

## CLINICAL UPDATE: PART II

# UNDER A HOSPITAL'S MOON: A TALE OF OBSERVATION CARE

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**A**s a hospitalist, I have dealt with inpatient and observation care issues for many years. Because hospitalists' patients are outpatient generalists' patients, these issues encompass the spectrum of patients cared for by SGIM members. Using two short clinical scenarios, I will highlight the daily concerns that hospitalists and their patients face; from financial burden, patient-physician relationship strain, readmission, to the safe recommendation of post-acute services.

Mr. DES and Mr. BMS are 68-year-old twin brothers. They have no significant past medical history—they exercise regularly and report remote nicotine use (1 pack per day x 15 years). They presented to the ED for Chest Pain and were admitted for further work up. Work up for both included a left-heart catheterization that revealed a 90% LAD obstruction, and each received a stent. They were discharged within 48 hours. Mr. DES, however, was admitted under INPATIENT STATUS, yet Mr. BMS was admitted under OBSERVATION CARE, paying \$817 out of pocket more than his sibling.

In brief, according to Centers for Medicare & Medicaid Services (CMS), observation care is a subset of outpatient services status, and is defined as the following:

“A well-defined set of specific, clinically appropriate services, which include treatment, assessment, and reassessment before a decision can be made regarding whether patients will require further treatment as hospital inpatients or if they are able to be discharged from the hospital ... and in the majority of cases the decision ... can be made in less than 48 hours, usually in less than 24 hours. In only rare and exceptional cases do outpatient observation services span more than 48 hours.”<sup>1</sup>

For those needing a quick review of how Medicare is structured, we can summarize it as four parts. Medicare Part A covers inpatient services and usually has a fixed annual deductible. Part B covers outpatient services, and usually carries a deductible and 80/20 cost sharing per service (80% CMS, 20% beneficiary); it does not cover pharmaceutical drugs and has no Skilled Nursing

Facilities benefits. Part C, or Advantage, refers to supplemental insurance plans and varies between different private insurers. Part D, or Medicare prescription drug benefit, is also considered supplemental insurance and subsidizes the cost of prescription medications and prescription drug insurance premiums for Medicare beneficiaries. Observation care is a subset of Outpatient status, hence covered by Medicare Part B; conversely leading to a highly variable financial liability to the beneficiary, particularly depending on services provided during hospitalization. The financial burden for the patient will vary based on plan and whatever supplemental insurance the patient may have; however, using the 80/20 example above a patient may receive a bill for 20% of all hospitalization cost plus 100% of medications.

Therefore, when a patient presenting to a hospital or clinic needs to be admitted, the provider decides if this should be as Inpatient (Medicare Part A) or Outpatient/Observation care (Medicare Part B). Nevertheless, in most hospitals the determination is made not by the provider, as stipulated in CMS guidelines, but by a review group including utilization management, social work, physician advisor, etc. In some cases up to 35% of instances, determination will mismatch a provider's clinical prediction. Several medical necessity screening tools (i.e., Milliman Care Guidelines<sup>R</sup> [MCG]) are available for CMS and its contractors, who occasionally use a tool that may not coincide with the one used by the admitting facility. Most tools include a combination of intensity and severity of illness as well as medical necessity documentation. Different jurisdictions, even within one hospital, may use different tools.

Based on a Medicare Payment Advisory Commission (MedPAC) report, outpatient services have increased by 47.4% in a 10 year-period (2006-2015) and inpatient discharges have decreased by 19.5% in the same time period. In 2013, in an effort to decrease prolonged outpatient hospital stays, CMS finalized the “2-midnights” rule, which was to be fully imposed by audits, and enforced by CMS, as of October 2015. This rule proposed that

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patients, expected to require at least 2 midnights (each Diagnosis Related Group [DRG] has a known mean Length Of Stay [LOS]) of medically necessary care while in the hospital, be classified as inpatient; while those below that timeline be categorized as observation. This rule however failed to achieve the goal of reducing prolonged observation stays. This failure may be in part due to the audit and recovery process, which is outsourced by CMS to external contractors. The Medicare's Recovery Audit Contractors (RACs) are in charge of auditing and enforcing suitability of payment. The RAC's payment incentives are based on amount of money recovered to CMS, in many opportunities by declining inpatient status claims and denying reimbursement for services provided. Recently CMS has replaced RACs by Quality Improvement Organizations (QIO), as of today; there is no available data to assess the outcome of this change.

In August 2015, the Notification of Observation Treatment and Implication for Care Eligibility Act (NOTICE Act, PL 114-42) was signed into law by President Obama; and was implemented, after bipartisan and bicameral support, in March 2017. The law requires that hospitals inform patients hospitalized under Observation Care, for 24 or more hours, about their status and the financial implications. Hospitals must obtain a signature from the patient on the Medicare Outpatient Observation Notice (MOON) form within 36 hours of applicable hospitalization. After recent media attention, families and beneficiaries have begun to contest their status; which is understandable, particularly because physicians make no obvious distinction, based on status, when they provide medical care. These situations are an added emotional load to patients during an already stressful situation and damage physician-patient relationship and trust.

Mrs. SNF and Mrs. LTC are

93-year-old twin sisters. They have been living independently for the last 25 years. Their family is worried about their ability to perform their activities but want to respect their autonomy. They have been seen in the ED on multiple occasions for falls and were admitted for failure to thrive. They underwent a complete work up which was non-contributory. During their three-day (midnights) hospital stay, Physical and Occupational Therapy recommended discharge to a Skilled Nursing facility (SNF). Mrs. SNF had been admitted under INPATIENT STATUS and was discharged to the SNF of her and her family's choice. All her SNF costs were covered by Medicare. Mrs. LTC on the other hand had been admitted under OBSERVATION CARE, which resulted in her facility costs not being covered under Medicare.

This is yet another downside of Observation status. At least three days of an acute inpatient stay are necessary, under Medicare rules, for a beneficiary to qualify for post-acute services such as a SNF. Outpatient stays do not count towards the three-days rule, henceforth placing the patients at risk for high out-of-pocket payments, and/or the choice to opt out of those necessary services placing them at risk for injuries and readmissions. In 2015, MedPAC recommended that CMS revise the 3-day rule for SNF placement and count "any" hospital day (inpatient or observation) towards the "3-days" requirement. Currently, this rule adds significant barriers for patients to access essential post-acute care. The Improving Access to Medicare Coverage Act of 2017 (S. 568/H.R. 1421), also known as the Courtney-Thompson Bill, is a bipartisan, bicameral bill introduced to Congress in an attempt to provide a permanent solution to the "three-days" issue. This bill states that beneficiaries who spend three days in the hospital, re-

gardless of the inpatient/observation classification, would be eligible for Medicare SNF benefits.

Many patient advocacy groups are actively working on the Improving Access to Medicare Coverage Act<sup>2,3</sup>, and other professional societies<sup>4</sup> have made Observation as their main advocacy imperative. I invite you to review the Society of Hospital Medicine White paper on Observation Stays<sup>4</sup> to further your understanding of the topic. The media<sup>5</sup> have been interested in the topic as well. Observation care can affect many of our elder relatives and the most fragile General Internal Medicine patients, and it is our duty to advocate for them.

In summary, observation stays for hospitalized patients:

- **Originally instituted as a means to decrease number of unnecessary admissions**
- **Count as Outpatient status, hence covered by Medicare Part B**
- **Do not count towards "readmissions" and therefore there are an incentive for hospitals to improve quality performance scores**
- **Carry a highly variable financial liability to the beneficiary and/or hospitals. Some beneficiaries are unable to cover the cost of their observation bills leaving the hospital responsible.**
- **Currently under the "two-midnights" rule**
- **Require an extra administrative burden related to Utilization Management determination of "admission status", and collection of signature on MOON form**
- **Use many severity tools for status determination, leading to inconsistency about how CMS rules are implemented and audited by QIOs (former RACs)**
- **Application of NOTICE and MOON form add emotional burden and stress to patients and families and may damage**

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**physician-patient relationships and trust**

- **Three-day inpatient stays (not observation days) are required to qualify for Medicare SNF coverage**
- **93% of hospitalists rated observation policy as a critical advocacy issue for them and their patients**

**References**

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