EMORY UNIVERSITY SCHOOL OF MEDICINE | Department of Emergency Medicine

OBSERVATION SERVICES:

2020 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

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Objectives:

A. Understand the structure of the Center for Medicare and Medicaid Services (CMS) and how to access information

A. Know CMS policies that impact observation care - definition, C-APC 8011, 2-midnight rule, out of pocket costs, SNF benefit, and the MOON

B. Learn potential future CMS issues with observation services – physician involvement, growth, unpackaging

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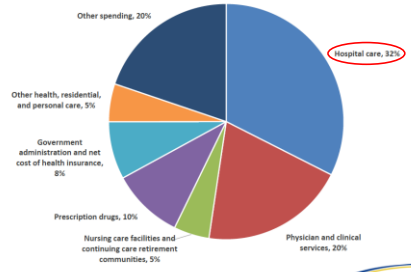
Background: U.S. Health System

The Nation's Health Dollar, Calendar Year 2016: Where It Went



NOTE: "Other spending" includes Dental services, Other professional services, Home health care, Durable medical equipment, Other nondurable medical products, Government public health activities, and Investment.

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

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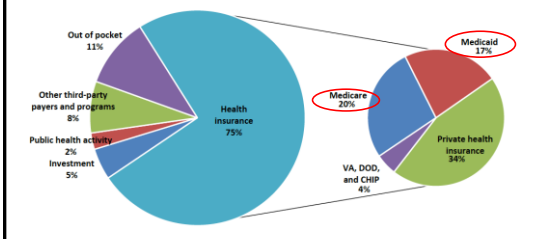
The Nation's Health Dollar, Calendar Year 2016: Where It Came From



NOTES: "Other third-party payers and programs" 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.

"Out of pocket" 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.

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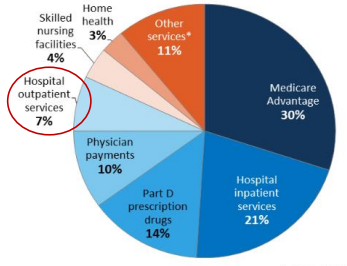
Figure 2

Medicare Benefit Payments by Type of Service, 2016



Total Medicare Benefit Payments, 2016: $675 billion

NOTE: *Consists of Medicare benefit spending on hospice, durable medical equipment, Part B drugs, outpatient dialysis, outpatient therapy, ambulance, lab, community mental health center, rural health clinic, federally qualified health center, and other Part B services.
SOURCE: Congressional Budget Office, June 2017 Medicare Baseline.

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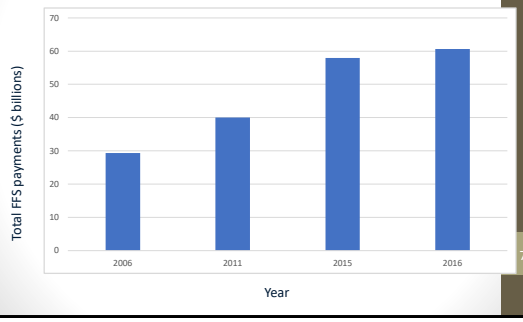
Growth in Medicare HOPD Spending



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Specific Services with Highest Share of HOPD Volume (Medicare FFS)

Service	Share of payments	Volume (thousands)	Payment rate	Total payments (billions)
Total	51%	-	-	-
All emergency visits	7	13,674	$300	$4.1
Clinic visits	6	30,842	102	$3.1
Comprehensive observation services	6	1,474	2,174	$3.2
Level 2 endovascular procedures	3	203	9,542	$1.9
Level 2 ICD and similar procedures	3	47	30,490	$1.4
Diagnostic cardiac catheterization	2	407	2,549	$1.0
Level 2 lower gastrointestinal procedures	2	1,400	753	$1.0
Level 1 intraocular procedures	2	518	1,746	$0.90
Level 3 electrophysiologic procedures	2	57	15,561	$0.89
Level 3 radiation therapy	2	1,668	506	$0.84
Level 3 nuclear medicine and related services	1	731	1,108	$0.81
Level 3 pacemaker and similar procedures	1	87	9,273	$0.81
Level 3 musculoskeletal procedures	1	184	4,962	$0.91
Level 3 ultrasound and related services	1	1,721	417	$0.72
Level 1 laparoscopy	1	191	4,001	$0.77

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Observation word salad:

1. DHHS
2. CMS
3. DRG
4. F.I.
5. MAC
6. OIG
7. RAC
8. IOM

1. HOP
2. OPPS
3. APC
4. T-status indicator
5. MOON
6. SNF
7. SAM
8. HRRP

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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. . .

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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

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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.

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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

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Medicare Contractors

- **Medicare Administrative Contractors** - A **Medicare** Administrative Contractor (**MAC**) is a private health care insurer that has been awarded a geographic area or "jurisdiction" to regionally manage the policies and medical claims for **Medicare** Part A and Part B (A/B) Fee-For-Service (FFS) beneficiaries.
  - Georgia = Palmetto

- QIO - A **Quality Improvement Organization** (**QIO**) is a group of health quality experts, clinicians, and consumers organized to improve the care delivered to people with **Medicare**.
  - Georgia = "Kepro"

- **The Recovery Audit Contractor**, (**RAC**), program was created through the Medicare Modernization Act of 2003 (MMA) to identify and recover improper Medicare payments paid to healthcare providers under fee-for-service (FFS) Medicare plans.

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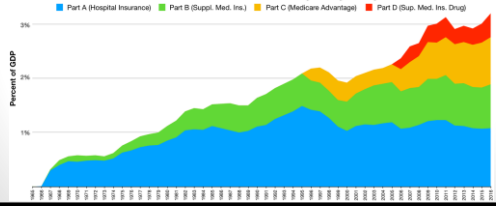
Medicare

Medicare Parts

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

Medicare Parts A, B, C, & D



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Medicare Outpatient (OPPS) Rulemaking process:

- **July**: Proposed Rule (Federal Register)
  - **2020** – 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

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How to find CMS policies:

- Search: "CMS Internet Only Manuals":
- Home > Regulations and Guidance > Manuals > Internet-Only Manuals (IOMs) Items >
- https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs.html
  - 100-02 Medicare Benefits Policy Manual
    - Chapter 6 Hospital Services Covered Under Part B
      - https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c06.pdf
  - 100-04 Medicare Claims Processing Manual
    - Chapter 4 – Part B Hospital
      - https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c04.pdf
    - Chapter 12 – Physician/Nonphysician Practitioners
      - https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c12.pdf

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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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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)

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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

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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/

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Observation Services – CMS history

- 1965 – earliest description of EDOUs
- 1980 – DRGs (IPPS) begin
- 1983 – CMS observation services begin - poorly defined
- 2000 – APCs (OPPS) begins. Observation dropped (packaged)
  - ***Shift to inpatient***
- 2002 – Observation APC created (3 dx, with stipulations)
- 2005 - Observation APC modified - stipulations lifted
- 2008 - Observation APC modified – all conditions covered
- 2008 – RAC roll out, targeting short inpatient stays
  - ***Shift to observation***
- 2013 – "Two midnight rule" launched – to reduce RAC audits
- 2016 – NOTICE ACT / MOON
- 2016 – Comprehensive APC (8011) – Observation

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DEFINITION: OBSERVATION - 2018

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

Table of Contents
(Rev. 3942, 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***.

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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
- 2020 APC 8011 Payment Amount = **$2,226**
  - Includes all other services (stress test, MRI, etc)
  - It does **NOT** include two things:
    1. **SNF inpatient time**
    2. **Self administered meds**

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Parts 405, 410, 412, 416, 419, and 486

Office of the Secretary

45 CFR Part 180

[CMS–1717–P]

RIN 0938–AT74

Medicare Program: Proposed Changes to Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs; Price Transparency of Hospital Standard Charges; Proposed Revisions of Organ Procurement Organizations Conditions of Coverage; Proposed Prior Authorization Process and Requirements for Certain Covered Outpatient Department Services; Potential Changes to the Laboratory Date of Service Policy; Proposed Changes to Grandfathered Children's Hospitals-Within-Hospitals

AGENCY: Centers for Medicare & Medicaid Services (CMS), HHS.
ACTION: Proposed rule.

39512 Federal Register / Vol. 84, No. 154 / Friday, August 9, 2019 / Proposed Rules

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

"**For CY 2020, we are proposing to continue with our current clinic and emergency department (ED) hospital outpatient visits payment policies**. . ."

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Observation and CMS policy Issues

1. NOTICE ACT and the MOON
2. Hospital readmissions and observation
3. Patient out of pocket costs
4. Self Administered Meds
5. Skilled Nursing Facility benefits

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

- ***UPDATE*** **--- Open comment period until September 27, 2019:**
  https://www.govinfo.gov/content/pkg/FR-2019-08-28/pdf/2019-18580.pdf
- Not just a policy, a **LAW (statute)** - 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

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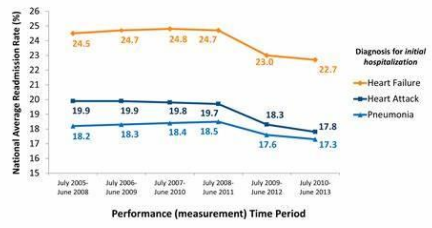
2. Why are readmissions falling?

Figure 2

National Medicare Readmission Rates Started to Fall in 2012



NOTES: National readmission rates include Medicare fee-for-service unplanned hospitalizations for any cause within 30 days of discharge from an initial hospitalization for either heart failure, heart attack, or pneumonia. Rates are risk-adjusted for certain patient characteristics, such as age and other medical conditions.
SOURCE: Kaiser Family Foundation analysis of CMS Hospital Compare data files.

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2. Are observation services "hiding" inpatient re-admissions???

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

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%

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

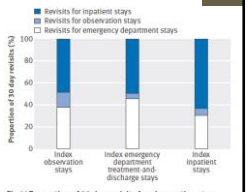

Fig 1 | Proportion of 30 day revisits for observation stays, emergency department stays, and inpatient stays after discharge from index observation stays, index emergency department stays, and index inpatient stays. Proportions represent average values over study period, 2006-11

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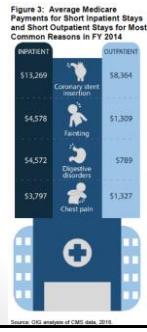
3. Do observation stays cost more?

Medicare – NO!

Patients – NO

[exception – PROCEDURES]



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Medicare out of pocket costs: simple math . . .

- Observation:
  - APC = ***$444***
    - $2,222 X 0.2
  - Self Adm Meds ~ $207
  - If both = ***$651***
    - $444 + $207
- Inpatient:
  - ***$1,364*** deductible

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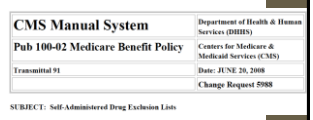
4. Self Administered Medications (SAMs)



- 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

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5. 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.

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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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