Advising the Congress on Medicare issues

Hospital short stay policy issues

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MEDPAC

Outline of today's presentation

- Background
  - One-day inpatient stays: utilization and profitability
  - Recovery Audit Contractors (RAC)
  - Observation stays: utilization and beneficiary liability
  - 2-midnight rule
- Conceptual discussion of policy options

Medicare admission criteria are purposefully flexible

- Technological change has resulted in migration of services to the outpatient setting
- Medicare inpatient admission criteria
  - Relies upon clinical judgment of the physician
  - Time-based definition: patients are expected to need hospital care for 24 hours
- Medicare observation guidance
  - Relies upon clinical judgment of the physician
  - Time based definition: majority less than 48 hours, usually less than 24 hours, in exceptional cases more than 48 hours

One-day inpatient stays are common and more profitable than longer stays

Number of days	Number of stays	Share of all stays	Payment-to-cost ratio
1	1,189,664	13%	1.55
2	1,527,903	16	1.30
3	1,785,826	19	1.10
4	1,247,603	13	1.03
5	891,372	9	0.96
6	655,007	7	0.89
7	496,658	5	0.84
8+	1,640,378	17	0.72

Source: MedPAC analysis of Medicare SAF inpatient claims and Medicare Cost Reports, 2012.
Note: Data exclude critical access hospitals, Maryland hospitals, and beneficiaries with Medicare Advantage in 2012. Payment-to-cost ratios are based on total payments including program payments and cost sharing.

Payment for one-day inpatient stays higher than outpatient observation stays in 2012

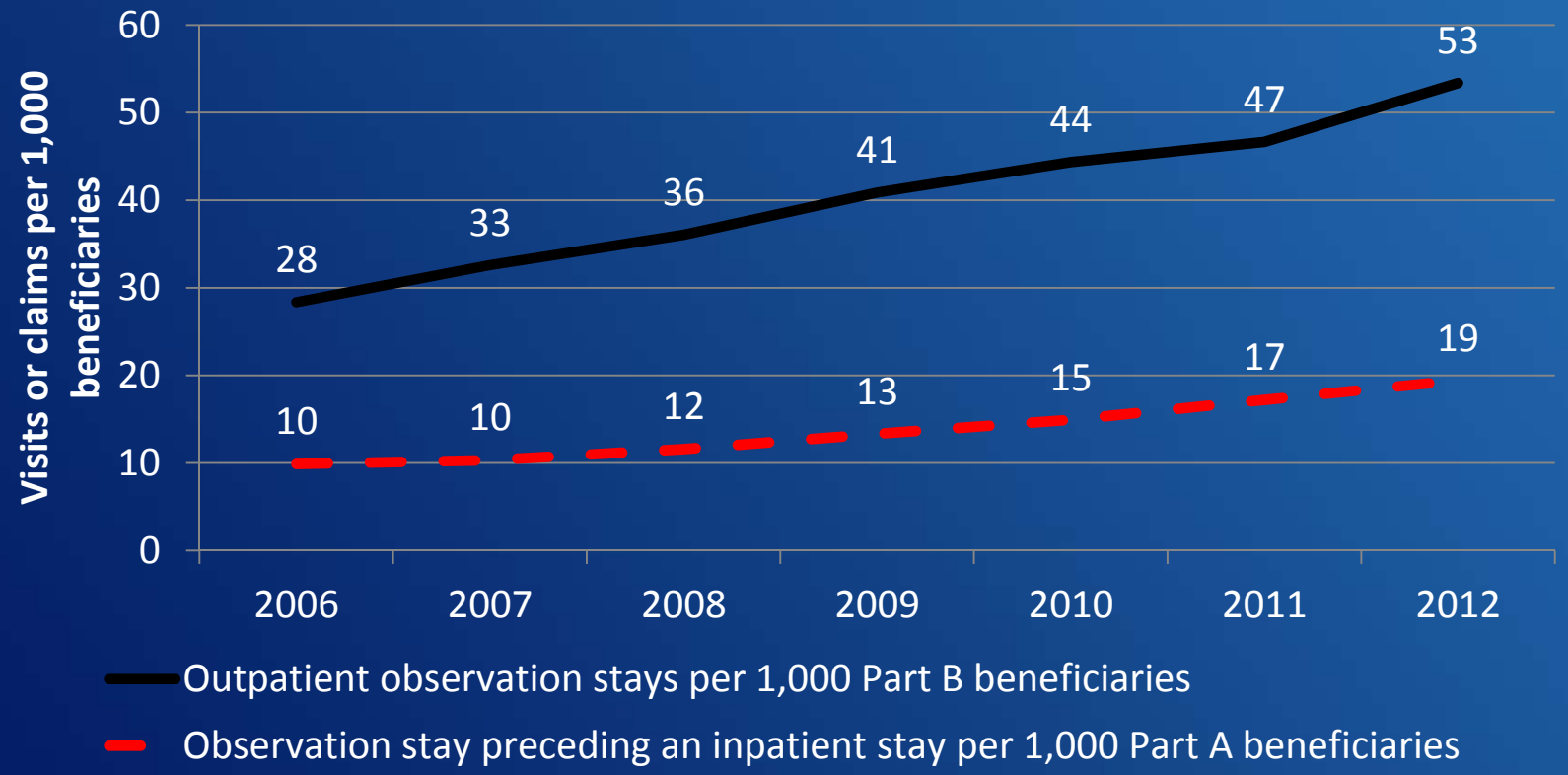
MS-DRG	Condition	Average Medicare inpatient payment (one-day stay)	Average Medicare outpatient observation payment	Outpatient payments as a share of inpatient payment (one-day stay)
313	Chest pain	$3,716	$1,655	45%
310	Cardiac arrhythmia	3,676	1,420	39
392	Digestive disorders	4,953	1,526	31
312	Syncope & collapse	4,972	1,689	34
641	Disorders of nutrition	4,467	1,341	30
247	Drug eluting stent procedure	13,748	9,921	72

Source: MedPAC analysis of SAF inpatient hospital claims and outpatient hospital claims.
Note: Payments reflect actual program payments (including IME and DSH add-ons) and beneficiary cost-sharing. The outpatient observation data are for claims that qualified for payment of composite APC 8002 or 8003. Outpatient claims for drug eluting stent procedures (MS-DRG 247) reflect outpatient surgical claims for one-day stays rather than observation stays. The bundle of services covered by the inpatient payments and outpatient payments are not entirely comparable (e.g., due to the inpatient 72-hour rule and outpatient not covering self-administered drugs).

Medicare Recovery Audit Contractor (RAC) program targeted short inpatient stays

- Description
  - 3-year window to review claims
  - Paid on a contingency fee basis
- Auditors target short inpatient stays
  - 87 percent of all payment denial dollars were for inpatient claims
  - Short inpatient stays account for many of the top denials
  - 71 percent of all medical necessity denial dollars were for one-day stays
- Concerns about the program
  - High hospital appeals rate: 45 percent of inpatient denials in 2012
  - Appeals process slow and ties up hospital revenue
  - Appeals backlog increased four-fold from 2012 to 2013
  - Administrative burden to hospitals
  - RAC 3-year claim review window out of sync with the 1-year window in which hospital are allowed to rebill claims (Medicare rebilling policy)

Observation stays utilization increased rapidly from 2006 to 2012



Source: MedPAC analysis of SAF inpatient and outpatient hospital claims

Observation stays are somewhat concentrated by diagnosis

- Most common observation diagnoses
  - Chest pain accounts for 23 percent of observation stays
  - 15 most common observation diagnoses account for 44 percent of stays
- Overlap between most common diagnoses of observation stays and one-day inpatient stays
  - Chest pain diagnoses the most common for both
  - 7 diagnoses on the top-15 lists of both types of stays
- Overlap with RAC denials

Implications for beneficiary liability

- Beneficiary liability less in observation than inpatient
  - Median for one-day inpatient stays = $1,156 (2012)
  - Median for one-day outpatient observation = $282 (2012)
- Supplemental coverage may insulate 85 percent of FFS beneficiaries from full liability
- Beneficiaries are at greater risk of not qualifying for SNF coverage and those discharged to a SNF may face higher financial liability (13,000 stays in 2012)
- Self-administered drugs not covered by Part B for hospital outpatients

CMS's 2-midnight rule alters admission criteria and generates concern

- Description
  - Instructs auditors not to review stays crossing 2-midnights for inpatient appropriateness, unless evidence of gaming
  - Stays of less than 2-midnights presumed appropriate for outpatient, with certain exceptions
- Concerns about the 2-midnight rule
  - Uncertainty of the Medicare admission criteria
  - Requirement for additional physician documentation
  - Incentive to increase length of stay to cross 2-midnights
  - Incentive to place more beneficiaries in observation initially
  - Hospitals concerned one-day inpatient stays now risk denial
  - RACs may remain focused on one-day inpatient stays

Payment policy implications

- Concern about admission appropriateness is driven by payment differences between short inpatient and outpatient stays
- Addressing this solely through regulatory actions like the 2-midnight rule and RACs may not be optimal
- Policy changes to reduce payment differences may be warranted
- Commission could explore options to reduce payments for short inpatient stays in a budget-neutral manner

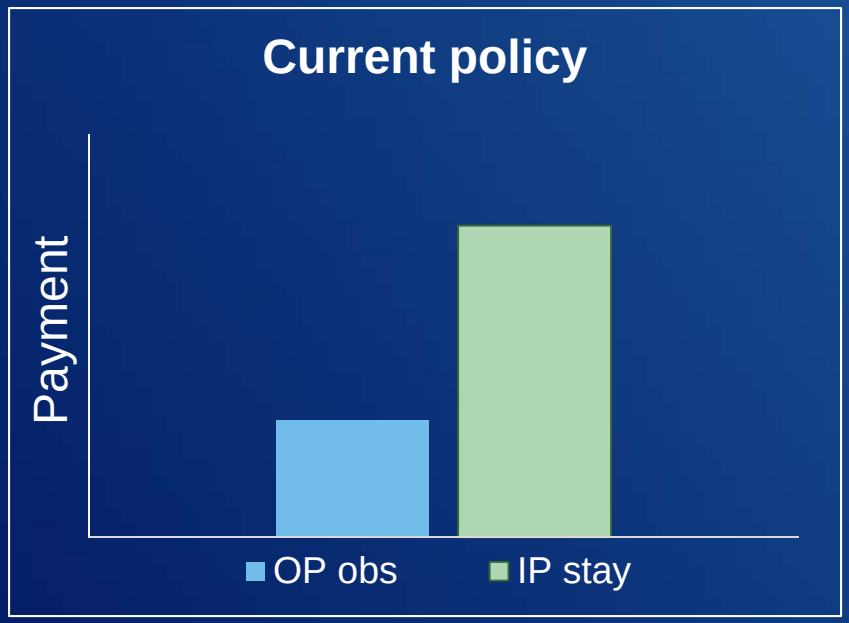
Key policy decisions

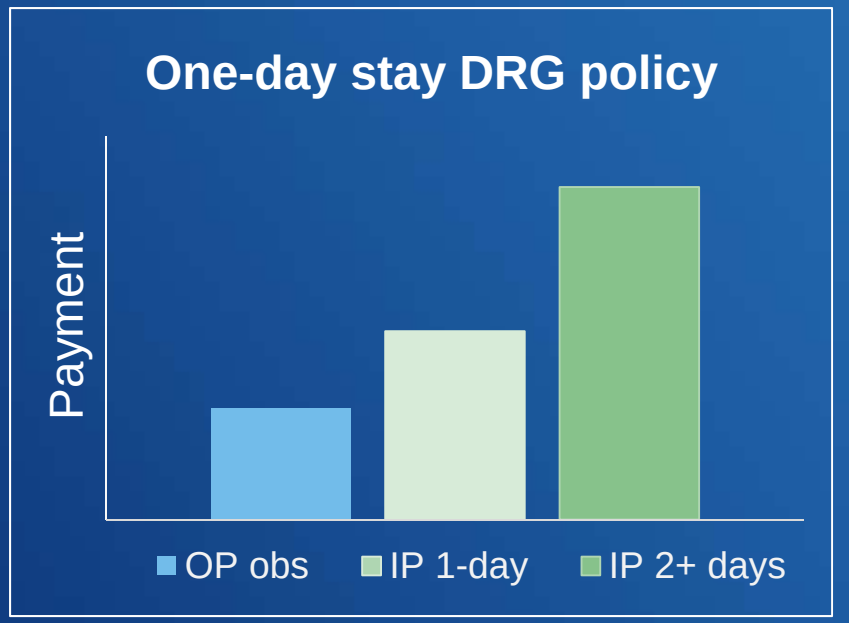
- How would a short stay policy be designed?
  - Which DRGs?
  - How would payments be structured?
- What kind of auditing would be needed?
- Any changes to related policies?
  - Observation days and SNF coverage rules?
  - Rebilling policy?

Which DRGs would a short stay policy apply to?

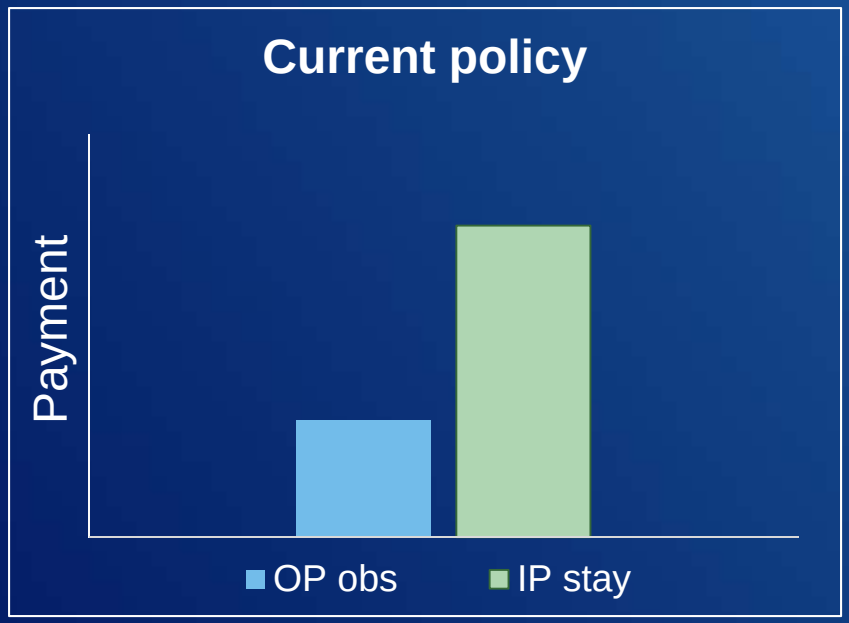
- Subset of DRGs
  - Could focus on DRGs where inpatient/outpatient substitution is an issue; other DRGs unaffected
  - Process would be needed to select and update DRGs
- All DRGs
  - Could focus on all DRGs since short stays are profitable across DRGs
  - DRG selection process would not needed

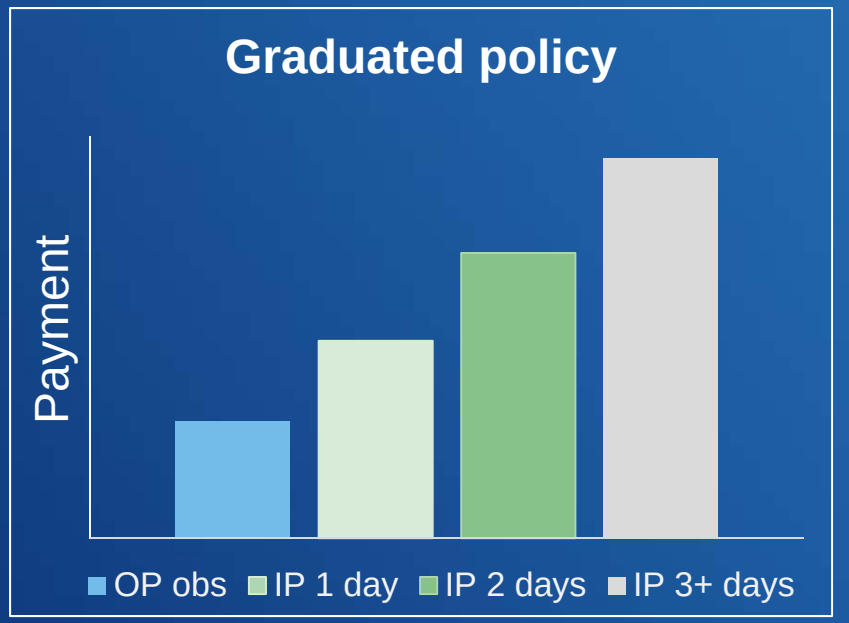
How should the policy be structured: one-day stay DRGs?



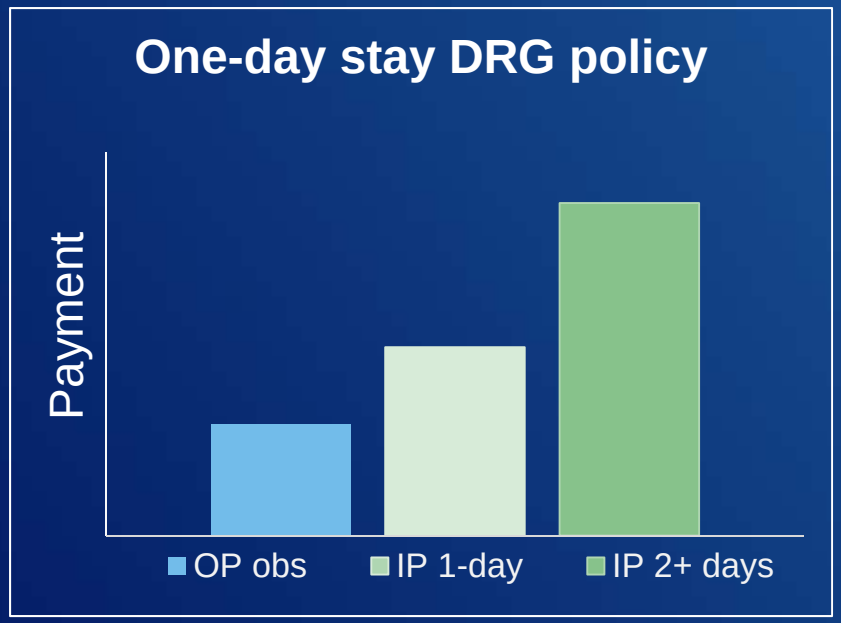


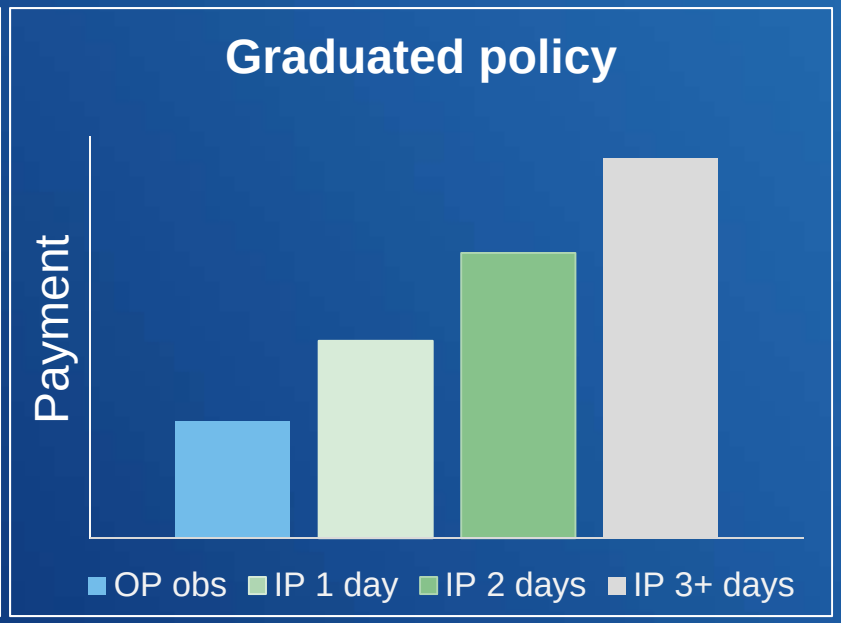
How should the policy be structured: graduated policy?





Comparing one-day stay DRG and graduated policies





Potential approaches to short stay payment

- One-day stay DRGs
- Graduated payment for short stays
- Site neutral approach across inpatient and outpatient
- Low cost outlier approach capping profit per case

What type of auditing would be needed with a short stay policy?

- 2-midnight rule's audit focus on one-day stays would not be consistent with a short-stay policy
- Role of auditors should be consistent with short-stay policy's incentives. For example:
  - ***One-day stay DRGs:*** Limited auditing to deter clustering at two-day stays, potentially focused on a subset of providers with the most clustering
  - ***Graduated approach:*** Limited auditing focused on providers with aberrant patterns

Should changes to related policies be considered?

- Should observation time count toward the SNF 3-day hospital stay threshold? Budget offset?
- Should the timeframe in which a hospital can rebill for a denied inpatient claim as outpatient be consistent with the timeframe for RAC review?

Issues for discussion

- Feedback on:
  - policy options
  - directions for future work
- Question about analysis