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Medicare's Skilled Nursing Facility (SNF) Three-Day Inpatient Stay Requirement: In Brief

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Contents

Contacts

Medicare beneficiaries are generally entitled to coverage for care they receive in a skilled nursing facility (SNF). However, Medicare beneficiaries can be liable for substantial cost sharing related to the care they receive in an SNF if that care is not preceded by a hospital inpatient stay of at least three days. On an increasing basis, however, Medicare beneficiaries are failing to meet this three-day inpatient stay requirement because they are receiving shorter inpatient hospital stays and overnight observation care as hospital outpatients, often for days at a time, which does not qualify for Medicare Part A-covered SNF care.[1]

Medicare SNF Coverage and the Three-Day Inpatient Stay Requirement

Enacted in 1965, Medicare is a federal program that provides health care coverage for its beneficiaries, a population generally made up of individuals over the age of 65 and individuals under the age of 65 with disabilities.[2] Today, the Medicare program consists of four parts:

- Part A (Hospital Insurance) covers hospital inpatient services, SNF care, hospice care, and home health services.
- Part B (Supplementary Medical Insurance) covers physician, outpatient, home health, and preventive services.
- Part C (Medicare Advantage, or MA) is a private plan option that covers all Medicare Part A and B services, except hospice.[3]
- Part D covers outpatient prescription drugs.

The SNF benefit was included in Medicare Part A to provide extended skilled nursing care for residents who were recently hospitalized but no longer needed the intensive treatments of an acute-care hospital.[4] Under Part A, Medicare provides payment for 100 days of skilled nursing care, therapy services, medical social services, drugs/biologicals, durable medical equipment, and bed and board per spell of illness.[5] These skilled nursing services typically are provided in a long-term care facility, such as a nursing home, that also provides custodial and less skilled care than is covered by Medicare. For SNF stays that are not covered by Part A, Part B may provide coverage for a limited amount of items and services, such as therapy services.

Upon enactment, Congress placed some restrictions on the SNF benefit. In addition to limiting SNF coverage to 100 days per spell of illness, Congress required a daily co-payment for days 21 to 100 (but not for days 1 to 20). As a prerequisite for SNF coverage, Congress also required that

[1] Zhanlian Feng, Brad Wright, and Vincent Mor, "Sharp Rise in Medicare Enrollees Being Held in Hospitals for Observation Raises Concerns About Causes and Consequences," *Health Affairs*, vol. 31, no. 6 (June 2012).

[2] For more information on Medicare, see CRS Report R40425, *Medicare Primer*, coordinated by Patricia A. Davis and Scott R. Talaga.

[3] With the introduction of Part C in 1997, Medicare Advantage (MA) organizations can design health plans that offer the skilled nursing facility (SNF) benefit without a three-day hospital inpatient stay. According to the Kaiser Family Foundation, 92% of MA plans waive the three-day requirement but may implement other utilization-management methods (such as prior authorization) to limit use of the SNF benefit. Additionally, unlike Medicare SNF coverage under Part A, two-thirds of MA plans include cost sharing for covered SNF days 1 through 20.

[4] For more information on Medicare's SNF benefit, see CRS Report R42401, *Medicare Skilled Nursing Facility Primer: Benefit Basics and Issues*, by Scott R. Talaga.

[5] A *spell of illness*, also referred to as the *benefit period*, begins when a beneficiary is admitted for hospital inpatient services and ends after 60 consecutive days during which the beneficiary was neither an inpatient of a hospital nor a resident of an SNF. See Section 1861(a) of the Social Security Act.

beneficiaries had at least a three-day hospital inpatient stay within 14 days prior to an SNF admission (later modified to 30 days).[6] The House Committee on Ways and Means included this three-day inpatient requirement to "help limit the payment of the extended care benefits to persons for whom such care may reasonably be presumed to be required in connection with continued treatment following hospital inpatient care and makes less likely unduly long hospital stays."[7]

The three-day hospital inpatient stay requirement was not unique to the Medicare SNF benefit at the onset of the Medicare program. The Medicare Part A home health benefit also had a three-day hospital inpatient stay requirement upon enactment; however, the Omnibus Budget Reconciliation Act of 1980 (P.L. 96-499) removed this requirement to permit greater access to home health services.[8]

The three-day inpatient stay requirement has been of growing interest to Congress in recent years. The increased interest may be due to the number of beneficiaries who had a prior hospital stay but did not or would not receive Part A coverage for SNF care because their hospital stay did not meet the three-day inpatient stay requirement. These beneficiaries may have had short hospital inpatient stays of less than three days; the average length of a hospital inpatient stay declined from roughly 12 days per discharge in 1972 to roughly 5 days per discharge in 2012.[9] Additionally, the three-day inpatient stay requirement may be of interest to Congress due to the increased number of beneficiaries receiving outpatient stays, including observation care, while at the hospital.

Hospital Outpatient Observation Care

Observation care is often characterized as a component of emergency medicine that allows hospitals to triage patients who do not immediately require hospital inpatient admission but are too sick to discharge. There are no clear standards as to when certain patients should be placed under observation rather than admitted as an inpatient, so hospitals often rely on the admitting physician's judgment. For patients under observation, the hospital provides assessment, ongoing short-term treatment, and reassessment before determining whether the patient should be admitted as an inpatient for additional treatment or is well enough to discharge.[10]

Observation care is provided on an outpatient basis, typically in the hospital ward or in an observation unit attached to the emergency department.[11] Hospitals that have dedicated

[6] The day of discharge is not counted toward meeting the three-day inpatient stay requirement. The Omnibus Budget Reconciliation Act of 1980 (P.L. 96-499) extended the required period in which the three-day hospital inpatient stay must occur from 14 days prior to SNF admission to 30 days prior to SNF admission.

[7] U.S. Congress, House Committee on Ways and Means, *Report of the Committee on Ways and Means on H.R. 6675*, 89th Cong., 1st sess., March 1965, No. 213 (Washington: GPO, 1965), p. 27.

[8] For more information on Medicare home health coverage, see CRS Report R42998, *Medicare Home Health Benefit Primer: Benefit Basics and Issues*, by Scott R. Talaga.

[9] Centers for Medicare & Medicaid Services (CMS), Table 5.1 in *Medicare & Medicaid Research Review: 2013 Statistical Supplement*, at https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MedicareMedicaidStatSupp/Downloads/2013_Section5.pdf#Table5.1.

[10] Additionally, hospitals cannot keep beneficiaries as inpatient residents solely to satisfy the three-day inpatient stay requirement for SNF care. Section 1862(a)(1)(A) of the Social Security Act statutorily excludes Medicare payments for care that is not reasonable and necessary. CMS's long-standing instruction has been and continues to be that care rendered for social purposes or reasons of convenience should be excluded from Medicare payment. Therefore, hospitals cannot keep patients solely to meet the three-day inpatient criteria for SNF coverage.

[11] "Principles of Observation Medicine," in *Observation Medicine*, ed. Louis G. Graff (Andover Medical Publishers, (continued...)

observation units may provide observation care in both medical or surgical beds in the hospital ward and observation units. Dedicated observation units have grown in popularity among U.S. hospitals. According to hospital survey data, in 2007, 36% of emergency departments had an observation unit, up from 19% in 2003.[12]

The Department of Health and Human Services (HHS) Office of the Inspector General (OIG) reported that, in 2012, Medicare beneficiaries had more than 600,000 hospital stays that were at least three days long but would not have qualified the beneficiary for SNF services because the patient was classified as an outpatient for some or all of the stay.[13] More than 25,000 of the beneficiaries in these 600,000 hospital stays were discharged to an SNF following their hospital stays even though they did not qualify for Medicare Part A SNF coverage. Because the three-day inpatient stay requirement was not met, such beneficiaries could have been liable for substantial costs related to bed and board, drugs/biologicals, durable medical equipment, and nursing care received during their SNF stays.

Studies have shown the number of beneficiaries receiving outpatient observation care to be increasing over the past few years.[14] In response to concerns regarding long observation stays[15] and short inpatient admissions, the Centers for Medicare & Medicaid Services (CMS) finalized a policy often referred to as the "Two-Midnight Rule" on August 19, 2013.[16] This rule was intended to address concerns about and provide clarification on when hospital inpatient admissions and hospital outpatient services are generally appropriate.[17] Additionally, to provide greater clarity to the beneficiary receiving observation care, the NOTICE Act (P.L. 114-42) was signed into law on August 6, 2015. The act requires hospitals to notify a beneficiary if he or she has been under observation for more than 24 hours and to communicate the implications of such status, including eligibility for SNF coverage.

(...continued)

Inc, 1993), p. 11.

[12] Jennifer L Wiler, Michael A. Ross, and Adit A Ginde, "National Study of Emergency Department Observation Services," *Academic Emergency Medicine*, vol. 18, no. 9 (August 29, 2011).

[13] Department of Health and Human Services (HHS), Office of Inspector General (OIG), *Hospitals' Use of Observation Stays and Short Inpatient Stays for Medicare Beneficiaries*, July 29, 2013, at https://oig.hhs.gov/oei/reports/oei-02-12-00040.pdf.

[14] For more information, see Medicare Payment Advisory Commission (MedPAC), *Report to the Congress: Medicare Payment Policy*, March 2016, p.62, at http://www.medpac.gov/documents/reports/chapter-3-hospital-inpatient-and-outpatient-services-(march-2016-report).pdf?sfvrsn=0.

[15] Patient advocates, led by the Center for Medicare Advocacy, brought a class-action lawsuit, Bagnall v. Sebelius, that allowing hospitalized Medicare beneficiaries to be placed in observation care deprives them of their Part A coverage. On September 23, 2013, a federal district court in Connecticut dismissed the case, citing precedent that the Secretary's decision to tie Part A coverage to formal hospital admissions was a valid interpretation of Medicare statute.

[16] CMS, "Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Fiscal Year 2014 Rates; Quality Reporting Requirements for Specific Providers; Hospital Conditions of Participation; Payment Policies Related to Patient Status," 78 *Federal Register* 160, August 19, 2013.

[17] For further information on the Two-Midnight Rule, see CRS In Focus IF10264, *Medicare, Observation Care, and the Two-Midnight Rule*, by Scott R. Talaga.

Modifying or Eliminating the Three-Day Inpatient Stay Requirement

Congress has considered modifying or eliminating the three-day inpatient stay requirement to avoid situations of non-covered but medically necessary SNF care. Legislative proposals have been introduced that would allow outpatient observation days to be counted toward meeting the three-day inpatient stay requirement.[18] Also, the Medicare Payment Advisory Commission (MedPAC) has recommended to Congress that up to two outpatient observation days be counted toward meeting the three-day inpatient stay requirement.[19]

The Center for Medicare & Medicaid Innovation (CMMI) within CMS is currently testing alternative payment models (e.g., Accountable Care Organizations, or ACOs) that may allow participating providers to waive the three-day inpatient stay requirement for SNF coverage. Three-day stay waivers involve certain requirements, including that the admitting SNFs under the waiver have earned at least a three-star rating on CMS's Nursing Home Compare Five-Star Rating System. These waivers are currently available within the Medicare Shared Savings Program, the Pioneer ACO model, the Next Generation ACO model, Model 2 of the Bundled Payments for Care Improvement Initiative, and the Comprehensive Care Joint Replacement Model.[20] Although these waivers add flexibility to Medicare's requirement for covered SNF care, under such alternative payment models, CMMI includes aggregate financial controls on total Medicare spending to prevent increased costs to the Medicare program.

It is unclear what the financial impact on the Medicare program would be if Congress were to include time spent under observation toward satisfying the three-day inpatient stay requirement. However, some information is available on the impact of eliminating the requirement. The Medicare Catastrophic Coverage Act (MCCA; P.L. 100-360) eliminated the three-day inpatient stay requirement beginning with services provided on or after January 1, 1989. This act was repealed, and the three-day inpatient stay requirement was reenacted starting January 1, 1990. The elimination of the three-day inpatient stay requirement for SNF services in 1989 had a noticeable effect on the Medicare program. Medicare-covered SNF admissions increased by 16% in the months after released guidance incorporated the change.[21] The MCCA made other legislative changes to the Medicare SNF benefit that were also repealed, including reduced cost-sharing and increased covered days of care. The combination of these changes to Medicare coverage increased SNF spending from $964 million in 1988 to $2.8 billion in 1989.[22] This experience suggests that eliminating the three-day inpatient stay requirement would have a

[18] For more information on modifying the three-day inpatient stay requirement, see H.R. 1179 and its companion bill, S. 569, in the 113th Congress. For more information on eliminating the three-day inpatient stay requirement, see H.R. 3531 in the 113th Congress.

[19] MedPAC, *Hospital Short Stay Policy Issues*, June 2015, at http://www.medpac.gov/documents/reports/chapter-7-hospital-short-stay-policy-issues-(june-2015-report).pdf?sfvrsn=0.

[20] The Pioneer Accountable Care Organization (ACO) Model and Next Generation ACO Model waivers for SNF care do not require a prior hospitalization. However, Model 2 of the Bundled Payments for Care Improvement Initiative and the Comprehensive Care Joint Replacement Model require a prior inpatient hospital stay of any duration. For more information on these payment models, visit http://www.innovations.cms.gov. For more information on the Comprehensive Joint Care Replacement Model, see CRS In Focus IF10310, *The Comprehensive Care Joint Replacement Model*, by Scott R. Talaga.

[21] HHS, OIG, *Influences on Medicare's Skilled Nursing Facility Benefit*, June 1991, at http://oig.hhs.gov/oei/reports/oei-05-89-01590.pdf.

[22] CMS, *Health Care Financing Review 2013 Medicare and Medicaid Statistical Supplement*, Table 6.1.

noticeable effect on SNF admissions and, without implementing other administrative or financial controls on the use of the SNF benefit, would have a large financial impact on Medicare SNF expenditures.

OIG Reports on the Three-Day Inpatient Stay Requirement

Reports suggest that the financial impact on beneficiaries from the three-day inpatient stay requirement could be much greater than it actually has been. The OIG reported that 25,245 SNF stays in 2012 were for beneficiaries who did not meet the qualifying hospital stay requirement; however, Medicare erroneously paid for 92% of these stays.[23] Additionally, a series of local-level OIG audit reports released between April 2003 and January 2005 revealed that a number of SNF stays were reimbursed even though the beneficiaries had not received a prior three-day hospital inpatient stay. A compilation of the OIG estimates indicates that roughly 28,000[24] SNF stays from 1997 through 2001 were reimbursed erroneously.

The OIG recommended that the funds from these erroneous reimbursements be returned to the Medicare program. However, in response to the OIG audits, CMS issued a memorandum in November 2003 instructing Medicare administrative contractors (MACs)—entities that process Medicare claims—not to recover the improper payments.[25] Additionally, CMS instructed MACs that had already recovered the improper payments to reverse such transactions and return the payment to the providers. CMS provided these instructions because it could not determine fault by the providers.

These studies highlight that Medicare may be improperly reimbursing beneficiaries for many SNF stays when patients have not met the three-day inpatient stay requirement. As noted by the OIG in its reports, these occurrences could be attributed to the billing and reimbursement process for SNFs. To receive reimbursement for SNF care, SNFs submit claims to MACs. These claims contain, among other things, diagnosis and procedure data, along with an indication of whether or not a beneficiary has had a three-day hospital inpatient stay. The OIG found that MACs typically did not cross-reference SNF claims with hospital inpatient claims to verify that the three-day inpatient stay requirement was indeed met. SNFs verify that the beneficiary had a three-day hospital inpatient stay either from the hospital (possibly via a patient transfer form or hospital discharge summaries) or from the patient and his or her family.[26] CMS does not require a standard

[23] HHS, OIG, *Hospitals' Use of Observation Stays and Short Inpatient Stays for Medicare Beneficiaries*, July 29, 2013, p. 15, at https://oig.hhs.gov/oei/reports/oei-02-12-00040.pdf. According to the 2013 *Medicare and Medicaid Statistical Supplement* released by CMS, total SNF admissions were over 2.5 million in 2012. The number of improperly paid SNF stays identified by the OIG reflects roughly 1% of all Medicare-covered SNF stays in 2012.

[24] CRS review of 18 HHS OIG reports—*Medicare Ineligible Payments to Skilled Nursing Facilities*—released between 2003 and 2005. The OIG compiled 33,435 potentially ineligible SNF stays attributed to 26 different fiscal intermediaries from 1997 through 2001. The OIG sampled 3,600 of the 33,435 SNF stays and found that roughly 86% of the potentially ineligible SNF stays were indeed ineligible for Medicare coverage and should not have been reimbursed. The total amount that the OIG requested be reimbursed to Medicare from the 26 fiscal intermediaries was $167.7 million.

[25] Memorandum from Gerald Walters, Acting Director, CMS Financial Services Group, and Gregory G. Carson, Director, CMS Medicare Contractor Management Group, to All Medicare Fiscal Intermediaries, November 26, 2003, at http://oig.hhs.gov/oas/reports/region5/50400062.pdf#page=14.

[26] CMS, *Medicare Claims Process Manual, Chapter 2 - Admission and Regsitration Requirements*, January 15, 2016, p. 10, at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c02.pdf.

hospital-SNF patient transfer form, and it is unclear whether hospitals include inpatient and outpatient status on transfer forms currently being used.

Considerations

Some steps are being taken to educate beneficiaries about the three-day hospital inpatient stay requirement and increase transparency regarding the Medicare Part A SNF benefit. Beginning August 6, 2016, the NOTICE Act (P.L. 114-42) will require hospitals to provide a notification form (as well as an oral equivalent of the notification form) to beneficiaries who are receiving outpatient observation services for more than 24 hours. This notification form is to be specified by the Secretary of HHS and will include an explanation to the beneficiary that he or she is an outpatient and provide the reasons for such status. It will also explain the implications of observation status for cost-sharing requirements and for SNF coverage. The beneficiary (or a person acting on the beneficiary's behalf) will be asked to provide a signature acknowledging receipt of the notification.

Education and transparency of hospital stay information may help beneficiaries make more informed decisions with respect to their care needs. However, beneficiaries may still be unaware upon discharge that their SNF care is not covered by Medicare Part A. Federal law does not require a hospital to notify a beneficiary in advance that he or she will not receive coverage for a posthospital SNF stay if the beneficiary has not met the three-day inpatient stay requirement. CMS does not require hospitals to use a standard patient transfer form that includes hospital stay information. For SNFs that are aware of the beneficiary's prior hospital stay status, federal law does not require the admitting SNF to notify a beneficiary in advance that his or her SNF stay will not be covered by Medicare Part A if the beneficiary has not met the three-day inpatient stay requirement.

Furthermore, increased transparency could potentially have an adverse effect on beneficiaries if hospital discharge patterns noted by the OIG have continued. The OIG found that Medicare erroneously paid for 92% of the 25,245 SNF stays that did not have a prior three-day inpatient stay in 2012.[27] Many of these improper payments were attributed to the SNF receiving incorrect or insufficient information from the beneficiary regarding his or her prior hospital stay. In these cases, increased transparency may improve the probability that beneficiaries without qualifying three-day inpatient stays will convey this information accurately to the SNF, which would, to some extent, correct such improper payments. However, if SNFs were to receive this patient-status information after the beneficiary had already been admitted to the SNF, Medicare Part A coverage would be denied and the increased transparency may inadvertently increase the number of beneficiaries not receiving Part A SNF coverage.

Recently, Congress has shown an interest in examining the three-day inpatient stay requirement in response to situations of SNF care not being covered by Medicaid when preceded by observation stays—rather than three-day inpatient stays—at the hospital.[28] Expanding coverage for SNF care may improve care outcomes and reduce cost sharing for certain beneficiaries who otherwise would have been ineligible for the benefit.[29] However, past experience with eliminating the three-

[27] HHS, OIG, *Hospitals' Use of Observation Stays and Short Inpatient Stays for Medicare Beneficiaries*, July 29, 2013, p. 15, at https://oig.hhs.gov/oei/reports/oei-02-12-00040.pdf.

[28] U.S. Congress, Senate Special Committee on Aging, *Admitted or Not? The Impact of Medicare Observation Status on Seniors*, 114th Cong., 1st sess., July 30, 2014.

[29] Regina C. Grebla et al., "Waiving the Three-Day Rule: Admissions and Length-of-Stay at Hospitals and Skilled Nursing Facilities Did Not Increase," *Health Affairs*, vol. 34, no. 8 (August 2015), p. 1324.

day inpatient stay requirement in 1989 suggests that doing so could greatly increase Medicare SNF expenditures. Legislative proposals have been introduced to modify the three-day inpatient stay requirement to include time spent in observation, but it is unclear how this modification would impact Medicare SNF expenditures. Three-day inpatient stay waivers currently available under Medicare Part C and certain CMMI payment models suggest that administrative flexibility with respect to this requirement may improve care and reduce costs for certain beneficiaries. These models, and the financial safeguards they place on Medicare spending, may provide insights to Congress on balancing concerns of increased Medicare expenditures and expanding access to necessary SNF care.

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