

CHAPTER

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**Hospital short-stay  
policy issues**

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# R E C O M M E N D A T I O N S

- 7-1** The Secretary should:
- direct recovery audit contractors (RACs) to focus reviews of short inpatient stays on hospitals with the highest rates of this type of stay,
  - modify each RAC’s contingency fees to be based, in part, on its claim denial overturn rate,
  - ensure that the RAC look-back period is shorter than the Medicare rebilling period for short inpatient stays, and
  - withdraw the “two-midnight” rule.

COMMISSIONER VOTES: YES 16 • NO 0 • NOT VOTING 0 • ABSENT 1

- .....
- 7-2** The Secretary should evaluate establishing a penalty for hospitals with excess rates of short inpatient stays to substitute, in whole or in part, for recovery audit contractor review of short inpatient stays.

COMMISSIONER VOTES: YES 16 • NO 0 • NOT VOTING 0 • ABSENT 1

- .....
- 7-3** The Congress should revise the skilled nursing facility three-inpatient-day hospital eligibility requirement to allow for up to two outpatient observation days to count toward meeting the criterion.

COMMISSIONER VOTES: YES 16 • NO 0 • NOT VOTING 0 • ABSENT 1

- .....
- 7-4** The Congress should require acute-care hospitals to notify beneficiaries placed in outpatient observation status that their observation status may affect their financial liability for skilled nursing facility care. The notice should be provided to patients in observation status for more than 24 hours and who are expected to need skilled nursing services. The notice should be timely, allowing patients to consult with their physicians and other health care professionals before discharge planning is complete.

COMMISSIONER VOTES: YES 16 • NO 0 • NOT VOTING 0 • ABSENT 1

- .....
- 7-5** The Congress should package payment for self-administered drugs provided during outpatient observation on a budget-neutral basis within the hospital outpatient prospective payment system.

COMMISSIONER VOTES: YES 16 • NO 0 • NOT VOTING 0 • ABSENT 1

# Hospital short-stay policy issues

## Chapter summary

Since the implementation of the acute hospital inpatient prospective payment system (IPPS), changes in technology and medical practice patterns have substantially shortened hospitals' average inpatient lengths of stay and have allowed many inpatient services to successfully migrate to the outpatient setting. As a result, the issue of whether a patient requires inpatient care or can be treated safely as an outpatient has received increasing attention. Medicare's requirements for medically necessary inpatient admissions give deference to clinicians and providers and thus are open to interpretation. One-day inpatient stays are relatively common in the Medicare program, accounting for over 1 million inpatient admissions (13 percent of the total) in 2012. Because hospitals generally receive higher payments for clinically similar patients served in an inpatient setting compared with an outpatient setting and the services provided are similar, hospitals may have a financial incentive to admit patients.

Medicare recovery audit contractors (RACs) have targeted short inpatient stays in their audit efforts, resulting in denials of these claims on the grounds that the patient's status as an inpatient was not appropriate. Hospitals have appealed many claims denied by RACs, but have expressed concern about the cost of pursuing appeals, large backlogs in the appeals process, and limited options for rebilling denied inpatient claims as outpatient claims. Partly in reaction to the heightened scrutiny of short inpatient stays, hospitals have

## In this chapter

- Introduction
- Differences between inpatient admissions and outpatient observation stays
- Medicare's Recovery Audit Contractor Program and claim rebilling policy
- Use of observation services
- Characteristics of hospitals with high rates of one-day inpatient and observation use
- Beneficiary liability tied to observation status
- Hospital short-stay policy options

increased their use of observation status instead of admitting patients. Greater use of outpatient observation stays has caused concern about beneficiaries' financial liability. While Medicare cost sharing for outpatient observation services is typically less than the inpatient deductible, for a subset of beneficiaries, the greater use of outpatient observation status has increased the likelihood that they will not qualify for Medicare coverage of post-acute skilled nursing facility (SNF) services (which requires a preceding three-day hospital inpatient stay). Beneficiaries in observation status may also be liable for hospital charges related to prescription drugs received in the hospital and not covered by the Medicare outpatient prospective payment system (OPPS).

CMS established the “two-midnight rule” in fiscal year 2014 in an effort to clarify admission appropriateness and alleviate concerns about increased use of observation, its impact on beneficiary liability, and hospitals' concerns about RAC audits. This rule provides Medicare auditors with guidance pertaining to how they should review inpatient admissions for patient status determinations. It stipulates that, for stays spanning two or more midnights (including time spent in the inpatient and outpatient settings), RACs should presume these stays are appropriate for the inpatient setting and exempt them from audit. However, RACs can audit these two-midnight stays if a hospital demonstrates aberrant patterns of use. By contrast, stays of less than two midnights remain subject to audit. Hospitals have noted concerns about the two-midnight rule because it conflicts with existing admission criteria deferential to physician judgment, increases the burden associated with physician documentation of inpatient admissions, eliminates many one-day stays, and causes a shift in a large volume of stays between the inpatient and outpatient settings. The two-midnight rule has been controversial, and its enforcement has been delayed by both CMS and the Congress.

The Commission has examined issues related to short stays and, on the basis of this examination, makes recommendations related to the RAC program, a short-stay payment penalty, and beneficiary financial liability.

- ***Reduce payment differences:*** Short inpatient stays have been scrutinized by RACs because Medicare generally pays more for short inpatient stays than for similar outpatient stays, and these inpatient stays are highly profitable. To address the payment difference between these stays, the Commission has explored two of the various payment policy approaches policymakers could consider. Under one approach, Medicare could create—as part of its IPPS—a new set of Medicare severity–diagnosis related groups specifically designed for the one-day hospital stay. Under another approach, Medicare could develop a

site-neutral payment—that is, equalize payments across settings—for similar short inpatient and outpatient stays. These options, each with mixed effects on financial incentives, would involve trade-offs. The Commission has not recommended a specific payment approach but, rather, identifies the advantages and disadvantages of each.

- ***The RAC program:*** The Commission makes a four-part recommendation to the Secretary to focus the RAC’s review on hospitals with the highest rates of short inpatient stays to reduce hospitals’ administrative burden, improve the accountability of the RACs for the claims they deny, synchronize the timing of RAC reviews and the hospital rebilling program, and withdraw the entirety of CMS’s two-midnight rule.
- ***Hospital short-stay payment penalty:*** The Commission recommends that the Secretary evaluate a payment penalty on hospitals with excess rates of short inpatient stays to substitute, in whole or in part, for RAC review of short inpatient stays.
- ***Beneficiary financial liability:*** The Commission makes three recommendations that would protect Medicare beneficiaries from financial vulnerabilities resulting from being placed in observation status.
  - The Commission recommends that the Congress revise the three-inpatient-hospital-day eligibility requirement for SNF admission to allow for up to two outpatient observation days to count toward meeting the criterion.
  - The Commission recommends that the Congress require hospitals to notify beneficiaries placed in outpatient observation status that their observation status may affect their financial liability for SNF care. The notice should be provided to patients in observation status for more than 24 hours and who are expected to need SNF services. The notice should be timely, allowing patients to consult with their physicians and other health care professionals before discharge planning is complete.
  - The Commission recommends that the Congress package payment for self-administered drugs provided during outpatient observation within the hospital OPPS on a budget-neutral basis. ■



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## Introduction

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As inpatient stays have shortened and some inpatient services have migrated to the outpatient setting, the issue of whether a patient requires inpatient care or could be treated successfully as an outpatient has received increasing attention. The high profitability of one-day stays under the inpatient prospective payment system (IPPS) and the generally lower payment rates for similar care under the outpatient prospective payment system (OPPS) have heightened concern about the appropriateness of inpatient one-day stays. This concern led Medicare's recovery audit contractors (RACs) to focus their audits on inpatient one-day stays, leading to a large number of claims denied on the grounds of inappropriate admission (see text box concerning RACs, p. 182). Hospitals responded by increasing their use of outpatient observation status. The RAC audits and resulting increased use of observation created concerns from both hospitals and beneficiaries. For hospitals, the RAC program increased administrative burden by requiring hospitals to respond to RAC medical records requests and track appeals of claim denials. For beneficiaries, being served in observation status increased their financial responsibility if they were discharged to a skilled nursing facility (SNF) or if they required daily oral medications while they were in the hospital. In response to these concerns, CMS adopted a two-midnight policy in fiscal year 2014. This policy instructed auditors to presume that hospital stays—counting time spent in outpatient and inpatient status—spanning two or more midnights (or stays a physician expected to span two or more midnights) are appropriate for inpatient status and that stays less than two midnights are appropriate for outpatient status (with certain exceptions). The two-midnight policy has been controversial, and its enforcement has been delayed by both CMS and the Congress.

In the fiscal year 2015 IPPS proposed rule, CMS requested comments about a payment policy for short inpatient stays that might replace or supplement the existing two-midnight rule. In particular, CMS solicited comments on how short stays might be defined under such a policy and how the payment rates could be set. In its June 2014 comment letter, the Commission expressed concerns about the potential for the two-midnight rule to address the issues it set out to resolve and stated that the Commission would explore options for a short-stay payment policy and other related policies.

This chapter summarizes the Commission's perspective on issues that brought about the increase in outpatient observation utilization and its general concerns about how Medicare reimburses for and audits short hospital stays. The chapter also makes recommendations related to these issues.

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## Differences between inpatient admissions and outpatient observation stays

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Medicare's criteria for inpatient admissions are deferential to physician judgment, but the difference between these criteria and the criteria for outpatient observation status are often unclear to providers. One-day inpatient stays—those which either cross one midnight or no midnights—are relatively common in the Medicare program.<sup>1</sup> Because Medicare generally pays more for patients who receive similar services in the inpatient setting compared with the outpatient setting, hospitals have a financial incentive to admit patients.

### CMS criteria for inpatient admission and outpatient observation status are unclear

CMS's long-standing guidance to physicians, hospitals, and Medicare auditors concerning when Medicare beneficiaries should be admitted to the inpatient setting gives deference to the clinical judgment of the physician. This guidance has historically consisted of a general definition of admission coupled with a loose, time-based definition of how long that care should last. CMS's Medicare Benefit Policy Manual states that admission is a complex medical judgment that can be made only after the physician considers the medical predictability of something adverse happening to the patient, the severity of the patient's condition, the need for and availability of diagnostics, the types of facilities available, hospital by-laws and admissions policies, and the relative appropriateness of treatment in each setting. It also states that physicians responsible for a patient's hospital care "should order admission for patients who are expected to need hospital care for 24 hours or more, and treat other patients on an outpatient basis" (Centers for Medicare & Medicaid Services 2014a).

If physicians are not sure whether patients require inpatient care, they can treat beneficiaries as outpatients under observation status. CMS's Policy Manual defines

**TABLE  
7-1**

**Average payment-to-cost ratios higher for inpatient stays with shorter lengths of stay, 2012**

Length of inpatient stay (in days)	Number of discharges	Share of discharges	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 or more	1,640,378	17	0.72

Note: Number of inpatient days reflects the number of midnights the inpatient stay crossed. One-day stays include stays that crossed zero or one midnight. Table includes fee-for-service inpatient prospective payment system hospitals and inpatient cases discharged as deceased but excludes Maryland and critical access hospitals.

Source: Medicare claims data from the 2012 inpatient standard analytic file.

coverable outpatient observation care as short-term treatment furnished while a decision is being made about inpatient admission and states that the decision to move patients out of observation “is usually made in less than 48 hours, often in less than 24 hours, and in exceptional cases in more than 48 hours” (Centers for Medicare & Medicaid Services 2014b).<sup>2</sup> Medicare pays for observation under the OPSS. If certain criteria are met, observation services are packaged with other outpatient services into a payment group in the composite ambulatory payment classification (APC) system used with Medicare’s OPSS. Emergency department services are among the most common outpatient services packaged with observation services in APCs. In 2012, qualifying observation stays were paid through one of two different composite APCs, depending on the severity of the case. In addition to payment for the composite observation APC, the hospital also receives payment for other nonpackaged ancillary services included on the claim—for example, higher priced drugs and diagnostic tests such as echocardiograms and imaging.

Medicare pays for observation as a part of the IPPS when a beneficiary’s stay includes an inpatient admission. For example, for beneficiaries who enter the hospital through the emergency department, then spend time in outpatient observation status, and then are admitted to the hospital as an inpatient, the hospital will receive a single IPPS payment based on the beneficiary’s diagnosis related group. In general, payment for the observation services

and other related outpatient services furnished by the hospital in the three days preceding the day of admission is included in the IPPS payment rate. Beneficiaries who spend time in both observation and inpatient status during a hospital stay may not be able to differentiate the two, and in particular this can lead to confusion for beneficiaries being discharged to a SNF. These beneficiaries are at times surprised to learn that they do not qualify for Medicare SNF coverage because the time they spent in outpatient status—emergency department and observation—does not count toward the SNF eligibility requirement of a three-day inpatient hospital stay (Feng et al. 2012).

Many commercial insurers manage inpatient stays differently from the Medicare fee-for-service program by using a variety of methods such as prior authorization policies or admission notification policies to validate the necessity of inpatient admissions. Under prior authorization, the hospital must contact the insurer for permission to admit the patient. Under notification policies, hospitals must notify the insurer as soon as the patient has been admitted. To make approval decisions, some insurers use automated computer systems or their own case managers inside the hospital. Insurers typically make these decisions within 24 hours.<sup>3</sup>

**One-day inpatient stays are relatively common and profitable**

Among Medicare beneficiaries, short inpatient stays are common and profitable for hospitals, relative to longer

inpatient stays. More than 1 million inpatient discharges in 2012 were for one-day stays, accounting for about 13 percent of all IPPS discharges (Table 7-1).<sup>4</sup>

The structure of the IPPS makes one-day inpatient stays profitable. Designed to be a system of averages, the IPPS generally pays a fixed amount per case for all patients who fall within a specific Medicare severity–diagnosis related group (MS–DRG), regardless of the length of stay; the payment rate is based on the average cost of all the cases in the group. The fixed MS–DRG payment gives hospitals the incentive to deliver care efficiently and control costs in a variety of ways, including shortening stay length. The payment rate for each MS–DRG is based on a relative weight that reflects the relative cost of the cases in one MS–DRG compared with other MS–DRGs. Each year, the weights are recalibrated using claims data from all hospitals in aggregate and from two years prior (the most current complete year available to CMS), to reflect the change in relative costs across the MS–DRGs. Over time, payment rates decline for MS–DRGs that have an above-average decrease in average cost per case. To the extent that an MS–DRG has an increasing prevalence of short inpatient stays and decreasing average cost as a result, the Medicare payment for the MS–DRG also would likely decline. But because recalibration is based on data from all hospitals and generates new MS–DRG weights based on overall average lengths of stay, individual hospitals with higher than average use of one-day stays may still benefit financially.

As would be expected under fixed MS–DRG payments, short inpatient stays are more profitable than longer stays. In 2012, across all MS–DRGs, payments exceeded costs by 55 percent (a payment-to-cost ratio of 1.55) for one-day inpatient stays (Table 7-1). By contrast, inpatient stays lasting eight or more days had the lowest mean payment-to-cost ratio (0.72), where costs exceeded payments by 28 percent.<sup>5</sup> The pattern of high payment-to-cost ratios for the shortest stays is observed across different types of stays. On average, medical one-day stays, which account for nearly three-quarters of all one-day stays, received payments that were double their costs (104 percent above costs, or a payment-to-cost ratio of 2.04). Surgical one-day stays received payments that were 17 percent above their costs (1.17). Stays in which the patient died during the hospital stay received payments that were 154 percent above their costs (2.54). One-day stays subject to the hospital-to-hospital and post-acute transfer policies received payments that were 30 percent (1.30) and 14 percent (1.14) above costs, respectively.<sup>6</sup>

In 2012, almost every one of over 700 MS–DRGs included some one-day stays, but these stays tended to be concentrated in certain MS–DRGs. The 15 MS–DRGs with the most one-day stays accounted for 30 percent of all one-day stays. Many of these 15 were also common to outpatient observation (e.g., chest pain, cardiac arrhythmia and conduction disorders, esophagitis, and syncope).<sup>7</sup>

Medical MS–DRGs tend to have higher payment-to-cost ratios than surgical DRGs for one-day stays. Among the 15 most common MS–DRGs for one-day inpatient stays in 2012, 12 were for medical stays and 3 were for surgical stays (Table 7-2, p. 180). Among the 12 medical MS–DRGs, payments exceeded costs by an average of between 32 and 199 percent (payment-to-cost ratios between 1.32 and 2.99). Among the three surgical MS–DRGs, payment exceeded costs on average by between 4 percent and 12 percent (payment-to-cost ratios between 1.04 and 1.12). The lower payment-to-cost ratio for surgical MS–DRGs compared with medical MS–DRGs likely reflects the fact that the costs associated with surgery are typically concentrated on the first day of the stay. In addition, higher payment-to-cost ratios for one-day stays are generally associated with MS–DRGs that have longer average lengths of stay.

### **Medicare pays more for inpatient short stays than for outpatient observation stays**

Medicare pays for inpatient and outpatient hospital care under two different payment systems—the IPPS, paid through the Medicare Part A benefit, and the OPSS, paid through the Medicare Part B benefit.<sup>8</sup> In general, the amount Medicare pays for one-day inpatient stays is higher than for similar outpatient observation stays. Certain hospitals receive add-on payments for inpatient hospital stays that increase this payment differential. These add-on payments are for hospitals providing indirect medical education and those qualifying as disproportionate share hospitals. Because the services provided in these inpatient and outpatient stays are similar, the payment differential gives hospitals a financial incentive to admit beneficiaries to inpatient status. Table 7-3 (p. 181) shows the average Medicare payment for an inpatient one-day stay and an outpatient observation stay for six MS–DRGs that are among the most common to both inpatient and outpatient stays.<sup>9</sup> In 2012, for these six MS–DRGs, Medicare paid roughly two to three times more for a one-day inpatient stay than for a comparable outpatient observation stay.<sup>10,11</sup>

**TABLE  
7-2**

**Fifteen most common one-day inpatient stays by MS-DRG, 2012**

MS-DRG	Type of MS-DRG	MS-DRG description	Geometric mean LOS for MS-DRG	Number of one-day stays	Payment-to-cost ratio for one-day stays
313	Medical	Chest pain	1.7	39,738	1.32
310	Medical	Cardiac arrhythmia & conduction disorders without CC/MCC	2.0	35,628	1.41
392	Medical	Esophagitis digestive disorders without MCC	2.7	29,952	1.82
871	Medical	Septicemia or severe sepsis without MV 96+ hours with MCC	5.3	28,590	2.99
247	Surgical	Percutaneous cardiovascular procedure with drug-eluting stent without MCC	1.9	27,762	1.12
312	Medical	Syncope & collapse	2.3	25,196	1.79
287	Medical	Circulatory disorders except AMI, with cardiac catheterization without MCC	2.4	24,620	1.40
39	Surgical	Extracranial procedures without CC/MCC	1.4	22,049	1.04
641	Medical	Disorders of nutrition, metabolism, fluids without MCC	2.8	21,559	1.84
69	Medical	Transient ischemia	2.2	20,087	1.65
812	Medical	Red blood cell disorders without MCC	2.7	19,438	2.03
309	Medical	Cardiac arrhythmia & conduction disorders with CC	2.9	19,019	1.86
690	Medical	Kidney & urinary tract infections without MCC	3.3	16,811	1.90
473	Surgical	Cervical spinal fusion without CC/MCC	1.5	16,245	1.04
292	Medical	Heart failure & shock with CC	3.9	13,850	2.13
All top 15 MS-DRGs				360,544	

Note: MS-DRG (Medicare severity–diagnosis related group), LOS (length of stay), CC (complication or comorbidity), MCC (major complication or comorbidity), MV (mechanical ventilation), AMI (acute myocardial infarction). Data include inpatient prospective payment system (IPPS) hospitals reporting Medicare cost report data but exclude critical access and Maryland hospitals and Medicare Advantage claims. “One-day stay” refers to a stay for which the beneficiary has one Medicare utilization day.

Source: MedPAC analysis of Medicare standard analytic file of inpatient hospital claims and Medicare cost report data. Geometric mean length of stay data are from the CMS 2012 IPPS final rule impact file.

## Medicare’s Recovery Audit Contractor Program and claim rebilling policy

The Tax Relief and Health Care Act of 2006 mandated the nationwide implementation of the Medicare Recovery Audit Contractor (RAC) Program in 2010 (see text box about the RAC program, p. 182).<sup>12</sup> As discussed below, the Commission is concerned about the administrative burden the RAC program places on hospitals, the lack of accountability RACs face with regard to the accuracy of their audits, and the lack of coordination between the timing of the of RAC claim denials and the timing of the Medicare rebilling policy.

### Administrative burden on hospitals

Hospitals report that the RAC program has increased their Medicare-related administrative burden. They assert that

RAC audits cause hospitals to expand their administrative staff and staff hours to handle RACs’ requests for medical records and to track claims through the appeals process, adding to hospitals’ overall costs. An American Hospital Association survey of its membership reported that, in the third quarter of 2012, costs associated with managing the RAC program totaled over \$100,000 for 9 percent of hospitals and approximately \$25,000 for 39 percent of hospitals (American Hospital Association 2014b). The process of filing an appeal and tracking it through the appeal process comes at a cost to hospitals. This cost may influence a hospital administrators’ decision whether or not to appeal a given claim denial. Nevertheless, in general, hospitals’ administrative costs of appealing claims are lower than the value of the payments tied to the denied inpatient claims.

**TABLE  
7-3**

**Average Medicare total payments for inpatient stays are higher than for similar outpatient observation stays, 2012**

MS-DRG	MS-DRG description	Average Medicare inpatient payment (one-day stay)	Average Medicare outpatient observation payment
313	Chest pain	\$3,716	\$1,655
310	Cardiac arrhythmia & conductive disorders	3,677	1,420
392	Esophagitis, gastroenteritis & miscellaneous digestive disorders	4,953	1,526
312	Syncope & collapse	4,972	1,689
287	Circulatory disorders except AMI, with cardiac catheterization without MCC	7,064	3,998
641	Disorders of nutrition, metabolism, fluid/electrolytes without MCC	4,467	1,341

Note: MS-DRG (Medicare severity–diagnosis related group), AMI (acute myocardial infarction), MCC (major complication or comorbidity). Payments reflect actual program payments (including indirect medical education and disproportionate share hospital add-ons) and beneficiary cost sharing. Data exclude Maryland and critical access hospitals. The observation data are for beneficiaries whose observation care meets the criteria for composite ambulatory payment classification payment for extended evaluation and management. Claims for outpatients are compared with inpatient claims for MS-DRGs that include patients with similar diagnoses and procedures. The bundle of services covered by the inpatient payments and outpatient payments are not entirely comparable in part because of the inpatient 72-hour rule and outpatient payments not covering self-administered drugs.

Source: MedPAC analysis of Medicare standard analytic file of inpatient and outpatient hospital claims.

In recent years, the volume of appeals has increased dramatically. The Office of Medicare Hearings and Appeals (OMHA) reported that, from fiscal years 2011 to 2013, the number of appeals occurring at the third of five levels of appeal increased over 500 percent.<sup>13</sup> The third level of appeal is the point at which adjudication involves an administrative law judge (ALJ) manually reviewing each claim, as opposed to the more general reviews that occur at levels one and two. The third level is also the point at which the majority of appeal overturns occur, the last level before the appeal is sent to a reviewing council or a court, and the level at which the current backlog exists. In fiscal year 2013, there were over 380,000 RAC-related appeals at the ALJ level; another 500,000 new appeals were added through the first 10 months of fiscal year 2014 (Office of Medicare Hearings and Appeals 2014). As of July 1, 2014, the ALJ backlog in OHMA exceeded 800,000 appeals. In addition, OMHA reports that the average appeal processing time is over 547 days in fiscal year 2015, up from 120 days per appeal in fiscal year 2011 (Office of Medicare Hearings and Appeals 2015).

To address the growing ALJ appeals backlog, in August 2014, CMS announced a one-time option for hospitals to settle appeals. CMS offered to pay hospitals 68 percent of the net payable amount of the denied inpatient claim in exchange for the hospital dropping the appeal. Hospitals that accepted the settlement agreed to settle all their appeals in one bundle, as opposed to settling appeals individually (Centers for Medicare & Medicaid Services 2015a).

RACs audits are industry-wide rather than focused on specific hospitals with use patterns that call for additional scrutiny. The American Hospital Association reported in 2013 that 90 percent of hospitals were affected by a RAC audit or request for information. Current rules limit the number of overall claims a RAC can audit from a given hospital, and RACs strategically select short inpatient claims for review based on the potential contingency fee value of the claim and the likelihood of being able to make a recovery. Because they are limited to reviewing a certain number of claims from each hospital, RACs have responded by auditing short inpatient stays from many hospitals rather than focus on hospitals with aberrant patterns of use. The result is that hospitals misusing a large number of short inpatient stays are being insufficiently audited, and hospitals that do not misuse short inpatient stays incur potentially unnecessary administrative burdens.

**Accountability of RACs**

RACs focus on short inpatient stays, and with the exception of losing payment when their claim denials are overturned, RACs are largely not held accountable for their audit accuracy. To date, RACs have focused their auditing on the differences in payment between clinically similar inpatient and outpatient stays. As a result, the majority of the overpayments identified by RACs are from Medicare Part A one-day inpatient stays. CMS estimates that, in 2013, over 94 percent of the overpayments were for inpatient hospital claims, adding that many of the individual claim denials with the highest overpayment

## Medicare Recovery Audit Contractor Program

The Congress mandated the Medicare Recovery Audit Contractor (RAC) Program to be implemented in 2010 to identify and correct overpayments and underpayments made to providers on behalf of the Medicare program. Currently, four RACs contract with CMS to audit hospital claims. The RACs are permitted by law to review claims dating back four years, but to date, CMS has limited the RACs' claim look-back period to three years. The RACs are paid based on a percentage of the dollars they recover from their claims auditing activities rather than through CMS's administrative budget. These contingency fees, negotiated between CMS and the RACs, range between 9.0 and 12.5 percent. Providers can appeal a RAC's overpayment determinations. In fiscal year 2013, the RACs identified overpayments totaling \$3.75 billion.

In addition to the RACs, four other types of Medicare contractors are responsible for conducting postpayment reviews of Medicare claims: Medicare administrative contractors, zone program integrity contractors, comprehensive error-rate testing contractors, and supplemental medical review contractors. The five

types of contractors have overlapping roles, but RACs handle the largest volume of these reviews. According to a Government Accountability Office analysis, RACs accounted for the vast majority (83 percent) of postpayment reviews in 2012 (Government Accountability Office 2014).

In December 2014, CMS released a list of 18 changes it intends to make to the RAC program. These changes are intended to be effective with each new RAC contract awarded on or after December 30, 2014. Among these changes is the limit on the RAC look-back period for patient status, reduced from three years to six months from the date the hospital provided the service to the patient (date of service). This change should allow hospitals to rebill more RAC-denied claims. RACs would also be required to maintain low claim overturn rates and high claim review accuracy rates to maintain full access to claims for review. CMS intends to use hospitals' past claim denial rates to determine what share of their claims will be eligible for RAC claim review. In addition, CMS intends to begin paying RACs their contingency fees later in the appeal process. ■

amounts were denials of short inpatient stays (Centers for Medicare & Medicaid Services 2014d). While the RACs' focus is not completely on inpatient stays, or short inpatient stays, denials of these stays appear to be the source of much of the program's revenues.

Determining the accuracy of RAC audits is obscured by the number of claims appealed in recent years. CMS reports that in 2013, the audit accuracy rates of RACs varied from 92.8 percent to 99.1 percent.<sup>14</sup> This high level suggests RACs are relatively accurate, but it is unclear how the recent appeals are factored into CMS's accuracy rates (Centers for Medicare & Medicaid Services 2014d). In terms of the outcome of appeals, CMS reports that, across all levels of appeal in 2013, about 8 percent of Part A overpayment determinations were completely overturned on appeal (Centers for Medicare & Medicaid Services 2014d). The audit accuracy rates and the appeal overturn rate generally correspond with one another and suggest reasonable accuracy. However, CMS also reports

that, among all Part A claim overpayment determinations made by RACs in 2013, providers appealed about 48 percent of denials. This appeals rate raises questions across the audit process continuum regarding the frequency of hospital appeals, the accuracy of RAC audits, and the processes of ALJs.

Research by the Department of Health and Human Services Office of Inspector General (OIG) demonstrates that a large share of hospital appeals of RAC denials that reach the ALJ level (a relatively small share of total RAC denials) are overturned by ALJs and that variation exists in ALJ rulings. In a 2012 report, OIG reported that, among all the appeals that reached ALJs, more than half were overturned in favor of the provider (Office of Inspector General 2012). To this point, OIG reported that, despite the random assignment of cases to the 66 ALJs they reviewed, the share of appeal rulings decided in favor of the appealing provider ranged from 18 percent to 85 percent. Variation to this degree suggests either that the

guidelines for ruling on inpatient cases are not clear or that ALJs may not uniformly possess the experience required for making clinical decisions on this subject. OIG found that ALJs often interpret Medicare policy less strictly than do qualified independent contractors and often favor the provider and beneficiary (Office of Inspector General 2012). OIG has cited problems with ALJs litigating Medicare disputes in the past.

The contingency fee structure of the RAC program differs from that of other Medicare auditors, and it does not directly hold RACs accountable for their audit accuracy. Contingency fees were adopted because they permit expansion of reviews without additional congressional appropriations for CMS's administrative budget. This structure also provides incentives for RACs to identify as many inappropriate claims and as much Medicare payment as possible. RACs must return the contingency fee to CMS if a hospital successfully appeals the denial of the claim. However, RACs face no penalties when denials are overturned on appeal and are not required to pay interest on the returned fee.

### Timing of RAC reviews

Stakeholders have also cited difficulties with regard to the disparate timing between the RACs claim review period and the Medicare hospital rebilling period. Currently, RACs are permitted to review claims that are up to three years from the date of service on the claim. Medicare's rebilling policy allows hospitals one year after a denied claim's date of service to resubmit a claim for the outpatient services included on that original claim (Centers for Medicare & Medicaid Services 2013a). However, hospitals may not replace denied inpatient care with what it asserts is equivalent outpatient care.<sup>15</sup>

The misalignment between the one-year rebilling window and the three-year RAC look-back period largely prevents hospitals from being able to rebill denied claims. CMS estimated in its 2012 OPSS proposed rule that 75 percent of inpatient admissions denied by RACs are not eligible to be rebilled as outpatient services because they fell outside the one-year rebilling period (Centers for Medicare & Medicaid Services 2013c). The lengthy appeals process may further diminish the chances of a hospital being able to appeal a denied claim beyond the first or second level of appeal and then have the opportunity to rebill for that denied claim because the appeal process is likely to take longer than the one-year rebilling time frame permits.

### Two-midnight rule leaves problems unresolved

CMS established the "two-midnight rule" in fiscal year 2014 to clarify criteria for admission appropriateness and alleviate concerns about increased use of observation, its impact on beneficiary liability, and hospitals' concerns about RAC audits. CMS's two-midnight rule provides additional guidance to its audit contractors, instructing them to use two midnights as the benchmark for assessing the appropriateness of inpatient admission rather than the Medicare Benefit Policy Manual's 24-hour guidance. The rule directs auditors to presume that inpatient admissions are reasonable and necessary when beneficiaries have more than one Medicare utilization day (stays that include two midnights) (Centers for Medicare & Medicaid Services 2013b). Under the rule, inpatient and outpatient stays spanning two midnights (or stays a physician expects to span two midnights) will be deemed appropriate for the inpatient setting, and auditors will not review or deny these claims. For inpatient and outpatient stays of less than two midnights, auditors are to presume the stay is appropriate for the outpatient setting, except under certain circumstances.<sup>16</sup> For claims they select for review, auditors are instructed to consider the claim appropriate for inpatient care if it meets any of the following three criteria:

- the stay crossed two midnights when both inpatient and outpatient time are counted,
- the patient received an inpatient-only procedure, or
- the physician had a reasonable expectation that the stay would cross two midnights and this assumption is supported by information documented in the medical record.<sup>17</sup>

The two-midnight rule may address some of the problems it was implemented to resolve. It largely alleviates hospitals of the risk of RAC audit for stays lasting more than two midnights, which should reduce their RAC-related administrative burden. In addition, some contend that a time-based criterion for inpatient status provides hospitals with a clearer definition to judge the appropriateness of their admissions.

The two-midnight rule may also change provider utilization patterns, even though it does not alter Medicare's admission criteria. Overall, the two-midnight rule will result in the movement of stays from outpatient to inpatient status and vice versa. (When the rule was

**TABLE  
7-4**

**Inpatient discharges by length of stay**

Length of inpatient stay (in days)	Share of inpatient discharges, 2012	Percent change in number of inpatient claims per Part A beneficiary		
		2006-2012	2006-2009	2010-2012
1	13%	-23%	-10%	-13%
2	16	-6	-1	-5
3	19	-1	1	-3
4	13	-12	-4	-6
5 or more	39	-17	-8	-7
All	100	-13	-5	-7

Note: Hospitals receiving inpatient prospective payment system payments and critical access hospitals are included in this analysis.

Source: MedPAC analysis of standard analytic file of inpatient hospital claims.

originally implemented, CMS estimated a net increase in inpatient stays.<sup>18</sup>) However, it is not clear that the changes in patterns of use will always be beneficial for the beneficiary or the Medicare program. The two-midnight rule will likely reduce the number of long observation stays (48 hours or longer) because, absent the RAC audit risk, hospitals can more easily serve these patients in inpatient status. At the same time, it could increase the use of short observation stays because hospitals might opt to place patients in observation status until their stays exceed two midnights. Such an increase before admission would exacerbate concerns about beneficiaries not qualifying for SNF coverage because observation status does not count toward the three-day hospital stay threshold for SNF eligibility. The two-midnight rule could also influence lengths of inpatient stays. Under the new rule, hospitals might lengthen stays beyond the two-midnight threshold to gain greater certainty that they will avoid a denial and the loss of reimbursement. Unnecessarily lengthening stays could have negative consequences for beneficiaries and represent overutilization of the program.

The two-midnight rule has been controversial within the hospital industry. Some hospitals have expressed concern that the rule has increased the burden associated with physician documentation of inpatient admissions. Others are concerned that the rule complicates the admissions process by adding auditing standards that do not coincide with the inpatient criteria deferring to physician judgment. Further, others believe that the rule will eliminate many

one-day stays and that the shift of cases between the outpatient and inpatient settings will result in financial loss to some providers.

Since CMS finalized the two-midnight rule in August 2013, both CMS and the Congress have taken actions to delay the enforcement of the policy. RACs are prohibited from enforcing the new policy or auditing any inpatient admissions until September 30, 2015, unless there is evidence of systematic gaming, fraud, abuse, or delays. During this enforcement delay, CMS will assess the extent to which hospitals understand and are complying with the new policy through the Medicare Probe and Educate program.

Under the Probe and Educate program, Medicare administrative contractors (MACs) conduct limited prepayment reviews of a sample of hospital inpatient claims spanning less than two midnights. MACs may select 2 samples of 10 claims from any hospital (25 claims from larger hospitals) to verify compliance with the two-midnight rule. Hospitals with high rates of denials receive further scrutiny. MACs are permitted to deny claims if they are not reasonable and necessary inpatient claims. MACs send letters to hospitals informing them which claims were denied and for what reasons, and they call hospitals with high rates of denials to communicate this information.

The Probe and Educate program may represent some value for hospitals, but its application to the review of all inpatient claims is problematic. On the one hand,

providers generally prefer prepayment review, such as Probe and Educate, to postpayment review, such as the RAC program, because it is less disruptive to the flow of revenues and involves less administrative cost. On the other hand, applying the Probe and Educate program to all inpatient claims would require a significant administrative commitment (and financial resources) from CMS and would likely slow the payment of claims. Therefore, the Probe and Educate program may not be a realistic replacement of the RAC program. Further, some stakeholders have expressed concern that MACs have inconsistently implemented the Probe and Educate program with regard to claim denial decisions and education efforts.

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## Use of observation services

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In response to greater scrutiny of short inpatient stays, hospitals have increased their use of outpatient observation status and opted for the lower payment associated with observation rather than risk denial of the higher paid inpatient services. As a result, the volume of one-day inpatient stays has declined, and the volume of outpatient observation stays has increased.

### Use of short inpatient stays declined

Discharges for short inpatient stays have declined rapidly in recent years. Between 2006 and 2012, the number of one-day inpatient stays declined 23 percent per Medicare Part A beneficiary, a more rapid rate of decline than for longer stays (Table 7-4).<sup>19</sup> Stays of other lengths declined between 1 percent and 17 percent over the same period, or a 5 percent decline overall (data not shown).<sup>20</sup> One-day inpatient stays declined at a faster rate in more recent years, after the implementation of the RAC program in 2010. From 2006 to 2009, the volume of one-day inpatient stays decreased 10 percent compared with the 13 percent decline from 2010 to 2012. Inpatient stays of other lengths also demonstrated an increased rate of decline between these two periods. These rates of decline suggest that providers felt pressure to reduce inpatient utilization during the two periods, particularly in the years after the implementation of the RAC program.

### Use of outpatient observation stays increased

Hospitals rapidly increased their use of outpatient observation status in recent years, both in number and

length of stays. Many of the most common diagnoses for outpatient observations overlap with the most common diagnoses for one-day inpatient stays and with the diagnoses that account for most of the Medicare RACs' payment denials. These overlaps suggest that the increased use of outpatient observations is hospitals' response to the RACs' greater scrutiny of short inpatient stays.

### Volume

In 2012, CMS processed claims for 1.7 million outpatient observation stays and another 700,000 inpatient stays preceded by observation. Between 2006 and 2012, the number of outpatient observation stays increased by 88 percent (from 28 to 53 visits per 1,000 beneficiaries), and the number of inpatient stays preceded by observation increased 96 percent (from 10 to 19 stays per 1,000 beneficiaries) (Figure 7-1, p. 186). The growth in observation was most rapid between 2011 and 2012, when outpatient observation volume rose 14 percent (from 47 to 53 visits per 1,000 beneficiaries).<sup>21</sup>

### Length of stay

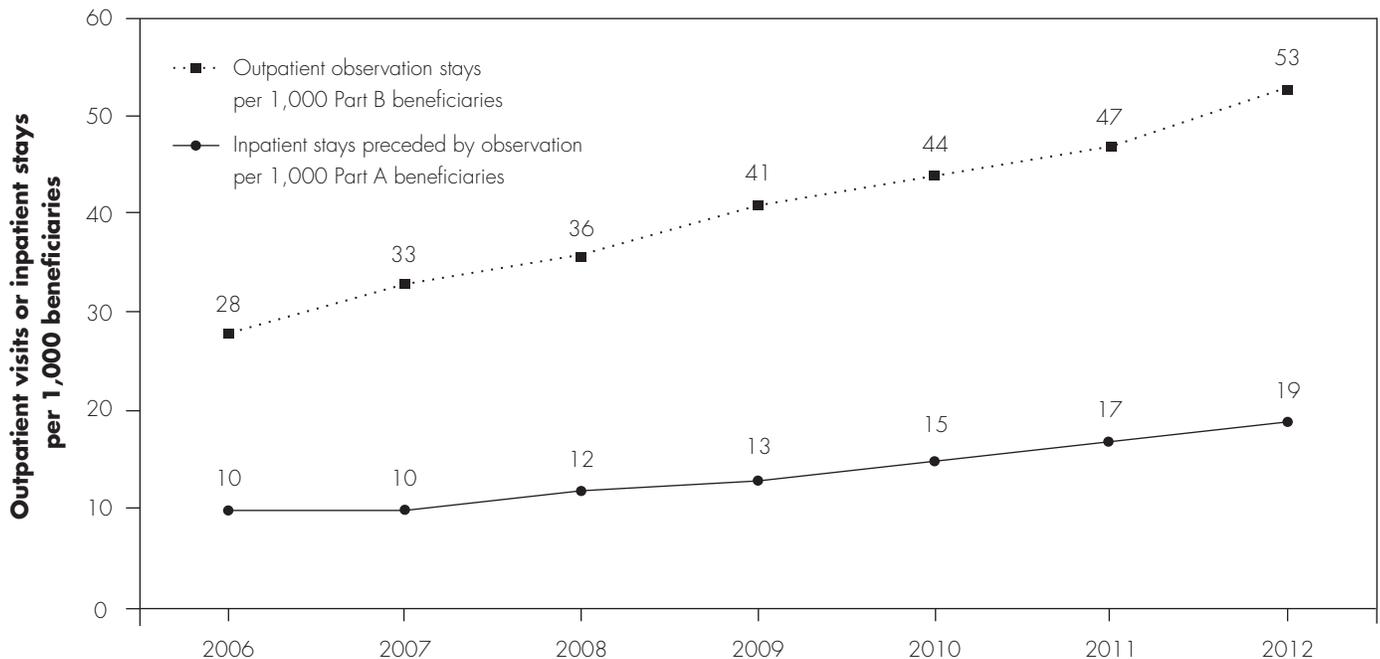
The average length of outpatient observation stays increased in recent years. From 2006 through 2012, the average length of outpatient observation stays increased from 25.6 hours per stay to 29.3 hours per stay. This increase was driven by a 228 percent increase in the number of stays of 48 or more hours. In 2012, there were over 250,000 outpatient observation stays that lasted 48 or more hours.<sup>22</sup>

### Common diagnoses

In 2012, outpatient observation stays were concentrated among relatively few diagnoses, many of the same diagnoses that were also common among short inpatient stays. To ensure that the diagnosis codes, which are in different coding systems for inpatient and outpatient admissions, were comparable, we used a cross-walk method to convert the principle diagnoses and procedure codes of outpatient claims into inpatient MS-DRGs. The outpatient observation stays translated broadly into 90 percent of all MS-DRGs, but most of these MS-DRGs contained very few cases. Instead, six MS-DRGs accounted for about 40 percent of outpatient observation stays and were common to one-day inpatient stays.<sup>23</sup> Specifically, they constituted 6 of the 10 most common one-day-inpatient-stay MS-DRGs and accounted for about 50 percent of one-day inpatient stays. These six MS-DRGs also generated the most RAC overpayment revenue.

**FIGURE  
7-1**

**Outpatient observation stays and inpatient stays preceded by observation per beneficiary increased between 2006 and 2012**



Source: Medicare inpatient and outpatient 2012 standard analytic file claims.

**Characteristics of hospitals with high rates of one-day inpatient and observation use**

In examining the distribution of one-day inpatient and outpatient observation stays across hospitals, the Commission found that certain hospitals use a disproportionate share of the stays. At the same time, a smaller group of hospitals is more likely to have long observation stays, defined as lasting 48 or more hours.

We calculated three ratios to better understand the variation in hospitals' use of one-day inpatient and outpatient observation stays: a one-day inpatient stay ratio, an outpatient observation stay ratio, and a long outpatient observation stay ratio.<sup>24</sup> Using these ratios, we examined variation in use by facility characteristics such as size, teaching status, Medicare volume, and location. The ratios were constructed using 2012 inpatient and outpatient Medicare claims data for hospitals paid under the IPPS, excluding Maryland hospitals.

To ensure adequate volume for legitimate comparison, we limited the calculation of the hospital-level ratios to only

those inpatient and outpatient stays that we grouped into one of 55 MS-DRGs. These MS-DRGs were selected because they either (1) ranked among the top MS-DRGs for both number of inpatient one-day stays and outpatient observation stays or (2) ranked among the top surgical MS-DRGs for both the number of one-day inpatient stays and the amount of dollars denied by the RACs for short inpatient stays that the RAC determined should have been provided in an outpatient setting. Using a cross-walk method, we grouped the outpatient claims' diagnosis and procedure codes into inpatient MS-DRGs.<sup>25</sup> (See text box, p. 188, for more information on the characteristics of beneficiaries served with one-day inpatient stays versus outpatient observation stays.)

**One-day inpatient stay use**

One-day inpatient stays were common across hospitals. On average, 6 percent of stays (ratio of 0.06) that came into the hospital either as an inpatient or outpatient case ended up as a one-day inpatient stay (Table 7-5). While one-day inpatient stays composed 9 percent or fewer discharges at most hospitals, a small group of hospitals utilized one-day inpatient stays at a higher rate. For example, the 90th percentile of hospitals, defined as

**TABLE  
7-5**

**Variation in hospital-level use of one-day inpatient stays and outpatient observation stays, 2012**

Utilization ratio and hospital group	Number of hospitals	Mean	Percentile				
			10th	25th	50th	75th	90th
One-day inpatient stay	3,248	0.06	0.02	0.03	0.05	0.07	0.09
Outpatient observation stay	3,248	0.09	0.02	0.05	0.08	0.12	0.16
Long outpatient observation stay	2,753	0.09	0.02	0.04	0.08	0.12	0.17

Note: Analysis is limited to 55 Medicare severity–diagnosis related groups with inpatient one-day stay and outpatient observation overlap. One-day inpatient stay ratio is defined as the number of one-day inpatient stays divided by the sum of all inpatient stays, outpatient observations stays, outpatient emergency department visits, and outpatient surgical stays. The outpatient observation stay ratio is defined as the number of outpatient observation stays over the sum of all inpatient stays, outpatient observations stays, outpatient emergency department visits, and outpatient surgical stays. The long outpatient observation stay ratio is defined the number of outpatient observation stays lasting 48 or more hours divided by all outpatient observation stays.

Source: MedPAC analysis of the standard analytic files of inpatient and outpatient hospital claims, 2012.

having a one-day inpatient stay ratio equal to or exceeding 0.09 (9 percent), had an average one-day stay ratio equal to 0.12 (12 percent) and accounted for 26 percent of the payments associated with one-day inpatient stays (data not shown). In general, this group of hospitals consisted of urban, teaching, and for-profit hospitals.

**Outpatient observation stay use**

On average, 9 percent of stays (ratio of 0.09) that came into the hospital either as an inpatient or outpatient case used outpatient observation status. The 90th percentile of hospitals, defined as those that had an outpatient observation ratio equal to or exceeding 0.16 (16 percent), had an average outpatient observation-stay ratio equal to 0.20 (20 percent) and accounted for 19 percent of the payments associated with outpatient observation stays (data not shown). These hospitals were disproportionately small, rural, government, and nonteaching hospitals.

**Long outpatient observation stay use**

Overall, 85 percent of hospitals had outpatient observation stays that lasted longer than 48 hours. Among these hospitals, an average of 9 percent of their observation stays lasted 48 hours or longer (ratio of 0.09). The 90th percentile of hospitals providing this type of stay, defined as those that had a long observation stay ratio equal to or exceeding 0.17 (17 percent), had an average long observation stay ratio of 0.24 (24 percent) and accounted for 1 percent of payments for long observation stays (data not shown). These hospitals were

disproportionately small and rural and accounted for a relatively small share of observation payments.

**Beneficiary liability tied to observation status**

Medicare beneficiaries’ financial liability for short stays depends on whether they are admitted to the hospital for an inpatient stay or remain in outpatient observation status. Beneficiaries in an inpatient setting are responsible for paying the Part A deductible, while beneficiaries in an outpatient setting are responsible for paying a coinsurance amount based on a share of allowed charges.<sup>26</sup> Overall beneficiary financial liability is higher for clinically similar cases when served in the inpatient setting compared with those served in outpatient observation status. However, the time that beneficiaries were treated in outpatient observation does not count toward the SNF coverage eligibility requirement of three inpatient days, making those who require SNF care financially liable for services provided by SNFs. In addition, beneficiaries are financially responsible for self-administered drugs (SADs) provided by the hospital while in an outpatient observation stay.

**Beneficiary out-of-pocket hospital liability by type of stay**

In 2012, for most beneficiaries, cost sharing was less for outpatient stays compared with inpatient stays. In that year,

## Characteristics of beneficiaries served with one-day inpatient stays versus outpatient observation stays

The Commission compared the characteristics of beneficiaries who received observation services with those who were admitted to a one-day inpatient prospective payment system hospital stay. We determined that these beneficiaries were largely similar in race, in the share living in an institutional setting, and in Medicaid eligibility. Beneficiaries with an observation stay lasting fewer than 24 hours had lower risk scores and were less likely to have 5 or more chronic conditions than those who were admitted to one-day inpatient stays.

Further, beneficiaries with longer observation stays (exceeding 24 hours) had more chronic conditions, higher risk scores, and were slightly older on average compared with beneficiaries with one-day inpatient stays. Beneficiaries with longer observation stays were also more likely to have a history of Alzheimer's disease and depression (Table 7-6). ■

**TABLE  
7-6**

**Characteristics of beneficiaries served in one-day inpatient stays similar to outpatient observation stays, but differences exist between outpatient observation stays, 2012**

Beneficiary characteristics	Share with inpatient one-day stay	Share with outpatient observation stay		
		All	Less than 24 hours	24 hours or more
Beneficiary with:				
Five or more chronic conditions	57%	57%	54%	60%
Alzheimer's or senile dementia	11	14	12	16
Depression	24	27	26	28
Median risk score	1.28	1.25	1.19	1.31
Average age	71	72	71	73

Source: MedPAC analysis of the 2012 Medicare standard analytic files of inpatient and outpatient hospital claims, the 2012 Master Beneficiary Summary file, and the 2012 Medicare risk score file.

the overall median beneficiary liability for an inpatient case was \$1,156 (the same dollar level as the inpatient deductible); this amount was the same for stays that included one midnight (Table 7-7). The median liability for outpatient observation stays that included one midnight was substantially lower at \$282. Outpatient surgical stays that included one midnight had median liability of \$1,116, slightly less than the inpatient deductible. At the 90th percentile, liability for outpatient surgical stays was about \$500 more than the inpatient deductible. Outpatient emergency department (ED) stays that included one midnight had a comparatively low median liability of \$107. In 2012, less than 4 percent of beneficiaries served in outpatient observation status had liabilities that exceeded the level of the inpatient deductible; many of

these beneficiaries did not themselves pay these amounts because they had supplemental insurance.<sup>27</sup>

### Beneficiaries discharged to a SNF without SNF coverage

Beneficiaries discharged to a SNF without qualifying for Medicare SNF coverage are among those most at risk of having higher financial liability if they are served in outpatient observation status. By statute, to qualify for Medicare SNF coverage, a beneficiary must have been an inpatient at a hospital for at least three consecutive calendar days preceding the SNF admission. The calculation of the three inpatient days applies only to the time between the inpatient admission date and the inpatient discharge date of a hospital stay. It does not include time spent in

**TABLE  
7-7**

**Median beneficiary out-of-pocket costs were higher for beneficiaries served in inpatient status, 2012**

Type of stay	Beneficiary out-of-pocket costs		
	10th percentile	Median	90th percentile
All inpatient	\$0	\$1,156	\$1,156
Stays that crossed one midnight:			
Inpatient one-day	0	1,156	1,156
Outpatient observation	150	282	723
Outpatient surgical	443	1,116	1,651
Outpatient emergency department	47	107	278

Note: Beneficiary out-of-pocket costs for inpatient stays that are equal to \$0 or less than the inpatient deductible are the result of beneficiaries having paid the inpatient deductible in the benefit period as part of a previous inpatient stay.

Source: MedPAC analysis of the 2012 Medicare standard analytic files of inpatient and outpatient hospital claims.

outpatient care, observation status, or in the ED before an inpatient admission to the hospital (Centers for Medicare & Medicaid Services 2014c). The rationale behind this policy is to ensure that Medicare SNF coverage is a post-acute care benefit, not a long-term care benefit.

SNF eligibility and coverage is of particular concern to policymakers and beneficiary advocates alike because when Medicare does not cover SNF care, the beneficiary is liable for the entire cost of the stay out of pocket. According to a recent study from OIG, about 4 percent of beneficiaries with outpatient observation stays were discharged to a SNF in 2012.<sup>28</sup> These beneficiaries could be liable for an average of \$10,500 out of pocket for a noncovered SNF stay (Office of Inspector General 2013).

Beneficiaries served in outpatient observation status may not realize that they have not been officially admitted to the hospital as an inpatient. The Medicare program does not require hospitals to notify beneficiaries of their outpatient observation status or inform beneficiaries that time spent in observation status does not count toward the SNF three-day threshold. Several states have passed laws requiring hospitals to inform patients about their status in observation, and several others have considered action.<sup>29</sup>

In general, few beneficiaries find themselves in a situation in which they spend three days in the hospital and subsequently receive SNF care without having been eligible for SNF coverage. In 2012, 102,000 hospital stays involved beneficiaries who were in the hospital for longer than three days, including time in outpatient observation

status and inpatient status, but did not meet the three-day inpatient requirement for SNF coverage.<sup>30</sup> Among this group of hospital stays, 12,000 were discharged to a SNF despite not meeting the SNF three-day eligibility rule. From 2009 to 2012, the number of hospital stays that were discharged to a SNF without SNF coverage increased more than 70 percent. Nonetheless, CMS may have inappropriately paid SNFs for more than 90 percent of these 12,000 stays in 2012, despite beneficiaries' lack of SNF coverage (Office of Inspector General 2013). Therefore, it is difficult to quantify the degree to which beneficiaries have been responsible for the full liability associated with a noncovered SNF stay.

The Commission's evaluation of SNF-related liability for beneficiaries served in observation has led to consideration of how many cases could be helped by a policy that modifies the existing SNF three-day prior hospitalization policy. Among the group of 102,000 stays (in which beneficiaries spent three days in the hospital but did not qualify for SNF coverage) were two distinct groups of cases. First, half (about 52,000) of these stays were in the hospital for three days, of which at least one was an inpatient day. The other half (about 49,000) of these stays were in the hospital for three days but never had an inpatient admission. To estimate how many cases from these two groups might be discharged to a SNF after their hospital stay, we considered that observation cases have lower risk scores than inpatient cases and that, in 2012, about 25 percent of inpatient cases were discharged to a SNF. If we assume that 20 percent of these 102,000 cases were discharged to a SNF, then that assumption

**TABLE  
7-8**

**Self-administered drug charges and costs per claim among hospitals that reported charges for self-administered drugs, 2012**

Type of hospital outpatient claim	Percent of claims that included self-administered drug charges	Per claim with self-administered drug charges	
		Average charges for self-administered drugs	Average estimated cost for self-administered drugs
Observation	75%	\$209	\$43
Emergency department	27	40	8
Surgery	32	115	24

Note Data are limited to the two-thirds of hospitals that reported self-administered drug charges on at least one claim. Data include claims for hospital outpatients and exclude critical access hospitals, hospitals without reliable cost report data, and beneficiaries enrolled in health maintenance organizations during the year. Self-administered drugs are identified by revenue center 637. Claims that contain more than one of type of service are categorized based on the following hierarchy: observation, emergency department, and surgery.

Source: MedPAC analysis of the standard analytic files of outpatient hospital claims and cost report data from CMS, 2012.

would generate approximately 20,000 reimbursable SNF stays. Alternatively, if the 52,000 stays with at least one inpatient day were to become eligible for SNF coverage, this situation would generate about 10,000 additional reimbursable SNF stays.<sup>31</sup>

**Self-administered drugs not covered for beneficiaries in outpatient observation**

Beneficiaries who receive care in a hospital outpatient department may face an additional liability for SADs. Drugs that are usually considered self-administered (such as oral medications) are covered by Medicare Part A for hospital inpatients but are generally not covered by Medicare Part B for hospital outpatients. If a hospital provides a SAD to a hospital outpatient, the drug is considered noncovered and the hospital bills the beneficiary for the drug at full charge. Beneficiaries who have Medicare Part D coverage may be able to submit a claim to their Part D plan to get some reimbursement for the drug. However, the hospital pharmacy may not be in the Part D plan’s network, or the amount the beneficiary is reimbursed by the Part D plan may be less than the amount the beneficiary owes the hospital for the drug.

To assess the scope of this concern, the Commission analyzed Medicare claims and cost report data on SAD charges and costs for hospital outpatients.<sup>32</sup> In 2012, about two-thirds of hospitals that submitted claims to Medicare for outpatient observation stays reported charges for noncovered SADs for at least some of their observation patients, while one-third of hospitals did not report SAD charges for any patients.<sup>33</sup> Among the two-thirds of hospitals reporting SAD charges, about 75 percent of

observation claims included charges for SADs (Table 7-8). These claims had average drug charges of \$209 per claim and an estimated average cost of \$43 per claim.

SADs were also charged on ED and outpatient surgical claims, but with a lower frequency and lower average cost. Among hospitals that reported charges for SADs in 2012, roughly 30 percent of these two types of claims included SAD charges. Average charges and costs for these drugs per ED claim were \$40 and \$8, respectively, and per outpatient surgical claim were \$115 and \$25, respectively.

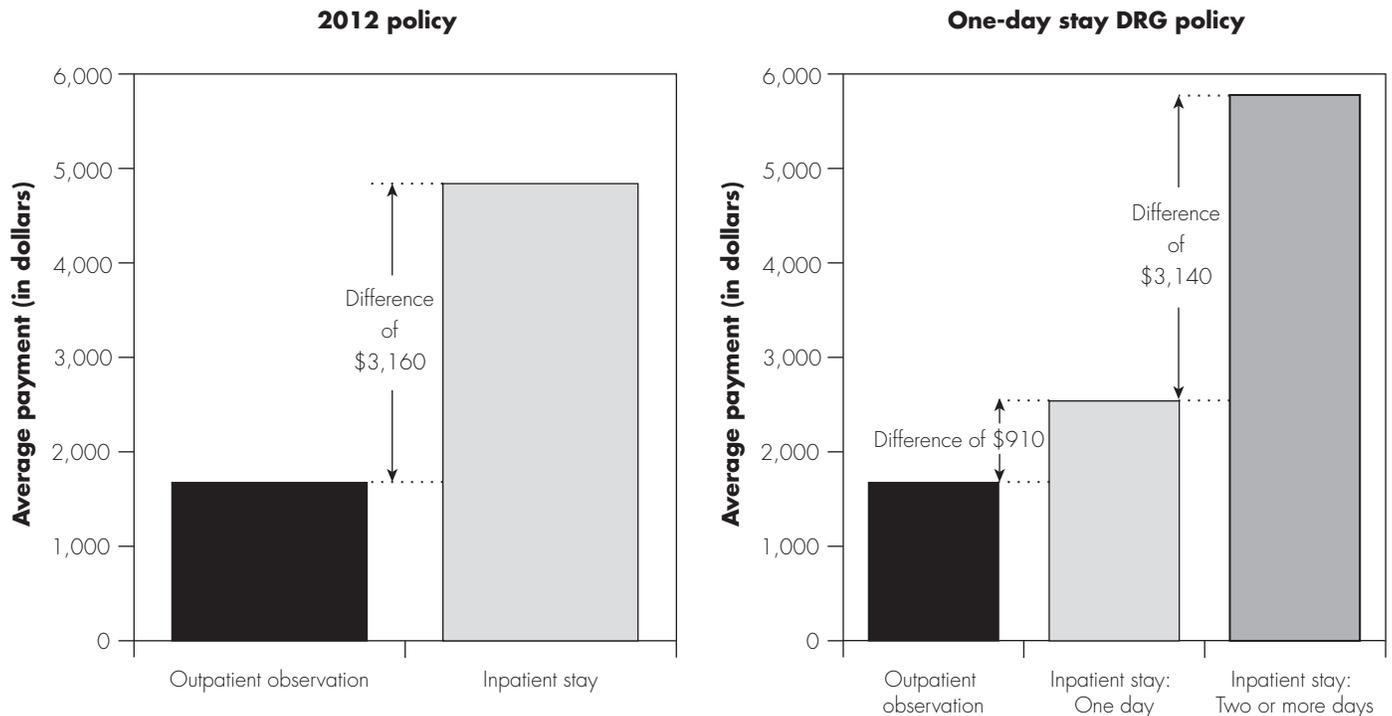
**Hospital short-stay policy options**

The Commission’s discussion of hospital short-stay issues has covered four general areas: payment for short hospital stays, the RAC program, a hospital short-stay penalty, and beneficiary financial liability. The Commission has noted several concerns related to hospital short stays that touch each of these areas.

- The Commission has concluded that one of the sources of the short-stay issue is the payment difference between short inpatient stays and similar outpatient stays. This cliff provides hospitals with the incentive to admit beneficiaries to inpatient care.
- The Commission has considered the necessity of the “two-midnight” rule.
- The Commission has identified several possible improvements to the RAC program that reduce the administrative burden on hospitals and CMS, improve

**FIGURE 7-2**

**Effect of simulated one-day stay DRG policy for selected medical DRGs**



Note: DRG (diagnosis related group). Chart includes results from a simulation of a one-day stay DRG policy. Displayed in the chart is the weighted average payment rate for the 10 medical DRGs with the most one-day inpatient stays that are also common to outpatient observation. Similar outpatient observation claims are identified by using a cross-walk process to link outpatient claims to Medicare severity–diagnosis related groups. Average payment includes add-on payments such as indirect medical education and disproportionate share hospital payments.

Source: MedPAC analysis of Medicare claims and cost report data.

RAC accountability when its claim denials are overturned, and align the RAC review window with the Medicare hospital rebilling program.

- The Commission has expressed concern about how the increased use of observation stays exposes beneficiaries to excessive financial liability when they are discharged to a SNF without having met the SNF coverage eligibility threshold and when they receive self-administered drugs during an outpatient stay.

### Payment policy approaches to hospital short stays

If policymakers want to address the financial incentives associated with payment differentials between short inpatient stays and similar outpatient stays, payment changes could be considered. For example, payment changes could be made to reduce or eliminate the payment difference between short inpatient stays and similar outpatient stays through one-day-stay diagnosis

related groups (DRGs) or through a site-neutral payment approach. However, there are trade-offs to these types of payment changes because they may create vulnerabilities elsewhere within the payment systems. The Commission has not recommended a specific payment approach but instead discusses the advantages and disadvantages of each of these options.

To lessen the payment difference between short inpatient stays and similar outpatient stays, policymakers could consider creating one-day-stay DRGs under the IPPS. With one-day-stay DRGs, Medicare would pay less for one-day inpatient stays and more for longer inpatient stays than the existing DRGs into which these stays are currently grouped. A one-day-stay DRG would not change the payment rate for a similar outpatient stay, but reducing the payment rate for an inpatient one-day stay would bring the two rates closer together.

Figure 7-2 illustrates the effect of creating special one-day-stay DRGs under the IPPS based on our simulation

## Inpatient one-day-stay diagnosis related group simulation

To illustrate the effect of creating one-day-stay diagnosis related groups (DRGs) on hospital financial incentives, we simulated a hypothetical one-day-stay DRG policy.

### Methodology for creating a hypothetical one-day-stay DRG policy

In the interest of maintaining the averaging principle underlying the DRGs as much as possible, we limited the number of DRGs that were affected by the one-day-stay policy. We selected 55 DRGs with substantial inpatient and outpatient overlap. In addition, we included any DRGs that were in the same DRG family (i.e., same base DRG) as the 55 DRGs to make the policy consistent across DRGs within the same family. This selection yielded a total of 93 DRGs, which accounted for about 61 percent of inpatient one-day stays and 73 percent of outpatient observation stays.

To construct one-day-stay DRGs, we split each of the 93 selected DRGs into 2 DRGs: a DRG for one-day

stays only and a DRG for stays of two days or more. We then collapsed the 93 one-day-stay DRGs into 44 one-day-stay DRGs by grouping one-day stays for the same base DRGs together. Payment rates were simulated for these new or modified DRGs under the assumption that the policy would be budget neutral within the inpatient setting (meaning that aggregate inpatient payments would be unchanged).

### Results of the simulation

Overall, a one-day-stay DRG policy reduces the payment difference between an inpatient one-day stay and similar outpatient stay, while creating a new payment cliff within the inpatient system between a one-day inpatient stay and longer inpatient stays. To illustrate this effect, our analysis compared the average payment rate across the top 10 medical DRGs and top 10 surgical DRGs (in numbers of inpatient one-day stays) under current policy and the illustrative one-day-stay DRG policy. Under current policy, for the 10 medical DRGs, Medicare paid roughly \$3,160 more,

*(continued next page)*

of an illustrative one-day-stay DRG policy. (See text box for more details on the simulation methodology.) Under the 2012 policy, for 10 selected medical DRGs, inpatient stays were paid \$3,160 more on average than similar outpatient observation stays. A one-day-stay DRG policy would reduce this payment difference to \$910 on average, but would create a new payment differential within the IPPS between one-day and two-day (or longer) stays. Our simulation estimates that inpatient stays of two or more days would be paid \$3,140 more on average than one-day inpatient stays for the selected DRGs. Thus, a one-day-stay DRG policy would reduce the financial incentive to admit a patient for one-day inpatient stays, but would create a financial incentive to extend an inpatient stay from one to two days.

Alternatively, a site-neutral approach—one that pays comparable rates for similar inpatient and outpatient stays—is another option. The effect of a site-neutral approach may be different for medical and surgical hospital stays. For medical stays, an example of a site-

neutral approach would be to pay observation stays that exceed a certain hour threshold (e.g., 24 hours) a rate comparable with a short inpatient medical stay (e.g., a one-day inpatient stay).<sup>34</sup> However, similar to a one-day-stay DRG policy, this approach would give hospitals the financial incentive to extend inpatient stays to reach the two-day threshold. Similarly, hospitals would have a financial incentive to keep a patient in observation until she or he met the 24-hour threshold. For medical stays, it would be difficult to eliminate the inpatient and outpatient payment differential because identifying similar stays would likely necessitate establishing length-of-stay criteria, which would create new payment differentials.<sup>35</sup>

Because surgery is a more clearly defined service, it might be possible to develop site-neutral payment for similar inpatient and outpatient surgeries without creating payment differentials based on length of stay. For example, criteria could be developed to identify surgical cases that occur in both the hospital outpatient and inpatient

## Inpatient one-day-stay diagnosis related group simulation (cont.)

on average, for an inpatient stay than an outpatient observation stay. For the 10 surgical DRGs, Medicare paid roughly \$4,240 more, on average, for an inpatient stay than for a comparable outpatient surgery. Under the simulated one-day-stay DRG policy, the payment difference, on average, between a one-day inpatient stay and a similar outpatient visit would be reduced to about \$910 for the 10 medical DRGs and \$2,300 for the 10 surgical DRGs. However, the one-day-stay DRG policy creates a payment differential between a one-day inpatient stay and longer inpatient stays. The average payment for an inpatient stay lasting 2 days or more would exceed the average payment for a one-day inpatient stay by roughly \$3,140 for the 10 medical DRGs and \$3,330 for the 10 surgical DRGs. Thus, the one-day-stay DRG policy reduces the financial incentive to admit a patient for a one-day stay who could otherwise be treated as an outpatient, but creates a financial incentive for a hospital to keep the patient as an inpatient for a second day.

The illustrative one-day-stay DRG policy would very modestly redistribute inpatient payments to hospitals. Hospitals that have an above average number of one-day inpatient stays as a share of all inpatient stays (in the DRGs affected by the policy) would experience a revenue decrease while other hospitals would

settings and that are also very common to the outpatient setting (e.g., more than half of cases are performed in the outpatient setting). Additional criteria could be developed for identifying surgeries appropriate for site-neutral payment, such as similarity in care delivered or resources used across inpatients and outpatients. For surgeries meeting these criteria, Medicare could pay hospitals a comparable rate regardless of whether the patient was admitted. A site-neutral approach for surgeries could take a number of different forms. For example, site-neutral payment for surgeries could be carved out of the IPPS and OPPS and moved into a separate payment system. Alternatively, surgeries qualifying for site-neutral payment could be subsumed under one of the existing payment systems (i.e., require all such surgeries be billed to and paid under either the IPPS or OPPS).

**TABLE  
7-9**

**Effect of illustrative one-day DRG policy on hospital revenues by percentile of change to hospital**

Hospital by percentile of revenue change	Percent change in revenues
Percentile	
5th	-2.2%
10th	-1.5
25th	-0.7
50th	0.0
75th	0.7
90th	1.4
95th	2.0

Note: DRG (diagnosis related group).

Source: MedPAC analysis of Medicare claims and cost report data.

experience an increase or no change in revenues (Table 7-9). Eighty percent of hospitals (between the 10th and 90th percentiles) would have a positive or negative revenue change of 1.5 percent or less. Ten percent of hospitals (below the 5th percentile and above the 95th percentiles) would have a positive or negative revenue change of roughly 2 percent or more. ■

Payment changes such as one-day-stay DRGs or site-neutral payment for medical stays would raise additional questions. For example, would a budget-neutrality adjustment be warranted to account for the potential increase in payments that could occur if providers lengthened inpatient stays in response to new payment differences between one-day and two-day inpatient stays? Another issue that would need to be considered is what type of audit oversight would accompany a revised payment policy. The approach used by the two-midnight rule of auditing one-day stays and generally exempting stays of two or more days from auditing would not be consistent with a one-day-stay DRG policy or a site-neutral policy. Instead, an approach to auditing focused on incentives driven by the new payment differentials under a revised payment system would be required.

Payment policy changes such as one-day-stay DRGs and site-neutral payment for medical stays would involve trade-offs. An open question is which set of incentives—those under the current payment systems or those under a revised payment system—are preferable. Several arguments can be made in favor of a revised payment system. Some stakeholders assert that short inpatient stays and observation stays represent similar care and that the distinction between an inpatient stay and an observation stay is not clear cut and essentially is artificial. From that perspective, reducing or eliminating the payment differences between short inpatient stays and similar outpatient observation stays would be a step toward rationalizing payments by paying similar rates for similar care. Revising the payment system may reduce the need to audit one-day inpatient stays for admission appropriateness because the financial consequences related to the admission decision would be reduced.

By contrast, several arguments can be made against revising the payment system and for retaining the current payment system. Because a revised payment system would create new payment cliffs and associated vulnerabilities, it may broaden the need for audit oversight. Moving away from the fixed inpatient DRG payments to one-day-stay DRGs or site-neutral payment also raises concerns about creating financial incentives for longer stays, which is counter to the original structure and intent of the DRG system. Additionally, policymakers may need to better understand how these potential policies might interact with the existing IPPS recalibration process. It is notable that the existing IPPS recalibration process may, over time, modestly lessen—although not eliminate—the payment cliff between short inpatient stays and similar outpatient stays.<sup>36,37</sup> Given the competing arguments for and against payment policy changes, the Commission has chosen not to recommend payment changes at this time. However, the Commission has noted interest in continuing to explore these and other potential hospital short-stay payment policy concepts in the future.

### **RAC program changes**

The Commission has identified several concerns with RAC program audits of short stays, including the administrative burden on individual hospitals and CMS, the greater need for holding auditors accountable for their performance, and the lack of synchronization of the RAC program’s look-back period and the allowable Medicare hospital rebilling window. The two-midnight rule addresses some of the problems it was intended to

resolve, but it also generates additional concerns among some stakeholders.

The Commission recommends changes to the RAC program that could alleviate some of the problems that led CMS to implement the two-midnight rule. In particular, reforming the RAC program in these three areas could make RACs more judicious in auditing claims and could mitigate the need for the two-midnight rule’s safe harbor from RAC audits. Therefore, the Commission asserts that the four components of this recommendation must be treated as a package rather than as separable elements.

## **RECOMMENDATION 7-1**

### **The Secretary should:**

- **direct recovery audit contractors (RACs) to focus reviews of short inpatient stays on hospitals with the highest rates of this type of stay,**
- **modify each RAC’s contingency fees to be based, in part, on its claim denial overturn rate,**
- **ensure that the RAC look-back period is shorter than the Medicare rebilling period for short inpatient stays, and**
- **withdraw the “two-midnight” rule.**

## **RATIONALE 7-1**

### **Administrative burden**

A RAC audit focus on hospitals with excessive use of short inpatient stays would create efficiencies for compliant hospitals. In other words, the share of hospitals demonstrating high use of short inpatient stays would be subject to greater RAC review, while the share of hospitals with low use of these stays would be subject to fewer or no RAC reviews of short hospital stays.

The hospital industry contends that the RAC program has increased hospitals’ administrative burden, thereby increasing their cost of providing care. The current RAC program reviews inpatient claims from a broad number of hospitals, which may amount to as much as 90 percent of all hospitals (American Hospital Association 2014a). Nearly all hospitals admit patients for short inpatient stays, but only a subset of hospitals accounts for a preponderance of these stays. However, the Commission notes that a policy designed to identify high-use hospitals would need to incorporate a risk-adjustment methodology because variation likely exists in the mix of hospitals’ short-stay cases. For example, hospitals that have higher than average shares of short stays—urban, teaching, and for-profit

hospitals—may conduct a high volume of certain types of surgeries. In addition, this recommendation focuses on short inpatient stays because RACs have placed greater emphasis on these stays. The Secretary should have the discretion to define short stays because this policy may create the incentive to lengthen stays and may change hospital behavior over time.

### **Accountability of RAC auditors**

The purpose of adjusting RACs' contingency fees based on their performance is to hold RACs more accountable for their decisions to deny hospitals' claims for short stays. If a denial overturn rate is used, the Secretary should have latitude to define the rate in a way that most accurately reflects RAC performance.

The contingency fee structure provides incentives for RACs to identify as many inappropriate payments and as many claims with the largest associated payments as possible. Currently, RACs must return the contingency fee to CMS if a hospital appeals the denial of the claim and wins its appeal, but RACs currently face no penalties when claim denials are overturned on appeal.

### **Rebilling claims following denial by RACs**

Currently, the timing of the RAC program claim denial process and the timing of the Medicare rebilling policy are out of sync, making hospitals' rebilling of denied claims administratively infeasible. Under current policy, RACs have a three-year look-back period to review claims, but hospitals have only a one-year window to rebill denied inpatient claims. An alignment of these two processes would enable hospitals to rebill more RAC-denied inpatient claims as outpatient claims. CMS's analysis of 2011 data concluded that 25 percent of RAC-denied inpatient claims were denied within one year of the claim's date of service. Therefore, we expect that 25 percent of the RAC-denied claims would have been eligible for rebilling had that program been in place.

The Commission believes the Medicare program should increase hospitals' opportunities to rebill RAC-denied claims. In these cases, a hospital service was provided to a Medicare beneficiary and the hospital should receive reimbursement for it. However, the Medicare rebilling program should maintain a time limit from the date service was provided because hospitals should have the incentive to submit claims accurately. The Commission believes hospitals should also be permitted to appeal RAC claim denials, but at a certain point, hospitals should need to choose between continuing an appeal and rebilling

for that claim. If the rebilling program were to have no time limit, we would be concerned that hospitals would have the incentive to initially submit more claims with inpatient status, knowing that they can always rebill for the denied claim after fully exhausting all levels of appeal. Such a scenario would not be beneficial for the program, beneficiaries, or providers because it could further congest the appeals process. To balance these concerns, the RAC look-back period should be shorter than the one-year rebilling window. The period should be short enough to provide hospitals with enough time between the look-back period and the rebilling window to enable them to rebill RAC-denied claims but long enough that hospitals do not have idle time between the look-back period and the rebilling window to fully exhaust the appeals process for every RAC-denied claim. For example, in the context of a one-year rebilling window, the RAC look-back period could be shortened to between 4 and 8 months. However, the Secretary also could adjust the rebilling window consistent with the principles above: hospitals should not be able to fully exhaust the appeals process before initiating rebilling, and there should be a clear window for hospitals to rebill denied claims. The rules regarding rebilling should be structured to ensure that hospitals cannot circumvent RAC review by delaying claims submission until after the RAC look-back period has elapsed. For example, the shortened RAC look-back period could apply only to claims that the hospital submitted within a specified time frame after the date of beneficiary discharge; otherwise, the standard RAC look-back period could apply.

### **Two-midnight rule**

Implemented in response to various stakeholders' desire to clarify the appropriateness of inpatient hospital admissions through a time-based admission standard and to provide hospitals with relief from RAC audits, the two-midnight rule addresses some of its stated goals but also generates some unintended consequences. The two-midnight rule likely reduces long observation stays, and it relieves administrative burden by exempting all stays longer than two midnights from RAC oversight (unless there is evidence of abusive practices). The scope of this exemption, or safe harbor, from RAC audits may be problematic because it provides hospitals with the incentive to lengthen stays to avoid RAC scrutiny and largely eliminates oversight for a large share of hospital claims. To avoid RAC scrutiny, hospitals might lengthen stays by increasing their use of short observation stays or inpatient stays in general to get beyond the two-

midnight threshold. Withdrawing the two-midnight rule, in conjunction with implementing the Commission's other audit-related recommendations, would be a better way to address the concerns associated with hospital short stays.

## IMPLICATIONS 7-1

### Spending

- We expect this recommendation will increase Medicare program spending. Targeted audits are unlikely to recover overpayments equal to those recovered under the existing RAC program. RAC-identified overpayments will decrease because imposing greater accountability will cause RACs to become more cautious in denying claims. The number of RAC-denied inpatient claims that are subsequently rebilled as outpatient claims will increase. Spending implications of the withdrawal of the two-midnight rule are unclear, but spending may increase if the Secretary decides to restore the 0.2 percent reduction made in the fiscal year 2014 IPPS final rule to account for the implementation of the two-midnight rule.

### Beneficiary and provider

- We do not expect that this recommendation will adversely affect Medicare beneficiaries with respect to access to care. The withdrawal of the two-midnight rule may have a mixed effect on beneficiary cost sharing because some stays would likely shift between inpatient and outpatient stays, and these settings have different cost-sharing structures. For providers, this recommendation may reduce administrative burden. Hospitals in aggregate also will experience an increase in revenues due to increased rebilling opportunities following inpatient claim denials. The impact on individual providers will depend on their utilization patterns. A subset of hospitals with high rates of short inpatient stays will receive increased scrutiny from RACs and may therefore experience increased claim denials and administrative burden. For the remainder of hospitals, this recommendation will reduce RAC scrutiny and thus decrease claim denials and administrative burden.

### Hospital payment penalty on short inpatient stays

Policymakers should continue to identify long-term options for reducing hospitals' administrative burden, lowering hospitals' costs, and reducing hospitals' financial incentive to admit patients while not discouraging clinical innovations that lead to shorter stays. The Commission

believes it is essential that the Secretary maintain adequate oversight of Medicare payments and that this oversight system be as efficient as possible. Concurrent with the RAC-related policies included in the previous section of the chapter, the Commission has discussed the concept of a payment penalty on hospitals with excessive short inpatient stays and believes there should be further study of this concept. Ultimately, a policy such as this could be implemented as either a replacement for or a supplement to RAC program audits of short inpatient stays.

## RECOMMENDATION 7-2

**The Secretary should evaluate establishing a penalty for hospitals with excess rates of short inpatient stays to substitute, in whole or in part, for recovery audit contractor review of short inpatient stays.**

## RATIONALE 7-2

The current RAC program has been effective in generating financial recoveries for the Medicare Hospital Insurance Trust Fund and inducing behavioral change in providers. However, the RAC program adds to the administrative burden of individual hospitals and increases the cost of the appeals process for the federal government. To alleviate these concerns, the Commission has considered a formula-based penalty on excess short inpatient stays that could serve to substitute, in whole or in part, for RAC reviews of short inpatient stays. This concept should be evaluated further because there are several design issues that could alter the penalty's potential effectiveness. As part of this study, the Secretary could consider gathering public feedback on this concept in future IPPS rulemaking. The Commission also intends to continue to explore the concept of the formula-based payment penalty on short inpatient stays.

### Design of the formula-based penalty

In designing a formula-based penalty, policymakers would need to address several fundamental design questions. For example, policymakers would need to determine how to define short stays, how to determine a short-stay penalty threshold, and how to determine the penalty amount.

**Defining short inpatient stays** Policymakers must decide on the definition of a short inpatient stay.

The Commission has defined short inpatient stays as those with a single overnight stay and those that are admitted and discharged on the same day. In addition, policymakers must decide whether utilization should be

measured by a simple count of short stays, by a count of excess short stays, or by another metric. To date, the Commission has considered a measure that counts excess short stays, which can be defined as the number of actual short stays minus the number of expected short stays. The Commission defines expected short stays as the product of a hospital's count of all inpatient stays multiplied by the national mean short-inpatient-stay utilization rate for each DRG (taking into account both inpatient and outpatient stays).

**Defining the short inpatient stay utilization threshold** The penalty threshold for relatively high use of short stays could be determined in a number of ways. For example, a hospital could be determined to be high use if its one-day inpatient stays accounted for 20 percent or more of its inpatient and outpatient stays. In calculating each hospital's short-inpatient-stay utilization, the Secretary would need to examine variation in hospitals' case mix and account for differences through risk adjustment because short-stay volume is affected by a hospital's mix of cases. The established threshold for high use could be adjusted over time based on changes in hospital short-stay utilization rates. For example, policymakers may wish to adjust the utilization rate threshold in subsequent years if hospitals, on average, begin reducing their use of short inpatient stays.

**Determining the payment penalty amount** A payment penalty amount could be determined in several ways. For example, the penalty could be a percentage reduction in the hospital's inpatient payment amount. Alternatively, the penalty could be valued as the average excess inpatient payment per one-day stay times the number of excess one-day stays above a certain threshold of stays.

### Consequences of a short-stay payment penalty

The design decisions made by policymakers would determine the outcome of a formula-based payment penalty, but in general, this policy would have positive and negative consequences.

#### Positive consequences

- A formula-based payment penalty could be a more efficient method of providing oversight of short inpatient stays. It could reduce hospitals' RAC-related administrative burden and reduce CMS's administrative burden in managing the RAC program. Hospitals may be able to reduce the number of staff they employ to handle RAC medical record requests or to track appeals through the appeals process.

- The penalty could be as effective as the RAC program at providing hospitals with the incentive to limit their use of short inpatient stays.
- In contrast to the existing RAC program, a payment penalty might be more transparent for hospitals. The penalty would have clearly defined thresholds compared with the more subjective RAC auditing process and ALJ appeals process.

#### Negative consequences

- Triggered by excess rates of one-day stays, the penalty would not distinguish between appropriate and inappropriate short inpatient stays on a case-by-case basis. Short inpatient stays can be broken down into two groups: appropriate admissions that are of short duration because of hospital efficiency and inappropriate admissions that could have been served in the outpatient setting. Because the penalty would be driven by a formula-based measure, utilization patterns of all one-day stays would determine the penalty. However, a formula-based measure may not be capable of differentiating between appropriate and inappropriate short stays. By contrast, the RAC program conducts a case-by-case review of appropriateness and is better able to differentiate these two types of one-day stays. Unlike the RAC claims review, a formula-based penalty could discourage clinically appropriate one-day stays that resulted from greater efficiency.
- Similar to the two-midnight rule, the penalty could provide hospitals with the incentive to avoid one-day inpatient stays by either increasing the use of observation status or lengthening inpatient stays beyond one day.

## IMPLICATIONS 7-2

### Spending

- We do not expect this recommendation to increase Medicare program spending at this time because the Commission recommends exploring the concept of a payment penalty rather than implementing a final policy.

### Beneficiary and provider

- We do not expect this recommendation to adversely affect Medicare beneficiaries or providers because the Commission recommends further exploration rather than implementation.

## Beneficiary protections

The recent increase in outpatient observation stays has exposed some Medicare beneficiaries—those who are discharged to a SNF without qualifying for SNF coverage and those who receive self-administered drugs—to greater financial liability. Beneficiaries treated in outpatient observation are not always aware of the key coverage and liability consequences of being served as an outpatient.

### Revise the SNF three-day prior hospitalization policy

Revising the SNF coverage eligibility requirement would permit time spent in outpatient observation status to count toward the three-day prior hospitalization threshold, but to protect the Hospital Insurance Trust Fund, such a revision would need to require that at least one of the three days be an inpatient day.

#### RECOMMENDATION 7-3

**The Congress should revise the skilled nursing facility three-inpatient-day hospital eligibility requirement to allow for up to two outpatient observation days to count toward meeting the criterion.**

#### RATIONALE 7-3

This policy seeks to balance reducing beneficiary liability for cases that currently do not qualify for SNF coverage with preventing the current SNF post-acute care benefit from expanding to a long-term care benefit. Allowing time spent in observation to count toward the three-day-stay requirement, while still requiring at least one of the three days to be an inpatient day, would allow more beneficiaries to qualify for SNF coverage and would limit the potential for a large increase in SNF use that might result from allowing observation to count for the entire three days. Beneficiaries who are never admitted or who are not in the hospital for three days would remain ineligible for SNF coverage. Overall, a partial reduction of the requirements for SNF coverage would increase SNF utilization.

In recent years, certain risk-bearing arrangements such as Medicare Advantage plans and some accountable care organizations (ACOs) within fee-for-service (FFS) Medicare have had the SNF three-day rule waived with the assumption that admitting patients directly to a SNF could reduce unnecessary hospitalizations. CMS should assess the need for the SNF three-day rule with regard to risk-bearing arrangements in general, including risk-bearing ACOs within FFS.

## Spending

- The Commission anticipates that this recommendation would increase program spending. An additional several thousand beneficiaries would qualify for SNF coverage, increasing the overall level of annual SNF spending. The overall impact of this policy on spending would also depend on the behavioral reaction of beneficiaries and providers. By establishing a lower threshold for Medicare SNF coverage, this policy could encourage further changes in behavior. For example, the lower threshold might encourage nursing facilities to return more beneficiaries to the hospital to requalify for the SNF benefit.

## Beneficiaries and providers

- The Commission anticipates that this policy would have a positive impact on the relatively small group of beneficiaries who are served in SNFs without Medicare SNF coverage. Such beneficiaries would see their out-of-pocket liability reduced dramatically. We anticipate that this policy would increase Medicare use and resulting payments to freestanding and hospital-based SNFs.

## Advanced beneficiary notification about observation status

Beneficiaries are often unclear about the differences between inpatient status and outpatient observation. Further, beneficiaries are occasionally surprised to learn that they failed to qualify for Medicare SNF coverage and are financially liable for the costs of SNF care. Thus, the Commission is concerned that some beneficiaries are not notified by the hospital treating them that they are being served in outpatient observation status rather than inpatient status.

To clarify beneficiary status, CMS has included some beneficiary education regarding observation services in recent publications. For example, the 2015 edition of *Medicare & You* directs beneficiaries (or family members on the beneficiary's behalf) to ask whether they are an inpatient or outpatient on each day of their hospital stay because their status may affect their financial liability. Further, a May 2014 CMS publication for beneficiaries called *Are You a Hospital Inpatient or Outpatient? If You Have Medicare—Ask!* provides details on the difference between inpatient and outpatient stays, including examples of what Medicare Part A and Part B cover and the coverage criteria for SNF care. The document also advises

beneficiaries to “always ask your doctor or hospital staff if Medicare will cover your SNF stay” (Centers for Medicare & Medicaid Services 2015b).

The Commission contends that the difficulty beneficiaries have in making distinctions between inpatient and outpatient coverage calls for requiring hospitals to notify Medicare beneficiaries, both orally and in writing, that their observation status could affect their cost-sharing liability and their coverage eligibility for SNF care as part of the discharge planning process.

#### RECOMMENDATION 7-4

**The Congress should require acute-care hospitals to notify beneficiaries placed in outpatient observation status that their observation status may affect their financial liability for skilled nursing facility care. The notice should be provided to patients in observation status for more than 24 hours and who are expected to need skilled nursing services. The notice should be timely, allowing patients to consult with their physicians and other health care professionals before discharge planning is complete.**

#### RATIONALE 7-4

Medicare currently does not require hospitals to notify beneficiaries of their outpatient observation status, regardless of the time these beneficiaries spend in the hospital. Medicare beneficiaries and beneficiary advocates often cite this lack of notification as a source of confusion for beneficiaries regarding SNF eligibility and cost-sharing liability. The Commission maintains that this notification should be provided at a time when a patient can best plan for posthospital care.

Several states now have laws or are considering laws that require hospitals to inform patients about their status in observation. Each state’s law includes at least one of the following parameters: how the notification is communicated (written or orally), when the notification is provided, and what coverage information the notification contains. The changes in discharge destination, admission patterns, and length of stay resulting from these policies remain uncertain given the recent implementation of the state laws. Further, given the narrow scope of the Commission’s recommendation for beneficiary notification, any changes that occur across the limited number of Medicare beneficiaries affected by this notification will be difficult to detect.

#### Spending

- This recommendation will have no significant effect on Medicare spending.

#### Beneficiaries and providers

- This recommendation will help provide beneficiaries with the basic coverage information they need to be able to work with discharge planners to determine the optimal post-acute care setting for their needs. Hospitals will have to make administrative changes to accommodate this policy and will incur an administrative cost to implement this policy.

#### Liability for self-administered drugs

Beneficiaries served in outpatient observation status can face high out-of-pocket costs for prescription medications they take while they are in the hospital. Specifically, if a hospital provides a self-administered drug (SAD) to a hospital outpatient, the drug is considered noncovered. The hospital bills the beneficiary for the drug at the full charge (approximately \$200, on average, for observation stays), which is typically substantially above the cost of the drug (approximately \$40, on average, for observation stays). By contrast, Medicare covers these drugs for hospital inpatient beneficiaries. As a result, beneficiaries face unexpected and occasionally large out-of-pocket costs for the SADs they received during their outpatient observation stay. The extent to which beneficiaries are affected by this issue varies by hospital. Some hospitals reportedly do not charge beneficiaries for SADs. Other hospitals contend that they must charge beneficiaries for SADs because of laws prohibiting beneficiary inducements. Some hospitals report that SAD charges are a source of patient dissatisfaction and that administrative resources, which are limited, are spent addressing these issues.

To address these concerns, Medicare should cover SADs under the OPSS, in a budget-neutral manner, for beneficiaries who are ordered to receive outpatient observation services. Under this approach, the Secretary would increase the outpatient payment rates associated with observation care—whether paid through the observation ambulatory payment classification (APC) or packaged into payment for other separately paid APCs on the claim—to reflect coverage of SADs, while the payment rates for other outpatient services under the OPSS would decrease slightly to offset the coverage, resulting in no additional Medicare spending.

## RECOMMENDATION 7-5

**The Congress should package payment for self-administered drugs provided during outpatient observation on a budget-neutral basis within the hospital outpatient prospective payment system.**

## RATIONALE 7-5

This recommendation would reduce beneficiary liability substantially. Beneficiaries in observation would no longer be liable for noncovered SADs at full charges. The beneficiary would face higher cost sharing for outpatient observation (reflecting Medicare's increased payment rate for observation), but this higher cost sharing would be counterbalanced by lower cost sharing on other nonobservation outpatient services. This recommendation would also make cost sharing for SADs more uniform across beneficiaries and OPPS hospitals. Payment for SADs should be packaged, rather than paid separately, to avoid creating the financial incentive to overprovide these drugs.

## IMPLICATIONS 7-5

### Spending

- This recommendation would cover SADs under the outpatient hospital payment system in a budget-neutral manner, so it would not increase program spending.

### Beneficiaries and providers

- Overall, this recommendation would reduce beneficiary liability for SADs. Hospitals would experience a small decrease in revenues obtained through beneficiary liability. This policy could also reduce hospital administrative burden associated with cost-sharing collections and beneficiary complaints regarding payment for SADs. ■

## Endnotes

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- 1 One-day stays include stays that crossed one midnight or no midnights. The length of inpatient stays is measured by the number of midnights a stay crossed. For example, a two-day stay is a stay that crossed two midnights.
- 2 Medicare beneficiaries typically enter into observation status through the hospital emergency department, but can enter through outpatient clinics or by direct referral. Hospitals manage observation patients either by placing them within an observation unit with staff specifically devoted to observation or by serving these patients in any available inpatient bed, with staff assigned to a broad range of patients.
- 3 Commercial insurers use a variety of strategies to encourage providers to avoid hospital admissions. In addition to policies requiring prior authorization and notification, some insurers clearly define admission criteria in provider contracts, implement care coordination programs, encourage hospitals to use hospitalists, and sign risk-based contracts with providers to give the provider an incentive to control patients' costs and keep the patient out of the hospital.
- 4 The length of inpatient stays is calculated by measuring the number of midnights the stay crossed. However, one-day stays include stays that crossed one midnight as well as stays that were discharged on the same day admission occurred.
- 5 Medicare's IPPS includes an outlier payment policy that provides hospitals with extra payments in cases where the costs of a case significantly exceed payments. Analyses of Medicare payment reported in this chapter include outlier payments.
- 6 The IPPS contains two different transfer policies that reduce payment for inpatient stays when a patient is transferred early in the stay to either another acute care hospital (hospital-to-hospital transfer policy) or certain post-acute care settings (post-acute transfer policy). Only 12 percent of one-day stays are affected by transfer policies (5 percent by the hospital-to-hospital transfer policy and 7 percent by the post-acute care transfer policy).
- 7 A few MS-DRGs in the top 15, such as septicemia and heart failure, had a substantial number of stays lasting one day because of deaths.
- 8 More information about Medicare's inpatient and outpatient prospective payment systems is available at <http://www.medpac.gov/documents/payment-basics/hospital-acute-inpatient-services-payment-system-14.pdf?sfvrsn=0> and <http://www.medpac.gov/documents/payment-basics/outpatient-hospital-services-payment-system.pdf?sfvrsn=0>.
- 9 To translate outpatient observation claims into inpatient MS-DRGs, we linked claims' outpatient Current Procedural Terminology (CPT) codes or Healthcare Common Procedure Coding System (HCPCS) codes to corresponding inpatient International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) procedure codes. We grouped the resulting outpatient claims into inpatient MS-DRGs using standard grouping software. Because the development of CPT to ICD-9-CM crosswalks is a clinically subjective exercise, we used several different versions of this crosswalk in our analyses.
- 10 This analysis is based on 2012 data, and changes were made to increase the payment rates moderately for observation in 2014. Observation care meeting certain criteria is eligible for payment through a composite APC for extended evaluation and management. The 2012 payment rate for the composite APC was \$394 or \$720, depending on how the patient entered observation (with the higher paid APC being the most prevalent). The total amount Medicare paid for observation in 2012 was more than the composite APC rate because certain services, such as imaging and clinical labs, received additional payment. In 2014, CMS established a single composite APC for observation and packaged some additional ancillary services into the APC, with the resulting 2014 APC payment rate being \$1,199. Some services remained separately billable in 2014, so total payment for observation would be more than this APC rate. In 2015, the observation APC payment rate increased to \$1,235.
- 11 Payment differences between short inpatient stays and comparable outpatient stays also exist for surgical stays, but the differences are generally smaller. For example, in 2012, payments for stays with MS-DRG 247 (percutaneous cardiovascular procedure with drug-eluting stent without MCC) were \$13,748, on average, when the case was a one-day inpatient stay and \$9,966, on average, when the case was a one-day outpatient stay.
- 12 The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 first established the Medicare RAC program as a demonstration project limited to California, Florida, and New York.
- 13 The Medicare appeals process has five levels, but RAC appeals are largely resolved after the first three levels. The process begins after the RAC makes a denial determination. The hospital has 120 days (4 months) to decide to appeal to the Medicare administrative contractor (MAC) (the first level of appeal). The MAC then has 60 days (2 months) to make a ruling. After the MAC's ruling, the hospital has 180 days (6 months) to decide whether or not to appeal to the qualified independent contractor (QIC) (the second level of appeal).

- If so, the QIC has 60 days (2 months) to make a ruling. Both the MAC and QIC appeal determinations involve an element of automation. After the QIC's ruling, the hospital has 60 days (2 months) to decide whether or not to appeal to the administrative law judge (ALJ) (the third level of appeal). The ALJ has 90 days (3 months) to make a ruling. This is the point at which the appeals process has experienced the most significant backlog. After the ALJ's ruling, the hospital has 60 days (2 months) to decide to appeal to the Medicare Appeals Council (the fourth level of appeal). The Council has 90 days (3 months) to make a ruling. After the Council's ruling, the hospital has 60 days (2 months) to decide whether or not to appeal to the federal court system (the fifth and final level of appeal). There is no established time line for the federal court's ruling, but assuming all these time lines are met, the process could take as long as 750 days (26 months). Hospitals control the pace of the appeal for 16 months (60 percent), and the other entities control the pace of appeal for 10 months (40 percent).
- 14 Audit accuracy rates represent how often RACs accurately determine overpayments or underpayments based on the validation of an independent contractor. The calculation of these rates is separate from the appeals process.
  - 15 A hospital may not replace denied inpatient care with what it contends is equivalent outpatient care because CMS intends for these beneficiaries to retain their inpatient status. CMS specifically excludes the following outpatient-only services from the hospital rebilling program: diabetes self-management training, physical therapy, speech-language pathology, occupational therapy, outpatient visits generally, emergency department visits, and observation. The hospital is also not permitted to alter the beneficiary's status from inpatient to outpatient.
  - 16 In addition to outpatient observation stays, the two-midnight rule has potentially had an impact on outpatient stays that do not contain observation status, such as surgical stays or other stays originating in the emergency department. We estimate that in 2012, there were about 200,000 of these nonobservation outpatient stays.
  - 17 CMS instructs physicians that, in deciding whether an inpatient admission is warranted, they should assess whether the beneficiary will require hospital services for two or more midnights (including time spent in the inpatient setting and the outpatient setting, such as in observation or the emergency department).
  - 18 In the fiscal year 2014 IPPS final rule, CMS estimated that the two-midnight policy would shift 360,000 stays from inpatient status to outpatient status and another 400,000 stays from outpatient status to inpatient status, a net increase of 40,000 inpatient stays. These cases represent less than 5 percent of all outpatient observation cases. As a result, CMS adjusted the inpatient base payment rates down by 0.2 percent for fiscal year 2014.
  - 19 Between 2012 and 2013, the utilization of one-day inpatient stays declined more rapidly (6 percent per beneficiary) than all other inpatient stays (3 percent per beneficiary).
  - 20 Between 2006 and 2012, surgical discharges declined 20 percent per fee-for-service Part A beneficiary, and medical discharges declined 11 percent per beneficiary. From 2011 to 2012, the decline of medical and surgical discharges was equal, at 6 percent, demonstrating the general migration of services to the outpatient setting.
  - 21 Between 2012 and 2013, the utilization of outpatient observation stays increased more than 4 percent per Medicare Part B beneficiary. Collectively, from 2006 to 2013, the number of visits per 1,000 beneficiaries increased 96 percent.
  - 22 In 2012, approximately 200,000 stays were between 48 hours and 71 hours in length, and nearly 50,000 stays were 72 hours or more.
  - 23 Six of the most common MS-DRGs across all outpatient observation stays in 2012 were chest pain (MS-DRG 313); esophagitis (MS-DRG 392); syncope (MS-DRG 312); cardiac arrhythmia (MS-DRG 310); disorders of nutrition (MS-DRG 641); and circulatory disorders except acute myocardial infarction, with cardiac catheterization (MS-DRG 287).
  - 24 The formula for the one-day-inpatient-stay ratio equals the number of one-day inpatient stays over the sum of all inpatient stays, all outpatient observations stays, all outpatient emergency department visits, and all outpatient surgical stays. The formula for the outpatient-observation-stay ratio equals the number of outpatient observation stays over the sum of all inpatient stays, all outpatient observations stays, all outpatient emergency department visits, and all outpatient surgical stays. The formula for the long-outpatient-observation-stay ratio equals the number of outpatient observation stays lasting 48 or more hours over all outpatient observation stays.
  - 25 The 55 MS-DRGs used for this analysis include the 6 MS-DRGs identified as common to both inpatient and outpatient observation stays. To translate outpatient observation claims into inpatient MS-DRGs, we linked outpatient CPT codes to corresponding inpatient ICD-9-CM procedure codes and then grouped the resulting outpatient claims into inpatient MS-DRGs using standard grouping software. We used several proprietary crosswalks of CPT to ICD-9-CM procedure codes because an official Medicare crosswalk does not exist.
  - 26 For inpatient stays, beneficiaries are responsible for a deductible amount in each benefit period (\$1,216 for fiscal year 2014) and a coinsurance payment amount if their stay

- is exceptionally long. For outpatient stays, beneficiaries are responsible for both a deductible amount and coinsurance. Medicare Part B beneficiaries are responsible for coinsurance of roughly 20 percent of the allowed amount, billed charges, or preset rate of the service, depending on the type of service received.
- 27 In 2012, approximately 85 percent of Medicare FFS beneficiaries had some form of supplemental coverage that shielded them from some or all of their inpatient deductibles and also outpatient Part B deductible coinsurance (Medicare Payment Advisory Commission 2014).
  - 28 Most of the remaining beneficiaries (84 percent) were discharged home, and a small share (11 percent) were discharged to other post-acute care settings.
  - 29 For example, Connecticut (2014), Maryland (2013), New York (2013), and Pennsylvania (2014) have state laws mandating hospitals to notify patients that they are in observation status. These laws vary in what exactly they require of hospitals. Two require notification be given to all patients in observation status and two require notification be given to patients after they have been in observation status for 24 hours.
  - 30 Between 2009 and 2012, the volume of these cases increased 61 percent, from 63,000 cases to 102,000 cases, or about 20 percent growth per year.
  - 31 Under a modified SNF three-day policy, a modest behavioral response such as increasing the length of stays might also result in SNF coverage for beneficiaries who had an inpatient admission and spent between 48 and 71 hours in the hospital. There were 46,000 of these stays in 2012.
  - 32 We focused on observation patients since the length of observation stays (on average more than 24 hours) can result in patients needing to get their regular medications from the hospital. We also included ED and outpatient surgeries in the analysis since these services can sometimes involve lengthy hospital outpatient stays, which might result in the need for SADs.
  - 33 Anecdotally, some hospitals report not charging beneficiaries for SADs, which might in part account for the lack of reporting of SAD charges in the observation claims for one-third of hospitals.
  - 34 In this example, observation stays of less than 24 hours would be paid a lower outpatient rate, and inpatient stays of 2 or more days would be paid a higher inpatient rate.
  - 35 Without length-of-stay criteria, Medicare would pay comparable rates for patients with similar diagnoses who received inpatient medical stays and outpatient observation stays (including outpatient stays that involved only a few hours of observation). This policy may not be desirable since the intensity and cost of these stays may not be similar.
  - 36 The relative weight for an inpatient DRG is based on the relative cost of inpatient cases in that DRG compared with the cost of cases in other DRGs. If, over time, a DRG experiences a reduction in inpatient length of stay, the relative weight—and resulting payment rate for that DRG—may decline. Because the inpatient DRG relative weight is based on the cost of all inpatient cases in the DRG (short and long), inpatient payments are likely to always remain higher than the outpatient payment after recalibration. Also, to the extent that, over time, short inpatient stays for a DRG shift from the inpatient to outpatient setting, average length of the stay and average cost for the remaining inpatient cases in that DRG could increase, possibly increasing the payment cliff between an inpatient and outpatient hospital stay for that condition.
  - 37 The Medicare claims used to recalibrate the relative weights for a payment year are based on claims for two fiscal years prior. These claims include those processed by Medicare during the given year (12 months) and the 6-month period after the close of that year. Inpatient claims denied by a RAC within that 18-month period are not included in the recalibration process. Claims denied outside of that 18-month period would be included in the recalibration process and would be reflected in the claims file as paid claims. Therefore, many short inpatient stay claims denied by RACs and currently in the appeals process may be included in the data used in the recalibration process.

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