Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

MEDICARE LIFETIME RESERVE DAYS

REPORT TO CONGRESS

Inspector General

December 2004
OEI-09-04-00100

Office of Inspector General

http://oig.hhs.gov

The mission of the Office of Inspector General (OIG), as mandated by Public Law 95-452, as amended, is to protect the integrity of the Department of Health and Human Services (HHS) programs, as well as the health and welfare of beneficiaries served by those programs. This statutory mission is carried out through a nationwide network of audits, investigations, and inspections conducted by the following operating components:

Office of Audit Services

The OIG's Office of Audit Services (OAS) provides all auditing services for HHS, either by conducting audits with its own audit resources or by overseeing audit work done by others. Audits examine the performance of HHS programs and/or its grantees and contractors in carrying out their respective responsibilities and are intended to provide independent assessments of HHS programs and operations in order to reduce waste, abuse, and mismanagement and to promote economy and efficiency throughout the department.

Office of Evaluation and Inspections

The OIG's Office of Evaluation and Inspections (OEI) conducts management and program evaluations (called inspections) that focus on issues of concern to the department, the Congress, and the public. The findings and recommendations contained in the inspections reports generate rapid, accurate, and up-to-date information on the efficiency, vulnerability, and effectiveness of departmental programs. The OEI also oversees State Medicaid fraud control units, which investigate and prosecute fraud and patient abuse in the Medicaid program.

Office of Investigations

The OIG's Office of Investigations (OI) conducts criminal, civil, and administrative investigations of allegations of wrongdoing in HHS programs or to HHS beneficiaries and of unjust enrichment by providers. The investigative efforts of OI lead to criminal convictions, administrative sanctions, or civil monetary penalties.

Office of Counsel to the Inspector General

The Office of Counsel to the Inspector General (OCIG) provides general legal services to OIG, rendering advice and opinions on HHS programs and operations and providing all legal support in OIG's internal operations. The OCIG imposes program exclusions and civil monetary penalties on health care providers and litigates those actions within the department. The OCIG also represents OIG in the global settlement of cases arising under the Civil False Claims Act, develops and monitors corporate integrity agreements, develops compliance program guidances, renders advisory opinions on OIG sanctions to the health care community, and issues fraud alerts and other industry guidance.

ABSTRACT

We conducted this study pursuant to section 953(d) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) concerning Medicare lifetime reserve days. Medicare beneficiaries are entitled to coverage of 90 hospital days during any spell of illness. If beneficiaries need more than 90 days, they are entitled to an additional 60 non-renewable days of care, called lifetime reserve days. As mandated by the MMA, the purpose of this study is to determine the extent to which hospitals notify Medicare beneficiaries about their lifetime reserve days and assess the appropriateness and feasibility of providing an additional notification to beneficiaries before they exhaust their lifetime reserve days. In calendar year 2003, approximately 37,000 beneficiaries used 1 or more of their lifetime reserve days.

Based on self-reported information from a random sample of 147 hospitals, 86 percent of hospitals provide written and/or verbal notices about lifetime reserve days to beneficiaries who have used or will use 90 days of benefits, while 14 percent do not. Because they cannot retrieve accurate and timely beneficiary utilization data, 33 percent of hospitals are unable to strictly comply with the Medicare Benefit Policy Manual guidelines that require hospitals to notify patients when they have 5 regular coinsurance days remaining. Based on information from hospitals and beneficiaries, providing a second notice may not be appropriate or feasible.

In response to our draft report, the Centers for Medicare and Medicaid Services will issue further clarification to explain its lifetime reserve days policies to hospitals.

OBJECTIVE

To (1) determine the extent and means by which hospitals comply with the current requirement to notify Medicare beneficiaries about lifetime reserve days and (2) assess the appropriateness and feasibility of providing an additional notification prior to beneficiaries exhausting their lifetime reserve days.

BACKGROUND

Statutory Mandate for Study

Section 953(d) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 requires the Office of Inspector General to conduct a study relating to the use of hospital lifetime reserve days. The report to Congress is to include the extent to which hospitals provide notice to Medicare beneficiaries in accordance with the current applicable requirements and the appropriateness and feasibility of hospitals providing an additional notice to beneficiaries before they exhaust their lifetime reserve days.

For the study, we conducted a survey of 147 hospitals from a simple random sample of hospitals with patients who used more than 1 lifetime reserve day. In addition to completing the survey, we requested that hospitals provide us with copies of the policies and notices that they use to inform beneficiaries about lifetime reserve days. To gather qualitative information, we selected a purposive sample of 10 hospitals from the random sample. We conducted in-depth interviews with those hospitals and some of their patients who had used lifetime reserve days.

Medicare Coverage for Inpatient Hospital Services

Under section 1861 of the Social Security Act (the Act), a beneficiary is entitled to an unlimited number of benefit periods, each of which includes 90 days of covered inpatient hospital services. A benefit period, or "spell of illness," begins on the first day the beneficiary is an inpatient in a Medicare certified acute care hospital or skilled nursing facility (SNF). The benefit period ends 60 days after the hospital or SNF discharges the beneficiary.

Section 1812 of the Act defines the scope of inpatient hospital benefits and includes the provision regarding 60 nonrenewable lifetime reserve days, which a beneficiary may draw upon whenever hospitalized for more than 90 days in a benefit period. Pursuant to the implementing regulations, which are contained in 42 CFR § 409.65, hospitals may bill

Medicare for lifetime reserve days, unless the beneficiary elects not to use them or is deemed to have elected not to use them. Hospital notification requirements are delineated in the Medicare Benefit Policy Manual, which was developed by the Centers for Medicare & Medicaid Services.

If the beneficiary elects not to use lifetime reserve days, the beneficiary becomes responsible for hospital charges beginning with the 91st day in the benefit period. Similarly, if the beneficiary uses all 60 lifetime reserve days and remains in the hospital beyond 150 days, the beneficiary becomes responsible for hospital charges on the 151st day.

FINDINGS

The following findings are based on the self-reported responses of a random sample of 147 hospitals as of August 2004. Because we randomly selected the hospitals and the confidence intervals are reasonably precise, it is appropriate to project the sample responses to the entire population of hospitals that have experience with Medicare beneficiaries who have used their lifetime reserve days.

Eighty-six percent of hospitals provide written and/or verbal notices about lifetime reserve days to Medicare beneficiaries who have used or will use 90 days of benefits. The remaining 14 percent of hospitals that do not provide the required notification did not typically offer a reason. Eight percent of hospitals with beneficiaries using lifetime reserve days indicate that they do not provide any information about lifetime reserve days either upon admission or sometime during the beneficiary's hospital stay. Some of the respondents that do not provide notices indicated that they lacked timely information about the number of lifetime reserve days beneficiaries had available. Case study hospital officials confirmed this concern about timely information. However, case study hospital officials said that they work routinely with beneficiaries to assist them in understanding their financial obligations.

Because the hospitals cannot retrieve accurate beneficiary utilization data, 33 percent of hospitals are unable to strictly comply with the Medicare Benefit Policy Manual guidelines that require them to notify patients when they have 5 regular coinsurance days remaining. In contrast, 61 percent of hospitals discuss the option to use lifetime reserve days each time a patient is readmitted, if the patient has only 5 coinsurance days left in the benefit period.

Providing a second notice may not be appropriate or feasible. While 64 percent of hospitals believe an additional notice could be helpful, hospitals and beneficiaries agree that it may be inappropriate and unfeasible to do so. For example, 66 percent of hospital officials stated that an additional notice would affect their operational costs and staff time. Furthermore, case study beneficiaries said an additional notice about exhausting their lifetime reserve days would not have affected their decisions about their care.

AGENCY COMMENTS

In response to our draft report, the Centers for Medicare and Medicaid Services will issue a Medlearn Matters article to further clarify the lifetime reserve days benefit. Specifically, the Medlearn article will inform hospitals how to obtain information about lifetime reserve days as well as clarify the Medicare coverage of inpatient hospitals under section 1861 of the Act.

TABLE OF CONTENTS

INTRODUCTION

OBJECTIVE

To (1) determine the extent and means by which hospitals comply with the current requirement to notify Medicare beneficiaries about lifetime reserve days and (2) assess the appropriateness and feasibility of providing an additional notification prior to beneficiaries exhausting their lifetime reserve days.

BACKGROUND

Statutory Mandate for Study

Section 953(d) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) (P.L.108-173) requires the Office of Inspector General (OIG) to conduct a study relating to the use of hospital lifetime reserve days (LRDs). The MMA requires OIG to submit a report no later than 1 year after enactment (December 8, 2004). The report to Congress is to include:

- the extent to which hospitals provide notice to Medicare beneficiaries in accordance with the applicable requirements,
- the appropriateness of providing an additional notice to beneficiaries before they exhaust their LRDs, and
- the feasibility of hospitals providing an additional notice to beneficiaries, before they exhaust their LRDs.

The MMA does not define the terms "appropriateness" and "feasibility." Therefore, based on discussions with legislative staff, we are defining "appropriateness" as helpfulness to beneficiaries and "feasibility" as the ability of hospitals to provide an additional notice in a timely manner.

Medicare Coverage for Inpatient Hospital Services

Under section 1861 of the Social Security Act (the Act), a beneficiary is entitled to an unlimited number of benefit periods, each of which includes 90 days of covered inpatient hospital services. A benefit period, or "spell of illness," begins on the first day the beneficiary is an inpatient in a Medicare certified acute care hospital or skilled nursing facility (SNF). The benefit period ends 60 consecutive days after the hospital or SNF discharges the beneficiary.

Section 1812 of the Act defines the scope of inpatient hospital benefits and includes the provision regarding 60 nonrenewable LRDs, which a beneficiary may draw upon whenever hospitalized for more than

90 days in a benefit period. The beneficiary pays 50 percent of the benefit period deductible as a daily copayment for LRDs (42 CFR § 409.83). In 2004, the deductible is $876; therefore, beneficiaries pay $438, as a daily coinsurance for each LRD that they use in 2004.

The Act and implementing regulations are silent concerning LRD notice requirements. The implementing regulations, 42 CFR § 409.65, state:

- Hospitals may bill Medicare for LRDs unless the beneficiary elects not to use them or is deemed to have elected not to use them.
- If the beneficiary elects not to use LRDs, the hospital may require the beneficiary to pay for any services after regular days are exhausted.
- A beneficiary will be deemed to have elected not to use LRDs if charges for such days are equal to or less than the applicable coinsurance.
- The beneficiary's election not to use LRDs must be in writing.
- The election may be filed at the time of admission or at any time up to 90 days after discharge.
- An election not to use LRDs may apply to an entire stay or to a single period of consecutive days in a stay, but cannot apply to selected days in a stay.

Regulations also allow the beneficiary to revoke an election not to use LRDs during hospitalization or within 90 days after discharge (42 CFR § 409.66). The beneficiary must submit the revocation in writing. The revocation not to use LRDs may not be filed after the hospital has filed a claim under the supplementary medical insurance program or the beneficiary dies.

After beneficiaries use all of their LRDs and exhaust their Part A benefits, they become responsible for hospital charges. However, beneficiaries remain entitled to Part B benefits for physician services and some ancillary services while they remain in the hospital during the same spell of illness. Beneficiaries continue to be responsible for hospital charges until a new benefit period begins, even if they are readmitted to another hospital or skilled nursing facility (42 CFR § 409.61).

The Centers for Medicare & Medicaid Services' (CMS) Medicare Benefit Policy Manual (Manual) provides the only guidance to hospitals regarding notification and implementing instructions for the LRD benefit. According to the Manual, section 30.1, "Hospital notice should be given when the beneficiary has 5 regular coinsurance days left and is expected to be hospitalized beyond that period." This section of the Manual does not require written notice. The Manual states, "The hospital should annotate its records at the time it informs beneficiaries of the option, but a written statement (by the beneficiary or representative) need only be included if patients elect not to use LRDs." (See appendix A.)

Lifetime Reserve Day Use

During 2003, beneficiaries used nearly 980,000 inpatient hospital LRDs. This represents less than 1 percent of the more than 98 million total inpatient hospital days that beneficiaries used in 2003. This percentage has remained consistent for the past 8 years.

According to the Medicare National Claims History (NCH), nearly 37,000 Medicare beneficiaries used 1 or more LRDs during calendar year 2003. This represents less than 1 percent of the more than 7.5 million Medicare beneficiaries who had inpatient hospital stays during 2003. Of these 37,000 beneficiaries, approximately 6,800 beneficiaries used 50 or more LRDs and about 4,400 used their entire 60 LRDs.

Beneficiaries who are less than 65 years old represent approximately 18 percent of Medicare beneficiaries. However, they account for a larger proportion of beneficiaries who use LRDs. One-third of the 37,000 beneficiaries who used LRDs in 2003 are less than 65 years old. Of those beneficiaries under age 65, 20 percent used 50 or more LRDs. While 29 percent of beneficiaries who used LRDs in 2003 are between 65 and 74 years old, 29 percent are between 75 and 84 years old, and 9 percent are 85 years or older. Of those beneficiaries 85 years or older, approximately 500 beneficiaries used 50 or more LRDs during 2003.

Three Diagnostic Related Groups (DRGs) are the most frequently used diagnoses that require hospital care beyond the 90 days in a benefit period:

- DRG 430—psychoses
- DRG 087—pulmonary edema and respiratory failure
- DRG 475—respiratory system diagnosis with ventilator support

These DRGs account for nearly 25 percent of the beneficiary claims that used more than 1 LRD.

METHODOLOGY

We used multiple methodologies to accomplish our objectives. We conducted a mail survey of hospitals; reviewed Medicare data; conducted case studies; and interviewed advocacy groups, professional associations, and senior services programs.

Hospital Survey

We selected a simple random sample of 150 hospitals using data from the NCH. From the NCH, we extracted all 2003 inpatient claims (received through December 31, 2003) for patients who used more than 1 LRD. From this data extract, we produced a database that contained 1 observation per hospital, from which we selected a simple random sample of 150 hospitals. To locate the hospitals, we matched the provider numbers with the Online Survey Certification and Reporting (OSCAR) database. For those provider numbers that did not match the database, we contacted the Medicare fiscal intermediaries for names and addresses.

Pretesting Survey Instrument We developed a survey of open and closed end questions. We conducted pretesting of the instrument with four representative hospitals: a tertiary teaching facility, a long-term acute care facility, an urban hospital, and a rural county hospital.

In addition to testing the survey instrument, we asked the hospitals to provide us with either a sample of a beneficiary LRD notice or a description of the type of notation that hospital staff made in the patient record regarding the option not to use LRDs. We also asked them for copies of policies describing their process for informing beneficiaries of the option not to use LRDs. We reviewed a sample of medical and financial records for beneficiaries who used LRDs in 2003.

Mail Survey From our random sample of 150 hospitals we excluded 3 hospitals that were under investigation by the OIG's Office of Investigations. As a result, we mailed 147 surveys. We addressed the survey to the Chief Executive Officer and asked that it be completed by the person(s) responsible for assuring that beneficiaries are informed of their Medicare benefits and hospital costs specific to LRDs. In addition, we asked the hospitals to include copies of their policies and the notices they use to inform patients about LRDs. We

conducted fax and telephone followups to hospitals that failed to respond by the request date, so that we received 100 percent of 147 surveys before beginning our data analysis. (See appendix B for selected survey questions.)

National Claims History Review

We conducted an analysis of the Medicare NCH of 100 percent of the beneficiaries who used 1 or more LRDs during 2003. We contacted the fiscal intermediaries for details of beneficiaries in which we found discrepancies between the NCH and what the hospitals in our case study reported. We analyzed the NCH to identify any common demographics or statistical issues that might be relevant to when and how beneficiaries are using LRDs. We used the NCH to verify some of the information we received in our case studies.

Case Study

To enrich our quantitative analysis and gather firsthand information from hospitals and beneficiaries with knowledge about LRDs, we developed a two-part case study that consisted of interviews with hospital officials and beneficiaries who had been inpatients in those hospitals. We identified a purposive sample of 10 hospitals from the random sample of hospitals we used for the mail survey. (See appendix C.) We selected three States in which each hospital had at least one beneficiary who used less than 10 LRDs and one who used more than 50 LRDs. We conducted onsite interviews with staff responsible for informing beneficiaries about their Medicare benefits and LRDs. These included patient financial services representatives, discharge planners, nurses, social workers, and senior financial managers. In addition to the interviews, we reviewed hospital financial and medical records to verify annotations regarding the LRD notifications.

For the second part of the case study, we identified 20 Medicare beneficiaries from the hospitals in our cluster. Ten beneficiaries used more than 50 LRDs, and 10 beneficiaries used less than 10 LRDs during 2003. Eleven beneficiaries were under age 65, and nine were over age 65. We were unable to locate or interview six of the beneficiaries. We subsequently interviewed 14 beneficiaries or their representatives. Four of the respondents were representatives for beneficiaries who had died before our contact. We conducted personal interviews with the beneficiaries or their representatives either by phone or at their residence.

Telephone Interviews

We selected 17 organizations that were likely to provide information to beneficiaries or their members about LRDs or might have anecdotal information regarding how well beneficiaries understand their Medicare benefits and LRDs. They consisted of five senior advocacy groups from four States; four senior citizens services programs in four States; five professional associations representing hospitals, health care finance, and nursing services; one fiscal intermediary; and two Medicare supplemental insurance carriers. We interviewed representatives of these organizations to gain a better understanding of how frequently they encounter LRDs and how they help beneficiaries understand the option.

This inspection was conducted in accordance with the *Quality Standards for Inspections* issued by the President's Council on Integrity and Efficiency.

Eighty-six percent of hospitals provide written and/or verbal notices about lifetime reserve days to Medicare beneficiaries who have used or will use 90 days of benefits

In response to our survey, 86 percent of hospitals, in compliance with the Medicare Benefit Policy Manual, give a verbal, written, or combination of notices about the LRD option to Medicare beneficiaries who have used or will use 90 days of benefits.[1] The remaining 14 percent of hospitals that do not provide the required notification did not typically offer a reason. Eight percent of hospitals with beneficiaries using LRDs do not provide any information about LRDs either upon admission or sometime during the beneficiary's hospital stay.

In response to the survey question that asked hospitals how they inform beneficiaries about the status of their remaining benefit days (including LRDs), 13 percent reported that they were unable to obtain information about the current benefit status in a timely manner. Several hospital officials whom we interviewed as part of our case studies confirmed this. Those officials said that hospitals might submit bills more than 60 days after the beneficiary has been discharged, thereby preventing a subsequent hospital or SNF from accurately determining the benefit status during a spell of illness. Thirty-three percent of hospitals reported that they are unable to comply with the Manual requirement to notify patients when they have 5 regular coinsurance days remaining. The hospitals are unable to retrieve accurate and timely information concerning LRDs from their fiscal intermediary or the Common Working File (CWF)[2].

Hospitals attempt to provide LRD notices in various ways

Based on the results of our hospital survey, 23 percent of hospitals have developed their own written policies that direct staff how to inform beneficiaries about LRDs. Sixty-one percent of hospitals further comply with the Manual by discussing the option to use LRDs with Medicare patients each time they are readmitted, if the patient has only

[1] Findings are based on the self-reported responses of a random sample of 147 hospitals as of August 2004. Because we randomly selected the hospitals and the confidence intervals are reasonably precise, it is appropriate to project the sample responses to the entire population of hospitals with Medicare beneficiaries using LRDs. For the confidence intervals concerning the statistics cited in this report, see Appendix B.

[2] The CWF is a Medicare benefit coordination and claims validation system. A hospital submits a claim to its fiscal intermediary who sends the claim to the CWF host site for edit checks and payment authorization. The host site edits and reviews the claim for entitlements, deductible status, and accuracy.

5 coinsurance days left in the benefit period. While not required to do so, 15 percent of hospitals have established a policy for notifying beneficiaries that they are exhausting their LRDs.

In nearly 73 percent of hospitals, the admission and billing departments are responsible for informing beneficiaries about their benefits, including LRDs. Hospital policies typically include statements such as:

- The coordinator will monitor days used…;
- From their Medicare available days, the case manager will write a note…; and
- Regarding the notification, a signed consent giving permission to use…done on admission.

Case study hospitals confirm survey results

Based on interviews with 10 case-study hospitals, hospitals are not consistent as to when and how the notice is given and where in the patient's record the notation is made. Five of the ten hospitals give the beneficiaries a form during the admission process that allows them to elect to use or not to use LRDs during the spell of illness. One hospital does not have a form, but makes a notation in the financial record when the beneficiary is informed of the option. Other hospital policies vary depending on the case information about the beneficiary and the beneficiary's financial coverage.

Hospital staff refers to the Manual (Chapter 5) for guidance. It states that the hospital should annotate its records and should make available an appropriate statement or form if the patient elects not to use LRDs. Frequently, a hospital staff member enters notations only if the beneficiary elects not to use LRDs. In four case study hospitals, the election to use or not to use LRDs was part of the patient's financial record. Two hospitals entered the notices as part of the medical record, and three kept a record in the patient's financial and medical records. One case study hospital does not retain any official record, but, according to the administrator, the social workers "… may annotate discussion about LRDs in their notes." Five of the ten case study hospitals have implemented specific hospital policies directing staff how and when to inform beneficiaries about making the election to use or not to use LRDs. The remainder uses the Manual as their primary reference.

Six of the ten case-study hospitals cited inaccuracy of the CWF as a major reason for not being able to provide timely notices. Inaccuracies

in the CWF may occur because of mistakes in hospital billing or delays in the billing processes, which could prevent the fiscal intermediary from entering the data into the CWF for 60 days or more. Multiple readmissions, self-referrals to specialty care, and transient beneficiaries also affect the reliability of the CWF data.

All of the 10 case-study hospitals have financial staff that work routinely with beneficiaries or their representatives to assist them in understanding their financial obligations. This includes the LRD option and the financial consequences of electing not to use LRDs. Seven of the case-study hospitals assign a financial counselor to each beneficiary who is identified as a "long-term stay" (approaching 90 benefit days) to work with the beneficiary or the beneficiary's representative to answer questions and provide assistance regarding benefits, payments, and options.

Hospitals do not interpret uniformly the notice requirements and beneficiaries find the LRD option confusing

According to 42 CFR § 409.65 (d)(1), "The beneficiary's election *not to use* lifetime reserve days must be filed in writing…" In addition, pursuant to 42 CFR § 409.65(d)(2), "…the election may be filed at the time of admission … or any time thereafter up to 90 days after the beneficiary's discharge." While the regulation states that the beneficiary must file an election *not to use* LRDs in writing, in practice hospitals implement the regulation differently. Of the 52 sample notices we received with the survey responses, 36 notices gave the beneficiary the choice of electing to use or not to use LRDs. Nine notices used the CMS suggested format in which the beneficiary only elects not to use LRDs. (See appendix A.) Two notices stated that by not signing the form the beneficiary agreed to use LRDs, and one notice stated that failure to sign indicated an election not to use LRDs.

Case-study beneficiaries and beneficiary representatives also mentioned that the LRD election option was confusing. (See appendix D.) Most of the beneficiaries said the definition of LRDs, their obligations, and options were overwhelming. One beneficiary said, "I never heard the term LRDs mentioned the whole time I was in the hospital." Another said, "There was so much paperwork I didn't know what I was signing." A beneficiary representative summed up the reactions of many of the interviewed representatives by stating, "This was the first time we had to make choices for my mother and we didn't know anything about the Medicare benefits. We just listened to the hospital." While 10 of the

beneficiaries had signed forms in their hospital records electing to use their LRDs, only 2 remember signing them.

Providing a second notice may not be appropriate or feasible

Based on the hospital survey, 64 percent of hospitals believe an additional notice might be helpful or very helpful. However, 66 percent of hospitals said that such a requirement would not be feasible because it would increase their operational costs and staff time. Of the 27 percent of hospitals that specifically stated that a second notice would not be helpful, almost one-third volunteered that the second notice would just add to the beneficiary's confusion. Overall, survey respondents listed the acuity level of the beneficiary, the lack of understanding by the beneficiary or the beneficiary's representative about LRDs, and the inaccuracy of the CWF regarding the status of days used as reasons a second notice would not be appropriate or feasible.

Case-study hospitals express reservations about the value of a second notice

Three of the ten case-study hospitals expressed legal and compliance concerns that could arise for not providing accurate information and not giving notice within the required timeframe. They stated that the information in the CWF would affect the accuracy and timeliness of their response. They also had concerns about the best way to deliver a second notice. The case-study hospitals generally agreed that if a second notice is mandated, it should come directly from CMS in a standardized form.

The case-study hospitals indicated that they routinely attempt to keep these beneficiaries or their representatives informed of their benefit status. While 4 of the 10 case-study hospitals have a policy to notify beneficiaries that they were about to exhaust their LRDs, all 10 hospitals agreed that financial planning was not done in a "vacuum." "We are working with these unique patients through their entire length of stay to help them identify appropriate financial resources or qualify for medical assistance." In addition, the hospital staff stated that the idea of "once in a lifetime" and "lifetime reserve" were rather ominous issues to discuss considering the health status of the beneficiaries at that time.

One case-study hospital official stated, emphatically, that the hospital did not inform beneficiaries about exhaustion of LRDs, as a matter of

policy. The official commented that such information would not be appropriate, because it would cause unnecessary stress on the beneficiary and family. The official also believes that by the time a beneficiary approaches exhaustion of LRDs, the hospital has explored the financial options available and is ready to assist the family with financial aid.

According to case-study beneficiaries, an additional notice is unnecessary

The 14 case-study beneficiaries and representatives did not think that an additional notice would have been helpful. Of the seven beneficiaries who used 50 or more LRDs, and to whom a second notice would have applied, all agreed that an additional notice would not have affected their decisions about their care. When asked about their LRD benefit, 8 of the 14 beneficiaries or representatives said that they were frightened by the idea that they might have to leave the hospital after exhausting their LRDs or that their level of care might decrease.

The fiscal intermediary concurred that an additional notice would not be beneficial, because the hospital may not have current information about the actual number of LRDs used. In some instances, the beneficiary could be given a notice of near exhaustion when, in reality, they had already used all of their LRDs.

Case study-beneficiaries and hospitals agreed that they frequently do not discuss LRDs because of the catastrophic nature of the beneficiary's illness. One beneficiary representative summed up the reactions of those interviewed by saying that none of these financial choices mattered at that stage of illness.

Anecdotally, two representatives who spoke for deceased beneficiaries stated that they were receiving bills now, nearly 1 year later, which they did not understand. They "wished" that someone had spent more time explaining the benefits. However, they agreed that they really had no choice regarding LRDs because of the financial consequences of not using them.

One Medicare advocacy attorney agreed with case-study beneficiaries who opposed the idea of an additional notice. He thought this was too traumatic a period for most beneficiaries to be given a notice that stated in part, "Medicare will no longer pay for your Part A hospital expenses." He added, "There is just too much paperwork for the beneficiary to handle now. This just adds to the confusion."

APPENDIX ~ A

Medicare Benefit Policy Manual: § 40.1 - Election Format (sample)

Election Not to Use Lifetime Reserve Days

I do not wish to have Medicare benefits paid on my behalf under the lifetime reserve provisions of section 1812 (b) of the Act for services furnished me by (name of hospital) beginning (date).

WHERE THE ELECTION MAY TERMINATE BEFORE THE END OF THE STAY IN ACCORDANCE WITH § 40, THE FOLLOWING MAY BE INCLUDED:

The last day to which this election applies is (date).

I understand that I will be responsible for all of the hospital's charges not reimbursed by Medicare because of this election, except those covered under Medicare Part B. Where Medicare Part B payments may be made for services furnished during this period covered by the election, I will be responsible for the deductible and 20 percent coinsurance amounts.

(Signature)

(Date)

(HI claim number)

APPENDIX ~ B

Selected Hospital Survey Questions			
Survey Question	**Response**	**Point Estimate**	**95% Confidence Interval**
In reference to the Medicare benefit period, what type of notice do you provide to Medicare beneficiaries who have used or will use 90 days of benefits, about their option to use lifetime reserve days? (check all that apply)	Written	54.4%	46.0% - 62.7%
	Verbal	69.7%	60.5% - 76.1%
	None	14.3%	9.1% - 21.0%
	Total hospitals that have some notification process	85.7%	79.0% - 90.9%
Do you discuss the option to use lifetime reserve days with Medicare patients each time they are readmitted after using 85 benefit days or more in the same benefit period?	Yes	60.7%	52.2% - 68.7%
	No	39.3%	31.3% - 47.8%
How do you inform Medicare patients (or their representatives) who have multiple readmissions in a single benefit period about their benefit days? (check all that apply)	Provide an additional copy of the standard notice with each readmission	28.3%	21.1% - 36.3%
	Provide counseling and medical records notation when the patient has been readmitted	19.3%	13.2% - 26.7%
	Provide verbal confirmation of benefit status during the admission process	49.0%	40.6% - 57.4%
	Other (describe)	30.3%	23.0% - 38.5%
Can you retrieve accurate beneficiary lifetime reserve days information (from external sources) in a timely manner to meet the current 5 day requirement?	Yes	66.7%	58.3% - 74.3%
	No	33.3%	25.7% - 41.7%
Do you currently have a hospital policy for notifying beneficiaries that they are exhausting their lifetime reserve days?	Yes	14.8%	9.4% - 21.7%
	No	85.2%	78.3% - 90.6%
How helpful would a Medicare policy be that requires an additional notice to Medicare patients (or their representatives) prior to exhaustion of their lifetime reserve days?	Very helpful	27.4%	20.3% - 35.4%
	Helpful	36.3%	28.5% - 44.7%
	Not very helpful	14.4%	9.1% - 21.1%
	Not helpful at all	12.3%	7.5% - 18.8%
	Don't know	9.6%	5.3% - 15.6%

Source: Hospital survey, Office of Evaluation and Inspections, 2004

APPENDIX ~ C

Case Study Hospitals			
Hospital	**Number of Beds**	**Number of Medicare Beneficiaries in 2003**	**Number of Beneficiaries Who Used One or More Lifetime Reserve Days in 2003**
1	659	3,312	18
2	171	2,041	12
3	42	32	3
4	1,299	12,419	109
5	456	55	3
6	518	3,824	33
7	22	913	110
8	697	6,638	10
9	27	83	30
10	853	772	10

Source: Online Survey Certification and Reporting Database (OSCAR), 2003

APPENDIX ~ D

Beneficiary Interviews		
Age	**Number of LRDs**	**Beneficiary Comments about LRDs**
35	60	The hospital explained the lifetime reserve days but I don't understand. I can't afford to lose my Medicare benefits. (Beneficiary)
67	2	I do not understand the lifetime reserve days benefit. Where can I go for help? I am most concerned about the care my spouse is getting. Everyone seems too busy to help. (Representative)
43	60	Unable to contact beneficiary or family.
26	2	Unable to contact beneficiary or family.
87	4	Family and beneficiary refused to be interviewed.
90	60	Family and beneficiary refused to be interviewed.
81	60	I understood the information about LRDs after the hospital explained it. The secondary insurance required that we use the LRDs. An additional notice would not have made any difference but something in writing might have helped us understand the charges. My parent handled all Medicare up to this episode. (Representative)
82	50	We were never given any options. An additional notice would not have made a difference. We had no choice. This was a very prolonged stay. (Representative)
73	55	The hospital was of little help. Our family called Medicare and searched the Medicare Web site for assistance. My parent does not understand Medicare benefits. (Representative)
61	60	Disabled. We were unaware of any choices. We were told I was ineligible for Medicaid because of a pre-existing condition. (Beneficiary)
4	5 *(D)*	We (parents) were told that Medicaid and private insurance were primary coverage. We were not informed of any Medicare obligations. (Representative)
38	4	Disabled. No recollection of any mention of LRDs or financial obligations. (Beneficiary)
41	5	Disabled. Medicaid and Medicare qualified. The hospital explained my benefits. I received good printed materials, but did not understand LRDs. It didn't matter about the option to use them. I needed to be in the hospital. (Representative)
11	53 *(D)*	Hospital provided no information at all. We called Medicare directly. (Representative)
83	54 *(D)*	Before this episode, my parent (beneficiary) took care of benefits. I (Representative) had no knowledge of options. The hospital gave me no useful information. (Representative)
60	6	I do not understand any of the Medicare benefits. I do not remember anything about LRDs. (Beneficiary)
61	9	I have no recollection of any information from the hospital. I have coverage under Medicaid and VA as well as Medicare. (Beneficiary)
87	60	Unable to contact beneficiary or family.
72	6 *(D)*	The hospital reported that no LRDs were used. The Beneficiary received a letter regarding the option to use LRDs. (Representative)
57	6	Unable to contact beneficiary or family.
		(D) Deceased beneficiaries

Source: Beneficiary interviews, Office of Evaluation and Inspections, 2004

APPENDIX ~ E

Agency Comments

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services
Office of Strategic Operations and Regulatory Affairs

200 Independence Avenue SW
Washington, DC 20201

DATE: DEC 1 2004

TO: George F. Grob
Assistant Inspector General
Office of Inspector General

FROM: Jacquelyn Y. White
Director, Office of Strategic Operations and Regulatory Affairs
Centers for Medicare & Medicaid Services

SUBJECT: Office of Inspector General (OIG) Draft Report: "Medicare Lifetime Reserve Days" (OEI-09-04-00100)

Thank you for the opportunity to review and comment on the above-referenced draft report. The CMS is strongly committed to educating beneficiaries and hospitals about Medicare. While a Benefits Policy Manual (BPM) has been published on Lifetime Reserve Days (LRDs), we intend to issue a Medlearn Matters article to provide further clarification of our policy. The CMS is always striving to further communication with its partners in a consistent way. This will provide healthcare institutions with the information they need to enhance communication with Medicare beneficiaries.

Section 953(d) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 requires the OIG to conduct a study relating to the use of hospital LRDs. The OIG conducted a survey of 147 hospitals from a simple random sample of hospitals with patients who used more than 1 LRD. The objective of the report was to (1) determine the extent and means by which hospitals comply with the current requirement to notify Medicare beneficiaries about LRDs; and (2) assess the appropriateness and feasibility of providing an additional notification prior to beneficiaries exhausting their LRDs.

Under section 1861 of the Social Security Act (the Act), a beneficiary is entitled to an unlimited number of benefit periods, each of which includes 90 days of covered inpatient hospital services. A benefit period, or "spell of illness," begins on the first day the beneficiary is an inpatient in a Medicare certified acute care hospital or skilled nursing facility (SNF). The benefit period ends 60 days after the hospital or SNF discharges the beneficiary.

Section 1812 of the Act defines the scope of inpatient hospital benefits and includes the provision regarding 60 nonrenewable LRDs, which a beneficiary may draw upon whenever hospitalized for more than 90 days in a benefit period. Pursuant to the implementing regulations, which are contained at 42 CFR section 409.65, hospitals may bill Medicare for LRDs, unless the beneficiary

elects not to use them or is deemed to have elected not to use them. Hospital notification requirements are delineated in the Medicare Benefit Policy Manual. If the beneficiary elects not to use LRDs, the beneficiary becomes responsible for hospital charges beginning with the 91st day in the benefit period. Similarly, if the beneficiary uses all 60 LRDs and remains in the hospital beyond 150 days, the beneficiary becomes responsible for hospital charges on the 151st day.

The OIG concluded that 86 percent of hospitals comply with the Benefits Policy Manual and provide notice about the LRD option to Medicare beneficiaries and the remaining 14 percent of hospitals do not provide the required notification. In addition, the OIG determined that while hospitals attempt to provide LRD notices in various ways, they are not consistent on how and where the notification is made, they do not interpret the notice requirement uniformly, and beneficiaries find the option confusing.

The CMS appreciates the efforts of the OIG in developing this informative report. As a result, CMS will issue a Medlearn Matters article to explain LRD policies to hospitals. This article will inform hospitals how to obtain information about LRDs as well as clarify the Medicare coverage of inpatient hospital services as stated under section 1861 of the Act.

The CMS recognizes the value in this report and looks forward to working with hospitals to bring uniformity and consistency in their communications with their fiscal intermediaries and the Medicare beneficiaries.

ACKNOWLEDGMENTS

This report was prepared under the direction of Paul Gottlober, Regional Inspector General for Evaluation and Inspections in the San Francisco regional office, and Deborah Harvey, Assistant Regional Inspector General. Other principal Office of Evaluation and Inspections staff who contributed include:

Tim Brady, *Project Leader*

Silvia Chin, *Program Analyst*

Rob Gibbons, *Program Analyst*

Linda Frisch, *Program Specialist*

Tricia Schmitt, *Program Specialist*

Bambi Straw, *Program Specialist*

Tricia Davis, D*irector, Medicare and Medicaid Branch*

Technical Assistance

Barbara Tedesco, *Mathematical Statistician*