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What The Inspector General Gets Wrong About Reforming Observation Hospital Care

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Under traditional fee-for-service Medicare, beneficiaries are eligible for skilled nursing facility (SNF) coverage within 30 days of leaving the hospital if the hospital stay included at least three consecutive inpatient midnights. Last month, the Office of Inspector General (OIG) released a report citing improper payments to SNFs when a qualifying three-inpatient nights hospital stay was not met. In calendar years 2013–15, the OIG

identified $84.2 million—about $28 million yearly—in improper SNF payments when this prerequisite did not occur. This represents just shy of 0.1 percent of the total $86 billion paid out for SNF care for more than five million beneficiaries during the same three years.

To perform this study, the OIG identified 22,052 SNF claims from 2013 to 2015 that were paid but did not appear to have met the three-inpatient nights requirement. Of these claims, the OIG audited a 99 claim sample and found 65 to be in error. The OIG extrapolated these results to arrive at the $84.2 million figure. The incorrect claims contained three or more hospital nights but mistakenly used "…a combination of inpatient and non-inpatient [outpatient, which includes "observation"] days to determine whether the 3-day rule was met."

Solving This Problem?

The Common Working File (CWF) is used to validate and verify Centers for Medicare and Medicaid Services (CMS) claims, including the three-inpatient nights requirement when a SNF claim is submitted. During the three study years, CMS had allowed SNF claims to bypass the CWF due to erroneous SNF claim rejections. In its February 2019 report, the OIG recommended CMS re-enable the CWF, which had already occurred in April 2018.

In its February 2019 report, the OIG also proposed that hospitals provide "…written notification to beneficiaries whose discharge plans include post-hospital SNF care, clearly stating how many inpatient days of care the hospital provided and whether the three-day rule for Medicare coverage of SNF stays has been met." Furthermore, the OIG directed CMS to educate hospitals about the importance of communicating number of inpatient days to hospitalized beneficiaries.

The OIG also recommended CMS require that SNFs:

1. obtain a copy of the hospital's written notification to the beneficiary;
2. provide their own written notification to patients when the three-nights requirement was not met; and
3. receive education about submission of accurate claims

Inpatient Versus Observation

It isn't hard to count how many midnights a patient stays in the hospital. The core issue is determining how many of those midnights are inpatient nights and how many are outpatient, which includes hospitalization under "observation." Erroneous claims

identified in the OIG audit contained both inpatient and outpatient nights, thus creating a situation where a patient was hospitalized for three consecutive midnights but not three consecutive inpatient midnights.

When President Lyndon B. Johnson signed Medicare into law in 1965 as an amendment to the Social Security Act, average hospital length-of-stay was 14.2 days for those ages 65 and older, and outpatient observation status did not exist. Today, largely through advances in medical treatment, Medicare beneficiary hospitalizations average only 5.1 days. Additionally, with the subsequent introduction of Medicare regulations, some hospital stays should be provided as an outpatient with observation services (rather than inpatient). A situation now exists where the three-inpatient nights requirement restricts postacute SNF Medicare benefits in ways that could not have been anticipated when the "3-midnight rule" began more than 50 years ago, on January 1, 1967. While current accountable care organization waivers under the original Medicare program, as well as Medicare Advantage, have more permissive approaches to the antiquated requirement, a majority of beneficiaries are still subjected to this onerous rule.

Adding to the anachronism of the "3-inpatient midnight rule," CMS redefined "inpatient" a little more than five years ago. In 2013, CMS established the "2-Midnight Rule" to determine inpatient or outpatient status. In general, patients who are expected to stay for fewer than two midnights of medically necessary care, with some exceptions, should be billed as outpatients under observation. Those expected to stay longer than two midnights should generally be considered inpatients.

Although the two-midnight rule seems simple, it is challenging in clinical practice to know exactly how long a patient will need to be hospitalized based on initial presentation, which is when the inpatient or observation order must be written. As a result, it is not surprising that the OIG found hospital stays containing a combination of inpatient and outpatient nights due to so-called "status changes" at the root of the problem.

According to the Medicare Payment Advisory Commission, in 2012, 30 percent of observation stays ended up converting to inpatient hospitalizations. Using 2014 Medicare claims, we found that 47.3 percent of observation revenue center codes were associated with an inpatient claim, indicating a high rate of status change from inpatient to outpatient, and vice versa. An earlier OIG report identified 633,148 hospital stays in 2014 that lasted longer than three midnights but did not contain three inpatient nights. Of these stays, 68 percent (432,740) included nights as hospital outpatients prior to the patient being admitted as an inpatient.

There are two distinctly different clocks used to determine eligibility for the two-midnight and three-midnight standards. For purposes of the statutory three-midnight rule that determines SNF eligibility, the clock begins when the patient is formally admitted as an inpatient (almost always with an inpatient order by a provider with admitting privileges). In contrast, the Medicare two-midnight rule clock starts when "hospital care begins," which can occur in a hospital bed, a hospital emergency department (ED), or, in the cases of transfers, at the transferring hospital or ED. For example, a patient may arrive at an ED, be assessed by a medical provider, and have vital signs taken and blood tests done at 11 p.m. However, a decision to hospitalize the patient as an inpatient is not made until four hours later, at 3 a.m. That first midnight counts toward the two-midnight tally for purposes of hospital admission but does not count toward the three-midnight SNF requirement.

Framing The Problem: Patients Over Paperwork?

Is the proposed regulatory burden worth it?

While every Medicare dollar is important, $84 million in erroneous billings is just 1/1000 of the $86 billion in SNF payments paid over three years. It is likely that implementing the OIG's additional paperwork and notification requirements would cost hospitals far more than the proportionally small $28 million yearly savings and runs counter to CMS administrator Seema Verma's Patients Over Paperwork initiatives.

Hospitals already use significant resources to ensure correct inpatient or observation billing status. John J. Reynolds found that 41 percent of all case management job postings are now for jobs related to status "leveling" (inpatient or outpatient observation) and CMS compliance, a marked change from prior case management tasks of quality, safety, and patient care. In a three hospital study, we found that Johns Hopkins, University of Utah, and University of Wisconsin employed an average of 5.1 full-time staff per hospital just to manage the audit and appeals process related to billing status. Not a single audit of the three hospitals questioned the quality or content of care, rather that billing should have been sent to Medicare Part B instead of Part A. Although hospital costs do not appear directly on Medicare's balance sheet, these are still Medicare dollars hospitals spend on paperwork and personnel instead of investments in patient care. Not surprisingly, given the Patients Over Paperwork initiative, CMS dismissed most of the OIG's recommendations.

In 2015, the NOTICE Act became law, requiring hospitals to deliver the Medicare Outpatient Observation Notice (MOON) to patients informing them when they are hospitalized as outpatients under observation, instead of as inpatients. While

transparency is important, this added regulatory burden did nothing to improve patients' right to appeal their status, nor to improve care. The OIG recommendation to simply establish, "…a requirement similar to the MOON" to notify patients of how many nights they stayed as inpatients is troubling and lacks insight to the regulatory burden already imposed to maintain a two-tiered hospital billing status that has little to do with actual patient care.

The OIG recommendation of "…explicitly communicating the correct number of inpatient days to beneficiaries…" is also perplexing, as it is unclear how a sensible conversation could occur with patients regarding the number of inpatient nights spent hospitalized. Due to the asynchronous clock issue, envision providers or hospital staff having to explain to a patient how she had stayed three-inpatient nights for purposes of the two-midnight rule, but only two midnights for purposes of the three-midnight SNF requirement. Not just theoretical, this scenario happens multiple times daily at our hospitals. Physicians chose their profession to care for patients, not to be the bearer of arcane Medicare rules.

Finally, it should be noted that 34 of the 99 cases identified in the OIG audit of potentially erroneously billed SNF stays were, in fact, properly billed. The regulatory burden and paperwork required to recover one of three claims that may now be denied in the CWF is another cost that downstream hospitals and SNFs will face going forward. Additionally, in future audits, will the Medicare beneficiaries involved, who are almost by definition elderly and vulnerable, become retrospectively financially liable for their SNF stays?

Solutions

Since 2000, the OIG has studied issues related to noncompliance with the three-inpatient midnight stay requirement 27 times. In the OIG study of calendar years 1996–2001, $169 million was paid in erroneous SNF charges when the three-midnight requirement was not met—or $28 million erroneously paid each year, identical to the present study. In essence, little has changed in the past two decades despite multiple OIG studies and recommendations.

A different approach is clearly needed—one that addresses the real underlying problem of a two-tiered billing status for hospitalized patients that has little, if anything, to do with actual patient care. Instead of adding more regulatory burden, notification, and monitoring, CMS and Congress should work to fix the underlying problem. First, CMS and Congress, if necessary, should establish the same clock for purposes of the two-midnight rule and three-midnight statute. The time care begins should start this unified clock. Second, Congress should support the recently reintroduced bills in the Senate and

House that would count all midnights in the hospital toward the three-midnight SNF requirement. With status change occurring in almost half of all observation encounters, the clinical distinction between observation and inpatient is blurry at best—yet carries real consequences for Medicare beneficiaries.

Ultimately, CMS should consider eliminating the oxymoron of "outpatient hospitalizations" in its Patients Over Paperwork initiative so that physicians and other workforce tied up in billing determinations can get back to work taking care of patients.

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Ronald Hirsch, MD • 22 days ago

Excellent summary and proposal. As if it is not confusing enough, there is a third clock- the observation hour counting clock to get paid for the observation APC. That starts with the observation order and needs 8+ hours exclusive of carve outs. And there is even another clock if we really want to create more insanity - the 24 hour observation clock for requiring the MOON.

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Ann Sheehy • 21 days ago

Thank you for the thoughtful comments. I am optimistic that all of us who see problems with the status quo can work together to change this policy!

^ | ˅ • Reply • Share ›

Mike Barrett • 22 days ago

To expand on Greg's comment below and having met the guy who authored the 3 day rule and interviewing him, it was clear the rule was intended to have some sort of gate on the demand. The working assumption "back in the day" is that if they were sick enough to be in the hospital......

Fast forward and now we are getting much better at understanding the complexities and intricacies of delivery both CARE and improved HEALTH in a finite resource reality.

After everyone has been "revenue cycle optimized" there is still a person who is begging that someone actually care about their health. As we move from fractured, transaction care to longitudinal health we replace old, overly simplistic gates on demand with thoughtful action to maintain and improve health as the primary activity of long term "resource cycle optimization" where the cycle is at least several quarters, if not years, and perhaps even a lifetime.

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Greg Sheehy • 22 days ago

This is a cogent explanation to a complicated problem. But the solution is easy, provided that common sense is used and we all maintain our focus. Medicare rules developed 54 years ago do not work well in today's health care environment, and skilled nursing care for seniors is a critical component of quality health care today. CMS must change, and Congress must ensure that they do.

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