Hospital short stay policy issues

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Recap: Hospital short stay issues

- Inpatient admission criteria are ambiguous and open to interpretation
- 1-day inpatient stays are profitable and paid more than similar outpatient stays
- Recovery Audit Contractors (RAC) have focused their audits on appropriateness of 1-day inpatient stays
- Hospitals have increased their use of outpatient observation
- Concern raised about observation's effect on skilled nursing facility (SNF) coverage and beneficiary liability for self-administered drugs

Outline: Issues and offset options

- Issues
  1. Reduce payment differences
  2. Reduce burden of RAC reviews
     - Target RAC reviews of short stays
     - Replace RAC reviews with a payment penalty
  3. Increase RAC accountability
  4. Protect beneficiaries: Revise SNF 3-day stay policy
  5. Protect beneficiaries: Liability for self-administered drugs
- Offset options

Issue 1: Reduce payment differences

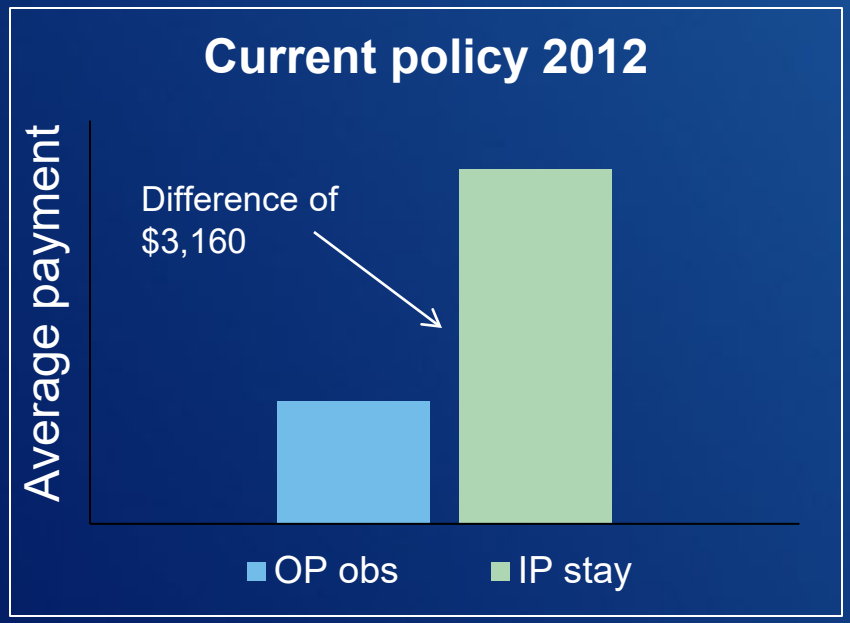
Payment policy changes could be considered to reduce or eliminate the payment differences between 1-day inpatient stays and similar outpatient stays. For example:

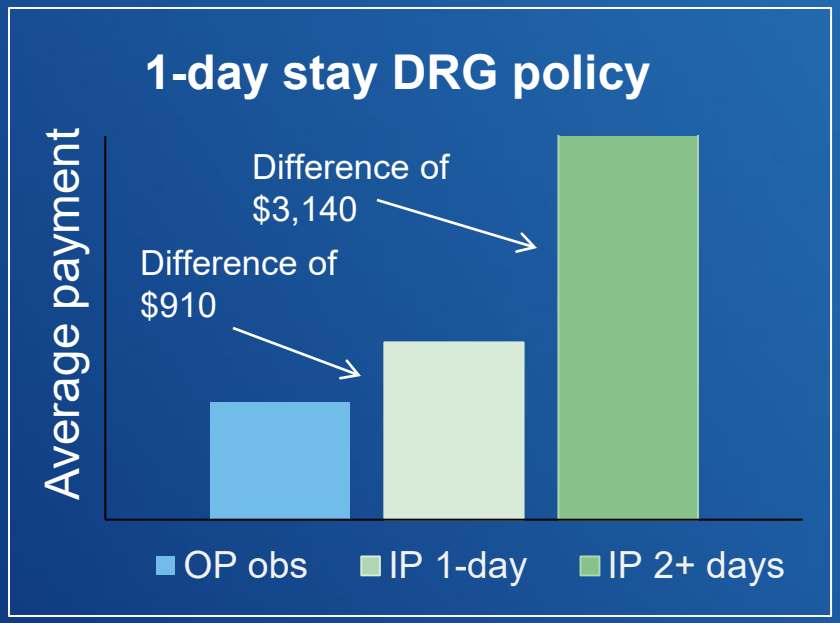
- 1-day stay DRGs for selected DRGs
- Site-neutral approaches to pay 1-day inpatient stays and similar outpatient stays the same rate

Effect on incentives mixed:

- Reduces or eliminates payment cliff between outpatient and 1-day inpatient stays
- Creates new payment cliff between 1-day and 2-day inpatient stays

Effect of simulated 1-day stay DRG policy for selected medical DRGs





Note: OP obs (outpatient observation), IP (inpatient). Chart includes results from a simulation of a 1-day stay DRG policy. Displayed in the chart is the weighted average payment rate for the 10 medical DRGs with the most 1-day inpatient stays that are also common to outpatient observation. Similar outpatient observation claims are identified by using a crosswalk process to link outpatient claims to MS-DRGs. Average payment includes add-on payments such as IME and DSH.
Source: MedPAC analysis of Medicare claims and cost report data.

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Data are preliminary and subject to change

RAC administrative burden and accountability

- Widespread RAC reviews of short stays have raised concerns about hospital administrative burden and RAC accountability
- December 30, 2014: CMS issued list of improvements to all future RAC contracts
- RAC patient status reviews limited to 6 months following claim date of service, rather than 3 years
- MedPAC eliminated our policy option pertaining to the timing of RAC reviews and the rebilling policy
- Other new RAC improvements impact our recent work

Issue 2a: Target RAC reviews of short inpatient stays

Policy option: Target reviews to hospitals with the highest rate of short inpatient stays

MedPAC model:

- Subset of hospitals (10 - 25 percent) receive RAC reviews, and all other hospitals exempt from review for patient status
- Subsets account for between 22 and 46 percent of payments for all 1-day inpatient stays ($1.7 to $3.6 billion in 2012)

New CMS rule: Permits the review of all hospitals, but the amount of a hospital's claims reviewed will vary based on past denial rates

Spending impact : Increase in program spending, but less clear due to new CMS rule

Issue 2b: Replace RAC reviews with a payment penalty

Policy option: Eliminate RAC reviews of short inpatient stays; penalize hospitals with excessive utilization of short inpatient stays

MedPAC model:

- Subset of hospitals penalized based on their 1-day stay utilization rate (average rate = 5 percent overall):
  - 10 percent of hospitals with highest rate (average rate = 12 percent)
  - 25 percent of hospitals with highest rate (average rate = 9 percent)
- If penalty equivalent to 3 percent of all inpatient payments (equivalent to 30 percent of all 1-day stay payments)
  - "10 percent" subset would generate 40 percent of RAC recoveries
  - "25 percent" subset would generate 90 percent of RAC recoveries
- Penalty must be large to match current RAC recoveries

Spending impact: Increase program spending, but less clear due to new CMS rules

Issue 3: Increase RAC accountability

Policy option: Modify RAC contingency fees to be based, in part, on the RAC's overturn rate

New CMS rule: Requires RACs to maintain certain denial overturn rates and audit accuracy rates to maintain full access to hospital inpatient claims data

Difference: Our option would reduce the RAC contingency fee directly, whereas the new CMS rule narrows the scope of claims for RAC review

Spending impact: Small savings, but less clear to due new CMS rules

Issue 4: Protect beneficiaries – revise SNF 3-day stay policy

Policy option: Retain the SNF 3-day threshold, count time spent in outpatient observation status towards the threshold, but require at least 1 of the 3 days to be an inpatient day

- Beneficiary concern: Small group of beneficiaries with high out-of-pocket costs due to being discharged to an uncovered SNF stay
- Rationale of benefit: Intent of SNF 3-day policy was to define the SNF benefit as a post-acute care, not a long-term care, benefit
- Financial interests of the program: Maintaining a 1-day inpatient requirement limits use to post-acute care

Spending impact: Increase program spending

Issue 5: Protect beneficiaries – liability for self-administered drugs

- Hospitals bill outpatient beneficiaries for self-administered drugs (SAD) at full charges and beneficiaries generally pay out-of-pocket
- Some hospitals do not charge beneficiaries for SADs while other hospitals believe they must charge for SADs due to laws prohibiting beneficiary inducements
- SADs are common for observation patients
  - 75% of observation claims include SAD charges (among hospitals that report these charges)
  - For claims with SAD charges, average SAD charges were $209 and average SAD costs were $43 (2012)

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Issue 5: Protect beneficiaries – liability for self-administered drugs (continued)

Option 1: Allow hospitals to waive SAD charges for observation beneficiaries

- Spending impact: No additional costs to Medicare
- Beneficiary impact: Likely to eliminate SAD-related financial liability for some beneficiaries, but others may still be liable for full charges

Option 2: Cap the amount hospitals can charge outpatient beneficiaries for SADs (e.g., hospital cost)

- Spending impact: No additional costs to Medicare
- Beneficiary impact: Reduces beneficiary liability for SADs

Option 3: Medicare covers SADs for hospital outpatients receiving observation

- Spending impact:
  - Option 3a - budget neutral: No additional cost to Medicare
  - Option 3b - new money: Increase Medicare spending
- Beneficiary impact: Reduces beneficiary liability (reduction larger under 3a than 3b)

Examples of offset options

- Hospital-related offsets
  - Extend hospital post-acute care transfer policy to hospice transfers
  - IPPS base rate adjustment
- SNF-related offsets
  - Benefit redesign policy: Enhanced SNF benefit, but increased beneficiary liability
  - SNF payment policy: Reduce SNF payments
    - Recover 2011 SNF overpayments
    - Explore nursing facility churning penalty
    - Adjust the SNF base payment rate

Hospital post-acute care transfer policy and hospice

Policy option: Include hospice in the hospital post-acute care (PAC) transfer policy

- PAC transfer policy reduces inpatient payments for certain DRGs when hospital stays are shorter than average
- Policy applies to transfers to LTCHs, psychiatric hospitals, IRFs, SNFs, and home health, but not hospice
- Under the transfer policy, hospital transfers to hospice would remain profitable for hospitals (estimated 31% margin in 2012)

Spending impact: Reduce Medicare program spending

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Potential SNF-related offsets

- Recover 2011 SNF overpayments
  - $4.5 billion overpayment to SNFs occurred in 2011 associated with implementation of new case-mix groups
- Explore nursing facility churning penalty
  - Nursing facilities have a financial incentive to hospitalize residents because a hospitalization may lead to a new SNF benefit period and higher SNF payments
  - A penalty for nursing facilities with excessive rates of potentially avoidable hospital admissions could be explored as a way to counterbalance these incentives

Issues for discussion

- Additional information on payment policy changes
- Feedback on policy options
  - RAC reviews of short stays
    - Targeted RAC reviews
    - Short stay payment penalty
  - RAC performance-based compensation
  - SNF 3-day policy and observation
  - Self-administered drugs
- Offset options
- Questions

New CMS rules for future RAC contracts

- Individual providers' past denial rate will be used to determine what share of their claims will be eligible for RAC claim review
- RAC patient status claim reviews will be limited to 6-months following date of service
- RACs must notify providers of outcomes of complex reviews within 30 days (instead of 60 days)
- Contingency fees paid to RACs after the second level of appeal
- RACs must broaden their review topics to include all types of claims and provider types
- RACs must maintain a claim overturn rate of less than 10 percent at the first level of appeal and a claim review accuracy rate of at least 95 percent. If they do not, the scope of claims available for review may be limited