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Health Policy Brief

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The Two-Midnight Rule. Hospitals are paid differently for treating inpatients versus outpatients. With a new rule, CMS has tried to clarify when it is appropriate to admit someone as an inpatient.

WHAT'S THE ISSUE?

Hospitals can provide services on either an inpatient or an outpatient basis. Medicare pays for inpatient services and outpatient services under separate and very different payment systems, which can produce substantially different payment amounts for similar patients receiving similar services. The cost-sharing implications for beneficiaries under the two systems can also vary significantly.

Until recently, the Centers for Medicare and Medicaid Services (CMS) had provided little guidance to hospitals on how to determine whether a particular patient should be treated on an inpatient or outpatient basis. In the absence of guidance—and in response to other CMS efforts to ensure proper payments, including creation of the Recovery Audit Program—hospitals' shifting of services between inpatient and outpatient settings has had significant implications for the beneficiaries receiving such services and for the Medicare program as a whole.

In 2013 CMS announced the so-called two-midnight rule to clarify when it expected a patient to be designated to inpatient status. Under this rule, only patients that the doctor expects will need to spend two nights in the hospital would be considered as hospital inpatients.

This brief describes the perceived need by CMS for the two-midnight rule, how it would work, and the implications for Medicare payment. It also reviews the heated response to the rule and its current status.

WHAT'S THE BACKGROUND?

Hospital inpatients are patients who are admitted to the hospital to receive services and are expected to occupy a hospital bed. Outpatients are people who are not admitted to the hospital but are registered as outpatients and receive services. Outpatient services can include planned procedures or care provided in the emergency department. In many cases, the same service could be provided on an inpatient or an outpatient basis, but Medicare pays hospitals very differently for inpatient versus outpatient care.

Payment for inpatient services. For a beneficiary admitted to the hospital as an inpatient, Medicare pays for the care under the inpatient prospective payment system (IPPS). The IPPS provides a single payment for all of the services provided to the beneficiary by the

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hospital during the inpatient stay, including nursing staff, room and board, use of operating or diagnostic facilities, and drugs. CMS assigns each inpatient admission (or case) to a Medicare severity diagnosis-related group (MS-DRG) based on the diagnosis codes reported by the hospital. The MS-DRG assignment determines how much the hospital will be paid for caring for that patient.

$36 billion

For fiscal year 2013, CMS estimated that the improper payment rate was 10.1 percent, which represented $36 billion.

The MS-DRG payment is based on the average cost of caring for Medicare patients with similar diagnoses and takes into consideration complicating conditions that might make it more difficult and expensive to treat a particular patient. Hospitals have discretion about what specific care is provided to each patient, and they generally do not receive additional payment for providing more services or for patients who stay in the hospital longer than usual, although hospitals can receive additional outlier payments to help pay for extremely costly cases. The MS-DRG payment includes all care provided by the hospital during the stay, regardless of the length-of-stay, and any services related to the hospital stay provided by the hospital during the seventy-two hours preceding admission, which can include items such as preoperative testing.

The MS-DRG payment reflects the average length of time that Medicare beneficiaries with similar diagnoses and severity of condition are in the hospital to receive care. An individual patient may end up staying in the hospital for a longer or shorter period than the national average depending on the clinical needs of that particular patient. If the patient has a shorter length-of-stay than the national average, then the MS-DRG payment the hospital receives is more likely to exceed the actual cost of caring for that particular patient than for patients whose hospital stay is closer to the average.

Payment for outpatient services. In contrast to the case-based payment for inpatient care, Medicare pays hospitals for outpatient care based on the services provided. Under the outpatient prospective payment system (OPPS), hospitals bill Medicare for the individual services rendered to a beneficiary during an outpatient visit. Under the OPPS, each outpatient service is assigned to a group of clinically similar services called an ambulatory payment classification (APC).

The APC payment is based on the average cost of providing services within the APC. Hospitals bill for all of the services administered to a beneficiary and can receive multiple APC payments for the care provided during a single visit. In general, the more services that an outpatient receives, the greater the OPPS payment the hospital receives.

There are some services for which Medicare will not pay hospitals if those services are provided on an outpatient basis. CMS identifies certain services, such as heart surgery or hip replacement, that it believes can be safely performed on a typical Medicare beneficiary on only an inpatient basis. These procedures are commonly referred to as "inpatient only" and are not payable under the OPPS.

Outpatient services include observation services, which may be used to determine whether a patient should be admitted as an inpatient or can be discharged from the hospital. Many patients who receive observation services are clinically similar to patients who have short inpatient stays, including having similar reasons for receiving hospital care and spending at least one night in the hospital. For example, chest pain is the number-one reason for patients who either have short inpatient stays or receive observation services as outpatients.

A patient who receives outpatient observation services at one hospital could be admitted for a short inpatient stay when treated at another hospital. However, Medicare pays considerably more for short inpatient stays than for observation services. For example, for patients with chest pain, Medicare paid $870 more for short inpatient stays in 2012 than it paid for observation stays.

Implications for beneficiaries. It can be difficult for a beneficiary to determine his or her status at the hospital based purely on the care provided. The facilities and equipment used to treat inpatients and outpatients are often the same. A patient may be at the hospital for several days but still be considered an outpatient for payment purposes, such as when a patient is kept at the hospital for observation. Despite the similarities in many aspects of care, because of the different payment methodologies for the different hospital settings, the amount the beneficiary pays can vary widely depending on whether he or she is an inpatient or an outpatient.

For inpatient care, a beneficiary pays a single deductible for the inpatient stay. For 2015 the inpatient deductible is $1,260. For outpatient care, the beneficiary pays a copayment that is typically 20 percent of the APC payment

amount but can be as much as 40 percent for some services. The OPPS copay amount is capped at the level of the inpatient deductible for each APC, which means that a beneficiary cannot pay more than $1,260 for an individual service.

However, beneficiaries still must pay a copayment for each separately payable OPPS service. As a result, the total copay for all services received on an outpatient basis may exceed the amount that the beneficiary would have paid if the same care was provided during an inpatient stay.

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In addition to the differences in cost sharing, hospital admission status can also affect a beneficiary's eligibility for other services. One of the requirements necessary for Medicare to cover a stay in a skilled nursing facility (SNF) is that the beneficiary must have had an inpatient hospital stay of at least three days prior to admission to the SNF.

Care received in a hospital emergency department or on outpatient observation status does not count toward this requirement, even if that care was provided for multiple days. The Office of Inspector General at the Department of Health and Human Services found that in 2012 more than 600,000 beneficiaries had hospital stays of three nights or longer that did not include three inpatient days and that more than 25,000 of those beneficiaries inappropriately received SNF benefits following those stays.

WHAT'S THE RULE?

Historically, hospitals and physicians have had considerable discretion over whether a patient is admitted to the hospital or is treated as an outpatient. CMS instructed physicians to generally admit patients expected to be in the hospital twenty-four hours or more but noted that a patient's admission would not be covered or not covered "solely on the basis of the length of time the patient actually spends in the hospital."

CMS emphasizes the role played by physicians in making this determination and its complexity: "The decision to admit a patient is a complex medical judgment which can be made only after the physician has considered a number of factors, including the patient's medical history and current medical needs, the types of facilities available to inpatients and to outpatients, the hospital's by-laws and admissions policies, and the relative appropriateness of treatment in each setting."

Medicare Recovery Audit Contractors (RACs) have the ability to review claims for inpatient stays and determine if the admission to the hospital was medically reasonable and necessary. If a RAC determines that the inpatient admission was not necessary and the care should have been provided on an outpatient basis, then the inpatient claim would be denied. In some cases, hospitals may be able to bill for the services provided during the denied inpatient stay under the OPPS.

Hospitals and doctors also have flexibility in determining how long a beneficiary should remain in observation status. CMS indicates that the decision to admit or discharge a patient can usually be made in less than twenty-four hours and would only be expected to exceed forty-eight hours in rare and exceptional circumstances.

Recent observations and trends discussed below led CMS to conclude hospitals still did not have sufficient clarity to make consistent admission determinations. The percentage of claims later determined to be improper admissions by RACs was twice as high for one-day stays (36 percent) compared to two- or three-day stays (13 percent).

In addition, the number of observation stays has increased considerably in recent years, and observation stays of longer than forty-eight hours have become more common. In 2011, 8 percent of beneficiaries received observation services for more than forty-eight hours, up from 3 percent in 2006.

In response to concerns over these trends, CMS asked for comments on multiple policy options to clarify when patients should be treated on an inpatient basis or to reduce payment incentives favoring one site of service over another. Those options included use of clinical decision-making tools, prior authorization for inpatient admission, a time-based criterion, and better aligning payments to resource use.

2013 guidance. Ultimately, CMS decided to create a time-based criterion based on the physician's expectation of the length-of-stay at the time of admission for RACs to follow in determining whether an inpatient stay was appropriate. This new rule, called the "two-midnight benchmark" by CMS and commonly referred to as the "two-midnight rule," specifi-

cally identifies the minimum stay length—a stay that spans two midnights—that CMS expects beneficiaries to be in the hospital during an inpatient stay.

Beneficiaries who are expected by their doctor to be in the hospital across two midnights would appropriately be admitted as inpatients, and their stays would be paid for under the IPPS. Beneficiaries who are not expected to remain in the hospital across two midnights should be treated as outpatients and their stays paid for under the OPPS. The two-midnight rule would not apply to services identified as inpatient-only, which are performed on an inpatient basis regardless of the length of the hospital stay.

Under what CMS calls the "two-midnight presumption," RACs, aiming to determine the appropriateness of inpatients' status, would not review inpatient claims that crossed two midnights following the inpatient admission order. Inpatient treatment during a stay that crosses two midnights is presumed to be medically necessary.

RACs may still review shorter inpatient stays to determine the appropriateness of inpatient admission but should take into consideration all of the time a beneficiary received care from the hospital, including time during which the beneficiary received emergency department or observation services as an outpatient.

This new standard is expected to have a significant effect on hospital payments, shifting some cases from inpatient status to outpatient and others from outpatient status to inpatient. The CMS actuary estimated that approximately 400,000 encounters would shift from payment under the OPPS to the IPPS, and approximately 360,000 encounters would shift from the IPPS to the OPPS. Because the rule would increase the number of cases that are paid for under the IPPS, CMS reduced all inpatient rates by 0.2 percent for fiscal year 2014 to keep overall IPPS payments at the same amount Medicare would have paid had the previous guidance remained in effect.

CMS originally planned to implement the two-midnight rule at the start of fiscal year 2014 on October 1, 2013. Shortly after finalizing the policy, CMS partially delayed enforcement of the two-midnight rule, and Congress then extended that delay through March 31, 2015. Under the delay, CMS will not conduct postpayment patient status reviews for claims with dates of admission from October 1, 2013, through March 31, 2015.

During this period, CMS will also undertake a "probe and educate" effort during which the Medicare claims processing contractors will review a sample of each hospital's inpatient claims to determine the appropriateness of the inpatient admission under the revised two-midnight rule. The contractors will then provide individual hospitals with education on the policy, as necessary, to correct improper payments.

Even though the two-midnight rule will not be used to make medical necessity determinations regarding the inpatient admission during this period, CMS instructed physicians to apply the standard in making admission decisions. CMS did not specify the documentation physicians will have to provide to demonstrate the expectation that a hospital stay spanning two midnights was reasonable. Instead, CMS anticipates that the information necessary to support this determination can be inferred from the patient's plan of care, treatment orders, and physician notes.

94%

Of the overpayments identified by Recovery Audit Contractors in fiscal year 2013, 94 percent were inpatient claims, many of them for improper short-stay admission.

WHAT'S THE DEBATE?

Hospitals are highly critical of the two-midnight rule. They describe it as arbitrary and note that the decision to admit a patient is complex, taking numerous factors into consideration that are not reflected in the time-based standard. They argue that the rule undermines the judgment of physicians and creates enormous administrative and financial hassles for hospitals.

Such a standard also penalizes hospitals for innovations that reduce length-of-stay. In addition to criticisms of the rule itself, hospitals fault CMS for failing to educate beneficiaries about the new benchmark and highlight the likelihood that beneficiaries will continue to be confused regarding their admission status.

Role of the RACs. Although Medicare applies automated screens to Medicare claims in order to prevent improper payment, most claims are paid without reviewing the patient's medical records. Nevertheless, because of the volume of Medicare claims, some improper payments are unavoidable. Such payments cost the Medicare program billions of dollars. For fiscal year 2013 CMS estimated that the improper payment rate was 10.1 percent, which represented $36 billion.

"The amount the beneficiary pays can vary widely depending on whether he or she is an inpatient or outpatient."

The RACs' mission is to identify and correct improper Medicare payments. Congress required that a permanent national RAC program be established by January 1, 2010, and CMS phased in implementation of the national RAC program in 2008 and 2009. Of the overpayments identified by RACs in fiscal year 2013, 94 percent were inpatient claims, many of them for improper short-stay admissions.

Unlike other Medicare contractors such as claims processing contractors, the RACs are paid on a contingency fee basis, receiving a portion of the improper claims they identify. The American Hospital Association (AHA) argues that RACs have chosen to focus on inpatient claims because of the financial incentives created by these contingency fees: Inpatient claims are generally high dollar compared to outpatient claims and, therefore, make the most lucrative targets for a contractor that receives a percentage of the claims it denies as improperly paid. If the denial of a claim by a RAC is overturned on appeal, the RAC has to return the contingency fee it received, but the RAC faces no other financial penalty for having identified the claim as improperly paid.

The Medicare Payment Advisory Commission (MedPAC) puts the RACs' actions and hospital response in context: "For several years the Commission has tracked the growth of observation cases and the shift of short-stay cases from the inpatient setting to the outpatient setting. We believe these trends reflect at least in part hospitals' responses to the ambiguity of Medicare requirements for inpatient admission, coupled with underlying payment inequities between clinically similar inpatient and outpatient cases. These factors influenced Medicare's Recovery Audit Contractors (RAC) and Medicare Administrative Contractors (MAC) to focus on the appropriateness of short inpatient stays. Their scrutiny led hospitals in turn to increase their use of observation status."

Keeping patients in observation and thus in outpatient status avoids the risk that an inpatient claim might be denied at a future date.

Appeals of RAC denials have overwhelmed the Office of Medicare Hearings and Appeals. Appeals from RAC claims increased 506 percent between 2012 and 2013, compared to growth of 77 percent in appeals of other types of claims. In an effort to reduce this backlog, in September 2014 CMS offered partial payment of 68 percent to any hospital willing to withdraw its pending appeals of claims denied based on patient status.

WHAT'S NEXT?

Under current law and absent additional action by Congress or CMS, Medicare contractors will begin applying the two-midnight rule in making payment determinations and reviewing claims as of April 1, 2015. Prior to that date, CMS has said it will evaluate the results of the "probe and educate" process and may issue additional guidance to ensure consistency in application of the two-midnight policy.

In the meantime, hospital associations are continuing to fight the rule. The AHA along with some state hospital associations have filed a lawsuit challenging the two-midnight rule in general and the 0.2 percent reduction in hospital payments in particular. The AHA also supported bills introduced during the last congressional session that would have required CMS to develop appropriate criteria for paying for short inpatient stays (HR 3698/S 2082) and that would reform the recovery audit process (S 1012).

MedPAC is already considering alternative policy options to address short inpatient stays and has emphasized the need to strike a balance between appropriate oversight of proper billing and administrative burden on Medicare providers. Options described at the November 2014 MedPAC meeting included creating new MS-DRGs for short-stay cases, targeting RAC reviews to those hospitals with the highest rate of short-stay admissions, and revising the RAC contracts to take into consideration the percentage of denials that are overturned on appeal. ■

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