Society of Hospital Medicine

Empowering hospitalists.
Transforming patient care.

The Hospital Observation Care Problem

Perspectives and Solutions from the Society of Hospital Medicine

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Contents

Executive Summary

Observation is an outpatient designation originally intended to give providers time to decide whether a patient should be admitted to the hospital as an inpatient or discharged back to the community. This decision was and should be based on the provider's clinical judgment of the patient's condition and the best course of action for proper care.

However, the intricacies of Medicare's observation policy have created a situation where observation care is being delivered outside of its purpose, often on hospital wards where it is virtually indistinguishable from inpatient care. The frequency and duration of observation care have grown significantly in recent years, well beyond its original intent and purpose.

Hospitalists provide the majority of observation care to Medicare beneficiaries. Based on 2012 Medicare physician pay data, the Society of Hospital Medicine (SHM) estimates 59% of hospital observation care in that year was provided to Medicare patients by hospitalists.[1] Hospitalists are also often the primary points of contact for patients as they navigate the impact of inpatient and observation care determinations, both during and after their hospitalizations.

In 2014, after the implementation of the two-midnight rule, SHM surveyed its membership for their experiences with, and perspectives on, hospital observation care. In 2017, SHM re-surveyed members to understand the state of hospital observation care after several legislative and regulatory changes. Through this new survey, hospitalists reported on their experience with the two-midnight rule, and the impact of the recent Notification of Observation Treatment and Implication of Care Eligibility (NOTICE) Act, which requires hospitals to inform patients through the Medicare Outpatient Observation Notice (MOON) form they are hospitalized under observation.

Despite these policy changes, the results of the survey show that hospitalists' concerns and frustration with observation care continues. Observation remains an important policy issue for hospitalists, and they continue to report significant problems with many aspects of observation including:

- A lack of education and clarity around observation rules
- The waste of healthcare dollars attributable to observation processes and policies
- Damage to physician-patient relationships
- Reform efforts to date only serving to maintain a policy that does not improve patient care

Based on their experience, hospitalists are resolute that policies for hospitalizations must be simplified to ensure patients can get the care they need and limit unexpected financial liabilities. Priorities include improving access to Medicare skilled nursing facility (SNF) coverage and reducing the administrative burdens associated with determining patient admission status. These priorities shaped SHM's recommended policy improvements:

Options to Improve the Status Quo

- Change SNF care coverage rules to ensure patients can access the care they need as ordered by their physician. Preferentially, Medicare's three-day inpatient stay requirement for SNF coverage should be eliminated. At a minimum, the time a patient spends receiving observation care should count toward the three-day inpatient stay requirement.
- Increase clarity from Medicare/Quality Improvement Organizations (QIOs) around correct application of the observation rules and standardize provider education to raise proficiency and confidence in applying these rules.

Comprehensive Observation Reform

Hospitalists believe the underlying policies around observation must be fully reformed to better reflect current realities in the healthcare system. Potential options, which could be piloted prior to national implementation, include:

- Creating a low-acuity Diagnosis Related Group (DRG) modifier to replace current observation stays
- Creating an advanced Alternative Payment Model (APM) for observation that includes the post-acute period
- Creating an inpatient payment method that blends inpatient and outpatient observation rates

Although measures aimed at simplifying the observation process have been implemented by the Centers for Medicare & Medicaid Services (CMS), observation continues to be a systemic problem. It is confusing and costly for providers, hospitals and patients.

Introduction and Background

What is Observation Care?

When a patient presents to a hospital emergency department, clinic, or transfers from another facility, providers must decide to admit that patient as an inpatient, discharge the patient or place the patient under observation. Providers utilize their clinical judgment when assessing the patient's condition to determine the best course of action for the individual patient. However, the intricacies of observation policy have made simple status determinations increasingly more difficult. Observation care was originally intended to be utilized when a patient's condition required additional time and monitoring prior to diagnosis. According to CMS, observation is defined as follows:

> A well-defined set of specific, clinically appropriate services, which include … treatment, assessment, and reassessment before a decision can be made regarding whether patients will require further treatment as hospital inpatients or if they are able to be discharged from the hospital … (and) in the majority of cases, the decision … can be made in less than 48 hours, usually in less than 24 hours. In only rare and exceptional cases do … outpatient observation services span more than 48 hours.[2]

This definition is not reflective of current clinical practice. Observation care often spans longer than 48 hours, muddles the line between inpatient services and outpatient care, and ultimately places undue burden on all parties in the healthcare system. Although intended to help providers simplify admission decisions based on a time determinant, observation has become an administrative burden for providers and facilities, and a source of confusion and frustration for patients. We acknowledge there are many patients who are truly lower acuity or are well-served by existing emergency department observation units, which are provider-initiated tools for providing high-quality care in a focused setting.

Since observation is considered an outpatient service, it is therefore billed under Medicare Part B, which covers physician visits, outpatient services and home healthcare. Patients hospitalized under observation can encounter significant financial burdens because Medicare Part B may carry greater out-of-pocket costs than Medicare Part A, which covers inpatient admissions. Medicare Part B services have a deductible and 80/20 cost sharing (80% Medicare/20% beneficiary) that is applied to all services provided but does not cover the cost of pharmaceutical drugs used in the hospital. Services covered under Medicare Part A have a consistent one-time deductible for the benefit period for inpatients. Depending on the services provided under observation, beneficiaries can experience highly variable financial liabilities. As of 2015, some observation stays may be bundled under a comprehensive ambulatory payment classification (C-APC) where the patient's out-of-pocket payment will not exceed the inpatient deductible, but little data on the usage or impact of this is publicly available.[3]

It is worth noting that a recent U.S. Department of Health & Human Services Office of Inspector General (OIG) report suggested that observation patients may pay less out of pocket than inpatients.[4] However, there are several caveats to this finding. The observation Part B dollar amounts used in the OIG report were only estimates. The report included only low-severity patients without secondary diagnoses, and long observation stays were excluded from the cost comparison despite being potentially the costliest observation encounters. The report also lacked information on services delivered. This makes it difficult to compare out-of-pocket expenses because reimbursement and patient out-of-pocket costs are a function of both the services billed and the insurance coverage for those bills. Finally, cost per benefit period was not assessed, despite the relevance of this for individual patients, especially those with multiple observation encounters in an inpatient benefit period. A more comprehensive report detailing reimbursement and patient out-of-pocket expense for equivalent services delivered under both outpatient and inpatient status would more accurately demonstrate the specific financial risk for these patients.

Observation care is often referred to by the colloquial "observation status," even though it is technically not itself a status determination but a subset of outpatient status. Throughout this white paper, we use the terms observation care, observation services, and observation status interchangeably to refer to the suite of services provided under outpatient observation care.

Challenges with Observation Policy

Difficulties with observation have been the subject of many recent media reports, garnering widespread attention and galvanizing beneficiaries and their families.[5] Patients are becoming aware of observation and are often encouraged to fight these status determinations. This is an understandable strategy for patients and families who need to ensure the Medicare coverage for their care is as comprehensive as possible. However, this approach can often lead to conflict and damage the physician-patient relationship as providers try to navigate Medicare rules, provide sound clinical care and respect patient wishes.

Observation care, in its current form, is often indistinguishable from inpatient care. In practice, it is not a "well-defined set of specific, clinically appropriate services." A recent study at the University of Wisconsin Hospital and Clinics identified a total of 1,141 distinct ICD-9 condition codes associated with observation billing claims during an 18-month study period. The top three observation diagnoses were chest pain, abdominal pain, and syncope and collapse, which accounted for only 18.8% of total observation encounters.[6] The large number of diagnosis codes, combined with the fact that the top three codes accounted for less than one-fifth of all observation encounters, demonstrates that observation is not "well-defined," and suggests that observation policy is markedly different from what is occurring in real clinical practice.

Although observation care is not meant to exceed 24 hours, and should only in rare and exceptional cases exceed 48 hours, it is not uncommon for patients to be under observation longer than these time periods, even after the implementation of the "two-midnight rule." Finally, these policies impact more Medicare beneficiaries each year. A recent Medicare Payment Advisory Commission (MedPAC) report documents a 47.4% increase in outpatient services per Medicare beneficiary from 2006-2015 with a concomitant 19.5% reduction in inpatient discharges over this same period.[7]

Patient access to post-acute services is also impacted since any time spent under observation does not count toward the three-day prequalifying stay required for Medicare coverage of SNF care.[8] This seemingly arbitrary requirement causes numerous obstacles for providers who know a patient cannot be safely sent home, but for coverage purposes, does not qualify for needed care at a step-down facility. If a beneficiary would clearly benefit from post-acute care after his or her hospital stay, but does not meet the three-day inpatient requirement, the patient will often forgo or truncate recommended SNF care to avoid out-of-pocket expense, which he or she may not be able to afford. This forgone care can lead to otherwise preventable complications (i.e., dehydration, falls, etc.), degradation of health status and a readmission to the hospital. This drives up otherwise avoidable readmission rates and has serious financial and health-related implications for both patients and Medicare. Recent changes to observation including the two-midnight rule have not addressed the issues with access to coverage for beneficiaries. (See Appendix for more detail about how observation and the two-midnight rule impact post-acute coverage).

Observation Care is Increasing—Why?

In an attempt to address the increased incidence of long observation stays and the expanding volume of outpatient hospital care, CMS proposed and finalized a rule that would offer a time-based criterion for when observation services should be provided. In what has now become known as the "two-midnight rule," any patient whose hospital stay is expected to cover at least two midnights of medically necessary care is generally considered inpatient. Likewise, if a patient's stay is expected to be less than two midnights, it should be classified as observation.[9] This rule was finalized by CMS on October 1, 2013, with full auditing enforcement as of October 1, 2015. However, the OIG's most recent report demonstrated that in the first year of the two-midnight rule (FY 2014), the rule did not perform as intended. Comparing FY 2014 to FY 2013, hospital inpatient stays decreased (–2.8%) and outpatient stays increased (8.1%), and despite the two-midnight rule, there were still 748,337 long outpatient stays (those of two midnights or longer), a decrease of just 2.8%. Further, compared to FY 2013, in FY 2014 there were 6% more hospital stays of three midnights or more that did not meet the three consecutive inpatient midnight eligibility requirement for SNF coverage.[10] Although this data should be considered preliminary, these findings suggest that the two-midnight rule has not fixed many of the core problems with observation policy, especially concerns over long lengths of stay and access to SNF coverage.
The increase in the use of observation may be attributed to multiple factors. One contributing factor may be that services traditionally performed in inpatient settings have been shifted to outpatient departments of the hospital. According to the OIG, some of the increase in observation care is due to a reduction in short inpatient stays (those less than two midnights in length), which they claim were previously inappropriately billed as inpatient.[11] A less likely possibility is that observation has increased due to the Hospital Readmission Reduction Program, since an observation hospitalization within 30 days of an incident inpatient admission does not count as a readmission. However, a recent study of this interaction between readmissions and observation stays did not show this effect.[12]

Observation may also be increasing due to the audit and recovery process. Medicare's Recovery Audit Contractors (RACs) have been charged with auditing and enforcing the appropriateness of payments, including inpatient versus outpatient observation status determinations. The RAC program pays independent contractors for the amount they recover for Medicare. Thus, RACs are incentivized to overturn hospital inpatient claims and deny reimbursement for services rendered. Consequently, hospitals may be utilizing observation more frequently in response to the fear of lengthy and costly appeals processes that coincide with audits. In recent years, CMS has made several programmatic improvements to the audit and appeals process,[13,14] and has replaced RACs with Quality Improvement Organizations (QIOs) as first-line auditors,[15] but the long-term impact of these changes remains unclear.

The NOTICE Act

On August 6, 2015, President Obama signed into law the Notification of Observation Treatment and Implication for Care Eligibility Act (PL 114-42) (the NOTICE Act), which requires hospitals to inform patients hospitalized under observation for 24 hours or more that they are under observation, and of the associated financial implications. The law, which enjoyed rare unanimous bipartisan, bicameral support, was operationalized on March 8, 2017, and required hospitals to obtain a patient signature on the Medicare Outpatient Observation Notice (MOON) form within 36 hours of the start of an applicable observation stay.[16] While the transparency established by the NOTICE Act is laudable and important, the NOTICE Act did not address the underlying flaws with observation policy, or its impact on patients. Informed patients may ask physicians to change their status, yet physicians must follow Medicare rules in assigning inpatient or outpatient (observation) status or risk committing Medicare fraud. This places a significant and unintended burden on the patient-physician relationship.

Hospitalist Perspectives on Observation Care

What is the Role of Hospitalists in Observation Policy?

Hospitalists are central players in the inpatient or observation hospitalization decision. In 2012, hospitalists provided 59% of all hospital observation care, followed by traditional internal medicine and family medicine providers practicing both ambulatory and inpatient medicine (21%). Cardiology (10%), emergency medicine (5%) and other specialties (5%) provide the remainder.[17] Hospitalists are often the primary points of contact for patients as they navigate the differences between inpatient and observation care determinations and how such determinations impact their care both during and after a hospitalization. Among SHM membership, consisting of more than 15,000 hospitalists, the two-midnight rule and the use of observation in general is an area of significant frustration and concern.

SHM Surveys: 2014 versus 2017

In 2014, SHM surveyed its members to garner their perspectives on observation policy to help inform policymakers. The survey, which consisted of 28 questions including two free responses, was utilized to develop a white paper, "The Observation Status Problem," highlighting hospital medicine's unique role in observation care and possible areas for improvement.

The survey illustrated three major areas of concern for hospitalists:

- Difficulty with the two-midnight rule and its failure to simplify admission decisions
- The negative impact on patients, including coverage and financial barriers
- The negative impact on clinical care and practice

In 2017, SHM decided to re-survey its members to see if perspectives and experiences had changed surrounding observation care, particularly with several years' experience under the two-midnight rule and recent implementation of the NOTICE Act. The 2017 survey illustrated that despite having more experience (91% of respondents were practicing before the two-midnight rule) with the two-midnight rule and associated regulations such as the NOTICE Act and MOON documentation requirements, hospitalists' perspectives on observation care remain unchanged. Just as in the 2014 survey, nearly all (93%) respondents rated observation policy as a critical issue for them and their patients. Respondents felt that the two-midnight rule, the NOTICE Act and other recent changes have not improved things, but instead:

- Create a continuing lack of clarity around observation for patients and providers;
- Are collectively an inefficient use of healthcare dollars; and
- Add significant stressors to the physician-patient relationship.

> ***"[Observation] impedes efficiency, strains the doctor-patient relationship, confuses patients, in an already stressful situation, and likely reduces patient/provider satisfaction, while adding nothing to patient care."***

Increased Patient Awareness, Increased Stress

The passage of the NOTICE Act is the most recent change to the landscape of observation care. Functionally, the act aims to ensure that patients are informed of their admission status in the hospital. In this respect, the NOTICE Act has been successful. Nearly 60% of hospitalist respondents indicate the NOTICE Act helps to inform patients that they are under observation. At the same time, awareness cannot be equated with understanding or ability to act on the information provided. Almost all respondents (87%) believe that the current rules for observation are unclear for patients, even with the passage of the NOTICE Act and use of the MOON document.

The NOTICE Act has created a new set of requirements for hospitals and providers to meet and new paperwork for patients to review. These bureaucratic changes have come at a cost. Hospitalists report the NOTICE Act has not improved patient care and has introduced impediments to clinician workflow. As one hospitalist aptly noted, "NOTICE and MOON help the patient become informed about a bad policy/system."

It is worth noting that hospitalists regularly receive requests from patients to change their status from under observation to acute inpatient after receiving the MOON document, or being informed of their status and its implications. A plurality of hospitalists (35.7%) reported hearing these requests for changes weekly, with nearly as many (29.8%) reporting hearing it at least once a month. Many hospitalists (61%) believe the NOTICE Act and MOON have created the perception that hospitalists can change patients from observation to acute inpatient, which is rarely the case due to Medicare regulations.

Even though patients and families are frequently requesting changes to their admission status, hospitalists, who are bound by Medicare policies, cannot grant the requests. Patients are becoming more aware, but current policy provides no recourse. Due to Medicare guidelines, nearly 90% of hospitalists report never or almost never changing patients from observation to acute inpatient at the patient's request. These requirements are a recipe for conflict between patients and their providers. A majority (68%) of hospitalist survey respondents believe the NOTICE Act and its requisite use of the MOON have created conflict between themselves and their patients.

> ***"The observation issue … can severely damage the therapeutic bond with patient/family who may conclude that the hospitalist has more interest in saving someone money at the expense of the patient."***

More Experience with the Two-Midnight Rule Has Not Improved its Application

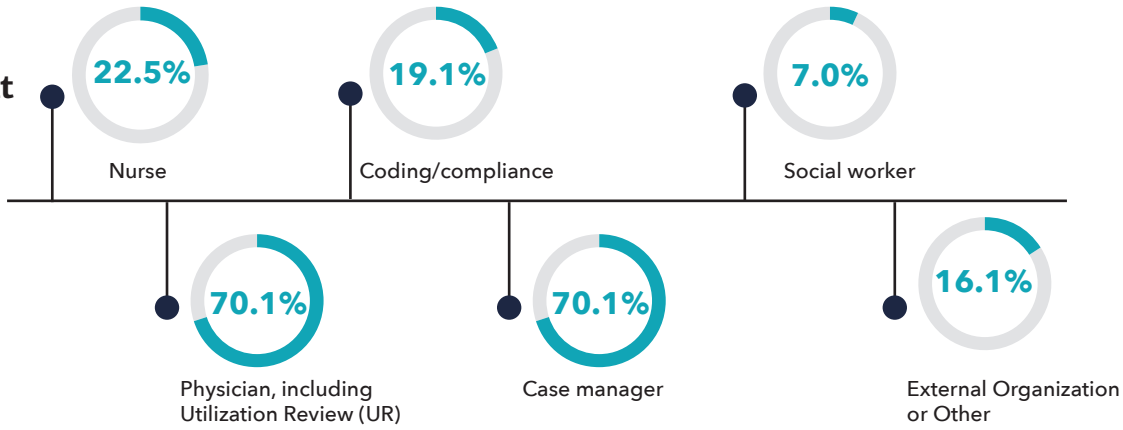
Despite the two-midnight rule for inpatient admissions being in existence over the last four years, there are still significant concerns over the policy and questions around how it can be implemented consistently. Although hospitalists indicate a good understanding of the two-midnight rule's guidance on when patients should be admitted as inpatients (68.5% strongly agree or agree), this does not translate into practice or workflow improvements. Even hospitalists who are acting as physician advisors, which are roles designed to help translate administrative policies to clinical staff, report confusion and frustration with the observation policy.

> ***"I am a physician advisor at my institution and should be as close to a subject expert as you would get (for a physician) but I still didn't know the answer to many of your questions [on observation policies]. I would be quite surprised if most physicians do."***

This confusion creates ample opportunities for subjective disagreements in the admission decision. Indeed, the average hospitalist is asked to change the status of his or her patients frequently after review by multiple parties, including case managers and utilization review (UR) teams. Nearly one out of every seven patients in observation must have their admission status changed after undergoing one or more levels of review. A recent study indicated that an average of 5.1 full-time employees, not including case managers, are required to navigate the audit and appeals process.[18] The result of multiple reviews and frequent status changes is significant outlays in time and resources to ensure compliance with observation rules—all of which represent an unnecessary financial drain on the overall healthcare system.

Parties involved in reviewing inpatient vs. observation determinations

Note: Respondents selected all that apply, meaning percentages will add up to more than 100%.



When asked if the two-midnight rule has improved hospital workflow, hospitalists were clear in their response: NO. Two-thirds of respondents indicated the two-midnight rule has not improved their ability to focus on providing care, and has added burden to their daily routines. This criticism increased from responses given in 2014, indicating that as hospitalists have become more familiar with the policy, they are seeing its limitations more clearly.

As well as viewing the policies around observation as burdensome distractions from providing care, more than 50% of respondents, both in 2014 and 2017, raised concerns about the cost of observation for patients.

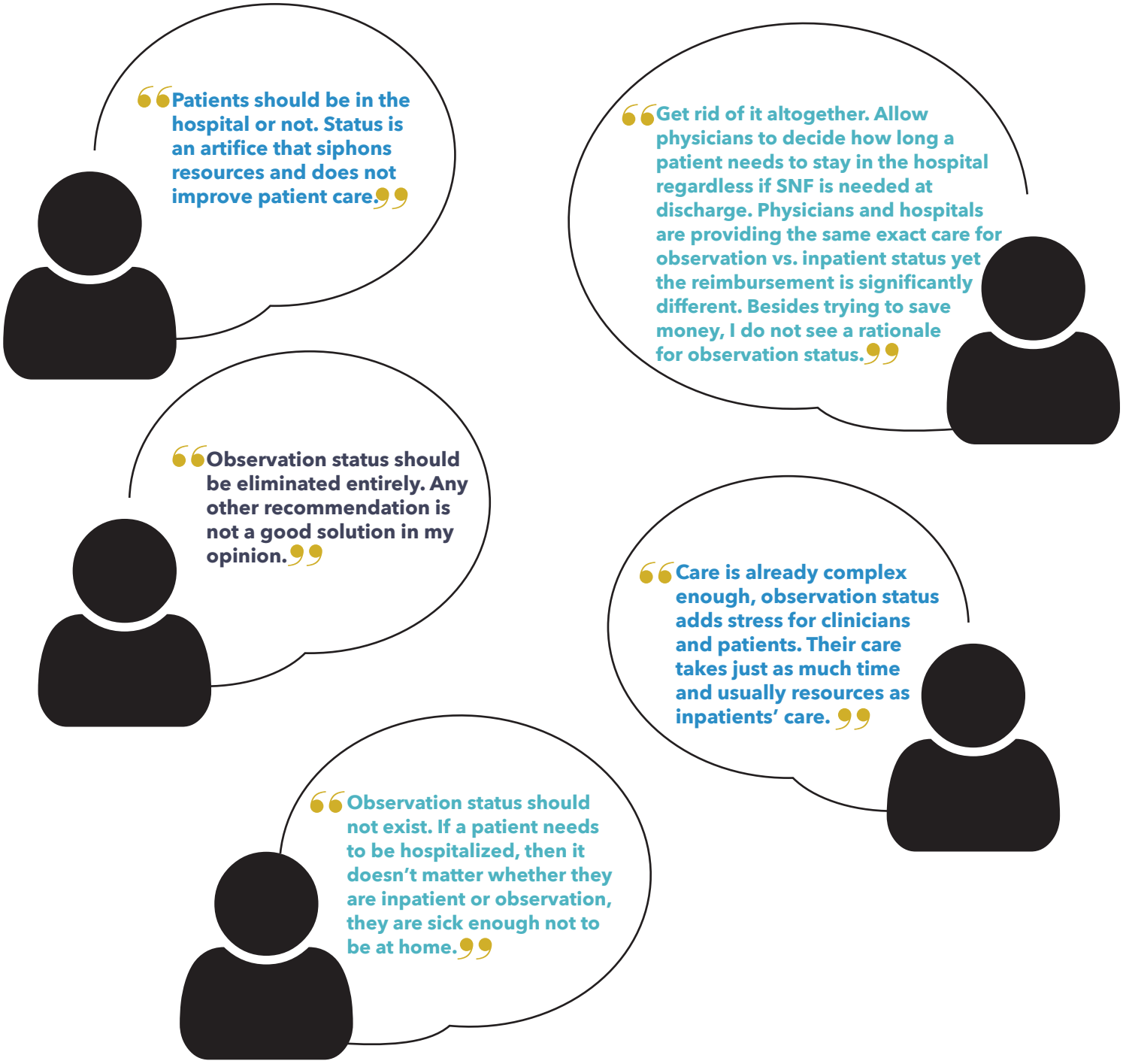
> ***"There are literally thousands of people running around trying to comply with these nonsensical regulations and whole businesses profiting off it. Not one patient benefits from this!"***

The survey results are clear: even with more experience and familiarity, hospitalists do not feel these regulations serve their patient population well. In fact, they believe quite the opposite, that observation puts a strain on patients, and their relationships with providers. Instead of improving things, the attempted simplification of observation care has made the situation more complicated, does not serve patients well and has increased the burden on providers' workflow. Significant reforms are still needed, as the fundamental problems with observation care remain unchanged.

> ***"Observation "puts us in the middle of coding and billing issues with patients and families. I know I need to document appropriately in the best interests of my patients, but this process doesn't help."***

Eliminate, Eliminate, Eliminate

When given the opportunity to speak freely about their perspectives on observation care, hospitalists were unified in their message: eliminate it. Many of the free responses in the survey advocated for eliminating the current policies as the best way to improve or change the status quo.



Hospitalists are understandably frustrated with a policy that adds significant disruption to their workflow, invites multiple third-party entities into care decisions (at significant cost) and acts as a wedge between them and their patients. The policy does not serve to improve patient care, and as such, merits significant attention for reform.

Policy Priorities

Recognizing the overwhelming need for changes to observation policy, SHM has established the following policy priorities:

Primary Priorities:

- Simplify hospitalization for Medicare beneficiaries, such that all patients are considered inpatients with a capped out-of-pocket amount for the inpatient deductible.
- Simplify and reduce complexity of payment policies for hospitalized patients, freeing up hospitalists to provide the care their patients need.
- All hospitalized Medicare beneficiaries should be eligible for provider-recommended SNF coverage regardless of their length of hospital stay. At a minimum, all patients, including those receiving observation care, should be eligible for post-acute SNF care after a stay of three hospital midnights.

Secondary Priorities and Objectives:

- Eliminate the guesswork in making status determinations at the beginning of a hospitalization, thereby alleviating the need for large amounts of limited, clinical and administrative resources being diverted away from actual patient care.
- Reduce the amount of hospital staff currently needed to manage front-end and back-end work related to outpatient versus inpatient billing status, audits and appeals.

Policy Recommendations

Options to Improve Current Policies

Address the barrier observation creates around patient access to post-acute care. Hospitalists see SNF coverage as a patient care issue that merits immediate attention. At a minimum, allow all Medicare beneficiaries access to SNF care, regardless of whether their time in the hospital is inpatient or observation. Support passage of the Improving Access to Medicare Care Coverage Act. Preferentially, we urge development of legislation that would eliminate the three-day stay requirement for SNF care entirely.

New data indicates that prior cost concerns over expanded SNF access may be unfounded. These data suggest that SNF use, and therefore costs to the Medicare Trust Fund, may not change if access is improved:

- Grebla et al. found that from 2006-2010, Medicare Advantage Programs with a SNF waiver did not lead to increased SNF use.[19]
- Dummit et al. showed via preliminary Bundled Payments for Care Improvement (BPCI) data that cost savings were largely from reduced SNF usage in the post-acute period when payments were bundled.[20]

We believe these data, taken together, suggest substantial shifts in the realities of healthcare delivery systems and costs, including cost being an element of pay for performance programs as a check on overutilization. As such, the Medicare SNF three-day stay policy is outdated and only serves as an administrative burden.

Increase clarity from Medicare/QIOs around correct implementation of observation rules. Hospitalists report confusion and continued issues with applying the observation rules consistently. Variable application and feedback in observation surveillance have plagued hospital status determinations. Standardization and consistency in messaging and implementation would greatly help provider adherence to correct status assignment. We urge CMS to improve its QIO and auditor education as well as increase standardized provider education to raise proficiency and confidence in applying these rules.

Comprehensive Observation Reform

Eliminate observation care and develop a new system. Hospitalists have spoken resoundingly about their experiences with observation policy and have indicated a strong desire for comprehensive reforms to this system. The time is now for policymakers to seriously confront this obsolete policy. We acknowledge there are many patients who are truly lower acuity or are well-served by existing emergency department observation units, but such units should be a part of providing high-quality appropriate care, not a means to comply with Medicare regulation. We believe the options presented below can be tailored to ensure patients receive clinically appropriate care in the correct setting – a "fit-for-purpose" approach to policymaking.

For any or all of the options below, Medicare or the Centers for Medicare & Medicaid Innovation (CMMI) could pilot programs or models to fully explore the impact prior to system-wide implementation.

Option A:

Eliminate hospital observation with use of a low-acuity DRG modifier.

A "low-acuity" DRG modifier for hospitalized patients could be created that would enable providers to indicate when they are treating a patient with a clinical condition that may not require the full spectrum of care captured in an existing DRG. Patients who need to be admitted to the hospital would be paid for either by a full DRG or by a DRG with this low-acuity modifier. Observation payments could then be returned to their original intent: an extension of an emergency department visit lasting less than 24 hours that takes place in an observation unit.

The Hospital Observation Care Problem

Once a patient's condition and clinical needs are fully known, a case manager or coder could retrospectively determine whether a low-acuity modifier should be assigned to the patient's DRG for his or her stay. DRGs that receive the low-acuity modifier would be reimbursed at a predetermined fraction of what the full inpatient stay would be. This would decrease usage of important clinical resources, such as physician time, being applied toward 'anticipatory guidance' for inpatient admission decisions – which is highly subjective and not evidence based.

Option B:

Eliminate hospital observation with an advanced APM model or bundled payment that would capture the post-acute period/SNF care.

Similar to a DRG with low-acuity modification, an advanced APM model would bundle services needed for an observation stay, and extend risk into the post-acute phase. These bundles would be similar to the clinical condition episode bundled payments under the Bundled Payments for Care Improvement (BPCI) model. Alternatively, there could be a global capitated payment for all hospital care billed under Medicare Part B as a complement to existing DRGs. This could give hospitalists and other hospital-based clinicians a per "unit" payment for all the patients they see, with risk extending into the post-acute phase. Auditing could also be done to ensure large shifts in practice do not occur (i.e., excessive SNF use). We note that shared savings and shared risk disincentivizes gaming and overutilization while encouraging providers to get patients the right care, in the right setting, at the right time.

Option C:

Eliminate observation by creating payments that blend inpatient/outpatient rates.
Under this option, all patients admitted to the hospital would be considered inpatient, and hospitals would bill according to their typical DRG and other billing rules. Those payments would be adjusted to a blended rate between the existing DRG and observation rates. A formula could be created to ensure that hospitals will not see a net decrease in their revenue as a result of this policy.

Conclusion

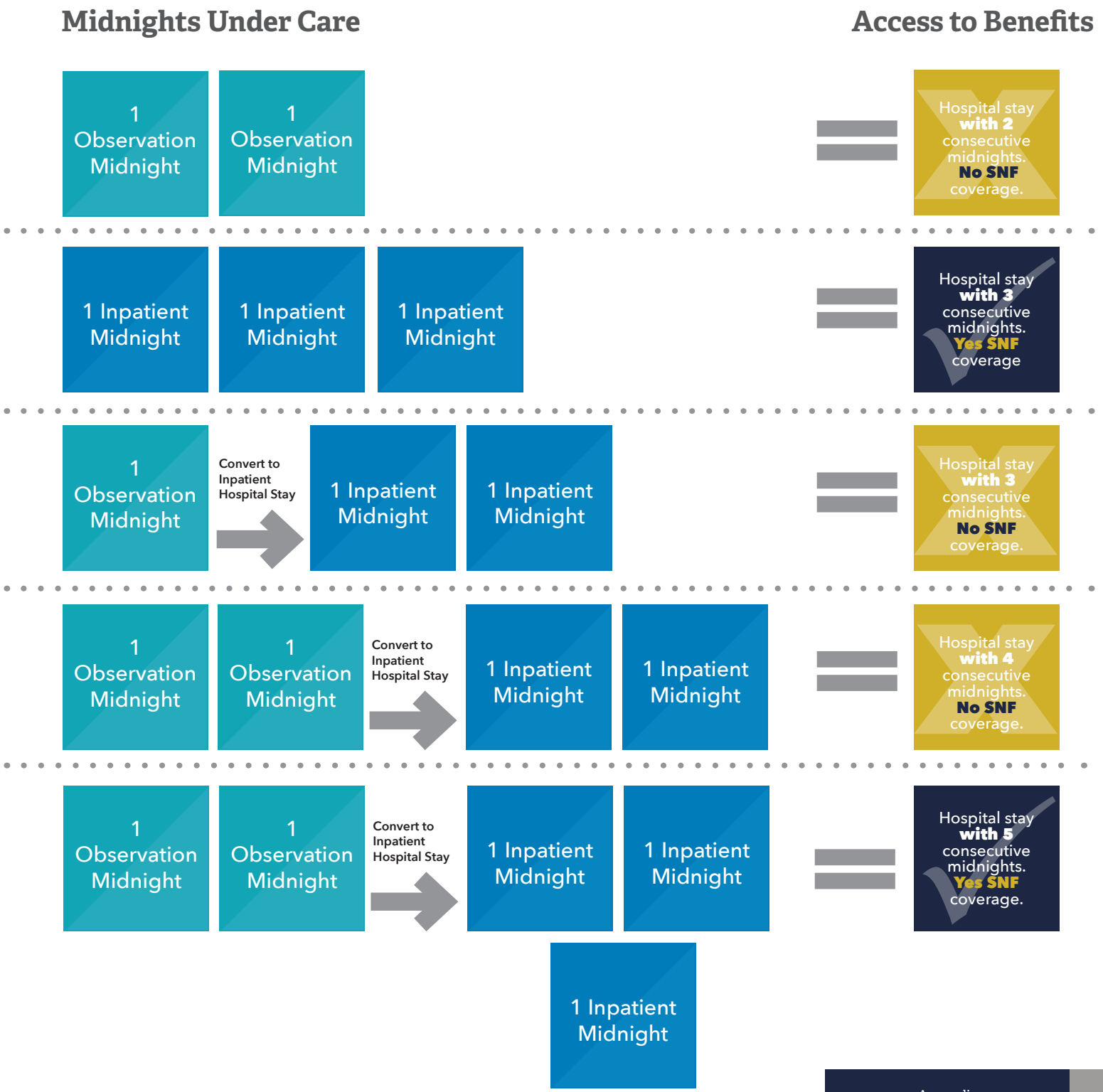
It is clear the current use of observation is not a sustainable policy. Providers, hospitals and their patients are feeling unnecessary pressures from observation policy and, in many cases, patient care is being undermined.

Admissions decisions should not include the challenges described by hospitalists and other providers, and should not be a point of contention among patients. Admission to a hospital should be focused on the patient's condition and best course of action for helping the patient to get well. Any new policy must reduce impediments to workflow, defer to physician judgment and decrease administrative burden. Patients should be able to access necessary post-acute care after their hospitalization without worry of financial calamity if their physician determines they require it.

Hospitalists resoundingly agree that significant reforms are still needed to resolve observation care problems. Policy changes should focus on the complete elimination of observation care, and could work up to that goal with smaller adjustments that may help to alleviate confusion and concern.

Appendix: Observation Time Never Counts Towards SNF Coverage

What's going on here? If a patient is converted from observation to inpatient, the midnight spent under observation counts towards meeting the two-midnight rule for inpatient admissions. It does not, however, count towards the three midnights of inpatient stays for Medicare skilled nursing facility (SNF) coverage.



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Lauren Doctoroff, MD, FHM
Beth Israel Deaconness Medical Center
Boston, Massachusetts

Suparna Dutta, MD
Rush University Medical Center
Chicago, Illinois

Bradley Flansbaum, DO, MPH, MHM
Geisinger Health System
Danville, PA

Rick Hilger, MD, SFHM
Regions Hospital
Saint Paul, Minnesota

Melinda Johnson, MD, SFHM
University of Iowa Hospitals and Clinics
Iowa City, Iowa

Kendall Rogers, MD, SFHM
University of New Mexico
Albuquerque, New Mexico

Ann Sheehy, MD, MS
University of Wisconsin Hospital and Clinics
Madison, Wisconsin

Joanne Zhu, MD, MS
WellStar Kennestone Regional
Medical Center
Marietta, Georgia

Josh Boswell, JD
General Counsel and Director
of Government Relations
Society of Hospital Medicine

Ellen Boyer
Government Relations Specialist
Society of Hospital Medicine

Joshua Lapps, MA
Government Relations Manager
Society of Hospital Medicine

With Support from the 2017-2018 Public Policy Committee

Joshua Lenchus, DO, FACP, SFHM
Chair
University of Miami Hospital Medicine
Miami, Florida

Ronald Greeno, MD, FCCP, MHM
Team Health
Los Angeles, California

John Biebelhausen, MD, MBA
Virginia Mason Medical Center
Seattle, Washington

Tim Bode, MD
Memorial Hospital
Jacksonville, Florida

Lauren Doctoroff, MD, FHM
Beth Israel Deaconess Medical Center
Boston, Massachusetts

Suparna Dutta, MD
Rush University Medical Center
Chicago, Illinois

Bradley Flansbaum, DO, MPH, MHM
Geisinger Health System
Danville, PA

Rick Hilger, MD, SFHM
Regions Hospital
Saint Paul, Minnesota

Ramon Jacobs-Shaw, MD, SFHM
NYU Langone Medical Center
New York, New York

Melinda Johnson, MD, SFHM
University of Iowa Hospitals and Clinics
Iowa City, Iowa

Megan Knight, PA-C, MPAS, FHM
Medical College of Wisconsin
West Allis, Wisconsin

Ajay Kumar, MD
Hartford Hospital
Hartford, Connecticut

Atashi Mandal, MD
Huntingdon Beach, California

Mark Murray, MD, SFHM
Takoma Regional Medical Center
Greenville, Tennessee

Dahlia Rizk, DO, FHM
Mount Sinai Beth Israel
New York, New York

Hammad Rizvi, DO, MBA, FHM
TeamHealth
Staten Island, New York

Kendall Rogers, MD, SFHM
University of New Mexico
Albuquerque, New Mexico

Ann Sheehy, MD, MS
University of Wisconsin Hospital and
Clinics
Madison, Wisconsin

Kerry Weiner, MD, MPH
Los Angeles, California

Joanne Zhu, MD, MS
WellStar Kennestone Regional
Medical Center
Marietta, Georgia

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