



Advising the Congress on Medicare issues

Recent Growth in Hospital Observation Care

Zach Gaumer and Dan Zabinski
September 13, 2010

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 |
|---|--|
| <p>1) General guidance:</p> <ul style="list-style-type: none">a) Reasonable & necessaryb) 8 or more hours of servicec) Medical record must contain: physician order, written request for observation, and timeframe <p>2) Timing: not rigidly specified</p> | <p>1) General guidance:</p> <p>Physicians should also consider predictability of adverse outcomes, severity, hospital resources, and other factors.</p> <p>2) Timing: admit patients expected to need hospital care for 24 hours or more</p> |

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

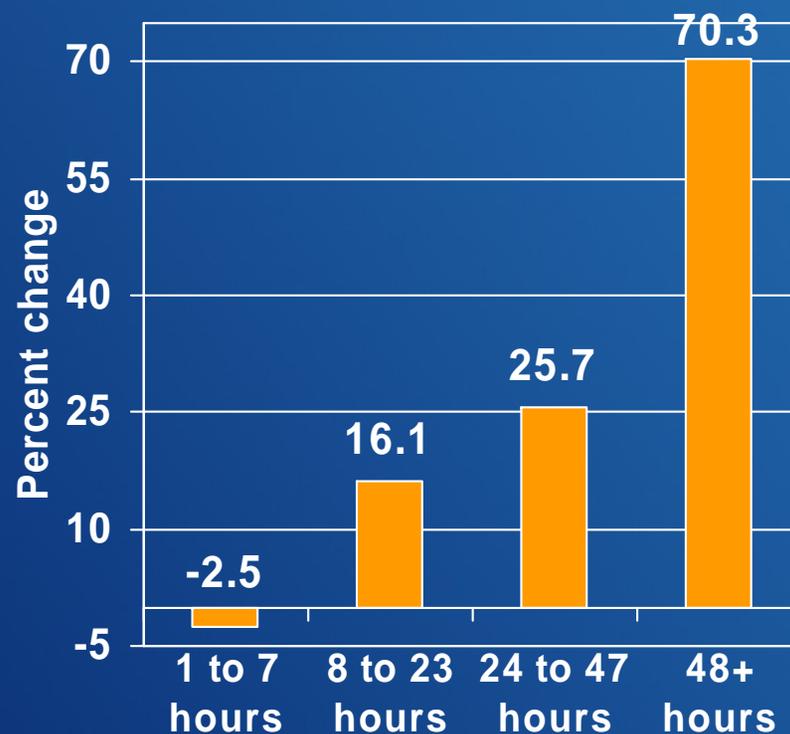
| Medicare outpatient observation care | 2006 | 2008 | Percent change (2006 to 2008) |
|---|------------|------------|-------------------------------|
| Claims | 911,500 | 1,116,000 | 22.4% |
| Claims (per 1,000 FFS Part B beneficiary) | 28 | 36 | 26.2 |
| Hours | 23,327,000 | 31,014,000 | 33.0 |
| Hours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

Percent change in number of claims, 2006 to 2008



Source: Medicare outpatient claims

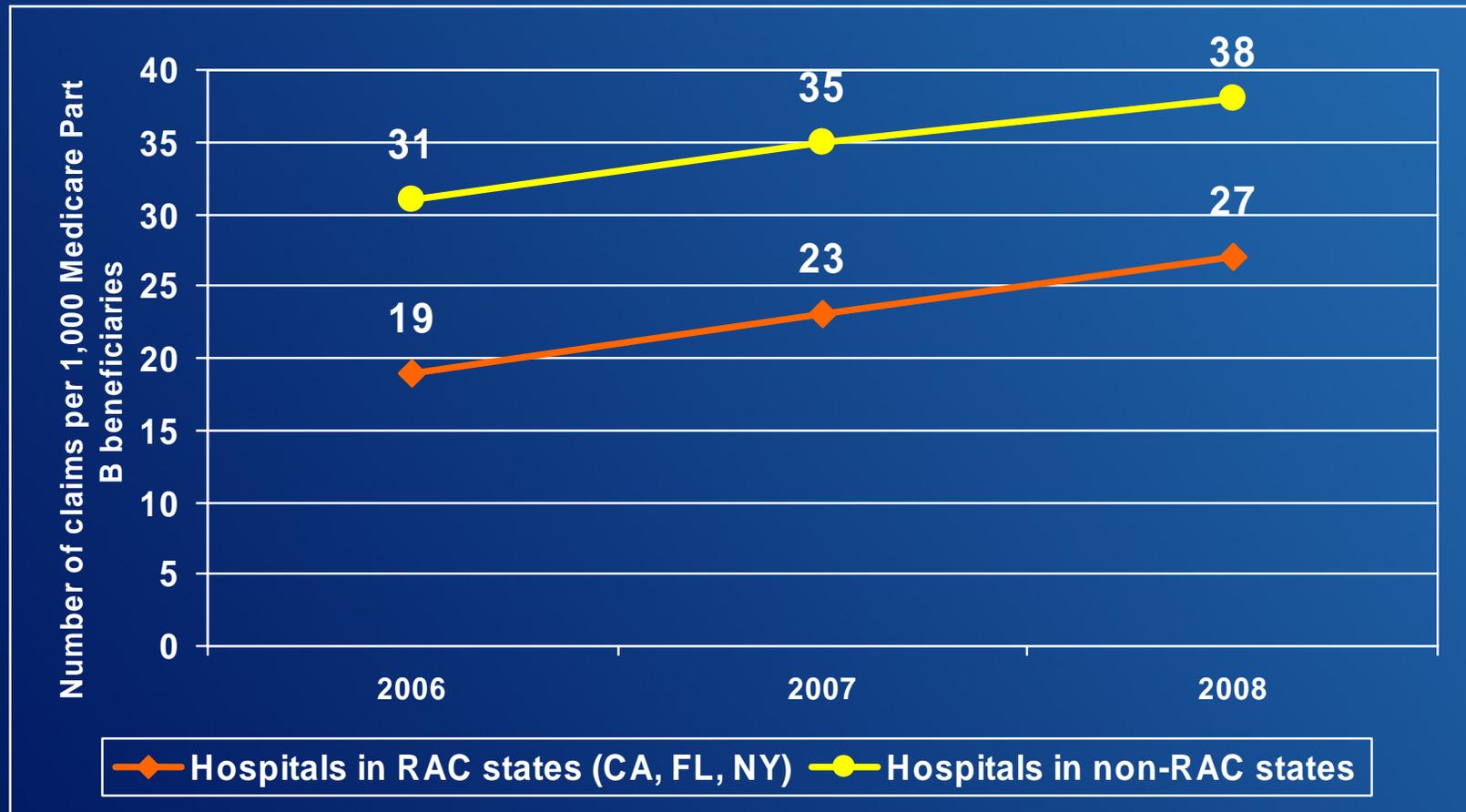
Cardiac conditions most common for observation claims (2008)

- 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

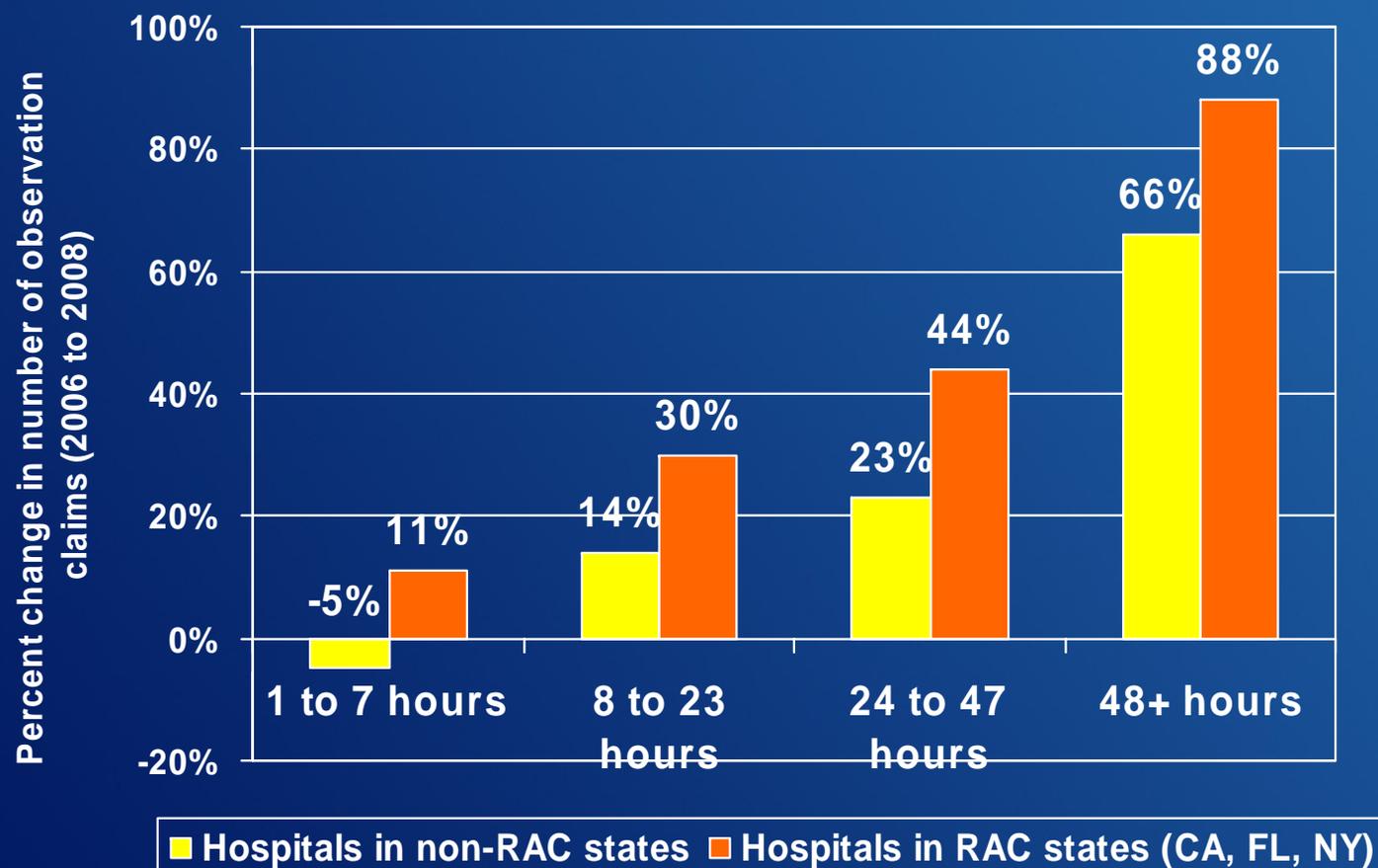
- Contracted auditors retrospectively identify past over or underpayments for any provider participating in the Medicare FFS program.
- Medicare RAC demonstration (March 2005 to April 2008)
 - California, Florida, and New York included throughout
 - Arizona, Massachusetts, and South Carolina included 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

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

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 deductible
 - 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