

**OBSERVATION STATUS  
COST SAVING OR COST SHIFTING?**

By Lauren Tucker, MJ

**ABSTRACT**

Observation units were developed to bridge the gap between hospital emergency rooms and inpatient hospital care. They have the intention of providing an opportunity for physicians to diagnose a patient with an uncertain condition, resulting in an “observation unit” stay of typically less than twenty-four hours. Once a diagnosis is achieved, the attending physician can then determine if the patient meets the criteria to be admitted as an inpatient or should be discharged. However, with recent fears of harsh readmission penalties and audits from the Center of Medicare and Medicaid Services’ (CMS) Recovery Audit Contractor (RAC) Program, hospitals have seen a dramatic increase in the number of patients being held under “observation status”. This simple change in patient status designation, without adhering to the guidelines set forth by CMS for observation status, has pushed a significant amount of cost onto the patient. Observation status is considered an outpatient service and, therefore, is covered under Medicare Part B as opposed to Medicare Part A. Moreover, many Medicare patients have lost coverage of post-acute skilled nursing care due to not fulfilling the three-day inpatient hospital stay requirement, further burdening these consumers with additional health care costs. Recent awareness of the need to change Medicare policies on observation status has gained bi-partisan support in Congress. As a result, the “Improving Access to Medicare Coverage Act of 2013” has emerged; however, no concrete changes in the Medicare policies have yet to be seen.<sup>1</sup>

**Publisher’s Note**

This article was originally published in June 2014. Given the attention to this subject matter by CMS and Congress, the author agreed at the publisher’s request to update the article as of June 2015.

**About The Author**

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<sup>1</sup> *Fact Sheet – Observation Stays Deny Medicare Beneficiaries Access to Skilled Nursing Facility Care*, **CENTER FOR MEDICARE ADVOCACY, INC** (Aug. 1, 2013), <http://www.medicareadvocacy.org/fact-sheet-observation-stays-deny-medicare-beneficiaries-access-to-skilled-nursing-facility-care/>.

## Recent 2015 Discussions Of Observation Status

The topic of Observation Status has recently gained increased attention after a Senate committee heard statements on May 20, 2015. Prior to its recent hearing, Observation Status seemed to “fly under the radar” and in many cases carried with it some harsh realities, mainly in the form of (a) increased consumer out of pocket costs and (b) not satisfying the criteria to be admitted to SNFs. This kind of “status” was then revealed after the fact to the victims, often at the time the patient was set to leave the hospital.

Those who spoke to the Senate committee highlighted several negative consequences of hospitals’ increased use of Observation Status in place of in-patient admissions. Moreover, the attention in Washington surfaced litigation over this issue such as *Bagnall v. Sebelius* (No. 3:11-cv-01703, D. Conn) in which a national class action lawsuit was brought against the Secretary of Health and Human Services claiming that Observation Status violated the “Medicare Act, the Freedom of Information Act, the Administrative Procedure Act, and the Due Process Clause of the Fifth Amendment to the Constitution”.<sup>2</sup>

The executive director of the Medicare Payment Advisory Commission (MedPAC) highlighted in his testimony the increased scrutiny that hospitals are experiencing with regard to inappropriate in-patient admission penalties as a result of RAC audits. This, many believe, is attributed to the increased use of Observation Status as a means of avoiding such penalties. Several planned and proposed corrective initiatives were discussed including: (a) decreasing the in-patient legitimate stay criteria to a “two midnight” rule to qualify for SNF admission, and (b) The Medicare Audit Improvement Act of 2015, which would replace the contingency fee paid to current RAC auditors with a flat fee coupled with payment reductions for high overturn rates of denials.<sup>3</sup> This said, neither of these initiatives has come to fruition; each side was able to present concerns with any *proposed* solutions.

However, in the May 2015 hearing supporters of Observation Status continued to present evidence that, if used correctly, Observation Status can result in shorter lengths of stay, more targeted and higher quality care and significant cost reductions for patients, hospitals and Medicare. *Health Affairs* published several articles on the positive outcomes and projections from the use of Observation Status. Specifically, a case study conducted in Georgia demonstrated that patients treated in a “type 1” Observation Unit had “23-28 percent shorter length-of-stay, a 17-44 percent lower probability of subsequent inpatient admission, and \$950 million in potential national cost savings each year”.<sup>4</sup>

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<sup>2</sup> *Observation Status & Bagnall v. Sebelius*, **CENTER FOR MEDICARE ADVOCACY, INC.**, <http://www.medicareadvocacy.org/medicare-info/observation-status/>.

<sup>3</sup> *Senate Committee Mulls Medicare Hospital Observation Status*, **MEDPAGE TODAY**, (May. 22, 2015), <http://www.medpagetoday.com/PublicHealthPolicy/Medicare/51715>.

<sup>4</sup> Michael A. Ross, Jason M. Hockenberry, Ryan Mutter, Marguerite Barrett, Matthew Wheatley and Stephen R. Pitts Protocol-Driven Emergency Department Observation Units Offer Savings, Shorter Stays, And Reduced Admissions *Health Affairs*, 32, no.12 (2013):2149-2156

The case studies and stories cited later demonstrate that there are significant advantages to the use of Observation Status. However, the key to its success lies in dedicated units with clearly defined protocols. In nearly all documented cases of the misuse of Observation Status patients were placed in in-patient units and unaware of their status due to a lack of distinction from other admitted patients.

The Senate committee hearing focused on solutions that centered on reducing the requirements for in-patient admissions to qualify for SNFs, stricter communication protocols for informing the patient of his/her observation status, and even issuing Medicare waivers to allow patients to be admitted to SNFs without satisfying the in-patient admission requirement as seen in the Beacon Health ACO.<sup>5</sup> However, perhaps this is getting too far off base by virtue of shifting the focus to unnecessary hypothetical solutions that are irrelevant if hospitals were using Observation Status appropriately.

When used correctly, with the necessary protocols and safe guards in place, Observation Status is successful for all parties. However, the current use of Observation Status has caused significant problems as outlined by several cases cited later. Perhaps the best solution would be to ensure that care is delivered in a distinct setting and by appropriate personnel to match the success stories, thus ensuring that all patients are receiving the quality of care they deserve.

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<sup>5</sup> *Senate Committee Mulls Medicare Hospital Observation Status*, **MEDPAGE TODAY**, (May. 22, 2015), <http://www.medpagetoday.com/PublicHealthPolicy/Medicare/51715>.

## Background

The need for observation units was first identified by the American College of Emergency Physicians (ACEP). They issued the first policy guidelines on practice management in observation units in 1988.<sup>6</sup> Then an ACEP membership section was formed in 1991 for observation medicine.<sup>7</sup> The goal of these observation units was to clarify whether hospital inpatient admission would be needed. Initially they were developed for patients presenting with chest pain, but today they are used for a variety of conditions including ischemic attack, asthma, and syncope.<sup>8</sup> Observation units “can increase the technical efficiency of hospitals [and]...improve utilization because 80% of patients are found during observation to not have a serious disease and therefore avoid hospitalization”.<sup>9</sup> ACEP has provided treatment protocols and guidelines for managing these types of units. By following the strict protocols set forth by this group for each type of patient complaint, it allows staff to avoid unnecessary tests, follow-up on results immediately and focus on getting the patient home as soon and as safe as possible.<sup>10</sup>

In November 1996 CMS refined its payment codes for observation services.<sup>11</sup> These services were deemed outpatient services administered under Medicare Part B, and could be delivered in any setting. In 2005 CMS started its RAC Program which allows contractors to retroactively audit hospitals for appropriateness of admission.<sup>12</sup> If the auditors determine that a patient did not meet the criteria to be admitted as an inpatient this program allows for CMS to recover the amounts that represent the overbilling due to inappropriate status designation. Whether a patient meets the criteria to qualify for inpatient or observation status is embedded in various screening tools such as Milliman or InterQual.<sup>13</sup> Over the past several years there has been a dramatic increase in the number of observation hours in hospitals across the United States. In a report to Congress in March 2010, the Medicare Payment Advisory Commission stated, “the increase may be explained by hospitals' heightened worries of more aggressive Medicare audits of admissions and Medicare's decision in 2008 to expand criteria that allow patients to be placed in observation status”.<sup>14</sup> Today there seems to be growing concerns that observation status is replacing inpatient status.

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<sup>6</sup> Charles Downey, *EDTUs: Last Line of Defense Against Costly Inpatient Stays*, **MANAGED CARE** (Apr. 2001), <http://www.managedcaremag.com/archives/0104/0104.edu.html>.

<sup>7</sup> Id.

<sup>8</sup> Christopher Baugh & Jeremiah Schuur, *Observation Care – High-Value or a Cost-Shifting Loophole?*, **NEW ENGLAND JOURNAL OF MEDICINE** (Jul. 25, 2013), <http://www.nejm.org/doi/full/10.1056/NEJMp1304493>.

<sup>9</sup> Charles Downey, *EDTUs: Last Line of Defense Against Costly Inpatient Stays*, **MANAGED CARE** (Apr. 2001), <http://www.managedcaremag.com/archives/0104/0104.edu.html>.

<sup>10</sup> Laura Landro, *Filling a gap between ERs and Inpatient Rooms*, **THE WALL STREET JOURNAL ONLINE** (Nov. 5, 2012), available at LEXIS News.

<sup>11</sup> Christopher Baugh & Jeremiah Schuur, *Observation Care – High-Value or a Cost-Shifting Loophole?*, **NEW ENGLAND JOURNAL OF MEDICINE** (Jul. 25, 2013), <http://www.nejm.org/doi/full/10.1056/NEJMp1304493>.

<sup>12</sup> Id.

<sup>13</sup> Christopher Baugh & Jeremiah Schuur, *Observation Care – High-Value or a Cost-Shifting Loophole?*, **NEW ENGLAND JOURNAL OF MEDICINE** (Jul. 25, 2013), <http://www.nejm.org/doi/full/10.1056/NEJMp1304493>.

<sup>14</sup> Susan Jaffe, *Growing Number Of Patients Find A Hospital Stay Does Not Mean They're Admitted*, **KAISER HEALTH NEWS** (Sep. 7, 2010), <http://www.kaiserhealthnews.org/Stories/2010/September/07/hospital-observation-care.aspx>.

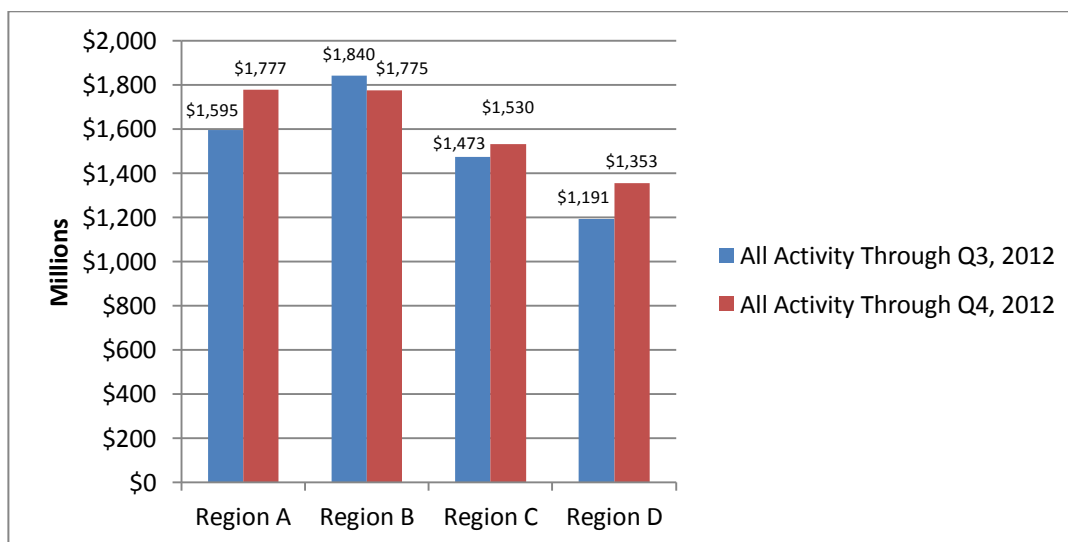
## Observation Status Benefits

Hospital observation status was implemented as a way for insurers to pay for a patient's brief stay when additional time was needed by a physician to diagnose a condition or adjust medication, but did not require a patient to be admitted as an inpatient.<sup>15</sup> These designated units and specialty trained staff would allow for patients to be treated for their specific condition with a reduced length of stay, which would translate to reduced costs for hospitals as well as Medicare.

## Medicare

Brigham Women's Hospital Observation Unit Director, Dr. Christopher Baugh, led a team which wrote to Health Affairs indicating that if every hospital had an observation unit Medicare could save over three billion dollars a year.<sup>16</sup> By having designated units for specific conditions that often require additional time for precise diagnosis or medication administration, it significantly reduces the amount of inpatient admissions, which in 2011 accounted for 24% of Medicare spending.<sup>17</sup> Since 1996, when Medicare redefined its payment codes to include observation status, it has been able to develop programs such as RAC to ensure that hospitals are not making inappropriate inpatient admissions. Additionally, as seen in Figure 1, with its expansion of observation criteria in 2008 Medicare has been able to recover a significant amount of money from overbilling due to incorrect admission status.

Figure 1 – “Among participating hospitals, \$6.4 billion in Medicare payments were targeted for medical record requests through the 4<sup>th</sup> quarter of 2012”.<sup>18</sup>



<sup>15</sup> A.J. Harper & Amelia Par, *An 'observation' on unexpected medical costs*, **PITTSBURGH TRIBUNE REVIEW** (May 18, 2013), available at LEXIS News.

<sup>16</sup> Stacey Singer, *Hospitals dodge admitting seniors; 'Observation status' avoids penalties but spikes families' costs*, **PALM BEACH POST** (Jul. 7, 2013), available at LEXIS News.

<sup>17</sup> Christopher Baugh & Jeremiah Schuur, *Observation Care – High-Value or a Cost-Shifting Loophole?*, **NEW ENGLAND JOURNAL OF MEDICINE** (Jul. 25, 2013), <http://www.nejm.org/doi/full/10.1056/NEJMp1304493>.

<sup>18</sup> *Exploring the Impact of the RAC Program on Hospitals Nationwide*, **AMERICAN HOSPITAL ASSOCIATION** (Mar. 8, 2013), <http://www.aha.org/content/13/12Q4ractracresults.pdf>.

Although approximately 59% of the medical records reviewed in 2012 did not contain coding admission errors, Medicare was still able to recover over two billion dollars in 2012 alone.<sup>19</sup> With concerns mounting about the projected bankruptcy of Medicare, the amount of potential and experienced savings for Medicare by utilizing observation units could be incredibly significant and potentially prolong its services.

## Hospitals

Dedicated hospital units provide the opportunity for physicians to diagnose and monitor patients with specific conditions while simultaneously reducing cost overall. They are able to study conditions and evaluate their patients according to standardized, proven clinical practices. This affords physicians additional time to determine if a patient should be admitted as an inpatient or discharged. This has the added benefit of reducing the occurrence of costly inpatient stays, retrospective alterations of patient statuses via RAC resulting in no reimbursement and costly readmissions. Christopher Baugh, Brigham Women's Hospital Observation Unit Director and his team estimated that hospitals that have an observation unit would save on average \$1572 per patient with an annual saving of \$4.6 million. If every hospital that does not have an observation unit had one, the annual national average savings would be \$3.1 billion.<sup>20</sup> These potential savings are quite significant for hospitals as many are undergoing budget cuts while simultaneously trying to prep for the impending health care provider shortage due to the aging population.

Michael Ross, an emergency room physician and Director of Observational Medicine at Emory University School of Medicine in Atlanta, co-authored a study of emergency room patients who presented with transient ischemic attack. It demonstrated that patients in observation units were discharged thirty-eight hours earlier on average than admitted patients and had a median rate of \$2092 versus \$4922 resulting in significant hospital savings.<sup>21</sup> A separate, unaffiliated study of four hospitals with observation units demonstrated that the average missed Myocardial Infarction (MI) rate is less than 0.5%.<sup>22</sup> With new federal health care regulations focusing on quality based performance indicators, examples of faster discharge rates and reduced lengths of stay coupled with improved, personal care and reduced misdiagnosis rates could result in even more financial benefits for hospitals in addition to the savings they accrue through utilizing observation status.

## Patients

Patients with certain conditions require and deserve dedicated staff who follow clearly defined protocols that are dependent on each patient's specific condition. For example, patients with chest pain may need additional or repeated blood tests, electrocardiograms (EKGs) or a stress test. Asthma patients may need time and additional medications to control their attacks. Monitoring and treating these types of patients intensely upfront can preclude additional problems and help people get better faster.<sup>23</sup> Studies have shown that these dedicated units can result in higher value care, which

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<sup>19</sup> *Exploring the Impact of the RAC Program on Hospitals Nationwide*, **AMERICAN HOSPITAL ASSOCIATION** (Mar. 8, 2013), <http://www.aha.org/content/13/12Q4ractracresults.pdf>.

<sup>20</sup> Christopher Baugh & Arjun Venkatesh, *Making Greater Use Of Dedicated Hospital Observation Units For Many Short-Stay Patients Could Save \$3.1 Billion A Year*, **HEALTH AFFAIRS** (Sep. 2012), <http://content.healthaffairs.org/content/31/10/2314.abstract?sid=3c1c77e8-027c-4c1e-9cc2-9c1b0152f8e9>.

<sup>21</sup> Michelle Andrews, *Patients can benefit from observation care at hospitals, but it can give them higher bills*, **WASHINGTONPOST.COM** (Feb. 12, 2013), available at LEXIS News.

<sup>22</sup> Charles Downey, *EDTUs: Last Line of Defense Against Costly Inpatient Stays*, **MANAGED CARE** (Apr. 2001), <http://www.managedcaremag.com/archives/0104/0104.edu.html>.

<sup>23</sup> Michelle Andrews, *Patients can benefit from observation care at hospitals, but it can give them higher bills*, **WASHINGTONPOST.COM** (Feb. 12, 2013), available at LEXIS News.

results in equal or better quality at a lower cost than inpatient settings.<sup>24</sup> Christopher Baugh, Brigham Women's Hospital Observation Unit Director, mentions that these units have a long history of offering efficient low cost health care services when utilized for instances when diagnostic clarity is needed.<sup>25</sup>

Patients report enjoying the quiet environment these units provide as most are transferred to observation units from chaotic, loud emergency rooms. Moreover, these units usually provide patients their own room and amenities that hospital rooms usually have, such as a television and bathroom. Staff members are also able to take advantage of point of care testing, which allows results to be obtained in a matter of minutes as opposed to waiting hours for results from the hospital's main laboratory. This reduces overall assessment time and test result significance can be communicated to patients immediately. This potential for expedited assessments, targeted treatment, and a relaxed environment really allows these units to provide a better quality of care coupled with reduced length of stay for the patient.<sup>26</sup> However, when not utilized properly observation status can have significant consequences.

### **Consequences of Medicare Observation Status Policies - Patients**

Recent publicity over the misuse of observation status has brought a significant amount of attention to the ways these policies can be seen as a cost shifting strategy. Although the use of observation status can result in lower costs for hospitals and Medicare, this cost is simply shifted to the patient when s/he is given this status inappropriately and care is not provided by appropriate personnel in designated observation units. The main consequences one sees from improper use of observation status are higher copays for drugs and hospital services, full cost of subsequent nursing care and a lack of informed, consistent status designation. Medicare does not require a physician to inform a patient of his/her status and allows a hospital to retroactively change a patient's status from inpatient to observation.<sup>27</sup> All three of these consequence categories reduce Medicare expenditures while shifting a majority of the cost onto the patient.

### **Higher Copays for Drugs and Hospital Services**

Observation status is considered an outpatient service. Therefore, patients are covered under Medicare Part B. Under Medicare Part B patients must pay a 20% copayment for each individual charge accrued.<sup>28</sup> In essence, patients are paying "à la carte" for each service they receive during their stay.<sup>29</sup> This differs from Medicare Part A, which covers patients who are admitted as an inpatient. Under Medicare Part A, patients pay one copayment resulting in Medicare covering all or most of their services. Moreover, under observation status there is no out of pocket financial cap on the amount of services a patient can receive. While a single charge cannot be more than a Medicare deductible, there is no limit on the total patient expenditures each day. Additionally, Medicare Part B

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<sup>24</sup> Christopher Baugh & Jeremiah Schuur, *Observation Care – High-Value or a Cost-Shifting Loophole?*, **NEW ENGLAND JOURNAL OF MEDICINE** (Jul. 25, 2013), <http://www.nejm.org/doi/full/10.1056/NEJMp1304493>.

<sup>25</sup> Stacey Singer, *Hospitals dodge admitting seniors; 'Observation status' avoids penalties but spikes families' costs*, **PALM BEACH POST** (Jul. 7, 2013), available at LEXIS News.

<sup>26</sup> Entire paragraph: Cathy Grimes, *UNDER OBSERVATION IN RIVERSIDE'S NEW UNIT*, **DAILY PRESS** (Jun. 29, 2013), available at LEXIS News.

<sup>27</sup> Paula Span, *In the Hospital, but Not Really a Patient*, **THE NEW YORK TIMES** (Jun. 22, 2012), [http://newoldage.blogs.nytimes.com/2012/06/22/in-the-hospital-but-not-really-a-patient/?\\_r=1](http://newoldage.blogs.nytimes.com/2012/06/22/in-the-hospital-but-not-really-a-patient/?_r=1).

<sup>28</sup> Christopher Baugh & Jeremiah Schuur, *Observation Care – High-Value or a Cost-Shifting Loophole?*, **NEW ENGLAND JOURNAL OF MEDICINE** (Jul. 25, 2013), <http://www.nejm.org/doi/full/10.1056/NEJMp1304493>.

<sup>29</sup> Michelle Andrews, *Patients can benefit from observation care at hospitals, but it can give them higher bills*, **WASHINGTONPOST.COM** (Feb. 12, 2013), available at LEXIS News.

does not cover some services such as medications that are considered eligible for self-administration.<sup>30</sup> It has been reported that due to the lack of an out-of-pocket cap on observation hospital bills, some consumers have accrued costs that not even the Medigap supplements insurance will cover.<sup>31</sup> This significant difference in payment strategy for Medicare Part B and the lack of an out of pocket cap on expenses can significantly shift the cost of care to the patient when policy guidelines are not followed for observation status. However, it is not only the costs that patients accrue while in the hospital that are significantly higher than inpatients, subsequent care costs are considerably larger as well.

### **Full Cost of Subsequent Nursing Care**

Patients must be admitted with an inpatient status for more than three consecutive days excluding the day of discharge in order to qualify for Medicare coverage of post-acute care in a nursing facility.<sup>32</sup> For patients that meet these criteria, Medicare provides twenty days of nursing home coverage and another eighty days of partial coverage as a benefit.<sup>33</sup> However, because observation status is considered outpatient services, the days these patients spend in the hospital do not count toward the Medicare three-day requirement. Medicare Part B does not allow for coverage of rehab services, often needed after a hospital stay of more than three days, as Medicare Part A does. The lack of coverage for post-acute nursing care results in significant out of pocket expenses for families in addition to the higher copayment costs of services received. This can result in patients spending away their assets faster in order to qualify for Medicaid and receive its nursing facility coverage. Furthermore, in addition to these out-of-pocket costs, another significant issue is that patients may not be aware that they will be expected to pay such a large amount for the services or the entire cost of subsequent nursing care until well into their stay or worse on the day of discharge.

### **Lack of Informed, Consistent Status Designation**

Miriam Nyman, an eighty-two year old patient, fell and broke her neck. She was taken to the emergency room and stayed in the hospital for four nights.<sup>34</sup> Aspasia Matsoukas, ninety-six, fell and broke her pelvis. She stayed in the hospital for two days when her son was called because the hospital refused to admit her.<sup>35</sup> Ann Callan, eighty-five, broke four ribs. She was in the hospital for six days.<sup>36</sup> These patients represent the many that have been told they were under observation status after spending several days in the hospital. These situations are allowable because Medicare does not mandate that patients be told they have not been admitted as an inpatient. However, Medicare does require that a patient be notified if his/her status is downgraded, which can happen during

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<sup>30</sup> Christopher Baugh & Jeremiah Schuur, *Observation Care – High-Value or a Cost-Shifting Loophole?*, **NEW ENGLAND JOURNAL OF MEDICINE** (Jul. 25, 2013), <http://www.nejm.org/doi/full/10.1056/NEJMp1304493>.

<sup>31</sup> Stacey Singer, *Hospitals dodge admitting seniors; 'Observation status' avoids penalties but spikes families' costs*, **PALM BEACH POST** (Jul. 7, 2013), available at LEXIS News.

<sup>32</sup> *Fact Sheet – Observation Stays Deny Medicare Beneficiaries Access to Skilled Nursing Facility Care*, **CENTER FOR MEDICARE ADVOCACY, INC** (Aug. 1, 2013), <http://www.medicareadvocacy.org/fact-sheet-observation-stays-deny-medicare-beneficiaries-access-to-skilled-nursing-facility-care/>.

<sup>33</sup> Stacey Singer, *Hospitals dodge admitting seniors; 'Observation status' avoids penalties but spikes families' costs*, **PALM BEACH POST** (Jul. 7, 2013), available at LEXIS News.

<sup>34</sup> Paula Span, *In the Hospital, but Not Really a Patient*, **THE NEW YORK TIMES** (Jun. 22, 2012), [http://newoldage.blogs.nytimes.com/2012/06/22/in-the-hospital-but-not-really-a-patient/?\\_r=1](http://newoldage.blogs.nytimes.com/2012/06/22/in-the-hospital-but-not-really-a-patient/?_r=1).

<sup>35</sup> Stacey Singer, *Hospitals dodge admitting seniors; 'Observation status' avoids penalties but spikes families' costs*, **PALM BEACH POST** (Jul. 7, 2013), available at LEXIS News.

<sup>36</sup> Susan Jaffe, *Growing Number Of Patients Find A Hospital Stay Does Not Mean They're Admitted*, **KAISER HEALTH NEWS** (Sep. 7, 2010), <http://www.kaiserhealthnews.org/Stories/2010/September/07/hospital-observation-care.aspx>.



a hospital stay.<sup>37</sup> Additionally, Medicare allows a hospital's Utilization Review (UR) Committee to retroactively change a patient's status from inpatient to observation if:<sup>38</sup>

1. "the change is made while the patient is still hospitalized"
2. "the hospital has not submitted a claim to Medicare for the inpatient admission"
3. "a physician concurs in the UR committee's decision"
4. "the physician's concurrence is documented in the patient's medical record"

Any physician in the hospital, regardless of whether s/he had any contribution to the patient's care, can confirm a decision by the hospital's UR Committee to deny inpatient admission status and instead deem the patient as under observation.<sup>39</sup> Being told that one was not admitted to the hospital often comes as a complete shock to patients because their care had been indistinguishable compared to other patients.

### *Indistinguishable Care as Observation Patients*

Only approximately one-third of hospitals have a differentiated observation unit.<sup>40</sup> Although this number has doubled since 2007 a majority of hospitals deliver observation services to patients mixed with other inpatients.<sup>41</sup> This is due to the fact that Medicare stipulates that observation services can be delivered in any setting. This often results in observation patients receiving the same care as other patients on inpatient units, further blurring the line of status designation. By mixing patient types, these individuals are not receiving their care based on proven protocols for their specific condition. This indistinguishable care from a patient stand point results in more confusion when they are told at discharge they were never fully admitted to the hospital despite the appearances, such as: a room, a bed, a gown, a chart, and a wristband.<sup>42</sup>

Medicare has taken steps to correct this deceit that patients experience with regard to admission status by developing brochures to introduce the reality of observation status. However, despite these efforts there is not much a patient can do once they are given observation status. This is mainly because Medicare has provided them with services on an outpatient basis thus never technically denying them coverage. Therefore, there is no way for a patient to challenge a hospital at the moment they discover they have been placed in observation status. Since 2010 there have been some favorable rulings for patients at the Administrative Law Judge (ALJ) level.<sup>43</sup> However, these victories have been won after lengthy appeal processes.

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<sup>37</sup> Id.

<sup>38</sup> Subsequent quoted bullets from: Judith Stein, *When Is a Hospital Inpatient Stay Not an Inpatient Hospital Stay – Hospital "Observation Services"*, **CMA HEALTH POLICY CONSULTANTS** (May 24, 2010), <http://cmahealthpolicy.com/2010/05/24/when-is-a-hospital-inpatient-stay-not-an-inpatient-hospital-stay-hospital-observation-services/>.

<sup>39</sup> Judith Stein, *When Is a Hospital Inpatient Stay Not an Inpatient Hospital Stay – Hospital "Observation Services"*, **CMA HEALTH POLICY CONSULTANTS** (May 24, 2010), <http://cmahealthpolicy.com/2010/05/24/when-is-a-hospital-inpatient-stay-not-an-inpatient-hospital-stay-hospital-observation-services/>.

<sup>40</sup> Christopher Baugh & Jeremiah Schuur, *Observation Care – High-Value or a Cost-Shifting Loophole?*, **NEW ENGLAND JOURNAL OF MEDICINE** (Jul. 25, 2013), <http://www.nejm.org/doi/full/10.1056/NEJMp1304493>.

<sup>41</sup> Michelle Andrews, *Patients can benefit from observation care at hospitals, but it can give them higher bills*, **WASHINGTONPOST.COM** (Feb. 12, 2013), available at LEXIS News.

<sup>42</sup> Paula Span, *In the Hospital, but Not Really a Patient*, **THE NEW YORK TIMES** (Jun. 22, 2012), [http://newoldage.blogs.nytimes.com/2012/06/22/in-the-hospital-but-not-really-a-patient/?\\_r=1](http://newoldage.blogs.nytimes.com/2012/06/22/in-the-hospital-but-not-really-a-patient/?_r=1).

<sup>43</sup> Judith Stein, *When Is a Hospital Inpatient Stay Not an Inpatient Hospital Stay – Hospital "Observation Services"*, **CMA HEALTH POLICY CONSULTANTS** (May 24, 2010), <http://cmahealthpolicy.com/2010/05/24/when-is-a-hospital-inpatient-stay-not-an-inpatient-hospital-stay-hospital-observation-services/>.

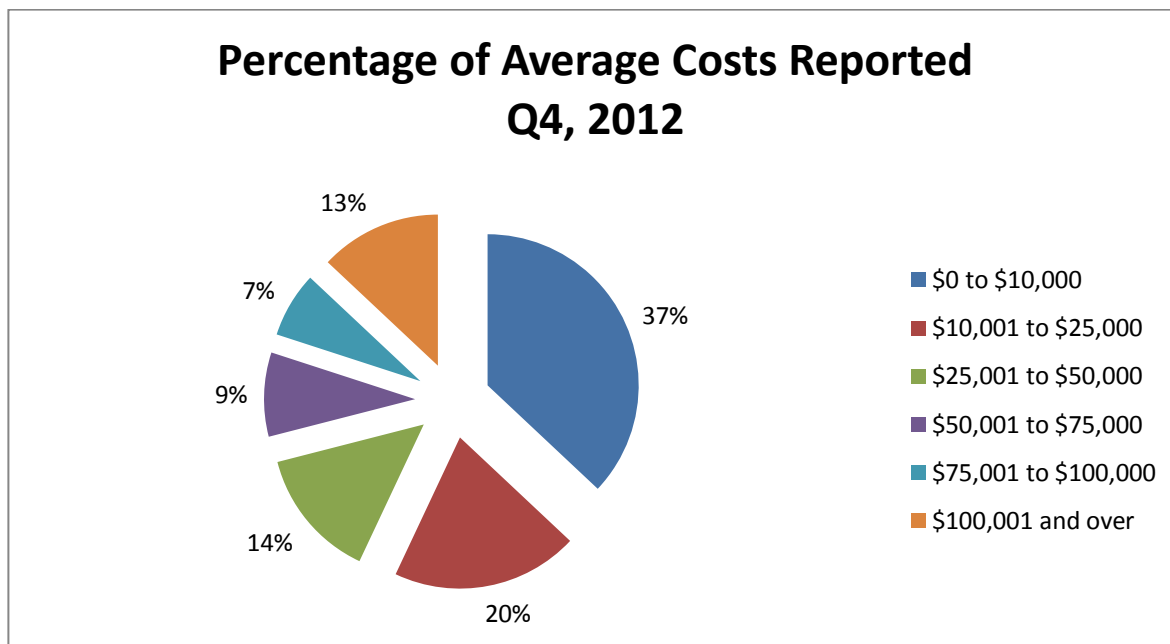
## Consequences of Medicare Observation Status Policies - Hospitals

Recently, hospitals have been under more scrutiny than ever before to reduce Medicare costs and penalties. Observation status gives them a unique opportunity to avoid two major penalties, which could explain why more and more observation hours are being observed in hospitals. This patient designation helps hospitals dodge RAC penalties and assists in avoiding readmission penalties – two costly policies implemented and now being radically enforced by Medicare.

### Recovery Audit Contractors (RAC)

In 2005 CMS began its RAC Program to allow auditors to retrospectively audit a hospital's inpatient admissions for appropriateness.<sup>44</sup> Criteria to determine appropriate admissions are embedded in screening tools; the most commonly known is InterQual. In 2011, inpatient hospitalizations accounted for 24% of Medicare spending.<sup>45</sup> Due to this huge financial impact, a primary focus for Medicare has been reducing the amount of inpatient admissions. Since 2006 RAC auditors have collected a significant amount of money for coding errors and evidence of fraud; one of the most lucrative errors is inappropriate admissions.<sup>46</sup> By the end of 2012, 90% of hospitals reported experiencing RAC activity.<sup>47</sup> Additionally, many hospitals report spending thousands of dollars managing RAC processes as seen in Figure 2.

Figure 2 – “63% of all hospitals reported spending more than \$10,000 managing the RAC process during the third quarter of 2012, 43% spent more than \$25,000 and 13% spent over \$100,000.”<sup>48</sup>



<sup>44</sup> Christopher Baugh & Jeremiah Schuur, *Observation Care – High-Value or a Cost-Shifting Loophole?*, **NEW ENGLAND JOURNAL OF MEDICINE** (Jul. 25, 2013), <http://www.nejm.org/doi/full/10.1056/NEJMp1304493>.

<sup>45</sup> Id.

<sup>46</sup> Stacey Singer, *Hospitals dodge admitting seniors; 'Observation status' avoids penalties but spikes families' costs*, **PALM BEACH POST** (Jul. 7, 2013), available at LEXIS News.

<sup>47</sup> *Exploring the Impact of the RAC Program on Hospitals Nationwide*, **AMERICAN HOSPITAL ASSOCIATION** (Mar. 8, 2013), <http://www.aha.org/content/13/12Q4ractracresults.pdf>.

<sup>48</sup> Id.

The pressure for hospitals to avoid such audits is crucial in order to avoid hefty increases in cost due to identified inpatient admission errors. If an auditor discovers a patient was incorrectly classified as an inpatient, the hospital is denied reimbursement for most services despite the fact that the services were medically necessary and coverable by Medicare.<sup>49</sup> Physicians are concerned about the unclear guidelines regarding which conditions meet the criteria for inpatient admission. This lack of clarity allows auditors to subjectively determine which services were medically necessary. Medicare identifies inpatient care as “required only if the patient’s medical condition, safety, or health would be significantly and directly threatened if care was provided in a less intensive setting”.<sup>50</sup> This general guideline lacks the specificity of which conditions are covered thus allowing each auditor to subjectively interpret this guideline’s meaning. With Medicare being more stringent on what is “medically necessary” in an effort to reduce costs, hospitals are often using observation status as a way to avoid additional audits. Another area that can trigger federal audits and unnecessary penalties is inpatient readmissions. Although not as financially lucrative, hospitals can also avoid additional costs by using observation status to reduce these numbers as well.

### **Inpatient Readmissions**

Hospitals have mounting pressure to avoid hospital readmissions. Significant numbers of unnecessary admissions and readmissions can result in federal audits and financial penalties. As a result there has been increased attention on hospitals using observation status as an overreaction to their high thirty-day readmission rates.<sup>51</sup> Hospitals can avoid penalties by using observation status because patients labeled as outpatients (e.g. observation status) will not trigger readmission penalties if they return to the hospital and need to be admitted as an inpatient. Similarly if patients who were admitted as inpatients return and are placed on observation status they too will not trigger the readmission penalties. Thus in order to avoid the harsh penalties that Medicare has inflicted on hospitals in recent years, hospitals have begun to use observation status as a way to avoid audits and their associated penalties. This is often done despite the condition of the patient, as any reimbursement is better than none at all. UW Hospital and clinics reported a loss of \$331 for each observation patient versus a profit of \$2163 for admitted patients.<sup>52</sup> However, due to harsh readmission penalties and audits, physicians may be more inclined to keep patients under observation status rather than admit them as inpatients.

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<sup>49</sup> *Fact Sheet – Observation Stays Deny Medicare Beneficiaries Access to Skilled Nursing Facility Care*, **CENTER FOR MEDICARE ADVOCACY, INC** (Aug. 1, 2013), <http://www.medicareadvocacy.org/fact-sheet-observation-stays-deny-medicare-beneficiaries-access-to-skilled-nursing-facility-care/>.

<sup>50</sup> Judith Stein, *When Is a Hospital Inpatient Stay Not an Inpatient Hospital Stay – Hospital “Observation Services”*, **CMA HEALTH POLICY CONSULTANTS** (May 24, 2010), <http://cmahealthpolicy.com/2010/05/24/when-is-a-hospital-inpatient-stay-not-an-inpatient-hospital-stay-hospital-observation-services/>.

<sup>51</sup> Stacey Singer, *Hospitals dodge admitting seniors; ‘Observation status’ avoids penalties but spikes families’ costs*, **PALM BEACH POST** (Jul. 7, 2013), available at LEXIS News.

<sup>52</sup> Joe Carlson, *Observation care stirs ire; JAMA study says CMS policy hurts hospitals’ bottom lines*, **MODERN HEALTHCARE** (Jul. 15, 2013), available at LEXIS News.

## Current Trends

The prevalence of observation status has increased significantly over recent years. In 2011 over 1.6 million patients were in observation status beds.<sup>53</sup> A 34% increase in the use of observation status was observed from 2007-2009 alone.<sup>54</sup> In this same time period, observation stays lasting longer than seventy-two hours rose by 88%.<sup>55</sup> On average, the overall length of stay for observation patients increased by 7%.<sup>56</sup> Furthermore, Medicare data shows that the number of patients with observation stays lasting longer than forty-eight hours rose from 3% to 7.5% during 2006-2010.<sup>57</sup> This dramatic increase in observation stays since the expansion of various Medicare policies has many critics concerned that observation status is replacing inpatient admissions. Monthly observation stays from 2007-2009 rose from 2.3 to 2.9 per 1000 Medicare beneficiaries. During that same time period, monthly admissions decreased from 23.9 to 22.5 per 1000 Medicare beneficiaries.<sup>58</sup> Conflicting data exists regarding the current average length of stay for observation patients.

A great deal of attention has been directed at the increase in observation status and the various policies that Medicare has introduced. Representatives Joseph Courtney (D-CT) and Tom Latham (R-IA) introduced the "Improving Access to Medicare Coverage Act of 2013".<sup>59</sup> This bi-partisan supported bill is acknowledging the need for observation days to count toward the Medicare three-day requirement for skilled nursing care. Senator Sherrod Brown (D-OH) introduced a companion bill, S.569, which has been cosponsored by Senator Susan Collins (R-ME).<sup>60</sup> Bi-partisan support of these changes to protect Medicare beneficiaries is significant and will likely expedite change in these policies in the coming years.

## Significance

Since the development of the idea of observation units and the expansion of Medicare's policies surrounding this topic, it appears that two models of care exist:

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<sup>53</sup> Cathy Grimes, *UNDER OBSERVATION IN RIVERSIDE'S NEW UNIT*, **DAILY PRESS** (Jun. 29, 2013), available at LEXIS News.

<sup>54</sup> *Fact Sheet – Observation Stays Deny Medicare Beneficiaries Access to Skilled Nursing Facility Care*, **CENTER FOR MEDICARE ADVOCACY, INC** (Aug. 1, 2013), <http://www.medicareadvocacy.org/fact-sheet-observation-stays-deny-medicare-beneficiaries-access-to-skilled-nursing-facility-care/>.

<sup>55</sup> *Senate Hearing on Oversight of Recovery Audit Contractors: Center's Statement Regarding Beneficiary Impact*, **CENTER FOR MEDICARE ADVOCACY, INC** (Jun. 25, 2013), <http://www.medicareadvocacy.org/senate-hearing-on-oversight-of-recovery-audit-contractors-centers-statement-regarding-beneficiary-impact/>.

<sup>56</sup> *Id.*

<sup>57</sup> Laura Landro, *Filling a gap between ERs and Inpatient Rooms*, **THE WALL STREET JOURNAL ONLINE** (Nov. 5, 2012), available at LEXIS News.

<sup>58</sup> Paula Span, *In the Hospital, but Not Really a Patient*, **THE NEW YORK TIMES** (Jun. 22, 2012), [http://newoldage.blogs.nytimes.com/2012/06/22/in-the-hospital-but-not-really-a-patient/?\\_r=1](http://newoldage.blogs.nytimes.com/2012/06/22/in-the-hospital-but-not-really-a-patient/?_r=1).

<sup>59</sup> *Fact Sheet – Observation Stays Deny Medicare Beneficiaries Access to Skilled Nursing Facility Care*, **CENTER FOR MEDICARE ADVOCACY, INC** (Aug. 1, 2013), <http://www.medicareadvocacy.org/fact-sheet-observation-stays-deny-medicare-beneficiaries-access-to-skilled-nursing-facility-care/>.

<sup>60</sup> *Fact Sheet – Observation Stays Deny Medicare Beneficiaries Access to Skilled Nursing Facility Care*, **CENTER FOR MEDICARE ADVOCACY, INC** (Aug. 1, 2013), <http://www.medicareadvocacy.org/fact-sheet-observation-stays-deny-medicare-beneficiaries-access-to-skilled-nursing-facility-care/>.

1. Protocolized care in designated units
2. Care provided in inpatient units billed as observation

Factors such as whether a hospital has a designated unit, prevalence of RAC activity and readmission penalties, and hospital payor distribution will determine which type of care a patient receives.

### **1. Protocolized Care in Designated Units**

Approximately one-third of hospitals across America have observation units. These serve as designated units that allow for physicians to have the necessary, additional time to make a proper diagnosis when patients present with certain conditions. An obvious example of one such condition is chest pain, where the actual diagnosis could require additional tests and the outcomes of such procedures have the potential to be a variety of prognoses. This targeted care has the potential to reduce the total length of stay for the patient and reduce costs for all payors. Moreover, by providing a separate unit for these patients and removing them from a stressful emergency room, the quality experience for the patient is heightened. This higher quality atmosphere is coupled with targeted more personal care resulting in a better patient experience.

For a hospital, by removing these patients from the emergency room into observation units, the risk of misdiagnosis is reduced and crowding in the emergency room can also be lessened. Proper use of designated observation units results in reduced costs, more targeted care, and an overall better patient experience.

### **2. Care Provided in Inpatient Units Billed as Observation**

The other two thirds of hospitals that do not have observation units and instead treat patients in inpatient settings with the status of an observation patient appear to be using observation as a cost shifting mechanism. By mixing patients with other inpatients the perception to the average patient is that they are an inpatient and will be billed and receive additional benefits accordingly. This leaves a great deal of opportunity for deception if status is not clearly communicated. Additionally, by placing these patients in inpatient units they are not receiving the targeted care they need, which was a principal reason for observation unit development. Observation status was designed for patients with specific conditions who needed additional monitoring but should remain in the hospital for no more than twenty-four hours, with a few exceptions, resulting in stays up to forty-eight hours. When patients are treated by caregivers in inpatient units they are not experiencing the standardized clinical practices demonstrated to be effective for quicker diagnosis and discharge.

Hospitals fear the growing pressure by Medicare to reduce inappropriate hospital admissions and readmissions. With such a large volume of hospitals reporting RAC activity, it is clear that observation status is being used as a mechanism to avoid retrospective status changes resulting in a loss of reimbursement. Moreover, observation status can serve as a loophole to avoid readmissions as a patient must be given an "inpatient" status to trigger readmission concerns. As a result of these pressures hospitals are increasingly giving patients an observation status instead of an inpatient status despite the fact that the patient may meet the InterQual criteria and, therefore, their stay would be covered by Medicare. This results in a direct shift of financial burden onto the patient.

Patients inappropriately placed in observation status, instead of being admitted as an inpatient, are billed under Medicare Part B. Thus they pay a 20% copayment for each procedure received. Additionally, they have higher drug costs, and their stay does not count toward the three day Medicare requirement for post-acute skilled nursing care. As a result patients pay more for their hospital stay and must pay out of pocket for all subsequent nursing care. Figure 3 compares a portion of Medicare fees and payments for a three day hospitalization for syncope. The left column represents billing for an inpatient and the right represents billing for an observation patient.

Figure 3<sup>61</sup>

	<b>In-Patient</b>	<b>Observation Status</b>
<b>Medications</b>	Patient pays \$0	Patient pays entire cost \$240
<b>Asprin, once daily</b>	Medicare Part A pays DRG Payment	Medicare Part B pays \$0
<b>Laboratory</b>	Patient pays \$0	Patient pays 20% of fees: \$28
<b>Basic metabolic panel with calcium x3</b>	Medicare Part A pays DRG Payment	Medicare Part B pays 80%: \$114
<b>Diagnostics</b>	Patient pays \$0	Patient pays 20% of fees: \$62
<b>Electrocardiogram x3</b>	Medicare Part A pays DRG Payment	Medicare Part B pays 80%: \$247
<b>Skilled nursing facility for 7 days</b>	Patient pays \$0 Paid by Medicare Part A: \$318 per day, or \$2,266	Patient pays \$248 per day, or \$1,736 Medicare pays \$0
<b>Total payments</b>	Patient: \$1,285 Medicare Part A: \$4,968 Medicare Part B: \$405	Patient: \$2,297 Medicare Part A: \$0 Medicare Part B: \$1,282
<b>Total revenue</b>	Hospital: \$3,926 Professional: \$506 Skilled nursing facility: \$2,226	Hospital: \$1489 Professional: \$354 Skilled nursing facility: \$1736

Although hospitals and professionals do not receive as much revenue from observation patients as they do from inpatient admissions, it can be inferred that they would rather be guaranteed some revenue rather than no reimbursement at all, which could be the case if RAC retrospectively changes a patient's status after determining that the patient was inappropriately admitted. It is because of Medicare's lack of clear guidelines, which results in subjective analysis of admissions by auditors, and the lack of designated observation units in most hospitals, that we see patients receiving the majority of the financial burden resulting from misused observation status.

<sup>61</sup> Christopher Baugh & Jeremiah Schuur, *Observation Care – High-Value or a Cost-Shifting Loophole?*, **NEW ENGLAND JOURNAL OF MEDICINE** (Jul. 25, 2013), <http://www.nejm.org/doi/full/10.1056/NEJMp1304493>.

## **Conclusion**

Observation status provides a unique opportunity for physicians to take additional time to diagnose patients who present with specific conditions. It has the potential to save both hospitals and Medicare billions of dollars a year nationally. With growing fears of the projected bankruptcy timeline of Medicare, observation status may be one way to prolong its viability. However, growing misuse of observation status has shifted a substantial portion of the financial burden onto the patient. Bi-partisan support of changes to the existing Medicare policies exists, and it will be interesting to see how changes play out in the coming years. Without changes to the current policies we will likely see fewer people able to afford skilled nursing care, which could result in an increase in Medicaid financed nursing care, an increase in home health care, or more long term care being provided by family and friends. The aging population presents significant challenges for the health care sector. Observation status has the opportunity to lighten some financial burdens of hospitals and Medicare if properly integrated into every hospital. Just as significantly, it also has the opportunity to heighten the quality of care these specific patients deserve.

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