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Observation Care Services for Medicare Beneficiaries in Rural Hospitals: Policy Issues and Stakeholder Perspectives

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Introduction

Hospital outpatient observation services have grown in frequency and duration over the past decade, raising concerns for the Centers for Medicare and Medicaid Services (CMS), policymakers, health care providers, and Medicare beneficiaries. CMS is particularly concerned about improper Medicare payments for beneficiaries with short inpatient stays (2 days or less) when the patient could have been treated as an outpatient.[1] Beneficiaries and their families are concerned about the significant out-of-pocket costs for outpatient observation care and potential post-discharge costs for those needing Skilled Nursing Facility (SNF) care. As they fulfill federally-contracted audit requests and experience claim denials, hospitals can face greater financial challenges and lost confidence from beneficiaries. Nursing homes can also become financially vulnerable if they care for recently-discharged beneficiaries who later find they are denied SNF coverage by Medicare because a patient did not meet the statutory and regulatory guidelines for reimbursement (i.e., a preceding three-day inpatient stay). These issues are particularly difficult for small and isolated rural facilities that are less viable than their larger rural and urban counterparts.

Information about the rural context for the utilization of hospital outpatient observation services is critical for policy development. Recent research using Medicare claims data documented a sharp rise in the prevalence and duration of hospital outpatient observation services between 2007 and 2009 and included metropolitan and non-metropolitan categories.[2] There has been limited systematic study of hospital outpatient observation services in rural communities,[3-5] and despite the recognized differences between the demographics, health status, insurance coverage, and poverty levels of rural and urban populations, little effort has been invested in understanding the potential influence of rurality on the utilization of observation services in rural hospitals.[6-8]

Purpose

This study aims to gain a greater understanding of the rural policy context surrounding the use of observation services by Medicare beneficiaries from 2010 to 2013. Policymakers need more information to promote equitable decision-making and a lasting settlement of the issues currently facing consumers and providers. This work is part of a larger study on rural observation services; a companion policy brief examines Medicare claims data for Critical Access Hospitals and describes the use of observation services across levels of rurality by Medicare beneficiaries, the demographics and health status of patients receiving these services, and the characteristics of their stays while under observation.

Methods

We conducted structured telephone interviews with representatives from state organizations knowledgeable about hospitals' and Medicare beneficiaries' experiences with observation services, including state hospital associations, Long-Term Care Ombudsman offices, and Quality Improvement Organizations (QIOs). Twelve states deemed likely to have recent experiences with observation services issues were selected by geographic location to provide a national sample (three from each of the four United States census regions: ME, VT, NY, MN, IA, WI, GA, NC, SC, CO, OR, and WA). Data collected from state hospital associations and QIOs were used to detail organizational, financial, and quality

Key Findings

- Although Medicare rules for hospital outpatient observation care services are, by law, uniformly applied in urban and rural communities, differences in rural demography and service capacity can create greater hardships for rural beneficiaries.
- Respondents reported that hospitals in their states experienced greater operating costs than Medicare allows for observation care services.
- Respondents reported that hospitals in their states were experiencing significant costs resulting from denied claims and the preparation for and response to federal audit requests.
- Hospitals, nursing homes, and patients need education on the status criteria, financial issues, and continuity-of-care issues related to the receipt of care while under observation.

issues facing beneficiaries and hospitals while information collected from the Ombudsman offices helped to illustrate the concerns of Medicare beneficiaries and long-term care providers. Using input from the three respondent groups, qualitative analysis was used to describe programmatic and state-level issues.

Thirty telephone surveys were completed by the end of the data collection period for a response rate of 83%. Six potential respondents did not complete phone surveys (three could not be scheduled within the timeframe of the study and three declined to participate because they were "unable to contribute"); these non-participants included three Ombudsman offices, one QIO, and two state hospital associations. Seven of the 12 states were represented by all three stakeholder groups, four states had at least two key stakeholders, and only one state was represented by a single stakeholder. Potential respondents were identified through recommendations and reviewing their organization's websites, emailed with an introduction to the project and the nature of their potential involvement, and called to finalize details. Respondents permitted us to record the calls.

Interview protocols shared common themes but were tailored to each of the three areas of expertise. Most survey questions were open-ended to encourage in-depth responses. Questions also probed for relevant experiences and views over the past three years and included information from colleagues, constituents, and first-hand-experiences. About half of the survey questions focused on urban and rural differences within the state. Following the interviews, respondent comments were transcribed, coded, and entered into a spreadsheet format for qualitative analysis to identify key policy-related themes at state and national levels. Follow-up phone calls were made to clarify any issues identified during transcription.

Results for Beneficiaries

Conversations with representatives of state hospital associations, Offices of the State Long-Term Care Ombudsman, and QIOs confirmed the gravity and importance of observation services issues and highlighted their understanding of concerns about the cost and quality implications for beneficiaries and hospitals in their states.

Respondents placed great emphasis on the financial and quality-of-life implications for Medicare beneficiaries receiving services while under observation, especially those in rural areas requiring SNF care after their hospital discharge. Representatives from the Ombudsman offices recalled cases where out-of-pocket expenses represented a significant financial burden for the beneficiaries. These conversations focused on the failure to meet the three-day inpatient criteria to qualify for SNF coverage and the quality issues related to beneficiaries who delayed or skipped the care needed for a full recovery. As described by respondents, post-discharge care at SNFs can be very expensive without Medicare coverage, ranging in the tens-of-thousands of dollars. These beneficiaries face financial situations compounded by additional co-payments and medication costs received while an outpatient in the hospital. One Ombudsman office representative noted that the economic effects of observation services can be particularly challenging for rural populations, who tend to have higher poverty levels and lower levels of long-term care insurance coverage compared to their urban counterparts.

While the experience of rural beneficiaries mirrors that of urban beneficiaries in many respects, respondents agreed that persistent workforce shortages and a lack of available SNF beds were key differences. Most rural areas have limited community-based and home health options and fewer assisted living facilities and nursing homes than urban areas. Rural nursing homes tend to have fewer beds than their urban counterparts, as well as greater difficulties retaining nurses and offering specialized services.[9] As a result, respondents felt that physicians may be more inclined to keep patients in the hospital under observational care until they are convinced that the patient will be safe at home. They also noted other factors that may come into the decision-making process for keeping a rural patient or sending them home, including greater distances to definitive care if needed, and the availability of transportation.

Respondents expect a rise in rural patient volume for post-discharge rehabilitative care, given aging rural demographics and the expected increase in prevalence of complex medical conditions. In describing the eligibility criteria for SNF coverage, they raised the issue of historic changes that have occurred in medical practice patterns over the fifty years since the regulations were issued in the early 1960s. Although it was not a rural-specific opinion, respondents felt the current criteria for SNF coverage eligibility were outdated and that patients receiving observation services today "are receiving the kind of services that inpatients received fifty years ago." One explained that "patients now receive surgery and go home the same day," suggesting that eligibility requirements do not reflect the evolution of medical care and associated outcomes.

A number of bills have been introduced in Congress to modernize CMS's criteria for SNF coverage. For example, one bill would count both inpatient and outpatient time a patient spends in a hospital toward meeting the three-day limit,[10] another would eliminate the three day requirement entirely,[11] and a third would eliminate the three day requirement depending on a SNF's staffing rankings on CMS's Nursing Home Compare website.[12] Both rural and urban Medicare beneficiaries could benefit if these or similar changes were made.

Another factor that respondents felt contributes to the overall confusion of patients about their inpatient or outpatient status was that hospitals are not required to tell them unless they

are being transferred from an inpatient service to an outpatient service.[13] A few Ombudsman office respondents noted that beneficiaries receiving observation care services do not have the same rights as inpatients because they "do not have the right to appeal their status or receive notification of that status."

Results for Hospitals

Respondents confirmed that CMS observation services regulations were applied universally across urban and rural hospitals. Several respondents noted that there is a considerable degree of ambiguity in how observation services are defined. The ambiguity lies largely with the lack of clinical definition needed for making critical decisions about admission or discharge; it has been reiterated by recent letters from the AHA (2010),[14] American Medical Association (2013),[15] and Congress (2013)[16] seeking clarification and improvement in CMS proposed regulatory changes to lessen the negative impact for beneficiaries and clarify criteria to be applied relative to observational care and post-discharge, medically-necessary SNF care. Guidelines for observation services use, inpatient admissions criteria, and the subsequent efforts by CMS to clarify them have not helped alleviate the confusion. Some respondents stressed that hospital behaviors had shifted as a result of Recovery Audit Contractor (RAC) program activity, major repayments, and legal actions to recover Medicare funds and exact penalties. Relief offered by CMS to rebill those services denied payment under Part A has had little impact because of the retroactive nature of recovery audits (covering the previous three years) and the tight timelines for filing and completing audit appeals.

Over half of the respondents stated that hospitals are much more cautious about using short inpatient stays because of the consequences of audits and are more inclined to use observation services to minimize risk of an audit-related loss. In addition to concerns over payment reclamations, hospitals have reported an increase in administrative and personnel costs to meet documentation requests by Federal auditors and to appeal their decisions. State hospital associations explained that CMS efforts led to major administrative burdens complicating some hospital operations and workflows, especially among small and rural hospitals with limited staff and fewer economic resources. All stakeholder groups mentioned how the "lack of education and outreach" from CMS to explain payment systems and regulations has resulted in a slow learning curve and ongoing confusion on how to categorize patients to be in full compliance with regulations and provide appropriate levels of care.

Several respondents mentioned scenarios where attending physicians might decide to keep a beneficiary a little longer under observation status to make sure they could continue to improve following discharge (e.g., lack of social support network, availability of nursing home and/or home health services). Some commented that this process has placed an administrative layer over the primary role of medical and clinical staff: it "takes the medical care out of it, and makes the hospital visit more of a paper trail," noted one respondent.

Informants reported that uncoordinated and poor communication between physicians, care teams, and discharge planners greatly contributed to issues related to observation services. While physicians are initially responsible for writing an order to place a patient under observation, inadequate or missed communications with nurses or others with patient care responsibilities can result in missed opportunities to educate patients about their hospital status and increase the chances of coding or billing errors. This can have major consequences for hospital reimbursements, which depend in part upon the documentation of the observation hours used during a patient's visit. Observation hours are calculated separately from time devoted to diagnosis and treatment.

Although hospitals are not required to notify outpatient beneficiaries of their change in status when they are placed under observation as an outpatient, respondents reported that some hospitals took it upon themselves to do so, providing information on the implications for payment and post-discharge services. There was, however, a general consensus among the respondents that patients and their families are often overwhelmed at the time they are placed under observation status, and training hospital staff to deliver this information could avoid patient misunderstandings as well as billing and coding errors on the part of hospital staff.

Limitations

Although every effort was made to ensure that respondents were the most knowledgeable about observation services use in their state, these results may not be representative of all stakeholders in these states or in other states where we did not conduct interviews.

Discussion

Rural Medicare beneficiaries, small rural hospitals, and nursing homes can be particularly vulnerable to CMS reimbursement policies regarding outpatient observation services and related care. Respondent comments portrayed a complex environment that could influence when providers decide to send patients home or keep them under observation. Concerns based on caretaker availability to help with home care, long distances to care or rehabilitation services, lack of transportation, and patients' medical fragility were listed. Additional research will be needed to drill down further into the factors influencing medical decisions to admit, hold under observation, or discharge rural elders.

Beyond discussions of new legislation, regulations, and repayments, there is a clear and present need to standardize the education of hospital staff and beneficiaries regarding the cost and quality implications of observation services. This is especially true for hospitals wishing to avoid costly repayment episodes and maintain compliance with coding and

billing requirements. There is also a need for more defined clinical guidelines for hospital inpatient versus outpatient care that promote the best interests of the patient. CMS has recently proposed a rule stating that patients under observation care who stay beyond two midnights may count that time toward meeting the three-day requirement for SNF coverage under Medicare, but stakeholders such as the AHA, AMA, and Congress have asked for delays in implementing it because of areas of ambiguity and continued burdens on Medicare Beneficiaries and hospitals.[14-17] Recognizing that the original statutory authority for SNF coverage under Medicare was based in 1960's medical practice and the beneficiary burden of the law, several proposed bills would eliminate the three-day requirement entirely.[10, 12]

Some respondents reported efforts to educate patients about implications for post-discharge coverage and reimbursement through flyers, while others reported educational initiatives between hospitals and nursing homes (e.g., collaborative agreements and discharge protocols) to minimize issues concerning beneficiary placement and care needs. As of October 2014, three states (CT, NY and MD) will require hospitals to give oral and written notice to patients placed under observational care.[18] As policy discussions continue, the best practices of these models should also be considered as a possible strategy to minimize the financial risks facing beneficiaries, hospitals, and nursing homes. Further exploration of these models within a rural context is needed to minimize unintended financial and quality consequences for rural beneficiaries and their care providers. ■

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