Recent Growth in Hospital Observation Care

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Presentation overview

- Background
- Extent of observation care growth
- Causes of observation care growth
- Impact on Medicare beneficiaries
Background: Definition of observation care

- Ongoing short-term treatment and assessment furnished while a decision is being made about whether or not to admit as an inpatient or discharge.

- Outpatient service

- Observation-specific clinical units becoming more common
Background: Criteria for observation and inpatient care

<table>
<thead>
<tr>
<th>Observation criteria</th>
<th>Inpatient admission criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1) General guidance:</strong></td>
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<tr>
<td>- Reasonable &amp; necessary</td>
<td>- Physicians should also consider predictability of adverse outcomes, severity, hospital</td>
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<td>- 8 or more hours of service</td>
<td>resources, and other factors.</td>
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<td>- Medical record must contain: physician order,</td>
<td><strong>2) Timing:</strong> admit patients expected to need hospital care for 24 hours or more</td>
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<td>written request for observation, and timeframe</td>
<td></td>
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<tr>
<td><strong>2) Timing:</strong> not rigidly specified</td>
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Background: Economics of observation

- Outpatient (OP) composite rate bundles emergency department or clinic visit.
- OP observation rate lower than equivalent inpatient (IP) rate (chest pain: $720 in observation vs. $7,600 as an IP)
- Reported financial benefits of observation: maximizes IP unit capacity, reduces unreimbursed admissions, and reduces staffing costs.
- Beneficiary liability differs under observation
  - Co-insurance vs. deductible: 20 percent observation co-insurance plus 20-40 percent co-insurance for other services versus ~$1,000 inpatient deductible
  - Time in observation not counted in SNF 3-day prior hospitalization policy, creates beneficiary liability
Nationally Medicare observation care increased from 2006 to 2008

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<tr>
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<tbody>
<tr>
<td>Claims</td>
<td>911,500</td>
<td>1,116,000</td>
<td>22.4%</td>
</tr>
<tr>
<td>Claims (per 1,000 FFS Part B beneficiary)</td>
<td>28</td>
<td>36</td>
<td>26.2</td>
</tr>
<tr>
<td>Hours</td>
<td>23,327,000</td>
<td>31,014,000</td>
<td>33.0</td>
</tr>
<tr>
<td>Hours (per 1,000 FFS Part B beneficiary)</td>
<td>729</td>
<td>999</td>
<td>37.1</td>
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</tbody>
</table>

Source: Medicare outpatient claims
Nationally, longest observation claims increased rapidly from 2006 to 2008

- Average length increased from 26 to 28 hours
- Claims 48 hours or longer increased over 70 percent
- Claims 48 hours or longer accounted for 8 percent of all claims in 2006 and 12 percent of all claims in 2008

Source: Medicare outpatient claims
Cardiac conditions most common for observation claims (2008)

- Chest pain accounted for 21 percent of claims
- 7 of 15 most common observation conditions are cardiac-related, accounting for 39 percent of claims
- 14 of 15 most common conditions in 2008 were also the most common conditions in 2006.
- Fastest growing conditions overall were: “unclassified condition”, “syncope”, and “vertigo”
- Fastest growing conditions for the longest claims were non-cardiac pain related conditions
Medicare Recovery Audit Contractor (RAC) program

- Contracted auditors retrospectively identify past over or underpayments for any provider participating in the Medicare FFS program.
- Medicare RAC demonstration (March 2005 to April 2008)
  - California, Florida, and New York included throughout
  - Arizona, Massachusetts, and South Carolina included from July 2007 to April 2008
  - $980 million (96 percent) in overpayments and $38 million (4 percent) in underpayments from FFS providers
  - $830 million in overpayments (85 percent) from inpatient hospitals
Lower level of observation care claims at hospitals in RAC states, 2006 to 2008

Source: Medicare outpatient claims
Nationwide trend: Claims of 48 hours or more grew faster than other claims in both RAC states and non-RAC states, 2006 to 2008

Source: Medicare outpatient claims data
Nationwide trend: Observation growth not centered in RAC states

- Hospitals in RAC states were no more likely to have rapid growth in observation claims.
  - 19 percent of all US hospitals
  - 20 percent of hospitals with most rapid observation growth

- Within RAC states, a disproportionate share of hospitals accounted for observation claims
  - 30 percent of hospitals accounted for 55 percent of all observation claims in 2008
  - 30 percent of hospitals accounted for 90 percent of increase in observation claims from 2006 to 2008
Substitution of observation claims for 1-day inpatient stays occurring nationally

<table>
<thead>
<tr>
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<th>Number of 1-day inpatient claims per 1,000 Medicare Part A beneficiaries</th>
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<tbody>
<tr>
<td>All US hospitals</td>
<td>49.1</td>
</tr>
<tr>
<td>Hospitals in non-RAC states</td>
<td>49.5</td>
</tr>
<tr>
<td>Hospitals in RAC states</td>
<td>47.3</td>
</tr>
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Source: Medicare inpatient claims data
Nationwide trend the result of a broad set of factors

- Private insurers are exerting pressure on hospitals to avoid short inpatient stays
- All-payer data displays similar observation claim growth
- Observation claim growth rate was higher for Medicare claims data in some states and higher for all-payer claims data in other states
- Recent study cites both Medicare and private-payer scrutiny as impetus for implementing observation unit
- Forum suggested regulatory changes may have had an influence on observation growth
Medicare beneficiaries may face greater financial liability

- Anecdotal reports of beneficiaries being surprised by outpatient and SNF bills

- Potential increase in financial liability for the beneficiary when served as observation patient
  - Outpatient co-insurance vs. inpatient deductible
  - Liable for SNF coverage
Conclusions

- Hospitals increased their use of observation care from 2006 to 2008, particularly for the longest claims.
- Increased scrutiny by public and private payers may be responsible for growth in observation care.
- Medicare beneficiaries are likely to experience greater financial liability as the result of hospitals’ substitution of observation care for inpatient care.