One of the inevitable consequences of aging is a reduction in reserve capacity. When illness strikes, older adults take longer to recover than younger adults. Couple that with short hospital lengths of stay, and it is easy to understand why many older adults need skilled nursing care following hospitalization to continue their rehabilitation and recuperation.

Currently, Medicare Part A provides coverage for post-acute skilled nursing care to beneficiaries who are hospitalized as an inpatient for 3 or more consecutive days. The Medicare Payment Advisory Commission reported a 70% increase in observation stays exceeding 48 hours between 2006 and 2008 (Gaumer & Zabinski, 2010). This editorial was written to inform frontline practicing nurses of the facts about observation status and to suggest action that, we hope, will end this practice that harms people who rely on Medicare.

Patients are often admitted under observation status when their diagnosis is uncertain or the severity of the condition is unknown. This is frequently the case for older adults who experience a fall or have an abrupt change in mental status, for example. Geriatric nurses recognize that episodes of incontinence, falls, or delirium can herald the onset of serious medical and/or mental health problems, particularly in frail older adults who do not mount the same response to acute conditions as younger individuals. These are patients who often need follow-up services for rehabilitation and prevention of negative sequelae.

Once a person is identified as an outpatient in observation status (reimbursed under Medicare Part B), he or she does not qualify for skilled nursing care post-discharge no matter how long he or she is hospitalized as an outpatient. One patient going to a skilled nursing facility (SNF) for rehabilitation following a 6-day hospital stay labeled observation was required to pay $17,388 for his 47-day stay in the SNF (Bagnall v. Sebelius, 2011). Another patient, unable to afford the SNF charge, shared with one of the authors that he went to an assisted living facility that could not meet his needs for rehabilitation. Thousands of patients and their families are faced with this dilemma each day in hospitals across the country.

FACT #1
Observation status is not addressed in the Medicare statute or regulations but is defined in the Centers for Medicare & Medicaid Services (CMS, 2011) manual as short-term services (24 to 48 hours) that are delivered while a decision is being made about the most appropriate level of care for that patient. Increasingly, more patients’ entire stay is designated as observation. According to anecdotal reports shared with one of the authors, patients have occupied hospital beds and received nursing and medical care for up to 13 days under this designation. When these individuals require post-acute care, that care is not covered by Medicare Part A because time spent in observation status does not count toward the 3-day qualifying inpatient stay (CMS, 2008).
FACT #2

Patients who are initially hospitalized under inpatient status can have their status retroactively changed from inpatient to observation status if the hospital determines that the inpatient status may be questioned by CMS, thus risking the hospital’s reimbursement under Medicare Part A. Astonishingly, it is not unusual for patients and their families to be completely unaware of this change in their status until they are leaving the hospital or are denied reimbursement for their stay at a SNF.

FACT #3

What seems to be driving this practice is that hospitals are relying on for-profit, proprietary systems of patient classification to protect their Medicare reimbursement and avoid allegations of fraud and abuse. These diagnosis-based systems, which are used by reviewers who determine whether hospitals correctly classify patients as inpatients, use criteria that do not consider patients’ comorbidities in the mix of needed services.

To date, a number of groups concerned about the quality of care older adults receive have advocated for change. On August 24, 2010, CMS hosted a Listening Session on observation status for Medicare beneficiaries, their families, and providers. More than 2,100 participants joined the call—the largest CMS call to date (T.S. Edelman, personal communication, August 24, 2010). With few exceptions, callers urged that all time spent in the hospital be counted toward the 3-day qualifying time for skilled nursing care.

The Center for Medicare Advocacy (the Center; http://www.medicareadvocacy.org), a nonprofit, nonpartisan law office that works to obtain and enforce rights of Medicare beneficiaries, people with chronic conditions, and those in need of long-term care, has monitored this situation for some time. On November 3, 2011, the Center and co-counsel National Senior Citizens Law Center filed a lawsuit seeking to end the use of hospital observation status in the Medicare program (Bagnall v. Sebelius, 2011). The suit was filed on behalf of seven individual plaintiffs from three states who seek to represent a nationwide class of people harmed by the illegal observation status policy and practice. Bagnall v. Sebelius contends that the use of observation status violates the Medicare Act, the Freedom of Information Act, the Administrative Procedure Act, and the Due Process Clause of the Fifth Amendment to the Constitution. For more information and to hear a recording of the news conference regarding observation status and the case, access http://www.medicareadvocacy.org/medicare-info/observation-status.

Bipartisan legislation introduced in Congress would count observation status days toward meeting the 3-day qualifying hospital stay needed for skilled nursing care.

Legislation introduced in Congress would count observation status days toward meeting the 3-day qualifying hospital stay needed for skilled nursing care.

REFERENCES


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