The 3-Night Hospital Stay and Medicare Coverage for Skilled Nursing Care

According to current Medicare coverage policies, Medicare requires a patient to have been a hospital inpatient for at least 3 consecutive days to receive coverage for rehabilitation in a skilled nursing facility (SNF) after hospital discharge.

Consider the following 2 clinical scenarios. In the first, an 80-year-old man who falls at home and can no longer walk independently is evaluated in the emergency department but does not meet criteria for hospitalization. He needs rehabilitation in an SNF to regain his ability to walk but must be admitted to a hospital for 3 nights to qualify for Medicare payment for this rehabilitation. Without a 3-night stay, the patient or his family must either pay the cost of SNF care (about $430 per day), admit him to a nursing home (about $300 per day), or hire caregivers to support him at home ($20-$30 per hour). In the second scenario, a 90-year-old nursing home resident develops pneumonia and dehydration. The licensed practical nurse responsible for her care is overwhelmed by many sick residents and moreover cannot administer intravenous fluids. She asks the covering physician for a hospital transfer. If the resident is transferred to the hospital for 3 nights, costing Medicare about $12,300, she can return to the same nursing home under the SNF benefit for an additional $430 per day.

On the surface, the 3-night stay rule appears to impose excessive and unnecessary costs on Medicare, the patient, or his or her family, without providing clear benefits. In the first scenario, the rule might provide incentive for an empathetic physician to assign a qualifying diagnosis or order diagnostic tests to justify a 3-night hospitalization, thereby enabling the patient to access rehabilitation to prevent further functional decline without having to pay its high cost. This action would not only increase the patient’s risk of developing delirium, antimicrobial-resistant infections, and adverse drug reactions in the hospital but also could be considered Medicare fraud.2

In the second scenario, the nursing home lacks the necessary staff, resources, and financial incentives to provide acute care. By transferring the resident to the hospital for 3 nights, the nursing home not only reduces its costs but also reaps the benefit of higher Medicare payments for SNF care when the resident returns. A June 2010 Medicare Payment Advisory Commission report to Congress identified how the 3-night stay rule is financially advantageous to nursing homes.3 Medical record reviews indicate that 40% to 60% of hospital admissions from nursing homes are avoidable; of these, 83% are for “ambulatory sensitive conditions,” such as pneumonia, congestive heart failure, cellulitis, urinary tract infections, dehydration, and chronic obstructive pulmonary disease, that should be manageable in a nursing home.4 In 2005, 39% of hospitalizations for dual eligible nursing home residents were potentially preventable, costing Medicare and Medicaid an estimated $2.6 billion.4

Given that Medicare payment policy and the 3-night rule may create incentives to hospitalize patients unnecessarily, it is important to understand the history of the policy and the challenges to eliminating it.

History of the 3-Night Rule
When the Medicare extended care benefit was established in 1965, the 3-night stay requirement provided a mechanism to limit the use of scarce postacute care beds and ensure that patients received appropriate medical assessments. In 1965, it usually took 3 days for a Medicare patient to be admitted and evaluated, to have a care plan developed, and to be discharged. This currently takes a day or two.

In 1982, the Tax Equity and Fiscal Responsibility Act permitted the waiver of the 3-night requirement, but only if its elimination did not increase Medicare costs or compromise the acute care orientation of the program. At the same time, the Health Care Financing Administration (HCFA, currently the Centers for Medicare & Medicaid Services) contracted with Abt Associates to evaluate demonstration projects in Oregon and Massachusetts that waived the 3-night stay. These projects resulted in an estimated annual net Medicare savings of approximately $182 million in Oregon and an annual net cost of approximately $122 million in Massachusetts in 1979.5 When these costs were projected to the entire Medicare population, the estimated net effect on cost was relatively small, ranging from a $28 million savings (0.14%) to a $13 million cost (0.05%) annually. Furthermore, waiver of the 3-night stay requirement seemed to have little effect on the quality of patient care. On the basis of these findings, HCFA opposed removing the rule.

The Medicare Catastrophic Coverage Act (MCCA) of 1988 also waived the 3-night stay requirement. In a study of 431 Pennsylvania nursing homes that compared expenditures before and after the enactment of the MCCA, there was a 243% increase in Medicare expenditures attributable to volume increases in SNF care.6 Without the 3-night stay requirement, nursing homes may have triggered the SNF benefit for changes in condition that were previously managed with customary nursing home services. The MCCA was repealed 1 year later, reinstating the 3-night stay rule.

These experiences raised important concerns that eliminating the 3-night stay requirement would result in high unnecessary costs or the misuse of hospitals and SNFs. However, the retention of this rule continues to...
present risks to appropriate care and costs, as demonstrated by the scenarios described above.

Recent Waivers
For community-dwelling patients like the man described in the first scenario, Medicare managed care plans, special needs plans, and the Program for All-Inclusive Care of the Elderly have been granted waivers of the 3-night rule. These plans have demonstrated modest cost savings and increased patient satisfaction, but this may be attributable to intensive case management and enhanced community-based services for beneficiaries at risk of hospitalization, rather than waiver of the 3-night stay. However, data are not available on the effects of the waiver alone.

For the nursing home population, institutional special needs plans such as Evercare have also been granted waivers. Evercare reduced the rates of hospitalization and emergency department use while increasing the level of satisfaction among residents and families. In response to the positive results of several institutional special needs plans, a March 2013 Medicare Payment Advisory Commission Report to Congress recommended that institutional special needs plans should be permanently reauthorized. However, the direct financial outcomes of waiving the 3-night stay for Evercare and other waiver programs have not yet been evaluated.

Current Challenges
There is an imperative in the United States to reduce the excessive use of hospitals and provide appropriate care in less expensive venues. This national priority should be consistent with an effort to eliminate the 3-night stay requirement and provide enhanced care for older patients wherever they live—in the community or a nursing home. However, given the risk of excessive use of the Medicare skilled nursing benefit without a gatekeeping function, Medicare costs could increase further. Therefore, elimination of the 3-night stay will require controls to prevent overspending.

One type of control is inherent in the global capitation and shared savings approaches used by Medicare Advantage plans and accountable care organizations. When clinicians are responsible for funding patient care from a global payment, they are less likely to overtutilize expensive resources. Here, the risk to patients is under-utilization of necessary interventions to increase savings. This in turn requires additional controls such as quality measures and external audits to guard against withholding of care.

Alternatively, an impartial third party could determine when the skilled nursing benefit should be triggered. Quality-improvement organizations already play a major role in deciding the criteria for Medicare-certified observation stays, hospital admissions, and rehabilitation services. This approach requires a cumbersome and costly preauthorization process, making it impractical and unlikely to succeed.

Conclusions
Although there is little empirical evidence that elimination of the 3-night stay rule will improve patient care without increasing Medicare costs, there is justifiable concern that this rule contributes to suboptimal care and increased costs attributable to avoidable hospitalizations. There is a critical need to update payments and policies that address conditions that cause avoidable hospitalizations. Rather than rely on the 3-night stay to identify appropriate patients for skilled nursing and rehabilitative services, the Centers for Medicare & Medicaid Services could implement specific functional criteria for skilled nursing care, such as an acute decline in mobility, impairment in activities of daily living, or presence of delirium, and use the savings from reduced hospitalizations to provide appropriate payments for home-based and nursing home-based treatments. For the community-dwelling patient described in the first scenario, a shared-savings model with efficient case management and quality controls would provide incentive for his primary care physicians to admit him directly to a high-quality SNF so he can regain his ability to walk. For the nursing home patient described in the second scenario, a financing model that uses shared savings or provides adequate fee-for-service payments to fund acute medical and nursing care in the facility could reduce the incentive to hospitalize the patient and enable her to receive appropriate treatment where she lives. These and other payment models could obviate the 3-night stay requirement and hopefully would reduce the risks and high cost of unnecessary hospitalizations.

**ARTICLE INFORMATION**

Published Online: September 16, 2013.

Conflict of Interest Disclosures: The author has completed and submitted the ICMJE Form for Disclosure of Potential Conflicts of Interest and none were reported.

Funding and Support: Dr Lipsitz is supported by the Atlantic Philanthropies Health and Aging Policy Fellowship, the American Political Science Association, a merit award from the National Institute on Aging, and the Irving and Edyth S. Usen Family Chair in Geriatric Medicine at Hebrew SeniorLife.

Additional Contributions: I thank Evan Shulman (Medicare-Medicaid Coordination Office, Centers for Medicare & Medicaid Services, Department of Health and Human Services) for his helpful suggestions.

**REFERENCES**


