

Support the Improving Access to Medicare Coverage Act

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Medicare beneficiaries are being denied access to Medicare's skilled nursing facility (SNF) benefit because of the way hospital stays are classified.

Under Medicare law, patients must have an *inpatient* stay in a short-term acute care hospital spanning at least three consecutive days (not counting the day of discharge) in order for Medicare to pay for a subsequent stay in a SNF. However, acute care hospitals are increasingly identifying patients as in "observation," an *outpatient* designation, rather than admitting them as inpatients.

Outpatients may stay for multiple days and nights in hospital beds and receive medical and nursing care, diagnostic tests, treatments, medications, and food, just as inpatients do. However, although the care received by patients in observation status can often be indistinguishable from the medically necessary care received by inpatients, outpatients who need follow-up care do not qualify for Medicare coverage in a SNF. As a result, the Medicare beneficiary ends up being responsible for paying for the SNF stay, which places an unfair burden on the beneficiary through no fault of the beneficiary. Counting observation days toward the Medicare benefit is a common-sense policy that does not affect hospital care but does protect the ability of beneficiaries to receive needed post-acute nursing home care. For these reasons, we support passage of the **Improving Access to Medicare Coverage Act (H.R. 3650/S. 2048)**.

Hospitals' use of observation status and the amount of time patients spend in observation status are both increasing.

An early study¹ found a 34% increase in the ratio of observation stays to inpatient admissions between 2007 and 2009, leading the researchers to conclude that outpatient observation status was increasingly becoming a substitute for inpatient status. The same study also documented increases in long-stay outpatient status, including an 88% increase in observation stays exceeding 72 hours. A 2013 report by the Department of Health and Human Services Office of Inspector General (OIG) found that in 2012, beneficiaries had 617,702 hospital stays that lasted at least three days, but that did not include three *inpatient* days. The pattern continued. In December 2016, the Inspector General reported that in FY 2014, 748,337 long hospital stays were called outpatient, including 633,148 outpatient stays of three or more days. Between FYs 2013 and 2014, outpatient stays increased by 8.1%, despite implementation of the two-midnight rule (see reverse side of document) that was expected to decrease long outpatient stays.

Support for counting time spent in observation status toward the three-day prior inpatient stay continues to grow:

- The Inspector General's 2013 report was supportive of counting observation days towards the three-day inpatient stay requirement.
- In September 2013, the Congressionally created Long Term Care Commission recommended that the Centers for Medicare & Medicaid Services (CMS) count time spent in observation status toward meeting the three-day stay requirement.
- In 2015, the Medicare Payment Advisory Commission (MedPAC) explored various policy options for counting time spent in observation toward meeting the SNF 3-day requirement. The Commission unanimously recommended that CMS revise the SNF 3-day rule to allow for up to two outpatient observation days to count toward meeting the requirement, recognizing that beneficiaries are needlessly facing barriers to accessing needed post-acute care.²

- Payment models, such as the Next Generation Accountable Care Organization (ACO), have recognized the confusion and flawed logic of the observation status issue and have allowed a waiver for the 3-day stay requirement, including time spent in observation. Counting observation stays would therefore more closely align with newer models of care and reduce confusion for patients.
- Recent efforts have focused on eliminating burden and unanticipated/surprise medical bills that are having a significant negative impact on out-of-pocket-costs and the patient-provider relationship. The unexpected financial impact of observation stays is often a surprise medical bill for Medicare beneficiaries.
- During the COVID-19 national public health emergency (PHE), CMS has waived the Medicare Part A SNF 3-day stay prior hospitalization requirement, regardless of condition, if a SNF level of care is needed. This waiver should be made permanent.
- A 2020 study found that Medicare beneficiaries residing in the most disadvantaged neighborhoods, as defined by Area Deprivation Index, are more likely to face repeated observation stays. These same patients are least likely to receive skilled nursing facility services when they need them, often resulting in a cycle of repeated hospitalizations as a result of not receiving the appropriate skilled nursing care.³

The Improving Access to Medicare Coverage Act of 2021 counts the time Medicare beneficiaries spend in observation toward the three-day stay requirement, so that Medicare patients who spend three days in a hospital, regardless of inpatient/observation designation, are able to access post-acute care in a SNF when they need it.

As mentioned earlier, legislation was re-introduced this Congress with bipartisan support that would create a full and permanent solution. The **Improving Access to Medicare Coverage Act (H.R. 3650/S. 2048)**, sponsored by Representatives Joe Courtney (D-CT), Glenn ‘GT’ Thompson (R-PA), Suzan DelBene (D-WA), Ron Estes (R-KS) and Senators Sherrod Brown (D-OH), Susan Collins (R-ME), Sheldon Whitehouse (D-RI), and Shelley Moore Capito (R-WV), would help Medicare beneficiaries who are hospitalized in observation by requiring that time spent in observation be counted towards meeting the three-day prior inpatient stay.

Recent efforts to address the problem of observation status have fallen far short of a comprehensive fix.

The NOTICE Act (P.L. 114 - 42), while a step in the right direction, does not go far enough to ensure patients have access to needed post-acute care services.

Since March 8, 2017, the NOTICE Act has required hospitals to inform patients who are receiving outpatient observation services for more than 24 hours that they are outpatients, not inpatients. Hospitals must use the Medicare Outpatient Observation Notice (MOON) and provide an oral explanation. While receiving notice informs patients of their status, the law – although a positive step forward – does not give patients hearing rights or count the time in the hospital for purposes of SNF coverage.

The “two-midnight” rule, which was intended to slow the growth in long outpatient stays does not eliminate, and in fact has exacerbated, the barriers beneficiaries face in accessing needed post-acute care services.

How the 2-Midnight Rule Works

In October 2013, CMS adopted the “two-midnight rule,” which establishes time-based criteria for physicians to use when deciding to admit a patient as an inpatient or keep the patient under outpatient observation. The rule states that for patients expected to require hospital services for at least two midnights, inpatient admission will be presumed appropriate for payment. Likewise, for patients expected not to require hospital services for at least two midnights, outpatient observation is presumed appropriate. The rule was intended to give admitting physicians additional assurance that their decision to admit would not be questioned by auditors, thereby reducing the incidence of long outpatient stays. CMS intended the two-midnight rule to decrease the number of long outpatient stays, and decrease the number of short inpatient admissions.

What the OIG Found

In a December 2016 report⁴, the OIG found that since the implementation of the two-midnight rule, total outpatient stays have increased and total inpatient stays have decreased – the opposite of CMS’s expectations – exacerbating an already challenging problem. It is now clear that while CMS intended to fix the problem through implementation of the two-

midnight rule, it has inadvertently worsened the situation for thousands of beneficiaries who are unable to access needed post-acute care. The report recommends that CMS analyze the potential impacts of counting time spent as an outpatient toward meeting the SNF three-day requirement so that beneficiaries receiving similar hospital care have similar access to post-acute care services.

While the rule and its revision reflect CMS's concerns about long outpatient stays, hospitals are unlikely to change their practices when CMS provides no meaningful guidance on when an inpatient stay of fewer than two midnights is appropriate. Physician decisions about patient status continue to be reviewed by hospitals under the same standards as before: short inpatient decisions are prioritized for review by Quality Improvement Organizations (QIOs); and the specter of audits by Recovery Auditors (still known as RACs) remains. The mission of the RACs is to identify and correct Medicare and Medicaid improper payments. A RAC's determination that a patient has been incorrectly classified as an inpatient requires the hospital to return most of the Medicare reimbursement for the patient's stay, despite the fact that the services were medically necessary and coverable by Medicare. Recently-imposed penalties for readmitting a hospital patient within 30 days potentially incentivizes the classification of patients as outpatients, rather than inpatients.

Preliminary early Hospital Readmissions Reduction Program (HRRP) results were inconclusive in identifying changes in readmission versus observation stay use, however behavioral changes may be measurable now that the penalty phase-in is complete and a significant expansion of covered conditions (covered beneficiaries) has occurred since 2015⁵.

Implementation of the recently promulgated regulations to phase out the Inpatient Only (IPO) list of 1,700 procedures by CY 2024 may significantly compromise SNF access to subsequent SNF care for a significant number of Medicare beneficiaries requiring complex surgical procedures.

On December 29, 2020 CMS promulgated the CY 2021 Outpatient Prospective Payment System (OPPS) and Ambulatory Surgical Center (ASC) final rules by eliminating some 300 primarily musculoskeletal-related procedures beginning the elimination of the Inpatient Only (IPO) list of 1,700 procedures for which Medicare will only pay when performed in the hospital inpatient setting⁶. The IPO list will be completely phased out by CY 2024. There was little consideration of the potential impact on shifting financial liability for scores of beneficiaries with complex medical conditions or unexpected post-surgical outcomes requiring subsequent SNF care. Elimination of the 3-day stay requirement or the inclusion of observation days after these formerly inpatient procedures newly being furnished by OPPS and ASC providers towards meeting the 3-day stay requirement would help protect beneficiary access to the SNF benefit.

¹ Zhanlian Feng, Brad Wright and Vincent Mor, Sharp Rise In Medicare Enrollees Being Held In Hospitals For Observation Raises Concerns About Causes And Consequences, Health Affairs, 31, no. 6 (2012):1251-1259.

² Medicare Payment Advisory Commission (MedPAC), June 2015 Report to Congress.

³ Ann M. Sheehy, MD, MS, et al, "Thirty-Day Re-observation, Chronic Re-observation, and Neighborhood Disadvantage" Mayo Clinic Proceedings, Vol. 95, Issue 12, pp. 2644-2654 (Dec. 1, 2020).

⁴ Department of Health and Human Services Office of Inspector General (OIG), December 2016 Report OEI-02-15-00020.

⁵ Medicare Payment Advisory Commission (MedPAC), June 2018 Report to Congress.

⁶ Centers for Medicare and Medicaid Services (CMS), 85 FR 85866 (Dec. 29, 2020).