



**American Hospital
Association**

Liberty Place, Suite 700
325 Seventh Street, NW
Washington, DC 20004-2802
(202) 638-1100 Phone
www.aha.org

October 27, 2010

Marilyn Tavenner
Chief Operating Officer
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W., Room 445-G
Washington, DC 20201

Dear Ms. Tavenner:

Thank you for your letter about extended observation services. We very much appreciate the opportunity to communicate with the Centers for Medicare & Medicaid Services (CMS) about this issue, which, as your letter states, “can have a tremendous impact on Medicare beneficiaries.” We, too, are concerned about that impact on affected patients and would like to work closely with you to address the issue in the most productive manner. Hospitals’ goal is to provide the right care at the right time in the right setting, and they strive to do this every day. In addition to public comment at the recent CMS listening session on this topic, and several conversations with your staff in the payment policy area, we also want to highlight some key issues for you in this letter.

You asked for information that we could share about the underlying causes of this trend toward extended observation services. To that end, we have engaged in a multi-prong effort to better understand the issue so we could offer constructive suggestions for how to address it on multiple levels. It is our hope that CMS will help us educate and provide clarity to the hospital field and to seniors about the use of observation services.

As an initial step, we invite you to assist us with a wide-ranging education effort to raise the hospital field’s awareness of the issue and the resources that your agency has available, such as the CMS pamphlet, *Are You a Hospital Inpatient or Outpatient? If You Have Medicare – Ask!* We have multiple publications such as *Hospitals & Health Networks*, *Trustee* and *AHA News* that can provide a forum for you to communicate directly with the hospital field. We will be in contact with your office directly to discuss how we can use these various outlets to both raise the field’s awareness, as well as improve the overall understanding of observation services for hospitals and patients.



Our research to date has found that no one single factor is driving the trend toward proportionately more observation services extending beyond 48 hours cumulatively. We recently asked more than 500 hospital leaders through the AHA's regional policy board and governing council process about whether their institutions were experiencing increases in observation services lasting longer than 48 hours and the reasons why they thought the increases were occurring. They identified several factors, including federal policies that should be reviewed to determine the impact they have on observation services. One factor is the evolution of medical practice patterns, such as whether to admit a patient for an inpatient stay or to furnish the service on an outpatient basis. Among those affecting this trend are changes to Medicare policy, the activities of Recovery Audit Contractors (RACs), and hospitals' concerns about enforcement actions.

Hospitals cannot discharge patients – whether from the inpatient or outpatient setting – before they are medically ready. With inpatient admission criteria becoming more stringent and with more patients coming to hospital emergency departments, it is not surprising that more patients may require observation services, or that observation services need to be longer. In these cases, while patients may not meet qualifying criteria for an inpatient admission, for patient safety and quality of care reasons, it may be important that they be actively observed in the outpatient setting.

Technology and Medical Practice Patterns

The evolution of technology and medical practice now allows many traditional inpatient hospital services to be furnished in outpatient departments. This can be seen in the number of inpatient services removed from CMS' "inpatient only" list under the outpatient prospective payment system (OPPS). As technology and medical practice patterns shift more services from the inpatient to outpatient settings, the qualifying criteria for an inpatient admission (such as those outlined in InterQual and Milliman guidelines) that hospitals, payers and Medicare contractors use when deciding whether an inpatient admission is "reasonable and necessary," as required by Medicare, have become more stringent. As these inpatient admission criteria become more stringent, more patients require observation services to ensure that they are stable and it is safe to leave the hospital.

Medicare Policy Changes

A number of Medicare policy changes also affect how hospitals furnish and bill for observation services. The requirement for reporting observation services has changed five times in the 10 years since the OPPS was implemented. For example, in 2006, CMS changed the codes for reporting observation services; midway through the year it also eliminated a claims-processing edit that rejected outpatient claims containing more than 48 hours of observation services. Many hospitals had implemented an internal coding edit to ensure that observation claims were not billed with more than 48 hours. Once CMS eliminated its edit, hospitals gradually followed suit by eliminating their internal edits. This is likely to have contributed toward the perceived increase in the number of observation claims reporting more than 48 hours in 2007 and 2008.

Similarly, modifications to the policy around “Condition Code 44,” which governs when a hospital may change an inpatient admission to an outpatient encounter for billing purposes, likely affected inpatient/outpatient status determinations. Inpatient status can be changed to outpatient status only after a decision by a hospital utilization review committee and agreement of the treating physician. Making this status change is elaborate operationally; therefore, physicians are more likely to order observation services when there is a question as to whether the patient’s condition qualifies for an inpatient admission.

Medicare Audits

The recent growth in furnishing observation care also may be due in part to hospital concerns about more frequent and involved post-payment reviews of inpatient claims – most notably, the “one-day stay” RAC audits, which focused on the appropriateness of short inpatient admissions. Private payers also are looking closely at these types of cases. The administrative burdens and financial consequences associated with these audits, and subsequent appeals, have caused hospitals and physicians to exercise greater caution when admitting patients for inpatient stays. Hospitals strive to get it right the first time. The AHA has asked CMS for improved education and clarification to rules related to RAC target areas, but CMS has done little to address these requests. We continue to believe that additional CMS education and clarifications will help alleviate some of the uncertainty in the admissions process and hospitals’ fears of aggressive RAC reviews. We also would like to work with you to ensure that new readmissions policy requirements contained in the health reform bill does not further contribute to this issue.

A related enforcement risk – prosecution under the *False Claims Act* – also may affect the decision to place patients in outpatient observation rather than admit them as inpatients. As recently as this month, the Department of Justice announced a hospital’s agreement to pay more than \$2 million to settle a *qui tam* suit alleging that, in order to receive additional Medicare reimbursement, the hospital admitted patients for inpatient stays when those patients should have been in observation beds. The costs of such suits in financial and human terms, as well as the damage that they do to a hospital’s reputation, likely makes hospitals more wary about admitting patients for short inpatient stays.

Hospitals and physicians do their best to ensure that the decision to admit a patient for observation as opposed to an inpatient stay is based upon clinical considerations. Nevertheless, the above factors influence that decision.

Need for Legislation

We recognize that legislation may be needed to completely resolve the issue. Among consumer groups’ most frequently articulated concerns is that patients who stay in observation do not qualify for a Medicare covered stay in a skilled nursing facility (SNF). Medicare beneficiaries only qualify for SNF coverage after a three-day inpatient stay. As the practice of medicine moves more care into the outpatient setting, this may become a more significant concern. A legislative effort to address this issue is underway in both the House and Senate. A bill (H.R. 5950) to count a period of observation exceeding 24 hours toward the three-day inpatient hospital stay required for Medicare coverage in a SNF has been introduced in the House by Rep.

Marilyn Tavenner
October 27, 2010
Page 4 of 4

Joe Courtney (D-CT). A similar bill awaits introduction in the Senate. The AHA supports both these bills.

We hope to work closely with you and your staff to resolve this issue for the benefit of our patients. We look forward to discussing the issue in greater depth.

Sincerely,

Rick Pollack
Executive Vice President