Hearing on Current Hospital Issues in the Medicare Program

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Ann Sheehy MD
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Hearing on Current Hospital Issues in the Medicare Program

U.S. House of Representatives,
Committee on Ways and Means,
Washington, D.C.

The subcommittee met, pursuant to call, at 9:39 a.m., in Room 1100, Longworth House Office Building, Hon. Kevin Brady [chairman of the subcommittee] presiding. Advisory

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Chairman Brady. Good morning. The subcommittee will come to order. Thank you all for joining us this morning.

In every dollar hospitals spend on inaccurate Medicare audits and appeals, are dollars lost that should have been used to care for seniors. We are here to discuss the problems facing the hospitals today but also to find solutions to bring sense to our Medicare program and improved care for America's seniors. Today's hearing will examine hospital issues including those related to CMS's Two Midnight Policy, as well as audits and appeals. This is a bipartisan concern shared by many different stakeholders, the Medicare program itself, and lawmakers on this committee.

In order to understand why CMS chose to pursue a Two Midnight Policy, we have to first explore the events leading up to the policy. After we review those events in today's hearing, Congress will be able to make an informed judgment about the merits of the policy and potentially pursue alternative solutions.

Our first panel will educate us on the different aspects of inpatient and outpatient payments and services for hospitals. If we want behavior to change and improve outcomes, we need to change the incentives.

Our second panel will feature national experts commenting on how Federal laws affect everyday medical practice. We will be hearing perspectives from across the spectrum of providers, auditors, researchers, and beneficiary advocates. As I have talked to stakeholders about current issues in the Medicare program, the Two Midnight Policy comes up over and over again.

In listening to a variety of different perspectives, I have come to understand the following. There are misaligned incentives in CMS's inpatient and outpatient payment systems, but hospitals are not doing anything wrong. They are simply responding to the incentives. No matter if the service is inpatient or outpatient, hospital still uses the same equipment and the same medical staff to deliver care. Yet there are two vastly different payment systems, and the systems don't relate to each other in any way. They are based on different coding rubrics, and they pay for different things. And often all this is decided after doctors have provided care.

Take for example, reimbursement for medical education. If the service is billed inpatient, the hospital qualifies for an extra medical education payment. However if the same service is billed to outpatient, the hospital doesn't receive any medical education money. So if you are a large teaching hospital and you could

bill under either payment system, why would you ever submit the bill for anything other than inpatient reimbursement. It is all about the underlying incentives.

Now let's examine the next piece of the puzzle, audits. I have heard from hospitals that audits are causing undue burdens. I have here from recovery audit contractors, or RACs as they are known, that they are simply responding to what CMS has defined as improper payments. Their emphasis on short hospital stays is due to, well, you guessed it, the underlying incentives. RACs are able to keep a percentage of any improper overpayments they recoup. Prior to the Two Midnight standard, there were no definitive rules governing which payment system was correct for short stays. I think we can all agree that RACs are an important program integrity tool. They are focusing on a legitimate discrepancy of Medicare payment. They, too, are responding to the incentives.

Although an important tool, auditing also causes unintended behavior changes. We will hear from several of our witnesses today that around the same time the RAC short- stay audits were in full swing, there was also an unprecedented spike in outpatient observation services. Observation is meant to be a temporary tool allowing clinicians to closely monitor patients without using full-blown inpatient hospital resources. However, observation services are now being used as a tool to avoid certain adverse effects, including RAC audits, in some cases avoiding readmission penalties.

The saga continues when we turn to the appeals process. Hospitals disagree with RAC audit denials for short stays. As a result, they appeal the decision. Hospitals have found a high level of success at overturning RAC denials at the Administrative Law Judge, or ALJ level. Same thing, responding to incentives, ALJ equals more likely to have an appeal overturned, so appeal every time. So much activity at the ALJ level has led to an extensive backlog of appeals.

Earlier this year the Obama administration suspended the assignment of new appeals at the ALJ level. Again we see unintended consequences, denying providers their basic due process rights occurring as a result of poor incentives. We intended to have a witness from the Department of Health and Human Services here today to testify on behalf of the Medicare appeals process. Unfortunate Chief L.J. Nancy Griswold was unable to join us, but HHS is committed to briefing the Ways and Means member bipartisan manner on this important topic.

At the conclusion of today's story, lies the heart of the issue, the Two Midnight Policy. In response to the inpatient-outpatient payment predicament, RAC audits, increase in observation stays, and backlog of appeals, CMS took its best shot at a solution, Two Midnight. Today we will hear from all of our witnesses on whether the Two Midnight solution is solving all or any of various problems identified in this tale.

I commend my colleagues on this committee, members on both sides of the aisle who have introduced bills to pursue different alternatives to the Two Midnight Policy. My colleague, Mr. Gerlach, along with original co-sponsors, Mr. Crowley, Mr. Reed, Mr. Roskam, Mr. Kind, have offered a sound proposal for our committee to work from.

Before I recognize Ranking Member Dr. McDermott for the purposes of an opening statement, I ask as always unanimous consent that all members' written statements be included in the record. Without objection, so ordered.

Chairman Brady. I now recognize ranking member Dr. McDermott for his opening statement.

Mr. McDermott. Thank you, Mr. Chairman.

This hearing today is really about serving the greater good. When this rule was proposed, the Two Midnight Rule, I submitted on the 22nd of July last year my comments about it, and much of what I thought was going to happen is now here, and we are going to hear about it today; and I am pleased that you are having this hearing.

I would like to enter into the record that letter so that it gets in the record.

Chairman Brady. Without objection.

Mr. McDermott. In recent years hospitals have been asked to do more with less. We have slowed the rate of growth of their payments and asked them to work harder to improve quality and decrease unnecessary readmissions. Furthermore although Congress just delayed yet again the transition to the ICD-10 classification system, hospitals have had to take steps to move to the new system while continuing to implement the meaningful use requirements and participate in delivery system reform efforts.

Many of these activities support the noble goal of improving care for patients that they serve, such as the accountable care organizations and the patient-centered medical home, while reducing long-term costs, but they require up-front capital investments. Hospitals are employing people and providing good and stable benefits for their employees, something other sectors should emulate. Hospitals are doing all of this in the face of a number of regulations and justifiable scrutiny.

The Administration recognizes the sacrifice this sector has put forward. As an example, the Administration has made efforts to reduce the unnecessary regulatory burden. Just this month the Administration released part 2 of the final rule to reduce unnecessary, obsolete, or excessively burdensome regulation on health care providers and suppliers.

I commend CMS for walking a fine line between regulating provider conduct and attempting to make these things easier from a burden standpoint. This is the agency's second foray into the ensuring that regulations make sense and they serve a purpose.

Unlike some of my Republican counterparts, I believe some level of regulation is necessary to ensure that we protect Medicare's finite resources for future generations. I think everyone in this room would agree that protecting Medicare as a bedrock institution of American life, thereby serving the greater good, does require some sacrifice. This necessary sacrifice must be shared and proportional. To that end I am among the first to call for reforms to the Medicare recovery audit contractor audit program, and I mentioned the letter that I put in.

As a result I suggest CMS reconsider the policy in this regard. Now, of course, several stakeholders have raised concerns that the recovery auditor contractors will be overzealous in pursuing recoveries related to this policy. People knew it when it was put in. It is not that I believe that the RAC should disappear. They perform a critical role in protecting taxpayer dollars, but I do believe that the program needs reform from a fairness and equity standpoint, and I am pleased CMS has taken some affirmative steps in this regard.

I have also been among the loudest voices calling for reform of some of the fraud and abuse laws to allow broad participation among providers and suppliers to participate in innovative partnerships that promote care coordination such as gain sharing and other shared saving programs while ensuring programmatic protections under the fraud and abuse laws remain in place.

I have also introduced H.R. 4658, which would make a modification to the civil monetary penalty law to allow providers to more easily participate in care coordination programs. I have also introduced H.R. 3144, the Fairness For Beneficiaries Act, which recognizes that the three-day stay often has negative ramifications for the Medicare beneficiaries and would eliminate that requirement.

Finally, as the author of the self-referral disclosure protocol provision included in the Affordable Care Act, I have been deeply involved with urging CMS to make certain changes to ensure overpayment disclosures made pursuant to the protocol can be settled in a timely and efficient manner.

All in all, hospitals are making shared sacrifices. They are going through a period of unprecedented change. They have demonstrated a willingness to work with us as we move to new delivery system models, and they have taken some financial hits. I appreciate the work that hospitals do but also recognize that giving the improper payment rate on the Medicare fee for service program and the Medicaid programs, they must be subject to some scrutiny by various contractors including the recovery auditors.

I think we would like to ensure that going forward, we will alleviate the regulatory burden where appropriate and ensure that Medicare dollars are being used in a way that sustains the Medicare program for future generations. Hospitals have demonstrated a willingness to work with us as a pursuit of these goals, and I think that we will hopefully from this hearing today be able to evolve some legislation.

I yield back.

Chairman Brady. Today, we will hear from witnesses on two panels. Sean Cavanaugh, Deputy Administrator and Director of the Center for Medicare at the Centers for Medicare and Medicaid Services.

Jodie Nudelman, the Deputy Inspector General for Audit Services at the Offices Inspector General of the Department of Health and Human Services.

And on the second panel we will have Amy Deutschendorf, Senior Director of Clinical Resource Management at Johns Hopkins Hospital Health System.

Dr. Ellen Evans, Medical Director of HealthDataInsights. Dr. Ann Sheehy, faculty on behalf of the Society of Hospital Medicine, and Toby Edelman, Senior Policy Attorney, Center for Medicare Advocacy.

Mr. Cavanaugh, congratulations on your new position at the CMS. The Ways and Means Committee is happy to welcome your first congressional testimony in your new role, and Mr. McDermott promises to take it easy on you.

You are now recognized for five minutes.

And I should say both to those testifying and the members today, we have two panels. We are going to be tight on time. We are going to hold real fast to the five-minute rule.

So, Mr. Cavanaugh, welcome.

Mr. Cavanaugh. Thank you, Chairman Brady.

As you point out, I just became Deputy Administrator at CMS a few weeks ago. However, I point out that I started my career in health care in this committee room working for a member of the Health Subcommittee. I have great memories of working in this room with colleagues from both sides of the aisle to improve the Medicare program, and I have deep respect for the role Congress plays and this subcommittee play in setting Medicare policy and doing appropriate oversight of the operations of the program. So it is an honor to return here today to this committee room representing the agency that administers Medicare.

When a patient arrives at a hospital needing care, one of the critical decisions that physicians or other qualified professionals must make is whether to admit the patient for inpatient care. This decision is often a complex medical judgment taking into account the patient's medical history, comorbidities and other factors. However, as Chairman Brady pointed out, because of statutory requirements, Medicare pays hospitals different rates for inpatient and outpatient services. So the decision about whether to admit a patient has implications for provider reimbursement, for beneficiary cost sharing, and also for post acute care benefits the beneficiary may qualify for.

Two years ago hospitals and other stakeholders were requesting that CMS provide additional clarity regarding the definition of inpatient care. Hospitals were growing frustrated with the administrative and financial burden incurred when recovery auditors denied a claim for services after care had already been provided. At the same time, CMS was hearing from its contractors that Medicare was reimbursing hospitals for inpatient care that should have been provided in a less costly outpatient setting.

Some hospitals reacted to the scrutiny of auditors by treating more patients on an outpatient basis, often in an observation status. Some observation stays lasted three, four or even more days. This caused problems for beneficiaries because it subjected them sometimes to higher cost sharing under the Medicare Part B benefit, and it also disqualified them from the post acute skilled nursing facility benefit since they weren't accruing the three inpatient days they need for that benefit.

In 2012, we solicited public feedback on possible criteria that could be used to determine when an inpatient admission is reasonable and necessary. We received a large number of responses, but there was not a consensus around any single approach. Last year CMS finalized a proposal that has become known as the Two Midnight Rule. The rule sets a physician expectation based benchmark for when CMS and its contractors will consider inpatient hospital admission and payment appropriate.

CMS, as we crafted that policy, we were seeking to balance several principles that I think many of us share. We wanted criteria that were clear to providers. We wanted criteria that were consistent with good, sound clinical practice and respected physician judgment. We wanted criteria that reflected the beneficiaries' medical needs, and finally, we wanted criteria that were consistent with the efficient delivery of care to protect the trust funds.

In November of last year, CMS announced a probe and educate strategy around the new standard in which the MACs are now conducting prepayment reviews on a sample of short stay inpatient claims from each hospital to determine compliance with the Two Midnight Rule. Claims for inpatient admissions that are not reasonable and necessary are denied, and the MACs work with the hospitals to educate them on this criteria.

As part of this strategy, we also prohibited the recovery auditors from conducting any post-payment reviews of claims for the medical necessity of the inpatient status through March of 2014. We used this opportunity to engage in a dialogue with stakeholders on the Two Midnight Rule. As we began hearing from stakeholders that more time was needed to understand the policy, we extended the probe and educate strategy through September, and Congress subsequently extended it through March 31, 2015. We believe these extensions are allowing hospitals time to fully understand the benchmark and for CMS to learn more about how this policy is being implemented and understood by hospitals.

In fact, preliminary data suggests that as a result of the Two Midnight Rule, the proportion of long outpatient stays is beginning to decline. However, in recognition of the continued calls from stakeholders for additional clarity around short stays, this year CMS is soliciting public input on two related issues.

First, we solicited comment on the advisability of creating a Medicare payment policy for short stay inpatient cases. Specifically we requested public comment on how to define short stays and how an appropriate payment might be designed. These comments are due to the agency at the end of June.

Second, we reminded the public that we are inviting feedback on creating additional exceptions to the Two Midnight Rule. We look forward to reviewing stakeholders' suggestions on these two subjects. Mr. Chairman, Ranking Member, I look forward to hearing this subcommittee's ideas regarding the Two Midnight Rule and the Recovery Audit Program. CMS is always looking to improve our policies and procedures, so we welcome this opportunity to hear from Congress and stakeholders.

With that I would be happy to take questions.

Chairman Brady. Thank you.

Chairman Brady. Ms. Nudelman, you are recognized for five minutes.

Ms. Nudelman. Good morning, Chairman Brady, Ranking Member McDermott and other distinguished members of the subcommittee.

Thank you for the opportunity to discuss the Office of Inspector General's work to improve the Medicare program.

My testimony today has three key takeaways. One, the Two Midnight hospital policy must be carefully evaluated.

Two, CMS should enhance its oversight of the recovery audit contractors; and, three, fundamental changes are needed in the Medicare appeals system.

I will begin with the Two Midnight Rule. The new policy provides guidelines for when hospitals bill for inpatient stays and outpatient services such as observation. These decisions have significant impact. They affect how much Medicare pays the hospital, how much beneficiaries must pay, and beneficiaries' eligibility for skilled nursing facility services.

Prior to the policy, OIG evaluated the hospital's use of observation stays and inpatient stays. Our findings continue to be relevant. We found that beneficiaries were in observation and short inpatient stays for similar reasons, but short inpatient stays were more costly. On average Medicare paid nearly three times more for short inpatient stays than observation stays. Beneficiaries paid almost two times more.

We also found that hospitals vary. Some hospitals use short inpatient stays for less than 10 percent of their stays. Others use them for more than 70 percent. Lastly, we found that some beneficiaries spent three nights or more in the hospital but did not qualify for the skilled nursing facilities under Medicare. That is because their stays did not include three inpatient nights.

Switching to our work on recovery audit contractors, or RACs, we found that these contractors play a critical role in protecting the fiscal integrity of Medicare. In fact, in fiscal years 2010 and 2011, RACs identified improper payments totalling $1.3 billion. Most of the recovered improper payments came from hospital inpatient claims. However, we also found that CMS needs to enhance its oversight of RACs.

Finally, OIG has found that the Medicare appeals system needs fundamental changes. We reviewed the third level of appeals which is handled by administrative law judges, or ALJs. Although this work predated the recent surge in appeals, our findings and recommendations are relevant to the current challenges. We found that ALJs decided fully in favor of appellants in over half of the cases and Part A hospital stays were most likely to receive favorable decisions.

Several factors led to ALJs reaching different decisions than the prior level. One is that some Medicare policies are unclear. This leads to more favorable decisions for appellants and to more variation among adjudicators. In fact, there is wide variation among ALJs. Their rate of favorable decisions range from 18 to 85 percent. We also found that improvements were needed such as ALJs moving to electronic files and CMS increasing its participation at hearings.

In closing, clear payment policies, strong oversight, and an effective appeals system are critical for Medicare to work well. CMS policy, the RACs, and the appeals system must each fulfill their important purposes. If they do not, beneficiaries, taxpayers and the Medicare program suffer. OIG is committed to continuing our efforts to improve Medicare.

Thank you for your interest and for the opportunity to discuss some of our work. I will be happy to answer any questions.

Chairman Brady. Thank you, Ms. Nudelman.

Chairman Brady. I think both witnesses have made the point that Two Midnight Policy, the inpatient, outpatient, the audits and the appeals all really work together, which is why we are doing this hearing all together.

So, starting with Mr. Cavanaugh, I am interested to hear your thoughts on the barriers to compare inpatient and outpatient services. Obviously we should be trying to find the best quality of care at the right site with the most cost effective payment.

So can you give me an example of a reimbursement difference, for a service that can be billed both inpatient and outpatient by a teaching hospital in a major city; what would be an example?

Mr. Cavanaugh. Well Chairman, as you pointed out in your opening statement, the outpatient payment system and the inpatient payment system are fundamentally different, and they start with different coding; so it is often hard to compare payments because we can't put the same claim through the outpatient system and the inpatient system. They are coded differently.

But on the inpatient system, we tend to pay a fixed amount, meaning a DRG-based payment. That DRG-based payment will include adjustments for possibly IME, for DSH. It could include a readmissions penalty or a hospital-acquired condition penalty, but it tends to be a fixed payment for the types of patient and the types of service being delivered.

On the outpatient side, it is more disaggregated, where we tend to pay per service. I think you heard from the OIG, and I think it is similar to data we have, that the magnitude of the difference in payment is quite substantial. The OIG mentioned that the short stay inpatient payments tended to be three times as costly to Medicare as the outpatient observation stays. That is consistent with data we have seen at the CMS. So that gives you a sense, that the systems for deriving the payment are different, and the magnitudes are quite different.

Chairman Brady. How do you address that?

Mr. Cavanaugh. I am not entirely sure how we address it. One idea that we received from stakeholders, and I know that it had some support in Congress, is to create a payment system that splits that difference, a short stay inpatient payment system and as I mentioned in my opening statement, we are soliciting comments on how to create such a payment system. I would say there are challenges.

Some of the cases that come in as short stay inpatient payments already have very low lengths of stay. Chest pain DRG, for example, has a two-day average length of stay. So the question is how would you create a short-stay payment around a type of case that is already fairly short. Those are the sorts of technical questions that we are asking for public input in the proposed rule this year.

Chairman Brady. Thank you.

Ms. Nudelman, you know, in your analysis do you think the Two Midnight standard will reduce observation stays or increase them, the length of them?

Ms. Nudelman. Again, our analysis is prior to the Two Midnight stay, and it is difficult to predict how things will look. What we did find is that hospitals extremely vary and, therefore, it is important to look at all of the data because their starting point is very different, and so it may impact hospitals very differently.

Chairman Brady. Mr. Cavanaugh, thanks for your emphasis describing the different cost-sharing implications affecting our Medicare beneficiaries. It often gets lost in this discussion and the difference between inpatient and outpatient. It is unfortunate the Medicare program has such vastly different cost-sharing rules for our seniors or Medicare beneficiaries between the two benefits.

This committee has focused earlier on the advantages of combining Medicare Parts A and B with the out-of-pocket costs to make sure we protect seniors in part because we are concerned about what seniors pay for cost sharing.

So, can you give us your thoughts on combining Parts A and B and how that might be helpful in trying to contain those cost sharing challenges for seniors?

Mr. Cavanaugh. I recognize that one of the goals is to speak to one of the problems that we have here, which is that inpatient versus outpatient generates very different liabilities for the patient. I would want to hear more about the proposal that the subcommittee is considering, and we have technical staff at CMS who can come provide assistance to you in the drafting of the bill if required and if that would be beneficial to you.

Chairman Brady. So you have not taken a look at the proposed combining Part A and B in the President's budget or in earlier health care proposals?

Mr. Cavanaugh. We don't have a proposal on that at this time, but like I said, if the committee has a proposal, we would love to see it and learn more about it.

Chairman Brady. Okay. Okay, final question. Mr. Cavanaugh, even though CMS doesn't have a direct role in the ALJ level Medicare appeals that Ms. Nudelman talked about, CMS must still be part of the solution to solve the backlog.

Does HHS have a working group to address Medicare appeals, and if so has HHS crafted recommendations to solve the backlog issues going forward?

Mr. Cavanaugh. Yes, Mr. Chairman. As you point out, there is an HHS-wide work group to address the backlog. CMS is part of that. I would be glad -- we are in the process of coming up with recommendations. I don't believe they are finalized yet.

Chairman Brady. What is the timetable on that?

Mr. Cavanaugh. I think we could brief the committee on them fairly shortly.

Chairman Brady. Right. Thank you Mr. Cavanaugh and Ms. Nudelman.

I now recognize Ranking Member Dr. McDermott for five minutes.

Mr. McDermott. Thank you, Mr. Chairman.

From a patient's standpoint you walk into the emergency room or whatever, and you get put in one of these statuses or the other. Does it make any difference to the patient, to the beneficiary, which status they are put in, as to how they are treated?

Mr. Cavanaugh. As to how they are treated, not from a benefit perspective; Is that the question?

Mr. McDermott. Yes, I am talking about how they are treated as a patient.

Mr. Cavanaugh. I would hope not. I would hope that the patient is receiving all the services they need medically, that are medically indicated.

Mr. McDermott. So then the difference is in the payment that is received by the hospital or that the patient has to make depending on which category they are in; is that correct?

Mr. Cavanaugh. Certainly the statute creates a stark difference between inpatient and outpatient care, yes, sir.

Mr. McDermott. Give us the amount of difference for a hospital, what they receive and what the patient has to pay, so we get some idea of who is bearing the weight here.

Mr. Cavanaugh. The amounts both that the hospital will receive and that the beneficiary would be liable for would vary tremendously on individual circumstances, so I can't give you a precise answer. I would say that when we did a rebilling initiative where we had hospitals take short inpatient cases and rebill them as outpatient, which involves some work, we did find that the outpatient payment to the hospital was about 30 percent of what the inpatient payment would have been.

Mr. McDermott. So they are getting 70 percent more if they bill them as an inpatient. Is that in Medicare payment for the DRG, the diagnosed-related group, or is it the indirect medical education payment and the DSH payment on top.

Mr. Cavanaugh. It includes everything.

Mr. McDermott. Okay. So you are saying you are including everything?

Mr. Cavanaugh. Yes, sir.

Mr. McDermott. So it is to the hospital's best interest to bring them in as an inpatient?

Mr. Cavanaugh. Certainly it generates more revenue.

Mr. McDermott. From a revenue standpoint. Because we said it doesn't make any difference how they are treated as people and as patients, so the only difference is how much money the hospital makes off of it; is that correct?

Mr. Cavanaugh. Again, it certainly makes a significant financial difference.

Mr. McDermott. Now, I have heard, and I think almost every member on this committee has heard from their hospitals, the usual assumption is that the RACs are overzealous and that somehow when we take them up to appeal, when we finally get to the appeal process, almost always it comes down in our favor. Could you give us the numbers of how many are overturned on appeal?

Mr. Cavanaugh. Certainly, Congressman. We had a report to Congress on the RAC program in the year of 2012, and in that report we showed that when the RAC denies a claim, when a RAC denies a claim, only 7 percent of those are ultimately overturned at some level of review all the way up through the ALJs.

Mr. McDermott. Only 7 percent are overturned.

Mr. Cavanaugh. That is correct.

Mr. McDermott. Where do the hospitals get the figure that they say, well, they are all overturned. When we finally go through this long, arduous process that is backlogged and everything else, it is always overturned. Where do they come up with that.

Mr. Cavanaugh. There could be two sources of the difference in these numbers. The first is any individual hospital's experience may vary tremendously. Some may have a better success rate. The other is, some of the numbers that I have seen quoted by the industry, they are using as the denominator only those that they choose to appeal, not all those that were denied, which a lower denominator would generate a higher rate of success.

Mr. McDermott. Does it get to more than a half?

Mr. Cavanaugh. In the numbers that we have seen that CMS has generated, I haven't seen anything that would get that high, no sir.

Mr. McDermott. The number I saw, I mean, you are holding back on the numbers you got. The ones that I have seen say 27 percent are the number that are overturned.

Mr. Cavanaugh. So, again, I don't mean to hold back the numbers. These are numbers that are in our public report to Congress, ultimately, and I will just state it as clearly as I can, of all the ones the RACs deny, only 7 percent are ultimately overturned.

If you took a low number of the ones the RACs denied and the ones the hospitals chose to appeal, it would generate a higher overturn number. I just don't happen to know that number. 14 percent.

Mr. McDermott. Fourteen percent?

Mr. Cavanaugh. I am being helped, yes.

So it essentially doubles the rate, but it doesn't get as high as some of the numbers you may have heard from others and, again, an individual hospital's experience may vary.

Mr. McDermott. Can you give us an explanation for why this problem? I mean, generally Congress doesn't run in and pass laws, and you don't make rules and regulations without there having been something to generate that. What is it that drove this in the first place?

Mr. Cavanaugh. I think it was a confluence of a number of factors. We were hearing from hospitals and beneficiaries who were really concerned about these long observation stays. That was causing confusion for beneficiaries including they didn't understand their status, and they also thought they were qualifying for the skilled nursing facility benefit.

We were hearing from hospitals who thought just dealing with the RACs, with what the hospitals would characterize as an unclear standard for inpatient care was a difficult situation to put them in and all these forces came together, and that is why CMS solicited input and tried to make a clearer policy. Because our goal is not to have a successful RAC program or to drive down the number of overturned appeals. Our goal is to have hospitals understand the rules, agree with the rules, and bill correctly at the outset.

Chairman Brady. Time is expired.

Mr. Johnson.

Mr. Johnson. Thank you, Mr. Chairman.

Mr. Cavanaugh, the value-based purchasing program which was enacted as part of ObamaCare is the Federal Government's most extensive effort yet to hold hospitals financially accountable for patient outcomes. Medicare compared hospitals on how faithfully they followed basic standards of care and how patients rated their experiences. In the first year of CMS value-based purchasing program, physician-owned hospitals demonstrated they thrive in delivering high-quality, low-cost care. Amazingly 9 of the top 10 and 53 of the top 100 hospitals were physician-owned hospitals.

CMS also recently released data that summarizes the utilization and payments for procedures and services provided to Medicare. Based on this release of information, we have now confirmed what many of us have known for some time, and that is that, physician-owned hospitals are costing Medicare less than hospitals without physician ownership.

And that doesn't consider all the cost savings associated with the higher quality of care they provide. The irony of all this is that the very law that created the hospital value-based purchasing program, ObamaCare, bans the same hospitals. This new accountability measure says they are some of the very best in the country. ObamaCare prohibits any new physician-owned hospitals from treating Medicare and Medicaid patients. This clearly discriminates against some of the most vulnerable patients in our health system.

While the law permitted those physician-owned hospitals that received Medicare certification to be grandfathered under the law, it prevents these same hospitals from being able to expand to meet the access and quality demands in their community. This makes no sense, and it flies in the face of the Administration's own benchmarks for quality of care and cost savings.

Mr. Cavanaugh, do you stand by the results of the value- based purchasing program which validates the quality of physician-owned hospitals?

Mr. Cavanaugh. Yes, the agency stands by the results of the value-based purchasing program.

Mr. Johnson. Do you stand by the data released by CMS showing the cost differential between treating patients at physician-owned hospitals versus hospitals without any ownership by physicians?

Mr. Cavanaugh. I apologize, Congressman. I am not familiar with those data, but I am happy to look at them and review them.

Mr. Johnson. I appreciate it if you would. I hope you all can support a bill that I have out there, H.R. 2027, which would establish a level playing field for physician-owned hospitals and ensure that patients will continue to have a choice in where they receive their health care.

Mr. Cavanaugh. Certainly we look forward to reviewing that legislation.

Mr. Johnson. Thank you, sir.

Thank you, Mr. Chairman.

Chairman Brady. Thank you.

Mr. Thompson is recognized.

Mr. Thompson. Thank you, Mr. Chairman, and thank you for holding this hearing today. I think this is something, as Mr. McDermott said, we are all hearing a lot about in our district.

Mr. Cavanaugh, I would like to just revisit the issue of the reversed audits, and you had mentioned 7 percent. Mr. McDermott said that he hears from his constituents that every one of them are overturned. I

am hearing that it is in the 40 percent from my hospitals, 40 percent and change and is there any way to qualify how these missed billing are done? Are they intentional? Are they mistakes? What is your experience?

Mr. Cavanaugh. Certainly my experience, which actually predates my time at CMS, as I mentioned in my opening statement I have only been the Director of Center for Medicare for a few weeks, but I do have experience working in the hospital industry. My experience has been most of them are not fraudulent. It is misinterpretation --

Mr. Thompson. So they are honest mistakes, or they find the process is confusing, have trouble getting to where they need to be?

Mr. Cavanaugh. Certainly that is what I have heard from much of the industry. I would also say by monitoring these very closely, the agency has at times found suggestions of fraud in some areas; but I don't think that is generally what is driving this.

Mr. Thompson. And is it pretty easy to recognize the mistakes vis-a-vis the fraud?

Mr. Cavanaugh. I would have to defer that question to my colleague who runs the program integrity side of CMI, CMS excuse me.

Mr. Thompson. I would like to know that if you could.

Mr. Cavanaugh. We would be happy to circle back with you after the hearing.

Mr. Thompson. Whichever it is, when a hospital has to go through the process of defending their claim, there is a lot of expense associated with that.

Mr. Cavanaugh. That is true.

Mr. Thompson. Are you able to qualify that?

Mr. Cavanaugh. Well, we don't collect data on what the hospital's expense is, but certainly my experience --

Mr. Thompson. They hire, what, lawyers?

Mr. Cavanaugh. At times.

Mr. Thompson. And they hire consultants --

Mr. Cavanaugh. Or consultants. There is also just the time and --

Mr. Thompson. And all the opportunity cost. They are defending their billing practices rather than providing health care to patients?

Mr. Cavanaugh. Yes, Congressman. And, again, that is why we feel perfecting the appeals process is important, but what is more important is having very clear guidelines at the outset of how these cases should be billed.

Mr. Thompson. And is there any way to minimize the cost to hospitals if their claim is reversed? They have to pay one way or the other, I guess.

Mr. Cavanaugh. Yes, if it is reversed. There are some things that we are doing. The recovery auditor contracts are being recompeted as we speak, and we hope to award new contracts this summer. In that process, as we set new terms with the appropriate auditors, we are trying to take steps to make things less burdensome for the hospitals. We are trying to revise the requests the auditors do for documents from the hospitals to try to limit that burden somewhat.

We are trying to ensure that there is an exchange of information between the auditors and the hospitals so the hospitals can make their case before they have to file a formal appeal, that they can work with the auditor to explain why they think it was appropriate as an inpatient case. So we are always looking for ways to improve this. And I think there is --

Mr. Thompson. Does the process incentivize the auditors to go after more than they should?

Mr. Cavanaugh. I don't think there is an incentive for them to go after more than they should, and I think the very low overturn rate that I quoted suggests that they are largely going after the right types of cases, but again I would rather they have --

Mr. Thompson. That's it is overturn rate that you quoted, the 7 percent.

Mr. Cavanaugh. Correct.

Mr. Thompson. But if it is closer to what Mr. McDermott said, where they are all overturned, or even if they are what my hospitals are experiencing at about 40-some-odd percent, it is not quite as low.

Mr. Cavanaugh. If I believed that --

Mr. Thompson. They say there is lies; there is damn lies, and there is statistics.

Mr. Cavanaugh. I just wanted to agree with you, though, that if there were overturn rates of 40 to 50 percent, I think that would be indicative of a larger problem than just the guidelines.

Mr. Thompson. What would that problem be?

Mr. Cavanaugh. I think it would indicate that the recovery auditors were not going after cases that were --

Mr. Thompson. Auditors are what?

Mr. Cavanaugh. That the recovery auditors, if they were getting over turned 40 or 50 percent of the time, it would indicate they were probably going after cases that were appropriately billed to start with but, again, that is not what we see in our data.

Mr. Thompson. So Mr. Chairman, can we further examine that, because if that's the case, they are being incentivized or for some reason they are going after cases they shouldn't.

Chairman Brady. At some point today, I am going to recognize Mr. Roskam, but at some point today I would like Ms. Nudelman to weigh in. I want to reconcile the differences in the numbers. I may be missing something here. And at some point -- I don't want to take Mr. Roskam's time. Mr. Roskam.

Mr. Roskam.

Mr. Roskam. Thank you, Mr. Chairman.

Mr. Cavanaugh, I just want to pick up on one of the themes that Mr. McDermott articulated in his opening statement where he said that he wanted to protect Medicare's finite resources, and I agree with that and you agree with that. I think one of the challenges is that there is a zero-sum game element to Medicare reimbursement right now, and so I want to draw your attention to an issue that I am sure is familiar with you.

That is Nantucket Cottage Hospital. As you know, that was part of the process by which the Affordable Care Act was passed. There is I don't think any celebration in this in that it is a zero-sum game proposition. I come from Illinois, and my home state is losing under this equation. Massachusetts, based on this manipulation, will essentially get $3.5 billion over 10 years. You recognize that that is a problem, don't you?

Mr. Cavanaugh. I am familiar with the provision you are talking about, and I would just simply say CMS is faithfully executing the law as written.

Mr. Roskam. You don't think that is a good allocation of resources, do you?

Mr. Cavanaugh. Again, I would just say that we are implementing the laws as required.

Mr. Roskam. Well, if it takes from my state and gives to another state, and what it does is it manipulates the definition of a rural hospital so that now Nantucket is now defined as rural, which boosts everybody up, because you know these rules better than I do, the entire state of Massachusetts is the beneficiary of one hospital in a particularly luxurious area, is now redefined as rural and therefore poor. That is a manipulation, isn't it?

Mr. Cavanaugh. Congressman, I think you have accurately described the mechanism of what is happening; and, again, we are bound to implement the law.

Mr. Roskam. But it is not a good idea, is it?

Mr. Cavanaugh. We are faithfully executing the law in this regard, sir.

Mr. Roskam. Well, you recognize there is bipartisan support to repeal this, don't you? This is one of these areas where there is a tremendous amount of bipartisan interest in trying to get back to this.

Senators McCaskill and Coburn have come alongside with one another. There is dozens of members of the House of Representatives, who have recognized this, and this is a situation where one state based on one statute is getting a disproportionate benefit, and it is not getting a disproportionate esoteric benefit. In other words, this isn't just simply borrowing from a future generation. This is saying, well, we are going to take from Illinois, and we are going to give to Massachusetts. That's a breakdown, isn't it? Isn't that a failure?

Mr. Cavanaugh. So, Congressman, the provision does involve some of the technical aspects of Medicare rate setting, and we have a lot of experts at CMS who we would be happy to bring down and provide you technical assistance if you have a legislative proposal in this request.

Mr. Roskam. Well, is a technicality when a luxurious vacation area is categorized as rural, thereby boosting every other hospital in the state and having an adverse impact on many other states?

I mean, so Massachusetts according to our staff that put this together in 2013 and 2014, is going to be receiving a benefit of $425 million. My home state of Illinois is down $62 million. Congressman Price's home state of Georgia is down $30 million. You just go on and on through the list. Congressman McDermott's home state is down $12 million. This is beyond just a technicality, wouldn't you say?

Mr. Cavanaugh. What I was suggesting is that it is a function of very technical parts of the rate setting within Medicare, and we are happy to look further into it and look at your bill and provide --

Mr. Roskam. Isn't that an over characterization to say it is a technicality? It is not just technically taking millions of dollars from my home state and these other states across the country to benefit one state through the boosting of this sort of hospital definition.

And if that is a technicality, then I shudder to think what is a big deal. It is more than a technicality. Wouldn't you acknowledge that?

Mr. Cavanaugh. I didn't mean to suggest it was a technicality. What I was trying to say is that it was a function of technical aspects of the rate setting system. As you said, the provision has a meaningful impact on Medicare rates.

Mr. Roskam. And wouldn't you technically think it is a bad idea?

Mr. Cavanaugh. Congressman, we are faithfully executing the law. If you have a provision to change it, we are happy to provide any technical assistance you might need.

Mr. Roskam. Thank you.

I yield back.

Chairman Brady. Thank you.

Mr. Pascrell.

Mr. Pascrell. Thank you, Mr. Chairman. I think we can work together, I really do, to find solutions that work for hospitals and for patients.

I have been hearing from hospitals in my state, Mr. Cavanaugh, about the various reporting requirements in programs that impact the work that those hospitals do. I don't think anyone here will disagree that there is much room for improvement in the RAC program, in policies related to short-term, as well as observation stays. However, we need to strike the right balance between ensuring that hospitals can comply and that Medicare has the ability to ensure program integrity. It sounds easy, but it is not.

One area of particular interest to me is the increased use of observation stays and how it impacts the beneficiary. So I cosponsored along with Joe Courtney and Tom Latham, it is bipartisan, the Improving Access to Medicare Coverage Act which would allow observation stays to be counted toward the three-day mandatory inpatient stay for Medicare coverage of skilled nursing facility services.

So here's my question then, Mr. Cavanaugh. A number of independent reports from Medpac, the HHS Inspector General, Brown University, very interesting study, indicated that there has been a substantial increase in the number of observation stay claims and a decrease in the number of inpatient stays.

According to Medpac, outpatient observation claims grew by 88 percent from 2006 to 2012. A Brown University study found that the average length of stay in observation increased by more than 7 percent. Could you tell me what is contributing to this trend and the rise in observation stays?

Mr. Cavanaugh. Certainly. CMS is aware of the growth in observation stays as well. One of the things we believe is contributing to it is the behavior of some hospitals that want to avoid auditors reviewing whether an inpatient stay was appropriate.

Mr. Pascrell. Do you want to write that on the record please?

Mr. Cavanaugh. Excuse me?

Mr. Pascrell. What do you mean; what are the hospitals doing?

Mr. Cavanaugh. And again, this is anecdotal having talked to some hospital associations and some individual hospitals that some hospitals have decided they would rather take the patient in observation status as an excess of caution rather than risk having an inpatient admission subsequently denied.

Mr. Pascrell. And what does that lead to?

Mr. Cavanaugh. Well, first of all, what I think is unfortunate, as you point out, is if the patient should have been receiving inpatient care, they are not accruing the days they need to qualify for the post-acute skill nursing facility benefit.

Mr. Pascrell. And that is pretty troubling. Under the current law, under what exists right now, Medicare requires that a patient be classified as an inpatient during a hospital stay for three days in order to qualify for coverage in a skilled nursing facility after they leave the hospital.

So, a number of Medicare beneficiaries have been cared for in the hospital on outpatient observation status rather than admitting them as inpatients, which has caused problems for Medicare coverage. That is serious.

Mr. Cavanaugh, do you believe that the three-day inpatient stay requirement for Medicare coverage of skilled nursing facility services is appropriate?

Mr. Cavanaugh. Congressman, I think CMS shares your interest in trying to find ways to improve the use of skilled nursing facility benefit. I am pleased to tell you there is two examples of where we are exploring very specific alternatives to this.

In the Affordable Care Act, the Secretary and CMS were given the authority to waive certain provisions of Medicare in order to test new payment and service delivery models. In the pioneer ACOs, which is run by the Innovation Center, and the bundled payments for care improvement also run by the Innovation Center, were running tests where participants in those models have waivers from the three-day prior hospitalization rule. We chose those environments in which to test this because we feel in those environments the providers have both a clinical and a financial, heightened clinical and financial responsibility, so we feel that it is the best possible environment to waive the rule without having excess utilization.

Those tests are fairly new, and we are going to evaluate them very closely, and when we have data to share, we would be happy to share them with this committee.

Mr. Pascrell. Thank you.

Thank you Mr. Chairman.

Chairman Brady. Thank you.

Mr. Gerlach is recognized. We will move to two-to-one questions so we can balance questions from now on.

Mr. Gerlach. Thank you, Mr. Chairman.

Thank you for testifying this morning to both of you.

On this Two Midnight Rule issue, in staying with the questions that my predecessors here have just posed, I think a lot of this can be boiled down to some of the information that we get from our subcommittee staff that summarizes the issues for the hearing today, and let me read if I can from that because, again, I think it crystalizes on the Two Midnight Rule where we are, and "For fiscal year 2014, CMS maintains 751 diagnostic-related group bundling codes for inpatient hospital payment. The outpatient payment system is focused on current procedural terminology, or CPT codes, that are maintained by the American Medical Association. The CPT codes map to ambulatory payment classifications, or APCs, for outpatient service reimbursement. For calendar year 2014, CMS maintains 813 APCs. There is no one-to-one matching of DRGs to APCs nor international classification of disease codes to CPT codes. Hospitals are responsible for knowing two different coding systems and two different payment systems for Medicare reimbursement." Seems to me that's the problem, isn't it? A patient comes into a hospital, presents with certain symptoms and certain complaints, but there is two different coding systems that a hospital is then required to utilize in terms of the reimbursement it will ultimately receive for whatever service is provided to the patient.

So does not the answer lie obviously to a new methodology that somehow blends these codes or smoothens these two different payment systems, one outpatient, one inpatient, so there is a fair way to reimburse for the service provided, not the length of stay on an arbitrary basis. Mr. Cavanaugh?

Mr. Cavanaugh. Thank you for that question, Congressman. I do think in this year's rule in which we requested input on a short-stay inpatient payment system, we were suggesting that we are open to the kind of thing you are talking about, which is trying to see if the solution here is to minimize the payment differences. I don't want to prejudge the result of that. We are waiting to receive public comment on how that might look, but I think it is an openness to a step in the direction you are discussing.

Mr. Gerlach. Is that openness towards getting to a system where again the reimbursement to the hospital is based upon a more simplified methodology, and the methodology that is tied to the nature of the service that is provided, not an arbitrary time period for which that patient is in the hospital?

And I would also, Mrs. Nudelman, if you would also reply to that as well.

Ms. Nudelman. I mean I defer to CMS and to Congress to make the policy, but I think the overall objective is going back to, you know, not paying vastly different amounts for beneficiaries that receive similar care. At the very least, a standardized crosswalk that crosswalks the outpatient and the inpatient procedures would be a useful tool.

Mr. Gerlach. Well, typically an inpatient reimbursement would be about three times what an outpatient reimbursement would be, so there would be a fundamentally unfair situation where somebody is discharged from the hospital at 10 p.m. before the second midnight and therefore the hospital receives a third of the reimbursement for the services that were otherwise provided or could have been provided if you just kept the person three more hours and discharged him or her at 1 a.m. after the two midnights had passed by and get three times the reimbursement.

So isn't there a fundamental flaw in just arbitrarily setting up a Two Midnight or any particular time period for determining reimbursement versus just the nature of the service that is needed to treat the patient, as Mr. Cavanaugh you alluded to some moments ago, that is the goal here, getting the patient properly cared for in the hospital setting, based upon the symptoms and problems and then the diagnosis that is made to deal with that.

Mr. Cavanaugh. I think, Congressman, it is fair to say CMS shares your goal. What I would caution you is anytime we create a new payment, there is a lot that goes into creating payment systems, and what you are articulating, I think, is a very worthy goal of a seamless payment system. It presents many technical challenges. However, again, we have expressed openness in our proposed rule to exploring payment

solutions to this, so we look forward to hearing any ideas this subcommittee has, and we look forward to working with you on this.

Mr. Gerlach. Thank you both.

Chairman Brady. Thank you.

Mr. Smith.

Mr. Smith. Thank you, Mr. Chairman, and thank you to our panelists here today.

It would seem the more regulations we have, the more difficult it becomes, at least to medical providers that tell me that it is more difficult to do their job and especially to -- it becomes more difficult to do the right thing.

And Mr. Cavanaugh, similar to concerns raised about the Two Midnight Rule, there is another regulation. CMS announced it will begin enforcing this year pertaining to the 96-hour rule at critical access hospitals. This regulation requires, as you know, physicians to certify at the time of admission they do not believe a patient will be there more than 96 hours or must transfer the patient or face non-reimbursement. I understand CMS has walked back this rule, allowing more time to file the certification. Is that true?

Mr. Cavanaugh. That is true. We have provided guidance to some of the hospitals that we will allow the certification to occur anytime up to 24 hours before the bill is submitted, and I think that will be coming out more formally sometime soon.

Mr. Smith. Okay. I assume that you have received a good bit of feedback, as have I, from hospitals and physicians. Can you reflect a little bit briefly, if you might, on the kind of feedback you received that would have prompted walking the rule back a bit?

Mr. Cavanaugh. Certainly we got a lot of input about the timing and the burden and whether the trade-off between what we were seeking and what the hospitals were requesting, whether there was any loss in the assurances we needed that the patient was seeing the appropriate level professional, and I think hospitals made a convincing case that there was room for some adjustment in the policy.

Mr. Smith. It would seem that the rule is unnecessary and even arbitrary. How did you arrive at the actual number of 96 hours?

Mr. Cavanaugh. Sir, that part is in the statute. The statute requires that the physician make a certification that the expectation, when the patient arrived, was that they would need no more than 96 hours.

Mr. Smith. What is the background on that 96 number?

Mr. Cavanaugh. I apologize. I don't know the story there. I just know it is statutory based.

Mr. Smith. And CMS has not enforced it up until they finally decided to start enforcing that, is that accurate? They had not been previously?

Mr. Cavanaugh. Again, I apologize. I have been in the job for just a couple of weeks. I do know that the requirement does trace back to the statute.

Mr. Smith. Okay. I have introduced a bill, H.R. 3993, the Critical Access Hospital Relief Act of 2014, which would repeal the regulation, and I would certainly encourage the agency's support of that. I think it

might even make a lot of folks' jobs more easy to carry out, and I know that we have got other burdens on the critical access hospitals such as the physician supervision, again arbitrary, hard to determine how that ever even came about in terms of a rule or regulation, and it is very discouraging for medical providers to be facing all of these regulations that, like I said earlier, make it difficult for the good actor to do the right thing.

I know we have seen advertising on television about addressing fraud in Medicare/Medicaid and other areas, and yet I still think that all of these regulations are making it more difficult for the provider to do the right thing. I am not convinced that it is actually preventing fraud. I can appreciate the fact that there are limited resources, that you acknowledge that and that we are all trying to operate in a world of limited resources, and yet I think that many of these regulations are accomplishing the exact opposite of what they were intending to accomplish, and it is a huge burden and I would hope that the agency would really reflect on that fact as we do move forward.

I thank you, Mr. Chairman.

Chairman Brady. Thank you.

Mr. Kind.

Mr. Kind. Thank you, Mr. Chairman. Thank you for holding this hearing. I want to thank our panelists for your testimony here today.

Just to maintain the momentum of some of my colleagues, especially my friend from Pennsylvania. As I have been talking to a lot of our providers back home in Wisconsin over the Two Midnight Rule, their sense is that it is awfully arbitrary, and they are having some definitional problems too, as far as what constitutes inpatient care versus observational status, outpatient care.

Has CMS, Mr. Cavanaugh, been working with the provider community to provide better definition or clarity in regards to those type of services, and what is the difference? I f they are in there under on observational status versus inpatient care, is there things you can point to that clearly distinguishes between the two types?

Mr. Cavanaugh. So, first on the first half of your question about whether we are working with providers. I would say we certainly are. I think it was a big part of our attitude, going into this year, as you recall, we suspended the recovery auditors looking at these cases for these purposes because we wanted to work with providers and we wanted to do it. So we have, as I said, the MACs going into each hospital and taking a small sample of cases and seeing whether they are complying with the rule.

And in instances where hospitals are, they are left alone for the rest of this year. In instances where hospitals are having trouble understanding or in implementing the new rule, the MACs are working with them to educate them.

So, I do feel like we have taken this pause in the recovery audit program, looking at these types cases, for the very reason you say which is to work with the hospitals and again, the origin of the rule was to respond to the request from the NG4 clarity. One of the things we may be look learning is that additional clarity is needed, or as we discussed, perhaps additional payment solutions are needed. We will wait to see how these discussions go. But I do think you raise an important point, that this is dialogue between us and the industry, and we do hope to learn quite a bit during this time.

Mr. Kind. Well, are there clear distinctions that can be made between inpatient and outpatient status, observational status within the hospital setting?

Mr. Cavanaugh. Certainly observation status is supposed to be used for a short period for the purposes of determining whether a patient needs an inpatient level of care, and during that time, there ought to be diagnostic and other monitoring being conducted. I would hesitate to go any further into distinctions because I am not a clinician, but I think your point is well taken, which oftentimes these are based on complex medical judgments that are difficult to translate into payment policy.

Mr. Kind. You mention that CMS is moving forward on a short stay payment rule right now, and you are starting to get some feedback, some comments on that. What are the various factors, just for the committee's benefit, what are the various factors that you are taking under consideration in putting that rule together?

Mr. Cavanaugh. The two questions we posed specifically in the proposed rule were, one, how would you define short stay cases, and there are examples of this. There are other payment systems out there that do use short stay payments, so it is not unprecedented, but it is a bit challenging here, as I mentioned earlier, in that some of the cases that are inpatient that are subject to RAC review are often already very short stay, even when they are legitimately inpatient, meaning they have an average length of stay of 2 days, so how do you -- cases are typically 1, 2, or 3 days already, how do you carve out a short stay.

And the second, and this has been the subject of several questions. The second question we posed to public was, how would you construct this new payment? I think questions have arisen, would it include the IME and DSH adjustments, and learnings like that, and I think these are real important issues where we need some pubic feedback before we move forward.

Mr. Kind. Is uncompensated care or underinsured individuals, is that going to be a factor, too, in the short rule?

Mr. Cavanaugh. Well, the way that currently gets into Medicare payment is typically through the DSH adjustment, and I think that is the fair question of whether it should be part of this as well.

Mr. Kind. Let me take you in a different direction. Obviously, recently, CMS did their physician reimbursement data dump that received a lot of attention, a lot of articles, a lot of focus, especially on some reimbursements that seemed outside the norm or other parameters than that.

We hear from the doctors in the follow-up questions that it wasn't just them. There were multiple docs or whatever using the same code in order to submit the billing information. Does that sound plausible to you that, that is what, in fact, what is taking place and why some doctors are being reimbursed 12 or $14 million in a single year?

Mr. Cavanaugh. It is true that in certain instances multiple providers can bill under the same identification number.

Mr. Kind. Why are we allowing that?

Mr. Cavanaugh. I will have to look into at that and get back to you, but I think there are legitimate reasons for that.

Mr. Kind. I would like to follow up. It just seems if we are trying to bring greater transparency, allowing multiple providers to use the same code seems to work against that issue. It is something that I think we are going to have to address.

Thank you, Mr. Chairman.

Mr. Cavanaugh. Be happy to look into that.

Chairman Brady. Thank you.

Dr. Price.

Mr. Price. Thank you, Mr. Chairman.

I want to thank the panelists as well. I think this is an incredibly important topic, and as a physician for over 20 years, know that we often times don't put the patient at the center of these discussions, and it is sometimes hard to do, especially when we are talking about money.

Mr. Cavanaugh, I was struck by the difference in the numbers that we hear recounted on the number of appeals that are either overturned or not, and your number of 7 percent astounds me because it is one that I have never heard before, so I suspect that includes all RAC audits that are done throughout the entire country. I don't want the answer to that, but I would like it in writing later.

But I think the question that we really need to ask is, of those cases that hospitals have appealed, that are inpatient stays denied due to medical necessity, what percent of those are overturned at the QIC level and then at the ALJ level. Do you have those numbers?

Mr. Cavanaugh. I don't believe I have them handy, but they are, we can get them, and we will get them to you soon.

Mr. Price. I would appreciate that. One, there is a hospital system in my area where 72 percent are overturned. 72 percent. So I would urge you to look at your testimony that says when you are however 40 percent or thereabouts, something is wrong, something is wrong with the system.

I want to revisit that in a minute, but I want to touch on the Two Midnight Rule. When does -- when a patient presents to the emergency room and is being admitted, when does the physician -- when is there a physician that has to sign that says that this admission is medically necessary?

Mr. Cavanaugh. That says the admission is medically necessary?

Mr. Price. And would qualify for the inpatient, for the Two Midnight?

Mr. Cavanaugh. The physician can give the order -- or other qualified professional can give the order verbally but has to countersign it at some point. It doesn't --

Mr. Price. But the order has to be given at the time of the admission?

Mr. Cavanaugh. Yes. For a patient to become officially an inpatient, a physician or other qualified personnel has to give an order.

Mr. Price. So we are asking our doctors to predict what is going to happen to that patient over the next two midnights; is that right?

Mr. Cavanaugh. It is based on a physician, the Two Midnight Rule is based on a physician's expectation, which this is expectation based on what they know at that time, and if a physician's expectation isn't fulfilled, meaning if the patient recovers or something else intervenes, the rule is not what happened but what the physician reasonably expected.

Mr. Price. Wouldn't we be better off if we said that doctors and patients and families ought to be making these decisions and not CMS?

Mr. Cavanaugh. Well, again, CMS, we are trying to leave it largely at to a doctor's discretion, but we are also, as I said in my opening statement, we are trying to balance many goals here.

Mr. Price. No, I got you. I got you. But many physicians out there will tell you that they don't feel that you are trying to allow them to practice medicine. Are there clinical studies or reports that back up the Two Midnight Rule?

Mr. Cavanaugh. I am not sure I understand the question, sir.

Mr. Price. Are there any clinical studies, scientists that have done studies, and say, yeah, this Two Midnight Rule makes sense from the patient's perspective and being treated?

Mr. Cavanaugh. Again, we crafted the rule --

Mr. Price. Is there any clinical studies?

Mr. Cavanaugh. The Two Midnight Rule is relatively new. I am not aware of any studies of it at this time.

Mr. Price. If you are, I would love to hear about it because I am not aware of any either. CMS contracts with these recovery audit groups to go get that money, right?

Mr. Cavanaugh. CMS contracts with recovery auditors to review improper --

Mr. Price. And you pay them a percent.

Mr. Cavanaugh. A contingency fee, yes.

Mr. Price. And when they -- when an appeal is overturned, do you go get that money back?

Mr. Cavanaugh. Yes, we do.

Mr. Price. From the RAC. How much is that?

Mr. Cavanaugh. I am sorry?

Mr. Price. How much money is that?

Mr. Cavanaugh. In total or any individual case?

Mr. Price. Total.

Mr. Cavanaugh. I would be happy to go back and find that number. I don't know it off the top of my head.

Mr. Price. Good. Okay, can different RACs have different criteria for what's medically necessary?

Mr. Cavanaugh. They are all supposed to tie to Medicare policy.

Mr. Price. And what is the clinical input that RACs are required to have to define what is medically necessary?

Mr. Cavanaugh. If you mean, the RACs are required to have a medical director who is supervising all of their medical policies.

Mr. Price. And do medical specialty societies have an opportunity to review all of that?

Mr. Cavanaugh. Of the work of the RACs?

Mr. Price. Yes.

Mr. Cavanaugh. Not directly, sir.

Mr. Price. All of this money that is used to comply with all of these rules and regulations cost money, doesn't it? The hospitals, it costs money?

Mr. Cavanaugh. Yes, sir.

Mr. Price. Millions of dollars, maybe more. Where does that money come from?

Mr. Cavanaugh. Well, Congressman, I think you are getting at a point that I would concede right away, which is our goal is not to have a lot of these cases reviewed, not to have a lot of cases overturned. Our goal is to have clear policies that hospitals agree with and can comply with.

Mr. Price. Comes from patient care though, right? Doesn't it? If the hospital has to put that money into complying with the rules from CMS that get more and more laborious, then that money is not going into caring for that patient, so when we hear one of our colleagues here say this really isn't affecting the patient, that is really not true, is it?

Mr. Cavanaugh. It is not a productive use of money, and it is why we are trying to reduce the need for this type of review.

Mr. Price. Thank you very much.

Chairman Brady. Thank you.

Mr. Renacci.

Mr. Renacci. Thank you, Mr. Chairman. I want to thank the panel.

Mr. Cavanaugh, Mr. McDermott asked you a question about -- talked a little about three people entering the hospital, and I just was interested in a response. You said, "I would hope that the patient receives all the benefits they are entitled to." I want you to keep that in mind when we go through a couple of questions I have for you.

Due to the increase in the length of observation days, more and more Medicare beneficiaries are losing out on skilled nursing coverage. The OIG found beneficiaries had over 600,000 hospital stays that lasted three nights or more but did not qualify them for SNF services, skilled nursing facility services.

I have spent the majority of my career, almost 25 years in the long-term care industry. I recognized the barrier to access that the current 3-day inpatient requirement has created for our seniors. For this reason, I have actually introduced legislation, H.R. 3531, the CARES Act that not only removes this barrier but also encourages hospitals and nursing facilities to communicate with each other before discharge.

Mr. Cavanaugh, the seniors in my district are often unaware of the 3-day inpatient requirement, and furthermore, seniors and their caregivers are unaware whether or not their hospital stays was billed as inpatient or observation. So I want you to think about that patient that enters the hospital, and they are entitled to long-term care under Medicare, and they end up in this quagmire of in observation day, not an inpatient day, and quite frankly, they probably could go directly to a nursing home in many cases because the doctor is only sending them to the hospital because that is a requirement, and it is actually costing the Medicare system dollars to send them through to that hospital just to get them the path to that nursing home.

So, if you think about that patient, and again, going back to your comment, "I would hope the patient receives all the benefits they are entitled to," you send the, we send this patient into a hospital because it is a requirement, they go through 3 days, they have to, you know, to get to the nursing home. The doctor already says they belong in a nursing home. Again, I was in the industry for 25 years. I can tell you these patients belong in that nursing home, and they get caught up in this observation day, but here is the problem. Then they are sent to the nursing home, and when they are sent to the nursing home, for 2,000 of the hospital stays, Medicare did not pay for NSF services, and the beneficiary was charged an average of $11,000.

So now we have this patient who started in the hospital, ended up in observation day, probably should have never went in the hospital if we had a different system that actually my bill would allow, lets them go directly into the nursing home because the doctor says that is the care that is needed.

So, has CMS implemented any policies that would really decrease the instances in which seniors, and again, that is what I am talking about, that person you talked about, the benefits that they are entitled, where there were seniors who were caught off guard and left off on the hook for thousands of dollars in medical bills.

Mr. Cavanaugh. Congressman, I think you raise a very important issue and one that was one of the driving factors to us looking at the Two Midnight Rule. I tell you two things. One, one of the impacts we are seeing, at least preliminarily of the effect of the Two Midnight Rule, is we are seeing a decrease in these long observation stays, and I believe those are probably shifts to inpatient status so potentially helping the beneficiaries you are talking about, but you are also talking about a larger issue of whether these patients need to go through the hospital in order to -- or should need to go through the hospital in order to access the skilled nursing facility benefit and as I mentioned to an earlier question, we are interested in exploring alternatives to that, too.

We currently have a subset of the pioneer ACOs, several of whom have had the 3-day hospitalization rule waived so they can test whether there are safe and effective ways for patients to be admitted to the SNF without the prior hospitalization, and we are, this year, also allowing some of the participants, both hospitals and post-acute care providers to do that as well in our bundled payment initiative. So we are hoping we will gain clinical and financial evaluation results from that, that we can share with this committee and maybe apply to broader Medicare policy.

Mr. Renacci. You would then agree -- it sounds like these studies will give us some of those answers, but you would agree sending somebody to the hospital and having the cost, the burden of that person in that hospital when it really could go to a nursing home might be a way of saving some dollars if we sent them directly to the nursing home?

Mr. Cavanaugh. We do feel there is potential there, but again, we are testing it, and I don't want to prejudge the results of these tests.

Mr. Renacci. All right. Thank you.

I yield back.

Chairman Brady. Thank you.

Mr. Crowley.

Mr. Crowley. Thank you, Mr. Chairman.

Thank you, Chairman Brady and Ranking Member McDermott for allowing me to join with you all at this hearing today.

And welcome, Mr. Cavanaugh. Good to have you here. I know I speak for all my colleagues when I say we look forward to working with you in your new capacity, new role at CMS.

Mr. Cavanaugh. Thank you.

Mr. Crowley. So, I represent parts of New York City, Queens and the Bronx. I know you are familiar with those areas quite well. We are fortunate to have a number of highly regarded hospitals and medical institutions, many of which are also academic medical centers, and I know you are familiar with all those as well.

These hospitals and others across the country are struggling with the implementation of the Two Midnight Rule, and while I appreciate CMS' efforts to try and clarify when the patient should be admitted as an inpatient, I have serious concerns about the overall policy. Our New York hospitals focused primarily on providing the best medical treatment with great efficiency rather than on what time the patient is admitted. The Two Midnight Policy sets an arbitrary standard that does not always reflect the clinical judgment of the treating physician.

Several months ago, Representative Gerlach and I introduced legislation to delay the enforcement of the Two Midnight Policy. I am glad that this delay was included in the most recent doctor's payment fix, and I thank the committee for all of its work in achieving that delay. But the problems with the underlying rule remain, and they need to be addressed. That is why our bill also orders the CMS to implement a new payment methodology for short inpatient stays that don't fit neatly into the divides of the Two Midnight Policy.

I was very pleased to see that CMS' proposed Medicare inpatient rule for next fiscal year includes requests for feedback on establishing a short stay inpatient methodology, which could help both providers and beneficiaries. I hope that CMS will continue to work closely with hospitals and patients in establishing this process and in taking into account the costs associated with operating, teaching, and safety in our hospitals. It is important a new payment system protect graduate medical education and disproportionate share hospital payments.

Now, I know the rulemaking process is under way, but can you comment at all on how you see this issue being addressed as you move forward, if there are any possible methods you have considered and are willing to consider?

Mr. Cavanaugh. Thank you, Congressman, and thank you for your kind words. I do know New York and the hospital industry there quite well, having worked there, and in one hospital and closely with many of the others.

You are correct. First of all, you are correct that Congress extended, and based on your legislation, the pause in the RAC review of medical necessity of inpatient stays until March of next year. I think that does give us all, both Congress and the administration, some time to think about how the policy is working and whether there are additional steps that are needed to make a clearer payment policy that we can all agree on.

One of those areas that we are going to spend a significant amount of time and resources on is exploring the possibility of a short stay outlier. I don't want to prejudge how we would do this because we are soliciting public input, but as I have said in response to several other questions, it is an intriguing idea, but it also poses, you know, real conceptual challenges. We are up to those challenges, but I don't want to under estimate them.

One of the things I would point out is, if it is going to be an inpatient short stay thing, we are still going to need a definition of when inpatient care is necessary because you will still have a distinction between inpatient and outpatient. We are going to have the challenge of how do you create short stay payment when certain DRGs are already very short stay. But I know, as I said, there is some very great minds up in the New York hospital industry that I know are working on this, and they have been in touch with us, we have been in touch with the other association, so we eagerly await their input.

Mr. Crowley. Thank you, Mr. Cavanaugh. I look forward to continuing to work with you in your new capacity, and I hope that you have that same open mind approach when you are dealing with the committee and the chairman and the ranking member as well, so thank you for being here today.

Mr. Cavanaugh. Thank you, sir.

Chairman Brady. Thanks. Mrs. Black.

Mrs. Black. Thank you, Mr. Chairman. I want to thank you for allowing a non-committee member to be here to listen to the testimony and have an opportunity to be able to ask a question.

Ms. Nudelman, in your written testimony, you talk about some hospitals use a short stay inpatient for less than 10 percent, excuse me, of their stays and others use it over 70 percent. Did you find any tends when you were looking at these vast differences between how hospitals use these and whether there is any type of hospital, in particular, that uses them differently?

Ms. Nudelman. Thank you for your question. As you know, we did see a lot of variation, but we did not look at whether there are certain types of hospitals that are more likely to use short inpatient stays. If the trend continues under the new policy, you know, this is a really important question to look into further.

Mrs. Black. I certainly think that, that is one that would give us a lot of information because if you are using it for certain types of hospitals is it cardiac hospitals, were they looking at orthopedic, I think it would be very interesting to take a look at the wide variance that is there between 10 and 70 percent.

And let me go to another area that seems to be a lot of variance, and that is, in your testimony on page number 5 underneath of the appeals, you note that about 72 percent of those who appeal are successful and yet we keep on hearing this number of 7 percent. There is a real disparity there. Can you break that down? There is something else there that we are not exactly understanding.

Ms. Nudelman. Sure. Let me try to do that. I think what we are seeing is there is about six, most of the appeals from RACs are not appeals. Most of the RAC decisions are not appealed, so according to our statistics, about 6 percent of the RAC decisions are appealed. Now, once those are reached higher levels, about half of those are overturned, so that maybe can help reconcile some of those issues.

Where the 72 percent comes into play is when we looked at the third level of appeals, the ALJ level, they overturn about 72 percent of hospital claims. That would include both RACs, that would include other issues than just the inpatient.

Mrs. Black. So, just to be clear.

Ms. Nudelman. Sure.

Mrs. Black. About 7 percent, 6 or 7 percent, depending upon who is talking about that number, but somewhere in that range of those decisions that are made by RACs are appealed, and of those that are appealed, in this case of Part A hospitals, 72 percent of those prevail, correct?

Ms. Nudelman. Overturn.

Mrs. Black. Overturn.

Ms. Nudelman. At the ALJ level.

Mrs. Black. ALJ level. Okay. Well, that makes a lot more sense because there is a lot of disparity between 6 percent and 70 percent, and so that helps me to understand a little bit better about where those numbers are coming from. Thank you very much.

Thank you, Mr. Chairman.

Chairman Brady. Thank you, Mrs. Black.

I am now confused about the appeal process. Can I, I don't mean to intervene here for a minute before I go to Ms. Jenkins. But, so 94 percent of the claims identified as overpayments on appeal, 6 percent left half, almost half are decided in favor of the appeal, is that right? So the over payments, 97 percent of them, at the end of the day, are considered accurate.

Ms. Nudelman. Just repeat that last part of your sentence. I just didn't hear that.

Chairman Brady. Of the RAC decisions on claims identified as overpayments, 94 percent aren't appealed. Of the 6 percent that are left, half are overturned, so --

Ms. Nudelman. That is according to our numbers.

Chairman Brady. -- you are saying 97 percent of those overpayments are upheld?

Ms. Nudelman. Yes.

Chairman Brady. Half of 6, 3, 94.

Ms. Nudelman. Yeah. And that is prior to the surge, and that is in fiscal years 2010 and 2011, so that could also be part of the issue.

Chairman Brady. Is there a dollar figure attached to that? For example, you may not appeal a $10 overpayment but you would a $10,000 one. Does your analysis show of those that were appealed a higher dollar value of those?

Again, Mrs. Black, I don't mean to jump, but you were leading down the right road. What do you know about that?

Ms. Nudelman. I don't have the dollar values in terms of what is appealed in terms of dollar amounts.

Chairman Brady. Can you try to figure that out?

Ms. Nudelman. We can.

Chairman Brady. Give us a little more texture about --

Ms. Nudelman. Absolutely.

Chairman Brady. Of that 6 percent, what do they look like, you know, and are the higher dollar values, are they in a certain area. And then 72 percent, tell me about that?

Mrs. Black. That is of the hospitals, the Part A hospitals are 72 percent. So, according to what I am reading here, at the ALJ level, appellants were most likely to receive favorable decisions for Part A hospital appeals at 72 percent.

And if I may, Mr. Chairman, just interject one other thing that I thought about that I keep hearing from these hospitals. Is the length of time it takes them to go from the original decision that is made by the RACs, to the time that they reach the ALJ level, can you give us an idea about how much time period there is in that typically?

Ms. Nudelman. Sure. I mean, particularly now with the postponement of assigning appeals, which the -- Omaha just put into place, and they are projecting just from what is publicly available that cases will not be assigned for at least 2 years, so that is pretty significant.

Mrs. Black. So there is a cost to the facility in that time period where they are trying to appeal it and the payments, they have been taken back, so thank you very much.

Chairman Brady. No agreements, so Mrs. Black, thank you.

And Ms. Jenkins, you probably never thought we would get to you. You are recognized for 5 minutes.

Ms. Jenkins. Well, Mr. Chairman, I just thank you for allowing me to join you at today's subcommittee hearing, and I appreciate this panel for being here.

These issues affect hospitals all over the country, and I have heard countless stories from Kansas hospitals, about the difficulties they face surrounding the Medicare program. Lawrence Memorial Hospital in Lawrence, Kansas has asked that I share their perspective on recovery audit contractors.

The hospital currently has $4.7 million being withheld because of RAC audits. It has appealed nearly all RAC audits, and so far has demonstrated a 96 percent success rate in the appeals process. So, Lawrence Memorial has brought to my attention what is a valid concern that I am hoping you will take into consideration. The hospitals are forced to disallow Medicare days and discharges that are currently held up in the RAC audit process because of the massive backlog at the ALJ level of appeal, and the hospital is concerned that these audits, which are likely to be resolved in their favor, will not be completed within the 3-year window during which it can reopen a cost report window and count towards the her meaningful use requirements. This is just one of countless hospitals in Kansas that is experiencing the immediate and similarly effects of the current flawed system.

As we continue to discuss a way forward on this topic, please take this problem into account. Secondly, I would like to highlight a program with the 83 critical access hospitals in Kansas and others around the country and what they are experiencing. I received a letter from the Anderson County Hospital in Garnett, Kansas, and I would ask that chairman's consent to insert the letter into the record.

Chairman Brady. Without objection.

[The information follows: The Honorable Diane Black]

Ms. Jenkins. This letter details the hospital's problem with CMS' final OPPS rule for 2014 regarding outpatient therapeutic services at critical access hospitals and supports legislation that I have introduced to delay enforcement of the rule until the end of 2014. This rule, while well intentioned, is creating a regulatory hardship in rule setting. So the letter notes that CMS has disallowed physicians at a hospital based rural health clinic from meeting the direct supervision requirements, which makes it very difficult for Anderson County Hospital to be reimbursed by Medicare for services rendered.

The most troubling part of the letter is that the hospital notes, that the physician supervision requirements have no impact on the quality of care and that the hospital will administer the outpatient therapy even without the Medicare reimbursement. This is a tale-tell sign of a misguided rule that has missed the point.

So, Mr. Cavanaugh, is it your opinion that requirements on physician's supervision of outpatient therapy services at critical access hospitals are feasible and would CMS benefit from a delay in enforcement in order to revisit this rule?

Mr. Cavanaugh. First of all, thank you for telling us about the experience of these two hospitals.

I don't have an opinion on the delay, but I am interested in the issue, and I am happy to look into it further outside of this hearing if you are willing to share that experience with me.

Ms. Jenkins. Okay. We will follow up with you and would like to work with you to give these folks some relief and better care for Kansans.

Mr. Cavanaugh. I am more than happy to look further into it.

Ms. Jenkins. Okay.

Thank you, Mr. Chairman. I yield back.

Chairman Brady. Thank you, Ms. Jenkins.

And before we dismiss the witnesses, Dr. McDermott and I would love to have both of you give us more perspective by letter of the 6 percent that are appealed for overpayments, the value of them relative to the other base of them, which are related to the two payment, Two Midnights Rule, any other insight you can give us on those. The numbers seem very low compared to what we have heard anecdotally, and we really would like to have more light shined on those areas if you don't mind. We'll follow up with you by letter, but we would love to have, I think the members would love to have that perspective.

Mr. Cavanaugh. We would be happy to do that.

[The information follows: The Honorable Lynn Jenkins]

Chairman Brady. With that, thank you very much, both of you, for testifying, and let's line up for a second panel.

Thank you very much. I made the introductions earlier, so we will, for the sake of time, go right into testimony.

Ms. Deutschendorf, you are recognized for 5 minutes, and welcome to all the second panel.

Ms. Deutschendorf. Chairman Brady, Ranking Member McDermott, and distinguished members of the subcommittee, thank you so much for this opportunity to testify today and share the Johns Hopkins experience on these important issues affecting hospitals in the Medicare program.

I am Amy Deutschendorf. I am a nurse. I am responsible for assuring the appropriate utilization of clinical resources for our patients in the right care setting, and that includes care coordination in the readmissions reductions initiative. My remarks today focus on two major changes, the CMS definition of an inpatient the Two Midnight Rule, and also the agency's recovery audit contractor program, both of which are draining precious hospital resources which need to be redirected to quality patient care delivery.

We know that the Two Midnight Rule was spawned out of an attempt to limit lengthy observation stays and add clarity to the definition of an inpatient, but unfortunately, the rule adds a new layer of complexity that not only does not meet that CMS objective but has created confusion and stress for our providers and our patients and has been operationally extremely difficult to implement.

Our observation rate has increased by 33 percent as a result of the Two Midnight Rule. It has taken away physician judgment in the determination of hospitalization as an inpatient and has instead required our physicians to become soothsayers as they try to project whether or not a patient who presents to the emergency department with a myriad of symptoms and comorbidities and determine if they are going to require a greater than a Two Midnight stay.

More importantly, under the Two Midnight Rule, we have patients who require the services that only a hospital can provide, sometimes in the intensive care setting, yet we are calling them outpatients in this new world. This concept belies any rationality and has created safety and quality of care concerns.

Medicare patients are being billed differently than other patients for equivalent services. They are subject to paying deductibles and copays associated with Part A benefits which could be up to 20 percent of their hospitalization. They think they are coming in for hospital care and their Part A benefit covers that. We have had patients who have actually left and refused important diagnostic studies and medications as a result of increased financial risk.

The Two Midnight Rule is especially devastating for academic and safety net hospitals. There has been a reduction in inpatient volumes as a result of the Two Midnight Policy which has redirected dollars for necessary hospital care to the outpatient system, causing a loss of payments for critical community programs, indirect medical education, general medical education, and disproportionate share payments at a time we need them the most.

Since its inception, RAC has created enormous financial and administrative burden on hospitals as we struggle to respond to the plethora of medical record requests and to the denials and mount appeal processes. RAC has targeted short stays, again, the assumption that these stays are medically unnecessary. In truth, short hospital stays are good and reflect the efficient and appropriate management of care, some of which can be very intensive.

Even though Hopkins has a rigorous compliance process for which we review every day of every single Medicare patient stay for medical necessity, RAC denied 50 percent of the medical records that were requested. We took 239 of these to discussion and immediately 135, almost 60 percent, were overturned at discussion even before the first level of appeal. The rest of our 92 percent are in the appeal process.

The RAC program is costing American hospital millions of dollars in the administrative burden to manage the RAC requests, denials, and appeals processes, as well as the financial hit for revenue losses for care that was provided to patients.

There are a lot of smart and committed legislators and policymakers who have put their heads around these issues to come up with solutions that are workable. Unfortunately, with each iteration and layer of new

ideas come complexities and unintended consequences that seem to yield the opposite result. In the case of the Two Midnight Rule, Congress and CMS should consider reverting to an earlier time, that before October 1st, 2013, and should reinstate the determination of inpatient hospitalization based on physician judgment with one caveat, the patients who are hospitalized for greater than two midnights for medical necessity and medically necessary hospital services should be presumed to be inpatients. If we are thoughtful about RAC reform, the short stay problem goes away and alternative short stay payment policies become unnecessary.

Congress should consider the formation of a multi-stakeholder collaborative working group to develop a sound alternative to the current Medicare audit program. We appreciate Congressman Gerlach's and Congressman Crowley's leadership as the lead sponsors of H.R. 3698 and Chairman Brady, thank you for your attention to this issue and holding a hearing on it. Having nearly half the members of this committee support this needed reform sends an important message to your hospitals and to CMS that this issue must be addressed.

The Two Midnight Rule and the RAC program are draining precious time, resources, and attention that need to be more effectively focused on patient care. Johns Hopkins and hospitals around the country stand ready to work with Congress and CMS to support these efforts.

Thank you so much for allowing me to testify.

Chairman Brady. Thank you.

Chairman Brady. Dr. Evans.

Dr. Evans. Chairman Brady, Ranking Member Dr. McDermott, members of the committee, thank you very much for this opportunity to testify before you today.

I am Dr. Ellen Evans, lead physician with HealthDataInsights, the Region D CMS recovery auditor. I am a proud graduate of the University of Texas Medical School, residency trained, board certified licensed family physician, with a certificate of added qualifications in geriatric medicine. I joined HDI during the RAC demonstration program. At HDI, I oversee all of our medical and clinical recovery audit activities.

The recovery audit program is not focused on fraudulent payments. We review claims to ensure compliance with Medicare practices and also identify underpayments that are returned to the providers. This program is a critical component of Medicare operations because over $30 billion are improperly paid by Medicare every year. Since the recovery audit program was passed and implemented in a bipartisan fashion in 2006, over 8 billion improperly paid Medicare dollars have been recovered, as well as over $700 million in underpayments returned to providers.

Recovery auditors identify the types of claims that are most at risk of improper payment by employing vast auditor experience and using Federal publications such as HHS, OIG, GAO, and CERT reports. Every issue a recovery auditor seeks to review is submitted first to CMS for a rigorous evaluation and approval process. Issues that are approved are posted to the recovery auditor's provider portal in advance of any activity.

CMS has limited the recovery audit medical record request to 2 percent of Medicare claims for any given provider. All medical reviews are conducted by licensed and experienced clinicians who undergo extensive screening and comprehensive training. When a provider disagrees with an audit finding, the provider can initiate a discussion period before formally appealing the denial. This is in addition to the usual CMS appeals process.

Though the program has proven to be cost effective, recent constraints have caused a significant decrease in recovery audit reviews. First, as part of the implementation of the Two Midnight Rule, a moratorium was

placed on recovery auditors preventing auditing of short stay hospitals for 18 months. Second, CMS announced the program would be suspended until new contracts are in place. The award date is currently unknown. These two changes will result in over $5 billion of improper payments not being restored to the Medicare trust fund.

Now, let me provide you some facts about the program. First, a recovery auditor is required to return all of its fee when a refinding is reversed upon any level of provider appeal. This means recovery auditors are incentivized to work accurately and precisely. Second, according to the most recent CMS report to Congress, only 7 percent of all recovery audit determinations have been overturned on appeal. Third, recovery auditors are accurate. An independent CMS validation contractor gave recovery auditors a cumulative accuracy score of over 95 percent. Finally, recovery auditors target improperly paid claims of all types, yet Medicare data has noted consistent high dollar errors for inpatient short stays.

Based on this data, it is imperative to the longevity of the Medicare trust fund to correct inpatient short stays. That being said, we understand the frustration expressed by the hospital community surrounding the Two Midnight Rule. We want to work with CMS and the providers to bring clarity to the rules. As the committee moves forward on this important issue, I offer the following recommendations for the program.

First, we support the ALJ appeal reforms outlined in the November 2012 HHS Office of the Inspector General report. Second, we support continued effort by CMS to offer providers front end education to increase provider knowledge of Medicare policies, and lastly, we support increased dialogue among recovery auditors, providers, policymakers, to improve the direction of the program. We are pleased to be a part of the dialogue today.

The recovery audit program must continue to play a role in the Medicare program, especially in light of the recent increases in an improper payment rate. I appreciate the opportunity to appear before you all today and would be pleased to answer any questions that you may have.

Chairman Brady. Thank you.

Chairman Brady. Dr. Sheehy.

Dr. Sheehy. Chairman Brady, Ranking Member McDermott, and members of the committee, thank you for the opportunity to testify today on observation status, the Two Midnight Rule, and related issues.

My name is Ann Sheehy. I am a physician at the University of Wisconsin Hospital in Madison, Wisconsin. I am a hospitalist, which is a physician who cares for patients primarily in an acute care hospital setting. I am also a member of the public policy committee of the Society of Hospital Medicine, an association that represents the Nation's more than 44,000 hospitalists.

Observation care is often provided in the same hospital beds as inpatient care, and to a physician and a patient, the care provider is indistinguishable but is considered outpatient not covered by Medicare Part A. Many Medicare beneficiaries ask how they could be outpatients when they are staying overnight in a hospital. Many ask me to change them to inpatient, which is something I cannot do under current policy. The centers for Medicare and Medicaid services describes observation as a well defined set of services that should last less than 24 hours, and in only rare and exceptional cases, spend more than 48 hours.

We published our University of Wisconsin Hospital data in JAMA Internal Medicine last summer. The average observation length of stay at our hospital was 33 hours, and almost 1 in 6 of our observation patients lasted longer than 48 hours. We also had 1,141 distinct observation codes. We concluded that observation status for hospitalized patients was markedly different from the CMS definition I just stated as mean length of stay was longer than 24 hours, observation stays beyond 48 hours were common, and the number of diagnoses codes showed that this was not well defined

These numbers demonstrate that observation care in real clinical practice is vastly different than how CMS intended observation to be. Any attempt to reform observation policy must recognize how far observation status has strayed from what observation should truly mean, and this problem is getting worse with more beneficiaries disadvantaged by observation. The most recent MedPAC report documented 28.5 percent increase in outpatient services from 2006 to 2012 with a 12.6 decrease in inpatient discharges over the same time period

As the committee is aware, CMS recently established a new policy to determine observation and inpatient status. As of October 1, patients staying less than two midnights with some exceptions were to be observation, and those two or more midnights would be inpatient, although full enforcement has been delayed through March 31st of 2015.

The Two Midnight Rule has presented new challenges in observation care. For example, a Medicare beneficiary may be hospitalized with pneumonia and is improved enough to leave the hospital after 40 hours of care. If that patient happens to get sick and present to our hospital Tuesday at 1:00 a.m., this means I would discharge them at 5:00 p.m. on Wednesday, a one midnight stay, but if the same patient becomes ill at 10:00 p.m. on Tuesday and needs the exact same 40 hours of care, I would discharge him at 2:00 p.m. on Thursday, a two midnight stay. Thus the time a patient gets sick, not different clinical needs, may determine the patient's hospital status and insurance benefits.

This is not just a theoretical finding. In a second JAMA Internal Medicine publication last year, we found that almost half of our University of Wisconsin Hospital less than two midnight encounters would have been assigned observation status instead of inpatient by virtue of time of day of presentation.

Clinically, the Two Midnight Rule hurts the new population of patients, those staying less than two midnights. As an example, a patient with diabetic ketoacidosis may be sick enough to require intensive care unit admission and an extraordinary amount of services that can be lifesaving, certainly a level of care that cannot be delivered safely as an outpatient. Yet these patients can improve quickly, sometimes in 24 to 48 hours. Now a short stay, even in the intensive care unit, can be considered outpatient.

The RAC program was well-intentioned, and Medicare fraud and abuse cannot be tolerated, yet we need more transparency and oversight of Medicare's current auditing programs. The reality is the RAC program costs all of us. In a recent 1-year period at the University of Wisconsin Hospital from October of 2012 to September of 2013, we appealed 92 percent of RAC audits for medical necessity, and we have won every single appeal that has been cited as of May 14 of 2014, which is already two-thirds of these cases.

Essentially, our hospital pays to repair these cases in order to prove we were right the first time, but the RAC pays no penalty for generating this work. These are Medicare dollars that hospitals spend not on direct Medicare beneficiary care, but on a process of defending themselves against RAC auditors.

In addition, the Federal Government ultimately pays for unchecked RAC activity in the appeals process as evidenced by the current OMHA case backlog. The RAC system generates a large number of these payment denials at no consequence to the RACs but at a direct cost to the Federal Government.

To again consider the patient with diabetic ketoacidosis needing intensive care for less than two midnights, why would I not just claim inpatient status? Because this case is counter to the current observation rule of two midnights and is highly vulnerable to audit. This means an auditor who never met the patient in question, a year or more after the patient discharges home, may decide to question my judgment as a physician and audit. Provider autonomy and ability to do what is right can be trumped by the RAC system.

In conclusion, observation status certainly merits reform and the Two Midnight Rule is not the answer. The Two Midnight Rule and observation status in general negatively impacts the delivery of good patient care. We need common sense solutions that most importantly consider the original intent of observation policy. I would caution, however, that observation reform will not be successful unless there is concrete reform of

the Federal auditing programs that enforce observation rules. The Society of Hospital Medicine looks forward to working with the committee on identifying workable solutions to problems associated with observation care and the Two Midnight Rule

Chairman Brady. Thank you.

Chairman Brady. Ms. Edelman..

Ms. Edelman. Mr. Chairman and members of the committee, my name is Toby Edelman. I am a senior policy attorney with the Washington, D.C. office of the Center for Medicare Advocacy. The center is a not-for-profit, nonpartisan public interest law firm based in Connecticut that provides education advocacy and legal assistance to Medicare beneficiaries.

We are very pleased to be invited to testify today about the impact on Medicare patients of outpatient status and observation status. Six years ago, a woman called our office with a Medicare problem. She had spent some time in the skilled nursing facility, but the facility told her that Medicare Part A would not pay for her stay because she had not been an inpatient in an acute care hospital for 3 days. She asked how that could possibly be true, after all she had been in the hospital for 13 days. It turned out that the hospital had called her an outpatient for all 13 days.

The Wisconsin woman had no way of knowing she was an outpatient in observation status. She was in a bed in the hospital for 13 nights, she had diagnostics tests, received physician and nursing care, medications, treatment, food, a wristband. Her care was indistinguishable from the medically necessary care she would have received if she had been formally admitted as an inpatient.

As in most hospitals, she was intermingled with inpatient, so even the physicians and nurses providing care to her didn't know whether she was an inpatient or an outpatient, and the hospital was not required by CMS rules to inform her that she was an outpatient or the consequences of that status. But solely because she was called an outpatient in observation status, Medicare Part A did not pay for her post-hospital care. Medicare limits payments to SNFs who are hospital patients, who are called inpatients for 3 consecutive days, not counting the day of discharge, what we call the Three Midnight Rule.

In the past 6 years, the center has spoken with literally hundreds of families from all over the country with similar experiences. It is a very rare day that goes by that we don't hear from at least one person and usually more. I would like to describe the more recent case and the consequences. A 90-year old man living at home with his wife had a fall. He went to the urgent care center and the physician there advised him to immediately go to the hospital because of a hematoma on his leg, was growing rapidly. The daughter who called me told me that as her father was being wheeled into the operating room, the hematoma burst. He had emergency surgery to evacuate the hematoma and remained in the hospital for four midnights, all outpatient. From the hospital, he went to the skilled nursing facility for rehabilitation, stayed for 18 days, and went home.

If the man had been formally admitted to the hospital as an inpatient, Medicare Part A would have paid the entire bill for his 18-day stay. Medicare Part A payment is comprehensive and pays for room and board, nursing care therapy, drugs, everything that the patient needs during that stay. Medicare pays 100 percent of the cost for the first 20 days in the SNF, and beginning on Day 21, the resident pays the copayment, up to 100-day maximum number of days in the benefit period, but because her father that been called an outpatient during his entire four day stay, Medicare did not pay, Medicare Part A did not pay. The man had to pay out of pocket the SNF charges. For room and board, the charges were 4,573 days, $73 for the 18-day stay. In addition, he had to pay Medicare Part B copayments for all of the therapy he received daily, and he had to pay for his prescription drugs.

An administrative law judge found that the man's primary care physician supported an inpatient admission, and she also found that he had not been informed of his outpatient status; nevertheless, she upheld denial of

Part A payment for his SNF stay solely because he was, as she described him, hospitalized as an outpatient. Obviously, from the perspective of patients and their families, what is happening makes no sense. When patients need to be in the hospital for the diagnosis and treatment of acute care conditions and when they are getting medically necessary care they need in the hospital for multiple days and nights, they do not understand why they are called outpatients and why their care in the SNF will not be covered.

You have heard from physicians and hospitals this morning about why calling hospitalized patients outpatients is causing hardship for them, and some of the issues that we have been discussing this morning are very complex, but the solution for Medicare patients is simple and straightforward. H.R. 1179 counts all the time in the hospital for purposes of satisfying the Three Midnight Rule. As of last week, there were 144 cosponsors. There is a companion bill in the Senate, and the bills are bipartisan.

The legislation is supported by a broad ad hoc coalition of 30 organizations, and I have attached our comment fact sheet to the end of my testimony with all of our logos on top.

We urge the committee to quickly move on this legislation as you consider these other far more complicated issues.

Thank you.

Chairman Brady. Thanks, Ms. Edelman.

Chairman Brady. Thank you all for your testimony.

Ms. Deutschendorf and Dr. Sheehy, do you think RACs disproportionately target high value inpatient claims?

Ms. Deutschendorf. Yes.

Dr. Sheehy. Yes.

Chairman Brady. In the appeals of those, could you give us what you think is the true cost of appeal. My assumption is, high value claims are more complex, there is more of the files reviewed. You are obviously bringing in medical professionals as well as appeals processing. In a case like that for a hospital, what is the true cost of that appeal roughly? I am sure it varies, but --

Ms. Deutschendorf. So we actually when RAC was proposed several years ago as a permanent part of the program, we actually went through a process to estimate the cost of an individual appeal. You have to add into that, all of the costs associated with the medical record requests, the issues in terms of loading this into software because of the mountain, and for a hospital like Hopkins it could be 600.

And then you have got 50 percent of those that may be denied, so then the tracking and everything that goes along with that. So there is all of that prior work, then there is the estimation of time it is for our nurses to review the cases, our physicians to review the cases.

Chairman Brady. What do you think that cost is overall?

Ms. Deutschendorf. So we estimated it was about $2,000 an appeal at the first and second level, but then when you get up to the ALJ level that requires another add on because you need attorney support with that as well as physician advisor support during that time.

Chairman Brady. What do you think that cost is?

Ms. Deutschendorf. I could probably get back to you, but I would say it is a couple of thousand dollars per, at the ALJ level.

Chairman Brady. In addition?

Ms. Deutschendorf. In addition.

Chairman Brady. After the first two steps; and the third step?

Ms. Deutschendorf. We as a health system spent about $4 million just gearing up for the RAC process to add on the additional personnel it would take to manage that process.

Chairman Brady. Is that compliance and appeal?

Ms. Deutschendorf. Compliance, appeals and medical records and just managing and tracking the whole process as well as software.

Chairman Brady. Thank you.

Dr. Sheehy, do you have an estimate on the cost of an appeal on a high value claim.

Dr. Sheehy. Yeah. I don't have an estimate on a single appeal, but I can say the resources our hospital puts forth in the whole auditing process, we have multiple nurse case managers that their entire job is to determine status and assist physicians in helping to determine the proper status.

Once an appeal is made, we have a team of lawyers, our CMO, two utilization review physicians, and multiple other nurse case managers staff, whose job is to fight the appeals process, so anyone looking at those numbers of staff can calculate that this is a costly endeavor to our hospital.

Chairman Brady. Okay. Did both of you hear Mr. Cavanaugh describe one solution as short stay outlier approach? Do you have a view on whether that helps, hurts, doesn't solve the problem?

Dr. Sheehy. I think you know, we have been talking about different solutions, and obviously I think CMS did intend the Two Midnight Rule to fix a problem in observation status. They recognized there were issues with the current observation policy. I think now we have seen the Two Midnight Rule also has issues, and we would hope that the there would be more consideration of policies going forward, thinking about the true definition of what observation truly means, a very short stay, a patient, a very well-defined subset of clinical needs prior to going forward and coming up with a new plan.

We would also strongly advocate for a pilot. I think with the Two Midnight Rule is evidence of rolling out a policy across the country with unintended consequences. I think a pilot would be of great benefit.

Ms. Deutschendorf. I would agree with that, with everything Dr. Sheehy said. One of the statements that was made earlier was there was disparity between the cost of observation stays, and I would submit that one of the reasons for that is the true definition of what observation used to be, and that was a period of time to help determine whether or not the patient needed hospitalization as an inpatient or could be sent home.

Those short stays in observation would be very less costly. By the time they need to be admitted, those are patients that require extensive diagnostic studies and extensive treatment, and sometimes those patients turn around in less than two days, and so we should not be penalized for being efficient in our ability to manage those patients as an inpatient.

Chairman Brady. Thank you.

Ms. Edelman, you made a point that drew my attention. You were making the case that if outpatients return to the hospitals within 30 days their return isn't a readmission because they were originally labeled as outpatient, and some portion of the report at the client hospital readmissions reflects the fact that many patients are called outpatients. Any idea how frequent that is, what percentage of the reported decline that might represent?

Ms. Edelman. We don't have data that would indicate what portion of the readmitted patients are not called readmitted because of observation, but actually the only reason that we have ever heard from families told by the hospitals that they are using observation status is the Recovery Audit Program.

Nobody has ever actually brought up the hospital readmissions issue, but we know that is now in effect, so it obviously has some impact because if somebody returns to the hospital as an outpatient, that does not count as an inpatient, and a penalty would not be applied.

Chairman Brady. Dr. Evans, when there are costs associated with the hospital appealing, especially in high value inpatient claims and they are overturned, the RAC returns the commission. Is that correct?

Dr. Evans. That is correct.

Chairman Brady. Do they share in the cost of that appeal at all.

Dr. Evans. Well, the cost of our work doing that appeal and the work doing the review initially.

Chairman Brady. But having lost that claim, does the RAC reimburse some portion of the cost?

Dr. Evans. Well, we are paying back all of the funds that were used on our part to do the work.

Chairman Brady. Right. That was because it was an improper determination up front, but do you share in the cost? So you don't receive your commission.

Dr. Evans. There is a financial penalty that occurs. There is not a payment for any of the costs of the hospital, so I am not aware of the --

Chairman Brady. So, the impact is you return the commission, but you don't share in the cost of the lost appeal?

Dr. Evans. We pay our portion of attending the appeal, and the provider pays their portion.

Chairman Brady. Say that again.

Dr. Evans. We pay our portion of attending the appeal, and the provider pays their portion of attending the appeal.

Chairman Brady. Okay. Win or lose, that is how it is divided?

Dr. Evans. That is correct. So when we win there is not any difference either.

Chairman Brady. Okay, I will finish with this. Listening to testimony today, there are an isolated number of short stay DRGs that may be problematic that was discussed earlier. In the oversight of the RAC program,

did CMS ever intervene to stop audits so they could insert a targeted payment approach to quickly and easily solve the problem of the short stay DRGs?

Dr. Evans. And you said a targeted DRG approach?

Chairman Brady. Yeah.

Dr. Evans. They haven't intervened. The intervention has been to stop the short-stay reviews with the Two Midnight Rule, but there has not been an intervention and I think what we have heard said today is there is a lot of variety, a lot of difference across providers in the rate of improper payment, for outpatient versus inpatient care, and I think we have also seen discussion that we need to look at where we go forward.

So for instance, CMS is proposing in the new contract, that we have a variation in the amount of medical records that are reviewed based on the providers' outcomes. So if we have a provider who has a very low rate of improper payment, we would expect to decrease as we go forward their number of records looked at. If we have a provider who has a higher rate, we would expect to increase that going forward. So CMS is looking at that, and so I think what I would say is we want to collaborate with you, and I think this opportunity to share information is very good; and I look forward to be involved in continuing this sort of information exchange.

Chairman Brady. Okay, thank you.

Dr. McDermott.

Mr. McDermott. Thank you, Mr. Chairman.

There was a Senator by the name of Daniel Patrick Moynihan who said there are a lot of simple answers around but we need a great complexifier and the fact is that we have a very complex question here, and the next level is going to be, it seems to me, even more complex because you have all agreed that the patients get treated the same whether they are observation or inpatient. The patient gets what they are supposed to get. So what we are discussing here is who pays how much to whom, and it is a question of whether the beneficiaries get charged more or the hospitals get less money. That seems to be where we are.

And one of the issues that has come up here, Ms. Edelman, is one that I would like to hear your thoughts about. There has been a talk about the different cost sharing between Part A and Part B, and people are suggesting that we roll Part A and Part B together, and that, that somehow will eliminate or alleviate or something in this whole process. I would like to hear from you as a patient advocate what you think will happen to beneficiaries if we roll the A and B together generally but also specifically in this outpatient observation status, because I think we don't want to make another step that makes it even worse. I mean, we were trying to fix a problem with what we did, so give me your ideas.

Ms. Edelman. Thank you for that question.

Simplifying the program, a complex Medicare program would be helpful. The problem with the Medicare redesign proposals that we have seen that combine Part A cost-sharing obligations, is that they also prohibit other insurance like Medigap policies that provide first dollar coverage and so the consequence is that these combined Part A-Part B cost-sharing obligations would shift costs to the patients. The idea of that is, in fact, to make people pay more out of pocket on the assumption that they will be more careful healthcare consumers, but what we know will happen is that people will avoid medically necessary care because they won't be able to afford it.

Medicare beneficiaries already spend a much higher proportion of their income on healthcare than younger people, and half of the Medicare beneficiaries have incomes of $23,500 a year. They really cannot afford to

pay more out of pocket, which would happen as a result of a number of these redesign proposals that we have seen.

Our program with a couple of other programs, Medicare Rights Center and California Health Advocate submitted a statement to this committee a year ago about concerns, about the Medicare redesign proposals. I would be happy to submit that for the record.

Mr. McDermott. How would the rolling of the two together affect this whole question of observation versus -- or would it just be there would be no question anymore. It would just be a patient in the system?

Ms. Edelman. Well, it would depend upon how the specifics of the redesign worked and how people would have to pay. Right now if people are inpatient, they pay the inpatient deductible. If they are outpatients, they pay the full cost out of pocket for the nursing home care and Part B copayments and medications and it is not clear what would happen with a combination of those two.

Mr. McDermott. Does the three day stay that has to be there to go into the nursing home, what happens to that?

Ms. Edelman. That is still in the statute unless that gets repealed. That has been in the Medicare statute from the beginning.

Mr. McDermott. So if they are in the hospital and the hospital calls it an observation, they do not get the credit for going into the nursing home?

Ms. Edelman. They do not get, the three midnights do not stay, so the woman in Wisconsin who was in the hospital for 13 days, consecutive days, as an outpatient did not have a three day qualifying inpatient stay.

Mr. McDermott. And rolling the Part A and Part B together would not change that?

Ms. Edelman. Wouldn't change the three midnight rule. That is still there.

Mr. McDermott. You know what we are trying to do. How would you design what we should do at this point?

Everybody's saying we should call a committee together or something, but I would like somebody to put something on the table and say, if anybody has an idea what we should do in this situation, I would like to hear it.

Ms. Edelman. Well, for the simple issue of qualifying for skilled nursing facility care, the H.R. 1179 does it by just counting all the time. It doesn't deal with whether observation makes sense or doesn't make sense. It doesn't deal with recovery auditors. It doesn't deal with all of these much more complicated issues. It just says if you have been in the hospital for three nights, the time should count.

And I would just say when Medicare was enacted in 1965; the average length of stay in an acute-care hospital for people age 65 and over was 12 plus days. The average length of stay now in the acute care hospitals for people 65 and over is 5 plus days. The three midnight rule is a problem considering how medicine is practiced today.

Mr. McDermott. Thank you.

Chairman Brady. Thank you.

Mr. Gerlach.

Mr. Gerlach. Thank you, Mr. Chairman.

Ms. Deutschendorf, in your testimony you basically say that the Two Midnight Policy now requires physicians to abandon the medical assessment component of the medical necessity test when determining the appropriate setting of care and instead imposes a rigid time-based approach. Can you elaborate or expand on that a bit?

Ms. Deutschendorf. So for our providers what happens now is the patient presents to the emergency department, and now they are faced with this question, do you expect that the time this patient will require hospital services will be greater than two midnights, which to Dr. Sheehy's point, could be depending on whether that patient arrives one minute before midnight on the first midnight and then stays 24 hours and one minute in the second midnight, or whether they would need to be hospitalized for up to 48 hours.

A lot can happen in 48 hours, and what we have found since October 1, is that we have tripled the amount of patients who have started out as an outpatient and has been converted to an inpatient after or just before the second midnight because, in fact, we got it wrong. Because we really don't know. Patients present to the emergency department with a myriad of problems, some of which are going to respond rapidly, some of which will not respond rapidly, and there is no way of knowing that, and we are doing the right things.

We do have an army of case managers and utilization management nurses who now have to run around the hospital looking for patients who have crossed the first midnight to see if these patients will require medically necessary services beyond the second midnight so that we can get than converted. We have been instructed by CMS that if the patient is going to cross the second midnight, they want them to be converted, even if they are going to go home in the next twelve hours. It is logistically a very difficult policy to implement and has required a lot of financial increases as a result of that.

Mr. Gerlach. H.R. 3698 would require the Secretary of HHS to establish a new methodology for utilization in situations involving the shorter stays in hospitals. We got some idea from Ms. Edelman about what she'd like to see relative to that kind of new methodology.

Could I have quickly the other three of you, please give us your thoughts as a follow-up to Mr. McDermott's question, what specifically change-wise and what kind of new methodology ought to be employed so that there is a fairness, an equity in terms of how hospitals are reimbursed for those that come in in a very short-stay kind of situation. Dr. Sheehy, can we start with you?

Dr. Sheehy. Thank you for that question.

I think it is a very complicated topic, and I think a simple answer is probably difficult to give. I think getting back to the principles of observation being a triaging definition, it was always meant to be a definition where someone needed a few additional hours to determine whether they should be fully admitted as an inpatient or discharged home.

I think we need to get back to the principles of that definition and come up with a methodology that respects that definition. I think we also need to think about the difficulty as a provider I have telling a patient who is staying overnight in a hospital, getting inpatient nursing care, getting intravenous medications and tests in a hospital setting, how I could explain that to that patient that they are an outpatient. I think getting back to the heart of what observation really means, I think is what we need to focus on coming up with a new policy.

Mr. Gerlach. And then you added that you thought that should be done on a pilot basis first to really test the idea to see if it really in a practical way is working before you expand it to the entire system?

Dr. Sheehy. That is correct. I think we will see the unintended consequences in any policy. I think we will understand better how a policy should be audited and do it on a smaller scale so hospitals across the country are not investing a lot of money on a whole new plan that has a lot of issues. We can figure out those issues and tweak the plan before it is implemented nationwide.

Mr. Gerlach. Dr. Evans, do you have a quick answer to that even though you look at it from the RAC perspective?

Dr. Evans. Well, first from the RAC perspective, again, I have said I think the collaboration and discussion is very good, and I think that the idea that there is some changes that can be made are good. If there were a pilot we would be willing to be involved in that. I would say I am here for the recovery audit work, but I am very interested in this personally. If after the meeting or something you wanted to talk to me as a taxpayer, I am a physician --

Mr. Gerlach. You are not having heart palpitations right now or anything?

Dr. Evans. No, I am not. I love this. I think it is really excellent to have this discussion. It is what I am doing my work for so that this would sort of happen. I am running over, okay.

I just wanted to say I have been medical director of skilled nursing facilities and worked at the MAC and now at the HDI, and I have got a lot of ideas, but I think we would support this type of reform, and we could offer discussion and support afterwards.

Thank you.

Mr. Gerlach. Thank you.

Chairman Brady. Thank you.

Mr. Kind.

Mr. Kind. Thank you, Mr. Chairman.

And I want to thank our panelists for an excellent presentation today and Dr. Sheehy, a special welcome to you. I have had the opportunity back home to visit UW Hospital System and the clinics, and I have always been very impressed with the quality of care, the outcome, the measurements that are being established back home. But you are probably sensing a source of frustration coming from this dais. This is some tough, complicated stuff, and we are trying to wrap our head around it and we are listening to you try to thread the needle on different statuses on observation, inpatient, outpatient.

As policymakers, we are going to have a hard time being able to provide direction at this level of expertise or knowledge that is required of it. It is really kind of a source of frustration that we have with the overall healthcare payment system that we have in our country today. This is fee for service. It is this coding. It is this payment based on how much is done, not how well it is being done, and there are tools in place right now; and many of us have been pushing hard and been very inpatient to move to a more value, quality outcome-based reimbursement system. If we can get those financial systems I think aligned right, we are going to unleash a heck of a lot of innovation in the health care system. Knowing what those benchmarks need to be, where those measurements are, and then figuring out how to meet them.

Because the truth is we don't have so much a budget deficit problem here in Washington as we have a healthcare spending problem, and that is what we are wrestling with. There are only a few options that we can go down the road with. One is greater cost shifting, you know, having patients bear more of the risk of higher costs. We see that with voucher proposals or what have you, or you are going to have some

indiscriminate provider cuts being made, and the provider community obviously isn't going to be very happy with that. We see this with sequestration and pushing those hospital cuts out for infinity it seems at this point.

Or we need to be working with the provider community to establish those quality measurements and then align the financial incentives so it is value based and no longer observational status or all these technical definitions that just weigh us down, and it is just exhausting having these conversations and getting the feedback from patients and providers alike.

So, I guess it is just a general question. Dr. Sheehy, I can start with you. If anyone else wants to chime in. Ideally where do we need to be going with the healthcare payment system of this country right now so that we are not having hearings like this talking about inpatient or outpatient or observational status and trying to figure out what the best policy is in addressing it?

Dr. Sheehy. Well, thank you for the question, and thank you for all the work you do for the State of Wisconsin on healthcare.

I would be more than happy to work with you in the future on these issues going forward. I think it is very complicated, I think there is certainly a role for quality measures in physician payment, and I think as hospitalists we are trying to figure out exactly how we fit into that payment model.

Going forward, though, I think, you know, I am from a small town in Wisconsin as well, I grew up near Madison where I work, and what I do on a daily basis is take care of patients in the hospital. Some of these patients might have been my neighbors or maybe a middle school teacher, and I think if we can get back to thinking about these are Medicare patients, they have worked their whole lives, and what is the right thing to do for them, I think we are going to find those solutions.

Mr. Kind. Ms. Edelman, I am concerned about the impact on the beneficiaries, the patients out there. It seems like they are getting caught and often not to their knowledge and just based on definitions that are applied to them and then the increased out-of-pocket expenses which they experience which creates a tremendous hardship and yet within the Medicare system itself, we have seen beneficiary payments come down dramatically in recent years, and hopefully that is sustainable, and hopefully that is due to some of the reforms that are taking place in the delivery system but also some of the new payment models out there.

How much concern do you have right now in regards to the cost shift that you are seeing with the beneficiary community?

Ms. Edelman. The cost shifting in the observation status is considerable, and we know that some people really do not have the money to pay for the nursing home care out of pocket when they are told what the cost is, and they go home and then what we hear is a couple of days later they have another fall, they break a hip, they are back in the hospital. So the costs to the system are very intense.

We know families are contributing huge amounts of money to pay for out-of-pocket costs because Medicare is not paying for the nursing home. So we have heard of a nephew being asked to bring a check to the nursing home today for $7,000 for his aunt to get care. People are doing that, families are kicking in money that they may not really have. We have heard of families cashing in life insurance policies that were intended for burials because they need to get the nursing home care. So it is having a tremendous impact on Medicare beneficiaries and their families trying to pay these high costs.

The average private rates are like $250 a day, but I was in the nursing home in Boston last month, and the private rates were 450 to 480 a day. Most people can't pay that.

Mr. Kind. Thank you.

Thank you, Mr. Chairman.

Chairman Brady. Thank you.

Mr. Smith.

Mr. Smith. Thank you, Mr. Chairman.

Ms. Deutschendorf, in your written testimony you referenced the Medicare Audit Improvement Act, H.R. 1250, obviously supported by numerous members of the House. I am wondering if you could reflect a bit on an alternative that I happened to introduce, H.R. 2329, the Administrative Relief and Accurate Medicare Payments Act. Have you reviewed that bill, and could you reflect on that at all?

Ms. Deutschendorf. I have not, but I would be happy to respond in writing.

Mr. Smith. All right. You bet. Thank you very much.

Mr. Smith. Ms. Edelman, what do you believe is the cost -- well, first of all, do you believe that Medicare beneficiaries are very familiar with the financing or the various -- I mean, we have heard a lot of technical things. I started to keep a list here, and I lost it amidst the paperwork here of just terminology and funding strategies and schedules of payments and so forth. How familiar are seniors with that type of thing?

Ms. Edelman. I think most people have no idea of what the terminology is or what it means.

Mr. Smith. And do you believe that there is a cost to that, given the existence of that disconnect with patients and, I mean, I don't believe we could really expect them to be familiar with all of these intricate details of a funding system. Is there any possible way just to have a system to where seniors are more familiar with what is going on with the funding, so not that it has to be out of pocket, but so that they can perhaps know more what their options are?

As you pointed out in your testimony, that they were considered an outpatient, but yet they were in the hospital for so long and certainly thought that they were an inpatient; what do you think the alternatives should be?

Ms. Edelman. Well, there are some bills that would suggest giving information to people to tell them, at least give them information that they are outpatients and a couple of states have passed laws, Maryland and New York, requiring that people should be informed that they are outpatients and what the consequence is.

But unlike other Medicare systems, they don't have an opportunity to contest their outpatient status. Generally if somebody goes into the hospital as an inpatient, the person immediately gets a form Your Rights As a Medicare Patient and if the hospital wants to discharge the person, and the person thinks I am really not ready to go, there is an immediate appeal to a representative of the Medicare program to make a decision.

In observation status there is no due process right for the Medicare patients. There is nothing they can do, so giving them information is helpful, but we also need to give them an opportunity to say I should be called an inpatient, not an outpatient.

Mr. Smith. Would you agree that the more the government has gotten involved, that the more expensive healthcare has become?

Ms. Edelman. Well, I don't know if the cost of the Government has been the cause of health care becoming expensive. Certainly before the Government was involved a lot of people didn't get health care, so it has

been critically important. Medicare is a very important program for older people, and most older people love their Medicare program. Without it they wouldn't get the health care they need.

Mr. Smith. Okay, thank you, Mr. Chairman. I yield back.

Chairman Brady. Mr. Pascrell.

Mr. Pascrell. Mr. Chairman, I would just like to make a couple of points in response to my friend, Mr. Roskam's comments in the last panel about state budget neutrality, which is interesting to define, and how it affects what we are talking about.

New Jersey is in a unique position because my state is an all-urban state with no rural or critical access hospitals. I would like to point out that the permanent adjustments have always been based on the national budget neutrality, always. So this includes adjustments for critical access hospitals and there ironically are 53 critical access hospitals in Mr. Roskam's state of Illinois. I think we need to make that clear.

Now, Ms. Edelman, your organization has done a significant amount of work in the area of observation stays, and you worked directly with a number of beneficiaries who have run into problems with the way they were classified. I think you have defined that. In your experience, do beneficiaries generally know whether they are classified as inpatients or under observation status, in your experience?

Ms. Edelman. Most patients do not know that they are in observation, and the Medicare program does not require hospitals to tell them. The only time --

Mr. Pascrell. Do they have a right to know that?

Ms. Edelman. Well, they should have a right to know it. Yes, they should. They should know and the consequence.

Mr. Pascrell. When do patients generally find out what their status is?

Ms. Edelman. Usually at the time of discharge.

Mr. Pascrell. When they pay their bills?

Ms. Edelman. Bring the checkbook to the nursing home because Medicare --

Mr. Pascrell. That's what I figured.

Ms. Edelman. -- will not be paying.

Mr. Pascrell. You mentioned earlier observation status is particularly problematic when Medicare beneficiaries need care in a skilled nursing facility after leaving the hospital. Because Medicare won't cover these services unless, unless, a patient has been classified as an inpatient for at least three days. Am I right so far?

Ms. Edelman. Yes.

Mr. Pascrell. Ms. Edelman, in the cases your organization has handled, what is happening to observation status patients in need of care at a skilled nursing facility after leaving the hospital?

Ms. Edelman. Some are not going because they can't afford it. Some are going and paying out of pocket and trying to appeal later through the Medicare summary notice form that they get, trying to appeal through the administrative process. But many of the people that I have spoken to do not pursue the appeals. They give up. It is just too complicated and too time consuming, and they give up.

Mr. Pascrell. Are many of these seniors paying out of pocket?

Ms. Edelman. Yes, they are paying out of pocket, and their families are as well.

Mr. Pascrell. So, Mr. Chairman, in conclusion if we don't identify and respect the right to know, and we had a Patients Bill of Rights, which is part of the reform process that we are now going through, then we defeat the purpose of what we are doing.

Seniors, anybody, has a right to know what status they are in, what that implies, and how much it is going to cost them eventually if they don't get out of that status or if they don't cross over. I think that this is serious business, I ask you to bring us to attend to it, and there is legislation here which is bipartisan, and I hope that you will do that, and thank you for the hearing.

Chairman Brady. Thank you.

Mr. Renacci.

Mr. Renacci. Thank you, Mr. Chairman, and I thank the panel for being here.

It is interesting because I think we are really talking about the problem, and then there's the symptoms of the problem. The problem is the hospital readmission reduction program, and quite frankly the policy that was written was probably, the thought was good, the outcomes are becoming bad because when a patient enters the hospital, they are either classified as observation. They are not admitted. There's all kind of things. They are outpatients. We are putting them in classifications. Why? Because we don't want to be penalized for the reduction program if you are in the hospital.

And again, I am not blaming the hospitals in that sense. They are trying to survive, too. But, quite frankly, who is getting hurt here but the patient? So let's look at the unintended consequences. We have patients that go into a hospital. They are the sickest of sick, we know they are coming back, and we have an issue there. It is one of the reasons why I introduced H.R. 4188, a bill that requires the Secretary of HHS to adjust the payment methodology to account for certain disparities really in patient population. This adjustment will really make a huge difference to hospitals across the country and the 9 million duly eligible beneficiaries that rely on these hospitals for critical care needs. We need to make sure. There are patients that are going to come into a hospital that are going to go back to the hospital, and those hospitals are being penalized. This bill would at least help that issue.

Now, on the other side, I still have a problem when you take a patient who quite frankly doesn't need to go to a hospital, should be going directly to the nursing home, but we have another policy that says you have to go to the hospital first, and you have to spend three days in that hospital and then that patient goes to that hospital and, of course, they spend three days. They don't know whether they are observation, they don't know whether they are inpatient.

Then they come out, they go to a nursing home, and then they are penalized because in many cases they ended up as an observation status. That is a problem, too. That is why we talked earlier about the bill I introduced to eliminate the three-day stay. Let's face it, there are some patients that have to go in the hospital, but there are some that could go directly to the nursing home, and I question why we would ever be paying you know, up to $11,000 to have someone stay in a hospital for three days versus going into a

nursing home where my statistics show the average stay is around 27 days. Quite frankly it doesn't make sense. We are spending money that is not necessary.

Ms. Edelman, I would ask you, you know, do you think the elimination of the three-day hospital stay is good policy?

Ms. Edelman. Well, I think it ultimately is what makes sense because as I said, the length of stay in hospitals has gone down so much that the three days is a very large portion of what time people actually do spend in the hospital.

The long-term care commission endorsed elimination of the three-day stay and so this is where I think as Congress is considering post-acute care reforms, which is a topic of discussion now, this should certainly be part of the discussion. We want to make sure that people are, that there is not a lot of gaming in nursing homes, so we want to be careful of that possibility; but this is where it needs to go to eliminate it. It doesn't make sense with the way medicine is practiced today.

Mr. Renacci. And I don't know if there is anyone else on the panel that when we talk about H.R. 4188, which is a bill that really takes a look at these hospitals where there are readmissions for the sickest of sick, the poorest of poor, if we shouldn't have an adjustment for those. Is there anyone?

Ms. Deutschendorf. So, as I stated in my opening comments, and thank you for asking, I am responsible for the readmission reduction program for the Johns Hopkins Health system and our hospital. We have been at this for 4 years, and we are working really, really hard to implement all of the strategies that were suggested in the demonstration projects and at an academic center such as ours where we take care of some of the sickest patients in the country who are transplants, who are duly eligible, et cetera, we have not been able to move that ball.

And, in fact, it is all about numerators and denominators, but as you take out the short stays out of the denominator, and your patients are sicker, your readmission rates go up. Despite what we are doing, and we do have some successes, but we have not been able to move that. So having that bill with taking out transplants, end stage renal disease, substance abuse, and psychoses and some of the other things, would certainly help us. The other thing that we have really learned about this has to do with patient's values, beliefs and preferences, so it is very important that we share this responsibility not just with the providers but also the patients.

Mr. Renacci. Thank you.

Mr. Chairman, I yield back.

Chairman Brady. Thank you.

Mr. Reed.

Mr. Reed. Thank you, Mr. Chairman.

I am way over here, so I appreciate, I will give you a different angle here to look at. I wanted to come today, and thank you Mr. Chairman, for holding this hearing, and thank you to the panelists.

This is something I am very concerned about coming from a rural section of the State of New York. My rural hospitals in particular are struggling to deal with these issues as well as many others, and I wanted to just read for the record a letter I received from one of our hospital directors at Jones Memorial Hospital in Wellsville, New York. She wrote, Dear Tom, Jones Memorial is a sole community hospital in rural upstate Western New York. Jones has an average daily census of 20 patients. As many rural New York state

hospitals, Jones has limited resources and actively trying to keep costs down to the overall healthcare system. Then she goes on. She writes in 2012 Jones began receiving draft program audit notices. The cases dated back to 2009, they received a total of 240 inpatient claim denials. To date Jones have appealed and won approximately 197 of those claims. Of the 240 claims, 18 were not successful on appeal.

The rest of the cases are still pending, so pretty good outcome in regards to challenging these requests. But this is what she said that really stuck out to me in the letter. Jones Memorial with an average daily census of 20 has to employ three full-time RN case managers to make sure that someone is here the majority of the time to ensure compliance with the Two Midnight Rule. These same case managers spend a lot of their time working on appeals for the RAC audits. We also have three billing and medical records staff that spend 30 percent of their time on RAC audits and appeals. The dollars being expended for a small hospital are unsustainable.

Now when I hear Eva write me that letter, and I know Eva very well, Eva Benedict, does a great job there at Jones Memorial, my concern is this. How are these rural hospitals going to sustain themselves if they have to take on those administrative cost burdens that we just articulated there and keep the doors open and comply with this complexity coming out of Washington, D.C.? Does anyone on the panel disagree with me that in particular our rural hospitals are at a distinct threat as a result of the burdens that are coming out of this ambiguity? Dr. Sheehy.

Dr. Sheehy. I can answer that question. My primary practice location is a University of Wisconsin Hospital which is a tertiary care referral hospital, but I also am privileged at one of our community hospitals and practice there. It is a small hospital and I agree with you. I think that the burden on smaller hospitals is enormous. I also think a lot of these smaller hospitals have contracted with, there are private companies now who will actually do what your hospital has described. Instead of hiring their own nurse case managers to do this, they will hire a private company now and pay them a lot of money to look at these claims for them and I think the cost is enormous. The cost to fight this process and to kind of learn how to do these audits and appeals, it is staggering.

Mr. Reed. Anyone else share that sentiment or oppose that sentiment? Because I agree with you, those are dollars that otherwise could be going to the community in regards to servicing their healthcare needs as opposed to complying with the administrative burdens. Do you have any idea, here's a hospital with 20 average daily census, and they have got essentially five full-time workers focused on filling out paperwork. How can we do better? Yeah, ma'am.

Ms. Edelman. I just want to say one thing about that. That hospitals are spending an enormous amount of time and money trying to make these inpatient-outpatient decisions.

The first thing they do is buy InterQual, which is a proprietary computer program. Then they are hiring staff just to make these decisions, and the American Case Management Association, which is part of our ad hoc coalition supporting H.R. 1179, did a survey of their members. These are the hospital discharge planners. Three quarters of the hospitals reported hiring staff just to be making inpatient-outpatient medical necessity decisions. A third of them had spent more than $150,000 and this is a couple of years ago, on that staff.

Then they are also using an outside secondary reviewer. The company that we know of used to report on its Web site how many medical necessity cases they had done. Since 1997, they had done 4 million. If they are charging we think maybe $200, $250 a case, that is a lot of money to go out of the Medicare system which should be designed for providing care to people, but it is only to make the decision whether people should be admitted as inpatients or called outpatients, and the care is identical. It really makes no sense.

Mr. Reed. Thank you.

My balance has expired, and I thank you for that input.

Chairman Brady. Thank you.

Ms. Black.

Mrs. Black. Thank you, Mr. Chairman.

Again thank you for allowing me to sit here with the committee and ask questions.

I want to go back to the issue of the ALJs and the amount of overturned cases and we just hear -- I know this is a complex situation, and we hear these numbers that keep floating around, and there is a report that I want to submit for the record, and it is from the Inspector General. The improvements are needed at the Administrative Law Judge level of Medicare appeals.

Chairman Brady. Without objection.

Mrs. Black. Because there are some good pieces in here as well. But, Dr. Evans, I want to start with you on this question because our members are hearing at least 70 percent number that the providers win these appeals at the ALJ level. I understand that there are two different ways that the ALJ adjudicates cases, and can you please explain how the RAC's view of the overturn rate and how these numbers can deceive when looked at out of context?

Dr. Evans. Yes. The report you refer to, the data that is in there is from 2010, and that was early on in the Recovery Audit Program. Now, I haven't done the analysis, and I would say that I think it is good that this has been brought up here, and I think there is some further investigation of the data that can be done among the different experts like OIG, et cetera.

But that data is from 2010, and at that time we were getting no information about any kind of ALJ hearings. We have attended a few in the demonstration, but we weren't hearing, and we were asking about those. What we found out was that they were 89, 90 percent. You know, the add quick has that information, but they were huge numbers. They were on the record. The on the record in general is a high overturn rate. It is pretty much they are all overturned. All of the contractors across CMS have data that shows that, and in fact CMS had done a study with one of the contractors, where the attendance of CMS at the hearing makes a difference in the outcome of those hearings where the Medicare rules and regulations and the medical record compared to the claim is reviewed.

So I think it is an area that can be looked at, but I think that is part of the difficulty. If you look at the last study, the 7 percent overturn across the board is the most current data that we have.

Mrs. Black. Could those who are providers weigh in on this from your perspective as well, of your cases that get to the ALJ level? Dr. Sheehy, let me go with you first.

Dr. Sheehy. Thank you for that question. We have little data on our ALJ Level 3 appeals at this time. The majority of our appeals are turned over in Level 1 or Level 2. I will just comment that I think the 2010 data, I think the RAC process and observation care has evolved so enormously in the last four years that I think it is worth looking at a new set of data and a new set of numbers.

We know that the RAC recovery rate, the recovery rate for back to the Government has increased. We know that the number of RAC audits have increased. This is why the OMHA has now put a hold on further audits and appeals. We know this is a lot due to RAC denials and so I think we really do need to look at a fresh set of numbers before we start thinking about a 7 percent number.

I can speak on behalf of our hospital. We appeal almost everything, and we win almost everything. The number that I cited in my testimony we appealed in our last one year, we appealed 92 percent of the audits

that the RACs made, and we have already won two-thirds of them. The rest are in Level 1 or Level 2 of appeals, so our history is that we will win almost 100 percent of our appeals. I think there are a lot of hospitals out there that are similar.

Mrs. Black. That is a good piece of information. Thank you so much.

Others want to weigh in on that? Yes?

Ms. Deutschendorf. We just have 10 cases at the ALJ level that have just made it there, and part of that has to do with the delay in the actual recoupment, so we were able to take 239 cases of our 430-some denials directly for discussion, and we spent a lot of time preparing with legal and also with our physician advisors and went straight to the medical directors of our RAC, and 135 of those cases were overturned just at the discussion; and the remainder of those are in the appeal process now. So that is a 50 percent, or a 55 percent overturn rate just at the discussion level.

I just want to say one other thing. We had 108 cases denied for intensity modified radiation therapy. All 108 of those cases were overturned at the discussion level, again because these were medically necessary services that the RAC really was not able to really understand why these cases were brought forward.

Mrs. Black. Thank you.

And, Mr. Chairman, thank you so much for this hearing. It just seems to me that one of the things that I have learned from this hearing is that this certainly needs to have more oversight, more investigation to find out just how the program is working, because I am so concerned as being a nurse for over 40 years, that the care that we are giving and, Dr. Sheehy, please every time you give a testimony, use that example of a diabetic ketoacidosis because it is so compelling to make the case for how you just don't know what that patient is going to need when you receive them into the hospital.

Thank you so much, Mr. Chairman. I will look forward to more hearings.

Chairman Brady. Thank you, Ms. Black.

I just have an inquiry, again, thank for all the witnesses, in the first panel again from Dr. Evans we heard repeatedly that RAC audits aren't a problem. 94 percent are not appealed. Of those who are only about half are returned. Percentage-wise this is a very small amount. Not a big problem. That is at odds with what we hear from our local hospitals in a major way.

And what I think I just heard from Dr. Sheehy and Ms. Deutschendorf is that is old data, that current appeals are much greater than that, and the overturn rate is substantial as well; and, while they may be a small percentage, these are more of the high-value claims, so proportionately more important, probably more expensive to appeal. Is that correct, in a nutshell? Well, what other perspective should we bring to this?

Dr. Sheehy. I think that is a correct assessment. Just another data point, in the OMHA letter to hospitals, one of the numbers they cited, which I think this is why I think this is old data, they said in January of 2012, the OMHA was hearing about 1,250 appeals a week and at the end of 2013, they were getting 15,000, so I think the rate has just accelerated over two years; and I think that number tells you how audits have changed, how our practice has changed.

Chairman Brady. Because the Inspector General's report was from 2010 and 2011, you are saying. Ms. Deutschendorf?

Ms. Deutschendorf. So I would agree with that, that the appeals have mounted as hospitals have been able to change their processes and also that they have rigorous utilization processes that they are also ensuring that they are meeting the compliance and meeting the regulatory requirements for Medicare review of inpatient stays.

We in our compliance program, we self deny almost $4 million a year in Medicare days that we feel we cannot justify for medical necessity. So we feel that anything that we appeal is justifiable. So anything that is denied by RAC, we will appeal.

Chairman Brady. Got it.

Dr. McDermott.

Mr. McDermott. I am like you, a little by confused by what I am hearing here, but it seems like what you are saying is that the RACs operate like the fishermen in my district. They go out and throw a great big net, and that is where the 12,000, you jump from 1,500 at the end of one year to 12,000 in the next. You will say, you have got a lot of stuff in there, most of which turns out to be not justified because they are going on volume. You are saying that the RACs are going on volume, and they got a lot of bycatch, and they have to throw it back because it doesn't work.

Ms. Deutschendorf. That is exactly right. They cast a very broad net, and then what is really considered improper, we would respectfully disagree that those are not improper payments, and we are appealing all of them. So, we are appealing 92 percent. It is almost exactly the same as what Dr. Sheehy has said.

Mr. McDermott. Thank you.

Ms. Edelman. If I could just say one thing, if it is so complicated for hospitals to do these appeals, you can imagine what it is like for beneficiaries doing it on their own. There is one gentleman from Chicago that I talk to every couple of months, and he is in his 80s. He is homebound. The last conversation we had he was describing his cancer and the therapy he is having, and he is trying to do this appeal for his wife. It is very difficult for beneficiaries if they even get to that stage to appeal their outpatient status.

Chairman Brady. Yeah. Thank you.

On behalf of Dr. McDermott, I would like to thank our witnesses for their testimony today, and I appreciate the continued assistance getting answers to the questions that were asked by the committee. These are challenging issues, interrelated, facing CMS, this committee, and our hospital providers.

My view is we have to address them head on in order to ensure seniors are treated fairly and do not face unnecessary charges, and it is equally important for providers and taxpayers to get these issues straightened out, so I look forward to working with all the witnesses and members of the committee to do just this.

As a reminder, any member wishing to submit a question to the record will have 14 days to do so; and if any questions are submitted to the witnesses, I ask that the witnesses respond in a timely manner. With that, the subcommittee is adjourned.

[Whereupon, at 12:32 p.m., the subcommittee was adjourned.]

Wisconsin Hospital Association

Watertown Regional Medical

Walter F. O'Keefe

Thomas M. Horiagon, MD MOccH

Texas Organization of Rural & Community Hospitals

Sherry Smith, LCSW

Pocono Medical Center

Patricia Windle

Patricia Klaiber

New York StateWide Senior Action Council

National Senior Citizens Law Center

National Kidney Foundation

National Association of Urban Hospitals

Nathan Marra

MRC

Missouri Hospital Association

Meridian Health

Medicare Advocacy Project

Marion P. Cunningham

Knollwood Retirement Community

Kirkland Senior Council

Karen L. Buckley

Gundersen Health System

George L. Marra

Doreen Grossman

Diane Walter

Denise Broccoli

Connecticut's Legislative Commission on Aging

APTA

AOPA

American Coalition for Healthcare Claims Integrity

America's Essential Hospitals

AMA

Alliance for Retired Americans

AHCA

Advocate Physician Partners

ACMA

AARP

AAMC