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Medicare, Observation Care, and the Two-Midnight Rule

Medicare cost sharing and posthospital coverage can depend on whether a beneficiary was *admitted* to the hospital and received treatment as an inpatient or received treatment as an outpatient. Some beneficiaries have been surprised to learn that despite having received treatment overnight in a hospital bed during their hospital stay, they were never formally admitted but instead were under *observation* as an outpatient. The *Two-Midnight Rule* implemented by the Centers for Medicare & Medicaid Services (CMS) is intended to clarify to hospitals when an inpatient admission is considered medically necessary.

Observation Care

Observation care typically is characterized as a component of emergency medicine that allows hospitals to triage patients who do not immediately require an inpatient admission but are too sick to discharge immediately. Under observation, the hospital provides assessment, ongoing short-term treatment, and reassessment before determining whether the patient should be admitted as an inpatient for additional treatment or is well enough to be discharged. However, there is some ambiguity with respect to which patients should be under observation and the duration of their observation stay. For example, according to a 2013 report by the Department of Health and Human Services' (HHS's) Office of Inspector General (OIG), chest pain was the most common reason for an observation stay in 2012 and the most common reason for a short hospital inpatient stay (less than two nights). Additionally, while 63% of observation stays were for one night or less, 11% of beneficiaries' observation stays were for three nights or more in 2012.

Observation care is provided on an outpatient basis but may be provided within a hospital ward, an observation unit, or both. Dedicated observation units have grown in popularity among U.S. hospitals. According to a 2011 academic study using National Hospital Ambulatory Medical Care Survey data, 36% of emergency departments had an observation unit in 2007, up from 19% in 2003. Similarly, a 2012 academic study of observation stay use relative to inpatient admissions among Medicare beneficiaries based on claims data showed an increase from 86.9 observation stays per 1,000 inpatient admissions in 2007 to 116.6 observation stays per 1,000 inpatient admissions in 2009.

Implications of Hospital Status

Whether a beneficiary is admitted to the hospital or treated as an outpatient can impact the beneficiary's cost-sharing liabilities. Under Medicare Part A, which provides inpatient hospital coverage, beneficiaries are required to pay an inpatient deductible ($1,260 in CY2015) if they are admitted to the hospital. Beneficiaries who receive hospital outpatient services, which are covered under Medicare Part B, typically pay 20% of the Medicare reimbursement amount for outpatient items and services after paying the annual Part B deductible ($147 in CY2015). According to a 2013 HHS OIG report, beneficiaries often incurred greater cost sharing for short inpatient stays than for observation stays when they received treatment for the same reason.

Whether a patient was admitted also can affect Medicare's coverage for post-acute care following the hospital stay. Medicare provides coverage for 100 days of skilled nursing facility (SNF) care per spell of illness. To receive SNF coverage, a Medicare beneficiary must have had a three-day inpatient hospital stay within 30 days of admission to the SNF, among other requirements. Time spent as a hospital outpatient does not count toward satisfying the three-day inpatient requirement for SNF coverage. P.L. 114-42 (The NOTICE Act), signed into law on August 6, 2015, requires hospitals to notify a beneficiary if he or she has been under observation for more than 24 hours and communicate the implications of such status.

Reviews of Short Inpatient Stays

Some researchers have suggested that the increased use of observation care might be in response to increased scrutiny of short hospital inpatient stays from Medicare and private payers. For instance, Medicare's Recovery Audit Program, which was implemented nationally in 2010, provides an increased level of scrutiny on short hospital inpatient stays. This oversight is conducted due to the incentives that exist within Medicare's inpatient prospective payment system (IPPS) for hospital inpatient care. Medicare's IPPS payment for inpatient care is provided to the hospital on a per discharge basis (typically not adjusted for length of hospital stay) for each inpatient admission. Thus, under the IPPS, shorter hospital inpatient stays generally are more profitable for hospitals than longer inpatient stays. In contrast, Medicare's reimbursement for outpatient observation care is provided on a per diem basis and often at a lower rate.

Under Medicare's Recovery Audit Program, recovery audit contractors (RACs) conduct post-payment reviews of Medicare claims to identify and correct improper payments. One type of post-payment review is a *patient status review*, which is an audit of a health care claim paid for a hospital inpatient admission to determine if the patient could have been safely and effectively treated as an outpatient (based on the available medical documentation). Patient status reviews can act as a safeguard against the incentives to admit patients for short inpatient stays rather than providing outpatient care.

Under the RAC program, following a patient status review, an RAC notifies the applicable Medicare administrative contractor (MAC; an entity that processes Medicare claims) when it identifies a Medicare hospital inpatient stay in which the patient could have been safely and effectively

treated in an outpatient setting. Hospitals may appeal RAC decisions of medically unnecessary hospital inpatient admissions. Additionally, a hospital that returns its inpatient reimbursement is able to rebill Medicare Part B for items and services that would have been payable under Part B had the beneficiary originally been treated as an outpatient rather than an inpatient (if the dates of services occurred in the last 12 months). Certain services cannot be rebilled to Part B because they specifically require an outpatient status on the date of service (e.g., observation services).

Two-Midnight Rule

In response to concerns over long observation stays and RAC determinations of medically unnecessary short hospital inpatient admissions, CMS finalized the Two-Midnight Rule on August 19, 2013. This rule was intended to provide clarification on when hospital inpatient admissions and hospital outpatient services generally are appropriate. Under the Two-Midnight Rule, if the admitting physician expects a beneficiary's treatment will require a stay in the hospital that crosses two midnights, or if the treatment includes a procedure that is specified by CMS as inpatient only, it generally is to be deemed appropriate and medically necessary under Medicare regulations for the physician to admit the beneficiary to the hospital as an inpatient and receive reimbursement under Medicare Part A. Such a decision to admit a beneficiary can come after the beneficiary has spent one midnight under observation or has received other hospital outpatient services. Hospital stays that are expected to be less than two midnights generally will be considered outpatient stays, unless such stays are a "rare and unusual" exception, of which only one has been identified (certain cases that involve newly initiated mechanical ventilation).

Additionally, with the implementation of this rule, CMS would instruct RACs to no longer conduct patient status reviews on inpatient stays of two midnights or more. For inpatient stays of less than two midnights, RACs could continue to conduct patient status reviews to determine if the inpatient stay could have been safely provided on an outpatient basis.

Hospital-advocacy groups contend that the Two-Midnight Rule is overly complicated, administratively burdensome, and undermines a physician's medical judgment. Hospital groups filed a lawsuit in U.S. District Court for the District of Columbia contending that the Two-Midnight Rule and related policies burden hospitals with arbitrary standards and documentation requirements and deprive hospitals of Medicare reimbursement to which they are entitled. CMS has stated that the Two-Midnight Rule does not override the clinical judgment of a physician but provides a benchmark for physician expectation of a medically necessary inpatient admission and consistent application of Medicare's Part A benefit.

CMS implemented the Two-Midnight Rule and instructed MACs to implement a "probe and educate" medical review period to assess hospitals' understanding of the rule and to assist hospitals in compliance with it. Additionally, CMS prohibited RACs from conducting patient status reviews on hospital inpatient admissions of less than two midnights between October 1, 2013, and October 1, 2014. The Protecting Access to Medicare Act (PAMA; P.L. 113-93) permitted CMS to extend the probe and educate period and to extend the moratorium on RAC patient status reviews of hospital inpatient admissions through March 31, 2015. Recently, the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA; P.L. 114-10) permitted CMS to further extend the probe and educate period and to continue the PAMA moratorium on RAC patient status reviews through September 30, 2015.

Recent Changes to the Two-Midnight Rule

On November 13, 2015, CMS released changes to the Two-Midnight Rule under the Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems final rule (see 80 *Federal Register* 70298). In the final rule, CMS stated it would continue to use the two-midnight benchmark for a medically necessary inpatient admission. However, CMS would provide added flexibility to this rule on a case-by-case basis for hospital inpatient stays of less than two midnights if the admitting physician determines that an inpatient stay is expected to be less than two midnights but documentation in the medical record supports the physician's judgment that an inpatient admission is necessary. Additionally, Part A payment would continue to be made for an inpatient stay of less than two midnights if the procedure is specified as inpatient only or for a case identified under the rare and unusual exception.

Beginning January 1, 2016, Quality Improvement Organizations (QIOs)—groups of regional and national health quality experts, clinicians, and consumers under contract from CMS—in replacement of MACs, would determine the appropriateness of payment for inpatient stays of less than two midnights. For short inpatient stays that do not fall under the inpatient-only procedure list or the cases identified as rare and unusual exceptions, Part A reimbursement would be subject to the clinical judgment of the QIO medical reviewer based on information contained in the medical record. QIOs would refer claim denials to the MAC for payment adjustment. QIOs also would educate hospitals about claims denied under the Two-Midnight Rule and collaborate with such hospitals to improve organizations' processes and/or systems. Upon referral from QIOs, RACs could conduct payment audits of hospitals that consistently fail to adhere to the rule or fail to improve their performance after QIO educational intervention beginning January 1, 2016.

Marco A. Villagrana, Analyst in Health Care Financing

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