAC review to only the information in the medical record that was known to the physician at the time of the decision to admit.
2. Instruct RACs to focus audits on other factors the agency has noted are relevant to the admission decision, instead of only factors like the patient's length of stay.
3. Provide accountability metrics for "incorrectly denying an inpatient stay – not just to recoup their contingency fee – to provide some check on the strong financial incentive RACs have to conclude that beneficiaries should not have been admitted."

RAC program

Payment integrity and auditing are very important in maintaining the viability of taxpayer funded programs. We recognize this, and for more than a decade Gundersen Health System has maintained a voluntary and robust compliance program modeled after the Office of Inspector General's Compliance Program guidance and the Federal Sentencing Guidelines. However, in recent years, we have experienced a significant increase in medical record requests from Medicare Recovery Audit Contractors (RAC). Medical claim requests by government auditors in general have increased over 200% from 2010 through the end of 2012. If payment for service is denied, Gundersen participates in the appeals process that can take months, even years to complete, and consumes numerous resources. In fact, we currently have nearly 90 appeals pending review from Qualified Independent Contractors (QIC).

As a solution to reducing costs of care while maintaining integrity in the program, we recommend lawmakers enact House Resolution 1250—the Medicare Audit Improvement Act. Currently, there lacks sufficient performance-based metrics for auditors; for example, there are no limits on the number of audit requests that can be made to hospitals. H.R. 1250 would establish performance-based measures to increase integrity and transparency. Specifically, the bill would limit the number of medical record requests, instill transparency in the audit process, and improve auditor performance. Although payment integrity measures are important for us as providers, under the new provisions, improvements would be made to the Medicare auditor activities.

Gundersen Health System continues to greatly appreciate the support of the Ways and Means Subcommittee on Health for value-based healthcare reform policies. We were very pleased over the past several months to advance meaningful value-based policy via repeal and replace of the Medicare

Sustainable Growth Rate. Just as measurements of cost and quality on providers in a value driven system, performance-based measures should also apply to the auditing process. Enactment of H.R. 1250 will increase efficiency, implement performance-based measures, and increase transparency in the Medicare auditing process.

Medicare Hospice and Part D Benefit

CMS states overlapping situations involving Medicare Part D and the hospice benefit in administering the services for palliation and management of terminal prognosis should be “very minimal.” In other words, medications provided under Medicare Part D would be presumably covered under hospice, and rarely involve prescription drugs for conditions not related to the hospice diagnosis. This assumption is not rare, and has negatively impacted terminally ill patients at our organization.

In prior comments on the proposed rule, we believed this policy would be shortsighted because there are often conditions unrelated to the hospice diagnosis, especially when the hospice diagnosis is cancer-related. Patients may often have underlying lung disease, diabetes, heart disease, kidney disease that is unrelated to kidney cancer, brain tumors, ovarian cancer, or even to other conditions such as Amyotrophic Lateral Sclerosis and Parkinson's disease. At times, patients may feel well with only 1-3 months to live and are enrolling in hospice, and may be reluctant to discontinue existing treatment for other underlying medical conditions they have become accustomed to as prescribed by their provider. Halting this treatment may cause significant symptoms and decline in function that would not be related to their primary hospice diagnosis. With reluctance to immediately stop existing medications, and understanding the gradual process to wean off medications, this policy would present challenges for our patients and providers. Also, we had stated the proposed policy changes may inadvertently limit the number of people who utilize hospice services, instead electing to continue under Medicare and Part D without the appropriate end-of-life services, compounding to increased costs with unnecessary hospitalizations.

As warned in comments to CMS, two negative outcomes occurred related to recent changes to the management of prescription coverage made by CMS for patients with Medicare Part D coverage who also enroll in the Medicare Hospice Benefit. In one example, a patient's Part D plan sponsor revoked continued coverage of viral medications for a patient entering hospice due to an end-stage respiratory disease because the virus was not the basis for the hospice admission. The appeals process ultimately distressed the patient, who died before Gundersen could advocate on their behalf during adjudication. In a second example, a patient revoked their hospice benefit when the patient learned their Part D plan sponsor might revoke continued coverage for prescriptions for a metabolic disease because it was not the basis for the patient's hospice stay, even though CMS has clearly stated that Part D plan sponsors must abide by the clinical determination made by the hospice physician or primary care physician as to whether a drug is unrelated to the terminal condition but still medically necessary.

Gundersen fully complies with the Conditions of Participation for hospice programs and we supply all medications for out hospice patients that are related to their terminal conditions. Halting of complicating treatments for non-hospice health conditions due to confusion over coverage determinations by Part D Plan Sponsors can cause distress, recurrence of disease symptoms and decline function. Gundersen believes the above examples illustrate the need for greater continuity in prescription coverage for drugs unrelated to the terminal condition. This will ensure patients have coverage for prescriptions they need to manage all of their health conditions, regardless of whether each health condition is the basis for the hospice stay. At Gundersen Health System, we are strong

supporters of payment integrity and support CMS's efforts to work with Part D plans to provide controls against duplication of payment for drugs related to terminal conditions.

Conclusion

On behalf of Gundersen Health System, we appreciate this opportunity to provide comments on important issues facing hospitals in the Medicare program. We believe the issues we illustrated, along with proposed solutions noted, will the patients we serve and continue to provide high quality care for the communities we serve.

Sincerely,



Michael D. Richards
Executive Director of External Affairs
Gundersen Health System