



**Am I in the Hospital or Not? Why Hospitals are
'Observing'--Not Admitting—Patients
Alliance for Health Reform
AARP Public Policy Institute
December 6, 2013**

¹ The Alliance makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material, this transcript may contain errors or incomplete content. The Alliance cannot be held responsible for the consequences of the use of the transcript. If you wish to take direct quotes from the transcript, please use the webcast of this briefing to confirm their accuracy.

ED HOWARD: Welcome. My name is Ed Howard. I'm with the Alliance for Health Reform, and on behalf of Senator Brunt, Senator Rockefeller, our Board of Directors, I want to welcome you to the program today on what's a relatively unknown part of Medicare—patients who are in the hospital but not admitted to the hospital. Instead, they're given what's called observation status. That decision may have substantial financial implications for both Medicare beneficiaries and hospitals themselves, maybe even some clinical impact. And we have some true experts, including my co-moderator today, who are going to lay out these issues in detail. Let me just say that both patients and hospitals find the current situation precarious and CMS finds itself trying to find a workable, affordable solution. Meanwhile, the use of observation status has grown substantially in recent years and I just should say in the nature of a commercial—in this room a week from today, we're going to be doing a briefing that we were just talking about on cost containment plans that might be of help in bending the healthcare cost care. I'm not going to be there because I'm going to be in a hospital, whether I'm admitted to a hospital I don't know. The doc tells me I'm going to stay one night and I'm coming out of surgery so I'll tell you, the next time you're here, whether or not this discussion helped me in the course of my brush with the healthcare system. We arranged it that way so there'd be some firsthand experience to feed back to you, you see.

We're very pleased to have, as a partner in today's program, the Public Policy Institute of AARP, an organization you may have heard of, but the institute itself has been around for what, 25 years or more? Turning out reliable, evidence-based research on policy issues affecting older people. And we're lucky to have, as a co-moderator today, Susan Reinhart, who's a Senior Vice President at AARP. She directs the Public Policy Institute. She also serves as the chief strategist for the Center to Champion Nursing in America, which is housed at AARP. She's a nurse. She's a sociologist and she's a veteran, I'm pleased to say, of several Alliance panels and we're glad to have you back, Susan.

SUSAN REINHART: Thank you. Thanks so much. Talk about up close and personal, Ed. We do know a lot of nurses. You'll have to tell me where you're going so I can make sure they're on their best behavior when you're there, and we did organize this just for you. So at least you know the main question when you go in is: am I an inpatient or outpatient, okay? That's the first thing.

So, first I just want to say that we, at the Public Policy Institute, have been really anxious to have this paper released and this discussion for a couple of years now, actually. Keith Lind, who you'll be hearing from in a moment, and I and a couple of our team members have been really thinking about this and looking at the data. Keith, in particular, with his colleagues on his paper, because we know what an important issue it is. So I wanted to just talk about the title: Am I in the Hospital or Not, because I was thinking about it last night—about that—that really it's the patient perspective, am I in the hospital or not. From the Public Policy perspective it's am I part—is this person Part A or Part B? Are they inpatient or outpatient? Are they a long term OS—Observation Status person—or a short term inpatient hospital person. It's really—I mean, as a sociologist it kind of blows

¹ The Alliance makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material, this transcript may contain errors or incomplete content. The Alliance cannot be held responsible for the consequences of the use of the transcript. If you wish to take direct quotes from the transcript, please use the webcast of this briefing to confirm their accuracy.

you away, all the different categories you could be. But from a patient perspective they think they're in the hospital, and Carol Levine will get more into that from a consumer perspective. But I also thought I'd start off with this, a bit of a story. About a month ago I was in Reno to give a presentation to nurses actually and one of them said, would you like to see my hospital in Incline, Nevada? Na-vaa-daa. I've got to say that right. Nevada. And I've never been to a critical access hospital in Incline. So she said, how many beds do you think we have? And I'm a Jersey girl, so small would be maybe 40. Four. Four hospital beds. And then she proudly shows me the four hospital beds and the one observation bed. So even in a critical access hospital there's an "observation bed" and, tell you the truth, it looked just like the others. So which is just kind of an interesting—so, I shared with her my report.

She was kind of interested that we would do that. So I'm just going to set the stage a little bit. What is Observation Status, or OS, and I expect, since you're in this room, you do know something about this and that you have an interest in it, but we're just going to, again, to set the stage. Observation is a status that has been around for a while. This is not a new category. It is apparently started with heart attack, with chest pain. I was looking at the little bit of the history. And the idea is that when someone comes in, typically through an emergency room the physician, other clinicians, are trying to determine what's going on here and when it isn't really particularly obvious that this person is a trauma patient, for example, and needs to be admitted, but has chest pain or you see somebody, seeing a fainting spell, dizziness could mean more, could mean dehydrated; a head bruise, or is this a concussion; different kinds of stomach problems—is this going to be appendicitis, is it a touch of the flu, what's going on here? So, somebody coming in with those kinds of symptoms are observation patients. And it makes sense clinically that you wouldn't want to send them right home, you want to observe them for a little while. And again, as I said, it started with chest pain.

And so, what has been happening though, is that how long can you be observed? That's what's going on. It typically had been about a year. Ah—a year—a day. [Laughter]. Well, when you're a patient it feels like a year. A day, and it seems to be going further and you'll hear more. So where are these observation or OS, observation status patients? Where are they? Most of them are moved from the emergency room—by the way, Observation Status doesn't really refer, ah, CMS, our CMS expert can say this, to a particular setting, it's a status that's why. But typically, the experiences that someone is coming from an emergency room and is either staying in the emergency room, so it could be on a gurney, literally in a hallway, or moved to an inpatient bed, so clearly the patient is thinking I'm in the hospital. I'm right there. I've got nurses taking care of me. I'm getting these services. Or, they might go to a dedicated observation status unit, and right now we have about a third of these—emergency rooms have created these observation status units with pretty elaborate clinical protocols to do that.

So why is this an issue? As I said, it's been around for a while. It's not like it happened last year, so why is it an issue? And it's getting a lot of attention because of the rapid

¹ The Alliance makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material, this transcript may contain errors or incomplete content. The Alliance cannot be held responsible for the consequences of the use of the transcript. If you wish to take direct quotes from the transcript, please use the webcast of this briefing to confirm their accuracy.

growth. And there's been other reports in the media that have talked about this. Why is it escalating? Why are so many patients being termed "observation status" right now and it's gotten attention in the courts. We'll hear more about that I think, has certainly joined the dialog with members of the audience, and policy makers. Part of it is because once you are considered an observation status person you are Part B. You are Medicare Part B. You're not an inpatient, you're an outpatient. And if you are under Medicare Part B there's no cap on a Medicare Part B. You're in the hospital. You're getting tests. Typically you're getting tests. They're observing you. They're doing blood work. They might do some x-rays. They're trying to determine clinically what's going on. Each one of those procedures has a 20 percent co-pay. It's like à la carte as opposed to being an inpatient where it's like a cost per day. And then you have to, you know, under Part A there is a cap. It's a one day that they, the person, is responsible for. This just keeps going. There's no cap on there. So that is a big problem leading to a financial burden for people, which is a big concern to AARP, of course, and to other consumers in the audience here and, again, Carol will speak to this too.

The other thing that has gotten a lot of attention, the other part of this, is that this time spent as an observation status patient does not count to the three-day consecutive day requirement under CMS rules to allow a person to be eligible for Medicare payment for a skilled nursing facility visit, which can go, you know, up to 100 days. Typically not that far, but you're not at all eligible then, so it all becomes out-of-pocket. A very serious concern and I know some of the data that Keith will talk about will arrive at that.

And so, if a person happens to know that, and that's a big question: do you even know whether, even though I've been in this hospital for three, maybe even four days, I haven't been inpatient. If you happen to know that you may forego a skilled nursing facility visit or stay because you don't have the money to pay for it. It could be extremely expensive, or you may go, not know that and get billed later. So there's lots of controversy around this. This is a serious concern for hospitals, for patients, policy makers are really grappling with it, and our purpose today is to bring data to this discussion and to bring other voices into initial discussion and then Ed and I would love to have you engage in our discussion.

I also wanted to mention this is on C-Span, right Ed? And we'll be taking questions from the audience. Is that correct?

ED HOWARD: More specifically, C-Span2 if you're looking for it later. Probably it will get repeated in the middle of the night, so if you can't sleep tonight you can probably review everything that's gone on. Let me, in speaking of reviewing, let me just do a little housework here, housekeeping. There obviously are lots of good things in your packet, including copies, hard copies, of the slides our speakers will be using and more biographical information than we'll be able to share with you up front. There's also a list of materials that go even beyond the resources that we've reprinted that you can access online at allhealth.org which is our website, in case you want to do more background

¹ The Alliance makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material, this transcript may contain errors or incomplete content. The Alliance cannot be held responsible for the consequences of the use of the transcript. If you wish to take direct quotes from the transcript, please use the webcast of this briefing to confirm their accuracy.

reading. There's going to be a video recording of this separate from C-Span on the Alliance website Monday or Tuesday, followed by a transcript a few days later that you can take a look at. If you're now watching on C-Span2 and have access to a computer, you can get to our website, allhealth.org, and if you click on the Briefing notice there, you can get to the slides that the speakers are using and follow along with the folks here in the room.

At the appropriate time, those of you in the room will be able to ask questions, either by filling out a green card that's in your packet, or going to one of the microphones in the back. I'm going to try something a little new for us, anyway. If you're watching on C-Span live and want to ask a question—I'm going to get in trouble here if I don't do it right—Tweet us a question at the hash tag observation status, and we'll see if we can get to them in the course of the conversation.

Now, oh, and there's a blue evaluation form in your packets that we would very much appreciate you filling out so that we can make these programs better for you every time we do them.

Okay. Let's get to the program. We have terrific panelists today, and a lot of them, so we want to let the initial presentations get completed and we'll save a lot of time to respond to your questions and to allow the speakers to interact with each other as well. The aforementioned Keith Lind leads off. Keith is a Senior Policy Advisor for AARP and a co-author of the research report that Susan was talking about on OS, and you have a copy of that in your materials. He holds degrees in both nursing and law, a pretty unusual combination. He's practiced law for almost 20 years, still continues his clinical nursing practice, oh, and he slipped in a period on the professional staff of the Senate Finance Committee as well. So he's got a very well-rounded background for his assignment today, which is to walk us through some of the intricacies of the rules governing OS and why its use has grown over the last few years. Keith, thank you very much for being part of our program today.

SUSAN REINHARD: And I just want to add that in addition to that great intro, that Keith has given tremendous stewardship of this work and I also want to thank Dr. Lina Walker, who's the director of the health team. There's others, I'm sure, and Dr. Debra Whitman who is in charge of policy at AARP. All of us were involved in shaping it, but this is the person who made it happen, so thank you, Keith.

KEITH LIND: Thank you, Susan. I'm just going to summarize some of the key points from the report, which should be in your packets and, if not, it's available on our website. But first, I'd just like to acknowledge my co-authors from Social & Scientific Systems, Center for Health Research & Policy, Lan Zhao, Claudia Shure, and Narinja Kolazar [Phonetic].

¹ The Alliance makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material, this transcript may contain errors or incomplete content. The Alliance cannot be held responsible for the consequences of the use of the transcript. If you wish to take direct quotes from the transcript, please use the webcast of this briefing to confirm their accuracy.

How many Medicare patients use observation services? Using Medicare claims data, we looked at a 5 percent sample for three separate years: 2001, 2006, and 2009, we found that during that period use of observation grew by more than 100 percent, with the greatest increase occurring in cases not leading to an inpatient admission, which I'm going to refer to as observation only, while observation followed by inpatient admission grew by a modest, more modest, 53 percent. In 2009, about 2,100,000 Medicare beneficiaries used either observation only, which is 78 percent in 2009—the blue bars on the top of the graph there—or observation followed by an inpatient stay, 23 percent in 2009, the red bar on the bottom on the right there.

Just to clarify, our definition included observation, both with and without inpatient admission, because from observation patients go either way: into the hospital or out of observation to home or other destinations. Our definition differs from that used by MedPAC and the Inspector General in their reports, both of which counted observation only for those patients in the outpatient setting, excluding those observation visits that were followed by inpatient admission. Those studies also looked at a shorter time period.

So, how long do patients typically stay in observation? Medicare guidelines say observation should usually last for less than 24 hours and, only in rare and exceptional cases, more than 48 hours. My understanding is that recent CMS rule changes have not formally modified this guidance. From 2001 to 2009, observation only increased the most for a length of stay exceeding 48 hours, that is by more than 250 percent. During the same period, length of stay of more than 48 hours for observation followed by an inpatient stay increased by a little over 100 percent. There's a widening gap between length of stay for observation only compared with observation followed by inpatient admission. CMS had a similar finding that observation lasting more than 48 hours grew from 3 percent to 8 percent of observation visits, or 267 percent over just 5 years, 2006 to 2011. We found that claims for observation only with a length of stay of less than 12 hours declined by 57 percent, and all inpatient claims during that period declined by 16 percent.

So, what's the financial impact of observation on beneficiaries? Compared with inpatient admission, some beneficiaries pay less, some pay more, a few pay a lot more, especially beneficiaries who require care in a skilled nursing facility, or SNF as I like to call it. Importantly, only about 8 percent of beneficiaries who were admitted to a SNF with less than a 3-day inpatient stay paid the full cost of care out of pocket because, for the other 92 percent, Medicare mistakenly paid SNF costs totaling 255 million dollars in 2012, according to a July 2013 memo by the Inspector General. While the IG wants to recover these improper payments, apparently this has been happening for many years. The impact of observation is uncertain on quality care and patient experience, especially for long observation stays. We simply lack good data on the effects. I think Carol Levine is going to talk more about this.

¹ The Alliance makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material, this transcript may contain errors or incomplete content. The Alliance cannot be held responsible for the consequences of the use of the transcript. If you wish to take direct quotes from the transcript, please use the webcast of this briefing to confirm their accuracy.

So, what factors are driving these trends? Nonclinical factors: Medicare payment policy changes, increased scrutiny, audits, denials of short inpatient stays. There are efficiency advantages. It's quicker to triage from the emergency room to observation, thus observation can reduce ER crowding and allow fewer ambulance diversions. Also, there's been increased reporting. Since Medicare won't pay extra for observation visits lasting more than 48 hours many hospitals used to truncate their reporting of time in observation. But, more recently, hospitals have modified their billing systems to report the full duration of long observation visits. Diagnosis and case mix we looked at, but those changes do not appear likely to account for growth on the use of observation. Since readmission penalties were started in 2012, observation is not counted as an admission or readmission, so these penalties may continue to drive up the future growth of observation. However, the effect of readmission penalties is not reflected in our data which ended in 2009.

So, our conclusions from our findings. Increasing use of observation is not a temporary short-term or recent trend. Rapid rise in observation raises concerns that it's becoming a substitute for inpatient admission. Increasing observation is driven by nonclinical factors. There's a questionable clinical benefit from long stay observations, uncertain impact of observation on quality of care, and questionable impact on the patient experience.

Implications. Observation affects relatively few but an increasing number of Medicare beneficiaries. Most pay less out of pocket in observation than if they were admitted and had to pay the inpatient deductible, which was almost \$1200 in 2013. A few beneficiaries incur very high out of pocket costs due to outpatient cost sharing that Susan described, and non covered SNF admissions. A few beneficiaries don't get needed SNF care due to non-coverage associated with a 3-day prior stay requirement. In our findings, we found 30 percent of beneficiaries who were discharged from observation and theoretically sent to a SNF did not appear to get admitted to the SNF. These findings were not in the report. For those affected, financial impacts can be substantial and potentially catastrophic. The Inspector General found that beneficiaries who require care in SNFs that was not covered by Medicare were liable for over \$10,000 in out of pocket costs. Admittedly, this was a small number of beneficiaries, about 2,100 in 2012. Apparently, Medicare paid for all but \$22 million of these SNF costs, according to the IG. Under the circumstances, it would seem appropriate for policy makers to consider options to address concerns raised by increased use of observation, in particular policies that could reduce the financial impact on beneficiaries.

So, we recommended several approaches that could address these concerns including eliminate the 3-day prior stay requirement for care in a skilled nursing facility. I'd note that prior inpatient stay is not required for coverage of other post-acute services such as inpatient rehab facilities, long term care hospitals, and home health care. I'd also note that the 3-day stay rule was repealed in 1988 by Medicare Catastrophic, but reinstated in 1989 when Catastrophic was repealed. It would appear that the effect of a rule change like this on Medicare spending would be minimal because Medicare's already paying all

¹ The Alliance makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material, this transcript may contain errors or incomplete content. The Alliance cannot be held responsible for the consequences of the use of the transcript. If you wish to take direct quotes from the transcript, please use the webcast of this briefing to confirm their accuracy.

but 22 million dollars of these costs, according to the IG. Until then, at least credit time spent in observation toward the 3-day stay requirement. I would add that since our report focused primarily on observation, some of these policy options may require further refinement. For instance, my understanding is that Massachusetts has applied for a waiver of the 3-day stay rule to test the impact of allowing SNF admissions from the community for certain high risk beneficiaries.

So, just to highlight the increasing impact of the 3-day stay rule, I wanted to focus briefly on how Medicare's inpatient length of stay has been falling. When the 3-day stay rule was adopted in 1965, Medicare's inpatient length of stay was about 13 days. By 2010, the inpatient length of stay had fallen to 5.4 days. More than a third of beneficiaries with an inpatient admission had a length of stay less than 3 days. Shorter inpatient stays have resulted in patients being discharged quicker and sicker. This has increased the need for post acute care in skilled nursing facilities and other post acute settings. At the same time, it's become increasingly difficult for patients to satisfy the 3-day stay requirement.

So, finally, some additional recommendations we put forth include: impose a cap on beneficiary liability for observation at the inpatient deductible level—this would limit the maximum financial burden for observation to the amount that beneficiaries would incur for an inpatient admission; count observation as an admission for purposes of the readmission penalty—this would strengthen provider incentives to reduce avoidable admissions and reduce potential gaming by closing a loophole that may encourage inappropriate use of observation to avoid the penalties; clarify Medicare criteria for observation versus inpatient status—this would reduce provider confusion and potential misuse of observation associated with non-clinical consideration. I think Marc Hartstein will talk more about this. And then, notify patients of their status when they're in observation and its potential impact on their out of pocket costs. This might reduce beneficiary confusion about whether later SNF care will be covered by Medicare.

Thanks for your attention and I think Ed wants to hold the questions until after the panel is finished.

ED HOWARD: Except for Ed's question. Just a clarification. You said, Keith, that it was quicker to triage from an ER to observation status. Why is that?

KEITH LIND: Basically because you don't have to move the patient. But you can. You can move them to a different bed or a different unit. You can decide what to do and move somebody or not as needed. It can be done in the ER. You don't have to go through an admitting process. The admitting process itself takes time. It requires an admitting physician whereas the ER doc can handle the disposition of an observation patient.

ED HOWARD: And, maybe it requires a bed that isn't available, too.

¹ The Alliance makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material, this transcript may contain errors or incomplete content. The Alliance cannot be held responsible for the consequences of the use of the transcript. If you wish to take direct quotes from the transcript, please use the webcast of this briefing to confirm their accuracy.

KEITH LIND: Well, maybe it just requires moving the stretcher, as it suggests. Could be either one. And I would just point out that the observation is not considered appropriate for post operative care. So, in your case, I don't think you'll be in observation, but be that as it may.

ED HOWARD: Okay. I'll keep you posted. By the way, the IG report that Keith was referring to is in your packets. I believe it's a lovely shade of orange, to help you find it.

We've heard about Marc Hartstein from Keith a couple of times, now we're going to turn and hear from Marc Hartstein. He's been with the Centers for Medicare and Medicaid Services for more than 20 years. He's worked mainly on Medicare physician and hospital payment issues. He now directs the Hospital and Ambulatory Policy Group at CMS which is a big deal. The four divisions he manages set payments for over 260 billion dollars of Medicare expenditures to over 900,000 Medicare beneficiaries. I'm sorry. 900,000 Medicare providers. He's been involved in recent CMS rule making on observation status and we're very lucky to have him here to tell us about that work and other aspects of it.

MARC HARTSTEIN: Okay, well thank you very much, Ed. It is very much a pleasure to be here. I appreciate that kind introduction. I'm always trying to impress my 13-year-old daughter with what I do at work and I'm going to go home tonight and I'm going to say, I was on TV today. And she's going to say, what were you on? And I'm going to say, C-Span. Actually, C-Span2. And she's going to say, well, C-Span2.

Alright, so I guess before I start making my remarks I want to just clarify one thing, and this is kind of like the issue and I may have given up on this, but there's really no such thing as, in Medicare parlance, there's no such things as observation status. Observation is not a status. Observation is a set of services. Outpatient is what the status is. It's kind of like when people say I'm literally out of this world. What they really mean is I'm figuratively out of this world but people have always used the modifier literally to describe something when they really mean figuratively, and I understand that literally has now become figuratively. So I think I'm going to give up on observation status. Maybe not yet, since I'm mentioning it here today.

But observation is a set of services. The patient status is outpatient. And the observation services are used to determine whether the patient needs to be admitted to the hospital for inpatient care or whether they can be satisfactorily discharged to another setting, whether that be home, skilled nursing facility, home health care, inpatient rehabilitation facility, or some other type of patient care setting. So really, the purpose of observation is to make a determination as to whether the patient needs further care on an inpatient basis or whether that patient can be treated on an outpatient basis and discharged.

I'm just going to give a little bit of history here because I think this is relevant to why this is an issue now versus in the past. So, from 1965 to 1983, Medicare paid for inpatient

¹ The Alliance makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material, this transcript may contain errors or incomplete content. The Alliance cannot be held responsible for the consequences of the use of the transcript. If you wish to take direct quotes from the transcript, please use the webcast of this briefing to confirm their accuracy.

hospital services, Medicare's share of the hospital's reasonable cost. So what that meant is that hospitals have these very sophisticated documents called cost reports. They accumulated costs in different cost centers for those cost reports. We figured out what Medicare's share of their costs were and that's what we paid them. From 1983 to the present we paid them based on the inpatient perspective payment system. Beneficiary liability for Part A inpatient services is the inpatient hospital deductible and the 3-day prior hospitalization was mentioned a couple of times, so I'm going to mention it here. You need to have a 3-day prior hospitalization in order to be eligible for skilled nursing facility services. It was actually inpatient co-insurance, but it doesn't happen until after day 60, so I don't think it's really relevant for this discussion.

It was the same for outpatient hospital services from the beginning of the Medicare program until 2000. Again, hospitals accumulated their costs in a cost report and Medicare paid Medicare's share of the hospital's reasonable cost. So it didn't really matter whether the patient was admitted and treated inpatient or the patient was treated on an outpatient basis, at least to how Medicare made its payments. It did have relevance to beneficiary liability because they have inpatient benefit days, they have the inpatient deductible versus the outpatient Part B deductible, but with respect to how Medicare paid, the hospital was really indifferent because it would get Medicare's share of its reasonable costs.

From 2000 to present, the outpatient side, we've been paying based on a perspective payment system as well. And now this is a very important distinction because if you're admitted to the hospital the patient services get paid under the inpatient hospital perspective payment system. If a patient is not admitted they get paid under the outpatient hospital perspective payment system, and that can have an important distinction in how the hospital is paid.

There's co-insurance for each service after the Part B deductible is met. Each individual service is capped at the inpatient deductible, although the total co-insurance, when you add up collectively all the services the patient receives in the outpatient department, could be more than the inpatient deductible. Time as an outpatient does not count toward the 3-day prior hospitalization for skilled nursing facility services.

So, the inpatient admission decision—and I put this slide up because this has really been the critical guidance for making that determine as to whether a patient is determined by a physician to be an inpatient, and I'll just read through it. An inpatient is a person who's been admitted to a hospital for bed occupancy for purposes of receiving inpatient hospital service. Generally, a patient is considered an inpatient if formally admitted—there's an inpatient order—as an inpatient with the expectation that he or she will remain at least overnight and occupy a bed. And the rest of this actually says, irrespective of whether they actually occupy the bed or not. Physicians should use a 24-hour period, so that gets to the point that you were saying. It could be that the patient doesn't ever reach a hospital bed. There may not be a bed available, the patient may pass, may be treated effectively

¹ The Alliance makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material, this transcript may contain errors or incomplete content. The Alliance cannot be held responsible for the consequences of the use of the transcript. If you wish to take direct quotes from the transcript, please use the webcast of this briefing to confirm their accuracy.

without actually getting to an inpatient bed, or there could be a variety of other circumstances. Physicians should use a 24-hour benchmark order admission for patients expected to need hospital care overnight or 24 hours, and the decision to admit is a complex medical judgment. So there's emphasis on the physician decision here. Factors leading to long stay outpatient cases—these were issues that were previously mentioned. In recent years there has been a lot of attention paid on the error rate, the comprehensive error rate testing program, and a finding that there's been a high rate of incorrect short stay admissions, so patients may have been in the hospital overnight or one day, or same day admission and discharge, and upon review a contractor looked at those and said that those stays could've reasonably been treated as outpatient and the patient did not need to be admitted. That, of course, has been widely reported in the press as a suggestion that Medicare has a high error rate, in other words, we're paying incorrectly for a high percentage of the dollars that we pay out. Inpatient admission is very expensive so that will account for a significant portion of the error rate. Recovery audit contractors, in the past several years, the recovery audit contractor program has been in place. These are contractors who review Medicare payments, not just inpatient cases but, of course, inpatient cases are high dollar cases. They receive a fee based on a percentage of the recovered incorrect payments so there have been a lot more scrutiny of inpatient hospital admissions in recent years than there were previously.

At the same time that there has been a larger focus on review of inpatient admissions and many more denials of inpatient admissions, there became a realization that long standing policies that really have never been paid much attention to actually have important implications; and that is, limited hospital rebilling for denied admissions. So, prior to March 2013, hospitals were only able to bill for Part B ancillary services and only within timely filing limits. So they were only really able to bill for a limited list of diagnostic services and if more than a year had lapsed since the date of service they were unable to bill for anything at all. So the hospitals were concerned that they may have provided medically necessary services to the patient, and there was no dispute or argument about that, however, they were unable to bill for any of those services because they were beyond timely filing or our regulations only allowed them to bill for these inpatient ancillary or diagnostic services.

So, what was the response to that? Longer beneficiary stays as outpatients, as has already been indicated, and the reason for this conference. A lot of concern about the time as long stay outpatients does not count toward the 3-day prior hospitalization for skilled nursing facility care. Charges, co-insurance for Part B outpatient, I think we've also heard—nobody, I think, has mentioned, but if the beneficiary receives self administered drugs in the outpatient department there are actually no benefits under the outpatient perspective payment system for those drugs, and the beneficiary may be liable. As has already been stated, the patient may be unaware that he or she is an outpatient, and then, what has happened is, hospitals really with no recourse for getting payment have decided to adopt, I'm sorry, appeal those inpatient denials because they really had no other way of getting

¹ The Alliance makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material, this transcript may contain errors or incomplete content. The Alliance cannot be held responsible for the consequences of the use of the transcript. If you wish to take direct quotes from the transcript, please use the webcast of this briefing to confirm their accuracy.

payment and they also had a lawsuit against the Secretary of Health and Human Services challenging our Part B rebilling policy which limited them to only the ancillary services.

The administrative appeals process has ended up referring some of those inpatient denials, upholding the inpatient denial, but referring those cases back for Medicare payment under Part B, which we did not think was consistent with our regulation and it's been followed by tens of thousands of hospital appeals seeking either Part A or Part B payment.

We did an administrator ruling earlier this year to try to take some of these issues off the table. We basically said where there were appeal rights pending on those cases a hospital could rebill for all Part B inpatient services that were medically necessary, not limiting them to the diagnostic services or the ancillary services that they were previously limited to. We suspended the timely filing rules and gave them an opportunity to bill those within a certain period of time of adjudication of the appeal, and then, in addition to that, we tried to address this issue going forward in the inpatient hospital rule by allowing hospital—by essentially changing the rule on Part B rebilling to allow hospitals to bill for all Part B services within one year of the date of service following an inpatient denial, or self audit. And this is actually a very important provision as well. The reason it's important is if the patient is admitted to the hospital you cannot change the patient's status back to outpatient unless you go through a complex process to put a condition code on the claim and the hospitals have said that that's very burdensome. So then, once the patient is discharged you can't change the patient's status back to outpatient, so the only services that you'd be able to bill for would be Part B inpatient services. By extending the list of Part B inpatient services to all services not just the limited ancillary services, a hospital can do what's called self-audit. Without changing the patient's status they can bill for all the services that otherwise would have been payable under Medicare Part B, even after the patient has been discharged from the hospital.

One of the things I want to say here is the patient status remains inpatient and the reason we did that is to protect the beneficiary rights to skilled nursing facility care. As has already been stated, the beneficiary requires a 3-day prior hospitalization in order to receive skilled nursing facility care. Even if the stay is not medically necessary, as long as the admission to skilled nursing facility care was not a departure from normal medical judgment, normal medical practice, the patient's skilled nursing facility stay can be paid. However, if the patient doesn't have inpatient status it cannot be paid. And then the 2 midnight rule is my last slide and I'll just go over this quickly. Again, this is try to provide more clarity and guidance to hospitals regarding when patients should be admitted to the hospital and we're hoping that this reduces the need for lengthy observation, lengthy stay in the hospital, outpatient department receiving observation services.

The physician must order inpatient admission. We put that in the regulation. That has been long standing policy. Hospital time prior to the formal admission following the

¹ The Alliance makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material, this transcript may contain errors or incomplete content. The Alliance cannot be held responsible for the consequences of the use of the transcript. If you wish to take direct quotes from the transcript, please use the webcast of this briefing to confirm their accuracy.

inpatient order does not count toward the 3-day prior hospitalization. That's consistent with what has been our long standing policy. And then the 2-Midnight Rule is if a patient is expected to be in the hospital more than two midnights then the hospitals can go ahead and admit that patient and there'll be a presumption of medical necessity that the inpatient stay was medically reasonable and necessary. So take, for instance, the patient who has one night of observation. If the physician still can't make a determination as to whether that patient should be admitted or discharged and want to keep that patient another night they would meet the 2-Midnight presumption, 2-Midnight benchmark. The physician can go ahead and admit that patient and there'll be presumption of medical necessity. We're counting both outpatient and inpatient time toward the 2-Midnight benchmark. And just some exceptions to the 2-Midnight policy: Inpatient only procedures, procedures like CABG's, coronary artery bypass grafts, that can't be provided on any other basis except an inpatient basis; and then, if the patient left against medical advice. And then there may be some rare and unusual circumstances where the physician expects the patient to stay less than two midnights but an inpatient level of care is still necessary.

So, I have gone over my time, so I apologize to my co-presenters, but I think we still have plenty of time for Q&A.

ED HOWARD: Terrific. Thank you very much, Marc. Linda does not have slides, does she?

LINDA FISHMAN: Oh, yes. I do.

ED HOWARD: Then, hang onto the clicker.

LINDA FISHMAN: Oh, I didn't know I was going next. I thought I was last.

ED HOWARD: Oh, no. I'm sorry. You are correct.

LINDA FISHMAN: That's the best for last.

ED HOWARD: That's right. We're going to turn, as Linda Fishman has told you, and I should have, to Carol Levine. Carol directs the Families and Health Care Project of the United Hospital Fund, which a New York City-based non-profit. The project focuses on developing partnerships between health care professionals and family caregivers, especially during transitions in healthcare settings. She has won, and I commend to you the biographical sketch in the materials, a trophy case full of awards for her work including a MacArthur Foundation Fellowship for her work in AIDS policy and ethics back in 1993. Now today we've asked her to look at the impact on patients of the current observation status situation. Carol, thank you very much for being with us.

¹ The Alliance makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material, this transcript may contain errors or incomplete content. The Alliance cannot be held responsible for the consequences of the use of the transcript. If you wish to take direct quotes from the transcript, please use the webcast of this briefing to confirm their accuracy.

CAROL LEVINE: Thank you. Thank you, Ed, and since you mentioned family care, Ed, a little bit of advice, make sure you take a family member with you when you go for your surgery. And make sure that you're okay before they let you go.

I call this talk Once Upon 2-Midnights Dreary with apologies to Edgar Allen Poe, but it just seemed appropriate. I wanted to ask, my basic question is, are observation status and the 2-Midnight rule patient and family centered, because that's the buzzwords these days. We want everything to be patient and family centered or person and family centered. And I want you to try to think for the older people of my age in the audience going to the hospital and for you younger folks going with your mother or your grandmother or grandfather, and think about what it means to go to the hospital, to the ED. Either you or the person you're accompanying is sick. They wouldn't be there otherwise. They're in pain and they're frightened. You, as a family member, are worried. You want to know what's going to happen. You want to find out what's wrong, so this is a highly stressful, anxiety producing situation. And I think, you know, keep that context in mind because it's about rules and it's about money but it's also about how a person feels in this situation.

So, you're in the ED and if you happen to be in New York City where I'm from, you're there for quite a while, as I know. I accompanied my sister for a two and a half day stay in the emergency department where she was moved several times, but from one corridor to the next, not even a little place with a curtain. So, you may be moved to a bed or the regular unit and the person appears to be getting regular hospital care as had been described and you think, mistakenly, that Medicare will cover the entire hospital stay. And the point of this is that when you're in this very anxiety producing situation, you really should not be worrying about the money part of it. That should be, when you have insurance like Medicare and maybe some other supplemental insurance, that somehow that should not be the uppermost thing in your mind, at least in my view.

So, part of this situation of being in the hospital is dealing with the hospital staff and it's not your regular doctor who's going to be there. Likely it's going to be a hospitalist who's in charge of the hospital care, who's probably very likely never seen the patient before and it may not even be the same hospitalist if you're there over the second midnight. So even if you're told, which is not necessarily going to happen, we're keeping you for observation, you don't know what that means. Now, New York State has passed a law that requires informing patient of their status as of January 2014. So, if you're told, then the logical thing for this person and family to do is blame the messenger. What do you mean we're not admitted? What do you mean there may be different costs? And I hear this happening quite a lot now. So this is putting on the hospital staff an additional burden of not only telling mom or dad or the daughter that it looks like maybe there might be a heart attack but we're not really sure. Or, it could be diverticulitis or it could be something really, really bad. This sets up a really bad environment for communication and that should be the focus—the care should be the focus, not the payment.

¹ The Alliance makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material, this transcript may contain errors or incomplete content. The Alliance cannot be held responsible for the consequences of the use of the transcript. If you wish to take direct quotes from the transcript, please use the webcast of this briefing to confirm their accuracy.

Now, as I understand it, and I will be happy to have clarification from Marc or others, there's no clear way to challenge this decision that you are not an inpatient but you're an outpatient. I spoke with the person at I-Pro, which is our quality improvement organization in New York state, and asked what a Medicare beneficiary or a family member could do to appeal that decision and she said, the decision for observation can't be appealed. What you can do, she said, is to file a regular complaint about quality of care. So, if you could make a case that being in this status or getting this group of services, as Marc puts it, somehow denied you the best quality of care, that would be a complaint. But just to say I don't want to be in observation status, I want to be an inpatient, not gonna work. At least that's my understanding.

We went over all of this so I'm not going to repeat it, but I do think the prescription drug part is important because these self-administered drugs, these are not like over-the-counter drugs. These are prescription drugs that you take at home and are important for your chronic conditions, which is probably not why you're in the hospital, or maybe, but those are not things that hospitals will let you bring from home. And again, Linda may clarify that. That can be a big issue for people, not just the payment of them, but how do you get them.

And, of course, as we've heard, the post hospital financial burden is where the real big money comes up, and the alternative of going to a SNF or rehab, we'll say, why you can, you know, you can get rehab at home and get a doctor's prescription and you can get services—it's not an equal alternative, I don't think, at least in my experience. And I've had experience with both inpatient, rehab, and rehab at home. It's not as intensive at home. It probably won't last as long. It'll be a few times a week. It won't be every day. Transportation, if you're going to an outpatient clinic, would be expensive, and there's no personal care that goes along with this, which may be necessary based on the person's condition.

So, again, as always, families fill in the gaps and try to handle all of the extra things that need to be done, so there's an impact beyond the financial that I think needs to be considered. As has been said, we don't have any data on, at least that I know of, on outcomes and readmissions because these observation patients were never admitted. We don't know what happened to them, at least to my knowledge. I think, and this is a speculation, but some people may interpret observation status as an indication that their health problem's not so serious. They're just going to watch me for a day? I don't think that's so bad. If I was really sick I would be admitted. Or they may think that, you know, they're not getting the full attention. It's not necessarily true, but that's the way people may think. They may go home rather than staying for observation services. Why should I risk paying extra, because you don't know what that charge might be. It might be less or it might be more. So, if people, they go home, they get sicker because they have not stayed or because they didn't get admitted, and then they're really admitted because it's likely that their condition has worsened. So, I think that's something that needs to be looked at.

¹ The Alliance makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material, this transcript may contain errors or incomplete content. The Alliance cannot be held responsible for the consequences of the use of the transcript. If you wish to take direct quotes from the transcript, please use the webcast of this briefing to confirm their accuracy.

Also, the lack of rehab may lead to functional decline—the need for more services, more costly services—so I don't think that we can look only at the immediate hospital period and the decision to go here or there. It's the trajectory. And with people with many chronic conditions, it's always, you know, what happens here? It's an episode but then what happens down the line? And I think we need to have more information to follow these people.

So, my original question: Are these statuses and the 2-Midnight Rule patient and family centered? I would say not so much. Thank you.

ED HOWARD: Thank you very much, Carol. Now we will get to Linda. Linda Fishman is our final speaker in the lineup. She is the Senior Vice President of Public Policy Analysis and development for the American Hospital Association. She came to AHA from CMS, if you don't mind the acronyms, where she headed the office of legislation and before that stint and service on the staff at the Senate Finance Committee. I don't know if you and Keith were there at the same time. Linda basically has had a big hand in almost every piece of Medicare legislation for the last generation. So we are very pleased to have you. You are personally being held responsible for the good and the bad. But today, we have asked her to lay out some of the challenges to the hospital segment in conforming to this recent Medicare rule that Mark told us about and what the impact might be, if changes to that rule. Linda, thank you very much for being willing to join us here.

LINDA FISHMAN: Well, thank you Ed – I'm really happy to be here today to talk to you about hospital response to the 2-Midnight Rule and I must say, Mark did a very thorough job of going over the history and the rules to which hospitals are responding at this point, but I could also see a number of faces in the audience who were a little bit overwhelmed at the pace at which Mark talked about what is called the 2-Midnight Rule and what I would like to do is maybe tease that apart a little bit and talk about how hospitals are reacting to the recent policy change.

Okay, so I would like to back up a little bit and talk about the history of how we got to where we are from the hospital's perspective. About two years ago, my boss, Rich Umbdenstock, received a letter from Marilyn Tavner, the administrator of the Centers for Medicare and Medicaid Services, notifying us about the explosion in the number of observation days and the number of patients receiving observation services. And said, do you have any notion of why this is occurring? And we asked our members, through our policy process, about what the problem was, if it in fact a problem. Virtually every one of about 400 hospital leaders raised their hand at this meeting we had and said, yes, observation is really increasing at our hospitals. About 2013 there was a proposal in one of CMS's rules that laid out four options and it said, we really are concerned about the increase in the number of observation days and what does the hospital community, as well as other providers, think about four different options? One was a time based

¹ The Alliance makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material, this transcript may contain errors or incomplete content. The Alliance cannot be held responsible for the consequences of the use of the transcript. If you wish to take direct quotes from the transcript, please use the webcast of this briefing to confirm their accuracy.

criterion that basically would set to fine observation within the span of say, 24 or 48 hours. A second option was to define observation about specific clinical criteria's such as for example InterQal and Millimen, which are used by hospitals to define certain clinical conditions. The third option was prior authorization for an admission to a hospital, which as we all know, would be very resource intensive with respect to the entire Medicare beneficiary population. And then finally, the agency thought about a proposed payment solution, and our members didn't like any of these options, frankly, when we asked them. I guess the least worst option was the time based criterion, but pretty much everyone agreed that a payment solution would certainly go a long way to helping reduce the number of observation stays.

At the same time, and Mark talked about this fairly well, the recovery audit contractors have really colored the situation with their review of improper payments and as they said, they work on a contingency basis, the hospitals have really sat up and taken notice about the [RAC's?] behavior and I will use that acronym. They had been denying payment for claims, particularly for short stays, independent of the need for medical necessity. And it turned out that a lot of our hospitals, many of our hospitals, would appeal these RAC decisions for a few reasons I will go into in a minute. And over all, the statistics showed that our hospitals win on about three quarters of all the cases that they appeal to the administrative law judges. And I think Mark referred to the fact that CMS and the ALJ's are simply drowning in the number of appeals. He also talked a little bit about the CERT rate and as I said, the need for clarity from the field in terms of the status of observation. Well, the result is the 2-Midnight Rule, as he mentioned, and it's based on basically two concepts. One is something he referred to as the benchmark and that is whether or not a hospital gets an in-patient payment for a particular claim. That is – an in-patient admission is appropriate if the physician expects a patient to stay in the hospital more than one Medicare utilization day, which is defined as spanning two midnights. Of course, the physician must document that the services were medically necessary for the patient to be there.

The second concept is the presumption and that involves the definition that any stay that spans two midnights or is on something called an in-patient only list, is reasonable and necessary and should not be subject to medical review unless there is systematic evidence of gaming or improper behavior on the part of a particular provider. The notion of the presumption was to remove from RAC review, if you will, a number of those claims, as long as they span two midnights, the presumption was that Medicare will not have a contract or review those claims. Well, the rule came out with respect to hospitals on October 1 and I would have to say that the field is generally very unhappy with this rule. There are some hospitals who have said it could be very helpful, but many of our hospitals are not terribly happy with having to implement it. However, I would like to point out that there are a number of things in the rule that are very positive, that CMS has said and represent an improvement. First of all, a number of our places have said that applying the 2-Midnight presumption, meaning not looking at the medical review of that particular set of claims will be really helpful.

¹ The Alliance makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material, this transcript may contain errors or incomplete content. The Alliance cannot be held responsible for the consequences of the use of the transcript. If you wish to take direct quotes from the transcript, please use the webcast of this briefing to confirm their accuracy.

For purposes of the 2-Midnight benchmark, starting the clock in terms of what defines the two midnights, will begin when the first outpatient services delivered. Previously to that in the proposed rule, the agency had said it would be when the patient is first moved to a bed. This is an improvement. It counts observation time in the emergency services toward the 2-Midnight benchmark, but it does not count it for purposes of the three day stay. Thirdly, physician judgment and a patient's complex medical factors are something that CMS said the review contractors should always look at. That has been a very long standing policy. But to our knowledge, CMS has never specifically told the RAC's that they were going to enforce that law to standing policy. And so we were pleased to see that.

And then finally, RAC's are able to take look backs of up to three years with respect to a claim, and assess that claim. What CMS has told these RAC contractors to do is to only consider the amount – that level of information that was available to the admitting practitioner at the time of the patient's admissions to the hospital. So those are all very positive aspects. The other little wrinkle that happened is that CMS decreased the hospital in-patient update as a result of 40,000 cases, moving from the outpatient setting to the more expensive in-patient setting. Our update for our perspective payment prices was cut by .2% point or about \$220 million to offset that additional spending. We have looked at the office of the actuary's assessment that is who did the analysis and we don't particularly agree with many of the assumptions that were made and the model is very sensitive to those assumptions.

On our positions to date, the rule, as I said, was effective as of October 1. Guidance on how to implement the rule did not really come out until around September 5th, around the physician order and certification requirements. And at that time, the guidance was somewhat conflicting and difficult to understand. Four days before October 1, on September 26th, the agency issued frequently asked questions or FAQs, and at that time extending a transition period for 90 days in which the agency would not apply the policy, would tell the Medicare administrative contractors, which are different from the RAC's, to do probe and educate audits of hospitals. A certain amount of claims would be pulled from every hospital and looked at with the intent of educating the hospital on how to implement the policy. Well, what we have heard from our hospitals is that this 2-Midnight rule is very difficult to implement and will take a lot of time to do it. Some of the reasons you see before you, there is vast education needed throughout a hospital. You have to educate all the different departments from nurses, physicians, utilization reviewers and the like. Electronic medical record systems need to be changed to accommodate these new policies as well as altering work flow processes for how the work gets done. And I will take questions about that later.

In terms of our position in fact of the delay that currently exists, on November 1, the agency extended its enforcement delay for yet another 90 days. And so we are in a holding pattern, if you will, where the rule is being implemented, but RACs are not

¹ The Alliance makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material, this transcript may contain errors or incomplete content. The Alliance cannot be held responsible for the consequences of the use of the transcript. If you wish to take direct quotes from the transcript, please use the webcast of this briefing to confirm their accuracy.

looking at those claims until April 1 2014 as the hospitals attempt to implement the rule. We feel that we need another additional six months in order to fully implement the rule and accommodate to all those reasons you saw on the slide before. And at the same time, we are asking the agency to consider the implementation or the proposal of a payment solution that would address observation in particular in the payment system. And the reason I say that is the payment for a particular service on the DRG side or the in-patient side, is much higher than what is on the outpatient side. And the notion would be that a payment for observation services would be somewhere in-between, which would be very helpful to the hospitals.

Finally, I was asked to speak about the Amicus Brief that the AHA filed some time ago now with respect to a case that was filed by the Center for Medicare Advocacy in the National Senior Citizen Law Center. We filed this brief not to take a position per se. And this case was somewhat related to the three day stays, as I understand it. We did not take a position on the three day stay, but we wanted to explain to the court, the difficult position that hospitals and physicians are in with respect to observation status and the perceived use of observation status and the unhappiness of beneficiaries with respect to that status, compared to the pressure we are feeling from the recovery audit contractors and even from the Department of Justice who has in the recent past looked at these types of payments with the notion of a violation of the False Claims Act, which is a very serious violation. And so I just wanted to offer that up as something that is available. And we continue to pursue, among all avenues with respect to our advocacy on this 2-Midnight rule, from a regulatory perspective, we continue to meet with CMS about implementation of the rule and encouraging the development of more guidance. We are talking to people in the Congress about a legislative remedy with respect to delay of implementation of the rule to get us that additional six months and we are also exploring legal avenues with the agency as well. So with that – I know I ran over my time – thank you, Ed.

ED HOWARD: Thank you, Linda. I have to tell you that I am not a poor country lawyer, I'm a poor small town, hardly ever practice lawyer and a lot of this stuff is very hard to digest if you haven't been immersed in it for the last couple of years. So now you get a chance to try to help us interpret it by asking penetrating and well worded questions either by going to one of the microphones in the back, writing your question on the green card that is in your packet, or if you are in the audience provided to us by C-SPAN, you can Tweet your question to #observationstatus. And let me start, if I can, if you will bear with me for just a second, if I can pursue a factor that has been mentioned by several of panelists and that is the role of the physician in all of this. Presumably the physician admits or doesn't admit – should we have had a physician – either a hospitalists or a family doc or somebody like that on this panel? What is the role that each of you or some of you, anyway, would like to comment on, of the physician in this controversy? Susan?

SUSAN REINHARD: I just want to say that we did try to get a physician on this, the Chief Medical Officer from the Robert Wood Johnson University Hospital, where I serve

¹ The Alliance makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material, this transcript may contain errors or incomplete content. The Alliance cannot be held responsible for the consequences of the use of the transcript. If you wish to take direct quotes from the transcript, please use the webcast of this briefing to confirm their accuracy.

on the board. In total honesty, because he had a lot of experience, but he actually had to take care of patients today. So he did share some thoughts and - are there any physicians in the house? There we go, so we have some physicians in the house that maybe would like to respond to that. But I can say that this notion that I think Carol raised and then Linda did too about this tug of war – and this includes nurse practitioners and physician assistants, to my understanding, getting involved in this too, where it's – well, we want to admit the person and we understand that this is going to be a financial burden and clinically this person should be an admission, but it's going to be challenged. And there will be financial ramifications for the hospital and one other thing I will just add and maybe a physician can say something about this, that the physician payment is not affected. I will put it that way. Maybe it's like five dollars less, whether you are an admitted patient or you are an observation patient, and so there isn't any particular financial incentive to try to spend the extra time, the paperwork, the burdens it takes to make this documentation stick. So that is the feedback I got from a really very talented and caring physician, but I welcome any physicians in the audience to respond as well.

ED HOWARD: And Linda, you wanted to add something?

LINDA FISHMAN: What we have heard from our hospitals who have talked to their physicians, obviously, is that physicians are very reluctant to attest that this person, this patient, will be staying in the hospital for more than two midnights. And so I think there is a certain pressure and reluctance for physicians to want to sign that order and become responsible for that policy recognizing that there are those pressures with respect to the Medicare auditors looking over our shoulder.

MARC HARTSTEIN: Yeah, I would also like to comment on the role of the physician. In one of my slides, I have put some emphasis on the decision to admit a patient as a complex medical judgment and that has not changed. Linda mentioned that in 2012 and the 2013 outpatient rule, one of the things we did was ask the hospital community and the public [unintelligible] whomever was interested in commenting on our rules, on four potential options. I think it was pretty clear the information that came back to us from the public comments was that they did not want us to remove the role of the physician in make a judgment about whether that patient needs to be treated on an inpatient basis or an outpatient basis. And in Carol's presentation, she talked about whether any of these policies are patient friendly. And I think in our view, or at least from the public comments that we have read, I think the concern about time based decisions and the concern about criteria based – and I guess even probably prior authorization, is that that really removes the role of the physician from making that determination and determinations as to whether they should be inpatient or outpatient. So I just want to really focus on that part of the policy was one, not a part of the policy that people liked when we had suggested it. I do think it is not patient friendly to take the physician out of that judgment and we decided to retain it in developing the 2-Midnight policy.

¹ The Alliance makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material, this transcript may contain errors or incomplete content. The Alliance cannot be held responsible for the consequences of the use of the transcript. If you wish to take direct quotes from the transcript, please use the webcast of this briefing to confirm their accuracy.

ED HOWARD: Alright, I believe you were first, sir? I would ask those of you coming to the microphone to identify yourselves and your affiliation and try to keep your questions as brief as you can so we can get to as many questions as we can.

DAVID HOGBERG: Thank you, David Hogberg, National Center for Public Policy Research and I was just curious, once a patient has been admitted as an inpatient, is there – do hospitals have any incentive not to admit them to a skilled nursing facility? Is there any financial incentive that is affecting us that way? That was my only question.

LINDA FISHMAN: No, not to my knowledge. You know, I think that hospitals, especially now given the Affordable Care Act, are very much focused on smoothing out care transitions and transferring the patient to the appropriate setting post inpatient stay and I don't think whether it's a skilled nursing facility and inpatient rehab center or home, there is any financial incentive to go anywhere.

BARBARA TOMAR: Hi, I'm Barbara Tomar from The College of Emergency Physicians. First I want to compliment you all in handling and trying to pull apart this incredibly technical issue and I think it's super confusing – the two night stay, the three day stay – since you just brought up the issue of physicians, I just wanted to make mention that emergency physicians to a large extent make the decision about admission for many, many Medicare patients. However, they don't really take on the role of admitting physician per se because most emergency physicians do not have admitting privileges in their hospitals and really don't want them because they don't want that responsibility for what happens once the patient leaves the emergency department. One of the other things I wanted to mention was, there is a couple of things in your packet about short stay observation dedicated protocol driven units of which many of our members are very interested in. I think this question actually may be for you, Linda. What do you think about more hospitals getting involved in those short stay clinical decision units as opposed to the longer stay on the hospital floors where I think a lot of confusion and then financial upset arises?

LINDA FISHMAN: Barb, we haven't really looked at it from the AHA perspective, but it sounds like a very promising idea and worth looking at.

SUSAN REINHARD: I would just like to add, I think there are some articles – the Health Affairs had a particular really good analysis of this, I encourage you to see that.

KEITH LIND: I would just mention that we did address that issue in the report, so those articles found that short stays – 12 to 24 hours actually can improve efficiency and have quality outcomes that are comparable to an inpatient admission, because they are protocol driven so there is more than one kind of observation status out there. Some of them – but none of them looked at long stays, more than 48 hours, and there are some hospitals that use protocols and some that don't or have dedicated units and some that don't. So your

¹ The Alliance makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material, this transcript may contain errors or incomplete content. The Alliance cannot be held responsible for the consequences of the use of the transcript. If you wish to take direct quotes from the transcript, please use the webcast of this briefing to confirm their accuracy.

experience in observation can be very different, depending on where you land. That is just an observation, so to speak.

ED HOWARD: Yes, go right ahead.

DR. CAROLINE POPLIN: I'm Dr. Caroline Poplin, I am a physician, so I would like to answer some of your questions – I should say I'm also an attorney and I am involved in a false claims act case that involves some of these things. The thing that – there are two things that haven't been mentioned that are critical in the decision to admit or to discharge. One of them is to admit the patient really has to need services that can only be provided in a hospital. Like, IV medications or some kind of very close monitoring, neurological checks every four hours or something like that. If you can give them an antibiotic pill, in theory, you should be able to discharge them. What is also involved is something that we touch on from time to time in these briefings and that is the social determinates of health and the patient situation at home. There are patients – if you know a patient is capable of getting good outpatient follow-up and is going home with a caregiver who is capable of taking care of them, then it is easier to send home a patient who really doesn't need to be in the hospital and for whom the hospital is in fact dangerous. And some people, a lot of people, don't have that. You get an elderly person a little mixed up, they arrive by ambulance – you can't send them home and they are really not appropriate for admission and so you are caught. It's wrong to admit to them and it's wrong to send them home. And maybe what we need are the Joanne Lynn, Bob Grisch type of arrangements where you could call on community services to monitor the patient at home. Of course you can't address that in a CMS situation, but those are the kinds of things that doctors have to think about all the time.

ED HOWARD: Thank you very much. Yes, go right ahead.

MARCIA GREENFIELD: Thank you, I'm Marcia Greenfield from Leading Age and we are part of a very large coalition of advocacy consumer groups ranging from AARP to the AMA to Leading Age, the ACA Center for Medicare Advocacy. A whole group of about 20-25 groups that have come together to support addressing one of the issues that you had so effectively raised today and that is the issue of the fact that observation status nights do not count toward the three day stay requirements. And we have been supporting as have 126 members of the House, both Republicans and Democrats and 26 members of the Senate, legislation that would basically count all those nights towards the three day stay requirement and that is a HR1179S569 so we believe that there is – you have pointed out the quandary that hospitals and docs and patients face and – but we do think that there is one simple way of resolving at least that one point, which is the ability to access enough benefits. So I wanted to mention that for your benefit.

ED HOWARD: Yes, go ahead.

¹ The Alliance makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material, this transcript may contain errors or incomplete content. The Alliance cannot be held responsible for the consequences of the use of the transcript. If you wish to take direct quotes from the transcript, please use the webcast of this briefing to confirm their accuracy.

SCOTT TRUGER: Hi, thank you. My name is Seth Truger, I'm a practicing emergency physician and I also work in the office of Congressman John Dingle here in the House. I want to thank you all. This is, as I'm sure everyone here appreciates, is a very complex issue and no easy answers. As an emergency physician, I can tell you, one of the main problems is that we traditionally have two options. The patient is either in the Emergency Department or in the hospital and there is clearly some more granular patients who fit somewhere in the middle and while I think most of us appreciate that CMS is trying to have some clarity in the situation, the time based criterion, as you mentioned, unfortunately gets a bit in-between the patient and the physician and that really goes, I think, to one of the main reasons why so many patients are currently billed as observation services, is because it's the hospital at the end of the admission determines that this admission maybe challenges a RAC audit, may not be able to build a part B, so the emergency physician who admitted the patient, the hospitalists or inpatient physician who is taking care of the patient, really doesn't necessarily have a huge part to play in that decision. There is the hospital, afraid they are not going to get the party they are billing.

MARC HARTSTEIN: Before we move on, I just want to mention the importance of one of the changes that we made in the inpatient final rule and that is to allow hospitals to bill for all part B services that are medically necessary when the patient has been admitted, if they decide after the patient has been discharged, that the patient should not have been treated on an inpatient basis. That is really a huge improvement in policy that I don't think is at all in controversy. I mean, I think the issue that we had previous to the adoption of this rule is if the person was discharged and the hospital felt like they should not have been admitted and they are likely to get a denial, there was really no way to get any payment, because they were limited to that limited list of part B ancillary services. So this provides a lot more flexibility to the hospital in the situation where it may – they may not be certain that the patient was appropriately admitted. They don't have the financial penalty associated with that decision, versus having always treated the outpatient and billing under part B for part B outpatient services. So that really provides hospitals with a lot more flexibility if let's say, the patient is admitted, the patient is discharged and then the utilization review committee disagreed with the inpatient admission decision. So I think this is an important change in policy that hopefully can help improve going forward where we are in on this issue.

SUSAN REINHARD: Marc, I just want to follow-up, if you don't mind for a moment, because there was a question raised that I think perhaps you can address or perhaps you, Linda. You have been saying that the new rule allows more payment of part B services, but the question has come up, how does the increase in observation status affect the level of nurse staffing in hospitals? In other words, to me it's a reimbursement question too. If they are a more observation status or whatever, payment, where it's not part A, how does that affect the financial decision of a hospital in paying for the adequate nursing staff that has to be there regardless of your inpatient – whether you are part A or part B? it's a good question, maybe we don't know the answer to that, but I thank you for the question.

¹ The Alliance makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material, this transcript may contain errors or incomplete content. The Alliance cannot be held responsible for the consequences of the use of the transcript. If you wish to take direct quotes from the transcript, please use the webcast of this briefing to confirm their accuracy.

ED HOWARD: Well, one thing that actually is on one of the other question cards and I think Keith might have covered it in the paper if not in his presentation; exactly what are we talking about in the difference between a payment to the hospital for an admission, versus the average payment for an observation status stay?

LINDA FISHMAN: That is why we have proposed a payment solution, because the inpatient payment is often quite a bit larger. It depends on the diagnosis and what you are coming in for, obviously, but what you get paid on the inpatient side is much greater than what you get paid on the outpatient side and I think one of the possible resolutions to this is a payment that is somewhere in the middle, kind of the Goldilocks kind of a concept where the porridge is just right type thing.

ED HOWARD: Marc, do you have anything to add to that?

MARC HARTSTEIN: I would just say, under the sequester we have been unable to afford any porridge.

ED HOWARD: If you will bear with me one more time, there is a question that follows up with my follow-up and Keith, if you want to weigh in, that's fine. The questioner asks, has the distinction between inpatient and outpatient out lived its usefulness? I.e., should we be thinking about a more fundamental overhaul of hospital payments or all payments that eliminates this distinction and focuses more on the underlying medical condition or services needed?

SPEAKER: So Ed, you are saying to combine A and B? A real reform?

ED HOWARD: I guess I am. And I'm not unaware that there are proposals like that.

LINDA FISHMAN: I will hop on the bandwagon there. I mean, I think with respect to the three day stay in some of the kinds of crazy rules about where beneficiaries get care in the part A and B distinction is kind of at the foundation of why this is so difficult and complicated and perhaps it is time to look at beneficiary, cautionary and how the benefit is structured and it's a 1965 design. So one might think about that, especially as – at least in the hospital field, as we move to new payment methodologies and structures, like accountable care organizations and value based purchasing and those kinds of things, I am not sure – you know, if we are going to move to population health, you know, I'm not sure those kinds of silos work in this 21st century.

TIM: Tim [name], I'm a pediatric cardiologist, I emphasize peds because I deal mostly with Medicaid, but I did represent cardiologists for a period of time recently and Susan, the question about the beds and the nurses is excellent, because the nurses are funded by the bed charge. And although hospitals can get a facility fee for outpatient care, they don't - I don't know if the ERs can charge a bed charge, but it's very important. My question actually has to do with the specialists and not the hospitalists and not the ER

¹ The Alliance makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material, this transcript may contain errors or incomplete content. The Alliance cannot be held responsible for the consequences of the use of the transcript. If you wish to take direct quotes from the transcript, please use the webcast of this briefing to confirm their accuracy.

doc, especially directed to Marc. If after the fact, the hospital decides to treat this as a part B admission, or part B billing, but the specialist has gone up under the impression that the patient was inpatient and submits an inpatient consultation, the ENM is about the same, but that is inpatient bill versus an outpatient bill and they are susceptible to the false claims act. And this has been happening with some of these RAC audits. I can't emphasize that it isn't just the hospitals that have this pressure for the RAC audits, it's also the physicians and this kind of non-clarity between, should I bill as an outpatient or should I bill as an inpatient, when it really doesn't matter, but it's a label and am I liable?

MARC HARTSTEIN: Yeah, so I will comment on that and maybe I will comment by starting – I remember when we got our first letter from the American Medical Association on this topic and I was thinking, okay we've got the American Hospital Association, we have got AARP, the Center for Medicare Advocacy, this is a really complicated issue and we have a lot of people who are interested in it. Then I saw the letter from the AMA and it was like, oh my goodness. We really have a lot of players in this. So we keep getting this question. And the issue is, a patient will bill for a visit service and there are distinctions between visits that are provided in the emergency department and visits that are provided to inpatients and visits that are provided to hospital outpatients. If the physician is seeing a patient that has been admitted, formally admitted to the hospital, and it is appropriate for that patient to bill a hospital inpatient visit, if the patient is being seen in the emergency department, it is appropriate for the hospital to bill an emergency department visit. If the patient is being seen in the hospital, but has not been admitted and the patient is not in the emergency department, then it is appropriate for the physician to bill for an outpatient hospital visit. Yeah, if the patient is admitted and the stay is later either denied as not part A inpatient or the hospital decides to bill part B inpatient, this is where I said the patient status remains inpatient. An inpatient visit is appropriate.

SUSAN REINHARD: We got a really good answer there, thank you. This is a very specific question that Carol could answer I think. Does the New York law require disclosure of the implications of observation status for patients – meaning that the cost sharing is unlimited and what impacts admission status?

CAROL LEVINE: I don't have the law with me, it's very short and I could send it to anyone who really wants to know. My recollection of it, it just sort of came about and I know there was a lot of advocacy around it from one group, but then it was just there, done, signed by the governor. And it does say something about the financial implications. It doesn't go very specifically into it. What it does say is that there – there is something about options for appealing, but as I said, I don't think there really are any. So the point of the law was to make people aware that there were financial implications about being – getting observation services rather than inpatient services. So yes, it's there, but how it's being – how it will be implemented and what the state will – Department of Health will do in terms of actual regulations about it, still hasn't happened as far as I know.

¹ The Alliance makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material, this transcript may contain errors or incomplete content. The Alliance cannot be held responsible for the consequences of the use of the transcript. If you wish to take direct quotes from the transcript, please use the webcast of this briefing to confirm their accuracy.

SUSAN REINHARD: Linda, this has come up, you may not know, can patients appeal?

MARC HARTSTEIN: I think – I'm not an expert on patient appeals, so I'm going a little out of my area of expertise here, but I was thinking about this as you were giving your presentation. The way the appeals process normally works is the patient has received a service, a particular service. And then Medicare denies that service, payment for that service, saying that that service was not reasonable and necessary. Then the patient can appeal that denial, saying no, I think that service was reasonable and necessary and there should be payment for that service. What is going on here is the patient is receiving hospital outpatient services and they would like to receive hospital inpatient services, so there hasn't been a denial of the hospital inpatient services, there is no appeal of the decision not to admit the patient. If there is an inpatient admission, the physician admits the patient and then the stay is later denied, the patient can appeal that inpatient denial, saying I should have received inpatient services, they were medically reasonable and necessary. So my limited understanding of this is that the patient can not appeal a decision not to order or not to do something.

KEITH LIND: Let me just expand on that a little bit. So right, I mean, I would agree with that and as Carol illustrated, so the way this might come up would be the patient is in observation, gets sent to a skilled nursing facility, the [SNF?] says you are not going to be covered or maybe they submit a claim and it's denied, the patient can appeal that denial of SNF coverage, but it is a done deal. The appeal is totally ineffective because they are precluded from coverage because they didn't have a three day stay. So it's absolutely a catch-22.

SUSAN REINHARD: I think we have our next question expert person who wants to respond to that.

AUDIENCE MEMBER: I'm [name] with the Center for Medicare Advocacy and we represent the plaintiffs in the unsuccessful challenge to the observation status. I want to say something about appeals. It is possible to appeal, but it is after the fact. A person had to have gone to a skilled nursing facility and paid for it and gotten the level of care the Medicare would pay for, meaning therapy five days a week or skilled nursing seven days a week or a combination of the two. And then when the person gets the Medicare summary notice, looks at the part B part, because part A is listed separately from part B and has to have two appeals. One of the hospital status, because everything would be listed under part B and one for the skilled nursing facility status. This is quite complicated and very confusing for people. We have a self-help packet on our website, MedicareAdvocacy.org, that tells people how to do this. Andrea Callo and I in the Washington office talk to people every day about this. Absolutely every day we get calls. And from the patient's perspective, this is not a complicated issue. Somebody is typically in the emergency room and they say you need to be – you need to stay here, we need to do more for you. So we have had people with emergency surgery, we have had people who were in the hospital 13 days as an outpatient, go to the nursing home and they say,

¹ The Alliance makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material, this transcript may contain errors or incomplete content. The Alliance cannot be held responsible for the consequences of the use of the transcript. If you wish to take direct quotes from the transcript, please use the webcast of this briefing to confirm their accuracy.

well you didn't have the three day stay, so we are hearing constantly about this problem. Probably the simplest way to explain it is one of our clients, Mrs. Barrows from Connecticut who spoke to the press and said, the hospital said to me, your husband is not an inpatient here. And she said, and I said to them, then who the hell have I been visiting everyday for the last week? He was in a bed. We have had client who have been in outpatient status and then switched to inpatient status, nothing changed. Same bed, same nurses, same doctors, same wrist band. No change. From the patient's perspective, it's identical. But I just wanted to say one final thing, because it's not really a question, but I just wanted to say this, that one of the concerns I really have is how much money we are spending to make the decision if somebody should be called an inpatient or an outpatient. Because what CMS says in the final rules is that the care is identical. People will get whatever they need, whether they are inpatients or outpatients. So what do hospitals do? The first thing they do is buy InterQal criteria. The InterQal program, it's a proprietary system; they buy it because that is what the RAC uses to evaluate whether people are inpatient and or outpatient. So they pay for that. Then the hospitals expand their utilization review committee because even if a physician says, admit my patient to inpatient status, the utilization review committee can reverse it and they do. Observation code 44, they are allowed to reverse the decision. So we know from the American Case Management Association, which was part of our coalition, trying to support Mr. Courtney's legislation. We know that they have hired additional staff in the hospitals to help look at the decision that the position is making should that have been inpatient or outpatient. And then the third thing hospitals do, is hire outside consultants, primarily executive health resources in Philadelphia and so if a hospital doesn't know if a person should be inpatient or outpatient, they are supposed to call EHR, they have doctors around the country, 24 hours a day, talking to them about whether people should be inpatient or outpatient. EHR says on it's website, it has done more than nine million cases since 1999. That is a lot of money, we think it's about \$250 a case times nine million. This is what we are spending money on, Medicare money, instead of providing healthcare to people. We are trying to decide if they should be called – if people should be called inpatients or outpatients. So I'm sorry, I don't have a question, but I just had to say these things. Thank you.

ED HOWARD: I suspect that your non-question will evoke some real answers as well. Panelists, any reactions to that?

CAROL LEVINE: I just had one – it just occurred to me. If you are in the hospital, Medicare patient and you are being told you are an inpatient. We are going to discharge you tomorrow. And you or your family member says, whoa, wait a minute, I can't go home yet, I'm appealing this discharge – you can get a very quick response from the QYU. You may have to pay if they deny it, but shouldn't there be some way to apply that same sort of fast expedited decision making so you don't have to wait until you get the \$10,000 bill to appeal it? I mean, it just occurred to me that might be something to try.

¹ The Alliance makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material, this transcript may contain errors or incomplete content. The Alliance cannot be held responsible for the consequences of the use of the transcript. If you wish to take direct quotes from the transcript, please use the webcast of this briefing to confirm their accuracy.

ED HOWARD: We have just a few more minutes and we have lots of cards, so I would ask you if you have a question you absolutely have to have asked, you had better get to a microphone, and B, if you are not going to a microphone, would you drag out the blue evaluation form and fill it out while we go through these last closing moments. Susan, let me just deal with a question here and then we will get to your card. The questioner says that the American Hospital Association disagrees, quoting Linda, with CMS's analysis that the 2-Midnight rule will lead to 40,000 more inpatient admissions. What does AHA's analysis show? Fewer inpatients? How many fewer? Linda? Do you have a number?

LINDA FISHMAN: Yeah and get out your pencils if you really want to understand this, but the 40,000 net cases that become inpatient cases are a result of 400,000 observation cases, going to the inpatient side. And then you have 360,000 surgical DRG cases going from the inpatient side to the outpatient side. They will be done in an outpatient basis, according to the actuary. But the actuary did not look at about 640,000 medical DRG's and these are the DRG's where it's not procedure based and they assumed that zero of those cases would go to the outpatient side, that they would all remain inpatients and we have a very hard time believing that that would be the case. And I would say this, I mean, at this point we do not know yet how this rule will change hospital and physician behavior and we won't know for about another six months, to see how hospitals and physicians adapt to this. But the model that the actuary used, is extremely sensitive to the assumptions and you can basically get a variety of answers based on where you think the action will occur. But that is how they got to their results and we disagree with those medical DRG cases.

ED HOWARD: Keith, you wanted to - ?

KEITH LIND: Just an observation that the inspector general in that memo also disagreed with CMS, that they didn't think that the 2-Midnight rule would actually shift cases from outpatient, inpatient as I recall.

ED HOWARD: Susan, you have a - ? Oh yes, go right ahead.

SETH TRUGAR: I'm Seth Truger, again, emergency physician. Just to your point, I think we know we have been paying – overpaying, for long time for outpatient surgical procedures. By switching them from inpatient DRG's to now they are going to be billed as outpatient short stays. Is that one way that we are kind of ham handedly, but ultimately making them work with the medical and non-surgical pay?

SUSAN REINHARD: Could be. Thanks for raising it, its interesting. This is a very timely question, I don't know if anyone has the answers, but there is a concern that the hospital re-admissions reduction program may lead to an increase in observation stays. I think Keith pointed this out too, to avoid the penalty. Is there any evidence this is happening? How does the 2-Midnight rule interact with this scenario?

¹ The Alliance makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material, this transcript may contain errors or incomplete content. The Alliance cannot be held responsible for the consequences of the use of the transcript. If you wish to take direct quotes from the transcript, please use the webcast of this briefing to confirm their accuracy.

LINDA FISHMAN: I guess that question is for me. As the AARP – as Keith pointed out, the AARP analysis stops with 2009 data and obviously the readmissions program was not in effect until 2012. I think it could be one of the factors that keep people from being admitted to inpatient status, but I also think that hospitals are working on care transitions with a great deal of energy with respect to where they send people after an inpatient admissions. So I think it's – there are many, many factors driving how hospitals are behaving with respect to the readmissions program and I don't know that I can isolate this particular rule on that. We will have to wait and see what happens. But it is something to watch in the future.

MARC HARTSTEIN: So I agree that the data that has been analyzed on the increasing length of observation, really precedes the application of hospital readmissions policy and I just want to reiterate again that the 2-Midnight policy is really intended to address these long stays in the hospital outpatient department, receiving observation services, really to assist the hospital and the physicians taking care of the patient in the hospital outpatient department. If they can't make that determination with two midnights, but the patient continues to need a hospital level of care, I think a physician earlier had mentioned that that is really a critical piece of information if the patient can't be treated anywhere other than a hospital, they need two midnights of hospital care and then the physician can safely admit that patient and the benchmark is met because they needed the two midnights in the hospital. And then there will be a presumption of medical necessity as long as the patient needed a hospital level of care – care in the hospital that could not be provided elsewhere. So that really is designed to try to address these long stays in observation and then in addition to that as I previously stated, allowing hospitals to build for the full compliment of part B inpatient services, attaches less risk to the determination as to whether to admit or not to the hospital, is in a position where they could admit the patient, but if the decision is incorrect, they can continue to get paid for all part B inpatient and outpatient services where there is not a financial penalty associated with that, but also provide them with improved guidance so that way when they have a patient who is in the hospital who needs two midnights of hospital care, they can go ahead and safely admit that patient and not have to worry about a future denial.

ED HOWARD: One of our questioners noted that he was dealing mostly with Medicaid and not Medicare. This questioner wants to know what other programs do with this bundle of issues? How is observation status treated under Medicaid, under private plans and I might add, under Medicare advantage plans, where the payment is fixed in advance. Anybody?

MARC HARTSTEIN: So this question frequently comes up to me and I have expertise in Medicare and I'm always responding by saying that the rules that we are developing apply to Medicare only. Medicaid and private insurers are free to develop their own policies on these kinds of issues. Medicare Advantage is a little different and I don't want to get into what Medicare Advantage's responsibilities are. But they are Medicare plans, so policies that apply to Medicare, may apply to them. I do not know in the specific

¹ The Alliance makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material, this transcript may contain errors or incomplete content. The Alliance cannot be held responsible for the consequences of the use of the transcript. If you wish to take direct quotes from the transcript, please use the webcast of this briefing to confirm their accuracy.

context. I do know that we have had a number of what we call “open door calls” to inform the hospital community and others about the application of these rules, trying to educate all of the people that affected and we have brought Medicare Advantage experts into those cause to help answer those questions.

ED HOWARD: Keith?

KEITH LIND: Just to follow up on that, MedPac looked at this a couple years ago, about an observation and because of the increase in observation, which they had found, they also looked at whether the recovery audit contractor’s Medicare scrutiny seemed to be driving this alone and they looked at a broader segment. They looked at both Medicare and private observation stays and they found that there was an increase in observation across the board, not just for Medicare, and they surmised that they were – private payers were also scrutinizing short stays in the same way that Medicare was and that might be driving it. I would just note that in the report I think we did look at whether or not, since we looked at Medicare beneficiaries both aged and disabled, we looked at whether the increase in utilization was different for people over 65 and under 65 and admittedly they are all Medicare, but if they are under 65, you would think, oh maybe they would be treated differently for some reason. But we found that the increase in utilization was the same regardless of age group, which suggested that probably people under 65 were being treated similarly.

ED HOWARD: We have come to the end of our time and I apologize to those of you who wrote some very thoughtful questions that we are not going to be able to get to. But we have covered a lot of ground and I have a hunch that we will continue to monitor this situation, observe it, I guess I should say. And make sure that the different interests that we have heard represented and defended here today, kept an airing that makes sure we get to the most rational decisions we can possibly make. Thanks to our friends at AARP, not just for co-sponsoring this briefing with us, but for obviously playing such a big part in the rationale of the conversation and thank you for some heavy slogging of content that you have managed to absorb and contain and ask you to help me thank our panel for going over some really tough ground with really well chosen words.

SUSAN REINHARD: On behalf of AARP, thank you, we had no idea how many people would come to such a meaty kind of conversation and you stayed and we thank you for your participation.

¹ The Alliance makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material, this transcript may contain errors or incomplete content. The Alliance cannot be held responsible for the consequences of the use of the transcript. If you wish to take direct quotes from the transcript, please use the webcast of this briefing to confirm their accuracy.