AMERICAN CASE MANAGEMENT ASSOCIATION

Eliminate Barriers to Care and Facilitation of Safe and Appropriate Transitions

Observation Services

Medicare statutes and regulations do not define observation services. The only definition appears in various CMS manuals, where observation services are described as: [1]

> "a well-defined set of specific, clinically appropriate services, which include ongoing short term treatment, assessment, and reassessment, that are furnished while a decision is being made regarding whether patients will require further treatment as hospital inpatients or if they are able to be discharged from the hospital."[2]

According to the CMS manuals, in most cases a beneficiary may not remain in observation services for more than 24 or 48 hours.[3]

Unfortunately, under current Medicare rules, time spent in outpatient observation services in a hospital does not satisfy the three-day inpatient hospital requirement which entitles the patient to Medicare coverage of any post-hospital extended care services in a skilled nursing facility (SNF). This means that Medicare beneficiaries are then charged directly for various services they receive in an acute care setting, including prescription medications, and for their SNF stay, rather than Medicare covering those costs. Patients who are medically qualified for SNF placement, but are unable to pay out-of-pocket, are often discharged to home because they did not satisfy the three-day stay requirement.[4]

ACMA's Position

Observation services and the three-day stay requirement are issues that adversely impact both patient and provider; creating barriers for case managers in providing appropriate care and facilitating safe transitions.

Our Request

Support efforts to halt the inappropriate use of observation services by co-sponsoring H.R. 1179 or S.569. This bill (Improving Access to Medicare Coverage Act of 2013) amends Medicare law to allow for the time patients spend in the hospital under observation services to count toward the requisite three-day hospital stay for coverage of skilled nursing care.

References

1. "Observation Status: Lawsuit, Bagnall v. Sebelius (No. 3:11-cv-01703, D. Conn), filed on November 3, 2011." Center for Medicare Advocacy, Inc. 31 May 2012 <http://www.medicareadvocacy.org/medicare-info/observation-status/>.
2. Medicare Benefit Policy Manual, CMS Pub. 100-02, Chapter 6, §20.6; same language in Medicare Claims Processing Manual, CMS Pub. 100-04, Chapter 4, §290.1.
3. *Id.*
4. American Case Management Association. "Observation Status and the 3-Day Stay Requirement." Survey. 19 April 2012.

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CMS Recovery Auditor Program (formerly the Recovery Audit Contractor (RAC) Program)

The Recovery Auditor Program was designed to identify and recover improper Medicare payments paid to health care providers under fee-for-service Medicare plans. However, since its creation, ACMA members have noted a number of issues related to CMS auditors, specifically, auditors misinterpreting and/or choosing not to follow CMS rules and guidelines regarding medical necessity. These are not isolated incidents; rather they represent a national trend.

According to the American Hospital Association (AHA):

- Nearly 60% of the hospital medical records reviewed by RACs are found to have no overpayment error[5]
- 49% of hospital denials are appealed[6]
- 72% of appeals brought before an ALJ are overturned in favor of the hospital[7]

ACMA's Position

ACMA understands the need for auditors to identify billing mistakes; however, more oversight is needed by CMS of audit contractors to prevent inaccurate payment denials and to make its overall auditing effort more transparent, timely, accurate and administratively reasonable.

Hospital case managers take seriously their obligation to properly bill for the services they provide to Medicare and Medicaid beneficiaries and are committed to working with CMS to ensure the accuracy of Medicare and Medicaid payments. However, redundant government auditors, unmanageable medical record requests and inappropriate payment denials are wasting hospital resources, contributing to growing health care costs, and taking case managers' attention that could more effectively be focused on patient care.

Our Request

CMS and Congress need to make the audit processes more fair and transparent. We request that you co-sponsor H.R.1250 or S.1012 (the Medicare Audit Improvement Act of 2013*)*. This bill proposes transparent and fair audit practices and assistance to hospitals in mitigating excessive overall audit burden, and would establish annual limits on documentation requests from RACs and impose financial penalties on noncompliant RACs.

References

5. AHA RACTrac survey of 2,400+ hospitals. Quarter 4, 2013 data.
6. Id.
7. Office of the Inspector General. November 2012.

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Integrated Chronic Care Delivery

Medicare is not doing enough to take care of chronically ill patients, and the limitations of the fee-for-service system prevent a coordinated focus on these patients and their needs. This is critically important because most Medicare enrollees suffer from multiple chronic conditions. According to CMS, in 2010, 68% of Medicare enrollees suffered from two or more chronic conditions, and accounted for 93% of Medicare spending (roughly $487 billion annually).[8] Additionally, 98% of hospital readmissions involved beneficiaries with multiple chronic conditions.[9] There are existing models of care that are meeting the needs of some chronically ill patients – at lower costs – but the vast majority of these innovative care delivery models are located in a few specific regions of the country, leaving millions of Medicare enrollees across the country without access to proven, integrated models of care.

ACMA's Position

A solution is needed that offers critical support for providers, focuses on the unique needs of Medicare enrollees, ends geographic disparities in integrated care and pays for a Medicare program taxpayers want and beneficiaries need.

Our Request

Support efforts to remove the barriers that prevent Medicare providers from building on existing successful delivery models, and provide a framework for encouraging innovative, nationwide chronic care delivery by co-sponsoring H.R. 3890 or S.1932. This bill (Better Care, Lower Cost Act) amends title XVIII (Medicare) of the Social Security Act to direct the Secretary of Health and Human Services (HHS) to establish an integrated chronic care delivery program (Better Care Program or BCP) that promotes accountability and better care management for chronically ill patient populations and coordinates items and services under Medicare parts A (Hospital Insurance), B (Supplementary Medical Insurance), and D (Voluntary Prescription Drug Benefit Program), while encouraging investment in infrastructure and redesigned care processes that result in high quality and efficient service delivery for the most vulnerable and costly populations.

References

8. Senator Ron Wyden."Summary: The Wyden-Isakson-Paulsen-Welch Better Care, Lower Cost Act." Retrieved from http://www.wyden.senate.gov/download/?id=7f456cdf-edae-4dcb-ba64-c33f0fcc21ce&download=1
9. *Id.*