Observation and the older patient

Navigating the paramedical shoals which threaten older hospital patients…and their providers

Insurance policies worth understanding

- Insurers generically
  - Inpatient versus observation
  - Authorization for skilled nursing
  - Penalties for readmissions
- Medicare in particular
  - The 2 Midnight Rule
  - The 3 Midnight Rule
  - Bundled episodes

Healthcare 101: struggle of payers and providers

- Payers (insurers) strive to minimize payment (= keep "medical loss ratio" low)
- Providers (hospitals and physicians) seek to maximize revenues

→ escalating spiral of gambits and counters

- The struggle over **hospital** costs is particularly intense: hospital costs account for ~35% of US health care spending. Cited in Bauchner H and Fontanarosa PB, JAMA, 2019
- By-product of struggle: administrative waste

What is Care Management?

- Care Management is actually **Utilization Management,** focused on optimizing utilization of hospital beds:
  - Length of Stay (LOS): Care Managers and Social Workers work to minimize LOS
  - Level of Care (LOC): Utilization Review nurses work to assign proper LOC—inpatient vs. observation
- Optimal LOS and LOC: essential to hospital fiscal health
- **Care Management means business**

What is Observation? The theory…

- Medicare defines obs as "**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"**
- "in the majority of cases, the decision…can be made in less than 48 hours"
- Insurers regard **patients in obs as outpatients**
- Obs is LOC limbo: in the hospital **physically, but not fiscally**

Why is Obs: the reality

- Medicare switched from charge-based reimbursement to prospective payment in 1983:
- Charge-based: hospital was paid for each hospital day and every service provided; this incentivized **long hospital stays, lots of services**
- Prospective: hospital is paid single lump sum for stay and services, based on Diagnostic Related Group; this incentivizes **multiple short stays**
- The multiple short stay gambit led insurers to counter with lower payment for short stays = Obs

Why don't hospitals like obs?

- Reimbursement for obs typically ~1/3 of amount paid for diagnostically related inpatient stays: Medicare average payment for inpatient $5,142, for obs $1,741. Cited in Wright B et al, Ann Emerg Med, 2018
- Payment for obs may not cover costs:
  - Observation: -$331 margin per stay
  - Inpatient +**$2163** margin per stay. Sheehy AM et al, JAMA Int Med, 2013
- However, efficiently managed obs can cost less than inpatient: obs units could reduce average per patient cost $1572. Baugh CW et al, Health Affairs, 2012

Why don't clinicians like obs?

- Clinicians are caught in middle:
  - Don't agree with payers' decisions re obs
  - Experience more intense pressure from hospital to discharge
  - Blamed and pressured by unhappy patients and families
  - Unable to place Medicare patient in SNF
- Professional fees (per visit payment) for treating patients in obs are lower than for inpatient

Why don't patients like obs?

- Patients in obs may be billed co-pays for tests, procedures, treatments because insurers regard obs as outpatient care
- Patients suspect obs means inferior care
- Patients experience cognitive dissonance:
  - sick but not sick enough
  - in hospital, but not inpatient
- Medicare requires inpatient stay prior to paying for SNF (more later)

Actually patients often pay less in obs

- Out-of-pocket costs for Medicare patients:
  - Inpatient: **$1408 deductible** (in every 60 day benefit period)
  - Obs: **$198 annual deductible, 20% co-pays** for most services and "self-administered" medications
- Inpatients and obs patients both pay 20% of professional fees +/- $198 annual deductible
- Median out-of-pocket costs per obs stay: $449 (<$1408 inpatient deductible) Goldstein JN et al Am J Medicine, 2018

More evidence obs may be better:

- MC beneficiaries often pay less out-of-pocket for:
  - **obs stays than they do for inpatient stays**. Study by DHHS OIG, 2012, cited in Adrion ER et al, Health Affairs, 2017
  - **multiple obs stays in 60 day period than for single inpatient stay**: average cumulative financial liability of $947 < $1100 inpatient deductible. Kangovi S et al, J Hosp Med, 2015
- Commercially insured patients paid substantially **less for obs care than for short stay hospitalizations** for 6 common conditions. Adrion, 2017

Other ways out-of-pocket costs are limited

- ~85% of MC patients carry supplemental insurance which covers much of cost-sharing in obs
- ~20% of MC patients are eligible for MA ("dually eligible")…which covers deductibles, co-insurance and co-pays

Defusing patient wrath

- Assure patient and family:
  - LOC is not your decision
  - Quality of care in obs is identical to inpatient
  - Out-of-pocket costs may be lower than inpatient
  - Patient will incur similar co-pays if has same tests in outpatient setting
- Control out-of-pocket costs by avoiding inessential services
- Consider whether MC patient qualifies for inpatient under 2 Midnight rule (more later)
- Consider appealing insurer's determination of obs (vide infra)

OK, that's what obs is, but what's inpatient?

- Level of Care for patients who require treatment that can be provided only in hospital
- Principle governing payment for all health care services: Medical Necessity. Patient is inpatient if **hospital is medically necessary**
- Hospital is medically necessary (= patient should be in-patient) if 2 conditions are **both** met:
  - **Severity of illness** (SI): is patient acutely ill?
  - **Intensity of service** (IS): could patient be treated in alternate (lower) level of care?

Finally, who decides whether patient is inpatient?

- Attending? X
- Hospital? X
- UR nurse? X
- The insurer ! (or, in rare cases, a judge !)
- Because there are penalties for calling a patient inpatient when insurer thinks not, hospital tries to assign proper LOC, aiming for inpatient where possible
- Initial assessment of LOC is done by hospital UR nurses

UR nurse uses InterQual to assign LOC

- Reviews record to select primary condition being treated
- Checks boxes (IQ criteria under primary condition) required to qualify ("meet") for inpatient
- If all required boxes checked = inpatient; if not, = obs
- If patient has inpatient order but:
  - doesn't meet inpatient criteria: UR nurse asks attending to enter obs order, or may offer to have insurer physician review
  - insurer has already denied inpatient: UR nurse asks attending to enter obs order or make "peer-to-peer" call to insurer physician to appeal denial

What is InterQual?

- Set of criteria for LOC issued in 1978 and revised annually
- IQ (or Milliman) criteria are used nationally by payers **and** providers
- Each primary condition under IQ has specific **Severity of Illness** and **Intensity of Service** criteria which must be met to qualify as inpatient
- Criteria are generally objective/quantitative measures:
  - Severity of Illness: VS, lab results, imaging findings
  - Intensity of Service: treatment, route, frequency, rate, monitoring
- IQ provides guidelines, but a physician's judgment is arbiter of LOC

Hospital's incentive to get LOC right, or, obs is better than nothing

- If patient has in-patient order at time of discharge, and insurer later decides patient should not have been inpatient, hospital will forfeit payment received
- Commercial payers: limited window (days to weeks) post-discharge for hospital to change status to obs to collect payment for obs
- Medicare and most Medicaid: no window post-discharge: if hospital switches inpatient to obs after discharge -> hospital cannot bill for hospitalization

What won't meet IQ for inpatient

- Extreme old age, frailty, long chronic problem list
- Symptoms alone: pain, dyspnea, nausea
- Diagnoses alone: COPD, CHF exacerbations
- Diagnostic work-up without acute treatment
- "Social" admissions: disability, lack of support, non-adherence
- Treatment feasible in "lower level of care": IV antibiotics, O2 at flow rates < ~ 6L/min or FiO2 <40%, wound care

Getting to inpatient when IQ not met

- Primary condition is not what UR nurse selected for review
- Condition change after UR review
- Co-morbid disorders complicating care
- Predictable risk of specific serious adverse event
- Failed outpatient treatment, e.g., antibiotics, steroids
- Events prior to hospital admission (office, EMS, ED)
- Intensive monitoring (neuro checks, telemetry, labs)
- **Must have SOI AND IOS to make case for in-patient**
- **IQ is guideline, not rule book**

At last, a case history: 66 yo in obs

- Admitted with hemoptysis, chest pain, odynophagia, right leg pain, hemoglobin 8.1, WBC 12.3, ESR 79, Na+ 128, creat 1.7, UA 12.3
- Medical history: recurrent DVT's, HFpEF, right TKR explant/chronic clindamycin, gout, DM, recent eosinophilic PNA, OSA, CKD 3, hypothyroidism, depression
- Home medications: allopurinol 100, amitriptyline 100, clindamycin 300 tid, furosemide 80 bid, insulin tid, levothyroxine 200, lisinopril 2.5, MS Contin 100 bid, pantoprazole 40, prednisone 10, simvastatin 40, TMP-SMZ DS 3x/wk, warfarin

"Hospital" course

- Warfarin held, IV heparin started
- Hemoptysis small, hemoglobin 8.1->8.6, WBC 12.3-> 11.3, Na+ 128->132, creat 1.7->1.5, troponins normal, EKG NSR, chest CTA no PE, **chronic DVT's femoral veins on 1st scan, DVT extension to right popliteal and peroneal on 2nd scan…while on heparin**
- EGD: esophageal ulcers c/w viral esophagitis->valganciclovir + fluconazole
- MRI: L5 disc herniation contacting nerve root->**IV hydromorphone**->oral morphine, gabapentin
- History of recent epistaxis, resolved
- **He didn't meet IQ**; insurer denied inpatient; doctor appealed and WON

Adept clinicians should also understand:

- Medicare 3 midnight rule
- Medicare 2 midnight rule
- SNF authorization
- Bundled payment: adapting in this reimbursement environment

Medicare **3** Midnight Rule

- MC covers SNF stay only after 3 MN stay **as hospital inpatient**
- If patient in obs is switched to inpatient, must have 3 inpatient MN's **after** switch
- Under-utilized nuance: 3 MN stay **within past 30 days qualifies for SNF**
- Rule aims to limit SNF benefit to patients with acute illness who would benefit from post-acute skilled services
- Medicare Advantage insurance policies often have waivers to 3 MN rule; 3 MN rule applies only to traditional fee-for-service MC

Medicare 2 Midnight rule

- Patient who is expected to require **medically necessary services** for 2 MN's or more should be **inpatient**
- Medically necessary services are "services generally appropriate for Medicare Part A payment" (?)
- Patient staying < 2 MN should be obs—most of the time
- Using the 2 MN rule:
  - Legitimate: patient has acute medical needs, even if may not meet usual inpatient level
  - Not acceptable: "social admission" or admission with goal of "placement": 2 MN rule is not a tactic for meeting 3 MN requirement

Prospective payment (DRG's) rewards readmissions ⇒ penalties for readmitting

- Insurers created two kinds of "disincentives" for readmitting:
  - Medicare Readmission Reduction Program: if hospital exceeds expected 30 day readmission rate for certain common diagnoses, hospital's reimbursement for all Medicare admissions is reduced by up to 3%
  - Bundling: if patient is readmitted within 30 days for **reasons medically related to index admission**, readmission will be "bundled" as "continuation of care" = hospital will not be paid for readmission.

What counts as a readmission?

- Sole criterion for bundling is medical relatedness of 2 admissions; whether readmission was avoidable or not is not material
- Medically related readmissions include:
  - Unresolved problem from first admission
  - Complication of admission: HAP, DVT, C diff diarrhea, surgical site infection
  - Recurrence of chronic disorder: COPD, alcohol intoxication, cirrhosis
- Admissions are bundled only when both index and return admission are inpatient:
  - This policy creates incentive to place readmitted patients in obs
  - Insurers aware hospitals use obs to avoid readmission penalties Carey K and Lin M-Y, Health Affairs, 2015; Jha A, cited in NYT by Frakt A, 1/4/16

Getting authorization for SNF

- **Medical necessity** guides insurer's decision to cover SNF
- Patient must require skilled services, not just custodial care
- Skilled = RN/LPN (complex wound care, IV med), PT, OT, ST
- Patient should demonstrate likelihood of functional improvement:
  - Motivated, and physically able, to participate in therapy
  - Capable of understanding and retaining instructions
  - Deficits are potentially responsive to therapy
  - Insurers vet PT, OT, ST and PM+R notes
- Patient medically stable for transfer, unlikely to require readmission

How bundled episodes may change practice

- CMS Bundled Payment for Care Improvement (BPCI): Single lump sum payment for hospital and "post-acute" care during 90 day period following hospitalization for specified disorders, procedures
- Strategies adopted by providers to control costs under BPCI: minimize post-acute care (PAC):
  - Reduce use of **institutional** PAC (SNF, IPR)
  - Reduce **duration** of PAC
  - Concentrate PAC among **small network** of high quality providers
  - **Extend hospital LOS**—spend some to save more
- Opportunity for geriatric medicine? We do PAC better

Hanging on to equanimity in a health care system that's none of those things

- Understand policies reviewed here
- Work the system (legally) using your understanding
- Take responsibility when you have authority; explain how system works when you don't
- Focus on your two duties:
  - Promote the well-being of the patient
  - Steward the shared societal resources with which you are entrusted (AMA Code of Ethics Opinion 11.1.2)