

Informing Medicare's Two-Midnight Rule Policy With an Analysis of Hospital-Based Long Observation Stays



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Study objective: Outpatient observation stays are increasingly substituting for standard inpatient hospitalizations. In 2013, the Centers for Medicare & Medicaid Services adopted the controversial Two-Midnight Rule policy to curb long observation stays and better define the use of hospital-based observation services versus inpatient hospitalizations. We seek to determine the extent to which Medicare beneficiaries exposed to long observation stays (>48 hours) are clinically similar to those with short observation stays (\leq 48 hours) because this has relevance to the Two-Midnight Rule.

Methods: Using 100% Medicare claims data from 2008 to 2010, we identified all patients with long observation stays (>48 hours) who were admitted through the emergency department (ED). We report beneficiary characteristics, as well as crude and risk-adjusted 30-day rates of mortality, readmissions, and return ED visits stratified by observation stay length.

Results: Seven percent of 2.8 million observation stays were greater than 48 hours. Beneficiaries with long observation stays tended to be older, women, nonwhite, and urban residents, with a greater number of comorbid conditions. Crude rates increased with observation stay length for all 3 outcomes. However, after directly standardizing the rates, we observed the reverse trend because all adjusted rates decreased stepwise with observation stay length greater than 48 hours in a dose-response pattern.

Conclusion: Patients with observation stays lasting longer than 48 hours are a clinically distinct population. Our findings support the conceptual underpinnings of the Two-Midnight Rule, but suggest that observation versus inpatient determinations should be based on actual length of stay rather than prospective prediction to reduce the administrative ambiguity this policy has created. [Ann Emerg Med. 2018;72:166-170.]

Please see page 167 for the Editor's Capsule Summary of this article.

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INTRODUCTION

Outpatient observation stays are increasingly substituting for standard inpatient hospitalizations. From 2007 to 2009, Medicare observation stays increased by 25% to greater than 1 million annually.¹ Moreover, the length of observation stays is increasing, often exceeding the 48 hours considered an appropriate upper limit by the Centers for Medicare & Medicaid Services (CMS).^{1,2} Although advocates find observation stays useful for condition-specific, protocol-driven applications,³ assigning patients to observation can have substantial consequences for patients, providers, hospitals, and payers. On average, Medicare pays hospitals \$5,142 for a short-stay hospitalization and \$1,741 for an observation stay, but if federal auditors determine that an inpatient hospitalization was unwarranted, the hospital's claim may be denied.⁴

Simultaneously, consumer advocates remain concerned about patients' out-of-pocket costs because the 20% coinsurance associated with outpatient observation (Part B) occasionally exceeds the inpatient deductible (Part A).⁴

CMS regulations mandate that physicians determine patient assignment to observation or inpatient status prospectively at admission. Although intended to be a decision based only on an assessment of the patient's medical needs, in practice, it frequently depends on additional nonclinical factors such as expected length of stay and the degree of documentation supporting the billed claim. In October 2013, to clarify whether short hospital stays should be observation or inpatient status and curb long observation stays, CMS adopted the Admission and Medical Review Criteria for Hospital Inpatient Services Under Medicare Part A, also known as the Two-Midnight

Editor's Capsule Summary

What is already known on this topic

Observation care is intended to last less than 48 hours, although an increasing proportion of observation stays are longer.

What question this study addressed

Medicare data from 2008 to 2010 were used to determine whether patients with a short observation stay (≤ 48 hours) were clinically similar to those with a longer stay (>48 hours) by comparing risk-adjusted mortality, hospital readmission, and return emergency department (ED) visits within 30 days.

What this study adds to our knowledge

Patients who have longer observation have higher crude mortality but lower adjusted mortality, readmission, and return ED visit rates, suggesting that longer-stay patients are different and benefit from the longer stay.

How this is relevant to clinical practice

Length of stay greater than 48 hours should determine whether care is classified as observation versus inpatient.

Rule. This rule states that any patient expected to remain in the hospital less than 2 midnights should be assigned to observation, whereas any patient expected to remain in the hospital greater than 2 midnights should be considered an inpatient. A survey conducted by the Society of Hospital Medicine found that 47% of physicians surveyed suggested that the rule has harmed patient care.⁵ The administrative cost of complying with the rule has been estimated to exceed \$2.5 billion a year,⁶ prompting the Medicare Payment Advisory Commission to recommend repealing the Two-Midnight Rule and replacing it with a financial penalty on hospitals with high rates of short-stay hospitalizations.⁷ Consequently, CMS implemented the rule gradually through December 2015, adopting a “probe and educate” process and making additional minor revisions.⁸

Central to this policy discussion is the extent to which patients placed in observation are clinically distinct from those admitted for short-stay hospitalizations and should therefore be subject to varying approaches to reimbursement. To date, the evidence is mixed, with some studies supporting⁹ and others refuting this premise.¹⁰ Therefore, to better inform the Two-Midnight Rule

debate, our objective was to determine whether long observation stays represent a clinically distinct patient group by examining the characteristics and health outcomes associated with these stays relative to those with shorter observation stays.

MATERIALS AND METHODS

Using 100% Medicare claims data from 2008 to 2010, which precedes implementation of the Two-Midnight Rule, we identified all observation stays originating through the emergency department (ED), using a combination of revenue center codes (0760 or 0762) and Healthcare Common Procedure Coding System codes (G0378 or G0379), and flagged long observation stays (>48 hours), using the actual number of hours a patient was under observation as reported in the units field of the claim. Under the Two-Midnight Rule, any stay greater than 48 hours would be classified as inpatient. Next, we examined beneficiary demographic characteristics stratified by observation stay length. Then we calculated crude 30-day rates of mortality, readmissions, and return ED visits stratified by observation stay length. Finally, we calculated directly standardized rates, adjusting for factors that were available in the claims data and that we hypothesized a priori were likely to be associated with our outcomes of interest or the likelihood of experiencing a long observation stay. These factors included age, sex, race, chronic conditions, weekend admission, season, rurality, and census region, using patients with observation stays less than or equal to 48 hours as the standard population. This study was approved by the University of Iowa Institutional Review Board.

RESULTS

We identified nearly 2.8 million observation stays, of which approximately 7% were long observation stays. Demographic characteristics of beneficiaries with an observation stay are shown in the [Table](#), stratified by observation stay length. Consistent with previous research, we found that individuals with long observation stays tended to be older, women, nonwhite, and urban residents, with a greater number of chronic conditions.² Often, these characteristics do not merely distinguish individuals around the 48-hour threshold, but are actually associated with increasing observation stay length greater than 48 hours.

In the [Figure](#), we present crude and adjusted 30-day rates for mortality, readmission, and return ED visits. For all 3 outcomes, we observed that the crude rates increased with observation stay length. For example, among patients with an observation stay less than or equal to 48 hours, the crude 30-day mortality rate was 1.9%, the crude 30-day

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