Audio recordings for this transcript:
http://media.cms.hhs.gov/audio/HospObservBedListeningSession082410_Part1.mp3
http://media.cms.hhs.gov/audio/HospObservBedListeningSession082410_Part2.mp3

Centers for Medicare & Medicaid Services
Listening Session:
Hospital Observation Beds
Moderator: Susie Butler
August 24, 2010
2:00 p.m. ET

Operator: Good afternoon, my name is Tracy and I will be your conference facilitator today.
At this time, I would like to welcome everyone to the Centers for Medicare and Medicaid Services Hospital Observation Bed Listening Session. All lines have been placed on mute to prevent any background noise. After the speaker's remarks there will be a open comment session. If you would like to give a comment during this time, please press * then the number 1 on your telephone keypad. Thank you. Ms. Susie Butler, you may now begin.

Susie Butler: So we'll be taking questions here or comments, I'm sorry, here in the room. And we'll ask you to come to the podium, tell us your name, where you're from and at that point, we'll start the two-minute clock. And sorry to just give you two minutes but with so many people wanting to give comments today, it was the best way to let everybody have a voice.

And then we'll alternate between folks at the podium and folks on the phone. So we'll be going back and forth to give you a chance to go back to your seat and someone else to line up and queue up and ask to ...

It is live folks. So, also a few questions have come up. This is being recorded. You will be able to hear this later. Folks on the phone, if you don't get, of course, it will definitely not help if you're not on the phone now, you won't hear this. But if you know of someone who wanted to call in and couldn't or wanted to attend and couldn't, two hours after today's meeting is concluded, the recording will be available.

And let me give you the number and I'll give it again at the end of today's meeting. It's 1-800-642-1687 and you have to use an ID, and the ID is 942-

44031. Let me give each – that seven numbers to you once again. This is the Encore feature and it's 1-800-642-1687 and the call ID is 942-44031.

We've got some opening remarks to get us started this morning. I'm going to Jon Blum. Get us started. Jon.

Jon Blum: Well, it's kind of odd to be up here when you're all down there. But I want to thank everybody, those on the phone and those here in person, to join us today for this portion of the meeting to hear about concerns regarding the growth in observation care.

CMS, we had noticed a small but a growing trend towards more observation care. That is of concern to the agency. We are here to listen. We are here to hear concerns, perspectives, thoughts from all different sides of the issues, from the provider community to the beneficiary community. We're not here to comment. We're not here to respond. We're not here to answer questions.

We have set up a separate web box for questions to be sent to us, but we're really here on the spirit to listen, to understand the concerns. We have contacted the three largest hospital associations to understand their perspectives to help explain this growing trend both in the number but also in the length of observation care.

The agency has been clear through its guidance documents that we don't expect observation care to last more than 24 or 48 hours. And to our mind, a diagnosis whether to send the patient home or to admit the patient should be made within that 48-hour span.

But at the same time, there could be other reasons why these cases are growing past 48 hours. To our minds, we don't see any payment policy incentive for this trend. Some have suggested that it is caused by payment incentive. And again, to our minds, the payment policies that we have in place, to us, don't seem to encourage the growth both in duration and in the number of observation care days.

This trend has implications for beneficiaries. Our cost sharing policies are based upon whether or not beneficiaries are in outpatient care versus inpatient

care. Observation care is outpatient services and therefore beneficiaries might have to pay higher cost sharing for certain Part B covered drugs. Then they have higher copayments just for the stay of care. Beneficiaries pay 20 percent on their Part B stay, outpatient stay but pay lower – pay different cost-sharing amounts for our Part A admission.

Beneficiaries may not qualify for skilled-nursing care reimbursement given the three-day stay policy, beneficiaries who are in observation care under the current law, current regulations don't count towards that three-day stay.

So we are here, I think, to understand why is this trend growing; what is the impact on beneficiary; how can CMS better educate beneficiaries. We have pamphlets out to help beneficiaries understand whether they're in inpatient care, outpatient care or observation care, and what are the implications for that for beneficiaries cost sharing and eligibility for other benefits. Should CMS change policy? Should CMS make changes to our guidance documents, regulations potentially?

So again, we're all ears. We want to understand why this trend is happening. We also want to understand the implications for non-beneficiaries, first and foremost but also for providers.

So thank you for all attending. I can't stand fortunately for the conversation but our staff is here and we are committed to listening, we are committed to take concerns. We want to make sure that we have the best policies going forward given there could be some very legitimate needs for this growth, but at the same time, there are concerns to beneficiaries, there are concerns for beneficiary cost-sharing, eligibility to other services, and we're not seeing payment policy incentives to explain this trend.

So thank you again. I look forward to seeing the summary and look forward to your participation.

Susie Butler: Great. Thanks, Jon. Thanks for setting the tone.

As Jon said, CMS folks are in the room and on the phone, but they're in a listen-only mode. So today we want to hear from you. So we'll be listening to

your comments. We'll be taking notes. And as I've said, we're recording the session so we'll be reviewing those notes as well.

Before we get started, a couple of other things I just want to set out. I hope you won't take advantage of an open mike to say naughty things about CMS, that's not really what we wanted to hear about today. So I've got friends in the control room that could cut the mike but we hope we don't have to do that. Instead, I hope that this is a chance really to share about the topic at hand.

Also, please stick to the two-minute rule. I will cut you off if need be. Again, I don't want to. One group has already approached me. They've timed their presentation at six minutes. So three people are going to do two minutes apiece and we can work with that.

Please remember this is not an official reading for the Federal Register or anything like that. This is just a chance for CMS to get some information and hear from you. I also want to say that this is not an opportunity for the media to take this information and ask questions or probing questions. There may be media folks on the line but this is not a media call per se. This is talking to industry and stakeholders about this issue.

One person I do want to call out and introduce is our Medicare Ombudsman Dan Schreiner. Can you wave hands? Folks on the phone, Dan is waving his hand.

Some of you have the opportunity to try to reach out the Medicare Ombudsman. The best thing to do is to call the 1-800 number, explain your situation. We have trained operators on 1-800 who will help people work through different situations and see when it's best to triage to whom. But also those things end up – those situations end with Dan and his very talented staff. So I just wanted to make sure we connected those in the room with Dan and those on the phone with how to reach the ombudsman's office.

So with that, make sure I didn't miss anything. I believe we're ready to hear from you. So Jon set up the subject very nicely. So I'm going to look to you to line up – queue up behind the microphone here. Again, please tell us who you are, where you're from, we'll watch the two-minute timer at that point and

then also, Joyce is assisting me with folks who are on the phone. At this point we have 1085 folks on the phone. I don't think we have two minutes for each of them, but hopefully, we'll get a good representation.

Somebody has got to be the brave soul to go first. We'll start in the room. Thank you.

Sandy Fitzler: I'm Sandy Fitzler from the American Healthcare Association.

According to the HHS strategic framework on multiple chronic conditions which we call MCC, approximately 75 million Americans have two or more concurrent conditions such as hypertension, diabetes, arthritis, heart disease, and more. We know that many patients who residing in nursing facilities have all of the mentioned conditions along with several others like depression and cognitive impairments.

MCC are common in individuals over the age of 55. And individuals with MCC account for a significant number of patients who have experienced observation stay. Individuals with MCCs are at risk for complications and poor outcomes. While the HHS strategic framework looks now to developing tools and strategies to address the increased prevalence of MCC, current research and evidence falls short in providing adequate direction to care providers and policy makers regarding care approaches.

With this in mind, a focus needs to be placed on the list of conditions and rules in use today that health providers determine an observation stay or a hospital stay. For MCC patients, stay determination cannot be made from a list or on the fear of a claim denial.

Long term care providers who specialize in caring for individuals with MCC know that the patient assessment needs to be holistic in that (inaudible) presenting condition; primary and secondary need to be considered to determine the most appropriate plan of care. Given this, we urge medical and payment audit professionals to consider the complexities of caring for individuals with MCCs. And we urge CMS to reconsider the use of observation stays for this population. Thank you.

Susie Butler: Thank you. Thank you very much. Do we have anyone on the phone who wants to make a comment? OK, we'll go back to the room. We'll switch between phone and room.

Elise Smith: Well, you're going to hear again from someone in long term care. I wish, however, that the hospital representatives will take some time in this meeting to explain a little better from their perspective the increased, presumably the increased number of observation stays and the increased lengths.

Susie Butler: Can we get your name and organization please?

Elise Smith: Of course, sorry. Elise Smith from the American Health Care Association. And we represent over something like 12,000 nursing homes. I hope that the 1,000 people on the phone will do the same as they have done with us. Call us and call the advocates. As they've called the advocates, I hope they will call CMS today and actually give examples.

The problem. There does seem to be a problem. I am assuming there is one of increased number of observation stays and the length. Observation stays seem to be a very perplexing concept. It is not in statute. All Congress was really aware of, all they envisioned were inpatient days followed by post-acute care days. That was the way it was. That's what they understood. And as you know time and time again, CMS has issued guidance on the criteria for observation stays only to have the issue more guidance. What is now driving this phenomenon?

My best guess and it can only be a guess, is preemptive action on the part of hospitals concerned about potential denials of inpatient stay for lack of medical necessity. And I want to say that if this is the case, I certainly cannot blame them. In fact, I would like to very much, have AHCA work with hospitals and CMS to address that problem, the so- called lack of medical necessity.

So what might be the resolution? Number one, enforce the rules. Let us say that CMS tells his contractor, no more approval of stays beyond 48 hours. If this is rigidly adhered to, beneficiaries would either go home or be admitted.

If they are admitted, that is a good thing from a clinical point of view, I would think. If they go home, I'm not so sure.

Susie Butler: Ten seconds.

Elise Smith: What?

Susie Butler: Ten seconds.

Elise Smith: OK.

Susie Butler: You have ten seconds left.

Elise Smith: OK. So, we believe that these days should be counted in so called inpatient days with inpatient days as an – as inpatient days on their own. We're now in a new era. We talk about seamless care, coordinated care, integrated care with a strong emphasis on care transitions. I'd like to see that concept taken into this arena and AHCA is hopeful on working with you all to do it. Thank you.

Susie Butler: Thank you for your comments. So far, we have no questions waiting on the phone. I'll invite those on the phone. Again, if you have questions, make sure you let the operator know. The other thing I'll tell you, we're now up to 1,600 – is that correct – on the phone. Someone asked me just now, if anyone is emailing you, saying they need to get into the call, is it happening? There's a long wait list on the call right now. People are still trying to get into the call. So just tell the folks that are emailing you to be patient. They'll get to you in as quickly as possible. OK.

Hi.

Michael Ross: Hello. I'm Dr. Michael Ross. I'm the chair of the Agency Advisory Panel, Visit and Observation Subcommittee and director of Observation Medicine at Emory University Hospital. The couple of comments in my two minutes here.

Susie Butler: OK.

Michael Ross: Observation is management to determine the need for inpatient admission which begs the question what's admission, that's in the hospital beneficiary

manual is defined as a patient the physician anticipates will require at least 24 hours of hospital care and stay overnight. So then the question is who are these patients that I call the six to 20 of our patients, patients that – patients that need more than six hours of care in the ED but if managed actively less than 24 hours of care.

There's been an increase in these cases by Medicare claims in part because the payment for observation changed a couple of years ago to cover all conditions instead of chest pain, asthma, CHF, it was expanded to all conditions. And actually, the increase was less than was expected by opening observation to all conditions increased by about a third instead about 50 to 70 percent.

Really, this begs the bigger question of there's been a shift of care from hospital setting to the outpatient setting over the last couple of decades. Some of the observation patients are managed actively in dedicated observation units. So those are managed in (inaudible), in the medical surgical bed.

What's clear is that most of the patients succeed in observation status or in an observation unit. But some patients really don't meet inpatient criteria, but they can't go home. They're debilitated, as the other speakers have mentioned, they're debilitated elderly patients that have conditions such as chronic back pain, head pain, and you can't send them home, you can't admit them. So that in part I think is responsible for the creep in stays over 36 hours, 48 hours.

Susie Butler: Thank you very much. Folks, if you're on the phone and trying to figure out how to ask a question, Joyce told me you need to press one and the operator will come on and queue you in. So it's not enough to want to ask a question, you need to press one.

Is there anyone else in the room while we're waiting for folks on the line? We have anyone on the line yet, Joyce? While we're waiting, I do want to – we mentioned the resource mailbox. I'm going to make sure that you have that address. It's extended observation – all one word – at cms.hhs.gov . That went live yesterday but no one knew about it. So extendedobservation@cms.hhs.gov .

OK. Anyone on the phone yet? Joyce is checking. OK. Anyone in the room? My trio. OK.

Roslyn Schulman: Hi, I'm Roslyn Schulman, a director of policy at the American Hospital Association. And today, I'm accompanied by two colleagues from two other hospital organization. Sienna Maze from the American – the Association of American Medical colleges and Jack Nicolaus from the Federation of American Hospitals.

Last month, each of our organizations received a letter from the Center for Medicare and Medicaid Services concerning a modest trend toward more observation services extending beyond 48 hours from approximately three percent in 2008, nearly six percent in 2008 – 2006 to 2008.

CMS expressed an interest in learning more about why this trend is occurring and asked whether we can provide any information to better inform potential CMS action. In response to the letter, our organizations has been busy reaching to our hospital and heath (system) members to learn more about how hospital observation services are currently furnished.

We've also sought their input on possible causes for the increase in the number of observation services extending beyond 48 hours. As a starting point, we commissioned a study to analyze four years of Medicare observation services claims data in order to better understand the trend that CMS identified.

This analysis is not yet complete. And so, I am not able to provide our final conclusions at this time. We will, however, be reporting the results of our analyses to CMS when they are ready.

From our effort so far, it is clear that hospitals and physicians are doing the best they can to ensure that their patients are receiving appropriate care at the appropriate time in the right location based on clinical considerations.

We have learned that patients are often placed in outpatient observation because they do not meet the criteria for admitting them as inpatient. However, for patient safety and quality of care reasons, it may be important

that patients who do not qualify for inpatient care be kept in observation. Hospitals cannot discharge patients before they are clinically ready to be sent home.

Jack Nicolaus: It also seems clear that several factors are likely contributing to this trend—the discussion with hospitals. The evolution of technology and medical practice now allows many traditional inpatient services to be rendered in outpatient departments.

The number of services which has been removed from the CMS inpatient-only list since the inception of the outpatient perspective payment system supports this point. This trend towards more complex services being furnished in outpatient departments has been accompanied by various changes to the criteria such as InterQual and Nomen which are used by hospitals to guide decisions about whether to admit a patient as an inpatient.

Consistent with the changes and practice patterns, the inpatient admission criteria have become more stringent overtime. As you know, patients can only be admitted to and remain in hospitals when inpatient level care is reasonable and necessary.

For most hospitals, these criteria are key determinants of what is considered to be reasonable and necessary. As the admission criteria became more stringent, it is not surprising that more patients may require observation services or that observation services may extend for longer periods of time.

In a related manner, decisions to admit patients for short inpatient stays have received prominent attention in audits by Recovery Audit Contractors particularly during the RAC demonstration program which coincides with the period during which CMS noted a trend toward longer observation services.

Concern about potential RAC audit of short stay claims may have also had an impact on the trend towards more and longer observation stays. We also note that the requirements related to reporting observation services have changed five times since OPPS was implemented in 2000.

However, the separate payment hospitals receive for eight or more hours of observation has remained the same since 2002. Thus, hospitals do not have a financial incentive to keep patients longer in observation status.

A critical policy change was made in 2006 that may have contributed towards the subsequent artificial increase in the number of claims which extended observation services. That is in 2006, CMS changed the codes for reporting observation services and also eliminated the claims processing edit that rejected outpatient claims containing over 48 hours of observation services.

Prior to its elimination, this edit likely limited the number of observation services that hospitals recorded as exceeding 48 hours. Many hospitals have implemented internal edits to their billing systems that adjusted the claim to report only 48 hours or less of observation time given there was no payment impact.

It is quite possible that the trend line recorded by CMS may in part reflect this change followed by the gradual response by hospitals to eliminate their internal claims edits and report all hours of observation services.

Sienna Maze: We are sympathetic to and understand the implications to Medicare beneficiaries that results from extended observation services including possible increases in out-of-pocket cost and difficulties in meeting the minimum inpatient daily requirement for skilled nursing facility care.

However, hospitals must operate within the policies that govern them. And we do not believe that discharging a patient from observation services at an arbitrary time limit of 48 hours is clinically appropriate simply because the patient does not qualify for inpatient care.

That said, hospitals could probably do a better job of communicating to Medicare beneficiaries under observation that they are not inpatient, but rather outpatient. In addition, hospitals could explain to those patients what that means in terms of their potential responsibility for paying for certain additional out-of-pocket cost as well as the implications for qualifying for any necessary skilled nursing facility care.

The AHA, AAMC, and the federation pledged to work with hospitals to help them educate and communicate with their patients around this issue. Once our view of the trend data is complete, we will respond to CMS with our final analysis and conclusion.

Further, we are happy to continue to work with CMS to better inform further actions the agency may want to take on this issue to better serve Medicare beneficiaries. We also encourage CMS and other stakeholders to share their analysis on likely causes of this trend.

Susie Butler: Thank you so much. Tracy, do we have some folks on the line who wants to give us a comment?

Operator: Yes, we do. You have a question from Denis Blaine from Florida. Your line is open.

Susie Butler: Yes.

Dr. Myerson: Yes, hi. This is actually Dr. Myerson in the Baptist Hospital in Miami. I'm medical director for care management. So on a daily basis have to deal with this distinction between observation and inpatient. I was wondering to make a few comments.

You know, observation as a time to make a decision on whether a patient needs to be admitted is really not how observation is used in practice. In reality, these are sick patients who need to be admitted to a hospital. And under a set of, rather arbitrary definitions which are very vague and difficult to understand and apply, we have to decide who's an inpatient and who is an outpatient when sometimes the distinction can be two or three points in their sodium level with the amount of IV fluids they're receiving.

So, on the admission, the time of admission, the emergency room doctor makes a decision whether a patient is well enough to go home or sick enough to be in a hospital, that's the E.R. decision. And then the distinction between observation and inpatient is based on these vague definitions.

So if a patient doesn't meet the criteria, whatever they are for inpatient admission, at the time of admission, then they're placed in observation. A day or two later, the patient is unlikely to meet that same definition.

So, if you know, to answer the question why the patient stay in observation so long, that's because they're not well enough to go home and yet they're not going to meet the definition that the RAC is going to use to audit hospital admissions because that may wind up being a one-day admission after two days of observation. And the third day, the patient is ready to go home.

And there is no classification that covers a patient who doesn't need the inpatient definition, but is not – is still not well enough to go home. So, rather than being a time to evaluate a patient after an E.R. visit to determine the medical necessity for admission, it winds up being a one or two-day hospital admission that kind of stretches out sometimes to three or four days.

What I'd like to suggest as an approach to this is since the concept of observation really hasn't – isn't practical, you know, kind of looking at it as an extension of emergency room visit, I'd like to propose abolishing the observation concept altogether. And make the definition of someone who needs to be admitted to a hospital is admitted to a hospital.

And the payment has to be different on day one. Some sort of formula could be established that would pay similar to observation for the first day so those patients who can be rapidly discharged wouldn't have to be rolled in to a DRG type of payment.

But right now, the system is impractical and it just locks up patients in the hospital and not well enough to leave or not – they're not sick enough to admit. And so, what do you do with them? That's really the dilemma that's facing hospitals.

Susie Butler: Thank you so much. I appreciate that. Anyone in the room? We do have folks in queue online. So, go ahead.

Valerie Rinkle: Valerie Rinkle with the Asante Health System, Medford Oregon. I just wanted to confirm the 48-hour limit that several years ago, there was an

outright cut-off in your claim submission and hospitals were not allowed to report observation stays longer than 48 hours.

Then there was a clarification by CMS that if there was medical necessity, you could have put over a mark on your claim and get the claim in the door. And I do think progressively hospitals are starting to learn that and submit more of those claims.

But I also know a lot of hospitals still have that arbitrary cut off and they're not completely reporting to you all the hours the patients are in observation. So I want to point that out. The second thing that I wan to point out is just like (has) been said a lot of more intensive acute services are migrating to the outpatient place as virtue by the inpatient-only list moving.

When you make that change look at all the medications that the patients need for their co-morbid condition and other services that are self administered drugs that are no longer going to be covered by Medicare when they recovered under the Part-A stay. And it becomes a huge financial liability to the patient.

It also becomes a point of patient relations issues with the hospital because the beneficiaries even if they've been educated in a hospital that they are on an outpatient observation stay, they do not – and told that they will have out-of-pocket liability associated with their self-administered drugs. They don't believe it's right. They don't understand it. And then they think the hospital is doing something wrong.

And so it really puts a lot of hospitals in a difficult position and CMS has taken the position that it would be an anti-kickback for hospitals to write those charges off. And as more therapeutic drugs becomes self administered that's a greater and greater cost to hospitals as well so it's problematic.

Susie Butler: Thank you. Tracy do have someone on the phone?

Operator: Yes. Your next question comes from the line of Michael Fagger form Washington. Your line is open.

Michael Fagger: Hello, I just kind of want to reiterate some of the earlier thoughts and give from a hospital compliance officer perspective the clear fact that CMS over the past five years is kind of instilled a fear into hospitals of keeping people as an inpatient. When we can't, they can't meet the guidelines out there but as others have said these people are too frail to go home. And hospital observation has become somewhat of a social safety net in this nation. That's all I have.

Susie Butler: Thank you. Tracy, another one from the phone please?

Operator: Your next question comes from the line of Ester Gerena from Illinois. Your line is open.

Esther Gerena: Hi. I just want to – this is Esther from Swedish Covenant. I just want to state that the hospitals are absorbing the cost of the nursing monitoring and observation. Now, that it's so limited where we get these composite rate payments, there isn't any amount being given to this nursing care that's being provided. And yes we are providing it for those patients that have special risk factors, they can't go home, that are too sick to go home and you know, I guess that Medicare consider that, all the care that we give and receive no payment for.

Susie Butler: Thank you. Anyone in the room?

Toby Iddleman: My name is Toby Iddleman I'm an attorney with the Washington DC office of the Center for Medicare advocacy. We're a not-for-profit organization public interest law firm that represents Medicare beneficiaries.

First, I really want to thanks CMS for holding this listening session. Our program has been concerned about observations for many years more than a decade and this is the first time we've had such an intense response from CMS, so we really appreciate it.

We've been concerned about observations for a long time but we also know that Medicare beneficiaries across the country now are increasingly finding themselves classified as outpatients when they've been in the hospital bed for a week or more. We've had clients who's been in the hospital for 13 days and

classified as observation patients. Often people don't know that they're in an outpatient status.

They've been put in a bed usually from the emergency room. They have a wristband, they have tests, they receive medications, health care services, food, they are seen by physicians and nurses, and they get no notice from the hospital or from anyone that they're inpatient. CMS has told our office that observation stays can be appealed but beneficiaries have found as a practical matter that it's often impossible to appeal. Frequently, it's only at the time of discharge from the hospital that patients learn o their outpatient status.

The hospital tells the adult-children to bring their checkbook to the nursing home because Medicare won't be paying for that care. Beneficiaries and their families are paying tens of thousands of dollars for nursing home care that Medicare would be paying except for the outpatient status.

Some people cannot afford to pay privately and they're going to inappropriate places sometimes home, getting no services at all or they're going to assist at living and not getting care or they're going to a nursing home very briefly and having to leave because can afford it.

We're concerned that hospitals – as hospitals begin creating observation units, the quality of care is going to decline even further for beneficiaries in the hospital because people will see they're on observation as opposed to inpatients.

We also think the use of observation stay is going to increase as health care reforms put the premium on avoiding inappropriate readmissions. We know that being in observation as an outpatient does not count as a readmission. So we think this is going to increase even further.

We think CMS can resolve the problem of observation status for beneficiaries by doing several things. Although I have to say I love what Dr. Myerson said from Florida just moments ago, let's just get rid of observation entirely. We certainly agree with that because there is no authority (inaudible) said. There is no authority in the law, we think it violates the law but I don't want to have a legal analysis. I just want to say three things that we think CMS can do.

First, count all the time in the hospital as inpatient stay for beneficiaries who are in observation and then admitted it to the hospital as inpatient. CMS count this time in this way for acute care hospitals. It bundles the observation time into the inpatient time. So treating the same time for the same person in the same way seems simple.

Second, we suggest that CMS administratively decide to enforce the Medicare manuals with the 24 and 28-hour time limits.

And third, require hospitals to give hospitalized patients an advance beneficiary notice so they can (inaudible) informed about their status and can get into the Medicare appeal system. Thank you.

Susie Butler: Thank you. We've had quite a few people join us on the phone since we've started so I want to reiterate some of the ground rules for folks. We're well over 2000 folks on the phone and we're asking people to keep their comments to two minutes. The folks on the room can see me tell them to hurry up, so things like that. On the phone, I may have interrupt you and I'm loathed to do that. So if you can keep your comments to two minutes, I'd appreciate it.

Tracy, I know we've got some folks in the queue. Can you open the phone lines for us, please?

Operator: Your next question comes from the line of Jackie Birmingham from Connecticut. Your line is open.

Jackie Birmingham: Thank you for the call – for taking my call. I recall the Medicare advocacy had a lawsuit two years ago. It was Landers versus Libbitt. And in that lawsuit, the claim was at that time in outpatient I think or emergency room, was not counted for the three-day stay. Now, the ruling was the original intent of the three-day qualifying stay is written in the law dating back to 1967.

This has caused more confusion and havoc and it's not only affecting hospitals but skilled nursing facilities. So if there is a way to – the observation status came in place because hospitals asked for it. We were dinged for

inappropriate admissions. We knew we couldn't discharge patients to an unsafe environment so we asked for observation status.

Now, we're asking, "Take it away." It will cost less in the long run to just admit the patient, give them care than it is to monitor this very confusing regulation, and a system where the patient is in the middle of nowhere and please consider abolishing that level of care. Thank you.

Susie Butler: Tracy, the next person is on the phone?

Operator: The next question comes from the line of Christi Sarasin from Massachusetts. Your line is open.

Christi Sarasin: Hi. And actually it's Christi Sarasin from Maryland and thank you for taking my call. There have been some great points that have been raised, a few that I could add. There is a lot of confusion related to when the patient does or does not lose the criteria. And everybody is trying to strictly adhere to InterQual or Milliman.

But there is the caveat out there that if an admission that's appropriate based on the physician's judgment and there isn't enough of a focus on that or getting that documentation that would support that. Also, it's easier to have a patient in observation than it is to actually try to change that status and then work through the conditions of participation to get that necessary physician concurrence and that necessary documentation that would have to be in the record as stated.

You also have circumstances where you have delayed assessment. This is a problem, because the patient must meet criteria at the time the order is written. And if that assessment is delayed as it commonly – and you'll see this over the weekend, you will see this during the evening – when it comes time for that assessment to be done, the patient actually doesn't need anymore.

So, as you try to abide by these guidelines, you've missed the opportunity to have this patient as an in patient. You must now keep them in observation. And so, for these reasons I think you are seeing the creep, the increased incidence of patients who are in observation.

Susie Butler: Thank you. Anyone in the room wants to make a comment?

OK. We'll go back to the phone. Tracy?

Operator: Your next question or comment comes from the line of Judith Stein from Connecticut. Your line is open.

Judith Stein: Thank you very much. This is Judith Stein. I'm the founder and executive director of the Center for Medicare Advocacy.

As Toby, I want to thank you for holding this call. She indicated for over 10 years we've seen observation cases but we've seen a dramatic increase. And while one can posit why, and I think we've heard many of the whys, what we know about is the harm.

We find people increasingly in the hospital who cannot get coverage then when they go to nursing home. Increasingly, they are having extraordinary out-of-pocket expenses. And while we might figure out how to communicate to people in the hospital, people in the hospital are, of course, are by definition sick. And if they're a Medicare patient, they're also by definition older and/or disabled.

And I can't understand the notion of an outpatient-inpatient. When I have been a hospital patient in a bed, in a Johnny with a test, I certainly wouldn't have been able to understand how I could be considered an outpatient. And I would say that that's surely the case for people who are older and disabled and sick.

There simply is no such thing as an outpatient-inpatient. It's become a term that was being asked to accept when it harms people. This observation status is, in fact, not part of the law and it is creating problems both for beneficiaries and for relationships between hospitals and beneficiaries and their families.

If it's an InterQual or other private organization notion of hospital standards, then we should have CMS speak out about what CMS wants the hospitals to do regarding their criteria because, to my knowledge, this is – observation

status is not in the law and the hospital inpatient criteria have not been changed for many, many years.

So, I would reiterate the urge to have this notion abolished and in the alternative to give notice to make sure it's no more than 24 hours and for all time a person spends in the hospital, whether or not they're eventually admitted, to count towards the three-day hospital stay, and finally, should they understand that they're in outpatient, inpatient observation status, have the right to appeal. Thank you very much.

Susie Butler: Thank you. I'm looking to see if anyone is getting wiggly in their seats and ready to come up to the microphone. Everybody froze as soon as I said that. All right, we'll go over back to the phone. Tracy?

Operator: Hi. Your next question or comment comes from the line of Beth Gale from Illinois. Your line is open.

Beth Gale: Hi. This is Beth Gale from Tshwaki Community Hospital. I would like to make a comment several years ago that CMS had a regulation where if the patient came in as an outpatient, they could go to directly to a skilled nursing facility.

They did not need the qualifying three-day inpatient stay. That was wonderful because for those patients that truly did not meet any patient criteria but they did need the skill level in a nursing home, we didn't have to keep them – to get them to qualify based on the documentation of the physician to get them as an inpatient. That would be most helpful.

Plus, the fact that even if you do give them information, which we do, outpatient, they are in an outpatient observation stay for which they would be responsible for their medication, for safety reasons, they can't take their own medication. But sometimes, they're just too sick to care or even listen or understand. So, it would be nice, again, just to get that non-three day coverage taken away.

Susie Butler: Thank you. Tracy, let's go to the next caller.

Operator: Your next question or comment comes from the line of Patti Cullen from Minnesota. Your line is open.

Patti Cullen: Thank you. I have a collection, I represent a variety of providers throughout the state, and they have continued to send me example. And so, I think I'm just going to take my time to read a few examples of …

Susie Butler: You have two minutes.

Patti Cullen: Directors of nursing, they're quick examples. Directors of nursing that have talked about the length of stay starting about last October where you have individuals who have stayed 13 days. The son didn't know it but the nursing home was unaware that the stay was not going to be covered.

The next case, there was someone who was in observation than an inpatient. However, the total time did not add up to the three days, and so when admitted into the nursing facility, the family was unaware that they were not going to be covered.

Again, that was a situation that started – we were seeing these incidents from beneficiary families starting about last October. We do have individuals who have been, simply, did not qualify for (inaudible) stay. Even though receiving skilled services, the family came to the facility fully expecting that, the facilities were put in a position of having to explain that, "No, it's not true. They did not get Medicare (inaudible)."

So, I think there was a lot of lack of communication, and at the end of the day, I think one of the prior callers said that impacting relationships is one of the downsides of this policy, and I would totally agree, its relationships between the families and the facilities but also between the facilities and the local hospitals that they've worked so closely over the course of the years.

So, I would be happy to share. I do have several dozen examples that have been sent to me. And I will rather than take time up, send it to the mailbox that you designated earlier if that would be helpful.

Susie Butler: That's great. And that mailbox will be read. So, thank you so much for your comments.

Next question on the phone.

Operator: Your next question or comment comes from the line of Marion Munagain from Wisconsin. Your line is open.

Marion Munagain: Just a couple of comments that I wanted to make.

And somebody already talked about the self-administered drug. You know, we – it's huge to satisfy these patients and families when they get these bills, but what they've – we also – what we also commented on is educate and communicate to them, which we do have a process.

The family as everybody else is saying, the patients and the family don't hear that. They hear that their patients – you know the family member, secondly, needs to be in the hospital. The bigger portion that we find is we have problems with patients who – if they think – their medication at home, as they bring it with them to the hospital you know we have process that's put in place to be able to work with that.

But it's these drugs that are being given to the patient, injections and everything while they're in observation status that are denied then as self-administered. You're talking a couple of hundred dollars of injection. And again, just to reiterate that, and then the same issue we're having is a lot of SNFs really upset with us when we transfer patient because they didn't have a three-day qualifying stay.

So that's all I have.

Susie Butler: Thank you.

I'm looking around the room again to see if anybody wants to speak. Great. We've got someone approaching the podium.

Kathleen Wilson: Hello. My name is Kathleen Wilson and I represent the American Medical Directors Association.

And in listening to those – the American Healthcare Association and the Center for Medicare Advocacy comments as well as some of the comments on the phone, we would agree with many of the examples that they provided for the reasons why patients are not admitted.

And we would add to that because some of the things that our physicians are telling, it could be as simple as the patient would qualify, but there's no bed available. And so, really briefly, what I would say is that all of these examples that we've heard today would lead us to support the physicians that all of our observation time be counted towards the qualifying three-day stay.

And that has been a position of AMDA for more than 10 years that you know the three-day stay, the eligibility requirement be eliminated, or more recently, with the emphasis on observation units to have that time count towards the three-day stay.

Thank you.

Susie Butler: Thank you.

Mike Ross: Hello. This is Mike Ross again.

A couple of additional comments. Fundamentally, these – the patients that we're talking about really fall between – the world of inpatients and outpatients, and that's, I think, where a lot of this friction arises, that these patients need more time than a traditional out-patient visit would allow, but at 24 hours or less, they don't really quite fit into the inpatient world.

And I think this is a friction of that fact that, really, they almost need their own category. As soon as we've decided that there's inpatient, outpatient and everything falls in those (inaudible) probably five percent, five to 10 percent of ED patients that really fall in that gap.

The other point of friction is, as mentioned, the hospital manual is a physician's definition of what an inpatient is; whereas, InterQual is a separate definition and observation really captures that friction that the – a lot of times

those two don't agree. These patients that need InterQual criteria for admission that the physician knows that if you manage the patient actively, that he could get the patient out less than 24 hours or there's patients that don't meet InterQual criteria that the physician knows he couldn't get out in 24 hours or less.

With that being said, the three points of – the three big points of contention all seem to be statutory issues as I understand it. One is the SNF qualification of three days or less. Personally, it doesn't make sense that the observation time does not apply towards that three-day requirement.

I think it is the premise of that argument is that outpatient observation is not the same level of care as inpatients. I would argue for the things that are happening nowadays, it's at least comparable to in-patient care and that time should be qualified as inpatient care.

Self-administered drugs, again, I think that's a statutory issue, but it seems like that's something that should be covered as well. And finally, the 20 percent co-pay, I think there's a limit on inpatient caps. I also think that there should a cap on outpatient 20 percent co-pays. Thank you.

Susie Butler: Great. Thank you very much. Let's go back to the phone. Tracy?

Operator: Your next question or comment comes from the line of Barbara Tomar from District of Columbia. Your line is open.

Barbara Tomar: Hi. This is Barb Tomar from the College of Emergency Physicians. And I think a lot of the other folks who have spoken have made a good clinical argument for the use of observation. And as representing emergency physicians, we strongly are in favor of the expanded use of observation under the Medicare outpatient prospective payment.

I think part of this is an education issue between a CMS policy and the beneficiaries and part of it is really a fairness issue, as Dr. Ross and others have just mentioned, which might entail changing the statute.

I recall we're strongly in favor of using any time in the observation to be counted toward the three-day stay rule. And I recall back in 2005 when the SNF draft rule came out that year, that question was asked, that CMS asked for comments and then nothing ever came of that because of the lawsuit which failed at the federal district court level.

One practical thing I'd like to remind everybody, and I think one person did mention it, is one of the biggest problems we have in emergency departments is boarding. So, even when you admit someone and there isn't room in the hospital for them to move to the inpatient side of the house, they stack up in the emergency department.

And for a lot of people that might prefer getting rid of observation and admitting patients, that's just going to be just a supply and demand problem as well. Thank you.

Susie Butler: Thank you. Next caller?

Operator: Your next question or comment comes from the line of Sandra Lubrant from Minnesota. Your line is open.

Sandra Lubrant: Hello. I'm Sandra Lubrant from Minnesota and I'm representing my mom, who's a Medicare beneficiary. On March 27th, my 81-year-old mother was brought by ambulance to Emmanuel St. Joseph in Mankato, Minnesota.

She woke up unable to move her legs; they performed three ADLs, transfer, toilet and dress. After during PT, and even dancing with my dad the day before, three hours later, she was admitted from ER to a room.

We have several hospital documents stated she was admitted as an inpatient, including a signed Medicare important notice. Within an hour of admittance, my dad signed this notice with the subtitle, "As a hospital inpatient, you have the right to..." He also signed this again on March 31st.

Days later, my dad was told he needed to go to a nursing home. By chance, he was told that Medicare would not cover the nursing facility because of her missing status with observation, claiming that the sudden change in her health

was due to natural aging. He was given the CMS bulletin entitled, "Are you a hospital inpatient or outpatient? If you have Medicare, ask." The hospital then led us to believe that her status was always observation.

On the third day, we asked if we could appeal and were told, "No." When I asked about the increased use of this status, some hospital staff – excuse me – cited direct demonstration project, the third-party review and InterQual.

After five days in the hospital, my mom was admitted to a nursing home. My parents were required to pay for the first 20 days in advance. They subsequently paid over $15,000.

How was it that the hospital is the catalyst of these decisions but carries no burden for decisions made? The burden is passed on to the elderly beneficiary—the family, the nursing home staff and government agencies advocating for patients. I continue asking the questions – questions in the hospital – of the hospital and my parents and I were treated in a shocking manner.

There are no protections in place that require hospitals to inform patients about these decisions. They are concerned with avoiding audits and protecting their revenue stream. They billed over 6-K in observation expenses for my mom's stay. Observation status is a loophole that enables hospitals to target patients who they expect will not appeal.

The quality improvement organization is unable to review observation stays. However, in our case, the quality improvement organization did help me see that the hospital was not forthcoming with all the records we requested for the appeal. This has been a nightmare experience for our family and it reflects poorly on those providing healthcare to our elderly. That's it.

Susie Butler: Thank you for your comment. Anyone else in the room? Tracy, we'll take the next phone call.

Operator: Your next question or comment comes from Sherry Scolf of Kentucky. Your line is open.

Sherry Scolf: Hi. I'm calling in regard to many of the situations that we've heard. But mine pertains predominantly with the billing status. When a patient is – comes in in the evening and is reviewed the next day. They are assigned as an inpatient and are reviewed the next day and determine that they really don't need inpatient criteria; we assign them as observation.

So, observation cannot be backdated, so my question is, what do we do with that time that they came in the evening before until the next morning when they were reviewed?

And around the country, different things are happening. One is, they are putting observation hours without the HCPCS code and some FIs or MACs are paying just the observation hours with the code.

Others, you can't get it out the door to CMS because they don't recognize if the code is not on there. So, there's not a billing consistency either with observation, that's a concern for us, and mirroring everyone else that have shared their concern, the patients don't understand, but neither do the doctors. They are not aware of some of the rules of CMS even though we try to provide that information to them. And we have many patients that come in and may be homeless, and they meet observation for one day and then they don't anymore, but we can't kick them out because they have no place and we have to get guardianship. And that can take a couple of weeks.

And so, we do care for these patients much longer than what the criteria is for observation, and we're not reimbursed as hospitals. And that's all I have to say.

Susie Butler: Tracy, the next caller?

Operator: Your next question or comment comes from Inna Bender from New York. Your line is open.

Inna Bender: Yes, hi. I'm just trying to raise an issue that came up in New York specifically. There's no such concept of observation service under the Medicaid program in New York. And those kinds of goals conflict with the Medicare you know observation status.

And that's something that Medicare needs to address as well. So, in New York you know you have to pretty much make a decision of the patient being either inpatient or outpatient within eight hours under the Medicaid program. And in Medicare world, there's no such concept of making a decision within eight hours.

So, the providers are kind of stuck in the middle of two conflicting regulations when it comes to making these decisions about whether the patient is inpatient or an outpatient. And also, the concept of observation being so unclear has a huge implication for providers when it comes to commercial population, or patients that have dual coverage.

A lot of commercial payers are using this observation status that has no clear definition anywhere as an excuse not to pay facilities for the true inpatient care. And I'm hoping that somewhere along the line Medicare takes that into consideration in their decision making or changes of the rules. Thank you.

Susie Butler: Thank you for your comment. I just want to take the opportunity to remind folks that may have joined the call late, the mailbox is extendedobservation@cms.hhs.gov . Also, if you joined the call link and you want to hear the beginning of the call and the opening remarks, you can call about two hours after we're done here to 1-800-642-1687, and through the encore presentation of today's listening session. And the ID that you'll need is 942-44031.

Let me turn back to the room here. Participants, do you have anything else you'd like say today? Going, going, gone. (Tracy), I just want to verify. I don't see anyone else in the queue. Do we have any other callers?

Operator: Not at this time.

Susie Butler: OK. I want to thank you all. Oh, somebody chimed in. They heard it was the last opportunity. We got one more caller.

Operator: Yes, they did. Your next question or comment comes from Julie Travis from Florida. Your line is open.

Susie Butler: All right. Hello?

Julie Travis: I didn't un-mute. I'm sorry. Can you hear me?

Susie Butler: Now we can.

Julie Travis: Sorry. My name is Julie. I'm a case manager in Florida, Central Florida. And I just wanted to thanks CMS for this opportunity and to thank all those you mentioned that to remove the whole entire observation status is definitely the solution.

My personal opinion after having done this on a daily basis since '04 is that, another tide of query would just really confuse the issue even further than we already are. Everyone across the country is having a problem with this whole observation category as it is.

And I also wanted to say that one of the reasons for extending observation time is that in the Florida at least in our area, we are inundated with the Medicare Advantage plans and they bombard me with request to convert to OGS on a daily basis. Sometimes, you know three days, four days, five days if they're not moving InterQual, they want them changed to OGS, which presents the problem for us because we're not supposed to do that according to Medicare regulations without an order or without the entire UR committee being involved and documenting in the record as the condition code 44, but they don't seem to follow that rule.

So someone could look into that with the general Medicare HMOs, we would be ecstatic. And also, have you ever tried to explain the difference between admitting somebody who's an inpatient versus admitting them as OGS? I was a manager in healthcare for 10 years prior to being case management and I can tell you real quick that I was baffled to find out that the reimbursement is so significantly low.

Generally, what I would say is, at least reimburse us for the charges that a hotel would charge and we've got professional people taking care of these patients and I think that we should be reimbursed. And I also want to point

you to a recent article in Modern Healthcare for August 2nd regarding how many losses, how much healthcare is losing.

And the reason why anybody is making a profit in healthcare these days is because of other investments and other avenues as trying to make money to help cover the cost of the patients we're not truly being reimbursed for.

Susie Butler: Julie, I have to cut you off now.

Julie Travis: All right. Thank you for your time.

Susie Butler: OK. I think I scared some folks. We've a big line now on the line. So let's take the next caller.

Operator: Your next question or comment comes from Kathlyn Krevetski from Virginia. Your line is open.

Kathlyn Krevetski: Hello?

Susie Butler: Hello.

Kathlyn Krevetski: Yes, can you hear me?

Susie Butler: Yes, we sure can. Thank you.

Kathlyn Krevetski: Thank you. I'm having troubles getting through. I work on the frontlines in Vermont and we deal with observation versus inpatient every day. And we – I feel very bad about the woman that was talking on behalf of her mother taking it out on the hospital. And I want you all to understand that is not unusual.

They blame it all on us when this happens. And we're just trying to abide by the law. And what I want to talk about because I have it in front of me or some of the diagnoses that come in, so we talk about observation.

But think of bringing your mother or father or other loved one in, when they don't want to come because they're elderly and they know it's going to cost them, but they come to the emergency room because they have no choice of

the matter because they're so sick, and too sick to actually know what's going on as far as the administrative observation versus inpatient. Here are some of the observation diagnoses that we cannot admit because they don't meet Medicare criteria.

Fever, vertigo, shortness of breath, gait and stability, syncope, abdominal pain, generalized weakness, displaced fracture, COPD exacerbation, dystonia, mental status changes, cirrhosis, ascites, ataxia, pelvic fractures, near-syncope, psychosis, pharyngitis, shortness of breath, major depression, alcohol dependents, GI bleed, diarrhea and cellulitis. They're here in the hospital, we're taking care of them because they are too sick to go home. We have no choice.

And for Medicare to say that we're having you know what's our financial incentive to do these, we're get paid for none of these, none of these. And these people are really sick and we're taking care of them because we have no choice. And for Medicare to look at this and say, "Gees, what's happening now?" I am so happy to hear other people talk to day about how things should change.

And they do need to be changed and just think of your mother or father coming in and being told, "Sorry." You worked whole life and you need sometime in a short term care facility which you have to pay out of the pocket because Medicare says you're not sick enough. Thank you.

Susie Butler: Thank you Kathlyn. Questions or comments? OK, we've got someone in the room.

Cathy Austen: Thank you. And my name is Cathy Austen. I'm with Sisters of Mercy Health System. I just wanted to clarify and make note of some of the confusion with regards to the observation along with the trend. I believe it's due to the fact that a lot of it was the demonstration project from 2005 to 2008.

At the advent of APCs back in 2000, a lot of hospitals were making their patients one-day stays when implants, ICDs or pacers were done and they'd really did not meet inpatient criteria. Thus a lot of them, actually, had gotten dinged for these one-day stays that they really should not have been.

So there's been a lot of education with divisions, I think, over the year or two and part of the confusion comes in to play that CMS doesn't recognize observation as a status. On the facility side, we do.

You are either admitted as an inpatient, an outpatient with extended recovery hours possibly or an observation. And this is because nursing and other department staff can actually see orders if the patient is placed in a bed. You can't just be placed in a bed and not occupy some kind of a status.

So, I think with also in regards to a couple of the other comments, for clarity purposes, if CMS could remove the criteria that requires the hospital to bill with G-codes, leave observation as it is along with applying the observation time up to the 72 hours for the three-day qualifying stay, that's going to clarify and clear up a lot of the confusion. Thank you.

Susie Butler: Thank you. Tracy, we'll go back to the phone now.

Operator: Your next question or comment comes from the line of Sandy Marks from District of Columbia. Your line is open.

Sandy Marks: Hi. This is Sandy Marks with the American Medical Association.

From an AMA's perspective, we think there really needs to be more discretion for the physician and the hospital to make the decisions regarding hospital admission rather than the physicians being driven either by hospital software programs or by fear of RAC audits.

We're particularly concerned about the situations where the patients actually are admitted as inpatients but then at some point in the future the stay is retroactively changed to be an outpatient stay. Out members had told us that this occurs when the hospital staff, using software, returns on Monday morning and reviews the admissions in the weekend.

In addition to the problems this presents for patients, which many of the other commenter have discussed, the status changes also have generated tremendous confusion for physicians who are trying to bill for the services they provide,

such as initial and subsequent hospital visits, because there is no inpatient admission on record after the change has been made.

We actually do not think eliminating observation care would be a good answer because then the patients could sit for a very long time in emergency departments, which would increase problems of emergency department overcrowding, as I think Barb Tomar mentioned before.

We also note that we really do not have a national policy on long-term care and that's what's driving a lot of these problems. The difference between nursing home care being affordable, because it's covered by Medicare, or being unaffordable, because no one is covering it, should not be the driving force in how hospital care is provided to these patients.

Susie Butler: Thanks Sandy. Tracy, the next caller.

Operator: Next question or comment comes from Mary Weather from Illinois. Your line is open.

Mary Weather: Thank you and thank you for hosting this session.

The issue over observation care has been a major issue in Illinois and certainly has been picked up for the last couple of years by the media by Judith Graham of the Chicago Tribune.

One of the – there's a few things that we think are driving this. One is you know if you look back up 15, 20 years ago, Medicare was paying the emergency. Admissions were too high for Medicare. They were about 25 percent of all of our cases who are coming through the ED. Now, we're well over 75 percent of our cases are coming in through the ED for Medicare patients.

So, we got a lot going on in the ED. And on top of that, if you go back about six or seven years ago, we used to have as a state about 50,000 cases for observation care. We're now over 300,000 cases. And of those 300,000 cases, about 40,000 of them are for chest pain.

And I agree with what's been said as the patients may not meet the criteria for admission to inpatient stay. They are up on inpatient units because when we took all the license observed care patients' beds for Illinois, we would have to double our patients in every single bed to cover 300,000 cases and have them occupied every day.

So, we don't have enough room, but we do have to place the patients up on units where it is very confusing. Nobody you know really wants to be in the hospital and these patients are oftentimes not well. And so we do get them up on the units.

And one of the challenges we have is they are not well enough to go home. I think that's been said. They're not well enough to go home. It's easy to look back on a record and say, "Well, they got better within a day. You should have decided this way." But again, these are not patients in the best condition.

I don't think any physician wants to send them home. That's why they're keeping them in observation care. And I do believe that we need some place for these patients to go.

Susie Butler: Mary, I'm going to have to cut you off. Thank you so much.

Mary Weather: OK. One question, why can't we have software, national software to avoid RAC audits that we can have in place at every hospital through every IT system so we can be doing the right thing? Hospitals aren't out to do the wrong thing, but we do need guidance. And this is very complicated as I think everyone has indicated.

Susie Butler: Thank you Mary.

I'll remind folks again, if you have suggestions, here's the extendedobservation@cms.hhs.gov .

We'll take one more call, Tracy.

Operator: Your next question or comment comes from the line of Janet Jodolwski from Ohio. Your line is open.

Janet Jodolwski: Hi there. You guys are scaring the bejesus out of me.

As the spouse of a Medicare beneficiary, I'm college educated, I'm a CPA, and I consider myself pretty well read and well educated on Medicare's if ands or buts and exceptions, but if I can't count on something I have received in writing at a hospital, when I go in like this prior caller had and I have to worry about my husband who has been in the hospital several times, even on his best days, would not understand – he wouldn't understand anything you guys have been discussing today. I don't understand at all. I don't pretend to. But he wouldn't understand any of it. He, nor would he care too.

But you could get him to sign something and override what I've done. This is really scary. And I just feel for all these facilities that have to deal with this. Try to explain it to someone like my husband that would be worthless. Hard enough to explain to someone like me.

And the system really does need some work. And that's all I wanted to say. It's just really scary. I feel like I have to be an attorney to let my husband walk in to a hospital door, a medical care facility.

Susie Butler: Thank you, Janet, for your comment. Tracy, the next caller please.

Operator: Your next question or comment comes from the line of Jayne McCauley from Pennsylvania. Your line is open.

Jayne McCauley: Hi. Thank you. I just would like you to repeat the number for the encore presentation because I was on hold for 20 minutes at the beginning. So, I really like to hear the beginning. So, if you can just give that number and conference ID number again, I'll appreciate it.

Susie Butler: Yes, I'd be happy to. The encore presentation should be available about two hours after today's presentation. Give or take a little bit. And that number is 1-800-642-1687. The caller ID is 942-44-031. And once again, the mailbox is extendedobservation@cms.hhs.gov .

We've got two questions left and one speaker in the room so we'll take the two – we'll take one of the two and then we'll take the speaker, OK?

So, Tracy, first person in the queue please.

Operator: Your next question or comment comes from the line of Rhonda Richards from Washington. Your line is open.

Rhonda Richards: Thank you.

This is Rhonda Richards from AARP. And again, I want to thank – echo the comments of others and thank CMS for hosting this Listening Session on Extended Observation today. It is – it is also an issue of concern to AARP and our members to our Medicare beneficiaries and their families.

We are, like other commenters, concerned about the increased out-of-pocket costs for beneficiaries as well as the impact on Medicare beneficiaries accessing still nursing care. If they are kept in observation status, then that time is not counted towards the three-day inpatient stay requirement.

We did weigh in back in 2005 when CMS had the opportunity in their skilled nursing facility payment rule and they solicited comments around observation stay. And we did weigh in at that time as well as now and urge that time spent in observation status as well as time in the ER count towards the three-day inpatient hospital stay. So, the beneficiaries are not hit with the higher out-of-pocket costs. They get the quality follow-up care that they need and have that access. Thank you.

Susie Butler: Thanks, Rhonda. Thanks for calling in.

Female: I (inaudible) healthcare. I just wanted to point out that it seems like CMS have an issue of determining what's paid under part A versus what's paid under part B and what qualifies for coverage for the three-day qualifying stay.

And I want to offer a solution that the State of Oregon has come up with our Medicaid program and that is the stay of 24 hours or less, it is paid under an outpatient, basis period. If it's more than 24 hours, it will qualify for inpatient.

And so, I submit that that might be a more administrative simply – simpler way for Medicare program to resolve this issue because more and more acute

services are going to be able to be performed in an outpatient basis. But those patients still need to be in a bed and receiving those nursing care services.

In order for CMS to do this, I want to point out that you'll have to work with the Uniform Billing Committee because the definition of admission date and time on the uniform bill is driven by the physician's inpatient order. And so it would be difficult for you to count that unless you got the data, that field changed.

Susie Butler: OK. Thank you.

And, Tracy, I believe we have one person in the queue.

Operator: Your next question or comment comes from the line of Sandra Sieck from Alabama. Your line is open.

Sandra Sieck: Thank you. I'd like to also thank CMS for exerting the energy since year 2000 to really go after observation services. I've been very fortunate to be actually involved to some of the changes.

And I would like to take a quick comment to say that if observation services is deleted, that we will have a massive problem – as explained from the previous caller – would be emergency visits. This is an extended stay beyond the emergency department. CMS has stepped up and is offering additional resources in a form of composite payment to help offset some of the costs.

And, yes, when you look at just the reimbursement, it is a distinct difference between inpatient, out. And I think, historically, we have gravitated 20 inpatient services because the DRG payment seems to be much higher.

But what we've also done on the inpatient side is as the caller explained about chest pain, just using that as an example, we place the patient into an inpatient bed, but our stay is – or leave the stays in decrease so low that we're hitting the 24-hour mark and then we look like we're pulling a full DRG with the minimum stay of over two days. But the patient is only there for one day, so we're milking the system.

And I think that the solution would be is, for CMS to actually provide additional education regarding observation, I think that the definition about start-stop times and how you bill, I think the CMS has done an excellent job with that. I think that the FIs and the MACs are not assimilating that information out correctly.

But I do think that we – through CMS restoration that we need more education. And I think that – I hope we continue observation service because we are providing good cost-quality and patient satisfaction that's been shown to many randomized trials or studies and showing that the impact of observation is definitely there.

If we do away with it, we're going to have a huge impact economically, negative impact on the inpatient and we're going to have bottlenecks in our emergency department.

Thank you for the comment.

Susie Butler: Thank you, Sandra.

I want to thank everyone for your attendance today both in person and on the phone.

Remind you again, this is an informal listening session. This is not something that CMS has to refund to, but we really, really, really appreciate you coming. I'm sure we'll be in touch again about other topics and other issues.

We've got a lot of things on our plate. No surprise there. We appreciate your commitment to this topic and we also appreciate your candor and your sharing with us. Thank you so much.

Like I said, you can listen to the encore later this afternoon, I hope. And also, you can send your comments to the Extended Observation box. Thanks, everybody.

Operator: This concludes today's conference call. You may now disconnect.

END