AARP Public Policy Institute

In Brief

Rapid Growth in Medicare Hospital Observation Services: What's Going On?

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The use of Medicare hospital observation services grew by over 100 percent from 2001 to 2009. This *In Brief* and related *Research Report* analyze how and why this happened and the impact of these changes on Medicare beneficiaries.

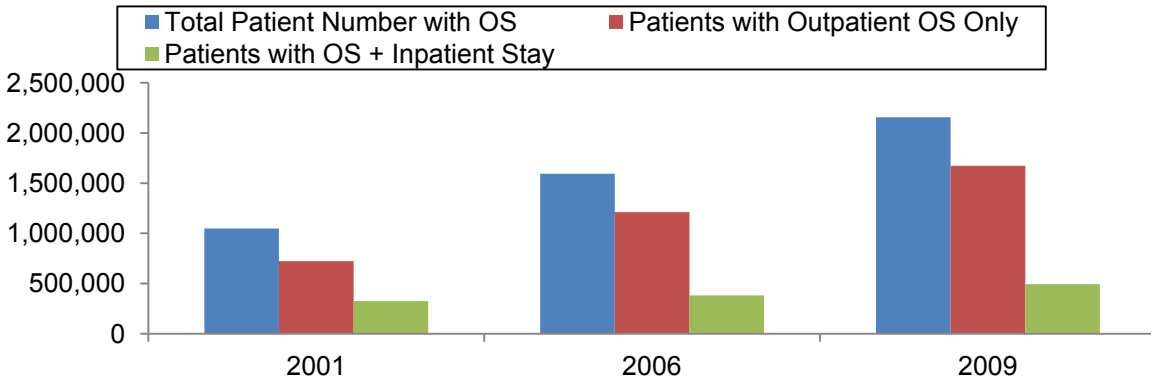
Hospital emergency rooms sometimes ask patients to stay for observation before being admitted or sent home. Known as hospital observation status, the use of this service has grown rapidly in recent years.

Observation status may be appropriate for patients with any type of insurance. However, Medicare makes distinctions between observation and inpatient status that are important to both Medicare beneficiaries and hospitals. Recently, complaints about high out-of-pocket costs incurred by some Medicare beneficiaries and concerns about quality of care have attracted the attention of the media, courts, and policy makers.

To help evaluate increased use of hospital observation services (OS), this study analyzed growth in the frequency and duration of OS by Medicare beneficiaries between 2001 and 2009—and found far greater increases than previous studies that covered shorter periods.

- Although only about 3.5 percent of Medicare beneficiaries used OS in 2009, Medicare claims for OS grew by more than 100 percent, with the greatest increase occurring in cases not leading to an inpatient admission.
- During the study period, both 1-day inpatient stays and inpatient stays of all

Figure 1
Medicare Beneficiaries with Observation Stay



Source: Social & Scientific Systems and AARP Public Policy Institute (2013). Authors' tabulations from Medicare outpatient, inpatient, and skilled nursing facility standard analytic files, 5 percent sample of beneficiaries, calendar years 2001, 2006, and 2009.

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lengths declined by about 16 percent, while the ratio of OS use to inpatient stays per 1,000 beneficiaries increased by 94 percent.

- The duration of OS visits has also increased dramatically. Observation service visits lasting 48 hours or longer were the least common, but had the greatest increase—almost 250 percent for outpatient OS only and more than 100 percent for OS with inpatient admission.

The magnitude of these changes raises concern that observation is becoming a substitute for inpatient admission and that some OS may be of questionable clinical benefit. While studies have shown that observation units may increase hospital efficiency and quality of care by allowing emergency departments to triage patients more quickly, these studies apply to relatively short observation stays of 12–24 hours in dedicated units. For longer stays, there are concerns about quality of care, as well as patient comfort for those who may be left waiting on a narrow stretcher in a noisy emergency room setting.

Use of observation status may also impose an unnecessary financial burden on Medicare beneficiaries. Unlike inpatient coverage, there is no cap on beneficiary cost sharing for OS visits. In some cases, Medicare cost sharing for outpatient services, including OS, may be greater than the inpatient deductible that beneficiaries would incur when admitted.

In addition, some beneficiaries may forgo or be denied coverage for necessary care in a skilled nursing facility (SNF) because time spent in OS does not count toward Medicare's 3-day prior inpatient stay requirement for Part A SNF coverage. As a result, some beneficiaries may incur out-of-pocket expenses for SNF care that can amount to thousands of dollars.

A number of factors appear to have contributed to the growth of OS, including: (1) Medicare payment policy changes; (2) increased scrutiny by both public and private payers of short inpatient stays; (3) efficiency advantages for hospitals of OS over inpatient admission; (4) increased reporting; and (5) incentives to reduce hospital admissions by increasing OS use to avoid readmission penalties. Since readmission penalties took effect in 2012, incentives to avoid them appear likely to drive up the use of OS even more.

Policy makers should consider options to address concerns raised by increased OS use, in particular, policies that may reduce the financial impact of OS on beneficiaries. Potential policy solutions include:

- Elimination of Medicare's 3-day prior stay requirement for SNF coverage. This would level the playing field with other postacute care services, such as home health agencies, inpatient rehabilitation facilities, and long-term care hospitals, which do not require prior inpatient admission for coverage. In addition, this change would alleviate much of the financial burden on beneficiaries who need SNF care.
- Until the 3-day prior stay rule is eliminated, credit time spent in OS toward the 3-day prior stay requirement, as proposed by bipartisan legislation pending in Congress, to reduce the impact of more frequent and longer OS use.
- Cap total beneficiary liability for OS and other outpatient services at the inpatient deductible amount.

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