OBSERVATION SERVICES:

2017 CMS UPDATES…

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Disclosure of Commercial Relationships:

Nature of Relationship	*Name of Commercial Entity*
Advisory Board	None
Consultant	None
Employee	None
Board Member	None
Shareholder	None
Speaker's Bureau	None
Patents	None
Other Relationships	CMS Technical Advisory Panel: AMI, HF, pneumonia
	Past CMS APC Advisory Panelist
	Chair – Visits and Observation Subcommittee
	Co-chair, Mission Lifeline Atlanta, AHA

Objectives:

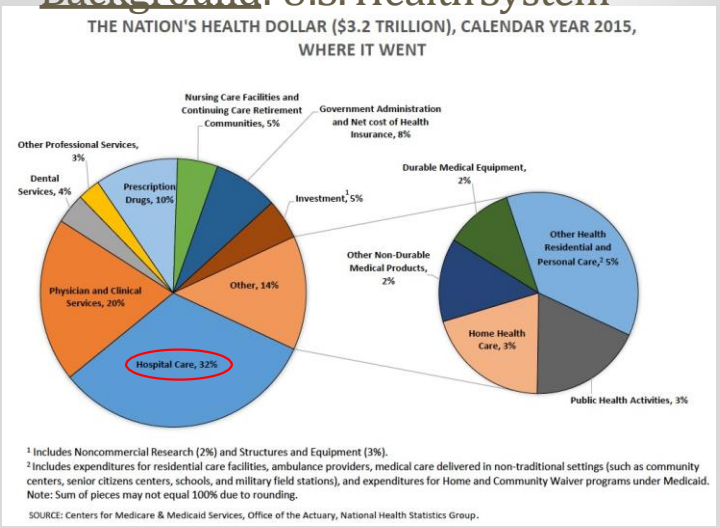
A. Understand the anatomy of the Center for Medicare and Medicaid Services (CMS)

B. Learn the history of CMS observation services policies

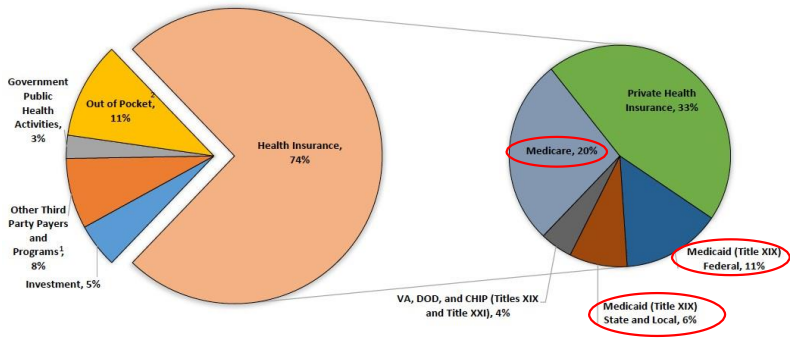
C. Know 4 CMS policies that discourage prolonged observation care
   - definition, C-APC 8011, 2-midnight rule, and the MOON.

D. Understand 3 patient centered observation issues
   - Readmissions, out of pocket costs, and risk of loosing SNF benefit

Background: U.S. Health System



THE NATION'S HEALTH DOLLAR ($3.2 TRILLION), CALENDAR YEAR 2015: WHERE IT CAME FROM



[1] Includes worksite health care, other private revenues, Indian Health Service, workers' compensation, general assistance, maternal and child health, vocational rehabilitation, Substance Abuse and Mental Health Services Administration, school health, and other federal and state local programs.
[2] Includes co-payments, deductibles, and any amounts not covered by health insurance.
Note: Sum of pieces may not equal 100% due to rounding.

SOURCE: Centers for Medicare & Medicaid Services, Office of the Actuary, National Health Statistics Group.

A. The Anatomy and Physiology of Medicare (or CMS) . . .

- U.S. Government:
  - Judicial Branch
  - Legislative Branch:
    - Senate
    - House of Representatives
  - Executive Branch
    - Cabinets
      - Secretary of State, etc . . .
      - ***Secretary of Health and Human Services***

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DHHS administers:

1. Assistant Secretary for Health
2. Public Health Service
3. Office of the Surgeon General
4. Public Health Service Commissioned Corps
5. Assistant Secretary for Preparedness and Response
6. Office of the Assistant Secretary for Preparedness and Response
7. Biomedical Advanced Research and Development Authority
8. Assistant Secretary for Legislation
9. Assistant Secretary for Planning and Evaluation
10. Assistant Secretary for Administration
11. Assistant Secretary for Public Affairs
12. Assistant Secretary for Financial Resources
13. ***Office of the Inspector General***
14. Administration for Children and Families
15. Administration on Aging
16. ***Agency for Healthcare Research and Quality***
17. Agency for Toxic Substances and Disease Registry
18. ***Centers for Disease Control and Prevention***
19. ***Centers for Medicare and Medicaid Services***
20. ***Food and Drug Administration***
21. Health Resources and Services Administration
22. Indian Health Service
23. ***National Institutes of Health***
24. Substance Abuse and Mental Health Services Administration

Center for Medicare and Medicaid Services (CMS)

- Employs approximately 4,100 employees:
  - 2,700 are located at its headquarters in Baltimore
  - The remaining employees are located in:
    - Hubert H. Humphrey Building in Washington, D.C.
    - 10 regional offices
    - Various field offices located throughout the United States.
- The head of the CMS is appointed by the president and confirmed by the Senate.

Regional Offices

- Region I – Boston, Massachusetts
  - Connecticut, Massachusetts, Maine, New Hampshire, Rhode Island and Vermont.
- Region II – New York City, New York
  - New Jersey, New York, as well as the U.S. Virgin Islands and Puerto Rico.
- Region III – Philadelphia, Pennsylvania
  - Delaware, Maryland, Pennsylvania, Virginia, West Virginia and the District of Columbia.
- ***Region IV* – *Atlanta, Georgia***
  - ***Alabama, Florida, Georgia, Kentucky, Mississippi, North Carolina, South Carolina and Tennessee.***
- ***Region V* – *Chicago, Illinois***
  - ***Illinois, Indiana, Michigan, Minnesota, Ohio and Wisconsin.***
- Region VI – Dallas, Texas
  - Arkansas, Louisiana, New Mexico, Oklahoma and Texas.
- Region VII – Kansas City, Missouri
  - Iowa, Kansas, Missouri, and Nebraska.
- Region VIII – Denver, Colorado
  - Colorado, Montana, North Dakota, South Dakota, Utah, and Wyoming.
- Region IX – San Francisco, California
  - Arizona, California, Hawaii, Nevada, the Territories of American Samoa, Guam, and the Commonwealth of the Northern Mariana Islands.
- Region X – Seattle, Washington
  - Alaska, Idaho, Oregon, and Washington

Medicare administers:

1. **Medicare**
2. Medicaid
3. State Children's Health Insurance Program (SCHIP)
4. Clinical Laboratory Improvement Amendments (CLIA)
5. Health Insurance Portability and Accountability Act (HIPA) of 1996

Note: Medicare eligibility is determined by the Social Security Administration

Medicare Parts

- **Part A:** Hospital Insurance - 1966
- **Part B:** Medical Insurance
- Part C: Medicare Advantage plans
- Part D: Prescription drug plans

Part A: Hospital Insurance

- Part A covers *inpatient* hospital stays, including semiprivate room, food, and tests.
  - Definition of an inpatient – to be discussed
- Part A — For each benefit period, a beneficiary will pay:

How much???

Part A: Hospital Insurance

- Part A covers inpatient hospital stays, including semiprivate room, food, and tests.
  - Definition of an inpatient – to be discussed
- Part A — For each **benefit period**, a beneficiary will pay:
  - A **Part A deductible of $1,316 (in 2017) for a hospital stay of 1–60 days**.
    - A $329 per day co-pay (in 2016) for days 61–90 of a hospital stay.
    - A $658 per day co-pay (in 2016) for days 91–150 of a hospital stay, as part of their limited Lifetime Reserve Days.
    - All costs for each day beyond 150 days[33]
  - **Benefit period – 60 days following the conclusion of inpatient or SNF care.**
    - **Reset if inpatient readmission occurs.**
  - **Coinsurance for a Skilled Nursing Facility is $165 per day (in 2012) for days 21 through 100 for each benefit period**.
- Covers hospice benefits

Ref:

https://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-releases/2016-Press-releases-items/2016-11-10-2.html

Part A: Rehab or Skilled Nursing Facility (**SNF**) payment

- The Four "IF"s:
  1. A preceding hospital stay must be **at least three days** as an inpatient, **three midnights**, not counting the discharge date.
  2. The nursing home stay must be for **something diagnosed during the hospital stay** or for the main cause of hospital stay.
  3. If the patient is not receiving rehabilitation but has **some other ailment that requires skilled nursing** supervision then the nursing home stay would be covered.
  4. The care being rendered by the **nursing home must be skilled**.
     - Medicare part A does not pay stays which only provide custodial, non-skilled, or long-term care activities, including activities of daily living (ADL) such as personal hygiene, cooking, cleaning, etc.

Hospital Inpatient Readmission Penalties . . .

- Medicare will take back hospital inpatient payments and far more, **4 to 18 times** the initial payment, if an above-average number of patients from the hospital are readmitted within 30 days.
- These readmission penalties apply after some of the most common treatments: pneumonia, heart failure, heart attack, COPD, knee replacement, hip replacement

Medicare Contractors

- MAC - Medicare Administrative Contractors: 2006
  - Primary contact between CMS and 1.5 million providers
  - Enroll providers, educate, review
  - Process 4.9 million claims/day, disburse $365 billion annually
- RAC - Recovery Audit Contractors: 2013
  - To identify and correct Medicare improper payments – either overpayments or underpayments
  - Demonstration project in 4 states between 2005 and 2009 collected $900 million in overpayments
  - Subsequently "rolled out" to entire country

Quality Improvement Organizations – "QIO"s

- a group of health quality experts, clinicians, and consumers organized to improve the care delivered to people with Medicare.
- Objectives – to improve effectiveness, efficiency, economy, and quality of services delivered to Medicare beneficiaries:
  - Improve quality of care for beneficiaries
  - Protect the integrity of the Trust Fund by ensuring that CMS pays for what is "***reasonable and necessary***" and in the most "***appropriate setting***"
  - Address – complaints, appeals, violations of EMTALA, etc.

Medicare Part B coverage includes:

1. ***Outpatient hospital procedures and visits***
2. Physician and nursing services
3. X-rays
4. Laboratory and diagnostic tests
5. Influenza and pneumonia vaccinations
6. Blood transfusions
7. Renal dialysis
8. Limited ambulance transportation
9. Immunosuppressive drugs for organ transplant recipients
10. Chemotherapy
11. Hormonal treatments such as lupron
12. Other outpatient medical treatments administered in a doctor's office.
13. Medication administered by the physician during an office visit
14. Durable Medical Equipment

Medicare Part B - **deductible**

- For "covered" services –
  - Begins after a yearly deductible of **$140**
  - **Then** Medicare pays 80% of approved services
    - Patients pays a 20% **co-insurance**
- Exceptions:
  - Most lab services – 100%
  - Outpatient mental health services – 55% (planned trending toward 20% over several years)

Medicare payment issues: Inpatient vs. Outpatient

Outpatient: ED or Obs

- 20% copayment for all unpackaged services
- Time does NOT count toward SNF
- Self administered drugs NOT covered

Inpatient

- Single deductible for MS-DRG (**$1,316**)
- Time counts toward 3-day SNF benefit
- Self administered drugs included

Where to find Medicare Part B coverage criteria:

- National Coverage Determinations (NCD)
  - at the national level
- Local Coverage Determinations (LCD)
  - multi-state area managed by a specific regional Medicare Part B contractor
- Other sources:
  - ***CMS Internet-Only Manuals (IOM)***
  - https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c04.pdf
  - The Code of Federal Regulations (CFR)
  - The Social Security Act
  - ***The Federal Register***

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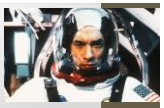
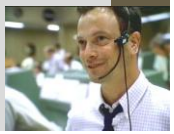
B. A Brief History of Observation Services:



1983: **Diagnosis Related Groups (DRG) Launched -**
"Houston, we have a problem"...

- The Problem:
  - Patients that are "too sick to go home, but do not meet inpatient admission criteria"
- The Solution:
  - CMS created a "fix": Observation ***Services***



DEFINITION: OBSERVATION

Observation services are those services furnished on a hospital's premises, including use of a bed and periodic monitoring by nursing or other staff, which are reasonable and necessary to evaluate an outpatient's condition or **determine the need for a possible admission as an inpatient**...

... Such services are covered **only when provided by order of a physician** or another individual authorized by State licensure law and hospital bylaws to admit patients to the hospital or to order outpatient tests. . .

. . . Observation services **usually do not exceed one day**. Some patients, however, may require a second day of outpatient observation services.

Observation services exceeding 48 hours will be denied.

B. The history of observation services policy:

as the Pendulum swings. . .

- 1984 – The creation of observation services (unstructured)
  - Pendulum swings to **observation**
    - Hospitals over-use for all outpatient surgeries
    - Lack of clarity leads to misuse – dropping off elderly patients for the weekend with no medical interventions.
- 2000 – CMS **stopped** paying separately for observation
  - Same issues which other payers were having
  - "Packaged" a observation payment into every ED / clinic visit
  - Created a powerful incentive to admit:
    - No separately identifiable observation payment
    - Payment made regardless of whether observation care received
  - Pendulum swings toward **inpatient** admission

Medicare Outpatient rule making process:

- **July**: Proposed Rule (Federal Register)
- **July** – Sept: Open comment period
  - Public / stakeholder organizations
  - HOP (Hospital Outpatient Panel)
  - Med Pac
- **Sept** – Nov: Closed comment period
- **Nov**: Final Rule (Federal Register)
  - Program Memorandum
  - Hospital Manual
  - CMS website
- **Jan 1**: Implementation date

Observation services history: as the Pendulum swings…

2003 – CMS **starts** paying observation for only 3 conditions with many stipulations
- Slight rise in observation visits

2007 – CMS removes stipulations, starts paying for all obs conditions, interqual grows, RAC and readmission penalties grow
- Pendulum swings to **observation**

2012 – CMS redefines inpatient: the 2-MN rule
- To decrease prolonged observation visits and SNF denials

2016 – Comprehensive APC, the NOTICE Act
- Packages all outpatient services into a single payment
- Patients must be notified if obs LOS>24 hr

Current CMS Payment Policy for Observation Services - **APC 8011** (effective 2016): "*Comprehensive Observation Services*" APC

- Current Hospital Payment Requirements:
  1. Physician order and documentation supporting the need for observation
  2. Preceding (packaged) HOSPITAL visit: any of the following
     - Clinic visit (HCPCS code G0463)
     - Type A or B ED visit - level 1 to 5 (HCPCS code 99281-99285)
     - Critical care (CPT code 99291)
  3. Minimum of 8 hours of observation:
     - "observation services of substantial duration"
     - HCPCS code G0378 X 8 or more
  4. No associated "T-status" procedure on the same or preceding day
     - Surgery or procedures

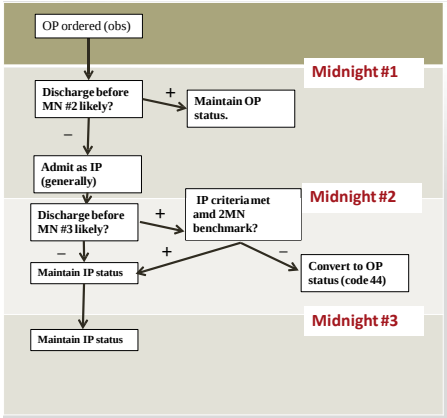
- NEW Status Indicator "J2" for C-APC
- 2017 APC 8011 Payment Amount = **$2,222**
  - Includes all other services (stress test, MRI, etc)
  - Does **not** include:
    - **SNF inpatient time**
    - **Self administered meds**

INPATIENT DEFINITION

Effective 2016

- A 2-midnight **benchmark**: FOR DOCTORS
  - An inpatient is a patient that is expected to stay in the hospital at least two midnights:
    - 24 hours and 1 minute, or 47 hours and 59 minutes
    - "Clock" starts at triage
  - Outpatient time (ED or observation) counts
  - Inpatient stays < 2-MN not paid as an inpatient
    - except death, transfer, AMA, etc

- A 2-midnight **presumption**: FOR REVIEWERS
  - If a patient met benchmark criteria, the admission will not be scrutinized by reviewers (RAC, MAC, etc)



- Type 1 Setting OBSERVATION PATIENTS:
- If a patient is not going to be discharged before second midnight – admit on second day (don't wait until third day).
  - Avoid IP conversion then discharge (abuse?) risk
  - Avoid risking 3 day SNF benefit
  - MAC and RACs will target patients for review for inpatient stays of 0-1 days

C. Four CMS Policies That Discourage Prolonged Observation Care

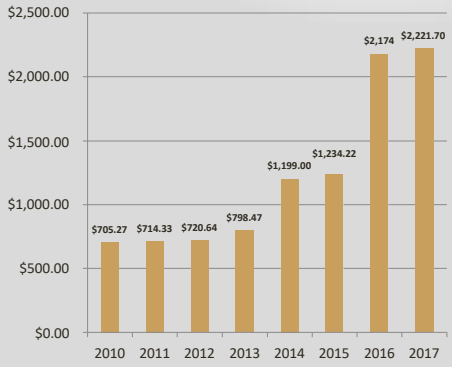
1. The definition of Observation Services
   - Less than 24hr, rarely up to 48hr
2. Comprehensive C-APC 8011
   - Packages all services into a single payment
3. The 2-midnight rule
4. The "NOTICE Act" and the "MOON"

1. DEFINITION: OBSERVATION

. . . Observation services **usually do not exceed one day**. Some patients, however, may require a second day of outpatient observation services.

Observation services exceeding 48 hours will be denied.

2. Comprehensive APC8011: CMS Favors Observation Services - 7 year Observation Facility Payment Trend



Year	CMS Payment
2010	$705.27
2011	$714.33
2012	$720.64
2013	$798.47
2014	$1,199.00
2015	$1,234.22
2016	$2,174.14
2017	$2,221.70
2018	*$2,289.33*

2. Comprehensive APC8011: Observation Big Hospital Payments in 2017 What's the Catch?

What's Included? Everything!
Labs, CT, US, most procedures, IVF, Meds
Except (S.I. F,G,H,L,U)

Comprehensive APC

- Bundling: Most Labs, ancillaries, radiology, procedures…

Observation
Now A Mini DRG

TABLE 7.—COMPREHENSIVE APC PAYMENT POLICY EXCLUSIONS FOR CY 2016

Ambulance services;
Brachytherapy;
Diagnostic and mammography screenings;
Physical therapy, speech-language pathology and occupational therapy services - Therapy services reported on a separate facility claim for recurring services;
Pass-through drugs, biologicals, and devices;
Preventive services defined in 42 CFR 410.2: • Annual wellness visits providing personalized prevention plan services • Initial preventive physical examinations • Pneumococcal, influenza, and hepatitis B vaccines and administrations • Mammography Screenings • Pap smear screenings and pelvic examination screenings • Low Dose Computed Tomography • Prostate cancer screening tests • Colorectal cancer screening tests • Diabetes outpatient self-management training services • Bone mass measurements • Glaucoma screenings • Medical nutrition therapy services • Cardiovascular screening blood tests • Diabetes screening tests • Ultrasound screenings for abdominal aortic aneurysm • Additional preventive services (as defined in section 1861(ddd)(1) of the Act);
Self-administered drugs (SADs) - Drugs that are usually self-administered and do not function as supplies in the provision of the comprehensive service;
Services assigned to OPPS status indicator "F" (certain CRNA services, Hepatitis B vaccines and corneal tissue acquisition);
Services assigned to OPPS status indicator "L" (influenza and pneumococcal pneumonia vaccines); and
Certain Part B inpatient services – Ancillary Part B inpatient services payable under Part B when the primary "J1" service for the claim is not a payable Medicare Part B inpatient service (for example, exhausted Medicare Part A benefits, beneficiaries with Part B only)

3. The Two-Midnight Rule

Report in Brief
December 2016
OEI-02-15-00020

U.S. Department of Health & Human Services
Office of Inspector General

Vulnerabilities Remain Under Medicare's 2-Midnight Hospital Policy

- Hospitals are billing for many short inpatient stays that are potentially inappropriate under the policy; Medicare paid almost $2.9 billion for these stays in FY 2014.
- Medicare pays more for some short inpatient stays than for short outpatient stays, although the stays are for similar reasons.
- Hospitals continue to bill for a large number of long outpatient stays.
- An increased number of beneficiaries in outpatient stays pay more and have limited access to SNF services than they would as inpatients.
- Hospitals continue to vary in how they use inpatient and outpatient stays.

CMS needs to address these continuing vulnerabilities by improving oversight of hospital billing under the 2-midnight policy and increasing protections for beneficiaries.

Table 1: Change in Stays From FY 2013 to FY 2014

Setting	FY 2014	Change From FY 2013	Percentage Change From FY 2013
Inpatient	9,083,804	-262,794	-2.8%
Outpatient	3,458,234	259,908	8.1%
Total	12,542,038	-2,886	

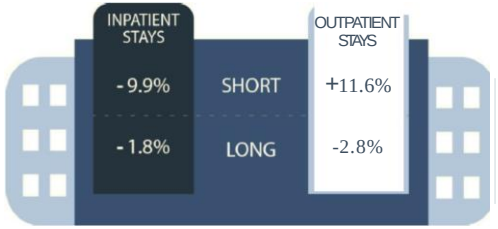
Source: OIG analysis of CMS data, 2016.

Table 2: Change in Short Inpatient Stays From FY 2013 to FY 2014

Short Inpatient Type	FY 2014	Change From FY 2013	Percentage Change From FY 2013
Appropriate under the 2-midnight policy	650,723	72,669	12.6%
Potentially inappropriate under the 2-midnight policy	423,544	-190,729	-31.0%
Total	**1,074,267**	**-118,060**	-9.9%

Source: OIG analysis of CMS data, 2016.

Figure 2: Changes in Types of Hospital Stays, FY 2013 to FY 2014



Source: OIG analysis of CMS data, 2016.

Change in Stays from FY 2013 to FY2014

Setting	Length of Stay	FY 2014	Change From FY 2013	Percentage Change From FY 2013
Outpatient	Short	2,709,897	281,156	11.6%
	Long	748,337	-21,248	-2.8%
Inpatient	Short	1,074,267	-118,060	-9.9%
	Long	8,009,537	-144,734	-1.8%
Total		12,542,038	-2,886	

Source: OIG analysis of CMS data, 2016.

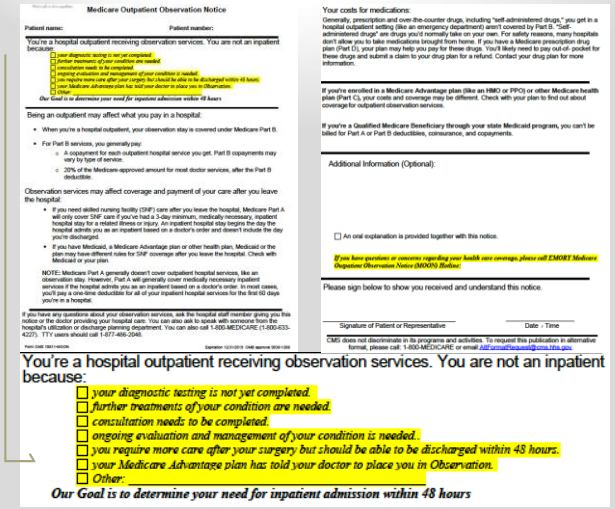
Why are people still hesitating to use the 2-MN rule?

- PTSD?
- Post-Interqual Stress Disorder
- Post-RAC Stress Disorder
- QIO use of Interqual to adjudicate uncertain cases (i.e. one outpatient midnight + one inpatient midnight)
  - Misguided belief that Interqual is coming back. . . .
- Medicare Part C plans – who write their own policy

4. The "NOTICE Act" and the "Medicare Outpatient Observation Notice" (or "MOON")

- Effective August 6, 2016
- **If a patient will be receiving observation services for more than 24 hours,** then **within 36 hours** the hospitals must notify patients (written and oral) in plain language:
  - That they are "**outpatient**" status and is not an "inpatient" of the hospital
  - The reasons **why** the patient is outpatient status
  - The **implications** of remaining in outpatient status – specifically, the related financial consequences including:
    1. Deductibles
    2. Coinsurance
    3. The lack of coverage for certain items or services not covered by Medicare
    4. The time spent as an outpatient will not count towards the 3-day acute care qualifying stay requirement for coverage of a skilled nursing facility.
- The notification must be signed by both the patient (or designee) and hospital staff
  - If patients refuse to sign, the refusal must be documented

The current "MOON"



Medicare Outpatient Observation Notice

Patient name: Patient number:

You're a hospital outpatient receiving observation services. You are not an inpatient because:

- ☐ *your diagnostic testing is not yet completed.*
- ☐ *further treatments of your condition are needed.*
- ☐ *consultation needs to be completed.*
- ☐ *ongoing evaluation and management of your condition is needed.*
- ☐ *you require more care after your surgery but should be able to be discharged within 48 hours.*
- ☐ *your Medicare Advantage plan has told your doctor to place you in Observation.*
- ☐ *Other:*

Our Goal is to determine your need for inpatient admission within 48 hours

Being an outpatient may affect what you pay in a hospital:

- When you're a hospital outpatient, your observation stay is covered under Medicare Part B.
- For Part B services, you generally pay:
  - A copayment for each outpatient hospital service you get. Part B copayments may vary by type of service.
  - 20% of the Medicare-approved amount for most doctor services, after the Part B deductible.

Observation services may affect coverage and payment of your care after you leave the hospital:

- If you need skilled nursing facility (SNF) care after you leave the hospital, Medicare Part A will only cover SNF care if you've had a 3-day minimum, medically necessary, inpatient hospital stay for a related illness or injury. An inpatient hospital stay begins the day the hospital admits you as an inpatient based on a doctor's order and doesn't include the day you're discharged.
- If you have Medicaid, a Medicare Advantage plan or other health plan, Medicaid or the plan may have different rules for SNF coverage after you leave the hospital. Check with Medicaid or your plan.

NOTE: Medicare Part A generally doesn't cover outpatient hospital services, like an observation stay. However, Part A will generally cover medically necessary inpatient services if the hospital admits you as an inpatient based on a doctor's order. In most cases, you'll pay a one-time deductible for all of your inpatient hospital services for the first 60 days you're in a hospital.

If you have any questions about your observation services, ask the hospital staff member giving you this notice or the doctor providing your hospital care. You can also ask to speak with someone from the hospital's utilization or discharge planning department. You can also call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

Your costs for medications:

Generally, prescription and over-the-counter drugs, including "self-administered drugs," you get in a hospital outpatient setting (like an emergency department) aren't covered by Part B. "Self-administered drugs" are drugs you'd normally take on your own. For safety reasons, many hospitals don't allow you to take medications brought from home. If you have a Medicare prescription drug plan (Part D), your plan may help you pay for these drugs. You'll likely need to pay out-of- pocket for these drugs and submit a claim to your drug plan for a refund. Contact your drug plan for more information.

If you're enrolled in a Medicare Advantage plan (like an HMO or PPO) or other Medicare health plan (Part C), your costs and coverage may be different. Check with your plan to find out about coverage for outpatient observation services.

If you're a Qualified Medicare Beneficiary through your state Medicaid program, you can't be billed for Part A or Part B deductibles, coinsurance, and copayments.

Additional Information (Optional):

☐ An oral explanation is provided together with this notice.

If you have questions or concerns regarding your health care coverage, please call 1MOMT Medicare Outpatient Observation Notice (MOON) Hotline.

Please sign below to show you received and understand this notice.

Signature of Patient or Representative Date - Time

CMS does not discriminate in its programs and activities. To request this publication in alternative format, please call: 1-800-MEDICARE or email: AltFormatRequest@cms.hhs.gov.

Form CMS-10611-NOON Expiration: 12/31/2019 OMB approval 0938-1358

Moon scripting - sample

- Our records show that you are a Medicare patient and that your doctor has chosen to manage you as an observation patient. This means that you will probably need less than 48 hours of care to see if you need to be admitted as an inpatient.

Traditional Medicare:

- For Medicare, Observation is paid as an "outpatient" visit - like clinic or emergency department visits. This means that you may be responsible for a "Medicare Part B copayment" instead of an inpatient "Part A deductible". You may also be responsible for the cost of self-administered drugs. Usually the "out-of-pocket" costs for an observation visit are less than inpatient admission.

- If you need to go to a skilled nursing facility for rehabilitation following your hospital stay, Medicare only covers those nursing home stays if you first spent three days as an inpatient. Medicare does not count observation time in the three days total.

Medicare Advantage:

- Your costs and coverages are determined by your plan. Please check with your plan about coverage for outpatient observation services

Your signature of this document indicates that you have received this document along with an explanation of Observation. Should you have any further questions, there are numbers on the letter for you to call to discuss further.

Useful MOON information

- Physicians order "inpatient" versus "observation" based on a strict Medicare guideline called the "2-Midnight Rule".
- Based on 2016 Medicare rates, the observation co-payment is only 34% of the inpatient deductible.
  - If Medicare average self administered meds are added to C-APC it is 40% of the inpatient deductible
  - Self administered drugs = "drugs you would normally take on your own".
- The majority of Medicare patients (94-98%) will pay less out of pocket through an observation visit than an inpatient admission.
- Based on older data, Medicare patients that miss out on nursing home (SNF) coverage represent 0.7% of all Medicare observation visits. That number is likely lower with the 2-MN rule.

D. Patient Centered Issues with Observation Services

1. Readmissions
2. Out-of-Pocket Costs
3. Self Administered Medications
4. Risk of Loosing SNF Benefit

1. Readmissions: Is observation "hiding" re-admissions?…

Hospital Inpatient Readmission Penalties:

- Medicare will take back hospital inpatient payments and far more, **4 to 18 times** the initial payment, if an above-average number of patients from the hospital are readmitted within 30 days.
- These readmission penalties apply after some of the most common treatments: pneumonia, heart failure, heart attack, COPD, knee replacement, hip replacement

The NEW ENGLAND JOURNAL of MEDICINE
This article was published on February 24, 2016, at NEJM.org.

SPECIAL ARTICLE

Readmissions, Observation, and the Hospital Readmissions Reduction Program

- Analyzed data from 3,387 hospitals, between 2007 and 2015
  - Targeted conditions = AMI, HF, pneumonia
- Readmissions declined:
  - Non-targeted conditions: 15.3% to 13.1% (-2.2%)
  - Targeted conditions: 21.5% to 17.8% (-3.7%)
- Observation visits increased:
  - Non-targeted conditions: 2.5% to 4.2% (+1.7%)
  - Targeted conditions: 2.6% to 4.7% (+2.1%)
- **No association** between re-admissions and observation stays
  - Observation visits did not account for hidden readmissions.

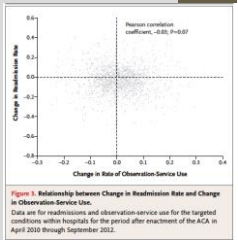


Figure 3. Relationship between Change in Readmission Rate and Change in Observation-Service Use.
Data are for readmissions and observation-service use for the targeted conditions within hospitals for the period after enactment of the ACA in April 2010 through September 2012.

Outcomes after observation stays among older adult Medicare beneficiaries in the USA: retrospective cohort study

Kumar Dharmarajan,[1] Li Qin,[2] Maggie Bierlein,[3] Jennie E S Choi,[4] Zhenqiu Lin,[2] Nihar R Desai,[1] Erica S Spatz,[1] Harlan M Krumholz,[1] Arjun K Venkatesh[5]

the bmj | BMJ 2017;357:j2616 | doi: 10.1136/bmj.j2616

Initial ED disposition	Return: ED	Return: Obs	Return: IP	Return: All
ED=>home	9.8%	1.4%	10.6%	19.9%
ED=>Obs	8.4%	2.9%	11.2%	20.1%
ED=>IP	7.3%	1.2%	15.3%	21.8%

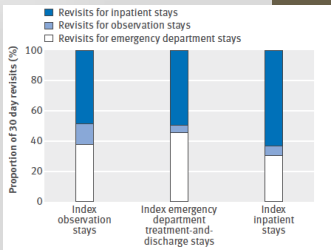


Fig 1 | Proportion of 30 day revisits for observation stays, emergency department stays, and inpatient stays after discharge from index observation stays, index emergency department stays, and index inpatient stays. Proportions represent average values over study period, 2006-11

Data represents type 1 => type 4 settings

All Medicare patients 2006-2011

Recidivism similar to ED patients

1/5 Medicare ED patients will return in 30 days

Is observation hiding readmissions? - NO

Hospital-Level 30-Day Risk-Standardized Days in Acute Care after Hospitalization for Heart Failure, Pneumonia, or Acute Myocardial Infarction

Submitted By:

Yale New Haven Health Services Corporation/Center for Outcomes Research & Evaluation (YNHHSC/CORE)

Prepared For:

Centers for Medicare & Medicaid Services (CMS)

July 8, 2014

Table 4. Heart failure: hospital-level unadjusted and risk-standardized distribution of overall acute care, readmissions, observation stays, and ED visits per 100 heart failure discharges, for hospitals with at least ten discharges per year

Description	Mean ± SD	Median (Q1, Q3)	Range
Observed days in acute care	142 ± 58	139 (104, 174)	0-530
Days of readmissions	129 ± 58	127 (92, 161)	0-525
Days of observation stays	7 ± 8	5 (2, 10)	0-109
Days of ED visits	9 ± 6	7 (5, 11)	0-56
Risk-standardized days in acute care	151 ± 12	150 (144, 157)	106-224

Notes: Data from 2010 FFS claims; N=438,545 discharges; 4,058 hospitals with at least ten discharges

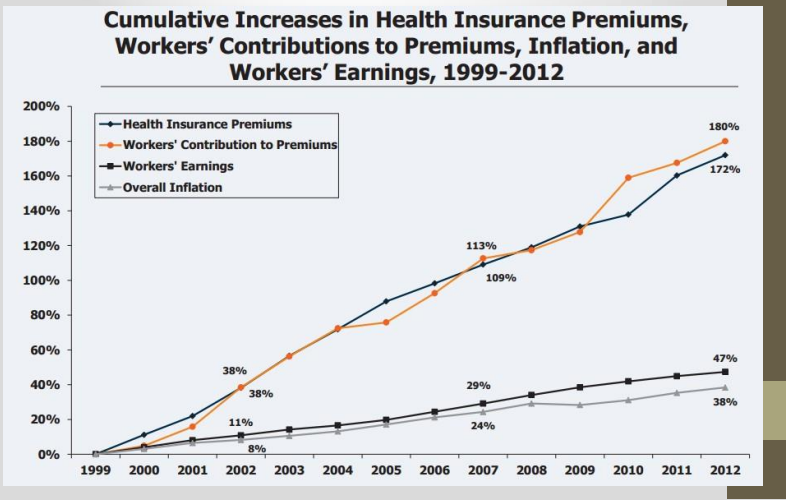
Table 5. AMI: hospital-level unadjusted and risk-standardized distribution of overall acute care, readmissions, observation stays, and ED visits per 100 discharges, for hospitals with at least ten discharges per year

Description	Mean ± SD	Median (Q1, Q3)	Range
Observed days in acute care	121 ± 62	111 (81, 148)	0-513
Days of readmissions	107 ± 62	97 (66, 134)	0-511
Days of observation stays	9 ± 10	7 (2, 13)	0-100
Days of ED visits	7 ± 5	7 (4, 9)	0-55
Risk-standardized days in acute care	115 ± 6	115 (112, 119)	92-149

Notes: Data from 2011 FFS claims; N=160,714 discharges; 2,219 hospitals with at least ten discharges

2. Out of Pocket costs: Patient co-pays are increasing

2013 Kaiser Employer Health Benefits Survey:
http://kff.org/private-insurance/report/2013-employer-health-benefits/



Do observation stays cost more?

Medicare – NO!

Patients – NO
[exception – PROCEDURES]

Journal of HOSPITAL MEDICINE www.journalofhospitalmedicine.com

ORIGINAL RESEARCH

Patient Financial Responsibility for Observation Care

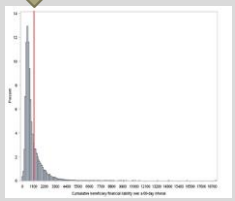
Shreya Kangovi, MD, MS[1,2,3a], Susannah G. Cafardi, MSW, MPH[4], Robyn A. Smith, BA[1,3], Raina Kulkarni, BS[3], David Grande, MD, MPA[1,2]

Journal of Hospital Medicine Vol 10 | No 11 | November 2015

- 20% sample of Medicare data from 2010-2012:
- Medicare claims 37,353,380
  - 20% sample 7,470,676
  - Observation visit (OV) 691,760 (9.3% of 20% sample)
  - ≥2 Observation visits 41,385 (6.0% of Obs visits)
  - Obs cost > IP deductible 11,008 (1.6% of Obs visits)

IP deductible = $1,100

Ave Obs = $469
Obs >2 visits = $947



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LETTERS TO EDITOR

In Reference to "Patient Financial Responsibility for Observation Care" and "Observation Versus Inpatient Hospitalization: What do Medicare Beneficiaries Pay?"

Brian J. Doyle, MD[1], Teryl K. Nuckols, MD, MS[2]

[1]Division of General Internal Medicine and Health Services Research, David Geffen School of Medicine at the University of California Los Angeles, Los Angeles, California and Veterans Affairs Greater Los Angeles Healthcare System, Los Angeles, California; [2]Division of General Internal Medicine, Department of Medicine, Cedar-Sinai Medical Center, Los Angeles, California, and the RAND Corporation, Santa Monica, California.

- The majority of Medicare beneficiaries use supplemental insurance to reduce their out-of-pocket burden:
  - Employer based plans
  - Medicaid
  - Federally regulated Medigap plans
- 1/3 of Medicare beneficiaries use Medicare Advantage plans that negotiate different re-imbursement structures for observation stays.
- Proposal – use more specific language when referring to cost

Table 2. Sample Medicare Fees and Payments for a Typical Hospitalization for Syncope

SERVICE	INPATIENT	OBSERVATION
Facility Fees	Patient pays Part A deductible: $1,288	Patient pays 20% of C-APC 8011: $434.83
	Medicare Part A pays Diagnosis Related Group (DRG) 312: $4,101* (pre deductible $2,813)	Medicare Part B pays 80% of C-APC 8011: $1,739.31
Professional Fees	Patient pays 20% of fees: $110.21 Medicare Part B pays 80%: $440.83	Patient pays 20% of fees: $78.82 Medicare Part B pays 80%: $315.29
• Initial evaluation	CPT 99223: $204.22	CPT 99220: $187.02
• Subsequent evaluation	CPT 99233: $104.98	–
• Discharge evaluation	CPT 99239: $108.20	CPT 99217: $73.45
• Computed tomography (CT) interpretation	HCPCS 70450: $43.35	HCPCS 70450: $43.35
• Echocardiogram (ECG) interpretation	HCPCS 93306: $64.49	HCPCS 93306: $64.49
• ECG interpretation x3	CPT 93010: $8.60 x3 ($25.80)	CPT 93010: $8.60 x3 ($25.80)
Medications	Patient pays $0 Medicare Part A pays DRG payment	Patient pays entire cost: $127** Medicare Part B pays $0
Laboratory	Patient pays $0 Medicare Part A pays DRG payment	Patient pays $0 Medicare Part B pays C-APC payment
Facility Diagnostics • Cardiac monitoring x48 hours • CT of the brain • Trans-thoracic echocardiogram • ECG x3	Patient pays $0 Medicare Part A pays DRG payment	Patient pays $0 Medicare Part B pays C-APC payment
Total Payments:	Patient: $1,398.21 Medicare Part A: $2,813 Medicare Part B: $440.83	Patient: $640.65 Medicare Part A: $0 Medicare Part B: $2,054.60
Total Revenue:	Hospital: $4,101 Professional: $551.04	Hospital: $2,301.14 Professional: $394.11
TOTAL COST:	$4,652.04	$2,695.25

These calculations are for traditional fee-for-service Medicare without a secondary payer. Part B payments assume the $166 annual deductible has already been paid. Part A payments assume the patient has not paid for any qualifying Part A services in the prior 60 days.
*DRG payment calculated as mean unadjusted 2013 Medicare payment amount.
**Average out-of-pocket medication costs based on 2013 Office of the Inspector General Report.[6]

3. SelfAdministered Medications (SAMs)

CENTERS FOR MEDICARE & MEDICAID SERVICES

How Medicare Covers Self-Administered Drugs Given in Hospital Outpatient Settings

Medicare Part B (Medical Insurance) generally covers care you get in a hospital outpatient setting, like an emergency department, observation unit, surgery center, or pain clinic. Part B only covers certain drugs in these settings, like drugs given through an IV (intravenous infusion).

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-02 Medicare Benefit Policy	Centers for Medicare & Medicaid Services (CMS)
Transmittal 91	Date: JUNE 20, 2008
	Change Request 5988

SUBJECT: Self-Administered Drug Exclusion Lists

- OIG data:
  - Average out of pocket cost to patients:
    - $207
    - Unchanged between 2013 and 2014

- Medications that a patient would give themselves
- Not part of acute condition
- Not given by IV infusion
- May or may not include subQ injections

4. Risk of loosing "SNF": OIG

- 2012 OIG analysis of CMS data:
  - 3 days, but less than 3 IP days = 617,702
    - Received SNF services = 25,245 (4%)
    - **This represent 0.6% of Medicare Observation patients**
- 2013 vs 2014 OIG analysis of CMS data:
  - 3 days, but less than 3 IP days = 633,148 (6% increase over 2013)
    - "Never an inpatient" = 32% of total
      - This group decreased 15.3% over 2013
    - "Started as obs" then an inpatient = 68% of total
      - This group increased 20% over 2013
      - ***FAILURE TO MAKE A TIMELY DISPOSITION!!!! – the case for a Type 1 Unit***

Table 3: Change From FY 2013 to FY 2014 in Hospital Stays That Lasted at Least 3 Nights but Did Not Include 3 Inpatient Nights

Type of Stay	FY 2014	Change From FY 2013	Percentage Change From FY 2013
3 or more nights as outpatient and never admitted as inpatient	200,408	-36,163	-15.3%
Began as outpatient and admitted as inpatient	432,740	72,342	20.1%
Total	**633,148**	**36,179**	**6.1%**

Source: OIG analysis of CMS data, 2016.

ORIGINAL ARTICLE

rigin and Disposition of Medicare Observation Stays

lan Feng, PhD,† Hye-Young Jung, PhD,‡ Brad Wright, PhD,†§ and Vincent Mor, PhD†*

Growing use of hospital observation care continues pite growing concerns from Medicare beneficiaries, acy groups, providers, and policy makers. Unlike

Key Words: Medicare, observation, SNF, out-of-pocket costs (*Med Care* 2014;00: 000–000)

- 100% of 2009 Medicare inpatient and outpatient claims:
  - >1 million observation visits
    - 2.9% (29,324) discharged to a SNF
      - 62% came from the SNF
      - 8% came from a NH
      - 26% (7,537) came from community (at risk)
    - ***0.75% (7,537) with SNF benefit at risk***
      - ***NOTE**: OIG (above) reported that CMS still paid 92% of these (inappropriately).*

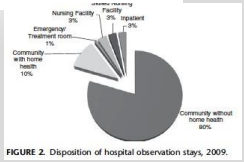


FIGURE 2. Disposition of hospital observation stays, 2009.

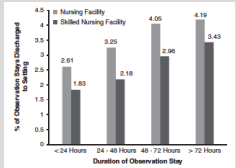
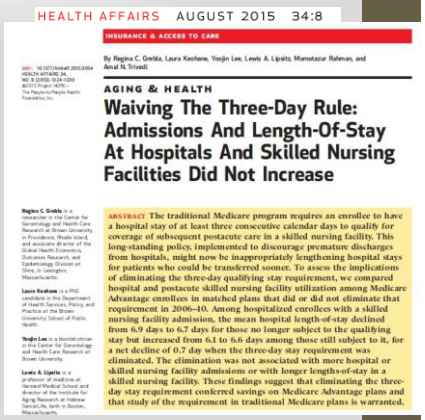


FIGURE 3. Disposition of hospital observation stays to nursing facilities and skilled nursing facilities, by duration of observation stay, 2009.

CMS should remove the 3-day rule

Medicare enrollees compared:

- 3-day rule actually increases hospital LOS by 0.7 days
- Removal of the rule is not associated with an increase in SNF placement or length of stays



HEALTH AFFAIRS AUGUST 2015 34:8

INSURANCE & ACCESS TO CARE

By Regina C. Grebla, Laura Keohane, Yoojin Lee, Lewis A. Lipsitz, Momotazur Rahman, and Amal N. Trivedi

AGING & HEALTH

Waiving The Three-Day Rule: Admissions And Length-Of-Stay At Hospitals And Skilled Nursing Facilities Did Not Increase

ABSTRACT The traditional Medicare program requires an enrollee to have a hospital stay of at least three consecutive calendar days to qualify for coverage of subsequent postacute care in a skilled nursing facility. This long-standing policy, implemented to discourage premature discharges from hospitals, might now be inappropriately lengthening hospital stays for patients who could be transferred sooner. To assess the implications of eliminating the three-day qualifying stay requirement, we compared hospital and postacute skilled nursing facility utilization among Medicare Advantage enrollees in matched plans that did or did not eliminate that requirement in 2006–10. Among hospitalized enrollees with a skilled nursing facility admission, the mean hospital length-of-stay declined from 6.9 days to 6.7 days for those no longer subject to the qualifying stay but increased from 6.1 to 6.6 days among those still subject to it, for a net decline of 0.7 day when the three-day stay requirement was eliminated. The elimination was not associated with more hospital or skilled nursing facility admissions or with longer lengths-of-stay in a skilled nursing facility. These findings suggest that eliminating the three-day stay requirement conferred savings on Medicare Advantage plans and that study of the requirement in traditional Medicare plans is warranted.

Summary

- The people making major decisions (or mistakes) are well intended people like you and I . . . Who don't know what they don't know.
  - They NEED YOU to educate them
- Medicare likes "good" observation services and does not like prolonged observation services
- Type 1 observation units are the essential link to good observation care

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