Observation Status—A Name at What Cost?

There has been considerable attention in the lay media regarding the "unfairness" and the financial burden placed on Medicare beneficiaries admitted by hospitals under an observation status. As a result, legal and public challenges[1,2] to the Centers for Medicare and Medicaid's (CMS) observation rule have been filed to reduce patients' financial liability when driven solely by the "status" assigned to their hospitalization. Partly because of this outpouring of patient-driven criticism, the CMS amended the previous observation admission rules. On October 1, 2013, the CMS implemented the "Two Midnight Rule"[3] to reduce the growing number of observation hospitalizations extending beyond 48 hours (between 2009 and 2011, the number of patients in observation beyond 72 hours increased by 88%)[4] and to lessen Medicare patients' financial burden due to hospitals' uncertainty surrounding level of care designations. For hospitals treating a majority of Medicaid patients, it would appear harder to quantify the financial impact to enrollees or to the health care system of the current observation system. Medicaid enrollees (especially children) are frequently not required to pay deductibles or copayments for emergency or hospital-based services. The designation of an enrollee's stay as observation or inpatient would appear to be cost-neutral to patients and to the health care system, but that is an incorrect assumption. Large quantifiable administrative and compliance costs exist from the current federal and state observation regulations that impact our health care system. The risk of not assigning the correct admission status to a patient's hospitalization is significant and has resulted in legal and financial penalties for hospitals and doctors. In the case of Medicaid and managed Medicaid patients, regulatory and compliance costs are shifted to hospital systems and payers and represent an additional cost of business. For patients with commercial insurance, designating hospitalizations as observation results in cost shifting to families who often bear a greater financial responsibility for patients admitted under an observation status.

A CASE IN POINT

Children's Healthcare of Atlanta (Children's) is the largest tertiary pediatric hospital in Georgia. Children's utilization review (UR) department reviews every order for hospitalization against the criteria used by payers and if needed contacts the treating physician to request a "status change." When this occurs, patients' medical care and treatment plan are unaffected; only their administrative designation changes. To calculate the cost to "get right" the admission status for each patient, we mapped the activities of Children's UR department and estimated the costs associated with assigning and changing the status designation of patients hospitalized at Children's. We then used the total 2012 hospitalizations as the denominator to arrive at an estimated UR administrative cost per hospitalization

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ABBREVIATIONS
CMS: Centers for Medicare and Medicaid
UR: utilization review

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to comply with federal and state guidelines around level of care designation.

In 2012, the estimated administrative costs attributable to assigning, modifying, and appealing the designation of hospitalized patients amounted to $65.10 per admission (Table 1 and Supplemental Appendix) or $2.3 million annually. It is not apparent how these activities improved patients' health, and we would argue that such benefit was nonexistent because their medical care was unaffected by them. Extrapolating Children's cost per admission (and acknowledging the limitations to other institutions and other populations) to comply with the current observation status designation guidelines to all US hospitals would suggest a 5-year cost of $12.9 billion to the health care system (assuming 39.5 million annual hospitalizations[5]). Such extrapolation is directional and must be considered in such context because other hospitals' UM review process could differ in a number of ways from Children's. Although UR nurses at Children's do not share job responsibilities as case managers, many do so at other hospitals. Therefore, a greater portion of the estimated staff costs around status determination could be considered more variable for our hospital than they may be for other institutions. However, it would be reasonable to assume that many hospitals could at a minimum, reallocate a meaningful share of their UR staff toward providing higher value added patient services.

OBSERVATION VERSUS INPATIENT HOSPITALIZATIONS: HOW DIFFERENT ARE THEY?

Pediatric admissions are frequently shorter in length than adult admissions for similar diagnoses[6] in part because of the absence of other comorbidities. Observation stays are paid by many payers at levels typically lower than short inpatient stays for similar diagnoses ($870–$2801 difference in average Medicare same case payments).[7] This payment structure would be economically rational if care under observation status were different than that provided under an inpatient designation. However, resource utilization under both settings appears to be comparable for pediatric patients. Fieldston et al[8] performed a retrospective review of 67 230 observation and 134 476 inpatient stays ≤2 days in length from a 2010 cohort of 33 children's hospitals in the Pediatric Health Information System. After adjusting for patient severity, the costs of resources used in caring for children under an observation status had significant overlap with the costs for children with similar diagnoses admitted under an inpatient status. These results suggest that children with lengths of stay ≤2 days (whether classified as

TABLE 1 2012 Estimated Administrative Costs Associated With Determination of Inpatient Versus Observation Admission Status at Children's Healthcare of Atlanta

Budget Category	Allocation Methodology	Annual Expenses Allocated
UR nursing staff[a]	Workflow analysis and level of care reviews as % total reviews	$ 1 533 748 (67.1%)
InterQual and Milliman review criteria[b] and external physician advisory company[c]	Level of care reviews as % total reviews	$ 312 944 (13.7%)
Revenue cycle staff[d]	Workflow analysis	$165 196 (7.2%)
Appeals staff[e]	Level of care appeals as % total appeals	$106 500 (4.7%)
Information technology support[f]	Allocation to support review criteria software	$67 000 (2.9%)
Managed care staff[g]	Workflow analysis	$60 500 (2.6%)
Equipment and supplies UR department[h]	Level of care reviews as % total reviews	$40 735 (1.8%)
Total annual cost		$2 286 624
2012 admissions[i]		35 140
Cost/admitted patient		$65.10

[a] Includes UR nurses responsible for level-of-care reviews and supervisors.
[b] Licensing fees paid for usage of externally developed review criteria used to determine inpatient or observation status. A smaller number of reviews are performed to determine changes in accommodation codes (ie, changes in billing from intensive care to medical/surgical beds) that were subtracted from the total number of reviews to determine the total licensing fees attributable to inpatient and observation level-of-care assignments.
[c] Executive Health Resources is a physician advisory company that performs secondary reviews for level of care determinations not addressed by InterQual or Milliman. This company is also contracted to perform secondary physician support when insurers deny payment for level of care determined by the hospital UR staff.
[d] Revenue cycle staff includes medical director and administrative director for UR Department in addition to vice president and director for revenue cycle.
[e] Staff responsible for appeal of cases when hospital disagrees with level of care determination assigned by payer.
[f] Includes staff allocated for support and annual upgrade of InterQual and Milliman review software and integration with the existing hospital electronic medical record system (EPIC).
[g] Managed care staff includes vice president and director for managed care and support provided by legal department.
[h] Includes computer equipment and office supplies.
[i] Includes all patients admitted under both inpatient and observation status to all three of Children's hospitals: Scottish Rite, Egleston, and Hughes Spalding.

observation or inpatient) have similar clinical needs. The Inspector General of the US Department for Health and Human Services recently reached a similar conclusion: that patients admitted as observation or inpatients are clinically indistinguishable.[6] Physicians are generally unaware of the specific criteria used to classify patients as observation or inpatient (InterQual's 2013 review criteria is 568 pages in length), and these criteria do not play a role in their clinical decision-making. Is it therefore rational that reimbursement for a service be driven by the administrative status documented on a patient's record when the resource utilization is comparable?

WHERE TO FROM HERE?

Observation was originally intended for a well-defined set of clinically appropriate conditions. Today "well-defined" means that more than 1141 observation codes are billed under observation care. Observation was also to be used to determine within 24 hours whether patients could return home or required continued management in the hospital. Today the mean length of observation stays is 33 hours, and 17% of observation stays span beyond 48 hours.[9]

There is not one simple fix to the current health care reimbursement system given the conflicting interests of all stakeholders. Yet we as physicians must lead and help change the adversarial zero-sum game in which payers, doctors, and hospitals have engaged for too long. The time may be right to consider basing reimbursements on the resources used to treat specific conditions, with safeguards to prevent the perverse incentives that have plagued fee-for-service models. A resource-based payment model could also be balanced by case-mix adjusted resource utilization benchmarks of comparable hospitals and include length-of-stay measures that allow for safe patient discharges and successful transfer of care to outpatient providers. An additional benefit of a resource-based payment system would be to encourage efficient care and innovation in health care practices. The proposed Two-Midnight Rule is less vague but fails to sufficiently consider the specifics of a patient's medical condition and baseline health status. It focuses on physicians' time "guesstimate" and on a time-based system that would appear to reward inefficient care by creating the incentive to prolong a hospitalization to meet the 2-midnight Cinderella mark. It risks classifying differently two patients hospitalized with the same condition solely based on their time of admission to the hospital without adequately reflecting their illness severity and comorbidities.

Is there any way to reimburse rationally, ethically, honestly, and proportionately in a robustly capitalist health care system? Perhaps not, but in this era of constrained health resources, we must be responsible stewards and eliminate care and activities that do not improve the health of our patients. What we call a hospitalization is irrelevant; it is the care we deliver that matters. Spending resources on low value-added activities for which we debate endlessly the designation assigned to a hospitalization when it does not affect our patients' well-being is not a wise investment in our patients' health.

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