

NOTICE OF OBSERVATION TREATMENT AND IMPLICATION FOR CARE ELIGIBILITY ACT

Mr. RYAN of Wisconsin. Mr. Speaker, I move to suspend the rules and pass the bill (H.R. 876) to amend title XVIII of the Social Security Act to require hospitals to provide certain notifications to individuals classified by such hospitals under observation status rather than admitted as inpatients of such hospitals, as amended.

The Clerk read the title of the bill.
The text of the bill is as follows:

H.R. 876

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the “Notice of Observation Treatment and Implication for Care Eligibility Act” or the “NOTICE Act”.

SEC. 2. MEDICARE REQUIREMENT FOR HOSPITAL NOTIFICATIONS OF OBSERVATION STATUS.

Section 1866(a)(1) of the Social Security Act (42 U.S.C. 1395cc(a)(1)) is amended—

(1) in subparagraph (V), by striking at the end “and”;

(2) in the first subparagraph (W), by striking at the end the period and inserting a comma;

(3) in the second subparagraph (W)—

(A) by redesignating such subparagraph as subparagraph (X); and

(B) by striking at the end the period and inserting “, and”;

(4) by inserting after such subparagraph (X) the following new subparagraph:

“(Y) beginning 12 months after the date of the enactment of this subparagraph, in the case of a hospital or critical access hospital, with respect to each individual who receives observation services as an outpatient at such hospital or critical access hospital for more than 24 hours, to provide to such individual not later than 36 hours after the time such individual begins receiving such services (or, if sooner, upon release)—

“(i) such oral explanation of the written notification described in clause (ii), and such documentation of the provision of such explanation, as the Secretary determines to be appropriate;

“(ii) a written notification (as specified by the Secretary pursuant to rulemaking and containing such language as the Secretary prescribes consistent with this paragraph) which—

“(I) explains the status of the individual as an outpatient receiving observation services and not as an inpatient of the hospital or critical access hospital and the reasons for such status of such individual;

“(II) explains the implications of such status on services furnished by the hospital or critical access hospital (including services furnished on an inpatient basis), such as implications for cost-sharing requirements under this title and for subsequent eligibility for coverage under this title for services furnished by a skilled nursing facility;

“(III) includes such additional information as the Secretary determines appropriate;

“(IV) either—

“(aa) is signed by such individual or a person acting on such individual’s behalf to acknowledge receipt of such notification; or

“(bb) if such individual or person refuses to provide the signature described in item (aa), is signed by the staff member of the hospital or critical access hospital who presented the written notification and includes the name and title of such staff member, a certification that the notification was presented,

and the date and time the notification was presented; and

“(V) is written and formatted using plain language and is made available in appropriate languages as determined by the Secretary.”.

The SPEAKER pro tempore. Pursuant to the rule, the gentleman from Wisconsin (Mr. RYAN) and the gentleman from Texas (Mr. DOGGETT) each will control 20 minutes.

The Chair recognizes the gentleman from Wisconsin.

GENERAL LEAVE

Mr. RYAN of Wisconsin. Mr. Speaker, I ask unanimous consent that all Members may have 5 legislative days within which to revise and extend their remarks and include extraneous material on H.R. 876, currently under consideration.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from Wisconsin?

There was no objection.

Mr. RYAN of Wisconsin. Mr. Speaker, this is commonsense legislation dealing with the Medicare program that is bipartisan that the Committee on Ways and Means marked up a couple of weeks ago.

I want to just commend my colleagues Congressman YOUNG from Indiana and Congressman DOGGETT from Texas for their work on this.

This is common sense. This tells patients what the rules are so that they know what is going to happen when they are in the hospital, so they know what kind of billing they are going to have.

I yield whatever time he may consume to the gentleman from Indiana (Mr. YOUNG), the coauthor of this legislation, for the purpose of describing this legislation.

Mr. YOUNG of Indiana. Mr. Speaker, I thank the chairman for taking up this important piece of legislation today. I also want to thank the gentleman from Texas (Mr. DOGGETT) for his leadership on this issue.

When seniors require a hospital stay, they are rightfully more concerned with their recovery than with understanding how the hospital classifies their status as a patient; but when that classification can impact future coverage of health care services related to their recovery, they deserve to be made aware of the potential ramifications.

This act, the NOTICE Act, would require hospitals to provide meaningful written and oral notification to patients who are in the hospital under observation for more than 24 hours. This notice would alert the beneficiary or person acting on their behalf of the Medicare patient’s admission status and the financial implications of that classification so he or she can advocate on their own behalf while in the hospital.

No one should be caught off guard by a large medical bill just because they weren’t aware of the status codes or the billing procedures. In a time of sickness and stress, families should

focus on the recovery of their loved ones instead of dealing with the hidden costs due to lack of notice.

Mr. DOGGETT. Mr. Speaker, I rise in support of the bill and yield myself such time as I might consume.

The NOTICE Act, as the name suggests, is about giving notice. In this case, it gives notice to patients when they are about to be billed personally, perhaps for many thousands of dollars, because they were characterized as under observation rather than regular inpatient status without them even knowing.

I am pleased to have worked on this legislation since last summer with Mr. YOUNG when we originally filed the bill, and I am appreciative of Chairman RYAN’s prompt consideration of it in our committee.

This is a consumer protection bill designed to provide at least limited protection to health care consumers. Currently, a hospital may either admit a patient as an inpatient or keep them under observation. This categorization might apply to heart murmur, irregular heartbeat, indigestion, or other symptoms that would cause a senior or an individual with a disability who is covered by Medicare to go into the hospital.

It probably makes little or no difference in the way the hospital treats the physical condition, but it can make a very big difference in terms of how the patient’s pocketbook is cared for. Indeed, the effect of being under observation is that the patient gets stuck with the bill for any skilled nursing home care that is required for rehabilitative services after the stay at the hospital.

Medicare will pay for that needed care if a Medicare recipient patient is hospitalized for more than 3 days as an inpatient, but Medicare will not pay for skilled nursing home care if someone is simply under observation. Since Medicare has paid nothing, there is also no gap to be covered by Medigap; and instead of being in a gap, folks like this are really left in just a giant black hole. A Medicare patient that is sucked into this hole will be billed for the entire cost of rehabilitation at the nursing home, which can run into tens of thousands of dollars.

This practice is happening more and more across America, though it is largely unknown to most people until they get caught up in it. In 2012, Medicare patients had more than 600,000 observation stays that lasted 3 days or more. According to one study, over a 6-year span, the number of stays under observation has increased by 88 percent. Many Medicare patients are being put under observation for a length of time that exceeds the guidelines that have been set by Medicare.

Last year on the NBC Nightly News, Kate Snow profiled Ms. Kelley-Nelum, who discovered that this costly classification had a big impact on her hospitalized husband. After repeated questioning and demanding to know why

her husband was under observation, she got the hospital to reclassify him. She later learned that had that not occurred, had she not been persistent in standing up for her ill husband, that they would have faced about \$22,000 in out-of-pocket rehabilitation bills.

Last year, with so many patients facing insurmountable out-of-pocket costs for skilled nursing care after unknowingly being placed under observation, The New York Times actually ran a piece that was designed to provide guidance to health care consumers about how to get out of this observation category. The first step is knowing you are in it, and this bill provides for that meaningful disclosure.

This legislation is endorsed by AARP, by the Alliance for Retired Americans, the Center for Medicare Advocacy, the National Association of Professional Geriatric Care Managers, LeadingAge, American Health Care Association, and the National Committee to Preserve Social Security and Medicare.

I include in the RECORD letters from two of those groups in support of the legislation.

AARP,
February 24, 2015.

Hon. LLOYD DOGGETT,
Rayburn Office Building,
House of Representatives, Washington, DC.
Hon. TODD YOUNG,
Longworth Office Building,
House of Representatives, Washington, DC.

DEAR REPRESENTATIVE DOGGETT AND REPRESENTATIVE YOUNG: On behalf of the nearly 38 million AARP members and the millions more Americans with Medicare, we are pleased to endorse the Notice of Observation Treatment and Implication for Care Eligibility (NOTICE) Act of 2015 (H.R. 876). Thank you for working together to address the growing problem of Medicare beneficiaries paying high out-of-pocket costs due to hospital stays in which they were classified as an outpatient, rather than being formally admitted as an inpatient.

As you know, the use of "observation status" has become more prevalent in recent years, and the duration of observation stays has grown longer. While there may be several reasons for these trends, it is clear that Medicare beneficiaries are spending more and more time in the hospital without being formally admitted. Admission as an inpatient activates Medicare Part A cost-sharing and a three-day stay requirement for skilled nursing facility (SNF) coverage; in contrast, observation status is billed under Part B, and can expose beneficiaries to unexpectedly high out-of-pocket costs amounting to thousands of dollars.

Beneficiaries must be informed and made aware of how any changes to their status will affect them. This legislation would require hospitals to provide meaningful written and oral notification to patients who are in the hospital "under observation" for more than 24 hours. While this does not solve all the problems regarding cost-sharing and access to SNF coverage, it is an important step to ensuring Medicare beneficiaries have access to information about their care. Clearly understanding their admission status will help patients, and their caregivers, better plan treatment options with their health care providers.

Again, thank you for your continued work to protect Medicare beneficiaries. If you have any questions, please contact me, or

have your staff contact Ariel Gonzalez, Director of Federal Health and Family.

Sincerely,

JOYCE A. ROGERS,
Senior Vice President,
Government Affairs.

AMERICAN HEALTH CARE ASSOCIATION,
Washington, DC, February 11, 2015.
Hon. LLOYD DOGGETT,
Rayburn House Office Building,
Washington, DC.

CONGRESSMAN DOGGETT: I serve as the president and chief executive officer of AHCA/NCAL, the nation's largest association of long term and post-acute care providers. The association advocates for quality care and services for the frail, elderly, and individuals with disabilities. Our members provide essential care to millions of individuals in more than 12,000 not for profit and for profit member facilities.

AHCA/NCAL, its affiliates, and member providers advocate for the continuing vitality of the long term care provider community. We are committed to developing and advocating for public policies that support quality care and quality of life for our nation's most vulnerable. Therefore, we are in support of the legislation, Notice of Observation Treatment and Implication for Care Eligibility (NOTICE) Act, that you and Congressman Todd Young (R-IN-9) have introduced again this Congress.

The NOTICE Act requires hospitals to give formal notice to patients within a period of time after classifying them as an inpatient or as an outpatient under observation. More specifically, the legislation works to ensure that hospitals notify patients entitled to Medicare part A coverage of their outpatient status within 36 hours after the time of their classification or, if sooner, upon discharge.

Often times, patients have no idea what their status is in a hospital or the importance of it. This can lead to thousands of dollars in out-of-pocket medical expenses should they need skilled nursing center care following their hospital stay. The observation stays issue is a financial burden on seniors and their families. It can cause unnecessary spend-down, accelerating the time frame in which seniors will have to turn to programs such as Medicaid to pay for their care.

This legislation is a positive step forward, and raises attention to a complex and critical issue hurting the nation's seniors. AHCA/NCAL applauds Congressmen Doggett and Young for serving as champions for seniors and those individuals who need our services the most.

Sincerely,

MARK PARKINSON,
AHCA/NCAL President & CEO.

Mr. DOGGETT. Mr. Speaker, I also appreciate the help we have received from the Center for Medicare Advocacy. They have had reports, again, from people all over the country being placed in this situation.

The hospitals may act in the best interests of a patient's health but not always in the best interest of the patient's pocketbook. The NOTICE Act will equip patients and their loved ones with the knowledge that they need to be effective advocates and avoid crippling financial repercussions.

Mr. Speaker, I reserve the balance of my time.

Mr. RYAN of Wisconsin. Mr. Speaker, may I inquire of the gentleman from Texas if they have any other speakers? We are prepared to close.

Mr. DOGGETT. I have one speaker on the way. If you are prepared to close and he is not arriving, then we will close.

Do you have any other speakers?

Mr. RYAN of Wisconsin. I will just say a few things. I yield myself such time as I may consume, Mr. Speaker.

This is basically common sense. What is happening is people on Medicare are going to the hospital. They don't know what their status is, whether they are considered inpatient or outpatient. As far as they are concerned, it is the same thing. The problem is they are being declared one or the other, unbeknownst to them, and that has a huge difference in the billing that they receive.

So what this bill simply says is you will know your status so that you can make an informed decision as a patient in a hospital, because there are huge financial implications to that status. This is very simple. It is good government.

I reserve the balance of my time.

Mr. DOGGETT. Mr. Speaker, I yield myself 15 seconds and will welcome my colleague, JOE COURTNEY, who has long sought to respond legislatively to protect health care consumers from the financial pain of this observation status.

While the passage of the NOTICE Act is an important step, Representative COURTNEY has an Improving Access to Medicare Coverage Act that would treat observation stays the same as inpatient stays. I support his legislation as he has supported, from the beginning, this initiative, and I appreciate his leadership.

Mr. Speaker, I yield 3 minutes to the gentleman from Connecticut (Mr. COURTNEY).

Mr. COURTNEY. Mr. Speaker, I want to, first of all, salute Congressman DOGGETT for his effort in terms of bringing this legislation forward. As the chairman of the committee said, this is really about giving patients a fighting chance to challenge this coding, a change that happens while people are in the hospital and have absolutely no idea that they are not being treated as full part A inpatient patients at hospital facilities.

The impact of being coded as observation versus inpatient may sound extremely arcane, but what that means is that at time of discharge, if a patient is medically prescribed to go to a nursing home for rehab care for a broken bone or for home health services for a heart condition, they are not covered by Medicare if they are in the observation bucket as opposed to the inpatient bucket.

The inspector general's office for Medicare issued a report in 2012 that 600,000 patients across the country with long-stay hospital visits over 3 days fell into this black hole, this no man's land where, again, their doctors are telling them that they need to have rehab services so that people can walk again and deal with activities of daily living; but the price for doing that, because you are in observation status,

can be tens of thousands of dollars, which is where long-term care facilities, nursing home coverage for private-pay patients, out-of-pocket patients, exist today.

This bill at least gives patients the opportunity to challenge that decision. But the fact of the matter is, what we need to do is to restore the 3-day rule, which is in statute. It has been there since 1965. Observation status is something new within the last 10 years, and what we need to do as a Congress is to restore that 3-day rule, which says to a patient: If you are coded observation or if you are coded inpatient, it should not interfere with your medically prescribed course of treatment at the time that you are discharged from the hospital.

That, unfortunately, is not going to be fixed as a result of this legislation. We should build on this legislation and again restore Medicare's promise, which, again, from day one, has said that medically prescribed care will be covered by the system at time of discharge from a hospital for longer than 3 days.

The horror stories of people who in some instances were in hospital for 9 days with broken bones, broken hips, who, again, are staring at a 10 to \$15,000 fee to be admitted to a nursing home—again, 600,000 cases in 2012.

So again, we need to build on this legislation, but fundamentally, we need to restore the 3-day rule which has been in statute since 1965. We will be introducing that legislation later this week. It will be a bipartisan bill. We think we can withstand the test of any pay-fors to make sure that it allows the Medicare system's finances to stay in a stable condition. In the meantime, we should pass this legislation today.

Again, I want to salute the Member from Texas for his leadership on this issue.

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Mr. DOGGETT. Mr. Speaker, I concur with the gentleman from Connecticut.

I yield back the balance of my time.
Mr. RYAN of Wisconsin. I agree, Mr. Speaker.

I yield back the balance of my time.
The SPEAKER pro tempore. The question is on the motion offered by the gentleman from Wisconsin (Mr. RYAN) that the House suspend the rules and pass the bill, H.R. 876, as amended. The question was taken.

The SPEAKER pro tempore. In the opinion of the Chair, two-thirds being in the affirmative, the yeas have it.

Mr. RYAN of Wisconsin. Mr. Speaker, on that I demand the yeas and nays.

The yeas and nays were ordered.
The SPEAKER pro tempore. Pursuant to clause 8 of rule XX, further proceedings on this motion will be postponed.

MEDICARE DMEPOS COMPETITIVE BIDDING IMPROVEMENT ACT OF 2015

Mr. RYAN of Wisconsin. Mr. Speaker, I move to suspend the rules and pass

the bill (H.R. 284) to amend title XVIII of the Social Security Act to require State licensure and bid surety bonds for entities submitting bids under the Medicare durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) competitive acquisition program, and for other purposes, as amended.

The Clerk read the title of the bill.

The text of the bill is as follows:

H.R. 284

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the "Medicare DMEPOS Competitive Bidding Improvement Act of 2015".

SEC. 2. REQUIRING BID SURETY BONDS AND STATE LICENSURE FOR ENTITIES SUBMITTING BIDS UNDER THE MEDICARE DMEPOS COMPETITIVE ACQUISITION PROGRAM.

(a) BID SURETY BONDS.—Section 1847(a)(1) of the Social Security Act (42 U.S.C. 1395w-3(a)(1)) is amended by adding at the end the following new subparagraphs:

“(G) REQUIRING BID BONDS FOR BIDDING ENTITIES.—With respect to rounds of competitions beginning under this subsection for contracts beginning not earlier than January 1, 2017, and not later than January 1, 2019, an entity may not submit a bid for a competitive acquisition area unless, as of the deadline for bid submission, the entity has obtained (and provided the Secretary with proof of having obtained) a bid surety bond (in this paragraph referred to as a ‘bid bond’) in a form specified by the Secretary consistent with subparagraph (H) and in an amount that is not less than \$50,000 and not more than \$100,000 for each competitive acquisition area in which the entity submits the bid.

“(H) TREATMENT OF BID BONDS SUBMITTED.—“(I) FOR BIDDERS THAT SUBMIT BIDS AT OR BELOW THE MEDIAN AND ARE OFFERED BUT DO NOT ACCEPT THE CONTRACT.—In the case of a bidding entity that is offered a contract for any product category for a competitive acquisition area, if—

“(I) the entity's composite bid for such product category and area was at or below the median composite bid rate for all bidding entities included in the calculation of the single payment amounts for such product category and area; and

“(II) the entity does not accept the contract offered for such product category and area,

the bid bond submitted by such entity for such area shall be forfeited by the entity and the Secretary shall collect on it.

“(ii) TREATMENT OF OTHER BIDDERS.—In the case of a bidding entity for any product category for a competitive acquisition area, if the entity does not meet the bid forfeiture conditions in subclauses (I) and (II) of clause (i) for any product category for such area, the bid bond submitted by such entity for such area shall be returned within 90 days of the public announcement of the contract suppliers for such area.”.

(b) STATE LICENSURE.—

(1) IN GENERAL.—Section 1847(b)(2)(A) of the Social Security Act (42 U.S.C. 1395w-3(b)(2)(A)) is amended by adding at the end the following new clause:

“(v) The entity meets applicable State licensure requirements.”.

(2) CONSTRUCTION.—Nothing in the amendment made by paragraph (1) shall be construed as affecting the authority of the Secretary of Health and Human Services to require State licensure of an entity under the

Medicare competitive acquisition program under section 1847 of the Social Security Act (42 U.S.C. 1395w-3) before the date of the enactment of this Act.

(c) GAO REPORT ON BID BOND IMPACT ON SMALL SUPPLIERS.—

(1) STUDY.—The Comptroller General of the United States shall conduct a study that evaluates the effect of the bid surety bond requirement under the amendment made by subsection (a) on the participation of small suppliers in the Medicare DMEPOS competitive acquisition program under section 1847 of the Social Security Act (42 U.S.C. 1395w-3).

(2) REPORT.—Not later than 6 months after the date contracts are first awarded subject to such bid surety bond requirement, the Comptroller General shall submit to Congress a report on the study conducted under paragraph (1). Such report shall include recommendations for changes in such requirement in order to ensure robust participation by legitimate small suppliers in the Medicare DMEPOS competition acquisition program.

The SPEAKER pro tempore. Pursuant to the rule, the gentleman from Wisconsin (Mr. RYAN) and the gentleman from California (Ms. LINDA T. SANCHEZ) each will control 20 minutes.

The Chair recognizes the gentleman from Wisconsin.

GENERAL LEAVE

Mr. RYAN of Wisconsin. Mr. Speaker, I ask unanimous consent that all Members may have 5 legislative days within which to revise and extend their remarks and include extraneous material on H.R. 284, currently under consideration.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from Wisconsin?

There was no objection.

Mr. RYAN of Wisconsin. Mr. Speaker, I yield myself such time as I may consume.

I simply want to, again, commend our committee, Republicans and Democrats, for working on a bipartisan basis to fix a problem in the Medicare Program that needs fixing.

I want to specifically highlight Mr. TIBERI, a senior member of our committee from Ohio, along with Mr. LARSON, a senior member of the committee from the Democratic side of the aisle, for working together to fix a very deep flaw in a competitive bidding system which needs a lot of work to be improved.

At this time, I yield such time as he may consume to the gentleman from Ohio (Mr. TIBERI) for the purpose of describing and explaining the need for this legislation.

Mr. TIBERI. Thank you, Mr. Chairman, for your support of H.R. 284, the Medicare Competitive Bidding Improvement Act which, as you said, I introduced with my friend and colleague from Connecticut, Mr. JOHN LARSON.

The bill does fix a fundamental flaw in the Medicare durable medical equipment Competitive Bidding Program by simply requiring that bids be binding. It will promote fairer competition. More importantly, it protects our seniors and supports small businesses.