OBSERVATION SERVICES:

2018 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 Expert Panel: AMI, HF, pneumonia Past CMS APC Advisory Panelist Chair – Visits and Observation Subcommittee Accreditation Management Board, American College of Cardiology

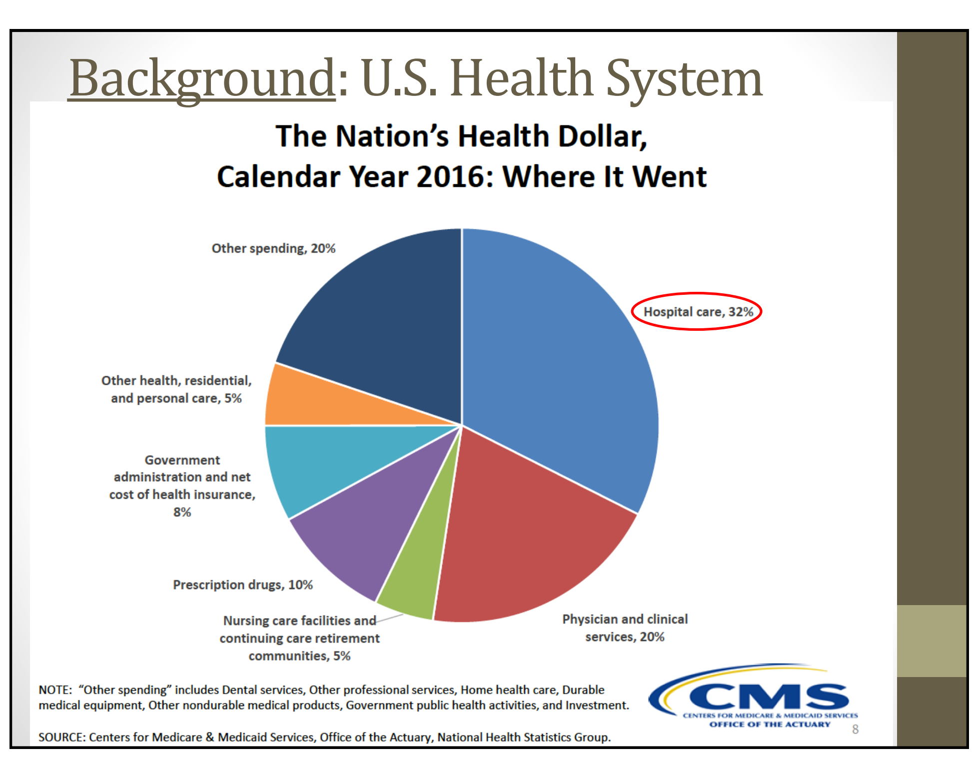
Objectives:

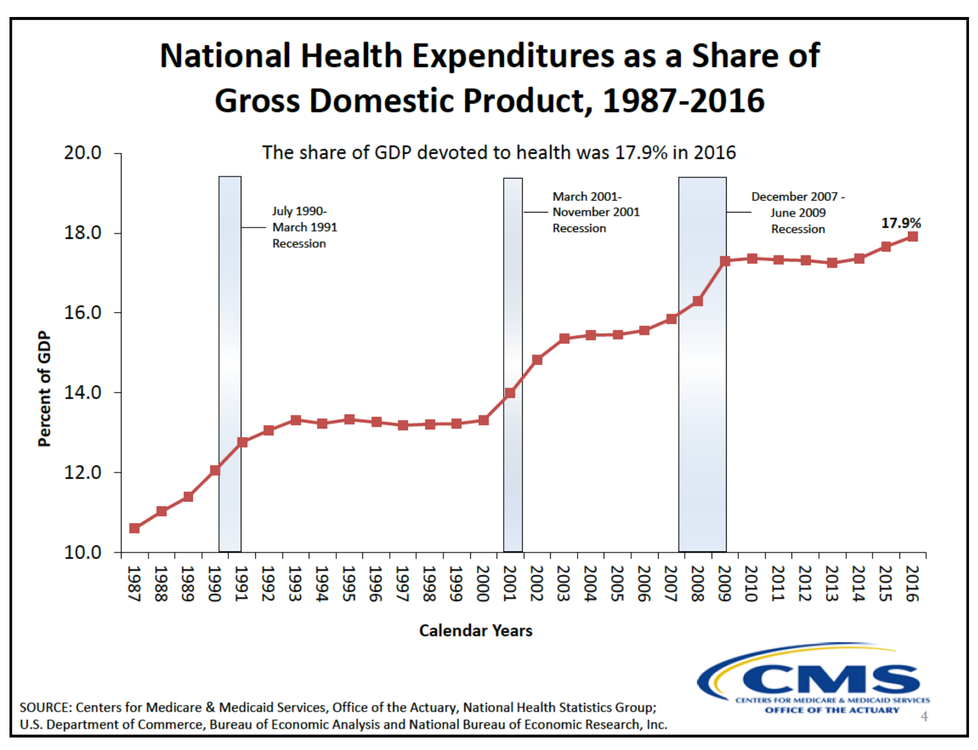
A. Understand the structure of the Center for Medicare and Medicaid Services (CMS)

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

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

Background: U.S. Health System




National Health Expenditures as a Share of Gross Domestic Product, 1987-2016
The share of GDP devoted to health was 17.9% in 2016
Percent of GDP
20.0
18.0
16.0
14.0
12.0
10.0
July 1990-
March 1991
Recession
March 2001-
November 2001
Recession
December 2007 -
June 2009
Recession
17.9%
1987 1988 1989 1990 1991 1992 1993 1994 1995 1996 1997 1998 1999 2000 2001 2002 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 2014 2015 2016
Calendar Years
CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES
OFFICE OF THE ACTUARY
SOURCE: Centers for Medicare & Medicaid Services, Office of the Actuary, National Health Statistics Group;
U.S. Department of Commerce, Bureau of Economic Analysis and National Bureau of Economic Research, Inc.
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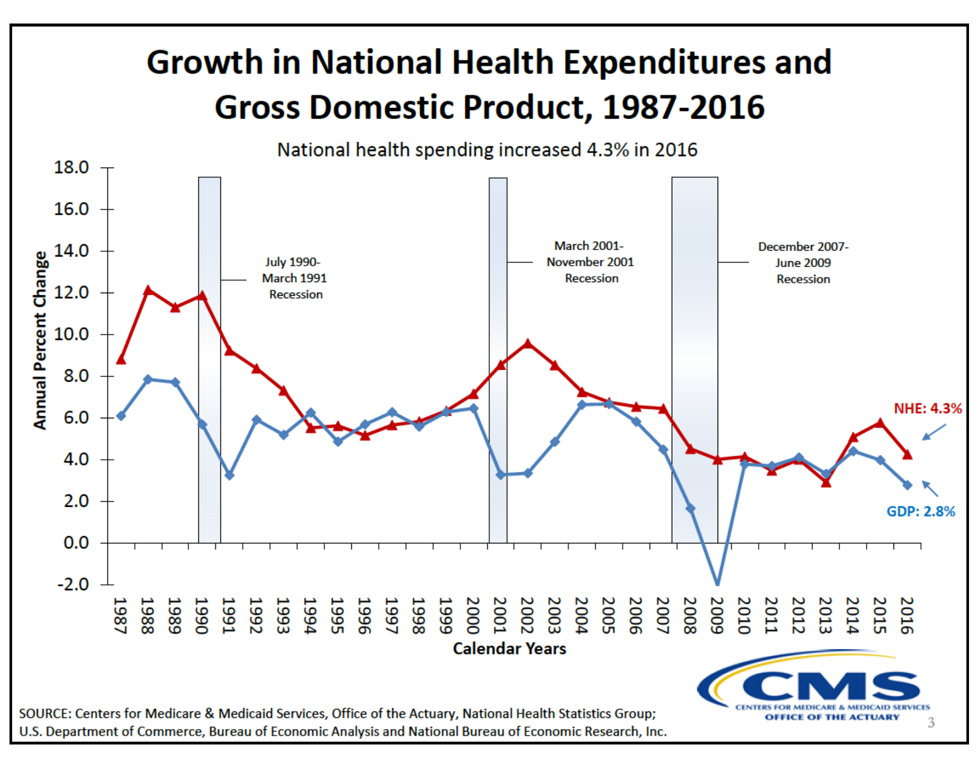
Growth in National Health Expenditures and Gross Domestic Product, 1987-2016
National health spending increased 4.3% in 2016
Annual Percent Change
18.0
16.0
14.0
12.0
10.0
8.0
6.0
4.0
2.0
0.0
-2.0
July 1990-
March 1991
Recession
March 2001-
November 2001
Recession
December 2007-
June 2009
Recession
NHE: 4.3%
GDP: 2.8%
1987 1988 1989 1990 1991 1992 1993 1994 1995 1996 1997 1998 1999 2000 2001 2002 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 2014 2015 2016
Calendar Years
CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES
OFFICE OF THE ACTUARY
SOURCE: Centers for Medicare & Medicaid Services, Office of the Actuary, National Health Statistics Group;
U.S. Department of Commerce, Bureau of Economic Analysis and National Bureau of Economic Research, Inc.
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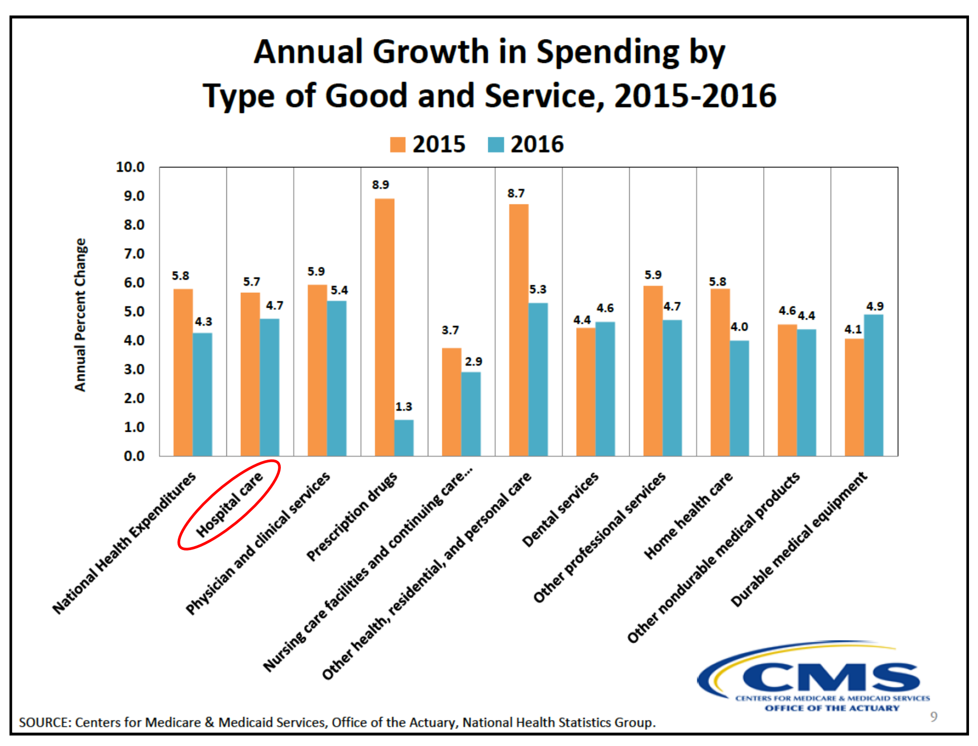
Annual Growth in Spending by
Type of Good and Service, 2015-2016
2015
2016
Annual Percent Change
10.0
9.0
8.0
7.0
6.0
5.0
4.0
3.0
2.0
1.0
0.0
5.8
4.3
5.7
4.7
5.9
5.4
8.9
1.3
3.7
2.9
8.7
5.3
4.4
4.6
5.9
4.7
5.8
4.0
4.6
4.4
4.1
4.9
National Health Expenditures
Hospital care
Physician and clinical services
Prescription drugs
Nursing care facilities and continuing care...
Other health, residential, and personal care
Dental services
Other professional services
Home health care
Other nondurable medical products
Durable medical equipment
CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES
OFFICE OF THE ACTUARY
SOURCE: Centers for Medicare & Medicaid Services, Office of the Actuary, National Health Statistics Group.
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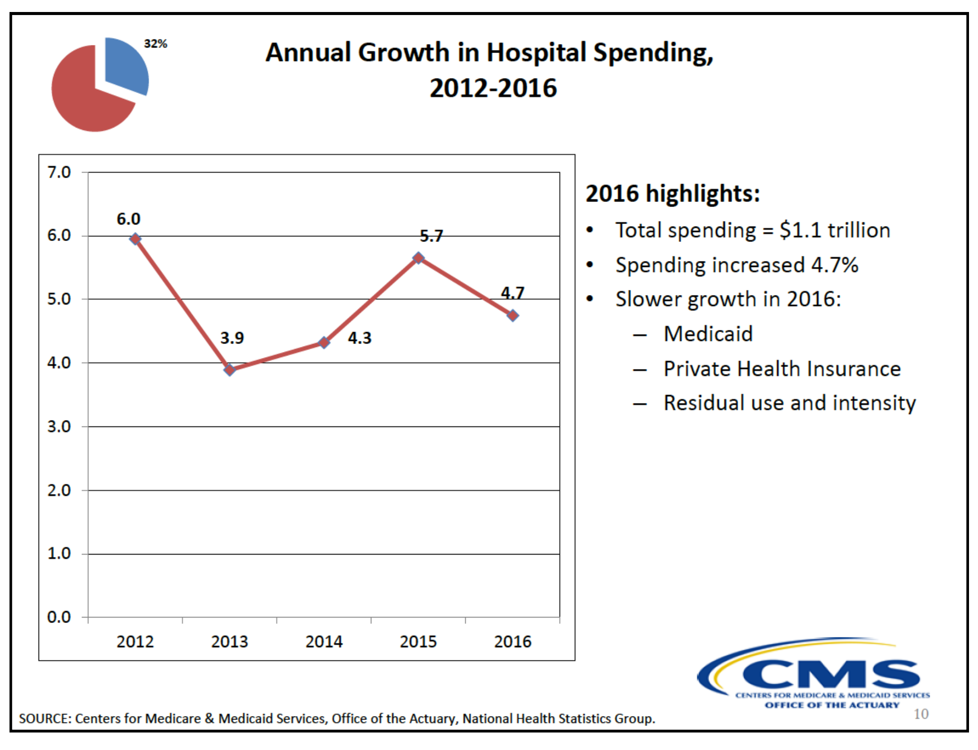
32%
Annual Growth in Hospital Spending,
2012-2016
7.0
6.0
5.0
4.0
3.0
2.0
1.0
0.0
6.0
3.9
4.3
5.7
4.7
2012
2013
2014
2015
2016
2016 highlights:
• Total spending = $1.1 trillion
• Spending increased 4.7%
• Slower growth in 2016:
– Medicaid
– Private Health Insurance
– Residual use and intensity
CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES
OFFICE OF THE ACTUARY
SOURCE: Centers for Medicare & Medicaid Services, Office of the Actuary, National Health Statistics Group.
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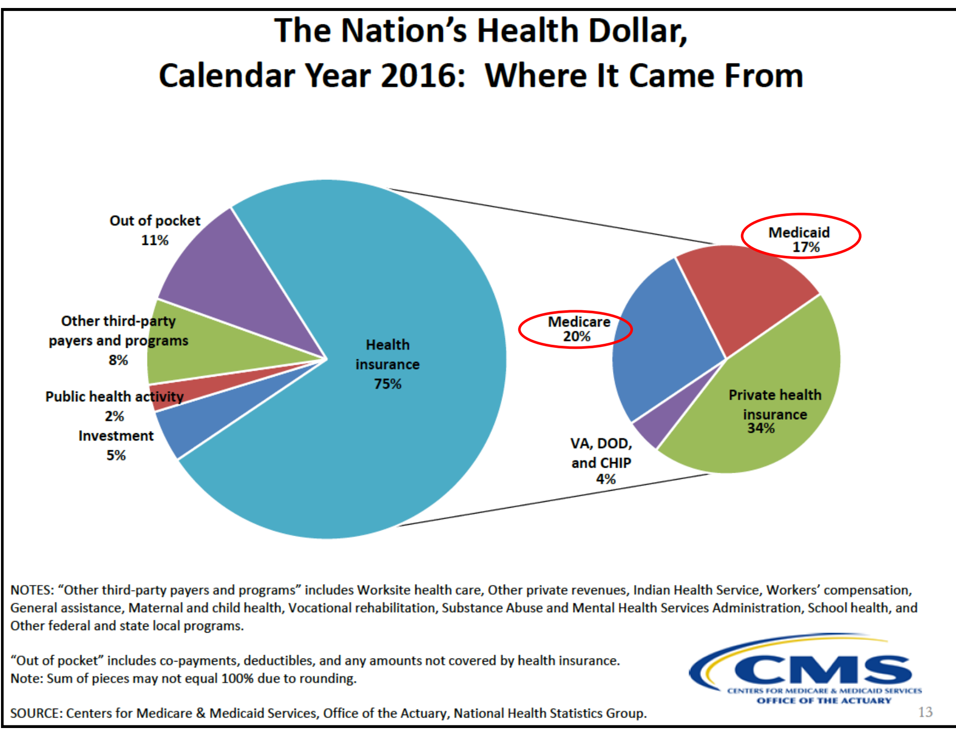

A. The Anatomy and Physiology of Medicare (or CMS) . . .

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

Dept of Health and Human Services (DHHS) administers:

Alex Azar
Secretary of HHS

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)

Seema Verma
Administrator
of CMS

- Employs about 6,000 employees:
  - 4,000 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.

CMS 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

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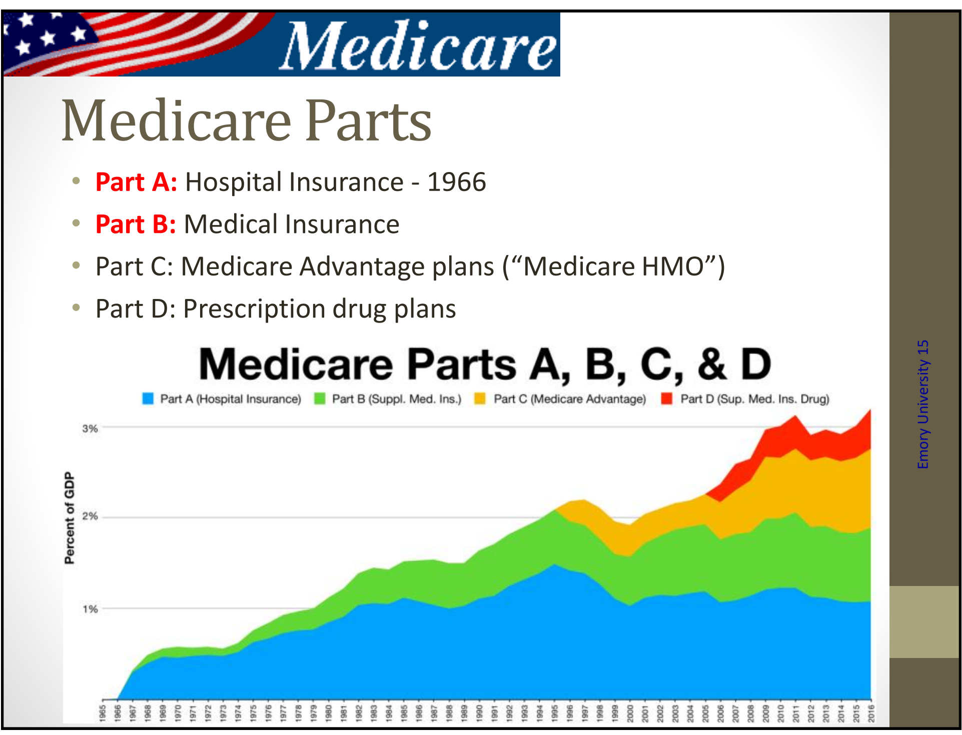

Part A: Hospital Insurance

- 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???

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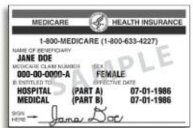
Part A: Hospital Insurance



- 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 $1,340 (in 2018) for a hospital stay of 1–60 days**.
    - A $335 per day co-pay (in 2018) for days 61–90 of a hospital stay.
    - A $670 per "lifetime reserve day" day co-pay (in 2018) after day 90 of each benefit period (up to a maximum of 60 days over one's lifetime).
  - **Benefit period – 60 days following the conclusion of inpatient or SNF care.**
    - **Reset if inpatient readmission occurs.**
  - **Skilled Nursing Facility Stay -** in 2018:
    - ■ $0 for the first 20 days of each benefit period
    - ■ $167.50 per day for days 21–100 of each benefit period
    - ■ All costs after day 100 of the benefit period
- Covers hospice benefits

Ref:
- https://www.medicare.gov/Pubs/pdf/11579-Medicare-Costs.pdf

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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.

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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

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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.

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)

CMS 2019 Update:
IPPS-inpatient Admission Orders Documentation requirements

- Effective 10/1/2018
  - "no longer require a written inpatient admission order to be present in the medical record as a specific condition of Medicare part A payment."
    - revise the regulation at 42 CFR 412.3(a) to remove the language stating that a physician order must be present in the medical record and be supported by the physician admission and progress notes, in order for the hospital to be paid for hospital inpatient services under Medicare Part A.
- ……but……
  - this policy would not change the requirement that a beneficiary becomes an inpatient when formally admitted as an inpatient under an order for inpatient admission.

Medicare Part B:

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 - **coverage**

- 2018 "covered" services –
  - Begins after a 2018 yearly deductible of **$183**
  - **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)
- **Medigap** (or Medicare Supplemental Insurance)
  - Covers Medicare deductibles and non-covered costs
  - **~25%** of Medicare beneficiary have some form of Medigap

https://www.kff.org/medicare/issue-brief/medigap-enrollment-and-consumer-protections-vary-across-states/

DEFINITION: OBSERVATION - 2018

Medicare Claims Processing Manual
Chapter 4 - Part B Hospital
(Including Inpatient Hospital Part B and OPPS)

Table of Contents
(Rev. 3941, 12-22-17)

290.1 - Observation Services Overview
(Rev. 1760, Issued: 06-23-09; Effective Date: 07-01-09; Implementation Date: 07-06-09)

Observation care is a well-defined set of specific, clinically appropriate services, which include ongoing short term treatment, assessment, and reassessment, that are ***furnished while a decision is being made regarding whether patients will require further treatment as hospital inpatients*** or if they are able to be discharged from the hospital . . .

... Observation 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.

. . . In only rare and exceptional cases do reasonable and necessary outpatient observation services span more than 48 hours. . . In the majority of cases, the decision . . .can be made in ***less than 48 hours, usually in less than 24 hours***.

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, HCPCS G0380-4)
     - Critical care (CPT code 99291)
     - Direct referral for observation (HCPCS code G0379, APC 5013)
  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
- 2018 APC 8011 Payment Amount = **$2,289**
  - Includes all other services (stress test, MRI, etc)
  - It does **NOT** include two things:
    1. **SNF inpatient time**
    2. **Self administered meds**

T-Status Procedures: Examples

HCPCS	Desc	SI
43239	Egd biopsy single/multiple	T
62270	Spinal fluid tap diagnostic	T
43235	Egd diagnostic brush wash	T
49083	Abd paracentesis w/imaging	T
36569	Insert picc cath	T
32555	Aspirate pleura w/ imaging	T
45380	Colonoscopy and biopsy	T
43247	Egd remove foreign body	T
45378	Diagnostic colonoscopy	T
97597	Rmvl devital tis 20 cm/<	T
36558	Insert tunneled cv cath	T
45385	Colonoscopy w/lesion removal	T
49452	Replace g-j tube perc	T
36581	Replace tunneled cv cath	T
49451	Replace duod/jej tube perc	T
36584	Replace picc cath	T
49450	Replace g/c tube perc	T
32557	Insert cath pleura w/ image	T
10022	Fna w/image	T
50435	Exchange nephrostomy cath	T
37200	Transcatheter biopsy	T
50434	Convert nephrostomy catheter	T
64483	Inj foramen epidural l/s	T
36561	Insert tunneled cv cath	T

Medicare Outpatient (OPPS) Rulemaking process:

- **July**: Proposed Rule (Federal Register)

  - **2019** – Observation – **NO CHANGE!!!**
- **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

37128 Federal Register / Vol. 83, No. 147 / Tuesday, July 31, 2018 / Proposed Rules

VII. Proposed OPPS Payment for Hospital Outpatient Visits and Critical Care Services

- As we did in the CY 2018 OPPS/ASC final rule with comment period (82 FR 59373), for CY 2019, we are proposing to continue with our current clinic and emergency department (ED) hospital outpatient visits payment policies.

C. Four CMS Policies That Discourage Prolonged Observation Care

1. The definition of Observation Services
   - Less than 24hr, rarely over 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”

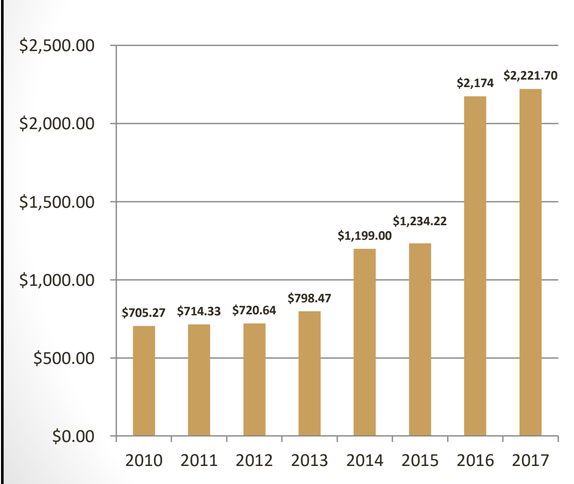
1. DEFINITION: OBSERVATION

Observation services must also be reasonable and necessary to be covered by Medicare. In **only rare and exceptional cases** do reasonable and necessary outpatient observation services span more than 48 hours. In the majority of cases, the decision whether to discharge a patient from the hospital following resolution of the reason for the observation care or to admit the patient as an inpatient ***can be made in less than 48 hours, usually in less than 24 hours***.

2. Comprehensive APC 8011:

CMS Favors Observation Services -

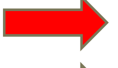
7 year Observation Facility Payment Trend



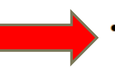
Year	CMS Payment
2010	$705.27
2011	$714.33
2012	$720.64
2013	$798.47
2014	$1,199.00
2015	$1,234.22
2016	$2,174.14
2017	$2,221.70
2018	***$2,289.33***

3. The Two-Midnight Rule

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.

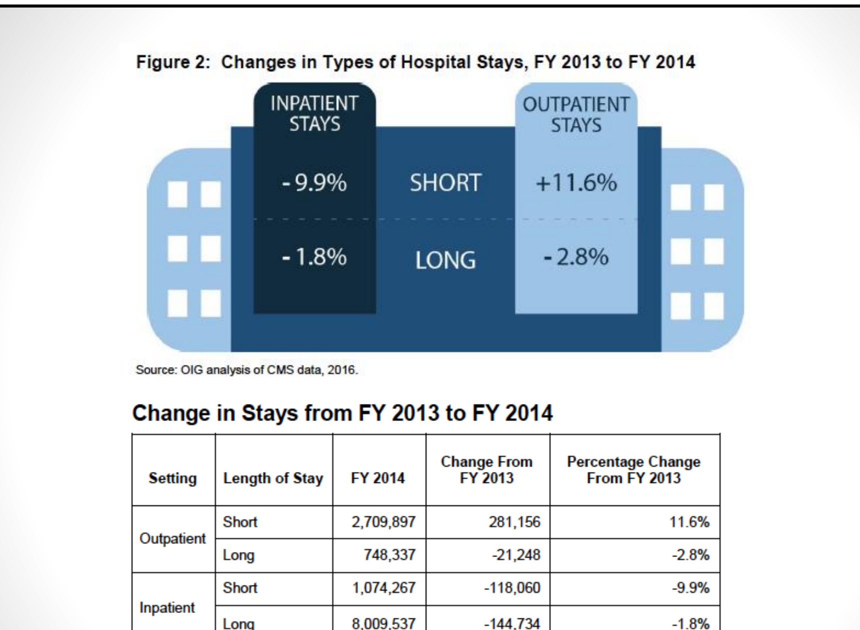


Figure 2: Changes in Types of Hospital Stays, FY 2013 to FY 2014

Source: OIG analysis of CMS data, 2016.

Change in Stays from FY 2013 to FY 2014

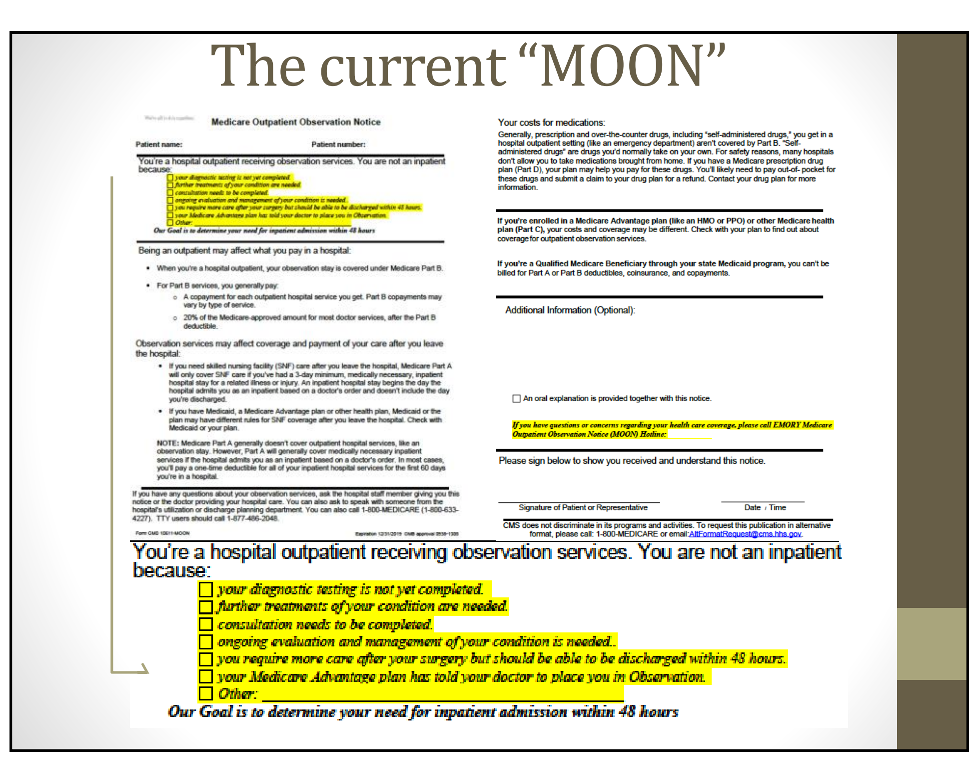
Setting	Length of Stay	FY 2014	Change From FY 2013	Percentage Change From FY 2013
Outpatient	Short	2,709,897	281,156	11.6%
	Long	748,337	-21,248	-2.8%
Inpatient	Short	1,074,267	-118,060	-9.9%
	Long	8,009,537	-144,734	-1.8%
Total		**12,542,038**	**-2,886**	

Source: OIG analysis of CMS data, 2016.

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

- Not a policy, a **LAW** - 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 EMORY 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.

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

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.

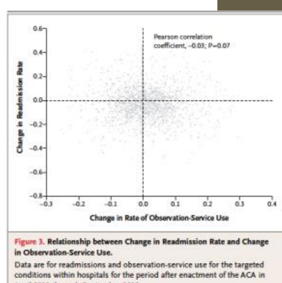


Figure 3. Relationship between Change in Readmission Rate and Change in Observation-Service Use.
Data are for readmissions and observation-service use for the targeted conditions within hospitals for the period after enactment of the ACA in April 2010 through September 2012.

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]

thebmj | 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%

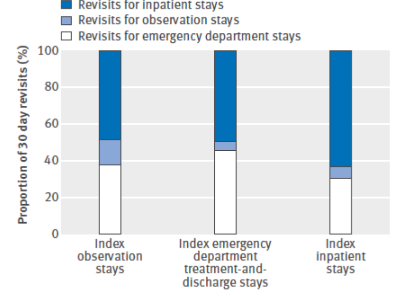


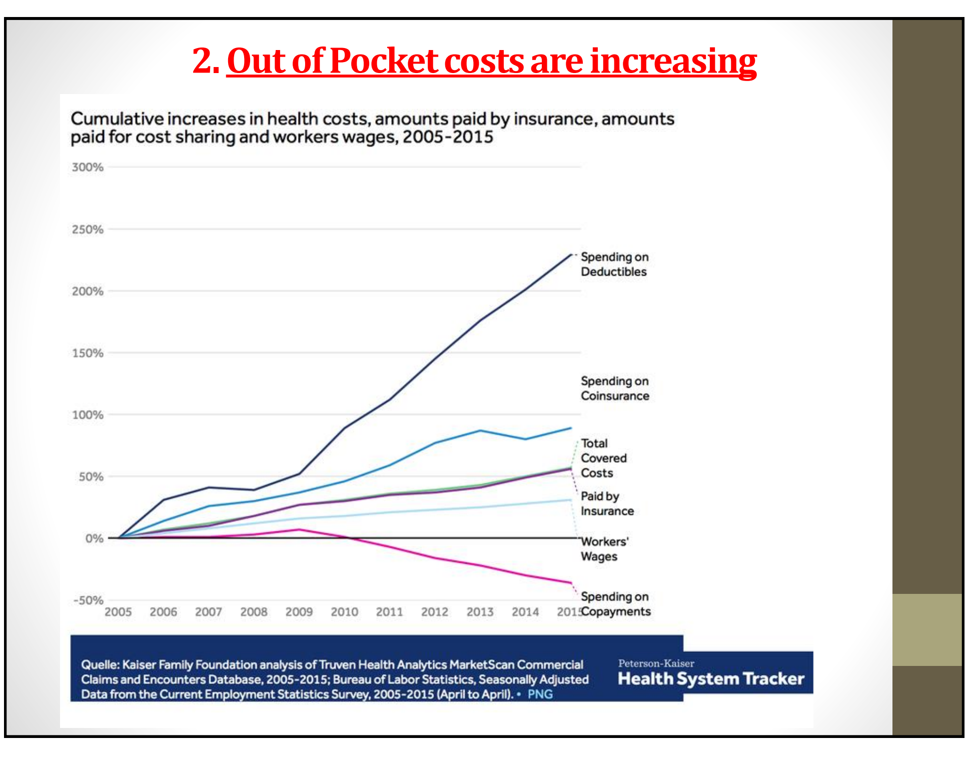
Fig 1 | Proportion of 30 day revisits for observation stays, emergency department stays, and inpatient stays after discharge from index observation stays, index emergency department stays, and index inpatient stays. Proportions represent average values over study period, 2006-11

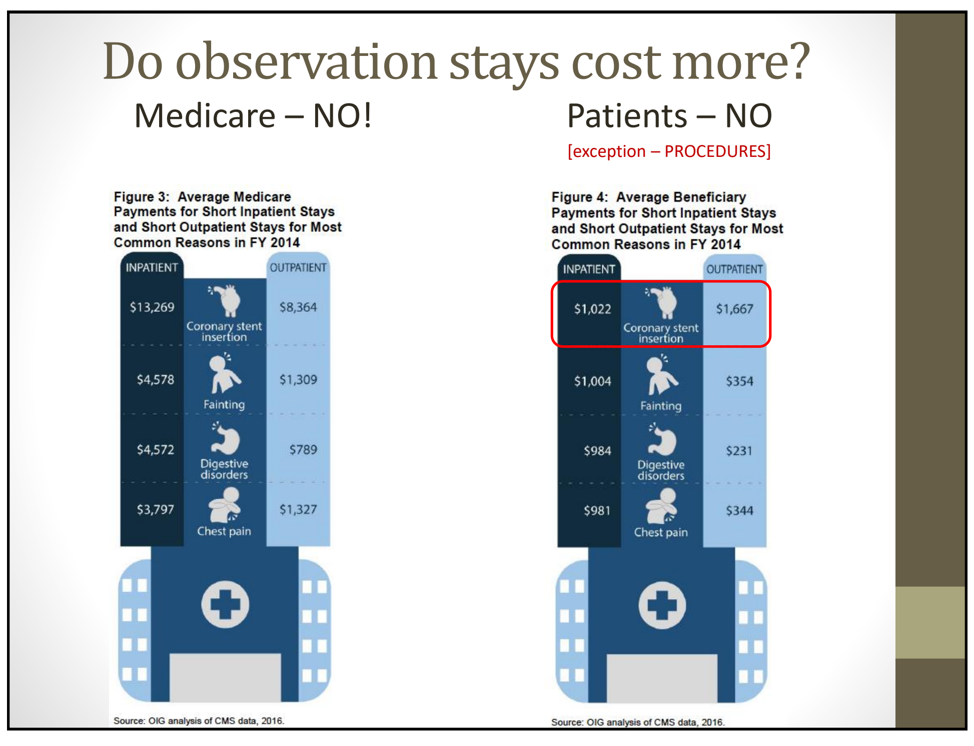
Data represents type 1 through type 4 settings

All Medicare patients 2006-2011

Recidivism similar to ED patients

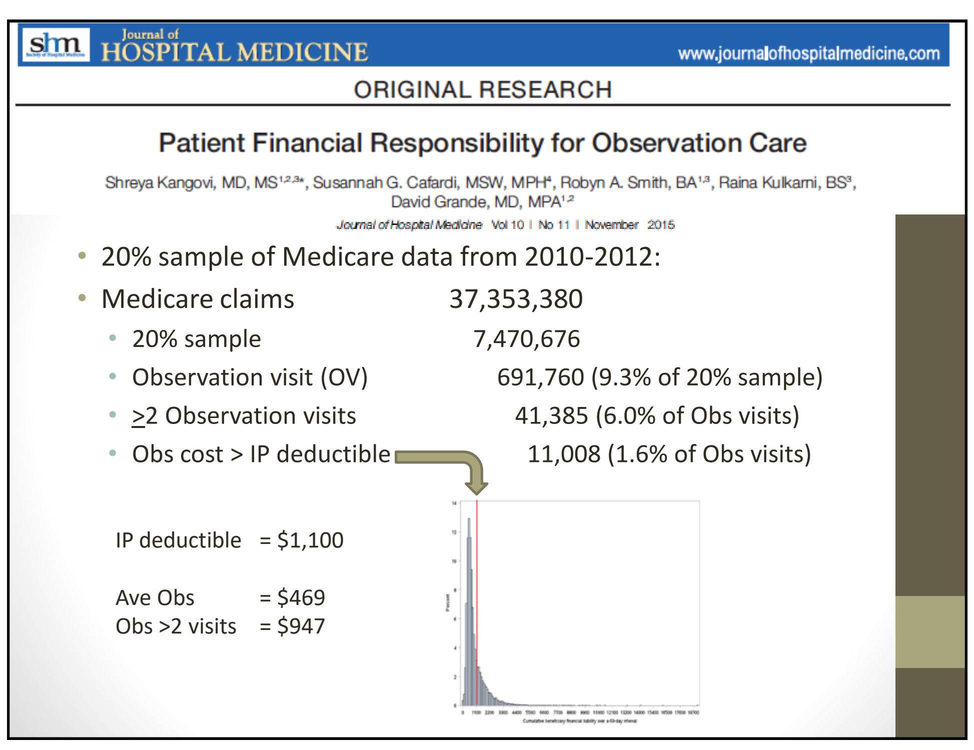
1/5 Medicare ED patients will return in 30 days


2. Out of Pocket costs are increasing
Cumulative increases in health costs, amounts paid by insurance, amounts paid for cost sharing and workers wages, 2005-2015
300%
250%
200%
150%
100%
50%
0%
-50%
2005
2006
2007
2008
2009
2010
2011
2012
2013
2014
2015
Spending on Deductibles
Spending on Coinsurance
Total Covered Costs
Paid by Insurance
Workers' Wages
Spending on Copayments
Quelle: Kaiser Family Foundation analysis of Truven Health Analytics MarketScan Commercial Claims and Encounters Database, 2005-2015; Bureau of Labor Statistics, Seasonally Adjusted Data from the Current Employment Statistics Survey, 2005-2015 (April to April). • PNG
Peterson-Kaiser
Health System Tracker


Do observation stays cost more?
Medicare – NO!
Patients – NO
[exception – PROCEDURES]
Figure 3: Average Medicare Payments for Short Inpatient Stays and Short Outpatient Stays for Most Common Reasons in FY 2014
INPATIENT
OUTPATIENT
$13,269
Coronary stent insertion
$8,364
$4,578
Fainting
$1,309
$4,572
Digestive disorders
$789
$3,797
Chest pain
$1,327
Source: OIG analysis of CMS data, 2016.
Figure 4: Average Beneficiary Payments for Short Inpatient Stays and Short Outpatient Stays for Most Common Reasons in FY 2014
INPATIENT
OUTPATIENT
$1,022
Coronary stent insertion
$1,667
$1,004
Fainting
$354
$984
Digestive disorders
$231
$981
Chest pain
$344
Source: OIG analysis of CMS data, 2016.

Medicare out of pocket costs: simple math . . .

- Observation:
  - APC = **$459**
    - $2,289 X 0.2
  - Self Adm Meds ~ $207
  - If both = **$664**
    - $459 + $207
- Inpatient:
  - **$1,340** deductible



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LETTERS TO EDITOR

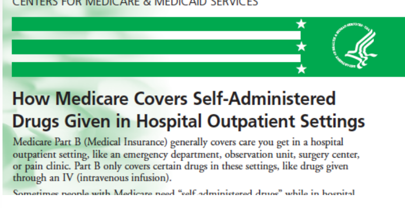
In Reference to "Patient Financial Responsibility for Observation Care" and "Observation Versus Inpatient Hospitalization: What do Medicare Beneficiaries Pay?"

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.

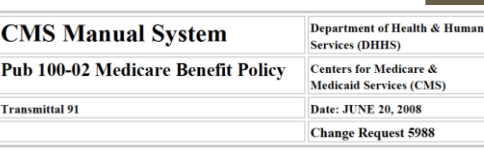
- The majority of Medicare beneficiaries use supplemental insurance to reduce their out-of-pocket burden:
  - Employer based plans
  - Medicaid
  - Federally regulated Medigap plans
- 1/3 of Medicare beneficiaries use Medicare Advantage plans that negotiate different re-imbursement structures for observation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

3. Self Administered 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

lian 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

DOI: 10.1377/hlthaff.2015.0054
HEALTH AFFAIRS 34,
NO. 8 (2015): 1324–1330
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The People-to-People Health Foundation, Inc.

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.

Regina C. Grebla is a researcher in the Center for Gerontology and Health Care Research at Brown University, in Providence, Rhode Island, and associate director of the Global Health Economics, Outcomes Research, and Epidemiology Division at Shire, in Lexington, Massachusetts.

Laura Keohane is a PhD candidate in the Department of Health Services, Policy, and Practice at the Brown University School of Public Health.

Yoojin Lee is a biostatistician in the Center for Gerontology and Health Care Research at Brown University.

Lewis A. Lipsitz is a professor of medicine at Harvard Medical School and director of the Institute for Aging Research at Hebrew SeniorLife, both in Boston, Massachusetts.

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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- MAC: https://www.cms.gov/Medicare/Medicare-Contracting/Medicare-Administrative-Contractors/MedicareAdministrativeContractors.html
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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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