ing measures. In addition, payers could advance and facilitate less onerous measures through claims analysis. Although claims and surveys are the basis of some quality measures, much performance is assessed through Web reporting: payers provide practices with measure-specific lists of eligible patients, and physician groups or institutions review records and report performance for each patient according to definitions of the target care. This is the approach used by the Centers for Medicare and Medicaid Service (CMS) for accountable care organizations (ACOs) and by the PQRS. Because organizations such as ACOs are responsible for defined populations, payers could monitor quality through claims analysis. Prescribing quality may be particularly amenable to this approach. Performance measures based on prescriptions claims could include, for example, the population-level ratio of second-line treatments to first-line options or the ratio of brand-names to generics in drug classes in which ample generics exist. Monitoring could permit efficient determination of clinicians' response to new drug warnings, and claims analysis could quantify long-term adherence to safe, effective drugs.

Accountable prescribing measures could also incorporate cost. Though some payers may hold providers accountable for prescription spending, CMS programs do not yet do so. CMS shared-savings calculations are currently based on inpatient and outpatient expenditures only, but that doesn't preclude the inclusion of prescription spending in quality measures. Although prescribing decisions should be driven primarily by safety and effectiveness, cost can be an appropriate tiebreaker among drugs that are equally safe and effective. Considering costs may also discourage use of newly approved brand-name drugs that lack safety or efficacy advantages — drugs with potential shortcomings that have had less time to emerge.

As insurance coverage expands, we must ensure that greater access to prescription drugs confers better health, not harm. The need to advance performance measures as health care reform proceeds is well recognized.[3] Ideally, we should assess outcomes valued by patients, but for reasons of feasibility, many measures focus instead on surrogate end points. To improve health, such end points must be based on strong evidence, and how you get there matters. Refining measures to incorporate best evidence and the notion of accountable prescribing could promote use of the safest and most effective drugs, better align measures with our professional responsibilities, and maximize the chance that meeting goal-driven performance measures will translate into improved population health.

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Observation Care — High-Value Care or a Cost-Shifting Loophole?

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A 2012 *New York Times* article told the story of Miriam Nyman, an 83-year-old Rhode Island woman who was hospitalized after a fall in 2009.[1] Mrs. Nyman broke her neck and spent 4 nights in the hospital, so she was shocked to learn that the entire hospitalization was classified as an outpatient visit and billed as an observation stay. That meant that her subsequent stay in a skilled nursing facility was not covered by Medicare, and she was left with more than $35,000 in out-of-pocket expenses. Similar cases reported elsewhere in the United States highlight a critical and overlooked Medicare policy that requires reform — hospital payment for "observation care."

Originally developed for chest pain, protocolized observation care in dedicated units has been

studied for conditions such as transient ischemic attack, asthma, and syncope. Clinicians evaluate patients in an observation unit according to standardized clinical pathways, typically for 24 hours or less, to determine the need for inpatient admission. Numerous studies show that this model can result in higher-value care — equal or better quality at a lower cost than inpatient settings — yet only about one third of U.S. hospitals have observation units.[2]

Starting in November 1996, the Centers for Medicare and Medicaid Services (CMS) refined its payment codes for observation care, which it defines as a group of outpatient services administered under Medicare Part B that can be delivered in any setting — a physician's office, an emergency department, a regular inpatient ward, or an observation unit. Medicare policies have changed over time, but a specific care setting has never been a requirement for delivering observation services. Observation billing is the same whether it covers protocolized care in dedicated observation units, post–day-surgery recovery and infusion therapies, or care on a traditional hospital ward.

Inpatient hospitalization, which in 2011 accounted for 24% of Medicare spending,[3] has become a primary focus of cost control for CMS. Although readmission policies have gained attention, a policy action addressing the appropriateness of inpatient admissions was implemented several years ago with more financial impact. With few tools at its disposal for reducing admissions, CMS developed the Recovery Audit Contractor (RAC) program. Starting in 2005, the program empowered contractors to retrospectively audit hospital inpatient admissions for appropriateness and recover amounts that represented overbilling. The main information at the auditor's disposal is whether a patient qualified for inpatient or observation status; status is determined according to the criteria for admission appropriateness embedded in a screening tool such as Milliman or InterQual. Such audits have led to recoveries of large amounts of money from hospitals, with 90% of all hospitals currently reporting RAC activity and more than $2 billion recovered in 2012 alone.[4]

In response, virtually all hospitals adopted systems to prospectively evaluate whether admissions meet those inpatient criteria and, if they don't, to assign patients to observation status. As a result, the annual number of observation hours for Medicare beneficiaries increased by nearly 70% from 2006 through 2010, from 23 million to 39 million.[3] Because the risk of high out-of-pocket costs increases with an observation stay's duration, it's worrisome that the number of observation stays exceeding 72 hours — well beyond the 48-hour time frame envisioned by CMS for observation care — increased by 88% from 2007 through 2009.[5]

Current CMS policy on observation care promotes cost shifting without rewarding higher value, since payment is time-based and does not reward the use of evidence-based clinical pathways or hospital units designed to provide efficient care for this group of patients. As a result, two distinct models of hospital care have emerged under the name of observation care: protocolized care in observation units and care in inpatient units billed as observation. When observation is used as a billing status in inpatient areas without changes in care delivery, it's largely a cost-shifting exercise — relieving the hospital of the risk of adverse action by the RAC but increasing the patient's financial burden. Though such payment policies might conceivably pressure hospitals to improve efficiency by redesigning inpatient care delivery by adopting observation-unit care protocols and staffing patterns, there is no evidence of such a change to date, and the number of observation stays longer than 48 hours is increasing.

Observation billing exposes patients to increased cost sharing in several ways. First, since observation is considered an outpatient service, Medicare patients are responsible for Part B's 20% coinsurance for each individual charge incurred. Second, during observation visits, Medicare does not cover some services, such as medications patients receive from the hospital but that are considered eligible for self-administration (e.g., oral antihypertensive medications). Third, time spent in observation does not qualify toward the 3 days of hospitalization needed to trigger Medicare's skilled-nursing-facility benefit.

Understandably, patients have been surprised when they receive an observation bill for what was perceived as an inpatient stay, particularly when out-of-pocket costs exceed the Medicare inpatient deductible. The patients most vulnerable to such expenses are those frequently hospitalized, because Medicare beneficiaries do not have to pay the Part A deductible again until 60 days after discharge from an inpatient hospitalization or any skilled-nursing-facility stay that follows. Although

Medicare Fees and Payments for a 3-Day Hospitalization for Syncope — Inpatient Stay versus Observation Stay.*		
Service	**Hospitalization Billed as Inpatient Stay**	**Hospitalization Billed as Observation Stay**
Facility fees	Patient pays Part A deductible: $1,184† Medicare Part A pays DRG 312: $2,742	Patient pays 20% of APC 8003: $160 Medicare Part B pays 80% of APC 8003: $638
Professional fees	Patient pays 20% of fees: $101 Medicare Part B pays 80%: $405	Patient pays 20% of fees: $71 Medicare Part B pays 80%: $283
Initial evaluation	CPT 99223: $198	CPT 99220: $180
Subsequent evaluation	CPT 99233: $101	—
Discharge evaluation	CPT 99239: $104	CPT 99217: $71
CT interpretation	HCPCS 70450: $41	HCPCS 70450: $41
Echocardiogram interpretation	HCPCS 93306: $62	HCPCS 93306: $62
Medications	Patient pays $0	Patient pays entire cost: $240‡
Aspirin, once daily	Medicare Part A pays DRG payment	Medicare Part B pays $0
Metoprolol extended-release, twice daily		
Atorvastatin, once daily		
Lisinopril, twice daily		
Latanoprost drops, once daily		
Laboratory	Patient pays $0	Patient pays 20% of fees: $28
Basic metabolic panel with calcium ×3	Medicare Part A pays DRG payment	Medicare Part B pays 80%: $114
Complete blood count with auto diff ×3		
Coagulation panel ×2		
Cardiac markers ×1		
Liver-function tests ×1		
Urinalysis ×1		
Urine culture ×1		
Diagnostics	Patient pays $0	Patient pays 20% of fees: $62
Electrocardiogram ×3	Medicare Part A pays DRG payment	Medicare Part B pays 80%: $247
Cardiac monitoring ×48 hr		
Transthoracic echocardiogram		
CT of the brain		
Skilled nursing facility for 7 days	Patient pays $0 Paid by Medicare Part A: $318¶ per day, or $2,226	Patient pays $248¶ per day, or $1,736 Medicare pays $0
Total payments	Patient: $1,285 Medicare Part A: $4,968 Medicare Part B: $405	Patient: $2,297 Medicare Part A: $0 Medicare Part B: $1,282
Total revenue	Hospital: $3,926 Professional: $506 Skilled nursing facility: $2,226	Hospital: $1,489 Professional: $354 Skilled nursing facility: $1,736

* Calculations are for traditional fee-for-service Medicare without a secondary payer. Part B payments assume that the $147 annual deductible has already been paid. APC denotes Ambulatory Payment Classification, CPT Current Procedural Terminology, DRG diagnosis-related group, and HCPCS Healthcare Common Procedure Coding System.

† This amount presumes that the patient has not paid for any qualifying Part A services in the previous 60 days.

‡ Average out-of-pocket medication costs are highly variable and depend on which medications the patient is taking and the hospital's charges. The $240 amount is based on our experience and conversations with observation-unit directors.

¶ The national average daily Part A payment is based on 2013 CMS base rates for an urban skilled nursing facility with a nursing index of 1.311 and a therapy index of 1.224 with the use of a nonrehabilitation resource utilization group. Patient expenses are based on the 2012 national average daily skilled-nursing-facility cost for a private room, reported at www.metlife.com/mmi/research/2012-market-survey-long-term-care-costs.html#keyfindings.

any single charge in an observation stay cannot exceed the inpatient deductible, there's no limit on the total patient expenses for such a stay.

The table lists the payments for a hypothetical 3-day hospitalization for a patient with syncope that causes clinically significant functional problems. We compare hospitalization billed as an inpatient stay with the same hospitalization billed as an observation stay in terms of the patient's costs, the CMS bill, and provider revenues. Generally, out-of-pocket costs are highest when no observation unit was used. Care in a dedicated unit costs less because it follows time-dependent protocols that reduce unwarranted variation in diagnosis and treatment, resulting in faster completion of diagnostic services and an average length of stay of about 15 hours.

Outrage over the use of observation status has led to proposed reforms that threaten the use of all observation care. For example, a class-action lawsuit was filed against CMS in 2011, claiming that observation services violate Medicare legislation and the due-process clause of the Fifth Amendment, regardless of the setting. The recently released rule for 2014 Medicare payments includes a modified definition of inpatient status; to qualify as inpatients, patients would have to receive only medically necessary services ordered by a physician and their hospitalization would have to last through two midnights. This period would begin "when the beneficiary is moved from any outpatient area to a bed in the hospital in which the additional hospital services will be provided." These changes attempt to cap observation stays at 2 days, addressing the issue of prolonged observation stays but failing to address the major concerns about cost shifting.

To encourage high-value observation care and minimize cost shifting, we believe that CMS should reform observation-payment policies beyond the recent proposal. First, capping the total out-of-pocket expense at the inpatient-deductible amount would keep observation stays from costing patients more than inpatient admissions, which are generally more resource-intensive. Second, covering self-administered medications would allow clinicians to continue to safely administer them, since asking patients to bring in their home medications creates an unrealistic expectation and a safety risk. Third, counting time in observation toward the 3 days of hospitalization that qualify a patient for skilled-nursing-facility benefits would protect the most vulnerable patients. Several bills recently filed in Congress support this last change.

Not all observation care is the same; payment reforms should protect patients from excessive out-of-pocket expenses and reward the efficient care delivered in observation units, which prevents prolonged hospitalizations. Public outcry about observation abuses has led to governmental attention, but reforms may threaten all observation care.

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