2023 CMS Updates: Observation Policy, the Law, and More

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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

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Objectives:

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

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

C. Understand future directions that CMS is going with observation services

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A. Background. . .

- **What is "Gross Domestic Product"?**
  - "The total value of goods produced and services provided in a country during one year."

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CMS National Health Expenditure Data Fact Sheet, 2020

https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NHE-Fact-Sheet

- **NHE grew 9.7% to $4.1 trillion in 2020, or $12,530 per person, and accounted for 19.7% of Gross Domestic Product (GDP).**
  - Medicare spending grew 3.5% to $829.5 billion in 2020, or 20 percent of total NHE.
  - Medicaid spending grew 9.2% to $671.2 billion in 2020, or 16 percent of total NHE.
  - Private health insurance spending declined 1.2% to $1,151.4 billion in 2020, or 28 percent of total NHE.
  - Out of pocket spending declined 3.7% to $388.6 billion in 2020, or 9 percent of total NHE.
- **Federal government spending for health care grew 36.0% in 2020, significantly faster than the 5.9% growth in 2019. This faster growth was largely in response to the COVID-19 pandemic.**
  - Hospital expenditures grew 6.4% to $1,270.1 billion in 2020, slightly faster than the 6.3% growth in 2019.
  - Physician and clinical services expenditures grew 5.4% to $809.5 billion in 2020, faster growth than the 4.2% in 2019.
  - Prescription drug spending increased 3.0% to $348.4 billion in 2020, slower than the 4.3% growth in 2019.
- **The largest shares of total health spending were sponsored by the federal government (36.3 percent)** and the households (26.1 percent). The private business share of health spending accounted for 16.7 percent of total health care spending, state and local governments accounted for 14.3 percent, and other private revenues accounted for 6.5 percent.

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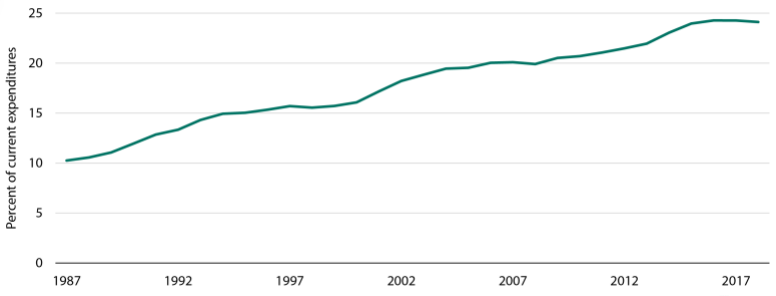
Health care represents

FIGURE C.

Public Health-Care Expenditures as a Share of Government Spending, 1987–2018



Source: CMS 1987–2018, Bureau of Economic Analysis 1987–2018; authors' calculations.
Note: Public spending is government current expenditures at the federal, state, and local levels. Public health-care expenditures are for federal, state, and local levels.

THE HAMILTON PROJECT BROOKINGS

- health care has doubled as a share of total government expenditures in the last three decades, from 11.9 percent in 1990 to 24.1 percent in 2018

https://www.brookings.edu/research/a-dozen-facts-about-the-economics-of-the-u-s-health-care-system/

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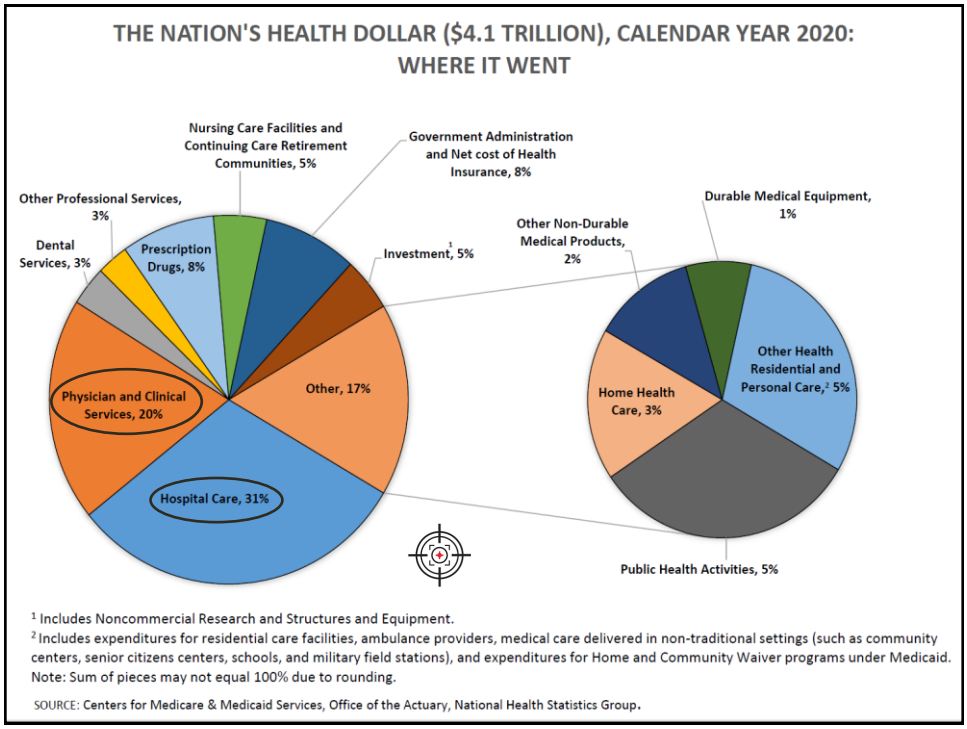
THE NATION'S HEALTH DOLLAR ($4.1 TRILLION), CALENDAR YEAR 2020:
WHERE IT WENT
Nursing Care Facilities and Continuing Care Retirement Communities, 5%
Government Administration and Net cost of Health Insurance, 8%
Other Professional Services, 3%
Dental Services, 3%
Prescription Drugs, 8%
Investment,[1] 5%
Other, 17%
Physician and Clinical Services, 20%
Hospital Care, 31%
Durable Medical Equipment, 1%
Other Non-Durable Medical Products, 2%
Other Health Residential and Personal Care,[2] 5%
Home Health Care, 3%
Public Health Activities, 5%
[1] Includes Noncommercial Research and Structures and Equipment.
[2] Includes expenditures for residential care facilities, ambulance providers, medical care delivered in non-traditional settings (such as community centers, senior citizens centers, schools, and military field stations), and expenditures for Home and Community Waiver programs under Medicaid.
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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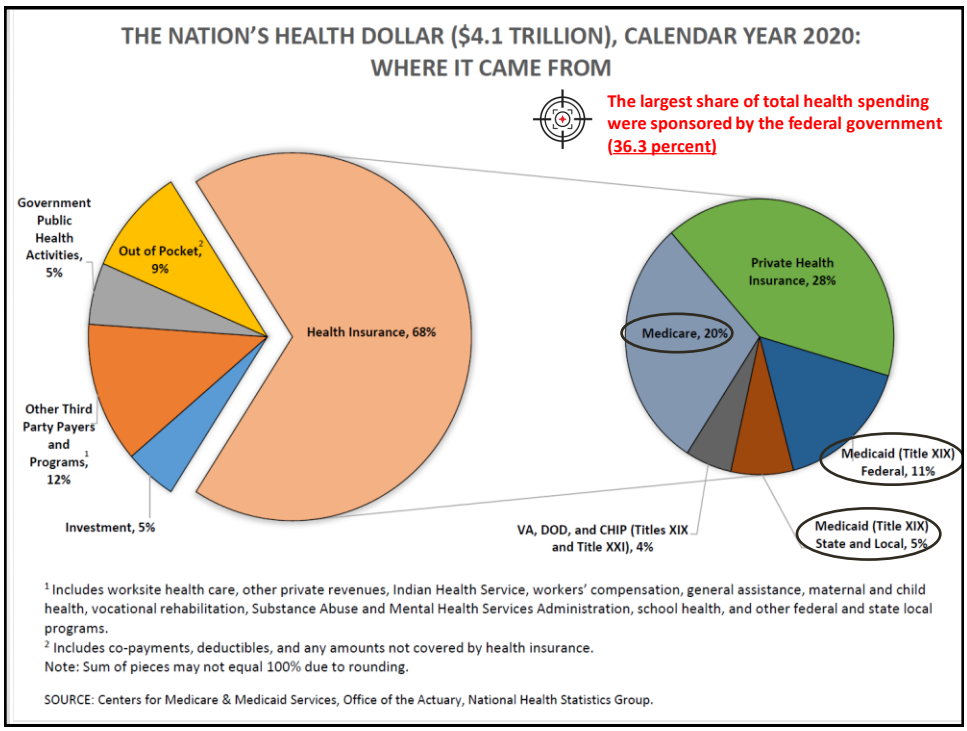
THE NATION'S HEALTH DOLLAR ($4.1 TRILLION), CALENDAR YEAR 2020:
WHERE IT CAME FROM
The largest share of total health spending were sponsored by the federal government (36.3 percent)
Government Public Health Activities, 5%
Out of Pocket,[2] 9%
Health Insurance, 68%
Other Third Party Payers and Programs,[1] 12%
Investment, 5%
Private Health Insurance, 28%
Medicare, 20%
Medicaid (Title XIX) Federal, 11%
Medicaid (Title XIX) State and Local, 5%
VA, DOD, and CHIP (Titles XIX and Title XXI), 4%
[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.

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First: Governmental Observation acronym 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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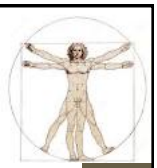
The Anatomy and Physiology of Medicare (or CMS) . . .



- 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:

Xavier Becerra
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)

Chiquita Brooks-LaSure
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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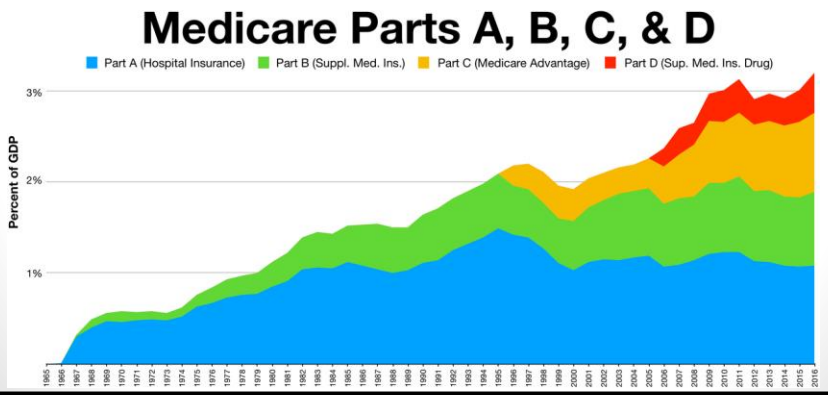
Medicare

Medicare Parts

- **Part A:** Hospital Insurance - 1966
- **Part B:** Medical Insurance - 1966
- Part C: Medicare Advantage plans ("Medicare HMO") - 1995
- Part D: Prescription drug plans - 2005



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Medicare Outpatient (OPPS) Rulemaking process:

- **July**: Proposed Rule (Federal Register)
  - **2023** – 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
  - Monthly premium rate of $274 and up.
- Part A — For each **benefit period**, a beneficiary will pay:
  - A **Part A deductible of $1,556 (in 2022) for a hospital stay of 1–60 days**.
    - A $389 per day co-pay (in 2020) for days 61–90 of a hospital stay.
    - A $778 per "lifetime reserve day" co-insurance payment for days 91- 150
  - **Benefit period – 60 days following the conclusion of inpatient or SNF care.**
    - **Reset if inpatient readmission occurs.**
  - **Skilled Nursing Facility Stay -** in 2020:
    - $0 for the first 20 days of each benefit period
    - $195 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
- https://www.cms.gov/newsroom/fact-sheets/2022-medicare-parts-b-premiums-and-deductibles2022-medicare-part-d-income-related-monthly-adjustment

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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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COVID, CMS, and SNFs . . .

SNF: Temporarily waived the requirement for 3-day prior hospitalization for coverage of nursing home stays, extended training requirement deadlines, and allowed facilities to transfer or discharge residents in order to group residents based on their COVID-19 status.

- https://www.cms.gov/files/document/covid-accomplishments.pdf

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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)

https://www.cms.gov/newsroom/fact-sheets/fact-sheet-two-midnight-rule-0

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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**

- 2022 "covered" services –
  - Begins after a 2022 yearly deductible of **$233**
    - Monthly premium (income adjusted) of $170 and up
  - **Then** Medicare pays 80% of approved services
    - Patients pays a 20% **co-insurance**

    https://www.medicare.gov/Pubs/pdf/11579-Medicare-Costs.pdf
- 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.cms.gov/newsroom/fact-sheets/2022-medicare-parts-b-premiums-and-deductibles2022-medicare-part-d-income-related-monthly-adjustment

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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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Parts 405, 410, 411, 412, 413, 416, 419, and 424

[CMS–1772–P]

RIN 0938–AU82

Medicare Program: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs; Organ Acquisition; Rural Emergency Hospitals: Payment Policies, Conditions of Participation, Provider Enrollment, Physician Self-Referral; New Service Category for Hospital Outpatient Department Prior Authorization Process; Overall Hospital Quality Star Rating

AGENCY: Centers for Medicare & Medicaid Services (CMS), Department of Health and Human Services (HHS).

ACTION: Proposed rule.

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

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

*"For CY 2023, we propose to **continue** with our current clinic and emergency department (ED) **hospital outpatient visits payment policies**. For a description of these policies, we refer readers to the CY 2016 OPPS/ASC final rule with comment period (80 FR 70448)."*

No changes!!!

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B. CMS policies that impact observation care

3 Ways that CMS **Discourages** Prolonged Observation Stays:
(which **Encourages** ED Observation Units)

1. The definition of Observation Services
2. Comprehensive APC 8011
3. The "Notice Act"

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1. DEFINITION: OBSERVATION - 2022

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

Table of Contents
(Rev. 11426, 05-20-22)
(Rev. 11457, 06-15-22)

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 commonly ordered for patients who present to the **emergency department**. . .

... 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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2. Comprehensive **APC 8011** (effective 2016): "*Comprehensive Observation Services*"

- Current Hospital Payment Requirements:
  1. **Physician order** and documentation supporting the need for observation
  2. **Preceding (packaged, day before or day of) 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
  5. Contains NEW Status Indicator "J2" for C-APC (not "J1").

https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R215BP.pdf

2022 APC 8011 Payment Amount = **$2,331**

- Includes all other services (stress test, MRI, etc)
- It does **NOT** include two things:
  1. **SNF inpatient time – temporarily waived**
  2. **Self administered meds**

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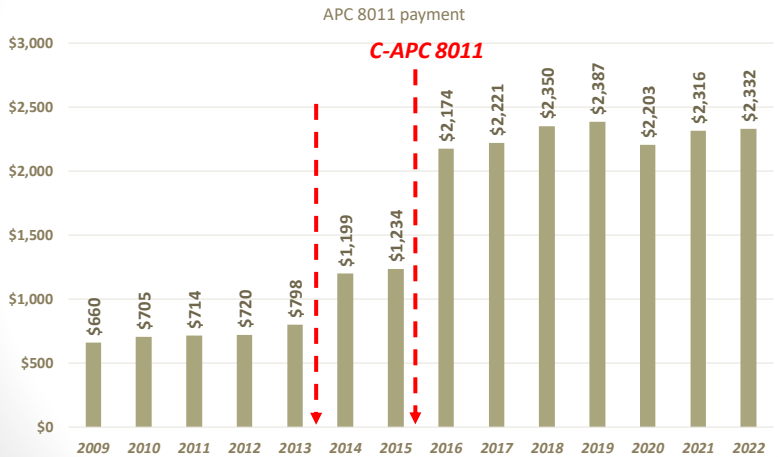
CMS OBSERVATION PAYMENT HISTORY:



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3. 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

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4 CMS Observation Issues:

1. Is observation hiding readmissions?
2. Does observation cost patients more – "out of pocket"?
3. Does observation jeopardize nursing home coverage?
4. Do "Self Administered Meds" create hidden patient costs?

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1. Is Observation "hiding" re-admissions? . . .

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%

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

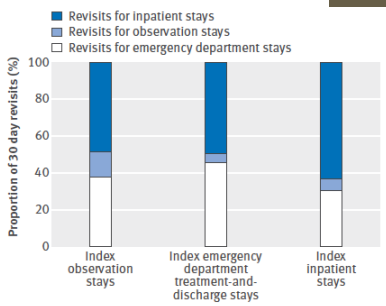

Fig 1 | Proportion of 30 day revisits for observation stays, emergency department stays, and inpatient stays after discharge from index observation stays, index emergency department stays, and index inpatient stays. Proportions represent average values over study period, 2006-11

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1. Is Observation "hiding" re-admissions? . . .

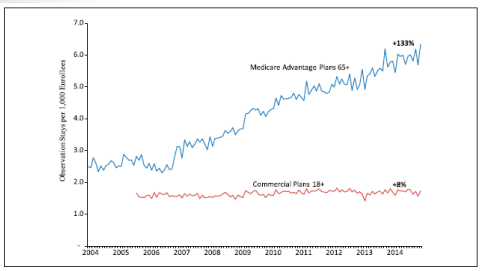

Figure 1. Monthly observation rate among Medicare Advantage (MA) plan enrollees (2004-2014) and commercial plan enrollees (August 2005-December 2014).

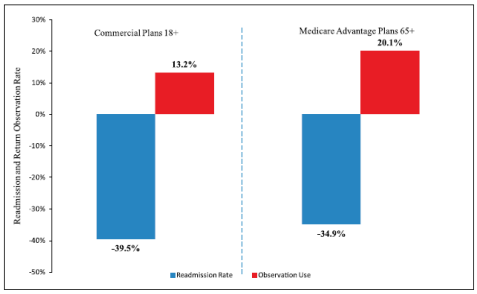

Figure 5. Changes in readmission and return observation rates within 30 days of discharge for private plan enrollees at the top 33% of hospitals with the largest drop in readmissions (2009-2014).

Data and Trends

Increasing Trends in the Use of Hospital Observation Services for Older Medicare Advantage and Privately Insured Patients

Medical Care Research and Review 2019, Vol. 76(2) 229–239

DOI: 10.1177/1077558717718026
journals.sagepub.com/home/mcr
SAGE

- From 2004-2014, elderly Medicare Advantage (part C)
  - Obs stays increased 133%
  - 30-day visits:
    - Readmissions decreased 35%
    - Obs stays increased 20%

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2. DO OBSERVATION STAYS COST MEDICARE PATIENTS MORE? - NO!

OIG study: Patients – NO
[exception – PROCEDURES]

- OIG study: observation costs patients less than inpatient stays 94% of the time (likely even better since the study)

Simple math: $1,556 vs $466

- **Inpatient admission:**
  - **$1,556 deductible**
- **Observation (outpatient) copayment:**
  - **20% of comprehensive APC:**
    - **$466 = 0.2 X $2,331**

- Only cost **not** included in APC
  - Self administered Meds= $207
    - If applicable = $652 = $207 + $445 = less than half
  - Nursing home benefit: observation time not included in the qualifying 3-day inpatient stay.
    - How often is this an issue? **= 0.7% of observation cases**
    - Best way to avoid – short observation stay before inpatient admissions = a type 1 setting.

Figure 4: Average Beneficiary Payments for Short Inpatient Stays and Short Outpatient Stays for Most Common Reasons in FY 2014

Source: OIG analysis of CMS data, 2016.

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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

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C. CMS and the Future of Observation Medicine

- COVID, Telemedicine and Observation Medicine
- Hospital at Home
- Rural Emergency Hospitals

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COVID and CMS response. . .

Broad categories of responses:

1. Health Disparities
2. Vulnerable Populations
3. Setting specific guidance (nursing homes, etc)
4. Telehealth
5. Mental and Behavioral Health
6. Additional resources

https://www.cms.gov/About-CMS/Agency-Information/OMH/resource-center/COVID-19-Resources/COVID-19-Resources-For-Health-Care-Professionals

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#4. COVID: Endorsement of telehealth for patient care:

- **CMS:** During the COVID-19 Public Health Emergency, the federal government is encouraging health care providers to adopt and use telehealth to see patients in appropriate situations.
  - https://www.telehealth.hhs.gov/providers/getting-started/
- **CDC:** Telehealth services help provide necessary care to patients while minimizing the transmission risk of SARS-CoV-2, the virus that causes COVID-19, to healthcare personnel (HCP) and patients.
  - https://www.cdc.gov/coronavirus/2019-ncov/hcp/telehealth.html?deliveryName=USCDC_2067-DM30432

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COVID and CMS . . .

- Jan 31st – Sec Azar declares COVID a **public health emergency**
  - https://www.phe.gov/emergency/news/healthactions/phe/Pages/2019-nCoV.aspx
- Sec of HHS issues **1135 waver**, then under 1135 authority issues a "**blanket waiver**" to cover the country for federal plans:
  - https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertEmergPrep/Downloads/1135-Waivers-At-A-Glance.pdf
- Under the **CARES Act**, CMS is waiving the requirements of section 1834(m)(1) of the ACT and 42 CFR § 410.78(a)(3) for use of interactive telecommunications systems to furnish telehealth services, to the extent they require use of video technology, for certain services. Emergency and Observation services are covered: https://www.cms.gov/files/document/covid-19-physicians-and-practitioners.pdf

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TeleCDU…

- **Is the APP granted authority to see the patient without the physician being physically or personally present?**

From: EDRIC STEPHENS [mailto:EDRIC.STEPHENS@palmettogba.com]
Sent: Tuesday, August 27, 2019 3:00 PM
To: Ross, Michael <MAROSS@emory.edu>
Subject: RE: [External] RE: MAC Question regarding billing observation services, APPs, and telemedicine

Good Afternoon Dr. Ross,

Our Provider Outreach and Education area stated the codes you are referring to are not covered telehealth services for 2019. They gave the link below of the covered services for telehealth. **For your second question, the APPs can see the patients, without the physician being in the room, as long as the APPs will be billing under their NPI. If the physician will be billing under his/her NPI, they will have to see the patients personally. I hope this answers your questions. If not, please let me know. Thanks.**

Edric Stephens
Manager, JM PCSP
http://www.palmettogba.com/JM
http://www.palmettogba.com/disclaimer

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Observation Medicine and CMS Future Directions:
1. Acute Hospital Care at Home

CMS Hospital at Home program

- https://qualitynet.cms.gov/acute-hospital-care-at-home
- https://qualitynet.cms.gov/acute-hospital-care-at-home/resources#tab2

- **5. Do you plan to expand this program to patients who meet *observation* criteria?**
  - *This waiver is intended to extend flexibility to patients who meet inpatient admission criteria, although it does not preclude treatment of observation status patients to the extent allowed by prior Public Health Emergency waivers*.

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AHCAH requirements

- Can your hospital provide acute care services at home? You are required to provide or contract for the following services:
  1. Pharmacy
  2. Infusion
  3. Respiratory care including oxygen delivery
  4. Diagnostics (labs, radiology)
  5. Monitoring with at least 2 sets of patient vitals daily
  6. Transportation
  7. Food services including meal availability as needed by the patient
  8. Durable Medical Equipment
  9. Physical, Occupational, and Speech Therapy
  10. Social work and care coordination

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Hospital at home

To be eligible for this waiver, a hospital must guarantee that each patient is admitted to Acute Hospital Care at Home ***from an Emergency Room*** or Inpatient Hospital, and that an admitting MD/APP performing a History and Physical Exam sees each patient in-person initially.

After this first in-person visit, an ***MD or Advanced Practice Provider*** must visit and examine each patient ***at least daily – this can be done remotely if appropriate*** based on the provider's evaluation of the patient's condition and course.

Explain how you ensure each patient can be remotely connected to a hospital team member immediately at all times.

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Observation Medicine and CMS Future Directions: 2. Rural Emergency Hospitals

Over the last decade, over 130 rural hospitals stopped providing inpatient services.

- . . . implementation of this new provider type under Medicare.
- . . . allow critical access hospitals (CAHs) and small rural hospitals (those with less than 50beds) to convert to Rural Emergency Hospitals (REHs) starting on January 1, 2023.
- CMS defines an REH "as an entity that operates for the purpose of providing emergency department services, ***observation care***, and other outpatient medical and health services in which ***the annual per patient average length of stay does not exceed 24 hours***.

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CMS REH proposed requirements:

1. Governing Body and Organizational Structure
2. Provision of Services
3. Emergency Services
4. Laboratory Services
5. Radiological Services
6. Pharmaceutical Services
7. Additional Outpatient Medical and Health Services
8. Infection Prevention and Control and Antibiotic Stewardship Programs
9. Staffing and Staff Responsibilities
10. Nursing Services
11. Discharge Planning
12. Patient's Rights
13. Quality Assessment and Performance Improvement Program
14. Agreements
15. Medical Records
16. Emergency Preparedness
17. Physical Environment
18. Skilled Nursing Facility (SNF) Distinct Part Unit

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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.
- Medicare likes "good" observation services and does not like prolonged observation services
- COVID and telemedicine are likely to continue to change CMS policies, including observation services.

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