

# Medicare Advantage health care utilization: observation stays

*Data Brief #6*

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## Trends in Medicare Advantage outpatient observation stays

In this data brief, the Health Care Cost Institute (HCCI) reports on national rates of utilization and trends of outpatient observation stays in the Medicare Advantage (MA) population, aged 65 years and older, for the period 2010 through 2014. This is the second HCCI brief in an ongoing series on the utilization of health care services by the MA population. The first brief reported on hospital readmission rates.<sup>1</sup>

MA, formerly known as Medicare Part C, is available to individuals eligible for fee-for-service (FFS) coverage. The MA program allows individuals to obtain health insurance through commercial health plans, in lieu of FFS coverage and provides similar coverage but the structure of the benefit design may differ.<sup>2</sup> As of 2015, over 31% of Medicare beneficiaries were enrolled in an MA plan.<sup>3</sup>

The HCCI data analyzed for this brief included health insurance membership and claims from MA enrollees in all 50 states and the District of Columbia. On average, the HCCI data accounted for approximately 25% of the national MA population over the study period.

### Observation stays

Prior to or following outpatient facility services, such as a same day surgery, health care providers may request that a patient stay for evaluation or testing without admitting the patient to the hospital as an inpatient. This continued evaluation is considered an observation stay and the services are classified as outpatient facility events, even if the observation stay lasts more than one day. Generally, observation stays are expected to be used in situations where the patient is not expected to stay more than two nights.<sup>4</sup>

Recently, the use of observation stays within the Medicare FFS population has become an area of focus for policy makers, health care providers, and patients because coverage and provider reimbursement differs for inpatient and outpatient events. These differences potentially have cost and access implications for Medicare FFS beneficiaries. For example, Medicare Part A (hospital insurance) pays for inpatient hospital services; Medicare Part B (medical insurance) covers, among other services, outpatient services. Due to differences in Part A and B coverage, it is possible that patients will face larger out-of-pocket payments for an outpatient stay than for an inpatient stay. Moreover, the FFS coverage rules have implications for whether follow-up services such as skilled nursing facility care will be covered.<sup>5</sup>

Within the MA population there are also likely cost and utilization implications to patients and providers based on the MA plan benefit design. However, there is generally less published research on the MA population compared to Medicare FFS. Therefore, we report on the rate of observation stays within the MA population. This brief contributes to the publicly available data on the patterns of health care utilization in the MA population. Examination of expenditures related to observation stays in the MA population is left for future reporting.

### The utilization of observation stays in the MA population increased from 2010 through 2014

Table 1 shows the rate of observation stays per 100 MA members for each year of the study period. The annual change in observation stays is also shown. Over the course of the study period, observation stays increased

## KEY FINDINGS

### Use of observation stays increased from 2010 through 2014.

Similar increases occurred in overall use and within 30 days of a hospitalization.

### The percent of multiple day stays and the average length of stay was constant over time.

Approximately 21% of observation stays spanned more than one day with an average length of stay of 1.55 nights.

81.8% from 3.14 to 5.71 per 100 MA members. However, substantially larger annual increases occurred in 2013 and 2014, with year over year percentage changes of 35.8% and 21.0%, respectively.

In Table 2, we report the percent of observation stays with a length of stay (LOS) of one or more nights (i.e. the percent of observations stays spanning 2 or more consecutive days). As noted above, observation stays are billed as outpatient facility events, but it is possible that an observation stay spans multiple days and includes one or more overnight stays in a hospital setting. The percent of multiple day observation stays was generally consistent over the study period. The 5-year average is 21.1% with the annual percentage of total observation stays spanning more than one day ranging from a low of 20.3% in 2011 to a high of 22.5% in 2013.

Table 2 also shows the average LOS for multiple day stays in each year of the study period. LOS is calculated as the number of consecutive days minus one; thus, LOS, is equivalent to the number of nights. The average LOS is also consistent over time with an average of 1.55 nights for years 2011 through 2013, increasing to only 1.60 in 2014.

It is possible that a two day, one-night stay is less than 24 hours. For example, a patient's observation stay may start at 6:00 PM and

last until 8:00 AM the next day. However, an average LOS of 1.60 implies that the average multiple day stay is more than 24 hours because a LOS greater than 1.00 requires three or more consecutive days. A stay spanning three days, for example beginning at 10:00 PM Tuesday and ending at 6:00 AM on Thursday, includes two overnight stays – Tuesday night, and Wednesday night.

#### **The rate of observation stays following hospitalizations increased for all categories of hospitalizations studied.**

We report 30-day all-cause observation stays following a hospital admission in Table 3. Because observation stays are billed as outpatient facility events, they are usually not included in counts of hospital admissions or hospital readmissions, even if the observation stay includes an overnight stay in a hospital. Therefore, there is interest in observation stays following admissions because they may be used instead of inpatient admissions, which in turn would reduce readmission rates. Table 3 reports observation stays as either per 100 hospital-wide admissions or per 100 admissions for one of four specific conditions: acute myocardial infarction (AMI), heart failure, pneumonia, or chronic obstructive pulmonary disease (COPD).

Observation stays within 30 days of a prior admission approximately doubled from 2010 to 2014 for all five categories of admissions analyzed. Observation stays following any hospital admission (i.e. hospital-wide admissions) increased to 2.44 in 2014 from 1.23 in 2010. Observation stays following a COPD admission increased the most over the study period from 1.03 to 2.21. The smallest increase over the study period, 1.91 to 3.41, was for observation stays following AMI admissions. However, the rate of 30-day all-cause observation stays following an AMI admission was the highest in every year.

Annual percentage changes in observation stays following hospitalization are shown in Table 4. Consistent with the trend in observation stays per member shown in Table 1, the largest increases

in observation stays following hospitalizations were observed in the last two years of the study period. Moreover, the annual percentage increases in observation stays per 100 hospital-wide admissions were similar in magnitude to the percentage increases in observation stays per 100 members in 2013 and 2014.

#### **Conclusion**

The results presented in this brief show that for a large, national MA population, aged 65 and older during the years 2010 through 2014, observation stays increased over time, both overall and within 30 days of a hospitalization. The percent and length of overnight observation stays, however, remained constant.

#### **Data and Methods**

The analysis sample was limited to individuals aged 65 years and older enrolled in an MA plan included in the HCCI database. Inclusion in the post hospitalization observation stay rate calculation also required at least one inpatient hospitalization with three or more months of MA plan membership prior to a hospitalization and at least 30 days of membership following a hospitalization.

Outpatient observation stays were identified by revenue codes 0760 or 0762, signifying either general or observation hours, or an observation HCPCS codes, G0378 or G0379. These claims were identified in claims with a hospital outpatient type of bill code with a first digit of 1 and a second digit of 3 (i.e. hospital outpatient).

The inpatient admissions, i.e. index admissions, used to identify 30-day all-cause post hospitalization observation stays were defined by the same criteria used to identify index admissions in our previous study of readmissions.<sup>6</sup> Eligible outpatient observation stays included an observation stay for any condition within 30 days of an index admission regardless of the reason for the observation stay. Only the first observation stay following a hospitalization was counted. This approach is consistent with the approach of only counting the first inpa-

tient readmission. Any additional observation stays within the 30-day window were excluded from the calculation of the rate.

The 30-day rate of all-cause observation stays were calculated as the sum of eligible observation stays divided by the total number of index admissions. The rate was then multiplied by 100 in order to report in terms of the number of observation stays.

#### **Limitations**

Although, this report provides new statistics on the utilization of health care within the MA population, the results may not be generalizable to all MA plans or members. The HCCI data set is a convenience sample from three national insurers and may not reflect the utilization of the full MA population or the trends of other MA payers.

There were likely numerous factors influencing the use of observation stays during the study period. However, no causal inferences can be drawn from the results presented in this brief and those influencing factors. Moreover, the analyses did not attempt to identify any causes underlying the observed rates or trends; and the analyses did not evaluate the impact of any particular federal, state, or insurer policies or initiatives targeting observation stay utilization. Additionally, the scope of this brief was limited to observation stay utilization measures. There are many other measures of health care services utilization and expenditures, which may provide additional insight into the utilization patterns of the MA population.

#### Endnotes:

1. Health Care Cost Institute. Medicare Advantage Health Care Utilization—Hospital Readmissions. November 2016. <http://www.healthcostinstitute.org/issue-brief-MA-readmissions>.

2. Centers for Medicare and Medicaid Services. Medicare Advantage Plans. <https://www.medicare.gov/sign-up-change-plans/medicare-health-plans/medicare-advantage-plans/medicare-advantage-plans.html>

3. Kaiser Family Foundation. Medicare Advantage Enrollment: Total Medicare Private Health Plan Enrollment, 1999-2015. June, 29, 2015. <http://kff.org/medicare/fact-sheet/medicare-advantage/>

4. Centers for Medicare and Medicaid Services. Are You a Hospital Inpatient or Outpatient?. <https://www.medicare.gov/Pubs/pdf/11435.pdf>

5. For example, in the Medicare FFS population an observation stay is covered by Part B (Medical Insurance) rather than Part A (Hospital Insurance). Additionally, coverage of skilled nursing facilities in Medicare requires an inpatient hospital stay. Even if the observation stay is more than one day it does not count toward the overnight stays required to SNF coverage. Derived from CMS Manual System: Pub 100-04 Medicare Claims Processing. June 23, 2009. CMS. Available for download

from: <https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R1760CP.pdf>

6. Health Care Cost Institute. Medicare Advantage Health Care Utilization—Hospital Readmissions. November 2016. <http://www.healthcostinstitute.org/issue-brief-MA-readmissions>.

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**Table 1: Observation stays per 100 Medicare Advantage members**

Year	Observation stays per 100 members	Annual Percent Change
2010	3.14	-
2011	3.35	6.9%
2012	3.49	3.7%
2013	4.72	35.8%
2014	5.71	21.0%

Source: HCCI, 2016.

**Table 2: Length of observation stays**

Year	Percent of observations stays with a length of stay >1 day	Average length of stay	Standard deviation of length of stay
2010	21.0%	1.50	1.03
2011	20.3%	1.55	1.05
2012	20.8%	1.55	1.06
2013	22.5%	1.55	0.98
2014	21.3%	1.60	1.13

Source: HCCI, 2016.

**Table 3: Thirty-day, all-cause observation stays per 100 Medicare Advantage inpatient admissions**

Year	Hospital-wide	AMI	Heart Failure	COPD	Pneumonia
2010	1.23	1.91	1.33	1.03	0.95
2011	1.39	2.07	1.50	1.30	1.04
2012	1.50	2.22	1.60	1.43	1.13
2013	2.03	2.88	2.09	1.75	1.60
2014	2.44	3.41	2.57	2.21	1.91

Source: HCCI, 2016.

**Table 4: Annual percentage change in thirty-day, all cause observation stays per 100 Medicare Advantage inpatient admissions**

Year	Hospital-wide	AMI	Heart Failure	COPD	Pneumonia
2010	-	-	-	-	-
2011	12.4%	8.2%	12.5%	25.6%	10.2%
2012	8.2%	7.5%	6.4%	10.2%	8.3%
2013	35.6%	29.8%	30.9%	22.2%	41.8%
2014	20.0%	18.3%	22.8%	26.8%	18.8%

Source: HCCI, 2016.