



Statement For The Record

By Stephen Brenton, President, Wisconsin Hospital Association

Submitted to the U.S. House Ways & Means Committee Subcommittee on Health

Hearing on Current Hospital Issues in the Medicare Program

To Accompany the Hearing Record for Tuesday May 20, 2014

Thank you Chair Brady, Ranking Member McDermott and Wisconsin Committee Members Ryan and Kind for the opportunity to provide this statement for the record for the subcommittee's May 20, 2014 hearing on issues facing hospitals and health systems with respect to the Medicare program.

The Wisconsin Hospital Association is proud to represent Wisconsin hospitals and integrated health care systems which are constantly driven towards delivering better results for patients and improved health care value for all consumers and payers in Wisconsin, including the Medicare program. Our national leadership on delivering value has been validated by entities like the Dartmouth Atlas, The Commonwealth Fund and the Agency for Healthcare Research & Quality among others. At the same time, our hospitals and health systems, as are those in all other states, are in the midst of massive health care changes, including moving forward with electronic medical records, implementing major care delivery reforms, testing new payment models, adjusting to substantial upheaval in the health care insurance market, managing significant regulatory policy shifts while all the while absorbing billions of dollars in reduced federal payments for hospital care provided to Medicaid and Medicare patients.

We believe our hospitals have been excellent partners with the Medicare program in their collective efforts to deliver high quality, cost efficient care to Medicare beneficiaries throughout urban, suburban and rural Wisconsin. Yet, our providers are forced to divert scarce health care dollars and resources to comply with a redundant, ill-targeted and burdensome Recovery Audit Contractor (RAC) program. That is why we encourage Congress to better focus the RAC program by passing legislation to address RAC program processes and unintended consequences.

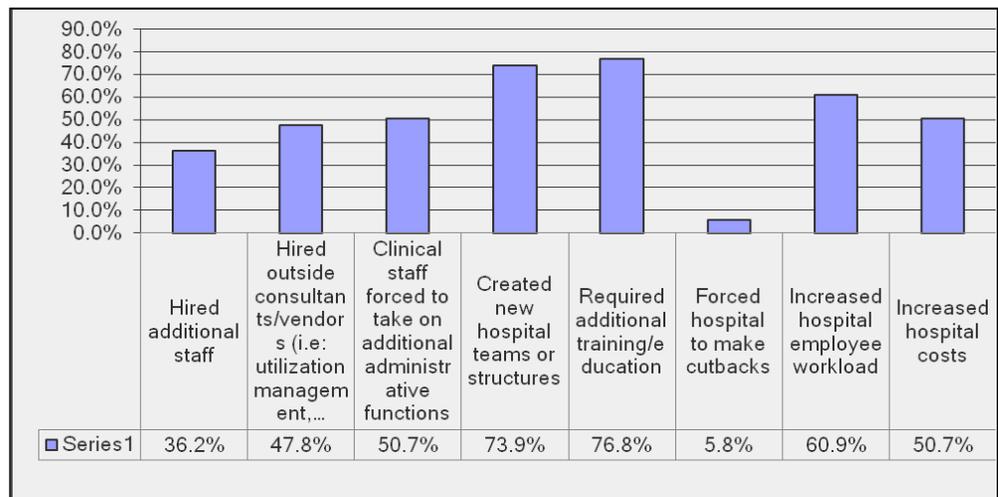
Recovery Audit Contractors, Wisconsin Experience

Hospitals are one of the most highly regulated industries and are also covered by numerous government programs charged with ensuring Medicare and Medicaid payment accuracy. The current audit landscape for hospitals includes any number of these oversight programs and contractors such as the: Comprehensive Error Rate Testing (CERT) program, Office of Inspector General (OIG), Medicaid Integrity Contractors (MIC), Medicaid Integrity Program (MIP), Payment Error Rate Measurement Program (PERM), Medicare Administrative Contractor (MAC), Zone Program Integrity Contractors (ZPIC), and the Recovery Audit Contractors (RAC) to name a few. **While WHA and our providers support fighting “waste, fraud and abuse” in government health care programs, we believe it is important to understand that there is a cost borne by the health care delivery system when those programs are overly complex, poorly structured or redundant.**

To gauge Wisconsin hospital experiences with the impact of the RAC program on hospital operations and resources, we recently surveyed our hospitals. Seventy-four hospitals responded (57%), representing all size hospital and all geographic locations throughout Wisconsin. The following three survey responses provide a striking look at the RAC program’s impact to date in our state:

- ***Wisconsin hospitals indicate the RAC finds nothing wrong with the overwhelming majority of records it requests.***

- ***All responding hospitals indicate the RAC program has diverted valuable resources (see graph)***



The above represents the percent of responding hospitals that selected a particular option. All hospitals selected at least one burden.

- ***Of the claims that were denied by the RAC, virtually all Wisconsin hospitals indicate appealing some of those denials while the vast majority of hospitals (84%) appeal at least 50% of all denied claims.***

With respect to this last bullet point, it demonstrates that hospitals believe the RACs are inappropriately denying a significant number of claims, forcing hospitals to appeal. One deleterious downstream impact of the volume of denied claims nationally is a massive backlog in the Medicare appeals process. In fact, the backlog is so bad at the Administrative Law Judge level that the Office of Medicare Hearings and Appeals recently announced a minimum *two year delay* for claims to be heard. This is unacceptable for the Medicare program, for hospitals and other providers, and for beneficiaries who have legitimate claims to be resolved.

Bipartisan Legislative Solutions

We believe our hospitals’ experiences are mirrored across the nation and demonstrate the need for reform. **That is why WHA supports, as do 213 bipartisan Members in the House of Representatives, the Medicare Audit Improvement Act, H.R. 1250. This legislation will establish a more structured and defined framework around Medicare audit-related programs, including important provisions to address ongoing problems. Among the provisions, H.R. 1250 would:**

- Establish a consolidated limit for medical record requests from various contractors;

- Improve auditor performance and transparency;
- Target medical necessity audits on widespread payment errors; and,
- Allow accurate payment for rebilled claims.

In addition to H.R. 1250, WHA supports additional legislation to address other unintended consequences of the RACs, one of which revolves around the issue of observation versus inpatient stays. This issue is the direct result of the RACs' particular focus on denying Medicare payment for shorter inpatient stays because the RAC deems, up to three years post-fact, that care should have been provided in the outpatient setting instead (regardless of the fact care was medically necessary).

Unfortunately, the fix put forth by the Centers for Medicare & Medicaid Services (CMS) in its FY 2014 Inpatient Prospective Payment System Rule, over objections from the hospital field, has caused even more confusion. While we appreciate CMS' attempt to address this RAC-caused problem, WHA does not believe the CMS "two midnight" policy is a workable solution. **Concerns continue to be expressed that the policy is flawed, overly complex and works to undermine the medical judgment of the treating physician by establishing an arbitrary time-based policy for inpatient admissions. WHA appreciates the delay in enforcement of this policy, including an additional six month delay recently passed by Congress earlier this year. However, we believe more needs to be done and would ask Congress to support H.R. 3698 which pulls the policy back altogether in order to replace it with a better vetted approach.**

Finally, in the sub-regulatory guidance stemming from this two midnights policy, CMS stated that, as a *condition of payment*, physicians at critical access hospitals (CAHs) must certify that a beneficiary may reasonably be expected to be discharged or transferred within 96 hours after admission to the CAH. If a physician cannot certify the reasonable expectation that a Medicare beneficiary will be discharged or transferred within 96 hours (barring unforeseen circumstances), then Medicare Part A payment is inappropriate. CMS appears to have brought to light a long-standing drafting error stemming back to the 1999 Balanced Budget Refinement Act (BBRA). It was in the BBRA that important improvements to the CAH program were made, including

establishing the 96 hour *annual average for the conditions of participation* in the Medicare program. It seems the BBRA did not appropriately cross-reference the corollary payment statute, leaving these two conflicting 96 hour statutes.

No one knows why CMS elected to bring this particular provision into the two midnight guidance or why it elected to do so at this point in time, well over a decade after the BBRA's original enactment. **What we do know is that failing to correct this drafting error jeopardizes beneficiary choice and access to care in rural communities across the country. That is why WHA asks Congress to quickly pass bipartisan legislation known as the Critical Access Hospital Relief Act, H.R. 3991. Passing H.R. 3991 will help ensure CAHs can provide care to Medicare beneficiaries close to home.**

In closing, WHA and our hospitals and integrated health care systems support fighting “waste, fraud and abuse” in government health care programs, but those programs must be more effectively deployed and take into account the downstream impacts they have which are ultimately borne by the health care delivery system, payers and patients. **Congress can do much to ensure a more effective approach by passing the following three bipartisan bills:**

- **Medicare Audit Improvement Act, HR 1250, to provide program improvements with Medicare audit-related activities;**
- **Two Midnight Rule Delay Act, HR 3698, to roll back and replace Medicare's two midnight policy with an effective, workable solution; and, the**
- **Critical Access Hospital Relief Act, HR 3991, to ensure Medicare beneficiary choice and local access to care in rural communities.**

Thank you again for this opportunity to submit comments for the record.