Centers for Medicare & Medicaid Services
TeleTown Hall: Implementation of the NOTICE Act
Moderator: Susie Butler
December 21, 2015
2:00 p.m. ET

Operator: This is Conference #5106309.

Good afternoon. My name is (Lindsey) and I will be your conference operator today. At this time, I would like to welcome everyone to the Centers for Medicare and Medicaid Services TeleTown Hall meeting for the implementation of the NOTICE Act Conference Call.

All lines have been placed on mute to prevent any background noise, after the speakers' remarks, there will be a time for comments. If you would like to comment at that time, simply press star then the number one on your telephone keypad. If you would like to withdraw your comment, press the pound key.

I would now like to turn the call over to Ms. Susie Butler. You may begin your conference.

Susie Butler: Thanks so much, (Lindsey), and welcome, everyone. My name is Susie Butler. I'm the director of the partner relations group in the Office of Communications here at CMS. And I want to thank you on this December afternoon for joining us for this TeleTown Hall. We've got quite a number of folks on the call and that tells me that you're interested in the topic.

On August 6, 2015, Congress amended Section 1866 (a)(1) of the Social Security Act with a Notice of Observation, Treatment and Implications for Care Eligibility Act, otherwise known in this conversation as the NOTICE Act. The NOTICE Act requires hospitals in the critical access hospitals to provide notification to Medicare beneficiaries receiving observation status – excuse me – observation services as outpatients for more than 24 hours at such hospitals and critical access hospitals.

So today, all view points are welcome and will be taken into consideration as we work through implementation of the NOTICE Act. Please note that CMS will not be responding to questions or comments today. Please limit your comments to 2 minutes so that everyone has an opportunity to share their thoughts or concerns. Your ideas may also be submitted via e-mail to notice_act@cms.hhs.gov. We will be reminding you of this e-mail address throughout the call. This is an informal opportunity to provide your thoughts on this topic. Anything you say during this listening session is not part of the formal regulatory comment process. That process will be announced in the federal register at a later date.

There are a number of CMS staffs on the call. With me are Arrah Tabe-Bedward, director Medicare Enrollment and Appeals group; Rita Wurm, the director of the Division of Appeals Policy; Kathryn Smith, technical advisor, Division of Appeals Policy; Dave Danek, health insurance specialist, Division of Appeals Policy; Evelyn Blaemire, health insurance specialist, Division of Appeals Policy; Janet Miller; health insurance specialist, Division of Appeals Policy.

So again, today, we're just asking to hear from you. Please keep your comments to 2 minutes so that everyone has an opportunity to talk. I will not hesitate to interrupt if we get a little too long winded, so let's not have that happened. Please give me your caller name and where you're calling from and please know that CMS is listening.

With that, I'll turn it over to (Lindsey) to begin this period of information. (Lindsey)?

Operator: At this time, if you'd like to comment, please press star then the number one on your telephone keypad. We'll pause to compile the comment roster.

And your first comment comes from the line of (Charles Love) with Johns Hopkins Medicine. Your line is now open.

(Charles Love): Hi. Thank you for taking my comment. Can you hear me?

Susie Butler: We sure can.

(Charles Love): Great. So in the – in the law, it says that we are – hospitals shooting for Medicare beneficiary – I'm sorry – Medicare beneficiaries of issues such as implications for the cost-sharing requirements under this title went for subsequent eligibility for coverage under this title for services furnished by a skilled nursing facility.

I think the second part is fairly straightforward. I think we can explain to patients about the three midnight inpatient hospitalization requirement to qualify under Part A for subacute rehab benefits, but the cost sharing is a little bit trickier. And to truly make an estimate of cost sharing – and I think what I'm understanding is that Congress wants is to explain to patients their different liabilities as to whether they would be hospitalized as an inpatient versus an outpatient with observation services. And as you know, that's non-trivial. It would depend on the beneficiaries, Part A, Part B, Part C and Part D benefits, and actually would depend on the individual contracts with their Part C and their Part D.

So the first question is fairly straightforward among that is does this NOTICE Act even apply to patients who have Medicare Advantage and the second question is how should hospitals approach providing patients with the necessary information given that the implication for cost sharing and calculations can be quite complex.

Susie Butler: Thank you for those questions. We're going to take those as comments and make sure that those go forward to the appropriate folks. I'll remind folks that no one is responding today that if you have specific questions or specific thoughts that you want to share with the group as they're working in this important work, please send them to notice_act@cms.hhs.gov.

(Lindsey), if you could go to the next, please?

Operator: Our next comment comes from the line of Roslyne Schulman with the American Hospital Association. Your line is open.

Roslyne Schulman: Thank you. Hi. This is Roslyne Schulman. I appreciate the opportunity to provide our views with CMS' upcoming rulemaking. I'll just jump into it. With regard to the implementation timeline, hospitals will need an adequate amount of time to develop and operationalize the policies and procedures to implement the NOTICE Act. So we believe that a six-month period after the final rule is issued would provide hospitals of the time necessary to do this. Hospitals will need time to evaluate and change existing policies and procedures, update their information systems and provide extensive education for their staff, so reasonable implementation period. It would also have the additional benefit of giving CMS time to issue clear and detailed guidance for their contractors and hospitals.

With regard to the note – what the notification has to actually include, the AHA urges CMS to clarify in its rulemaking than an all purpose notification the beneficiaries about applicable Medicare outpatient policies regarding co-payments and self-administered drugs and eligibility for SNF services should be appropriate. That is we believe that CMS should permit hospitals to develop the use of standard document describing these Medicare policies rather than requiring an entirely individualized notification for each beneficiary.

We further believe that it would be helpful if CMS would have provided in its rulemaking a template for a written notification for hospitals optional use. With regard to the timing of the required notification, we urge CMS to clarify whether and how the hospitals notification would have applied to beneficiaries who after having received more than 24 hours of observation are subsequently admitted to the hospital as inpatients.

Further, CMS should address how the notification requirement will apply to beneficiary who was admitted as an inpatient after having been an outpatient observation for less than 24 hours but then is subsequently revered to condition code 44 to outpatient status. So with the number of hours of observation the beneficiary received before being admitted count towards the 36-hour deadline for notification or does the clock start for notification upon the second course of observation.

Next, we recommend that CMS not limit which hospital staff may provide the oral explanation to the beneficiary. Instead, hospital should be permitted to determine which staff are best equipped to provide the oral explanation in an appropriate and a timely manner.

With regard to the beneficiary's signature requirement, the Act provides that if a beneficiary refuses to provide a signature, the notification has to be signed by staff from the hospital who presented the notification. We recommend that CMS also apply the same process in other situations that are outside the hospital's control such as if the beneficiary is unable due to his or her medical or mental condition to receive and sign a notification and no patient representative is available.

And then last, we encourage CMS …

Susie Butler: Roslyne?

Roslyne Schulman: Yes?

Susie Butler: Is that your last one? Go ahead.

Roslyne Schulman: Last one. We encourage CMS to describe in its proposed rule how it intends to enforce the NOTICE Act provision from the penalties for noncompliance. We would support a graduated process that begins with notifying and educating the provider about the regulatory requirements and it allows time for the hospital to develop and put into place corrective action plan.

Thanks again.

Susie Butler: Thanks so much. Next caller.

Operator: Our next comment comes from Pat Cornell from Peninsula Regional Medical Center. Your line is now open.

Pat Cornell: I think most of the comments that I have had already been addressed. Thank you.

Operator: And our next comment comes from the line of (Vita Fender) with the Jamaica Hospital Medical Center. Your line is now open.

(Vita Fender): Our comments have been addressed as well. Thank you.

Operator: And your next comment comes from the line the (inaudible) with the Minnesota Board. Your line is open.

Female: Yes. I'm with the Minnesota Board on Aging. Thank you. I've got a question regarding the notice offering any information about appeal rights that beneficiaries will have to appeal an actual observation stay. That is my only question or statement. Thank you.

Susie Butler: Thanks so much. We'll make sure that's recorded. Next question.

Operator: Our next comment comes from the line (Marie Dougherty) with Vermont Hospital. Your line is now open.

(Marie Dougherty): Yes. Mine was actually the same concerns as clarification to an appeal process that may be put in place similar to the important message. Thank you.

Operator: And our next comment comes from the line of (Tina Gozmeti-Taylor) with Five Star Quality Care. Your line is now open.

(Tina Gozmeti-Taylor): Thank you. As a manager of a large organization that owns and operates several SNFs across the country, we've been used to issuing these advance beneficiary notices for years now. So a lot of what I'm hearing is, you know, geared towards the hospital. But as a SNF operator, I would like CMS to have some sort of a requirement for hospitals to share those notices that are issued to beneficiaries to transferring facilities to our SNF. We want to make sure that the – that we're notified because it has such a financial impact on the beneficiary. Thank you.

Operator: And again, to comment, press star one on your telephone keypad. Your next comment comes from the line of Edwina Garber with Pocahontas Memorial. Your line is now open.

Edwina Garber: Hello. I wanted to reinforce also what has already been stated that I think a template or a standard universal form would be great for us to use instead of everybody trying to make their own form. And then I think I've gotten a little confused during some of the other questions or conversations regarding SNFs and that type of thing because I thought this conversation was regarding observation stays which is, you know, hospital related. So I just needed some clarification there.

Susie Butler: Again, we're only listening today, but thank you for your comment.

Operator: Your next comment comes from the line of (Claire Whitzac) with Voices for Quality Care. Your line is now open.

(Claire Whitzac): Thank you. Voices is very interested in this (inaudible) because it falls directly on the people they deal with most as a long-term care and specifically in SNFs. I would want to say in all purpose form of any kind does not add anything to the knowledge of the individual who receives it. If we don't know, that person has – most people have no knowledge at all of the technical aspects of hospital billing. We have done the best we can to put out a notice that you need to know whether you're an observation, whether you had been admitted or – the minute somebody hits the hospital room, they think they've been admitted. Thank you.

Operator: And our next comment comes from the line of Kim Liska with Mary Washington Healthcare. Your line is now open.

Kim Liska: Thank you. Effective July 1st of 2015, the state of Virginia implemented mandatory delivery of observation letters to patient. So I wanted to give you a little bit of hint on information. In our organization, patient access and care management department share the responsibility for the delivery of the letter. It's required regardless of the length of time that the patient remains in observation status. It has been problematic and that it added another layer of paperwork and documentation for us. Patients are not always alert enough to understand and/or to accept the letter and sign for it. In addition, some patients have threatened to leave the facility or they have pleaded with their physicians to make them inpatient.

We feel that CMS should not require hospitals to provide these notifications. If in the end it is required, it should not be based on length of stay as that would make the tracking more complicated for hospitals. And my question is will we be penalized if we deliver the deliver to all patients regardless of the length of stay. Thank you.

Susie Butler: Thank you for your comment.

Operator: Your next comment comes from the line of (Teresa Alzine) with the New Jersey Hospital Association. Your line is now open.

(Teresa Alzine): Good afternoon and thanks for having this call today. Just a quick question, like the caller just before me, New Jersey has a process that's already mandated for our hospitals. My question is if a state's process meets the intent and spirit of whatever regulations CMS promulgates, can that state continue to use its process or will it be superseded by what CMS puts forward? Thank you.

Operator: And the next comment comes from the line of Valerie Rinkle with HCPro. Your line is now open.

Valerie Rinkle: Yes. It's – my question has to do with appeal rights as has been previously raised, but I was wondering if there would be an opportunity to have the QIOs be responsible for appeals with regard to observation in the same way that they're responsible for the discharge appeal and that by doing so as well as the medical necessity reviews, they would skid a more full-pledge picture of how particular providers are treating their patient population and help to advise them more holistically and educate them as to the proper way to go to potentially avoid appeals. I think as previous callers have said, the whole notice requirement leads beneficiaries to believe that they have a role to play in changing their status, which of course they can't. If the provider and the physicians are following all of the regulations, the beneficiary really can't influence their status based on the regulations.

And then the final question I have is with regard to notice, is it – will CMS allow it to be issued in the emergency department and to clarify in future regulations when a beneficiary arrives either via transfer from another

provider, an inpatient transfer (inaudible) or comes in to the emergency department and doesn't meet even the criteria for observation. It's completely a social admission. And how the notification should proceed with regard to that issue and the beneficiary particularly if it's still social but there's not really a safe discharge plan? Thank you.

Susie Butler: Thank you so much.

Operator: Your next comment comes from the line of Stuart Gordon with National Association of State Mental Health Program Directors. Your line is now open. Mr. Gordon, your line is open.

Stuart Gordon: I'm sorry. I was on mute. Thank you. We'd be seeking application – seeking clarification on application of the regulations to psychiatric hospitals and psychiatric units within general hospitals and particularly under those circumstances where law enforcement personnel maybe bringing the patient to the hospital for observation. Thank you.

Operator: And your next comment comes from the line of Louise Della Bella with Saddleback Memorial. Your line is now open.

Louise Della Bella: Yes. I was just wondering when a patient comes in the E.R. and is basically placed as an inpatient and within a few hours we determined that they're – no. I'm sorry – considered observation. A few hours, we determined that they're truly inpatient because it takes that time to get the record together. Are we going to be mandated to have an observation notice giving to them within a few-hour window of time because it seems a bit confusing to the patient? You know, there was a time when Medicare allowed a few hours to change, get in the right status before they actually consider that order, you know, concrete. But now, since there's no longer that window of time, what happens with the patient that does get changed from inpatient to (obs) within a few hours or the other way around in a few hours. That's it.

Operator: And your next comment comes from the line of (Mickey O'Neill) at Vassar Brothers Medical Center. Your line is now open.

(Mickey O'Neill): Hi. I just wanted to raise a comment again about the all purpose form. I know a previous caller had concerns about that. I think the form would be all purpose for any observation patient. But similar to our HINN letters, it is nice to have that outlined and simplified for us in the hospital to deliver to the patients.

I also wanted to reiterate the comment about patients whose mental status does not allow them to participate in receiving information or receiving forms and there may not be a clear responsible party or patient advocate to go to. This presents a challenge for hospital workers to try to identify someone to get the message. So if we're working against the timeframe, that's really a hardship.

Operator: And our next comment comes from the line of Dixie Eisenhower with Community Hospital of the Monterey. Your line is now open.

Dixie Eisenhower: So my comment is that we've actually been giving a letter to our patients about observation for a couple of years now and the biggest issue that we have is patients – you can give them all the paperwork you want, they sign the paperwork, they say they understand, but in essence, they really do not. And I think that the biggest issue for education for the clientele is how do you understand the regulations because many clients or patients come to the hospital and in their mind because they can't walk or because their caregiver left or whatever the reason is in their mind they're in the hospital and they've here for three midnights. Now, that becomes the key for them. They don't understand why they're observation versus inpatient. Because they're here, they should be inpatient. They paid into Medicare. Medicare should pay for it.

And so, I'm not sure how you (craft) the message. We've tried many, many different ways and we have still yet to be successful to really (craft) the message that patients and families really have an understanding of. They sign our message. We talk to them everyday about it. And yet, they still don't quite get what – how those regulations were administered, how those decisions were made by the doctor, and it just goes on and on and on.

And so, I am not sure even doing any of these is still going to be successful for hospitals, we're still going to be the bad guy that's going to be the patient and the family a message that is not to their liking. And so, we're always the ones they sort of shoot the messenger. We're always the ones that don't come out looking well when we're really here just to help and try and take care of whatever the issues or the concerns that the patient has, but it becomes very challenging when you're looking at regulations where the patient and family just don't really understand those.

Operator: And your next comment comes from the line of (Jill Robinson) with County Medical Center. Your line is now open.

(Mary McFlag): Yes. Thank you. This is (Mary McFlag) from (Hand Up) and County Medical Center and I just wanted to ask again if some of the other callers mentioned there are state rules in effect also in Minnesota as well as some other states and we would request respectfully that CMS address those either specifically or generically in the rule so that it's very clear which takes precedence, if a state can be followed or if the state rule is completely non-appropriate when it's a Medicare patient.

Also, I did want to also ask that we would appreciate seeing a template. I'm not sure if we're going to ask in the comments for it to be a mandatory template, but I think as an educational purpose to piggy back on the previous caller, you know, how to (craft) this is not easy and we would appreciate that CMS expertise. Thank you.

Operator: Our next comment comes from the line of (Bradley Brian) with Providence Health and Services. Your line is now open.

(Bradley Brian): Yes. Thank you. I'd like to add some comments with regard to the appeal process for patient's place and observation bed. Currently, there's conflicting information coming from the QIO, specifically Livanta and our MAC Noridian, about how to manage these cases. Currently, Livanta is accepting HINN 1 appeals for patients who disagree with the observation status and there's conflicting information within Livanta and Noridian has denied knowledge of this process. So we really don't have any written regulation to

follow. However, the QIO has been accepting appeals from patients who call in with regard to their observation status. So if we could get clarification from CMS on how these cases should be handled and if the patient truly does have an appeal right when they're in an observation status would be helpful.

Operator: Your next comment comes from the line of (Elaine Feldman) with Hackensack University. Your line is now open.

(Elaine Feldman): Thank you very much and good afternoon. My question is actually for CMS to reconsider the short payment and DRG because now we put ourselves in another complex process where observation will be bundled. We're really there at that short-term DRG payment and we would be taking away a lot of confusion for our elderly Medicare beneficiary if we were able to stay in that inpatient setting, short-term reimbursement and do away with observation. Thank you.

Operator: And your next comment comes from the line of (Steve Gilles) with Partners Healthcare. Your line is now open.

(Steve Gilles): OK. Thank you for sponsoring this call today. I guess my comment focuses on asking for clarity. I agree with comments earlier about, you know, the specificity of the 24-hour period. It just seems a little bit non-functional given the two-midnight rule and the fact that you have patient that technically if they're receiving care – hospital care either as an observation or an outpatient in the emergency department over the first midnight that considered an outpatient. But technically, if they're going to remain receiving hospital care for a second midnight, they would technically be eligible to admit to inpatient under the two-midnight rule. So it just – it would be great if we could create observation rules and transparency for communication to patients that helps them understand the context of being admitted the two-midnight rule as well as being in an observation status or an outpatient status prior to the two-midnight rule being fulfilled. That's all I have. Thank you.

Susie Butler: Thank you.

Operator: And again, to comment, press star one on your telephone keypad. Your next comment comes from the line of Lori Balek of Northwest Hospital. Your line is now open.

Lori Balek: Hi. My name is Lori Balek. I'm director of clinical care coordination. We'd been giving the (obs) letter for the past four to five years. We are working on making a more specific one that we will be handing out. We do have our PAS and clinical care coordination department working together to hand them out. What we would request is we would like that the (obs) days are counted towards the thee midnight if the CMS could look into that. That's our biggest complaints, not so much about what their payment is, but those three midnights are about 90 percent of our patient advocate complaints.

Another comment I have is that the QIO has accepted patients have called when they were in observation status. So I was just wondering is the admission denial going to be the route for appeals for (obs) status. Like I said, we did have the QIO accept a patient who was (obs) that they looked at also.

Those are my comments. That's all. Thank you.

Operator: And your next comment comes from the line of (Laura Daniels) with (DeKalb) Medical. Your line is now open.

(Laura Daniels): Good afternoon. Thank you. I would like CMS to clarify the expectation would be to update the patient who would had been 24-hour (obs) but then converted to inpatient before the second midnight, would we need to notify them that the (obs) notice that they had signed was no longer applicable at that time?

And then I also would like CMS to address for patient who have an initial inpatient order but do not stay to midnight and are found not to meet inpatient criteria and we do self-audit on them, would this notification have any (bearings) on those patients? Thank you.

Operator: Your next comment comes from the line of (Linda Holo) with (Tri-Health). Your line is now open.

(Linda Holo): Hi. Thank you for taking my comment. I also reiterate the concern about having a standardized form in a template for all of us to use so we are assured that we're complying with all the rules of this NOTICE Act. And I would also comment that the burden of trying to manage the case of notice of greater than 24 hours seems to be unnecessary burden put on us at the hospitals. And if we were able to provide this the time the patient is placed in observation initially it would allow us to become – be more compliant with that notice.

And then also we would like to be able to offer the patient an opportunity to appeal without admitting and providing an admission notice if there was a methodology for patient to appeal their observation status that would great. Thank you.

Operator: Your next comment comes from the line of (Bennett Campos) with Hospital of Providence. Your line is now open.

(Bennett Campos): Good afternoon. Thank you for taking my comments. My comments on clarification of the appeals process, this year we had several patients who had been discharged home and have called me to appeal or were trying to change their observation status. And so, I just wanted to know what's the process for that and what role would the hospital place after patients have been discharged and patients want to appeal and what role does a physician played because patients have actually asked her doctors to change their status and we have not proceeded with that at all. That was – those were all my comments.

Operator: Your next comment comes from the line of John Sheridan with eHealth Data Solutions. Your line is now open.

John Sheridan: Yes. Thank you. I would like to have CMS specifically write the rules in the Medicare Benefit Policy Manual specific to this notice for the short stay. Without guidance in the Medicare Benefit Policy Manual, both providers and beneficiaries are held hostage to administrative complications that can occur on a case-by-cases basis. I further believe that CMS will benefit from clarification of this policy and procedure in the Medicare Benefit Policy Manual because this will force all of the interested parties, beneficiaries and providers, to examine the meaning of this notice and that it will exist in

posterity in the Medicare Benefit Policy Manual. So that is my comment. Thank you.

Operator: Your next comment comes from the line of (Mandy Taylor) with Northwest Medical. Your line is now open.

(Mandy Taylor): I've heard this comment several times, but I just wanted to – I just wanted to give my opinion that I do think CMS should come up with a standardized form that everyone is on the same page and we're all given them the same information to have signed. Thanks.

Operator: Your next comment comes from the line of (Andrew Wheeler) with Michigan Hospital Association. Your line is now open.

(Daniel Lan): This is (Daniel Lan) and at the Missouri Hospital Association. I'd like CMS to address the ambiguity and the underlying statute that was passed which refers to this law applying to each individual who receives observation services as an outpatient. It's not clear from the law from the committee reports underlying it that it actually applies to, A, Medicare, Medicare Advantage, Medicare – and Medicaid or to as its literal reading all individuals. I'd like to be clarified in the regulation that is developed by the agency. Thank you.

Operator: Your next comment comes from the line of (Debra Shawn) with (Mimic) Consulting Incorporation. Your line is now open.

(Debra Shawn): Hi. Thank you. I would request that CMS address in some kind of detail the specifics of the cost sharing requirements that would apply given the change that's happening with the comprehensive observation (APC) that goes into effect in 2016 (so) the patient has cost sharing from that perspective versus that – at the time that the patient is receiving observation services and they get to that 24-hour point the benefit procedures is provided afterwards. There might be a different cost sharing that occurs rather than the potential of the comprehensive cost sharing in terms of the beneficiary co-pay, so just some specifics around that would be helpful for CMS to clarify. Thank you.

Operator: And again, to comment, press star one on your telephone keypad. Your next comment comes from the line of (Janine Tom) with Saint Vincent Hospital. Your line is now open.

(Janine Tom): Hi. Good afternoon. My comment also is along the lines of Pennsylvania has instituted this requirement. I also agree that the appeal process to clarify that and the – for the beneficiary as well as for the providers. And I also would provide the comment as to what education is provided to beneficiaries at the point of Medicare enrollment so that there is some knowledge prior to someone being in the acute situation.

And my third point is that beneficiaries have been requesting this in the EDs so they can actually make the decision as one of the other callers indicated as to whether they're going to stay or go and how we need to build processes to support that depending on what CMS's determinations are. Thank you.

Operator: Our next comment comes from the line of (Sheila Gossin) with Rural Wisconsin Health Cooperatives. Your line is now open.

(Sheila Gossin): Thanks for taking my call. CMS is providing a definition of observation and how to count and bill observation hours. So if there is a timeline for observation notice deliverance, i.e. the 24-hours CMS needs to advise if this is to be administered within 24 medically necessary hours or 24 clock hours. Thank you.

Operator: Your next comment comes from the line of (Mickey O'Neill) at the Vassar Brothers Medical Center. Your line is now open.

(Mickey O'Neill): Hi. Thank you for taking my call again. I think I want to echo what our previous caller has said in the interim is that education and information prior to the patient getting to the hospital is critical. I would like to see CMS do some sort of campaign to make sure that beneficiaries are aware and also that they're aware of the compliance issues that hospitals have for patients to come in and insist that they want to be an inpatient so they can qualify the three midnights for a skilled facility stay. I just think that there needs to be a better understanding prior to patients being in the hospital when they're not feeling well and there are other things that they need to have their attention on. It's a

very steep gradient for us to climb as we deliver these notices and try to achieve some sort of understanding. It's just not always good timing for patients and families.

I'd also like CMS to make some efforts to make it easier for patients to receive additional services and a higher level of care from their homes without using the hospital as a clearinghouse for discharge planning to other levels of care.

Thank you so much for taking my comments.

Operator: Your next comment comes from the line of (Darmain Harris) with (Osaha) Hospital of Baltimore. Your line is now open.

(Darmain Harris): Thank you. Just wanted to make you aware that we are using advanced beneficiary notice to notify all patients that they are not meeting the criteria when the doctors discharge them from the hospital and the patient refused to be discharged because the patient is now under custodial care to notify them that you know that they need to leave and not to remain and incur a cost. Is that appropriate?

Male: From being discharged from the hospital.

(Darmain Harris): From being discharged from the hospital getting the (ABN).

Male: But they're being – they're being discharged from (obs).

(Darmain Harris): From being discharged from (obs).

Susie Butler: Thank you for your comment.

Operator: Our next comment comes from the line of (Bruce Herman) with (Health and) Health Initiative. Your line is now open.

(Bruce Herman): Yes. Thank you very much for having this call. The comment I'd like to make is to reinforce comment I heard earlier once or twice, but it's very critical. The enforcement and appeal process for this observation notice and observation status should clearly go through the QIOs. It should live in the

same place that the appeal and medical necessity for short inpatient stays lives and now for retrospective Medicare stay. So it's really key to keep – to keep that in the same location to avoid the hospitals and the patients having to appeal and manage their status through competing organizations. Thank you.

Operator: And your next comment comes from the line of (Cindy Kraft) with APGA. Your line is now open.

(Cindy Kraft): Thank you very much. I would just like to ask for consideration of the impact not just on skilled nursing facility due to the observation status but also the impact it has had on home health in relation to our bundled payment methodology that can really confuse the issue and cause problems for our payment side as well. So I think that, you know, looking at the scope of this activity I would just ask for consideration in the ultimate regulatory language that it expands some of that to make sure that home health is recognized as part of this issue, not just the skilled nursing facility impact.

Operator: And your next comment comes from the line of (Ronald Hersch) with (Ocuda). Your line is now open.

(Ronald Hersch): Thank you. I want to remind CMS that there are patients who do spend the night in the hospital after outpatient surgery and they're nor considered observation. But yet again, they're spending a night in a hospital bed and accruing hours and the ask CMS to address whether those patients fit in to this requirement for this notice.

And my second suggestion is for CMS to stop allowing politicians to write laws about which they have no real knowledge. They just confuse everybody. Thank you.

Operator: And our next comment comes from the line of (Ricky Moy) with Lifeline Health. Your line is open. (Ricky Moi), your line is open.

(Ricky Moi): Hello? Hello?

Susie Butler: We can hear you.

(Ricky Moy): OK. I would like CMS to consider addressing to our patient that the physician is the individual that addresses and orders status for inpatient or outpatient or outpatient with observation services. I personally watched and sat with patients who believe they have the right to demand, require, to be an inpatient status when clearly regulatory directions help the patient (that they cannot) and they just don't understand that, so CMS could look at how patients can be notified that this is not the patient's discretion to be in observation but rather an physician order would be helpful. Thank you.

Operator: Our next comment comes from the line (Margaret Fisher) with Newton-Wellesley Hospital. Your line is now open.

(Margaret Fischer): Hi. I'd like to see CMS consider eliminating the admission important message because the patient could conceivably get a notice of observation and important message all on the same day and it's just too much paperwork and it's not meaningful to the patient's status at the time. And also, I'd like to see some results from the pioneer ACOs across the country that are using the SNF waiver status for patients that might be in observation and maybe publish some findings on the results of all of that activity. Thank you.

Operator: And your next comment comes from the line of (Sherry Jezinski) with Center for Hannah-Beth Jackson. Your line is now open.

(Sherry Jezinski): Thank you. My comment represents the consumer or the patient point of view completely and we would like to ask that there would a form that would be also a copy given to the patient and that the explanation perhaps could in order to customize them for that person's need could have perhaps check boxes that would enable this distinctions in each – you know, each individual situation. Also, we would like to recommend that consumers be involved to some extent in designing of these forms so that it ensures that the language is understandable to them.

And then secondarily, we would like to see that the explanation of this be included in the Medicare (MU) Annual Update and also the Annual Notice of Changes and both of those books so that consumers can be aware of them beforehand. Thank you.

Operator: Your next comment comes from the line of (Kathy Stratman) with Saint Francis Memorial. Your line is now open.

(Kathy Stratman): Good afternoon. I guess I would like to just start, number one, can you hear me?

Susie Butler: Yes. You're coming through fine.

(Kathy Stratman): Great. So I'm going to start with Merry Christmas and Happy New Year. You know, I would like to definitely (diddle) what has been said by every single comment or prior to me besides too much paperwork with all these notices that these Medicare beneficiaries given, it is confusing to them.

Second of all, I would love – I would think it should be required that whoever is coming up with these rules and regulations spend a week in my shoes and work in a hospital and actually do the work that's involved with all the physicians explaining to patients, the nurses trying to care for the patient, the utilization management people trying to – what status is appropriate, you know, and finally because I'm just going to end it before I say something that I'll regret, you know what? Do away with observation. If a patient is sick enough or ill enough to be in a hospital and that is a physician's decision then they're inpatients. If that patient wants to be admitted and they're not sick enough or the doctor hasn't ordered it, then they get the HINN. Oh, that's right, another notice that we all have policies on.

You know, I've been in this job for a long, long time, and you know, this observation thing has been a can of worms. It has turned into some real messy stuff, people's understanding of what it is, and beneficiaries understanding it. But again, on a happy note, Merry Christmas. Thank you.

Operator: And again, that is star one to comment. Your next comment comes from the line of (Jill Robinson) with County Medical Center. Your line is now open.

(Jill Robinson): Good afternoon. Thank you for taking my comment. The Medicare payment advisory committee have recommended that two days of observation along with a day of inpatient stay should be considered when – for the three – for the three nights stay that qualifies the person for SNF coverage.

The other thing that concerns me about this whole thing is that when a patient is notified that they are in observation status. There was a very sad hospital statistic from Connecticut that once they were notified that they were no longer inpatient status that that's against medical advice. Now, this is – this is rather a distressing thing. You think they belonged in hospital. If they finally decide that they're going to dismiss them, that the patient left against medical advice when they clearly needed to be in the hospital. Yet, they were observation.

Susie Butler: Thank you so much. Thanks for your time.

Operator: Your next comment comes from the line of (Claire Whitzac) with Voices for Quality Care. Your line is now open.

(Claire Whitzac): Thank you for taking my call. This is my second time. I don't want to be (piggy) but I didn't say when I said that no new information was added by a standard form that we would use for everybody. That's not what Congress enacted. They enacted the people know that they are up for grabs. And I can tell you they don't. They don't understand. I agree.

I can certainly understand why these are 90 percent of the hospital complaints. We've got a big education job. Most people don't understand how hospital system works. If you're going to create that form, make sure that there is a place for the person who signed this, having received it. We have a form having to do with how people were handled end of life here in Maryland. There is no place for the person to sign it and it is turning up after people die.

So I would strongly submit that there needs to be a signed – a place for the person not only to sign it as having received it but the date. They may not understand what it is. You can color it red if you really want to call their attention to it and that clear statement on such a form that says it could cause you dollars. I can hear everybody in the hospital going, "(Argh). But you do have computers, don't you?" And I'm quite certain that somebody is right in your program that would make that computation based on what is known about the person's coverage when they come in the door.

I – there are so many other things we're going to be submitting, written comments, and thank you for taking this one.

Operator: Our next comment comes from the line of (William Mann) with (White Forrest). Your line is now open.

(William Mann): Yes. Good afternoon. Thank you for taking my call. This is unrelated to regulation, but self administer drugs have to be prudent to be able to be taken by more than 51 percent of the Medicare beneficiary. Yet, these forms are not proven to be understandable by more than 51 percent of the Medicare beneficiaries. So the education is paramount. We struggle everyday with their understanding of observation, inpatient, what have you. So I employed CMS and Medicare to start looking at their forms and their education to be understandable by more than 51 percent of the beneficiaries. Thank you.

Operator: Our next comment comes from the line of (Laura Hudler) with Central Vermont Medical. Your line is now open.

(Laura Hudler): Thank you. Good afternoon. I just have a concern that we're talking a lot about the appeals of observation level of care and there is no appeal process. So it's even more concerning that Livanta is accepting appeals for observation. Livanta's Web site clearly states there's no appeal right for Medicare beneficiaries in an observation space status. So it's just really concerning that our QIO isn't really totally aware of the regulations. And if they're allowing for an appeal, what do we do with that when you really can't change after the patient has been discharged. You can't change someone to an admission. Thank you.

Operator: And again, ladies and gentlemen, if you would like to comment, please press star one on your telephone keypad. Your next comment comes from the line of (Diana Stanton) with Jackson General Hospital. Your line is now open.

(Diana Stanton): Good afternoon. I want to make a comment regarding the lady that said Merry Christmas and Happy New Year. I totally agree. We should go open a new can worms. We need to have CMS go back and look at all patients. You need to be acute inpatient or you're not admitted and everything else should be then on a true outpatient basis by the physician in the office.

And once again, I think if we would go back and look at that, we wouldn't have (for us) this form here that were called nothing but a lot of confused members and a lot of confused hospitals. We really need to go back and look at the observation do away with it and all patients being inpatient criteria. If they don't, they're not inpatient. Thank you and have a good day.

Operator: Your next comment comes from the line of (Danielle Lan) with (ICAP) program. Your line is now open.

(Danielle Lan): My comment was made. Thank you.

Operator: Our next comment comes from the line of (Sheryl Edsra) with Catholic Elder Care. Your line is now open.

(Sheryl Edsra): Good afternoon and thank you for taking my call. I come from the SNF side of things, but I also have a mother who is 90. And so, I think I talk about the consumer side of things. Quite a while ago, people just never worry about whether or not Medicare would be covered or how their bills would be covered.

Nowadays, with the observation state, if a person doesn't have those three inpatient stays, they can easily come to a nursing home and have a bill that's $8,000 to $10,000 for four weeks and I don't care how sick I am. I would want to know that before I make a decision about coming to long-term care.

My other comment is that a year or a year and half ago we would accept people and when we would call the hospital we would be told that they were inpatient and then we would call a week later that status would be reversed to an observation state. I'm not sure how that happened but then the person couldn't access their Medicare benefits and because we weren't aware in a timely in manner, it was expensive for us to (chew). So, I understand the idea that people don't really get, you know -- people don't understand our denial notice is either when we give them. But if somebody tells me that I may have to pay for something like part of my hospital stay or a stay at a nursing home and it's going to cost me thousands of dollars, I pay attention to that. Thanks for listening.

Operator: Our next comment comes from the line of (Cynthia Ng) with Union General Hospital. Your line is now open.

(Cynthia Ng): My comment is I feel like it's our job as a hospital to tell our patient their admission status. I agree with that -- are you in-patient or are you observation. However, I think its Medicare and Medicare Replacement Plans job to explain the cost sharing implications because every plan is different when they have a secondary and what have they (met) of that deductible, et cetera. That's just not realistic that we're going to be able to do that.

It's my recommendation that if you want to do that, then have somebody available at the CMS where a patient can call and discuss that with them. Thank you.

Operator: And again, ladies and gentlemen, if you would like to comment, press star one on your telephone keypad. Your next comment comes from the line of (Becky O'Neal) with the Vassar Brothers Medical Center. Your line is now open.

(Becky Oneal): Hi, thank you again. I just wanted to comment on previous callers who brought up the fact that Livanta is looking up some observation cases. In fact, I think this may be as a result of pre-admission HINNs, which is one of our HINN that we can give when we expect the patient will be admitted. So, I know we have had that situation come up a couple of times for IM and sometimes patients get admitted and sometimes they don't but the pre-admission HINN is issued with the best intentions and best knowledge with the case manager health at that time of delivery. Thank you so much.

Susie Butler: We have no further callers in the queue so, I want to thank everyone for joining us today for the tele-townhall. If you're like me, your best thought comes as soon as we hang up, and as soon as I said that, two more folks (passed in). So, we're going to go ahead. I'll save my closing comments for just a second and we'll go ahead and take those callers who are currently in the queue.

Operator: And your next comment comes from the line of (Marty Roach) with the state of Maryland. Your line is now open.

(Marty Roach): Good afternoon. I am (Marty Roach) with the Maryland Department of Aging and I regulate continuing care of retirement communities, and we started having trouble with outpatient status in 2012. And we passed the bill in 2013 for the notice, and it requires them to explain to them the outpatient status, the billing implications in the outpatient status and the impact of the outpatient status on the patient's eligibility for Medicare rehabilitation. Because we were getting the complaints from the skilled nursing facilities, that we're getting people discharged from the hospital that didn't have the three-midnights and they were discharging them to the skilled nursing facility and two or three weeks later the person is discovering they have a huge bill. Thank you for my comment.

Operator: Your next comment comes from the line of (Jennifer Bartland) with Infirmary Health. Your line is now open.

(Jennifer Bartland): Yes, we would like to say that we agree with the questions and comments that were previously stated today, but we would like to add to it. There's been a couple of people who've, that have mentioned a little bit with regard to Medicare Advantage Plans and you know, Medicare Advantage Plans already have terrible transparency issues with providers, us included, and I'm sure other people would say the same. We would like to know that CMS is going to give any sort of specific guidelines to the (MA) plans in the Medicare manual with regard to the NOTICE Act being brought on the same along with their terrible transparency issues, if not, just so providers (are saving) their own insured.

The (MA) plans we do not feel should be able to pick and choose when they apply the Medicare guidelines, which we know they do. They should have to report to CMS if they're going to choose to adopt these rules or not adopt them and carry on with our current processes. We are already are struggling with them. They brutalize providers with (MBUS) denials that totally lack clinical rationale for the denials and total disregard for our appeals and the language contained in our appeals. So, with the NOTICE Act on the (same),

the (MA) plans are going to have a totally new area of strategy in adding ludicrous denials which will lead to even more appeals to fight with them.

We're seeing them do (DRG) validation audits to lower the (DRG) however many times we already know that they're not accurately reporting this information back to CMS which would negatively impact their risk scores. And so with this new facet, we're quite certain that there's going to be a whole new area of denials where they're going to misapply or inconsistently apply to the patients and the case that is on the table. So, we would like to see CMS respond to that as well. Thank you.

Operator: Your next comment comes from the line of (Toby Edelman) with Center for Medicare. Your line is now open.

(Toby Edelman): Thank you. I'm with the Center for Medicare Advocacy. We represent Medicare beneficiaries and I have two comments. I agree with a couple of prior commenters suggesting that all the time spent in the hospital should be counted for purposes of (four-da) coverage of subsequent stay whether the time is in-patient or out-patient. When this rule, the three-midnight rule was enacted by Congress 50 years ago, the average length of stay for people 65 and older was over 13 days -- it is now five -- so, we need all the time to count.

My second concern is the part of the law that says that the notice, the written notice on the -- that the written notice has to say the reasons for such status, and we would suggest that that needs to be specific not just a statement by the hospital the person doesn't need in-patient criteria. That has no meaning at all. So, we would like that notice to say specifically what it is about the person's medical condition that makes the person an out-patient not an in-patient. Thank you.

Operator: And again, to comment press star one on your telephone keypad. Your next comment comes from the line of (Steven Meyerson) with (ACPA). Your line is now open.

(Steven Meyerson): Well, thank you. Yes, ACPA is American College of Physician Advisors and I know the subject has already been raised by other callers. Our

recommendation of eliminating observations altogether and I just wanted to mention that both the ACPA and the American College of -- the ACMA. No, the American Society of -- I can't think of what it is. ACMA recommended to CMS that observation be eliminated. That anyone who needs to be kept in the hospital past the emergency room should be considered an in-patient. CMS responded in the final rule, the OPPS final rule, saying that they're afraid there'll be some (gaming) of system and that hospitals would try to admit more patients in order to get the part A DRG payment, which would be more than that would be paid for an observation case.

Now, the recommendation is that the DRG for this short in-patient stays that would occur instead of out-patient observation, would be paid at about the same rate that CMS is currently paying the hospitals for observation so that there wouldn't be any increase in revenue to the hospital and no reason to (game) the system. However, the adjustment in the DRG to match the observation payment would also not put any strain on the Medicare funds.

So, making everyone that need to stay in the hospital overnight, an in-patient would also solve the problem of patients not qualifying for (SNF) because once they've had three nights in the hospital, which by the way CMS has already said we're going to give the presumption of medical necessity once the patient has been on the hospital for two midnights. Then that three-night stay will meet that requirement and there's no reason why that shouldn't qualify for the (SNF) benefit. I'm sorry ACMA is American Case Managers Association. I went blank on that, but in any case, also these major national organizations which represent both case managers and physician advisors recommend eliminating observation and classifying any patient requires care in the hospital overnight as an in-patient with adjustment of all the payments so that there's no stress on the Medicare funds and at the same time we solve a lot of these problems and make life much simpler both the hospital and the patient.

This would save hospitals an immense amount of money because they wouldn't have to have the extensive administrative burden of classifying patients and re-classifying patients and self-auditing and appealing and all those things would essentially go away as long as there is medical necessity

for that night in the hospital. Even a one night stay could be in-patient. CMS has already said that that's acceptable as long as it's an expected two-midnight stay. Well, why the need to have that …

(Multiple Speakers)

Susie Butler: Steven, I have to stop you. Your time has exceeded.

Operator: And again, to comment press star one on your telephone keypad. Your next comment comes from the line of (James McCann) with CaseNetwork. Your line is now open.

(James McCann): At CaseNetwork, we do a lot of work with avoidable re-admissions and when we (unintended) the consequences of the observation, it seems to be that re-admissions are dropping but were nearly seeing a spike in the observation status. Now, we don't know that necessarily that that's intentional but it certainly does confuse the issue on reducing re-admissions which is a primary goal CMS and for the Affordable Care Act. That's my comment. Thank you.

Operator: And again, ladies and gentlemen, if you would like to make a comment, please press star one on your telephone keypad.

And there are no further callers in queue. I'll turn the call back over to the presenters.

Susie Butler: Thanks Lindsey. I think one just popped in and folks, I'm giving you a second because if I said earlier you think of your comment after the call is over and we still have a little time on the clock but unless there are folks in the queue, we will end the call. So, if you want to make a comment while we're still live, if you want to get your opinion across or your thoughts, your ideas during this time period, please get in line to make that, make your voice heard. And Lindsey, let me throw it back to you because the next time I get the microphone, I will be ending this call so, thanks so much folks.

Operator: Your next comment comes from the line of (Josie McKorkle) with Forrest General Hospital. Your line is now open.

(Josie McKorkle): Yes, well, I would like to address the issue regarding your Medicare replacement policy. I know we have (got lines) with this new notice that says we have to get patients information if they stay more than 24 hours and that notice has to be given within 36. However, we have issues with the Medicare replacement policies where these policies -- I'm sorry, but anyway, these placement policies, they want to pay us 48 and 72 hours of (ops) versus in-patient. So, I would like to see CMS address this Medicare replacement policies and how we're going to deal with patients who stay 48, 72 hours and even longer because the replacement policy don't want to pay for in-patient stay. And that's all of my comments and I agree with what everyone else had spoken about.

Operator: And again, if you would like to comment, press star one on your telephone keypad. Your next comment comes from the line of (Melinda Hutchison) from Thomas Health System. Your line is open.

(Melinda Hutchison): Thank you. I just want to reiterate what some other folks have said -- to have Medicare look at only having an (omission). Doing away with observation, it would be doing us a great service to the Medicare population as well as the hospital decreasing a lot of work on both ends, and that's all I have to say. Thank you.

Operator: Again, if you would like to comment, press star one on your telephone keypad. And again, it is star one on your telephone keypad, if you would like to make a comment. And there are no comments at this time.

Susie Butler: Thanks Lindsey. And again, thanks everyone during this busy holiday season for taking time to share your thoughts and opinions and ideas with CMS. I want to share again the place where you can send your thoughts and ideas, that's notice_act@cms.hhs.gov. That mailbox is not going to send you a response. It's just where you can send your thoughts on this topic. The mailbox will remain active until January 4th and then sometime after that, you'll be seeing something in the Federal register. We don't have dates on that at this point but I'm sure that if you found this call, you'll find that Federal register notice as well.

Thank you for your time. Thank you for your thoughts and input. Have a wonderful holiday season.

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

End