



**American Hospital
Association®**

800 10th Street, NW
Two CityCenter, Suite 400
Washington, DC 20001-4956
(202) 638-1100 Phone
www.aha.org

March 30, 2015

Glenn M. Hackbarth, J.D.
64275 Hunnell Road
Bend, OR 97701

Dear Mr. Hackbarth:

The Medicare Payment Advisory Commission (MedPAC, or the Commission) will vote this week on recommendations for its June Report. On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, the American Hospital Association (AHA) asks that commissioners consider the following perspectives on the Medicare Recovery Audit Contractor (RAC) program and changes in payment policy for short inpatient stays before making final recommendations. These issues would have a significant impact on hospitals, health systems, other providers and Medicare beneficiaries. We also have some observations about the 340B Drug Pricing Program.

HOSPITAL SHORT STAY POLICY ISSUES

At its March meeting, the Commission continued its discussion regarding hospital short inpatient stay issues, including consideration of several draft recommendations. **The AHA appreciates the Commission's willingness to tackle this complicated set of issues and believes that it has the opportunity to make significant policy recommendations in this area. We support many of the draft recommendations, but have concerns that others would not achieve the Commission's articulated goals.** We urge the Commission to consider our comments prior to finalizing its recommendations.

Recommendations Related to the Medicare RAC Program. We commend MedPAC for addressing the misaligned financial incentives in the RAC program. However, we believe the draft recommendations do not fully address the RAC program's systemic problems. Specifically, the Commission discussed four draft recommendations related to the Medicare RAC Program that would require the Centers for Medicare & Medicaid Services (CMS) to:

- Modify each RAC's contingency fees to be based, in part, on its claim denial overturn rate;
- Direct RACs to focus reviews of short inpatient stays on hospitals with the highest rates of this type of stay;
- Shorten the RAC lookback period for reviewing short inpatient claims; and
- Evaluate a formulaic penalty on "excess" short inpatient stays to substitute for RAC review of short inpatient stays.



First, we support the draft recommendation for CMS to base each RAC’s contingency fees, in part, on its denial overturn rate. RACs should be held financially accountable for their overzealous audit behavior, and this change could help address the misaligned financial incentives that drive inappropriate RAC denials. It is important, however, that the amount of the performance adjustment be significant in value. It also is important that CMS accurately define and vet with stakeholders the metrics that measure RACs’ overturn rates – currently, the agency’s methodology is flawed and artificially deflates the overturn rates. For example, it does not currently account for the fact that appeals of RAC denials are rarely heard in the same year the denial was made.

Further, CMS’s forthcoming RAC contracts will likely not account for overturns at all levels of appeal – the agency proposes to include only overturns at the first level of appeal in calculating a RAC’s overturn rate. However, these first-level appeals consist of Medicare Administrative Contractor desk audits of the paper record, and are largely considered to be cursory reviews that are biased toward upholding the denial. It is not until the third level of appeal, heard by an administrative law judge (ALJ), that hospitals receive a review of all evidence by an objective party (that is, a reviewer who is not a Medicare contractor). As such, hospitals appealing inpatient claims to an ALJ have won overturn of the denial 72 percent of the time, according to the Department of Health and Human Services’ Office of Inspector General. The final outcome of an appealed claim must be used to calculate fair and accurate overturn rates.

We do not believe the additional RAC-related recommendations under the Commission’s consideration, though well-intentioned, would achieve the stated goal of relieving hospital administrative burden. First, the draft recommendation that CMS focus reviews of short inpatient stays on hospitals with the highest rates of short stays would neither reduce RAC scrutiny or administrative burden for hospitals that are not targets of the short stay audits nor decrease the overall number of claims audited and denied by RACs. This is because RACs are not limited to auditing short inpatient stays; they may receive approval from CMS to audit any number of Medicare payment rules. Further, CMS allows RACs to audit a certain number of claims per hospital, based on the hospital’s Medicare volume (e.g., for large hospitals, RACs can request 600 records every 45 days). The contingency fee structure encourages RACs to demand the maximum number of records every time period. Unless CMS also reduces the audit limits, RACs simply will shift their focus to other audit issues for those hospitals that do not have high rates of short stays.

Similarly, the draft recommendation that CMS evaluate a formulaic penalty on “excess” short stays to substitute for RAC reviews of short inpatient stays would not curb RAC review for those hospitals unless corresponding reductions are made to RAC audit limits. These hospitals simply would be subjected to the penalty *in addition to* routine RAC audits. We are deeply concerned about the concept of applying penalties based on an arbitrary threshold of what constitutes an “excess” number of short stays. It is unclear how an “excess” number of short stays would be determined. Setting an arbitrary threshold clouds the role of physician judgment, flies in the face of the Medicare program’s longstanding policy that medical necessity drives coverage decisions, and ignores legitimate variation in practice. It is imperative to establish any and all policies in a way that recognizes medical necessity and the critical role of physician judgment.

It is unclear how the above two recommendations, both of which target hospitals with high numbers of short stays, would be implemented. Under the existing two-midnight policy, those stays spanning less than two-midnights are generally considered outpatient cases; short inpatient stays, in principle, generally do not exist. We are unsure whether the Commission intends the two-midnight policy to remain in place or whether it would be replaced by these recommendations.

Finally, the draft recommendation to shorten the RAC lookback period for review of short stay inpatient claims would create a more level playing field and likely would allow hospitals to rebill more claims. **However, even if the RAC lookback period is shortened to six months for patient status reviews, as CMS has proposed for its next round of RAC contracts, hospitals would not be able to pursue any appeals rights before the one-year filing limit expires.** They would therefore have to continue to forgo their appeals rights in order to rebill claims. This is because a hospital could not receive and reply to an audit request from a RAC, receive a RAC denial, prepare an appeal, and receive an appeal decision before the one-year filing limit expires. As is illustrated in the appeals timetable included as Exhibit 1 (attachment), it can take six months from the date a RAC denial is received just to get through the first level of appeal. **Alternatively, as noted below, we urge the commission to recommend elimination of CMS's application of the one-year filing limit to rebilled claims.**

Hospitals carefully evaluate claim denials to determine whether to invest time and resources in filing an appeal; they appeal claims because they stand behind the clinical judgment of the physicians who made the decision to admit the Medicare beneficiary. Hospitals that have provided medically necessary services to Medicare beneficiaries should not face the choice of conceding to outpatient payment – which is often lower – or being penalized for pursuing their appeals rights by potentially receiving no payment at all.

We continue to urge the Commission to consider and support the following additional changes that would address the systemic problems with the RAC program:

1. **Prohibit any payment structure that encourages RACs to deny claims.** The current contingency fee structure is one-sided in that RACs can deny claims with impunity. Instead, RACs should be paid similarly to other Medicare contractors, such as through a cost-based contract.
2. **Impose a financial penalty on RACs when a denial is overturned on appeal.** A penalty assessed in such instances would curb overzealous RACs and create a level playing field for both RACs and providers in addressing incorrect payments.
3. **Require RACs to consider only the medical documentation available at the time the admission decision was made in determining whether an inpatient stay was medically necessary.** Currently, RACs can review claims three years after the date of service and are able to utilize information that may not have been available to the

physician at the time of the admission decision in order to deny claims. This requirement would restrain RACs' current practice of second-guessing physicians' judgment based on the outcome rather than the facts the physician had at the time.

4. **Eliminate application of the one-year filing limit to rebilled Part B claims.** When a Part A claim for a hospital inpatient admission is re-opened and denied by a Medicare review contractor because the inpatient admission was determined to be not reasonable and necessary, the hospital should be able to submit a subsequent Part B claim for services provided within 180 days of a revised or final determination. This would allow hospitals to either rebill immediately after the claim is denied or pursue their appeals rights and receive a final determination on the Part A claim before rebilling under Part B.
5. **Limit RAC auditing of approved issues to a defined time period, instead of approving them indefinitely, as is now the practice.** After the issue's audit time period has expired, RACs should be prohibited from auditing that issue. CMS should then analyze the audit results and offer education to providers in that jurisdiction if warranted. A RAC would need to seek new approval from CMS to audit for that same issue again, but must wait a certain defined time period to allow providers to incorporate education before requesting new approval. Additionally, a senior CMS official should be held accountable for approval of audit issues.

Notice of Observation Status. The Commission also discussed a draft recommendation that would require all acute-care hospitals to notify beneficiaries placed in outpatient observation for longer than 24 hours of their observation status and that their status may affect their cost sharing for their current hospital stay as well as coverage for skilled-nursing facility (SNF) services. **The AHA agrees that hospitals and practitioners need to communicate clearly with the patient and his/her family about patient status in the hospital. Many of our members already have similar processes in place regarding notification of observation status and its cost-sharing responsibilities and implications for coverage of subsequent SNF services.**

MedPAC is not alone in its desire to address this issue. Some states currently have laws requiring patient status notification. For example, New York's observation status law went into effect last year and requires all hospitals to inform patients who are assigned to observation status that they are not admitted to the hospital, but are under observation status. At least five other states have passed similar laws, and eight more currently have legislation pending that would require such notice. At the federal level, the House of Representatives recently passed legislation that would require hospitals to provide written notification of observation status and oral explanation for individuals who are in observation status for greater than 24 hours (H.R. 876).

If the Commission moves forward with this recommendation, we urge it to better define the parameters around the requirement in its report. First, there should be an exception to this notice requirement for situations that are outside of the hospital's control – such as when a patient is unable, due to his/her medical or mental condition, to receive and sign the acknowledgement and no patient representative is available. In addition, hospitals do not have access to specific coverage and cost-sharing information until the patient has been discharged and the claim

submitted. Therefore, the information hospitals are required to provide related to cost-sharing for hospital services, as well as coverage for SNF services, should allow a more general notification to the patient about Medicare policy regarding co-payments for outpatient services and eligibility requirements for SNF services. The use of a standard document describing such Medicare policy in an easy-to-understand format should be permitted.

Self-Administered Drugs. MedPAC discussed a recommendation that Congress package payment for self-administered drugs (SADs) provided during outpatient observation into the hospital outpatient prospective payment system (PPS) in a budget-neutral manner. **The AHA supports the concept of packaging the cost of SADs into the outpatient procedures with which they are furnished. However, we recommend that the Commission expand this packaging to include SADs provided to beneficiaries in conjunction with *all* covered outpatient PPS services.** This would result in a more consistent policy and greater reduction in beneficiary out-of-pocket costs and hospital administrative burden, as well as a greater improvement in beneficiary satisfaction. Limiting the packaging of SADs to observation services could actually increase hospital administrative burden somewhat because hospitals would need to distinguish whether or not the beneficiary was an observation patient for purposes of billing for non-packaged SADs.

In addition, we urge the Commission *not* to recommend that the packaging be implemented on a budget-neutral basis. MedPAC estimates that hospital outpatient margins are already negative 12.4 percent; absorbing additional cuts is untenable. Further, any increase in Medicare outpatient PPS expenditures that would result from implementing this policy outside of budget-neutrality would be offset to some degree due to the reduced expenditures under Medicare Part D, which currently covers SADs furnished in a hospital outpatient department setting for many beneficiaries.

Payment Policy Changes that could be Considered to Reduce the Payment Differences between Short Inpatient Stays and Similar Outpatient Stays. MedPAC staff did not present a draft recommendation related to payment policy approaches to reduce the payment differences between short inpatient stays and similar outpatient stays at the March meeting. **However, we urge the Commission to continue its analysis of this issue.**

The AHA has modeled and analyzed several potential short stay payment (SSP) policy approaches. While our models reduced payment differentials between inpatient stays and similar outpatient stays, we found, consistent with MedPAC's analysis, that new payment differentials between short-stay and non-short stay inpatient cases were created. Our results do, however, show that creating a SSP policy is technically feasible and can be done in different ways, each of which has its strengths and weaknesses. While our analysis leaves many questions unanswered, and our work is ongoing, we shared our results with CMS in a [letter](#) on February 13, 2015. We hope that our work will inform the work of the agency related to potential SSP solutions as it formulates the fiscal year (FY) 2016 inpatient PPS proposed rule.

We also continue to urge the Commission to consider alternative designs prior to making a SSP policy recommendation. At the September and November meetings, MedPAC staff

presented a payment policy option that could reduce the payment differences between short inpatient stays and similar outpatient stays. This targeted approach focused on 94 existing diagnosis related groups (DRGs) that had either a high number of inpatient one-day stays and outpatient observation short stays or a large amount of dollars denied by the RACs for patient status. The Commission's analysis split each into two DRGs – one for stays of at least two days and another for one-day stays only. It then collapsed the 94 one-day stay DRGs into 44 DRGs by grouping similar conditions together.

The AHA strongly believes that hospitals must be appropriately and adequately reimbursed for the care they provide to beneficiaries. **While we support the design of a SSP policy, we are concerned that MedPAC's targeted approach will not fully address the problems created by the two-midnight policy because it creates short-stay DRGs for only certain conditions.** Our analysis shows that nearly all DRGs have short-stay cases and that approximately half of the DRGs (377) have 10 percent or more short-stay cases.

The AHA has modeled a similar targeted approach and found that it was the most disruptive of the models considered. It would be the least workable in terms of administrative burden and year-to-year change. Specifically, the DRGs in this model would need to be reviewed periodically because the conditions that have a high percentage of short stays, number of short stays, or number of RAC denials change over time due to changes in technology, medical practice and RAC activity. While we could not review how the conditions with a high number of RAC denials change over time, we did review how the conditions with a high percentage or number of RAC denials change over time. We found that, of the 25 DRGs with the highest percentage of short stays in FY 2013, only 18 were in the top 25 in FY 2008. Of the 25 DRGs with the highest number of short stays in FY 2013, only 17 of those were in the top 25 in FY 2008.

Finally, the AHA urges the Commission to consider conducting an analysis of the justification for a 0.2 percent reduction to the standardized amount that CMS implemented in its FY 2014 final rule as a result of the agency's assumption that the two-midnight policy would increase inpatient PPS expenditures by \$220 million. Data from more than 500 hospitals for two fiscal quarters of FY 2014 show that, post-two midnight implementation, short inpatient stays have decreased while outpatient observation stays have increased – the opposite impact estimated by CMS. **We continue to believe that the permanent prospective payment reduction is unwarranted, and look forward to gaining access to and analyzing more complete data from the post-two midnight implementation period.**

PART B DRUG PAYMENT POLICY ISSUES

At the March meeting, the Commission also discussed the 340B Drug Pricing Program and Medicare payment for Part B drugs to hospitals participating in the 340B program. We understand that the House Committee on Energy and Commerce asked the commission to prepare a report on the 340B program, and we appreciate the opportunity given the hospital field to provide input to the report. Many AHA members, including critical access and urban safety-net hospitals, participate in the 340B program. For more than 20 years, Congress has provided

relief from high prescription drug costs and enabled certain hospitals to stretch scarce federal resources to expand and improve access to comprehensive health care services for more patients, especially low-income and uninsured individuals.

We also appreciate the Commission's reluctance to make recommendations about the 340B program. Since the program is administered by the Health Resources and Services Administration (HRSA), recommendations in this area would mean the commission has strayed from its mission of making Medicare policy recommendations into non-Medicare payment policy areas that the commission has historically avoided.

Some stakeholders and interest groups, however, continue to spread misinformation about the program. Here are the facts:

- The 340B program accounts for only 2 percent – or \$6.5 billion – of the \$325 billion in annual drug purchases made in the United States.
- 340B hospitals provided \$28.6 billion in uncompensated care in 2013, which is four times the amount of drugs purchased through the 340B program. Participants reinvest the savings they receive on the discounted drugs in programs that enhance patient services and access to care. They also use these savings to provide free or reduced-priced prescription drugs to vulnerable patient populations.
- In 2013, one out of every three 340B hospitals had a negative operating margin.¹
- 340B hospitals are subject to oversight by the HRSA Office of Pharmacy Affairs and must meet numerous program integrity requirements. These include yearly recertification, audits from HRSA and drug manufacturers and maintaining auditable inventories of all 340B and non-340B prescription drugs. In recent years, HRSA implemented additional program integrity efforts, and the AHA has encouraged HRSA to develop a process to help financially distressed providers meet the new program integrity provisions.

We also compliment the Commission's restraint in not pre-empting HRSA's plans later this year to issue comprehensive interpretive guidance to improve program oversight. Areas which HRSA is expected to address include the definition of patient eligibility, contract pharmacy arrangements and mechanisms to prevent ineligible patients from receiving the benefit and duplicate discounts for Medicaid patients.

The 340B program is critical to the financial viability of its participants. It creates savings on outpatient drug expenditures to reinvest in patient care and health activities to benefit communities and saves money for state and federal governments. Any action to restrain the 340B program will require resources to make up for the deficit caused by a diminished 340B program.

¹ American Hospital Association Annual Survey, data for 2013.

Glenn M. Hackbarth, J.D.

March 30, 2015

Page 8 of 8

We appreciate your consideration of these issues. Safeguarding adequate payment for hospital services will ensure Medicare beneficiaries continue to have access to high-quality, innovative and effective care in their communities. If you have any questions, please feel free to contact me or Priya Bathija, senior associate director of policy, at (202) 626-2678 or pbathija@aha.org.

Sincerely,

Linda E. Fishman
Senior Vice President
Public Policy Analysis and Development

Cc: Mark Miller, Ph.D.
MedPAC Commissioners

Attachment

Hospital Timeframes to Rebill vs. Appealing Patient Status Denials

This timeline presumes implementation of the CMS RAC program changes announced in December 2014, as well as adherence by hospitals and contractors to statutory and contractual timeframes.

