Will New MOONs Shed Light on Midnight Madness?

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Health Benefits ABCs

Observation status is used by hospitals to assess whether a patient (usually in the emergency department) should receive continued outpatient treatment, be admitted as an inpatient, or be discharged. The financial difference between observation status and inpatient status to the Medicare beneficiary can be significant. Costs for observation status, which is outpatient, fall under Part B and inpatient costs fall under Part A. Observation status costs are even greater for patients without Part B. Additionally, there are implications after hospitalization. Observation status does not count toward the three inpatient days required for skilled nursing facility (SNF) coverage.

Patients are often unaware that they are classified under observation status vs. inpatient and are unaware of the implications. Efforts by the Centers for Medicare & Medicaid Services (CMS) to address these issues include the "Two-Midnight" rule and the implementation of the Medicare Outpatient Observation Notice (MOON), which is scheduled to go into effect on March 8.

Two-Midnight Rule

Implemented in FY2014 by CMS, the two-midnight rule addresses vulnerabilities in hospitals' use of inpatient status and observation status. The rule establishes that inpatient status is generally appropriate if physicians expect care to last at least two midnights. The goal of the rule was to decrease the use of short inpatient stays (less than two midnights), decrease the use of long outpatient stays (two midnights or longer), and promote the consistent use of inpatient and outpatient status in hospitals.

In July 2013, while CMS issued a notice of proposed rulemaking for the two-midnight rule, the Office of Inspector General (OIG) completed the report Hospitals' Use of Observation Stays and Short Inpatient Stays for Medicare Beneficiaries in response to concerns from CMS and members of Congress. OIG found that short inpatient stays were often for the same reasons as observation stays, such as for chest pain. Medicare paid an average of three times as much for short inpatient stays as observation stays and, generally, beneficiaries paid two times more. The report also found inconsistencies between hospitals in the use of inpatient and observation stays. For short inpatient stays, hospitals varied between the use of short inpatient stays for 10 percent of patients at some hospitals to more than 70 percent at other hospitals.

In December 2016, OIG followed up with the report Vulnerabilities Remain Under Medicare's 2-Midnight Hospital Policy, which examines the implementation of the two-midnight rule. CMS had expected short inpatient stays and long outpatient stays to decrease under the new rule. OIG found that short inpatient stays decreased by almost 10 percent in the year after the rule implementation while long outpatient stays decreased only by three percent. Despite this decrease, OIG found that there were still vulnerabilities in this area. Of the short inpatient

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stays, the report found that 39 percent, or $2.9 billion in payments, may be inappropriate under the rule's definition of what qualifies for an appropriate short inpatient stay. This was a decrease of almost one-third from the previous year.

Inappropriate classification for similar issues can have significant financial costs to Medicare and beneficiaries. Medicare paid an average of three times as much for a short inpatient stay compared to a short observation one and beneficiaries paid almost twice as much. Beneficiaries also incur financial costs when they have a hospital stay longer than three nights but not three inpatient nights. If such beneficiaries require SNF care after their hospital stay, it will not be covered by Medicare. The number of hospital stays that lasted at least three nights but did not include three inpatient nights increased by six percent.

Finally, OIG found that there is continuing variation among hospitals in how they classify patient stays. For example, hospitals varied between one and five percent for short inpatient stays – a smaller range than in 2013. Classification of long outpatient stays varied between two and 11 percent – a similar range to 2013.

OIG recommended:

- Routine analysis of hospital billing, targeting for review those with high or increasing numbers of potentially inappropriate stays under the rule
- Identifying and targeting for review potentially inappropriate short inpatient stays
- Analyzing the potential impacts of counting outpatient time toward the three-night requirement for SNF coverage
- Exploring methods for protecting beneficiaries in outpatient stays from paying more than they would have paid as inpatients

CMS agreed with recommendations and noted that quality improvement organizations (QIOs) were pursuing the first two recommendations. On the third recommendation, regarding counting outpatient time toward the three-night requirement for SNF coverage, CMS noted that it will analyze the potential impacts but currently lacks the statutory authority to make the change. CMS stated that it was reviewing its existing statutory authority regarding the fourth recommendation.

Resources for SMPs

- CMS: Are You a Hospital Inpatient or Outpatient? If You Have Medicare – Ask!
- CMS: Quick Facts About Payment for Outpatient Services for People with Medicare Part B
- Kaiser Health News: FAQ: Hospital Observation Care Can Be Costly for Medicare Patients
- Center for Medicare Advocacy: Observation Status Webpage

Medicare Outpatient Observation Notice

Although hospital classification of a patient as an inpatient or under observation has significant impacts on a patient both financially and in post-hospital care, many patients are not aware of their status. In 2015 Congress passed the Notice of Observation Treatment and Implication for Care Eligibility (NOTICE) Act. The NOTICE Act requires hospitals to provide oral and written notification to Medicare beneficiaries in outpatient

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observation status for more than 24 hours of their status, the reason for the determination, and its implications. The notification must be provided no later than 36 hours after beginning services or upon release, if sooner.

In accordance with the act, CMS developed the Medicare Outpatient Observation Notice (MOON), which is scheduled to go into effect on March 8. When receiving observation services, patients may be delivered the MOON before receiving more than 24 hours of care and no later than 36 hours after services are initiated or at discharge, if sooner. An oral explanation of the MOON must be given, ideally when the notice is delivered.

English and Spanish MOONs and an instruction manual are available through the CMS Beneficiary Notices Initiative. The components of the notification include:

- Patient's name and patient number
- Explanation of why the beneficiary is not an inpatient
- Explanation of how being in observation status affects coverage and post-hospital coverage at a SNF
- Potential medication costs
- Notice that coverage costs may differ in Medicare Advantage or if the patient is a Qualified Medicare Beneficiary (QMB)
- Room for additional information indicated in the instruction manual that is not required
- Patient or representative signature and date

SMPs should be aware of certain limitations in the MOON. The Center for Medicare Advocacy notes that the MOON will not be distributed to all outpatients; it is only required for outpatients in observation status. Additionally, the MOON is not considered to be an initial determination notice and is not appealable by beneficiaries. CMS estimates that more than 1 million MOONs will be delivered per year.

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