Advising the Congress on Medicare issues

Recent Growth in Hospital Observation Care

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Presentation overview

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

Background: Definition of observation care

- Ongoing short-term treatment and assessment furnished while a decision is being made about whether or not to admit as an inpatient or discharge.
- Outpatient service
- Observation-specific clinical units becoming more common

Background: Criteria for observation and inpatient care

Observation criteria	Inpatient admission criteria
1) General guidance: a) Reasonable & necessary b) 8 or more hours of service c) Medical record must contain: physician order, written request for observation, and timeframe 2) Timing: not rigidly specified	1) General guidance: Physicians should also consider predictability of adverse outcomes, severity, hospital resources, and other factors. 2) Timing: admit patients expected to need hospital care for 24 hours or more

Background: Economics of observation

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

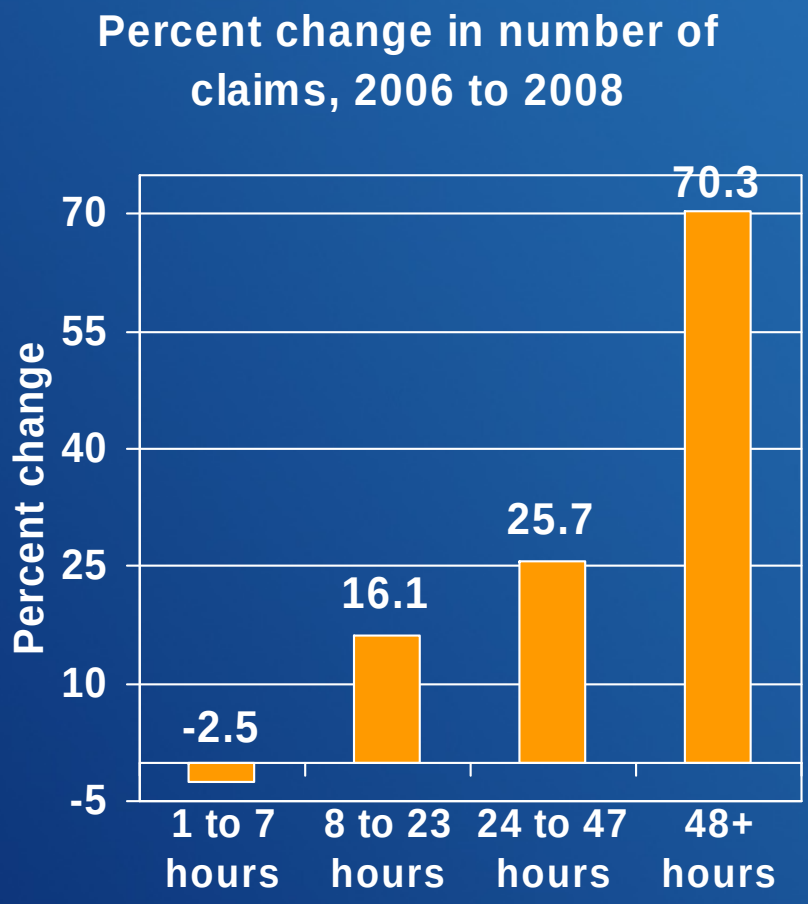
Nationally Medicare observation care increased from 2006 to 2008

Medicare outpatient observation care	2006	2008	Percent change (2006 to 2008)
Claims	911,500	1,116,000	22.4%
Claims (per 1,000 FFS Part B beneficiary)	28	36	**26.2**
Hours	23,327,000	31,014,000	33.0
Hours (per 1,000 FFS Part B beneficiary)	729	999	37.1

Source: Medicare outpatient claims

Nationally, longest observation claims increased rapidly from 2006 to 2008

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



Source: Medicare outpatient claims

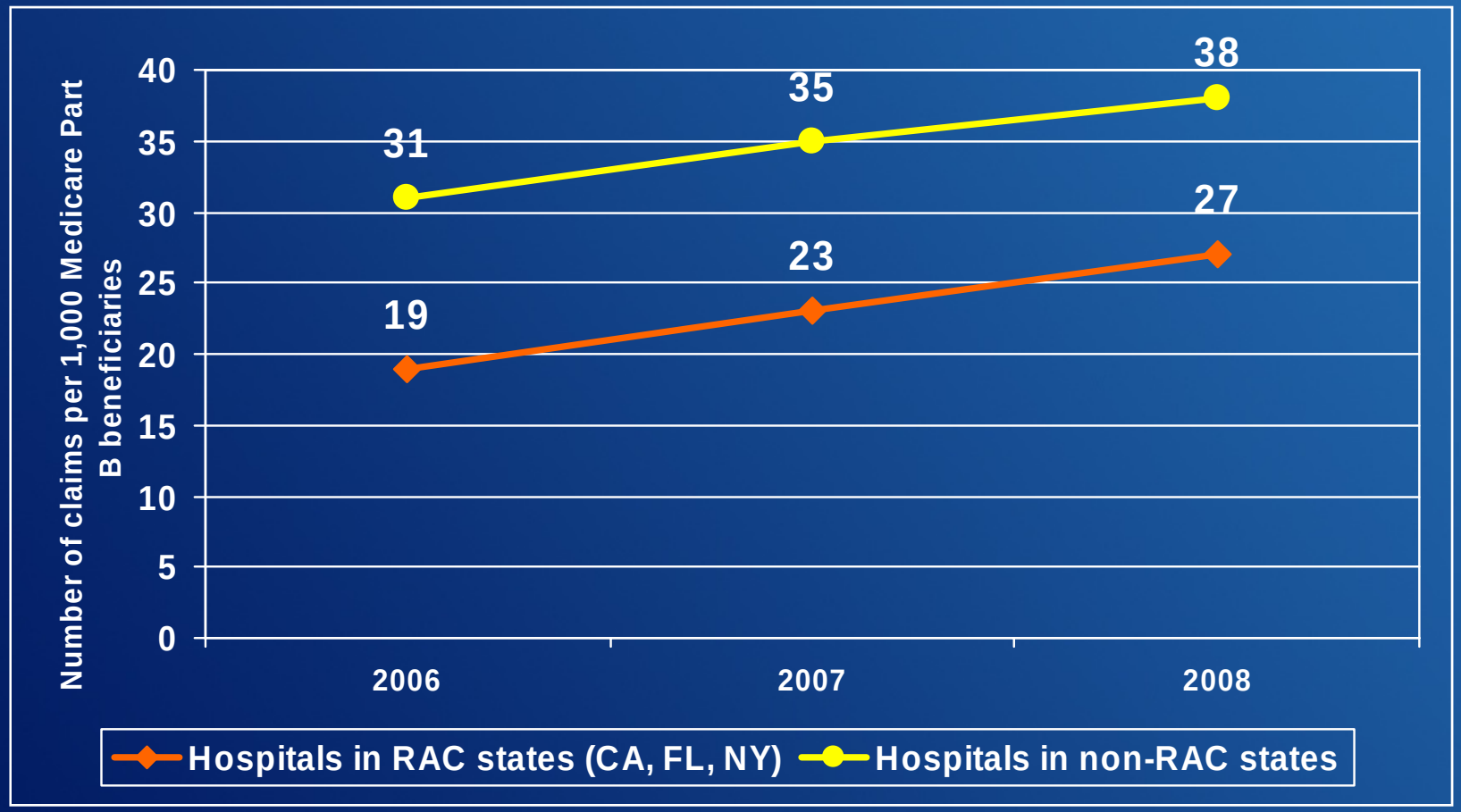
Cardiac conditions most common for observation claims (2008)

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

Medicare Recovery Audit Contractor (RAC) program

- Contracted auditors retrospectively identify past over or underpayments for any provider participating in the Medicare FFS program.
- Medicare RAC demonstration (March 2005 to April 2008)
  - California, Florida, and New York included throughout
  - Arizona, Massachusetts, and South Carolina included from July 2007 to April 2008
  - $980 million (96 percent) in overpayments and $38 million (4 percent) in underpayments from FFS providers
  - $830 million in overpayments (85 percent) from inpatient hospitals
- TRHCA of 2006 expanded RAC program nationally, beginning January 1, 2010.

Lower level of observation care claims at hospitals in RAC states, 2006 to 2008



Source: Medicare outpatient claims

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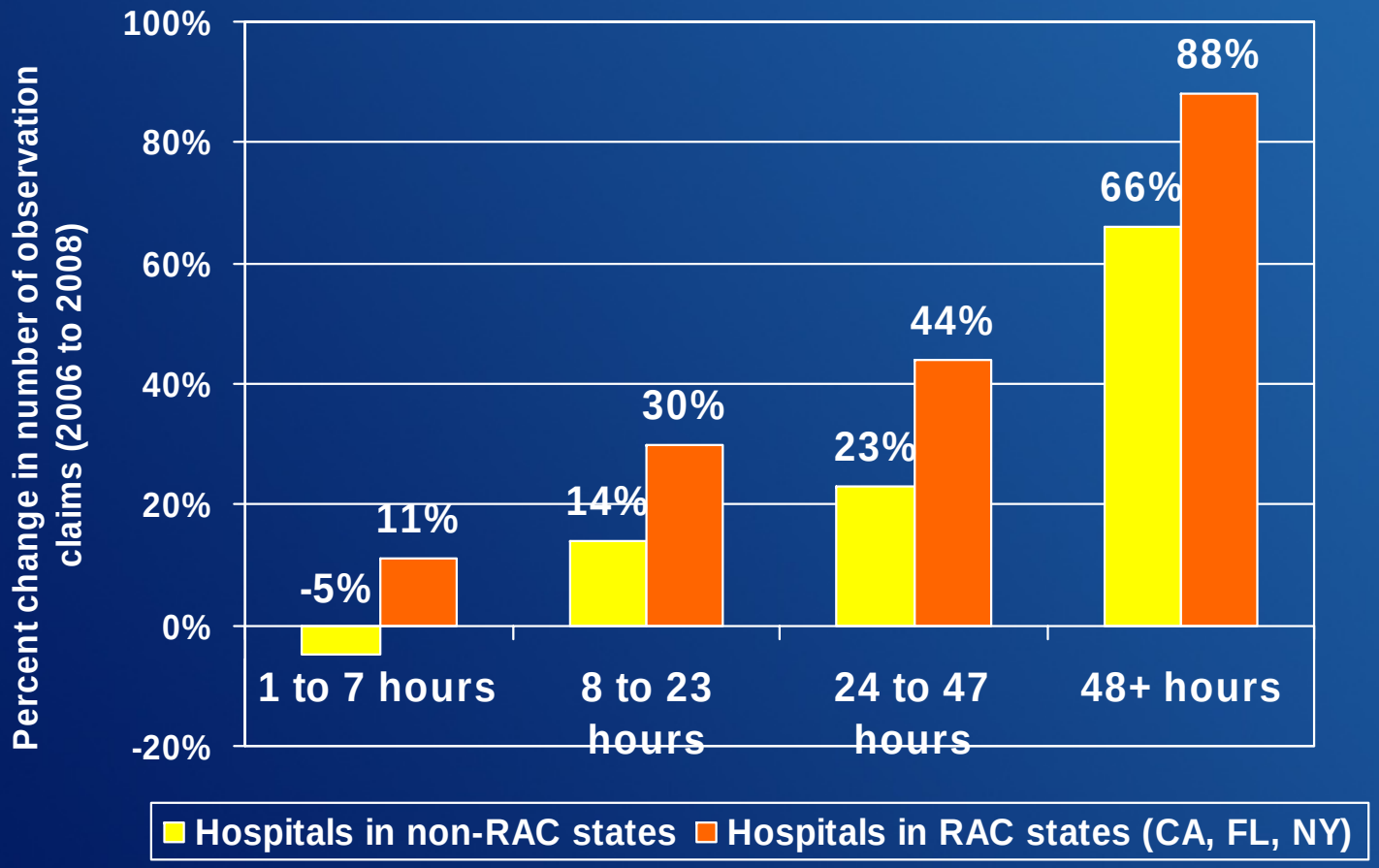
Nationwide trend: Claims of 48 hours or more grew faster than other claims in both RAC states and non-RAC states, 2006 to 2008



Source: Medicare outpatient claims data

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Nationwide trend: Observation growth not centered in RAC states

- Hospitals in RAC states were no more likely to have rapid growth in observation claims.
  - 19 percent of all US hospitals
  - 20 percent of hospitals with most rapid observation growth
- Within RAC states, a disproportionate share of hospitals accounted for observation claims
  - 30 percent of hospitals accounted for 55 percent of all observation claims in 2008
  - 30 percent of hospitals accounted for 90 percent of increase in observation claims from 2006 to 2008

Substitution of observation claims for 1-day inpatient stays occurring nationally

	Number of 1-day inpatient claims per 1,000 Medicare Part A beneficiaries		
	2006	2008	Absolute change (2006 to 2008)
All US hospitals	49.1	46.2	-2.9
Hospitals in non-RAC states	49.5	46.8	-2.7
Hospitals in RAC states	47.3	43.7	-3.6

Source: Medicare inpatient claims data

Nationwide trend the result of a broad set of factors

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

Medicare beneficiaries may face greater financial liability

- Anecdotal reports of beneficiaries being surprised by outpatient and SNF bills
- Potential increase in financial liability for the beneficiary when served as observation patient
  - Outpatient co-insurance vs. inpatient deducible
  - Liable for SNF coverage

Conclusions

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