

Hospital policy issues

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Statement of
Mark E. Miller, Ph.D.

Executive Director
Medicare Payment Advisory Commission

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Chairman Brady, Ranking Member McDermott, distinguished Committee members. I am Mark Miller, executive director of the Medicare Payment Advisory Commission (MedPAC). The Commission appreciates the opportunity to discuss hospital payment issues with you today.

MedPAC is a small congressional support agency that provides independent, nonpartisan policy and technical advice to the Congress on issues affecting the Medicare program. The Commission's work in all instances is guided by three principles: ensuring beneficiaries have access to high-quality, coordinated care; protecting taxpayer dollars; and paying providers and plans in a way that accomplishes these two goals.

The Commission has done extensive work on issues related to hospital payment policy. By law, each year the Commission is required to assess the adequacy of hospital payments and recommend payment updates for hospital inpatient and outpatient services. To evaluate whether aggregate payments are adequate, we consider beneficiaries' access to care, changes in the volume of services provided, hospitals' access to capital, quality of care, and the relationship of Medicare's payments to the average cost of caring for Medicare patients (a Medicare margin).

In addition to these annual payment adequacy assessments, over the years the Commission has examined several hospital payment policy issues. The goal of these analyses is to ensure that payments are accurate and equitable across different types of hospitals and across different types of hospital services. For example, at various points, the Commission has analyzed graduate medical education (GME) payments, disproportionate share hospital (DSH) payments, and rural hospital add-on payments to determine whether they are set at an empirically justified rate and are effectively targeted to achieve their policy goals. More recently, the Commission has looked at refinements to the hospital readmissions penalty, recovery audit contractor (RAC) reviews of short inpatient hospital stays, and whether payment rates for certain services are encouraging providers to shift these services to more costly sites of care.

In the testimony that follows, I will provide an overview of trends in the hospital sector and then describe a range of Commission recommendations to improve the accuracy of fee-for-service (FFS) hospital payment rates.

Background

In 2013, the 4,700 hospitals paid under the Medicare prospective payment systems and the critical access hospital payment system received \$118 billion for 10.1 million Medicare inpatient admissions and nearly \$49 billion for 196 million outpatient services. Medicare inpatient discharges declined 4.4 percent per Medicare FFS Part A beneficiary between 2012 and 2013 and fell by a total of about 17 percent from 2006 to 2013. Inpatient volume declined more rapidly in rural hospitals than urban hospitals. Between 2012 and 2013, the total number of rural hospitals' inpatient discharges declined 5.2 percent compared with a 2.3 percent decline in urban hospitals. Among privately insured individuals under age 65, inpatient discharges per capita declined by 3.5 percent in 2012 and another 2.7 percent in 2013 (Health Care Cost Institute 2014). This trend suggests that inpatient volumes declined for all insured patients through 2013, not just Medicare beneficiaries.

From 2012 to 2013, the use of outpatient services increased by 3.8 percent per Medicare FFS Part B beneficiary; over the past seven years, the cumulative increase was 33 percent. This growth in part reflects a secular shift in care from the inpatient setting, as well as the trend of hospitals purchasing freestanding physician practices and converting them into hospital outpatient departments (HOPDs). As hospitals do so, market share shifts from freestanding physician offices to HOPDs. From 2012 to 2013, hospital-based evaluation and management visits per beneficiary grew by 9.4 percent compared with 1.1 percent growth in physician-office-based visits. Other categories of services, such as echocardiograms and nuclear cardiology, are also shifting to the higher cost site of care. Among other effects, the shift in care setting increases Medicare program spending and beneficiary cost-sharing liability because Medicare payment rates for the same or similar services are generally higher in HOPDs than in freestanding offices.

The Commission's annual payment adequacy assessment has consistently found that there is adequate access to and supply of hospital beds. The average hospital occupancy rate declined from 64 percent to 60 percent between 2006 and 2013, suggesting excess capacity in many markets. In the 10 metropolitan areas with the lowest number of hospital beds per capita, the

average occupancy rate was 60 percent, compared with an average occupancy rate of 56 percent in the ten metropolitan areas with the highest number of beds per capita. There were 15 hospital openings and 25 hospital closures in 2013, resulting in a net decrease of approximately 1,000 hospital beds, a 0.1 percent reduction in existing bed capacity. Bed capacity is likely to continue declining, reflecting the continued decline in inpatient use and the corresponding rise in outpatient use. As mentioned, Medicare utilization of outpatient services increased 33 percent over the past seven years.

Turning to other payment adequacy factors, hospital quality is uneven but has improved. Hospitals spent \$20 billion in capital expenditures, increased their employment, and generally have strong access to capital markets. However, hospitals' overall Medicare margin—a measure of the relationship between Medicare payments for, and hospitals' costs of, providing care to Medicare patients—is negative. In 2013, the median hospital margin was –5.4 percent. Relatively efficient hospitals (i.e., hospitals with lower costs and better quality over three years) had a median margin of 2 percent in 2013.

Part of the reason Medicare margins are low is that hospitals have high costs per case driven in part by lack of fiscal pressure from private payers. The Healthcare Cost Institute reports that payment rates from private insurers have grown at an average of over 5 percent annually from 2011 through 2013. Commercial rates, on average, are about 50 percent higher than hospital costs and over 50 percent higher than Medicare rates. For example, Aetna and Blue Shield of California pay hospitals rates that are often 200 percent of Medicare's rate for inpatient care and 300 percent of Medicare's rate for outpatient services in California (California Department of Insurance 2014a, California Department of Insurance 2014b). In 2013, hospital all-payer margins were a record-high 7.2 percent.

The Commission has shown that higher payments from private insurers allow hospitals to have higher costs which, in turn, makes Medicare margins more likely to appear inadequate. There is evidence that higher private insurer payments result from hospital consolidation—that is, hospitals have gained greater market power relative to private insurers. When financial

resources are abundant hospitals spend more—increasing their number of inputs and cost per input. All else equal, higher costs per case result in lower Medicare margins.

Of course, hospitals vary in their circumstances. Some hospitals have market power, a higher percentage of private payer patients, and stronger revenue from investments and donations. These hospitals tend to have higher costs. Hospitals without these characteristics have lower costs. Put differently: hospitals with the most revenue have the highest costs per admission. For example, we found that hospitals with low private payer profits from 2008 to 2012 had a median standardized Medicare cost per case in 2013 that was about 9 percent less than the national median, and generated a median overall Medicare profit margin of 4 percent. In contrast, hospitals with high private payer profits over the same period had higher costs per case (3 percent above the national median) and lower Medicare margins (-9 percent). This analysis suggests that hospitals can constrain their costs, but the lack of pressure from private payers is discouraging them from doing so.

MedPAC's 2015 hospital recommendations

Based on its annual assessment of payment adequacy indicators, MedPAC recommended a package of hospital payment policy changes for 2016. The package included a payment update and two policies to equalize payment rates between different settings.

The update recommendation is higher than current law because payment adequacy indicators are largely positive, but Medicare margins are negative. One objective of the Commission's annual payment adequacy analysis is to recommend an appropriate aggregate level of payment through the update. The second objective is to recommend adjustments in payment policies to set appropriate relative prices across services and across sites of care. The two site neutral recommendations in the Commission's 2015 update recommendation package address this second objective.

One problem with the current system of relative prices is that differences in prices across care settings are causing distortions in provider incentives. For example, hospital outpatient

department rates are not aligned with rates paid for the same services in physicians' offices, giving hospitals an incentive to acquire physician practices and bill for the same services at outpatient rates, increasing costs to the program and to the beneficiary. To remove this incentive, we recommended setting outpatient rates equal to, or closer to, physician office rates for a set of services that are often performed in both locations.

A similar problem exists for hospital inpatient services. Long-term care hospitals (LTCHs) are currently paid much higher rates than traditional acute care hospitals (ACHs). Historically, there have been few criteria defining LTCHs, the level of care they provide, or the patients they treat. The Commission and others have repeatedly raised concerns that the lack of meaningful criteria for admission to LTCHs means that these providers can admit less-complex patients who could be cared for appropriately in less expensive settings. Comparatively attractive payment rates for LTCH care have resulted in an oversupply of LTCHs in some areas and may generate unwarranted use of LTCH services by patients who are not chronically, critically ill (CCI). To reduce incentives for LTCHs to admit lower acuity patients—who could be appropriately cared for in other settings at a lower cost to Medicare—the Commission recommended that standard LTCH payment rates be paid only for LTCH patients who are truly CCI. LTCH cases that are non-CCI should be paid at the appropriate inpatient prospective payment system (IPPS) rates. The Commission recommended that to meet the CCI criteria and qualify for LTCH payment rates, patients must have had a preceding stay in an intensive care unit (ICU) of at least eight days, or have received mechanical ventilation for 96 hours or more during an immediately preceding ACH stay. Congress implemented a version of this policy in the Pathway for SGR Reform Act of 2013, which defines patients with a preceding ICU stay of at least three days as appropriate for LTCH-level payment.

Special hospital add-on payments

Our analysis of payment adequacy addresses whether Medicare's aggregate payments to hospitals are sufficient, and whether payment rates are set appropriately across services and sites of care. The Commission also considers how well Medicare's inpatient payments are distributed among different types of hospitals, given that almost 15 percent of inpatient payments are made

in the form of three policy adjustments: indirect medical education (IME), disproportionate share hospital (DSH) payments, and uncompensated care payments. In addition to IME and DSH payments, Medicare has several payment programs designed to help rural hospitals. These include extra payments for rural referral, sole community, and Medicare-dependent hospitals (MDHs) within the IPPS and separate cost-based payment for critical access hospitals (CAHs).

IME and DSH payments

Indirect medical education (IME) payments are designed to support the higher costs of patient care associated with teaching. Based on a formula, IME payments are an adjustment—a percentage increase—to the amount Medicare pays for each admission to a teaching hospital. The amount of the IME add-on varies based on hospitals’ “teaching intensity” (as measured by the ratio of residents to hospital beds). Therefore, hospitals’ IME payments are tied to their Medicare inpatient volume and case mix, as well as the size of their residency programs (subject to their resident cap number). Medicare’s IME payments totaled an estimated \$6.5 billion in 2013, but repeated Commission analyses finds that only 40 percent to 45 percent of these payments can be analytically justified to cover the higher patient care costs of Medicare inpatients. In essence, the current adjustment is set at more than twice what can be empirically justified, resulting in over \$3.5 billion directed to teaching hospitals with little accountability for their use of these funds. One argument that has been made for paying above the empirical cost is that the payment system does not adequately reflect the higher severity of patients treated in teaching hospitals. However, based on earlier Commission recommendations, payment system refinements were implemented in 2007 to better capture differences in patient severity. These changes increased payments to major teaching hospitals.

Similarly, the DSH adjustment has a weak relationship to the cost of treating low-income patients. The original justification for Medicare DSH payments was that poor Medicare patients were thought to be more expensive in ways that were not accounted for by the original DRG system. By 2011, both the Commission and other researchers concluded that, at most, 25 percent of the DSH payments were empirically justified by the higher costs at hospitals treating low-income Medicare patients. Therefore, hospitals that served high shares of poor Medicare patients

and Medicaid patients were given higher Medicare payments than were justified by the costs of their Medicare patients. In 2010, Congress enacted several changes to DSH payment policy in the Patient Protection and Affordable Care Act (PPACA). The pool of Medicare DSH dollars was divided into two pools: one available for traditional DSH and one for (non-Medicare) uncompensated care costs. Under PPACA changes, 25 percent of the old Medicare DSH pool is allocated for DSH payments, and the remaining 75 percent is designated for uncompensated care payments (the Commission has raised concerns about the measure used to allocate uncompensated care payments). The amount that is paid out for uncompensated care is set to decline as the national rate of uninsurance decreases.

Financing graduate medical education

Despite the tremendous advances our graduate medical education (GME) system has brought to modern health care, the Commission finds that it is not aligned with the delivery system reforms essential for increasing the value of health care in the United States. Two specific areas of concern are education and training in skills needed to improve the value of our health care delivery system (including evidence-based medicine, team-based care, care coordination, and shared decision making) and workforce mix (including trends in specialization and limited socioeconomic diversity). We cannot accomplish delivery system reform without simultaneously ensuring that our residency programs produce the providers and skills necessary to integrate care across settings, improve quality, and use resources efficiently.

The Commission has made five recommendations to the Congress to address these challenges. The broadest of these recommendations rests on two principles: decoupling Medicare payments for GME from Medicare's inpatient FFS payment system and ensuring that resources for GME are devoted to programs meeting high educational standards. The Commission recommends that approximately 60 percent of IME payments be awarded to hospitals and other entities that meet educational and program design criteria, instead of making these payments only to teaching hospitals through an inpatient add-on. Under this recommendation, the Secretary of Health and Human Services would consult with a range of organizations and individuals with the necessary expertise and perspectives to establish the desired standards—specifically, representatives from

organizations such as program-accrediting bodies, certifying boards, training programs, health care organizations, health care purchasers, and patient and consumer groups. From these deliberations, the Secretary would develop residency programs that encompass training in a range of settings in addition to the hospital, including offices, clinics, nursing homes, and rural locations, as well as developing a residency program curriculum that fosters the skills noted above, including team-based care. The Secretary's objective would be to create a GME payment system that fosters greater accountability for Medicare's dollars and rewards education and training that improves the value of our health care delivery system. Funding for this initiative would come from the amount that Medicare pays hospitals above their empirically justified costs for IME—currently estimated to be over \$3.5 billion.

The remaining four recommendations:

- 1) Address concerns raised by the graduate education community that Medicare resources are not being used for educational purposes by making the amount of Medicare resources being paid to teaching hospitals more transparent;
- 2) Call for an objective analysis of workforce needs based on reformed care delivery and better organization of responsibilities among physicians and other health care professionals in lieu of increases in the number of Medicare subsidized slots based on simplistic straight line projections of workforce needs;
- 3) Call for analyses to understand the value of different specialty residency programs to hospitals to better support future discussions of Medicare's GME subsidies across specialties; and
- 4) Call for an examination of a range of Department of Health and Human Services programs designed to increase the racial, ethnic, socioeconomic, and rural diversity of the medical school population.

Rural hospital add-on payments

A key objective of Medicare's rural payment adjustments is to maintain access to care. Areas with low population density may have small, isolated, low-volume care providers. In these cases,

costs may be above average because the low population density prevents economies of scale, and the low volume and high costs may be beyond a provider's control. Special payments by federal or local sources may be needed to maintain access to care in these communities. However, in some cases, the special payments are not well targeted to address access.

Rural hospital background

In its June 2012 report, the Commission examined rural Medicare beneficiaries' access to care, rural providers' quality of care, special rural Medicare payments, and the adequacy of Medicare payments to rural providers. Rural and urban areas have comparable levels of inpatient and physician utilization. They also have generally comparable levels of post-acute care use, though post-acute care utilization is somewhat lower in frontier areas. Both urban and rural beneficiaries report high levels of satisfaction with their access to care.

The Commission also found similar levels of quality among rural and urban settings, particularly in the post-acute care setting. However, the Commission did find differences in quality of care between urban and rural hospitals. Smaller rural hospitals do not perform as well as urban hospitals on most process measures and on condition-specific 30-day mortality rates. The Commission's analysis of 2010 Medicare data is consistent with other findings in the literature over the past 20 years (Joynt et al. 2011, Keeler et al. 1992).

The Commission found that the adequacy of payments to rural hospitals has improved over time, in part due to the creation of special add-on payments to support these providers. In 2001, when rural hospitals' inpatient profit margins were below urban hospitals' profit margins, the Commission concluded that Medicare payment rules favored large urban hospitals. As a result, the Commission recommended increasing rural hospitals' base payment rates to the rates paid to large urban hospitals, increasing rural disproportionate share payments, and implementing a low-volume adjustment for isolated rural providers serving areas with low population density that lack economies of scale. The Congress enacted legislation consistent with the Commission's recommendations by 2004 and then endorsed a series of other changes that further increased

rural hospital payments. These changes to the hospital prospective payment system, along with expansion of the CAH program, have improved rural hospitals' financial stability significantly. The 860 rural IPPS hospitals have higher Medicare margins than urban hospitals on average, and the 1,300 CAH hospitals are paid based on their Medicare costs.

Principles for evaluating rural add-on payments

One challenge for policymakers is that the current mix of rural payment adjusters is not guided by a coherent set of underlying principles. The adjusters evolved separately, and there is not a clear common framework for how they are intended to work together to preserve access without duplicative, overlapping adjustments. In addition, they are not always targeted to the areas with the greatest concerns about access to care. The lack of targeting stems in part from Medicare's definition of "rural." Medicare defines rural as all areas outside of metropolitan statistical areas, so many adjustments can apply to rural areas with a single local provider, as well as rural areas with many competing local providers. The Commission has created a framework of principles for rationalizing rural add-on payments that includes targeting providers that are necessary for access, empirically justifying (and not duplicating) payments, and maintaining incentives for cost control.

Principle: Target payment adjusters to low-volume, isolated providers to preserve access

Payment adjusters should be targeted to providers that are necessary to preserve beneficiaries' access to care. Generally this means that Medicare's special supports should go to providers who are located in low population density areas and are distant enough from other providers to serve as a vital source of care. Currently, special adjustments often go to rural providers located in close proximity to other rural providers. For example, 16 percent of CAH hospitals and 9 percent of sole community hospitals are located within 15 miles of another hospital.

Many of the current adjustments focus on increasing payments to low-volume providers. However, there are two types of low-volume providers. One type is isolated providers who have low volumes because of low population density in their markets. These providers often have difficulty covering their fixed costs given their low volume of cases. For these providers, low

volumes are inevitable and beyond their control. A second type of provider has low volumes because neighboring competitors attract patients away from the low-volume provider. These providers are not necessary for access, and it may be inappropriate to give a low-volume adjustment to two competing low-volume hospitals that are 5 or 10 miles from each other. By focusing low-volume adjustments on isolated providers, rather than making the adjustment available to all providers with low volumes, Medicare can best use its limited resources to serve Medicare beneficiaries. Such a policy may also encourage two nearby hospitals to merge, increasing patient volumes.

Principle: Empirically justify the magnitude of payment adjustments

The magnitude of the adjustment should be determined empirically. For example, it is necessary to determine the degree to which a low patient volume makes it more difficult for a provider to cover its fixed costs. Patient volume should be measured as total patient volume rather than solely Medicare patient volume, because economies of scale depend on total volumes of patients.

Principle: Maintain incentives for cost control

It matters not only how much money is paid to rural providers, but also how it is paid. For example, Medicare's approach of paying prospective payment rates to providers puts stronger pressure on providers to control their costs. Cost-based payments reduce this incentive. Therefore, cost-based reimbursement could be limited to the most isolated providers with very low case volume and highly variable costs that are hard to predict.

Principle: Set equal quality expectations for nonemergency services, but recognize that emergency services may need to be subject to different quality standards

Expectations for quality of care in rural and urban areas should be equal for nonemergency services that rural providers choose to deliver. That is, if a provider has made a discretionary decision to provide a service, that provider should be held to a common standard of quality for that service, whether the service is provided in an urban or a rural location. Emergency services may be subject to different quality standards to account for different levels of staff, patient volume, and technology between urban and rural areas.

Refining the hospital readmissions penalty

Noting high hospital readmission rates (around 19 percent) and little improvement in these rates over time, the Commission recommended a penalty for hospitals with relatively high readmissions rates. Congress subsequently enacted a hospital readmission reduction program (HRRP) in 2010. Since the introduction of the penalty, readmission rates have fallen for Medicare beneficiaries across all types of hospitals. In 2013 Medicare beneficiaries experienced roughly 100,000 fewer readmissions than in 2012.

Given the positive effects of the penalty, the Commission believes that the policy should be continued, and has recommended expanding readmissions penalties into several post-acute care sectors. However, the calculation of readmissions rates and penalties could be refined to address three issues with the current policy.

- Under current policy, aggregate penalties remain constant when national readmission rates decline. This means that some providers will always be penalized, even if the entire sector improves its readmissions rate substantially. Instead, the Commission would set a fixed target for readmission rates. Penalties would go down when industry performance improves.
- In 2015, the HRRP covers five conditions (heart failure, acute myocardial infarction, (AMI), pneumonia, chronic obstructive pulmonary disease (COPD), and planned hip and knee replacement surgery). Single-condition readmission rates face significant random variation due to small numbers of observations. Instead, the Commission would use an all-condition readmission measure to increase the number of observations and reduce random variation.
- Hospitals' readmission rates and penalties are positively correlated with their low-income patient share. To avoid unfairly penalizing hospitals that treat large shares of low-income patients, the Commission would evaluate hospital readmission rates against a group of peers with a similar share of poor Medicare beneficiaries. Each peer group would have its own target readmissions rates, meaning hospitals with

higher shares of poor patients would have an easier target rate than hospitals with lower shares of poor patients. Though penalties would be adjusted to account for socioeconomic status, Medicare would continue to report an unadjusted readmissions measure to avoid masking disparities and reducing pressure to improve care for low-income patients.

Hospital short-stay issues

Since the implementation of the IPPS, payment incentives along with changes in technology and medical practice patterns have substantially shortened hospitals' average inpatient lengths of stay, allowing many inpatient services to successfully migrate to the outpatient setting. As a result, the issue of whether a patient requires inpatient care or could instead be treated safely as an outpatient has received increasing attention. Because hospitals generally receive higher payments for clinically similar patients served in the inpatient setting as compared with the outpatient setting, hospitals may have a financial incentive to admit patients.

Created by the Congress and implemented nationwide in 2010, 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 patients' status as an inpatient was not appropriate. Hospitals have appealed many of the RACs' claims decisions, 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.

In reaction to the heightened scrutiny of short inpatient stays, hospitals have increased their use of outpatient observation status. Greater use of outpatient observation status, in turn, 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 self-administered prescription drugs received in the hospital and not covered by the Medicare outpatient prospective payment system (OPPS).

In an effort to clarify admission appropriateness and alleviate concerns about increased use of observation and its impact on beneficiary liability, as well as hospitals' concerns about RAC audits, CMS established the "two-midnight rule" in 2014. This rule stipulates that for hospital 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 are exempt from audit. By contrast, stays of less than two midnights remain subject to audit. The two-midnight rule has been controversial, and its enforcement has been delayed by both CMS and the Congress.

Short-stay policy recommendations

In response to these issues, the Commission has developed a set of recommendations designed to provide greater protections for beneficiaries and reduce administrative burden for hospitals while ensuring that the program is not paying too much for hospital care. Several of these recommendations provide guidance on refining and targeting the RAC program. The remaining recommendations seek to reduce the financial burden that beneficiaries may face from hospitals' increased use of outpatient observation status.

Recommendations to improve hospital oversight

The Commission has recommended to the Secretary a package of policies to improve the RAC program. First, the Commission recommended targeting RAC audits to hospitals with the highest rates of short inpatient stays. Currently, RACs are auditing short inpatient stays broadly, across all hospitals. A more targeted policy would focus auditing efforts on hospitals with aberrant patterns of short inpatient stays, while reducing administrative burden for hospitals using short inpatient stays appropriately.

Second, the Commission recommended adjusting RACs' contingency fees based on their performance to make RACs more accountable for their decisions to deny hospitals' claims for

short stays. The contingency fee structure of the RAC program provides an incentive for the RACs to identify as many inappropriate claims and recover as much Medicare payment as possible. RACs lose payment if their denials are overturned, but face no further penalties for overturned denials and are not required to pay interest on the returned fee.

Third, the Commission recommended realigning the RAC look-back period and the Medicare rebilling window because the timing of the RAC program claim denial process and the timing of the Medicare rebilling policy are not coordinated. Currently, RACs are permitted to review claims that are up to three years old (from the date of service on the claim), while Medicare's rebilling policy allows hospitals only one year after a denied claim's date of service to resubmit a claim for the outpatient services included on the original claim. The Commission believes the Medicare program should align hospitals' ability to rebill RAC-denied claims because 1) a service was provided to a Medicare beneficiary and the hospital should receive reimbursement for it, and 2) alignment may reduce the number of appeals. However, the alignment between the look-back period and the rebilling period should strike a balance. It should reimburse a hospital for the outpatient service provided when an inpatient claim is denied but it should not allow hospitals to appeal all denied claims and still collect outpatient payments. The balance should encourage hospitals to pursue appeals for only those admissions for which the medical record presents strong evidence for the admission.

Finally, the Commission recommended the withdrawal of the two-midnight rule because, while the rule addresses some of its stated goals, it also eliminates RAC oversight for a large group of inpatient claims. 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.

Concurrent with the RAC-related policies described above, the Commission has discussed the concept of a payment penalty on hospitals with excessive numbers of short inpatient stays to improve the efficiency of program oversight. The Commission believes that this concept warrants further evaluation and recommended that the Secretary evaluate a penalty on hospitals

with excess rates of short inpatient stays to substitute, in whole or in part, for RAC review of short inpatient stays.

Recommendations to reduce beneficiary liability

Hospitals' increased use of observation status has led to greater financial liabilities for certain beneficiaries. The Commission has made three recommendations to address this issue. First, the Commission recommended that the Congress revise the skilled nursing facility three-inpatient-day hospital eligibility requirement to allow up to two outpatient observation days to count toward meeting the criterion. By statute, in order to qualify for Medicare SNF coverage a beneficiary must have been an inpatient of a hospital for at least three consecutive calendar inpatient days preceding the SNF admission. Beneficiaries served in observation status and subsequently discharged to a SNF are therefore liable for the entire cost of their SNF stay. The Commission's recommendation would permit time spent in outpatient observation status to count toward the three-day prior hospitalization threshold, but would require that at least one of the three days be an inpatient day. This recommendation seeks to balance reducing beneficiary liability for cases that currently do not qualify for SNF coverage with protecting the taxpayer and maintaining the SNF benefit as a post-acute care benefit.

The Commission recommended that the Congress require acute care hospitals to provide beneficiaries in outpatient observation status with a timely notification that their observation status may affect their financial liability for SNF care. Beneficiaries served in observation status often do not realize that they have not been officially admitted to the hospital as an inpatient, and are often unclear about how it may affect their financial liability for SNF care or other services they receive while in the hospital. The policy should apply to beneficiaries who have been in observation for more than 24 hours and who are expected to need SNF care.

Beneficiaries who receive care in a hospital outpatient department may face an additional liability for self-administered drugs, such as daily oral medications taken by the beneficiary at home. These drugs are covered by Medicare Part A for hospital inpatients, but are generally not covered by Medicare Part B for hospital outpatients. Patients in outpatient observation, who tend

to have longer stays than other beneficiaries treated under outpatient status, are more likely to encounter this problem. Among the two-thirds of hospitals reporting SAD charges, about 75 percent of observation claims included charges for SADs. These claims had average drug charges of \$209 per claim, relative to an estimated average cost of only \$43 per claim. The Commission recommended packaging self-administered drugs during outpatient observation (on a budget neutral basis) to protect beneficiaries from paying full hospital charges for self-administered drugs, which are typically substantially above the cost of the drug.

Payment policy approaches to hospital short stays

The substantial payment difference between similar inpatient and outpatient stays creates a financial incentive for hospitals to admit patients to inpatient status. One way to reduce this financial incentive and ensure that admissions decisions are being made on a purely clinical basis is to reduce payment differences for similar stays in the inpatient and outpatient settings. The Commission explored two payment policy approaches to lessen payment differences between similar inpatient and outpatient stays. Under the first approach, Medicare could create—as part of its inpatient payment system—a new set of Medicare severity–diagnosis related groups specifically designed for inpatient one-day hospital stays. Under the second approach, Medicare could develop a site-neutral payment—that is, equalize payments across settings—for similar short inpatient and outpatient stays.

Under a one-day-stay DRG policy, Medicare would pay less for one-day inpatient stays and more for longer inpatient stays than it currently does. This would lessen the payment differential between a one-day inpatient stay and similar outpatient stay. However, one caution is that a one-day-stay DRG policy would create a new payment differential between a one-day inpatient stay and longer inpatient stays. A one-day-stay DRG policy would reduce the financial incentive to admit a patient for one-day inpatient stays, but it would create a financial incentive to extend an inpatient stay from one to two days.

Alternatively, a site-neutral approach would pay comparable rates for similar inpatient and outpatient stays. The effect of a site-neutral approach may be different for medical and surgical

hospital stays. For medical stays, it would be difficult to eliminate the inpatient and outpatient payment differential without creating new vulnerabilities because identifying similar stays would likely necessitate establishing length-of-stay criteria. 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.

Payment policy changes such as one-day-stay DRGs and site-neutral payment for medical stays would involve trade-offs. On the one hand, 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. On the other hand, a revised payment system would create new payment cliffs and associated vulnerabilities, and therefore may simply shift the focus of audit oversight. Moving away from the fixed inpatient DRG payments to one-day-stay DRGs or site-neutral payment for medical stays also raises concerns about creating financial incentives for longer stays, which is counter to the original structure and intent of the DRG system. Given the competing arguments, the Commission has not made any recommendations to pursue payment changes at this time, but it has noted interest in continuing to explore these and other potential short-stay payment policy concepts in the future.

References

California Department of Insurance. 2014a. Aetna Life Insurance Company rate filing.

California Department of Insurance. 2014b. Blue Shield of California Life & Health Insurance Company rate filing.

Health Care Cost Institute. 2014. Health care cost and utilization report: 2013. Washington, DC: HCCI.

Joynt, K. E., Y. Harris, E. J. Orav, et al. 2011. Quality of care and patient outcomes in critical access rural hospitals. *Journal of the American Medical Association* 306, no. 1 (July 6, 2011): 45–52.

Keeler, E. B., L. V. Rubenstein, K. L. Kahn, et al. 1992. Hospital characteristics and quality of care. *Journal of the American Medical Association* 268, no. 13 (October 7): 1709–1714