

## Improving Healthcare Value: COVID-19 Emergency Regulatory Relief and Implications for Post-Acute Skilled Nursing Facility Care

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Rarely, if ever, does a national healthcare system experience such rapid and marked change as that seen with the COVID-19 pandemic. In March 2020, the president of the United States declared a national health emergency, enabling the Department of Health & Human Services authority to grant temporary regulatory waivers to facilitate efficient care delivery in a variety of healthcare settings. The statutory requirement that Medicare beneficiaries stay three consecutive inpatient midnights to qualify for post-acute skilled nursing facility coverage is one such waiver.

This so-called Three Midnight Rule, dating back to the 1960s as part of the Social Security Act, is being scrutinized more than half a century later given the rise in observation hospital stays. Despite the tragic emergency circumstances prompting waivers, the Centers for Medicare & Medicaid Services and Congress now have a unique opportunity to evaluate potential improvements revealed by COVID-19 regulatory relief and should consider permanent reform of the Three Midnight Rule. *Journal of Hospital Medicine* 2020;15:495-497. © 2020 Society of Hospital Medicine

*Medicare beneficiary who requires skilled care in a nursing home? Better be admitted for at least 3 days in the hospital first if you want the nursing home paid for. Govt doesn't always make sense. We're listening to feedback.*

—Centers for Medicare & Medicaid Services Administrator  
Seema Verma, @SeemaCMS, August 4, 2019, via Twitter.<sup>1</sup>

On March 13, 2020, the president of the United States declared a national health emergency, granting the secretary of the United States Department of Health & Human Services authority to grant waivers intended to ease certain Medicare and Medicaid program requirements.<sup>2</sup> Broad waiver categories include those that may be requested by an individual institution, as well as “COVID-19 Emergency Declaration Blanket Waivers,” which automatically apply across all facilities and providers. As stated by the Centers for Medicare & Medicaid Services (CMS), waivers are intended to create “regulatory flexibilities to help healthcare providers contain the spread of 2019 Novel Coronavirus Disease (COVID-19).” These provisions are retroactive to March 1, 2020, expire at the end of the “emergency period or 60 days from the date the waiver . . . is first published” and can be extended by the secretary.<sup>2</sup>

The issued blanket waivers remove administrative requirements in a wide range of care settings including home health, hospice, hospitals, and skilled nursing facilities (SNF), among others. The waiving of many of these administrative requirements are welcomed by providers and administrators alike in this time of national crisis. For example, relaxation of verbal order signage requirements and expanded coverage of telehealth will, almost certainly, improve accessibility, efficiency, and requisite coordination and care across settings. Emergence of these new “COVID-19” waivers also present rare and valuable opportunities to examine care improvement in areas long believed to need permanent regulatory change. Perhaps the most important of these long over-due changes is the current CMS process for determining Part A eligibility for post-acute skilled nursing facility coverage for traditional Medicare beneficiaries following an inpatient hospitalization. Under COVID-19, CMS has now granted a waiver that “authorizes the Secretary to provide for Skilled Nursing Facilities (SNF) coverage in the absence of a qualifying [three consecutive inpatient midnight] hospital stay. . . .”<sup>2</sup> Although demand for SNF placement may shift during the pandemic, hospitals facing capacity issues will more easily be able to discharge Medicare beneficiaries ready for post-acute care.

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### POST-ACUTE SKILLED NURSING FACILITY COVERAGE

When Medicare was established in 1965, approximately half of Americans over age 65 did not have health insurance, and older adults were the most likely demographic to be living in

poverty.<sup>3</sup> Originally called “Hospital Insurance” or “Medicare Part A,” these “Inpatient Hospital Services” are described in Social Security statute as “items and services furnished to an inpatient of a hospital” including room and board, nursing services, pharmaceuticals, and medical and surgical services delivered in the hospital.<sup>4</sup> In 1967, Medicare beneficiaries staying three consecutive inpatient hospital midnights were also afforded post-acute SNF coverage for up to 100 days. As expected, hospital use increased as seniors had coverage for hospital care and were also, in many cases, able to access higher quality post-hospital care.<sup>5</sup>

Over the past 50 years, two important changes have shifted Medicare beneficiary SNF coverage. First, due to efficiencies and changes in care delivery, average length of hospital stay for Americans over age 65 has shrunk from 14 days in 1965 to approximately 5 days currently.<sup>5,6</sup> Now, fewer beneficiaries spend the necessary three or more nights in the hospital to qualify for post-acute SNF coverage. Second, and most importantly, CMS created “observation status” in the 1980s, which allowed for patients to be observed as “outpatients” in a hospital instead of as inpatients. Notably, these observation nights fall under outpatient status (Part B), and therefore do not count toward the statutory SNF coverage requirement of three inpatient midnights.

According to CMS, observation should be used so that a “decision can be made regarding whether patients will require further treatment as hospital inpatients or if they are able to be discharged from the hospital. . . . In the majority of cases, the decision can be made in less than 48 hours, usually in less than 24 hours.”<sup>7</sup> At the time of its development, this concept fit the growing use of Emergency Department observation units, in which patients presented for an acute issue but could usually discharge home in the stated time frame.

## OBSERVATION CARE

In reality, outpatient (observation) status is not synonymous with observation units. Because observation is a billing determination, not a specific type of clinical care, observation care may be delivered anywhere in a hospital—including an observation unit, a hospital ward, or even an intensive care unit (ICU). While all hospitals may deliver observation care, only about one-third of hospitals have observation units, and even hospitals with observation units deliver observation care outside of these units. Traditional Medicare beneficiaries who stay three or more nights in the hospital but cannot meet the three inpatient midnight requirement to access their SNF coverage benefits because of outpatient (observation) nights are often left vulnerable and confused, saddling them with an average of \$10,503 for each uncovered SNF stay.<sup>8</sup> As emergent evidence demonstrates striking racial, geographic, and socioeconomic-based health disparities in COVID-19, renewal of the “three-midnight rule” could have disproportionate and long-lasting ramifications for these populations in particular.<sup>9</sup>

Hospital observation stays (or observation nights) can look identical to inpatient hospital stays, as defined by the Social Security statute<sup>4</sup>; yet never count toward the three-in-

patient-midnight tally. In 2014, the Office of Inspector General (OIG) found there were 633,148 hospital stays that lasted three midnights or longer but did not contain three consecutive inpatient midnights, which resulted in nonqualifying stays for purposes of SNF coverage, if that coverage was needed.<sup>10</sup> A more recent OIG report found that Medicare was paying erroneously for some SNF stays because even CMS could not distinguish between three midnights that were all inpatient or a combination of inpatient and observation.<sup>11</sup> Additionally, because care provided is often indistinguishable, status changes between outpatient and inpatient are common; in 2014, 40% of Medicare observation stays occurring within 30 days of an inpatient stay changed to inpatient over the course of a single hospitalization.<sup>12</sup> Now, in the time of COVID-19, this untenable decades-long problem has the potential to be definitively addressed by a permanent removal of the three midnight requirement altogether.

## PROGRESS TOWARD REFORM

Several recent signals suggest that change is supported by a diverse group of stakeholders. In their 2019 Top 25 Unimplemented Recommendations, the OIG acknowledged the similarity in observation and inpatient care, recommending that “CMS . . . analyze the potential impacts of counting time spent as an outpatient toward the 3-night requirement for skilled nursing facility (SNF) services so that beneficiaries receiving similar hospital care have similar access to these services.”<sup>13</sup> The “Improving Access to Medicare Coverage Act of 2019,” reintroduced in the 116th Congress, would count all midnights spent in the hospital, whether those nights are inpatient or observation, toward the three midnight requirement.<sup>14</sup> This bill has bipartisan, bicameral support, which demonstrates unified legislative interest across the political spectrum. More recently in March 2020, a federal judge in the class action lawsuit *Alexander v Azar* determined that Medicare beneficiaries had the right to appeal to Medicare if a physician placed a patient in inpatient status and this decision was overturned administratively by a hospital, resulting in loss of a beneficiary’s SNF coverage.<sup>15</sup> Although now under appeal, this judicial decision signals the importance of beneficiary rights to appeal directly to CMS.

Given the mounting support for reform, it is probable that cost concerns and allocation of resources to the Part A vs Part B “buckets” remain the only barrier to permanently reforming the three-midnight inpatient stay policy. Pilot programs testing Medicare SNF waivers more than 30 years ago suggested increased cost and SNF usage.<sup>16</sup> However, more contemporary experience from Medicare Advantage programs suggest just the opposite. Grebla et al showed there was no increased SNF use nor SNF length of stay for beneficiaries in Medicare Advantage plans that waived the three inpatient midnight requirement.<sup>17</sup>

Arguably, the current COVID-19 emergency blanket SNF waiver is not a perfect test of short- or long-term Medicare costs. First, factors such as reduced hospital elective surgeries that may typically drive post-acute SNF admissions, as well as potentially reduced SNF utilization caused by fear of

COVID-19 outbreaks, may temporarily lower SNF use and associated Medicare expenditures. The existing waiver of statute is also financially constrained, stipulating that “this action does not increase overall program payments. . . .”<sup>2</sup> Longer term, innovations in care delivery prompted by accelerated telehealth reforms may shift more post-acute care from SNFs to the home setting, changing patterns of SNF utilization altogether. Despite these limitations, this regulatory relief will still provide valuable utilization and cost information on SNF use under a system absent the three-midnight requirement.

## CONCLUSION

Rarely, if ever, does a national healthcare system experience such a rapid and marked change as that seen with the COVID-19 pandemic. Despite the tragic emergency circumstances prompting CMS’s blanket waivers, it provides CMS and stakeholders with a rare opportunity to evaluate potential improvements revealed by each individual aspect of COVID-19

regulatory relief. CMS has in the past argued the three-midnight SNF requirement is a statutory issue and thus not within their control, yet they have used their regulatory authority to waive this policy to facilitate efficient care in a national health crisis. This is a change that many believe is long overdue, and one that should be maintained even after COVID-19 abates. “Govt doesn’t always make sense,” as Administrator Verma wrote,<sup>1</sup> should be a cry for government to make better sense of existing legislation and regulation. Reform of the three-midnight inpatient rule is the right place to start.

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