

**Joint Statement from the AHA, AAMC and FAH
Before CMS' Listening Session on the
Recent Trend of Medicare Beneficiaries Receiving Extended
Observation Care as a Hospital Outpatient**

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I am Roslyne Schulman, a Director for Policy at the American Hospital Association. I am accompanied here today by my colleagues, Diana Mayes from the Association of American Medical Colleges (AAMC) and Jeff Micklos from the Federation of American Hospitals (FAH). Last month each of our organizations received a letter from the Center for Medicare & Medicaid Services (CMS), citing concern about a modest trend toward more observation services extending beyond 48 hours – from approximately 3 percent in 2006 to nearly 6 percent in 2008. CMS expressed interest in learning more about why this trend is occurring and asked whether we can provide any information to better inform potential CMS actions.

In response to the letter, our organizations have been busy reaching out to our hospital and health system members to learn more about how hospital observation services are currently furnished. We've also sought their input on possible causes for the increase in the number of observation services extending beyond 48 hours

As a starting point, we commissioned a study to analyze four years of Medicare observation services claims data, in order to better understand the trend CMS identified. This analysis is not yet complete and so I am not able to provide our final conclusions at this time. We will be reporting the results of our analyses to CMS when they are ready.

From our efforts so far, it is clear that hospitals and physicians are doing the best they can to ensure that their patients are receiving appropriate care, at the appropriate time, in the right location based on clinical considerations. We have learned that patients are often placed in outpatient observation because they do not meet CMS criteria for admitting them as inpatients. However, for patient safety and quality of care reasons, it may be important that patients who do not qualify for inpatient care be kept in observation. Hospitals cannot discharge patients before they are clinically ready to be sent home.

It also seems clear that several factors are likely contributing to this trend. In discussion with hospitals, the evolution of technology and medical practice now allows many traditional inpatient services to be rendered in outpatient departments. The number of services which have been removed from CMS' "inpatient only" list since the inception of the outpatient prospective payment system (OPPS) supports this point. This trend towards more complex services being furnished in outpatient departments has been

accompanied by various changes to the criteria, such as InterQual and Milliman, which are used by hospitals to guide decisions about whether to admit a patient as an inpatient. Consistent with the changes in practice patterns, the inpatient admission criteria have become more stringent over time. As you know, patients can only be admitted to and remain in hospitals when inpatient-level care is reasonable and necessary. For most hospitals, these criteria are key determinants of what is considered to be “reasonable and necessary”. As the admission criteria become more stringent, it is not surprising that more patients may require observation services or that observation services may extend for longer periods of time.

In a related matter, decisions to admit patients for short inpatient stays have received prominent attention in audits by Recovery Audit Contractors, particularly during the RAC demonstration program, which coincides with the period during which CMS noted a trend towards longer observation services. Concern about potential RAC audit of short-stay claims may have also had an impact on the trend towards more and longer observation stays.

We also note that the requirements related to reporting observation services has changed five times since OPSS was implemented in 2000. However, the separate payment hospitals receive for 8 or more hours of observation has remained the same since 2002. Thus, hospitals do not have a financial incentive to keep patients longer in observation status.

A critical policy change was made in 2006 that may have contributed towards a subsequent artificial increase in the number of claims with extended observations services. That is, in 2006, CMS changed the codes for reporting observation services and also eliminated a claims processing edit that rejected outpatient claims containing over 48 hours of observation services. Prior to its elimination, this edit likely limited the number of observation services that hospitals reported as exceeding 48 hours. Many hospitals may have implemented internal edits to their billing systems that adjusted a claim to report only 48 hours or less of observation time, given there was no payment impact. It is quite possible that the trend line reported by CMS may, in part, reflect this change, followed by the gradual response by hospitals to eliminate their internal claims edits and report all hours of observation services.

We are sympathetic to and understand the implications to Medicare beneficiaries that result from extended observation services, including possible increases in out-of-pocket costs and difficulties in meeting the minimum inpatient stay requirements for skilled nursing facility (SNF) care. However, hospitals must operate within the policies that govern them. And, we do not believe that discharging a patient from observation services at an arbitrary time limit of 48 hours is clinically appropriate simply because the patient does not qualify for inpatient care.

That said, hospitals could probably do a better job of communicating to Medicare beneficiaries under observation that they are not inpatients but rather outpatients. In addition, hospitals could explain to those patients what that means in term of their potential responsibility for paying for certain additional out-of-pocket costs, as well as the implications for qualifying for any necessary skilled nursing facility care. The AHA, AAMC and FAH pledge to work with hospitals to help them educate and communicate with their patients around these issues.

Once our review of the trend data is complete, we will respond to CMS with our final analyses and conclusions. Further, we are happy to continue to work with CMS to better inform further actions the agency may want to take on this issue to better serve Medicare beneficiaries. We also encourage CMS and other stakeholders to share their analyses on likely causes of this trend.