

# Hospital short-stay policy issues

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Statement of  
Mark E. Miller, Ph.D.

Executive Director  
Medicare Payment Advisory Commission

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Chairman Collins, Ranking Member McCaskill, distinguished Committee members. I am Mark Miller, executive director of the Medicare Payment Advisory Commission (MedPAC). The Commission appreciates the opportunity to discuss its recommendations on hospital short-stay policy issues.

MedPAC is a small congressional support agency that provides independent, nonpartisan policy and technical advice to the Congress on issues affecting the Medicare program. The Commission's work in all instances is guided by three principles: to assure beneficiaries have access to high quality, coordinated care; to protect taxpayer dollars; and to pay providers and plans in a way to accomplish these goals.

## **Introduction**

Since the implementation of the acute hospital inpatient prospective payment system (IPPS), payment incentives along with changes in technology and medical practice patterns have substantially shortened hospitals' average inpatient lengths of stay, allowing many inpatient services to successfully migrate to the outpatient setting. As a result, the issue of whether a patient requires inpatient care or could instead be treated safely as an outpatient has received increasing attention. Medicare's requirements for medically-necessary inpatient admissions give deference to clinicians and providers and thus are open to interpretation. Because hospitals generally receive higher payments for clinically similar patients served in the inpatient setting as compared with the outpatient setting, hospitals may have a financial incentive to admit patients.

Created by the Congress in 2003, Medicare Recovery Audit Contractors (RACs) have targeted short inpatient stays in their audit efforts, resulting in denials of these claims on the grounds that the patient's status as an inpatient was not appropriate. Hospitals have appealed many of the RACs' claims decisions, but have expressed concern about the cost of pursuing appeals, large backlogs in the appeals process, and limited options for rebilling denied inpatient claims as outpatient claims. In reaction to the heightened scrutiny of short inpatient stays, hospitals have increased their use of observation status. Greater use of outpatient observation status, in turn, has caused concern about beneficiaries' financial liability. While Medicare cost sharing for

outpatient observation services is typically less than the inpatient deductible, for a subset of beneficiaries, the greater use of outpatient observation status has increased the likelihood that they will not qualify for Medicare coverage of post-acute skilled nursing facility (SNF) services (which requires a preceding three-day hospital inpatient stay). Beneficiaries in observation status may also be liable for hospital charges related to self-administered prescription drugs received in the hospital and not covered by the Medicare outpatient prospective payment system (OPPS).

In an effort to clarify admission appropriateness and alleviate concerns about increased use of observation, its impact on beneficiary liability, and hospitals' concerns about RAC audits, CMS established the "two-midnight rule" in 2014. This rule provides Medicare auditors with guidance on how they should review inpatient admissions for patient status determinations. It stipulates that for stays spanning two or more midnights (including time spent in the inpatient and outpatient settings), RACs should presume these stays are appropriate for the inpatient setting and are exempt from audit (though RACs can audit these two-midnight stays if a hospital demonstrates aberrant patterns of use). By contrast, stays of less than two midnights remain subject to audit. Hospitals have noted concerns about the two-midnight rule because it conflicts with existing admission criteria deferential to physician judgment, increases the burden associated with physician documentation of inpatient admissions, and may result in revenue gains or losses caused by stays shifting between inpatient and outpatient status. The two-midnight rule has been controversial, and its enforcement has been delayed by both CMS and the Congress.

Over the last year, the Commission has undertaken extensive work to understand these issues, including analyses of data on trends in the frequency and length of inpatient and outpatient stays, Medicare's payments for these stays, and beneficiary's resulting financial liability. We have also had conversations with a broad range of stakeholder groups including hospitals, RACs, and beneficiary advocates to better understand how Medicare's policies are affecting each of these actors. Through the course of this work, the Commission developed a set of recommendations designed to provide greater protections for beneficiaries and reduce administrative burden for hospitals while ensuring that the program is not paying too much for hospital care. In the

testimony that follows, I will briefly provide some background information about the differences between inpatient and outpatient observation stays. Then I will describe the Commission’s discussion of options for reducing payment differences between similar inpatient and outpatient short hospital stays, for which the Commission did not make a recommendation. Then I will describe the five recommendations the Commission made to improve to the RAC program, further evaluate a short stay payment penalty, and address financial liability concerns for beneficiaries.

### **Background: Differences between inpatient admissions and outpatient observation stays and their use**

Medicare’s criteria for inpatient admissions and outpatient observation status are deferential to physician judgment. CMS’s longstanding guidance to physicians, hospitals, and Medicare auditors is that Medicare beneficiaries should be admitted to the inpatient setting if they are “expected to need hospital care for 24 hours or more.” ([Centers for Medicare & Medicaid Services 2014a](#)). If physicians are not sure whether patients require inpatient care, they can treat beneficiaries as outpatients under observation status. CMS’s Policy Manual defines coverable outpatient observation care as short-term treatment, furnished while a decision is being made about inpatient admission, and states that the decision to move patients out of observation “is usually made in less than 48 hours, often in less than 24 hours, and in exceptional cases in more than 48 hours” ([Centers for Medicare & Medicaid Services 2014b](#)).

Medicare pays for inpatient and outpatient hospital care under two different payment systems, the IPPS, paid through the Medicare Part A benefit, and the OPSS, paid through the Medicare Part B benefit. The IPPS is designed to be a system of averages, and generally pays a fixed amount per case (based on the average cost of all cases in the group) for all patients who fall within a specific Medicare severity–diagnosis related group (MS–DRG), regardless of the length of stay. This structure is designed to give hospitals an incentive to deliver care efficiently and control costs in a variety of ways, including shortening stay length. Observation services are paid under the OPSS, which—in contrast to the IPPS’s fixed amount per case—is akin to a fee-schedule system that prices individual services or procedures. (See MedPAC’s hospital inpatient

and hospital outpatient “Payment Basics” documents at [www.medpac.gov](http://www.medpac.gov) for more detail on how these payments systems work.)

Under a fixed IPPS MS–DRG payment, short inpatient stays are more profitable and longer stays are less profitable. In 2012, across all MS–DRGs, payments exceeded costs by 55 percent (1.55) for one-day inpatient stays (Table 1). By contrast, inpatient stays lasting eight or more days had the lowest mean payment-to-cost ratio (0.72), with costs exceeding payments by 28 percent.

**Table 1: Number of inpatient discharges and average payment to cost ratio by length of stay for IPPS hospitals, 2012**

Length of inpatient stays (days)	Number of discharges	Share of discharges	Payment to cost ratio
1	1,189,664	13%	1.55
2	1,527,903	16	1.30
3	1,785,826	19	1.10
4	1,247,603	13	1.03
5	891,372	9	0.96
6	655,007	7	0.89
7	496,658	5	0.84
8+	1,640,378	17	0.72

Note: Number of inpatient days reflects the number of midnights the inpatient stay crossed. One-day stays include stays that crossed zero or one midnight. Table includes fee-for-service IPPS hospitals and inpatient cases discharged as deceased, but excludes Maryland and critical access hospitals. Payment data include all claim-level payments made to the hospital, including outlier, disproportionate share, indirect medical education and other payments.

Source: Medicare claims data from the 2012 inpatient standard analytic file

Hospitals generally receive higher payments when beneficiaries with similar conditions are served in the inpatient setting, relative to outpatient observation status. In 2012, for six MS–DRGs that are among the most common to both inpatient and outpatient stays, Medicare paid roughly two to three times more for a one-day inpatient stay than for a comparable outpatient observation stay (Table 2). The payment differential is even more pronounced because most hospitals receive add-on payments, such as indirect medical education (IME) and disproportionate share hospital (DSH) payments, as a part of their inpatient payment but not their

outpatient payment. This differential gives hospitals a financial incentive to admit beneficiaries to inpatient status.

**Table 2: Comparison of total inpatient and outpatient observation payments for six similar conditions, 2012**

<b>MS-DRG</b>	<b>Condition</b>	<b>Average Medicare inpatient payment (1-day stay)</b>	<b>Average Medicare outpatient observation payment</b>
313	Chest pain	\$3,716	\$1,655
310	Cardiac arrhythmia & conductive disorders	3,677	1,420
392	Esophagitis, gastroenteritis & miscellaneous digestive disorders	4,953	1,526
312	Syncope & collapse	4,972	1,689
287	Circulatory disorders except AMI, with cardiac catheterization without MCC	7,064	3,998
641	Disorders of nutrition, metabolism, fluid/electrolytes without MCC	4,467	1,341

Note: MCC (major complication or comorbidity), MS-DRG (Medicare severity–diagnosis related groups), IME (indirect medical education), DSH (disproportionate share hospitals), APC (ambulatory payment classification). Payments reflect actual program payments (including IME and DSH add-ons) and beneficiary cost-sharing. Data exclude Maryland and critical access hospitals. The observation data are for beneficiaries whose observation care meets the criteria for composite APC payment for extended evaluation and management. Claims for outpatients are compared with inpatient claims for MS-DRGs that include patients with similar diagnoses and procedures.

Source: MedPAC analysis of Medicare standard analytic file of inpatient and outpatient hospital claims

In response to greater scrutiny of short inpatient stays, hospitals decreased their use of one-day inpatient stays and increased their use of outpatient observation stays, thus opting for the lower payment associated with observation rather than risk denial of the higher-paid inpatient services. Between 2006 and 2012, on average the number of one-day inpatient stays declined 3.8 percent annually per Medicare Part A beneficiary while stays of all other lengths declined 1.9 percent annually per beneficiary. However, after the RAC program was implemented nationally in 2010, one-day inpatient stays declined at a faster rate than before implementation of the RAC program, on average 6.6 percent annually from 2010 to 2012 versus 3.3 percent annually from 2006 to 2009.

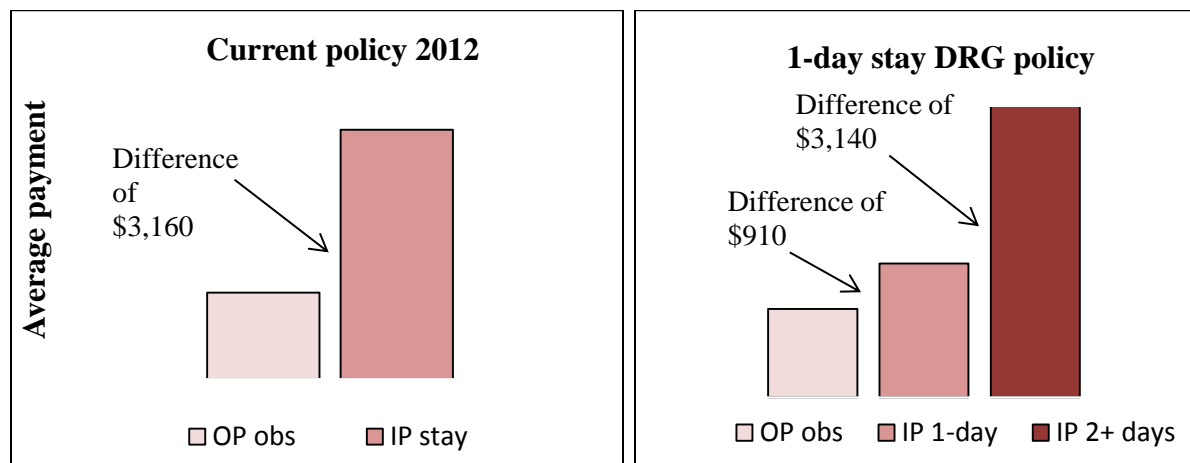
Meanwhile, hospitals have rapidly increased their use of outpatient observation status. In 2012, CMS processed claims for 1.7 million outpatient observation stays and another 700,000 inpatient stays preceded by observation. Between 2006 and 2012, on average the number of outpatient observation stays increased 14.7 percent annually per FFS beneficiary (the number of inpatient stays preceded by observation on average increased 16 percent annually per beneficiary from 2006 to 2012). From 2010 to 2012, the volume of outpatient observation stays increased 10.2 percent annually, suggesting that the increase in observation is only due in part to the implementation of the RAC program and the shifting of one-day inpatient stays to observation.

### **Payment policy approaches to hospital short stays**

The substantial payment difference between similar inpatient and outpatient stays creates a financial incentive for hospitals to admit patients to inpatient status. One way to reduce this financial incentive and ensure that admissions decisions are being made on a purely clinical basis is to reduce payment differences for similar stays in the inpatient and outpatient settings. The Commission explored two payment policy approaches to lessen payment differences between similar inpatient and outpatient stays. Under the first approach, Medicare could create—as part of its inpatient payment system—a new set of Medicare severity–diagnostic related groups specifically designed for inpatient one-day hospital stays. Under the second approach, Medicare could develop a site-neutral payment—that is, equalize payments across settings—for similar short inpatient and outpatient stays.

Under a one-day-stay DRG policy, Medicare would pay less for one-day inpatient stays and more for longer inpatient stays than it currently does. As shown in Figure 2, this would lessen the payment differential between a one-day inpatient stay and similar outpatient stay. However, one caution is that a one-day stay DRG policy would create a new payment differential between a one-day inpatient stay and longer inpatient stays. A one-day-stay DRG policy would reduce the financial incentive to admit a patient for one-day inpatient stays, but would create a financial incentive to extend an inpatient stay from one to two days.

**Figure 2: Effect of simulated 1-day stay DRG policy for selected medical DRGs**



Notes: Note: OP obs (outpatient observation), IP (inpatient). Chart includes results from a simulation of a 1-day stay DRG policy. Displayed in the chart is the weighted average payment rate for the 10 medical DRGs with the most 1-day inpatient stays that are also common to outpatient observation. Similar outpatient observation claims are identified by using a crosswalk process to link outpatient claims to MS-DRGs. Average payment includes add-on payments such as IME and DSH.

Source: MedPAC analysis of Medicare claims and cost report data.

Alternatively, a site-neutral approach would pay comparable rates for similar inpatient and outpatient stays. The effect of a site-neutral approach may be different for medical and surgical hospital stays. For medical stays, it would be difficult to eliminate the inpatient and outpatient payment differential without creating new vulnerabilities, because identifying similar stays would likely necessitate establishing length-of-stay criteria. Because surgery is a more clearly defined service, it might be possible to develop site-neutral payment for similar inpatient and outpatient surgeries without creating payment differentials based on length of stay.

Payment policy changes such as one-day-stay DRGs and site-neutral payment for medical stays would involve trade-offs. On the one hand, revising the payment system may reduce the need to audit one-day inpatient stays for admission appropriateness because the financial consequences related to the admission decision would be reduced. On the other hand, a revised payment system would create new payment cliffs and associated vulnerabilities, and therefore may simply shift the focus of audit oversight. Moving away from the fixed inpatient DRG payments to one-day-stay DRGs or site-neutral payment for medical stays also raises concerns about creating financial



incentives for longer stays, which is counter to the original structure and intent of the DRG system. Given the competing arguments, the Commission has not made any recommendations to pursue payment changes at this time, but has noted interest in continuing to explore these and other potential short-stay payment policy concepts in the future.

## **RAC program recommendation**

The Commission has identified several concerns with RAC program audits of short stays and has recommended to the Secretary a package of policies to improve the RAC program. The Tax Relief and Health Care Act of 2006 mandated the nationwide implementation of the Medicare Recovery Audit Contractor (RAC) program in 2010. RACs are tasked with identifying and correcting overpayments and underpayments made to providers on behalf of the Medicare program, and are paid on a contingency fee basis. The RAC program identified \$3.75 billion in improper payments in FY 2013 (Centers for Medicare & Medicaid Services 2014c). The Commission believes that oversight of the Medicare program is critical. However, the Commission is also concerned about the administrative burden the RAC program places on hospitals, the accountability of RACs with regard to the accuracy of their audits, and the lack of coordination between the timing of RAC claim denials and the Medicare rebilling policy. The Commission has recommended the Secretary make changes to the RAC program to alleviate these concerns, and has also recommended that the two-midnight rule be withdrawn. The Commission considers the four components of this recommendation to be a unified package.

### **Recommendation 1: The Secretary should**

- **Direct Recovery Audit Contractors (RACs) to focus reviews of short inpatient stays on hospitals with the highest rates of this type of stay,**
- **Modify each RAC's contingency fees to be based, in part, on its claim denial overturn rate,**
- **Ensure that the RAC look-back period is shorter than the Medicare rebilling period for short inpatient stays, and**
- **Withdraw the "two-midnight" rule.**

The Commission recommended targeting RAC audits to focus on hospitals with excessive use of short inpatient stays to reduce administrative burden for compliant hospitals. Hospitals report that the RAC program has increased their Medicare-related administrative burden, and that this has occurred broadly across the industry rather than being focused on specific hospitals with aberrant patterns of use. According to the American Hospital Association, hospitals have expanded their administrative staff and staff hours to handle RACs' requests for medical records and to track claims through the appeals process, adding to hospitals' overall costs ([American Hospital Association 2014](#)). Current rules limit the number of overall claims a RAC can audit from a given hospital, and because short inpatient claims are more attractive financial targets, RACs have focused on these claims. Short inpatient claims are associated with potentially large contingency fees and the ambiguity of the admission criteria make denying these claims easier to justify. CMS estimates that in 2013, over 94 percent of the overpayments recovered by RACs were for inpatient hospital claims ([Centers for Medicare & Medicaid Services 2014c](#)). Broadly pursuing short stays may provide insufficient attention to hospitals with disproportionately high numbers of short stays and impose unnecessary burden on hospitals using short stays appropriately. Therefore, the Commission's recommendation to target RAC auditing efforts will reduce administrative burden for many hospitals, and increase administrative burden on the subset of hospitals that account for a disproportionate percentage of short stays.

The Commission recommended adjusting RACs' contingency fees based on their performance to make RACs more accountable for their decisions to deny hospitals' claims for short stays. The contingency fee structure of the RAC program provides an incentive for the RACs to identify as many inappropriate claims and recover as much Medicare payment as possible. RACs lose payment if their denials are overturned, but face no further penalties when denials are overturned and are not required to pay interest on the returned fee. While CMS reports that in 2013 the audit accuracy rates of RACs varied from 92.8 percent to 99.1 percent, they also report that providers appealed about 48 percent of inpatient claims that were denied ([Centers for Medicare & Medicaid Services 2014c](#)). The number of appeals has dramatically increased in recent years, rising over 500 percent from 2011 to 2013 and exceeding a total of 800,000 appeals in the Administrative Law Judge (ALJ)-level backlog by July 2014. ([Office of Medicare Hearings and](#)

[Appeals 2015](#)). Therefore, the Commission believes basing RAC contingency fees in part on their denial overturn rate, or the measure the Secretary deems most appropriate, could make RACs more accountable for their denial decisions and could potentially lead to a reduction in the number of RAC-denied claims appealed by hospitals.

The Commission recommended realigning the RAC look-back period and the Medicare rebilling window, because the timing of the RAC program claim denial process and the timing of the Medicare rebilling policy are not coordinated. Currently, RACs are permitted to review claims that are up to three years old (from the date of service on the claim), while Medicare's rebilling policy allows hospitals only one year after a denied claim's date of service to resubmit a claim for the outpatient services included on the original claim ([Centers for Medicare & Medicaid Services 2013a](#)). Thus the hospital may still receive some payment for the services it provided. However, hospitals have argued that the misalignment of the RACs' claim review period and the Medicare hospital rebilling window often prevents them from being able to rebill denied claims. For example, if a RAC denies a claim that is two years old, hospitals cannot rebill the claim to receive payment for the outpatient services it provided. CMS estimated that in 2011, 75 percent of inpatient admissions denied by RACs are not eligible to be rebilled as outpatient services because they fell outside the one-year rebilling period ([Centers for Medicare & Medicaid Services 2013b](#)). The Commission believes the Medicare program should increase hospitals' ability to rebill RAC-denied claims, because 1) a hospital service was provided to a Medicare beneficiary and the hospital should receive reimbursement for it, and 2) it may reduce the number of appeals. However, Medicare should maintain a time limit on rebilling from the date the service was provided because hospitals should have the incentive to submit claims accurately. The Commission believes hospitals should be permitted to appeal RAC claim denials, but at a certain point, hospitals should need to choose between continuing an appeal and rebilling for that claim. To balance these concerns, the RAC look-back period should be shorter than the rebilling window, and long enough that hospitals cannot fully exhaust the appeals process for every RAC-denied claim.

The Commission recommended the withdrawal of the two-midnight rule, because while the rule addresses some of its stated goals, it also eliminates RAC oversight for a large group of inpatient claims and undermines the principles of the prospective payment system. On the one hand, the two-midnight rule will likely reduce long observation stays and relieve administrative burden by exempting all stays longer than two midnights from RAC oversight. On the other, it largely eliminates RAC oversight of claim status reviews for the 87 percent of inpatient stays that are two days or longer and provides hospitals with the incentive to lengthen stays to avoid RAC scrutiny. Withdrawing the two-midnight rule, in conjunction with implementing the Commission's other audit-related recommendations, would be a better way to address the concerns associated with hospital short stays.

### **Hospital payment penalty recommendation**

Concurrent with the RAC-related policies described above, the Commission has discussed the concept of a payment penalty on hospitals with excessive numbers of short inpatient stays to improve the efficiency of program oversight. The Commission believes that this concept warrants further evaluation and made the following recommendation.

#### **Recommendation 2: The Secretary should evaluate a penalty on hospitals with excess rates of short inpatient stays to substitute, in whole or in part, for Recovery Audit Contractor review of short inpatient stays.**

The Commission recommended the Secretary study a formula-based penalty on excess short inpatient stays that could serve to substitute, in whole or in part, for RAC reviews of short inpatient stays, because the RAC program adds to the administrative burden of individual hospitals and increases the cost of the appeals process for the federal government. The Commission concluded that the provision of one-day inpatient stays was relatively concentrated—10 percent of hospitals accounted for 26 percent of the payments for one-day inpatient stays in 2012—and hospitals with high use of these stays could be identified. This concept should be evaluated further by CMS, due to the various design issues that may alter the penalty's effectiveness.

## **Beneficiary protection recommendations**

Overall, beneficiary financial liability is lower for clinically similar cases when care is provided in outpatient observation status than in inpatient status. However, beneficiaries served in observation can be exposed to greater liability if they are discharged to a SNF or their stay involves self-administered drugs. Beneficiaries in inpatient status are responsible for paying the Part A deductible, and in 2012 the median inpatient beneficiary liability was \$1,156 (equal to the inpatient deductible). Beneficiaries in outpatient observation status, like other outpatients, are responsible for Part B coinsurance (approximately 20 percent of allowed charges), and in 2012 the median liability for a one-day observation stay was lower, at \$282. Beneficiaries' financial liabilities can increase if they are subsequently discharged to a SNF without having met the SNF three-day inpatient stay requirement for Medicare coverage or if they receive medications defined as self-administered drugs (SADs) while in the hospital. Therefore, the Commission has recommended revisions to the SNF three-day prior hospitalization policy, beneficiary notification of their observation status, and packaging payment for self-administered drugs delivered in the outpatient observation setting.

### **Revise the SNF three-day prior hospitalization policy**

By statute, to qualify for Medicare SNF coverage a beneficiary must have been an inpatient of a hospital for at least three consecutive calendar inpatient days preceding the SNF admission. The calculation of three inpatient days does not include time spent in outpatient status (including observation). The rationale behind this policy is to ensure that Medicare SNF coverage is a post-acute care benefit, not a long-term care benefit. Beneficiaries served in observation status and subsequently discharged to a SNF without qualifying for Medicare SNF coverage are liable for the entire cost of their SNF stay. We estimate that about 12,000 of these cases occurred in 2012, and research from the Health and Human Services' OIG found these beneficiaries had an average liability of approximately \$10,500 ([Office of Inspector General 2013](#)).

**Recommendation 3: The Congress should revise the skilled nursing facility three-inpatient-day hospital eligibility requirement to allow for up to two outpatient observation days to count toward meeting the criterion.**

The Commission's recommendation would permit time spent in outpatient observation status to count toward the three-day prior hospitalization threshold, but would require that at least one of the three days be an inpatient day. This recommendation seeks to balance reducing beneficiary liability for cases that currently do not qualify for SNF coverage with protecting the taxpayer and maintaining the SNF benefit as a post-acute care benefit. By allowing time spent in observation to count toward the three-day-stay requirement, while still requiring at least one of the three days to be an inpatient day, more beneficiaries would qualify for SNF coverage, reducing their liability for SNF care. At the same time, it would limit the potential for a large increase in SNF use that might result from allowing observation to count for the entire three days. We estimate that there were approximately 52,000 stays in 2012 where the beneficiary was in the hospital for three days, including at least one inpatient day. Not including the behavioral response we would anticipate from this policy change, we estimate there could be, at a minimum, 10,000 additional Medicare covered SNF stays per year if beneficiaries are discharged from hospital to SNF at historical rates.

### **Beneficiary notification about observation status**

Beneficiaries served in outpatient observation status often do not realize that they have not been officially admitted to the hospital as an inpatient. Further, beneficiaries are often unclear about the differences between inpatient status and outpatient observation and how either may affect their financial liability for SNF care or other services they receive while they are in the hospital. The Medicare program does not require hospitals to notify beneficiaries of their outpatient observation status or inform beneficiaries that time spent in observation status does not count toward the SNF three-day threshold. Several states have passed laws requiring hospitals to inform patients about their status in observation.

**Recommendation 4: The Congress should require acute-care hospitals to notify beneficiaries placed in outpatient observation status that their observation status may affect their financial liability for skilled nursing facility care. The notice should be provided to patients in observation status for more than 24 hours and who are expected to need skilled nursing services. The notice should be timely, allowing patients to consult with their physician and other healthcare professionals before discharge planning is complete.**

The Commission's recommendation serves to mitigate confusion, as cited by Medicare beneficiaries and beneficiary advocates, regarding the difference between inpatient and outpatient status and the cost-sharing and post-acute care coverage implications associated with each type of care. The Commission maintains that this notification should be provided at a time when a patient can best plan for post-hospital care.

### **Liability for self-administered drugs**

Beneficiaries who receive care in a hospital outpatient department may face an additional liability for drugs that are considered self-administerable, such as daily oral medications taken by the beneficiary at home. These drugs are covered by Medicare Part A for hospital inpatients, but are generally not covered by Medicare Part B for hospital outpatients. When a beneficiary is provided a SAD in the outpatient setting, such as observation status, the hospital bills the beneficiary for the drug at full charges. The average amount beneficiaries in outpatient observation status were charged for SADs in 2012 was \$209 per claim, while the estimated average cost the hospital reported for these SADs was \$43 per claim.

### **Recommendation 5: The Congress should package payment for self-administered drugs during outpatient observation on a budget-neutral basis within the hospital outpatient prospective payment system.**

The Commission recommended packaging self-administered drugs during outpatient observation to protect beneficiaries from paying full hospital charges for self-administered drugs, which are typically substantially above the cost of the drug. This recommendation would reduce beneficiary liability substantially because beneficiaries in observation would no longer be liable for non-covered SADs at full charges. Payment for SADs should be packaged into the observation stay payment, rather than paid separately, to avoid creating the financial incentive to overprovide these drugs.

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