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August 22, 2017

The Honorable Pat Tiberi
Chairman, Subcommittee on Health
U.S. House Committee on Ways and Means
Washington, DC 20510

The Honorable Kevin Brady
Chairman, U.S. House Committee on Ways and Means
Washington, DC 20510

Dear Chairman Tiberi and Chairman Brady:

The Medicare Rights Center (Medicare Rights) is pleased to submit comments in response to the Subcommittee on Health’s “Medicare Red Tape Relief Project.” Medicare Rights is a national, nonprofit organization that works to ensure access to affordable health care for older adults and people with disabilities through counseling and advocacy, educational programs, and public policy initiatives. Each year, Medicare Rights provides services and resources to nearly three million Medicare beneficiaries, family caregivers, and professionals.

Medicare Rights fields nearly 20,000 questions on its national helpline annually and assists more than 2.5 million Americans through its educational programs and online tools. We regularly observe that Medicare beneficiaries, as well as health care providers, are tripped up by complex policies and burdensome procedures. As such, we appreciate the Subcommittee’s investigation into this issue.

At the same time, we encourage the Subcommittee to achieve the appropriate balance. We suspect that the Subcommittee will uncover policies that appear to be “red tape” at first glance, but actually serve to protect beneficiary health, quality of life, and access to care. As the Subcommittee looks to minimize “red tape” it is vital that the key purposes of identified rules and regulations remain at the forefront of the discussion.

Washington, DC Office:
1444 I Street NW, Suite 1105
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202.637.0961

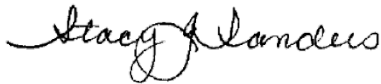
www.medicarerights.org www.medicareinteractive.org

To aid in the Subcommittee's process, we identified several areas where people with Medicare encounter significant, troublesome "red tape." Our attached comments focus on the following opportunities:

- Eliminate conflicting laws and beneficiary confusion concerning Part B enrollment;
- Simplify "equitable relief" requests concerning delayed Part B enrollment;
- Streamline Part D coverage determinations and appeals;
- Eliminate conflicts between Medicare and Medicaid coverage rules for Durable Medical Equipment (DME);
- Enhance the Medicare Improvements for Patients and Providers Act (MIPPA); and
- Allow Medicare coverage of Skilled Nursing Facility (SNF) care following an observation stay.

Our choice of these topics is informed by nearly 30 years of experience assisting people with Medicare, their family members, and health care professionals. We look forward to remaining engaged as the Subcommittee continues its investigation. For additional information, please call 202-637-0961. Thank you.

Sincerely,

A handwritten signature in cursive script that reads "Stacy Sanders".

Stacy Sanders
Federal Policy Director
Medicare Rights Center

CC: The Honorable Richard Neal, Ranking Member, U.S. House Committee on Ways and Means
The Honorable Sander Levin, Ranking Member, Subcommittee on Health

Please Provide Responses to the Fields Below Electronically to be Accepted

Medicare *Red Tape* Relief Project

Submissions accepted by the Committee on Ways and Means, Subcommittee on Health

Date: 8/22/2017

Name of Submitting Organization: Medicare Rights Center

Address for Submitting Organization: 1444 I St NW, Suite 1105, Washington, DC 20005

Name of Submitting Staff: Stacy Sanders, Federal Policy Director

Submitting Staff Phone: 202-637-0961

Submitting Staff E-mail: ssanders@medicarerights.org

Statutory X Regulatory ___

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Short Description: Eliminate conflicting laws and beneficiary confusion concerning Part B enrollment.

Summary:

The basic rules underpinning Part B enrollment were adopted more than fifty years ago, when Medicare was first established, and have not been updated since. While many individuals are automatically enrolled in Medicare because they receive Social Security benefits, an increasing share of newly eligible beneficiaries are deferring Social Security at age 65 and must actively enroll in Medicare. Knowing whether and when to enroll in Part B requires that a person understand when to sign up during time-limited windows, how their current insurance will work with Medicare, and what penalties may result if enrollment is delayed.

The consequences of missteps can be significant and often lead to a lifetime of higher Part B premiums. The most recent data indicates that 750,000 people with Medicare are paying a Part B late enrollment penalty (LEP) and the average LEP amounts to nearly a 30% increase in a beneficiary's monthly premium. (P. Davis, "Medicare: Part B Premiums," Congressional Research Service (August 2016), available at: <https://fas.org/sgp/crs/misc/R40082.pdf>.) In addition to this considerable penalty, many retirees and people

with disabilities face significant out-of-pocket health care costs, gaps in coverage, and barriers to care continuity resulting solely from honest enrollment mistakes.

Adding to the complexities and the significant consequences of delayed enrollment, those about to become eligible for Medicare receive no notification from the federal government about the enrollment process or its complex rules. In addition, antiquated Part B enrollment periods and coverage start dates, including those associated with the Initial Enrollment Period (IEP) and General Enrollment Period (GEP), are wholly misaligned with key and complementary Medicare programs, including Medicare Advantage (MA) and the Part D prescription drug benefit. For example, the MA and Part D annual enrollment period starts in October, but the GEP for Part B starts in January.

This misalignment—combined with limited notice and information—leads many newly eligible beneficiaries astray and often results in a fraught Part B enrollment process, as opposed to an intuitive and seamless one. Unsurprisingly, an enrollment process created in 1965 is not working for those who sign up for Medicare in 2017.

Related Statute/Regulation:

Section 1804 of the Social Security Act (42 U.S.C. 1395b–2)

Proposed Solution:

Pass the **Beneficiary Enrollment Notification and Eligibility Simplification (BENES) Act** (H.R. 2575) that:

- Provides advance notification of Medicare Part B enrollment rules to people approaching eligibility; and
- Aligns and simplifies Medicare Part B enrollment periods with Medicare Advantage and Part D.

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Short Description: Simplify "Equitable Relief" requests concerning delayed Medicare Part B enrollment.

Summary:

Created through federal law, equitable relief is an administrative process that allows people with Medicare to request relief from the Social Security Administration (SSA) in the form of immediate or retroactive enrollment into Part B and/or the elimination of a Medicare Part B LEP. For equitable relief to be granted, SSA must determine that a person's failure to enroll in Part B was "unintentional, inadvertent, or erroneous," (42 U.S.C. § 1395p (h); POMS at HI 00805.170) and was the result of "error, misrepresentation, or inaction of a federal employee or any person authorized by the federal government to act in its behalf." (Equitable relief may be available for those given misinformation from their employer or insurer if the inaccurate information was about whether the insurer would be primary or secondary to Medicare, and if the person is eligible for Medicare due to disability, not age. POMS at HI 00805.320.)

The equitable relief process is broken. First, it denies fundamental due process to beneficiaries who appeal late enrollment decisions. Second, it provides no remedy for individuals becoming eligible for Medicare who are

misinformed by an employer, employment-based or individual market health plan, insurance broker, state employee, or other official source. With respect to due process, no formal process exists for equitable relief: there is no explicit mechanism to request relief and no clear route for challenging decisions. No timeframes govern when SSA must make a determination of equitable relief and there is no formal requirement that SSA provide notification on its decision. Further, the federal government does not track equitable relief cases or requests, meaning there is no data with which to evaluate the process and its outcomes.

Through a process entirely lacking in any standardization and without clear guidelines, individuals must prepare and submit a substantive case to SSA as to why relief should be granted. Often times, it is those with pressing health needs and those who are facing significant financial hardship that must navigate this opaque system, for which there is no road map. And without appropriate pathways for relief, people who mistakenly delay Medicare enrollment must live with the consequences, potentially including higher out-of-pocket health care costs, lifetime premium penalties, gaps in health coverage, and disruptions in care continuity.

Related Statute/Regulation:

Subsection (h) of section 1837 of the Social Security Act (42 U.S.C. 1395p)

Proposed Solution:

- Require or encourage SSA to track equitable relief requests and publicly release this data
- Advance legislation to standardize equitable relief requests, as follows:
 - Create a standard application for equitable relief requests;
 - Establish a timeframe for SSA decision-making;
 - Develop a standard decision letter to communicate SSA determinations; and
 - Implement at least one level of independent review for adverse SSA determinations.

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Short Description: Streamline Medicare Part D coverage determinations and appeals.

Summary:

Year after year, about a third of calls to the Medicare Rights Center's national helpline concerned denials of coverage and appeals, making up the largest proportion of inquiries to the helpline. Frequently, these calls involve prescription drug denials under Medicare Part D. We continuously find that people with Medicare denied coverage for a medication are unfamiliar with how to navigate this circumstance and are unaware of their appeal rights. (Medicare Rights Center, "Medicare Trends and Recommendations: An Analysis of 2015 Call Data from the Medicare Rights Center's National Helpline (March 2017), available at <https://www.medicarerights.org/pdf/2015-helpline-trends-report.pdf>.)

Indeed, recent findings by the Medicare Payment Advisory Commission (MedPAC) confirm that many beneficiaries are unaware of their right to appeal and do not know how to go about initiating the appeals process. (Presentation by Sokolovsky, L., Suzuki, S. and L. Metayer, "Part D exceptions and appeals"

(September 2013), available at: [http://www.medpac.gov/transcripts/part d exceptions & appeals.pdf](http://www.medpac.gov/transcripts/part%20d%20exceptions%20&%20appeals.pdf); CMS, “Fact Sheets: Part D Reconsideration Appeals Data, Part D Fact Sheets CY 2011” (2011), available at: <http://www.cms.gov/Medicare/Appeals-and-Grievances/MedPrescriptDrugApplGriev/Reconsiderations.html>.)

Along these same lines, we observe the following trends with respect to Medicare Part D appeals:

First, we find that people with Medicare are not provided individualized information or adequate education when refused a medication at the pharmacy counter. As such, beneficiaries and their providers must embark on a tedious fact-finding search to learn the reason for the refusal and to determine the best path forward. Pharmacists may have limited or incomplete information and can only direct a beneficiary to call their Part D plan for the denial reason. Beneficiaries often face long call wait times and inconsistent customer service when trying to obtain this.

Next, we observe that the multi-step Part D exceptions and appeals process proves onerous and time-consuming for beneficiaries, pharmacists, and prescribing physicians. Although denied coverage at the pharmacy counter, this refusal does not constitute a formal denial by the plan, which would entitle the person to an appeal. Instead, with the support of the prescribing physician, a beneficiary must formally make an exception request. Only upon receipt of a written denial in response to this request, known as the coverage determination, is the beneficiary permitted to request a formal appeal, termed a redetermination.

While this multi-step process is described clearly here, it is important to note that this course of action may involve multiple phone calls and long wait times, often up to many days, for beneficiaries seeking access to a needed medication. A person must correspond with both their plan and their prescribing doctor on multiple occasions to see the coverage determination and redetermination phases through.

The current system is constructed in such a way that Part D plans are effectively granted three chances to make a correct determination about covering a prescribed medication: at the pharmacy counter, in the coverage determination, and in the redetermination. It is worth noting that this three-step process is distinct from Medicare Advantage (MA), Original Medicare, and Medicaid appeal frameworks. In these health programs, a beneficiary receives a notice of non-coverage after a service is received or prior to the service because it is not authorized. Unlike Part D, beneficiaries are not expected to formally request notice of non-payment after refusal of a service.

In sum, Part D enrollees, pharmacists, and physicians struggle to navigate a needlessly onerous coverage determination and appeals process—resulting in beneficiary delays in access to needed prescription drugs, abandonment of prescribed medications, reduced adherence to treatment protocols, and higher health care costs.

Related Statute/Regulation:

42 U.S.C. 1395w-104
42 C.F.R. 423.558

Proposed Solution:

- Advance legislation or regulation to combine a point-of-sale refusal with a formal request for a coverage determination. Allowing the pharmacy counter refusal to serve as the coverage determination serves the dual purpose of removing a burdensome step for beneficiaries and their doctors while also expediting the appeals process for those who need it; or
- Via legislation or regulation, require that the current pharmacy counter notice explain the reason (i.e., prior authorization, step therapy, quantity limits, off-formulary, non-covered, etc.) that the beneficiary is being turned away at the pharmacy counter. This simple, straightforward information would better equip Part D enrollees and their providers to navigate the appropriate next steps, whether by requesting a coverage determination or pursuing an alternative medication.
- Establish automatic review of adverse Part D appeals determinations by an independent review entity, as is the case for Medicare Advantage medical denials.
- Allow tiering exceptions on the Part D specialty tier. Tiering exceptions are currently not allowed for medications on the specialty tier—despite the fact these are among the highest cost medications, making them unaffordable for many beneficiaries with fixed incomes and limited resources.

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Name of Submitting Staff: Stacy Sanders, Federal Policy Director

Submitting Staff Phone: 202-637-0961

Submitting Staff E-mail: ssanders@medicarerights.org

Statutory X Regulatory ___

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Short Description: Eliminate conflicts between Medicare and Medicaid coverage rules for Durable Medical Equipment (DME) for dually eligible beneficiaries.

Summary:

We observe that the misalignment of payment procedures in Medicare and Medicaid results in denials, delays, and higher than appropriate health care costs for essential DME among dually eligible beneficiaries. While having both sources of coverage should enhance benefits, the logistical problems created by the misalignment of Medicare and Medicaid processing rules lead to barriers in accessing needed care among vulnerable older adults and people with disabilities that individuals solely on either Medicaid or Medicare do not experience.

Often, these problems arise when beneficiaries transition from Medicaid-only status to dual Medicare-Medicaid status. In these instances, individuals who previously obtained their DME through Medicaid without difficulty are now unable to locate suppliers who will serve them as dually eligible beneficiaries. This is because suppliers are concerned they will not receive payment from either Medicare or Medicaid. We believe this

concern is rooted in the misalignment of procedures in Medicare and Medicaid for obtaining DME, as explained below.

Unlike Medicaid, Medicare generally does not require or provide prior authorization for coverage of DME. Medicare approves or denies DME only *after* delivery of the DME and submission of a claim for payment. For Medicare-only enrollees, DME suppliers know they can bill the patient directly if Medicare denies payment, so the suppliers generally will provide the items regardless, and then seek Medicare payment first. For those dually eligible, however, providers are generally prohibited from billing the enrollees directly if Medicare does not pay. Consequently, they are reluctant to provide the needed equipment in the first place.

Medicaid programs, in fulfilling their requirement to be payer of last resort, are required to avoid paying claims for which another party, such as Medicare, could be responsible. As such, state Medicaid agencies generally require that a claim be submitted to Medicare first and will only pay after there is a Medicare decision on that claim. Thus, DME suppliers generally cannot bill Medicaid until they receive a coverage decision from Medicare; but, as explained above, a coverage decision from Medicare only occurs after delivery of the DME.

Without any assurance that the DME will be covered by Medicare, and without the ability to bill Medicaid absent a Medicare decision, many suppliers express concern that they will not be paid by either agency. This misalignment of Medicare and Medicaid coverage rules leaves both suppliers and beneficiaries in a bind, causing vulnerable older adults and people with disabilities to go without needed DME.

Related Statute/Regulation:

Subsection (h) of section 1837 of the Social Security Act (42 U.S.C. 1395p)

Proposed Solution:

In 1998, Connecticut's legislature adopted a requirement, consented to by the state Medicaid agency in response to a lawsuit brought by a dually eligible beneficiary, requiring the Medicaid agency to process prior authorization requests for DME for Medicaid beneficiaries whether or not they also are on Medicare. (Conn. Gen. Stat. § 17b-281a.) This system works because Connecticut providers know that if Medicare payment is not forthcoming, the existing Medicaid prior authorization means that the Medicaid payment will eventually be forthcoming. And this process fully complies with the requirement that Medicaid be the payer of last resort because actual Medicaid payment will only be made after Medicare payment is denied.

- Advance federal legislation to require all states to adopt the Connecticut prior authorization solution. Requiring state Medicaid programs to prior authorize DME for dually eligible beneficiaries, as it does for those who receive only Medicaid, will eliminate an access barrier that exists in many states and provide needed reassurance to DME suppliers; or
- Alternatively, draft guidance or regulation encouraging states to adopt this practice; supporting states in efforts to account for differences in processing practices or sharing best practices.

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Short Description: Enhance the Medicare Improvements for Patients and Providers Act (MIPPA).

Summary:

Medicare Savings Programs (MSPs) are state-administered Medicaid programs that help people with Medicare afford out-of-pocket health care costs in Medicare. There are four MSPs, with different benefits and qualifying income levels and asset tests:

- The Qualified Medicare Beneficiary (QMB) program covers people at or below 100% of the Federal Poverty Level (FPL) and pays Medicare Part A (Hospital Insurance) and Part B (Medical Insurance) premiums, deductibles, and copayments;
- The Specified Low-Income Medicare Beneficiary (SLMB) program covers people between 100-120% of the FPL and pays Part B premiums;
- The Qualifying Individual (QI) program covers people between 120-135% of the FPL and pays Part B premiums; and

- The Qualified Disabled Working Individual (QDWI) program covers higher income individuals who are disabled and have returned to work and pays Part A premiums.

Each of these programs also includes an asset limit, amounting to \$7,390 in 2017. (Medicare Rights Center, “Medicare Savings Program Financial Eligibility Guidelines” (2017), available at <https://www.medicareinteractive.org/pdf/MSPFinancialEligibilityGuidelines.pdf>.) These standard income and asset limits act as a federal floor. Through existing flexibilities, states may expand access to MSPs through higher income and asset limits or by eliminating the asset test altogether.

Another program, the Part D Low Income Subsidy (LIS) helps people with Medicare afford Part D premiums and cost-sharing. “Full LIS” covers the Part D premium and deductible and is available for people with Medicare up to 135% of the FPL. “Partial LIS” reduces the Part D premium and deductible and is available for people with incomes greater than 135% of the FPL but less than 150%. Like the MSPs, the LIS program includes an asset limit, amounting to \$8,890 in 2017. Unlike the MSPs, LIS is administered by the Social Security Administration (SSA).

The Medicare Improvements for Patients and Providers Act (MIPPA) raised the federal minimum for the MSP asset limit to align it with the asset limit for full LIS—\$7390—not including the LIS program’s disregard of \$1,500 per person for burial expenses. In addition, people with Medicare who apply for LIS can opt to have their income and asset data sent by SSA to their state Medicaid department to initiate an MSP application.

But there are still related issues in MSP enrollment that MIPPA did not change, specifically several aspects of MSP-LIS income and asset counting that remain unaligned such as the burial expenses disregard that LIS includes but MSPs do not. In other examples, SSA no longer includes life insurance as an asset when calculating LIS eligibility, while some states include such insurance in asset counting for the MSPs. SSA also does not count non-monetary help as income, while states continue to count help like food or housing as income.

In addition, while some states automatically create MSP applications from the SSA data, MIPPA does not require states to take any action on the information. As a result, how states use the data varies significantly, ranging from states that create full-fledged MSP applications to states that do not use the data whatsoever.

Thus, MIPPA’s goal of reducing applicant burden has not been fully realized. MIPPA came about after years of underutilization of MSP and LIS benefits. From 2008 to 2011 a study into the effects of MIPPA found:

Historically, few eligible Medicare beneficiaries actually participate [in MSPs]. Only a third of Medicare beneficiaries who qualify for cost-sharing benefits enroll in limited Medicaid. Uptake drops to 13 percent for members who only qualify for Part B premium subsidies. Failing to enroll may influence beneficiaries’ access to care: individuals who were eligible for Medicaid cost-sharing coverage but do not enroll were more likely to report avoiding physician visits due to cost than individuals enrolled in limited Medicaid. Obstacles to limited Medicaid enrollment include eligible beneficiaries’ lack of awareness about the availability of financial assistance and a complicated application process. (Laura M Keohane et al., “Reforming Access: Trends in Medicaid Enrollment for New Medicare Beneficiaries, 2008–2011,” Health Services Research (August 6, 2015), available at <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4799898/>.)

The red tape and hurdles involved in MSP application and enrollment continue to dampen MSP participation among those eligible for the program’s benefits. (Kirstin Blom, “Medicare Savings Programs: New Findings on Enrollment,” Medicaid and CHIP Payment and Access Commission (MACPAC) (April 20, 2017), available at <https://www.macpac.gov/wp-content/uploads/2017/04/Medicare-Savings-Programs-Eligible-But-Not-Enrolled.pdf>.) According to the Medicaid and CHIP Payment and Access Commission (MACPAC), many people

who are eligible for an MSP do not enroll. (MACPAC, “Medicare Savings Programs: New Estimates Continue to Show Many Eligible Individuals Not Enrolled” (August, 2017), available at <https://www.macpac.gov/wp-content/uploads/2017/08/Medicare-Savings-Programs-New-Estimates-Continue-to-Show-Many-Eligible-Individuals-Not-Enrolled.pdf>.) For example, only 53% of those eligible for QMB, the most comprehensive of the MSP programs, are enrolled. The percentages decrease from there for SLMB (32%) and QI (15%). According to MACPAC, one of the reasons for this low enrollment is the application process: “The process of enrolling in an MSP may be burdensome because the Medicaid application process is complex. In focus groups, many seniors cited the complicated Medicaid application and renewal process, which includes income verification, as a barrier to enrollment in Medicaid.” (*Id.*)

Related Statute/Regulation:

Subsection (h) of section 1837 of the Social Security Act (42 U.S.C. 1395p)

Proposed Solution:

Advance legislation to enhance MIPPA as follows:

- Require states to accept the information transmitted through SSA as an MSP application in full to establish a one-stop application process;
- Align LIS and all MSPs for income and asset calculations to ensure consistency across programs; and
- Make permanent outreach and enrollment funding provided in MIPPA to community-based organizations to educate people with Medicare about MSPs and to screen them for the benefits.

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Short Description: Allow Medicare coverage of Skilled Nursing Facility (SNF) care following an observation stay.

Summary:

Medicare covers SNF care under certain circumstances. The beneficiary must have Medicare Part A, must require SNF care, and must have a qualifying hospital stay. (42 CFR 409.30.) A qualifying hospital stay is at least three consecutive days in the hospital as an admitted inpatient.

This requirement was included in the original Medicare legislation (The Social Security Amendments of 1965, Pub.L. 89-97.) to "help limit the payment of the extended care benefits to persons for whom such care may reasonably be presumed to be required in connection with continued treatment following hospital inpatient care" while at the same time making "less likely unduly long hospital stays." (U.S. Congress, House Committee on Ways and Means, Report of the Committee on Ways and Means on H.R. 6675, 89th Cong., 1st sess., March 1965, No. 213 (Washington: GPO, 1965), p. 27.) But progress in medicine since that date has permitted shorter hospital stays in general, without eliminating the ongoing need for follow-up SNF care to ensure patients' safety and well-being.

In addition, many beneficiaries go to the hospital and remain there for several days without ever being admitted as inpatients. This type of stay, usually called an “observation stay,” looks exactly like an inpatient admission from the patient’s perspective. Importantly, if beneficiaries are never admitted as inpatients, even if they spend over three days in the hospital in observation, they will not be eligible for Medicare coverage of SNF services. And they do not have the ability to appeal their classification as outpatients. This means that if they are transferred to a SNF, they will be responsible for the entire cost of their care.

According to the Congressional Research Service (CRS):

[I]n 2012, Medicare beneficiaries had more than 600,000 hospital stays that were at least three days long but would not have qualified the beneficiary for SNF services because the patient was classified as an outpatient for some or all of the stay. More than 25,000 of the beneficiaries in these 600,000 hospital stays were discharged to an SNF following their hospital stays even though they did not qualify for Medicare Part A SNF coverage. Because the three-day inpatient stay requirement was not met, such beneficiaries could have been liable for substantial costs related to bed and board, drugs/biologicals, durable medical equipment, and nursing care received during their SNF stays. (Scott R. Talaga, “Medicare’s Skilled Nursing Facility (SNF) Three-Day Inpatient Stay Requirement: In Brief,” Congressional Research Service (June 2, 2016), available at <https://www.ahcancal.org/advocacy/solutions/Documents/Congressional%20Research%20Services%20Report%20on%20Three-Day%20Stay%20Requirement.pdf>.)

The use of observation stays is increasing as a result of multiple factors, including but not limited to:

- Medicare payment policy changes and increased reporting;
- Increased scrutiny by both public and private payers of short inpatient stays;
- Efficiency advantages for hospitals of observation stays over inpatient admission; and
- Incentives to reduce hospital admissions.

Hospitals are now required to provide patients with a Medicare Outpatient Observation Notice (MOON) if they are being kept in observation rather than admitted. But the notice is purely informational; the beneficiary cannot challenge the outpatient status or file a legal appeal.

Both the three-day requirement and the observation stay exclusion can usurp the provider’s role in determining what care is medically necessary and in the best interest of the patient. Providers must provide safe and adequate care and discharge planning for patients, and hospitals are not permitted to discharge a beneficiary if there is no such safe discharge plan. A SNF will not generally accept a private pay patient who does not have the resources to guarantee payment, so this is a quandary for patients and providers when a beneficiary needs SNF care but cannot afford to private pay.

In a worst-case scenario, beneficiaries may self-discharge against medical advice and return home before they are physically or mentally ready, and potentially suffer further devastating and expensive acute health effects. Barring this, the beneficiary may end up staying in the hospital past the time they would otherwise have been transferred into less costly care options.

Related Statute/Regulation:

42 U.S.C. 1395f

42 U.S.C. 1395x

42 CFR 409.30

42 CFR 412.3

Proposed Solution:

Several options are available to eliminate the bureaucratic hurdle Medicare beneficiaries and providers currently must navigate to ensure this population receives the SNF care they need for their safety and well-being:

- Advance legislation to eliminate the three-day stay requirement;
- Alternatively, advance legislation to include observation stays as inpatient stays for the purpose of Medicare coverage of SNF care (See, e.g., Improving Access to Medicare Coverage Act of 2017, H.R. 1421, 115th Cong. (2017).); or
- Adopt regulations to include three-day observation stays as inpatient for the purpose of Medicare coverage of SNF care.