Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

VULNERABILITIES REMAIN UNDER MEDICARE'S 2-MIDNIGHT HOSPITAL POLICY

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December 2016
OEI-02-15-00020

Report in Brief
December 2016
OEI-02-15-00020

U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
OFFICE OF INSPECTOR GENERAL

Vulnerabilities Remain Under Medicare's 2-Midnight Hospital Policy

Why OIG Did This Review

The Centers for Medicare & Medicaid Services (CMS) implemented the "2-midnight" policy in fiscal year (FY) 2014. The policy establishes that inpatient payment is generally appropriate if physicians expect beneficiaries' care to last at least 2 midnights; otherwise, outpatient payment would generally be appropriate.

CMS implemented the 2-midnight policy to address three vulnerabilities in hospitals' use of inpatient and outpatient stays: improper payments for short inpatient stays; adverse consequences for beneficiaries of long outpatient stays, including that they may not have the 3 inpatient nights needed to qualify for skilled nursing facility (SNF) services; and inconsistent use of inpatient and outpatient stays among hospitals.

This report follows up on previous Office of Inspector General (OIG) work and compares data from the year before and the year after the implementation of the 2-midnight policy.

How OIG Did This Review

We analyzed paid Medicare hospital claims from FY 2013 and FY 2014. We identified inpatient stays using Part A hospital claims and outpatient stays using Part B hospital claims. We defined a "short stay" as one that lasted less than 2 midnights and a "long stay" as one that lasted 2 midnights or longer. For short inpatient stays, we determined whether claims information met CMS's criteria for payment under the 2-midnight policy (e.g. if the stay included an inpatient-only procedure).

What OIG Found

OIG found that the number of inpatient stays decreased and the number of outpatient stays increased since the implementation of the 2-midnight policy. Further, short inpatient stays decreased more than long outpatient stays. However, despite these changes, vulnerabilities still exist.

- Hospitals are billing for many short inpatient stays that are potentially inappropriate under the policy; Medicare paid almost $2.9 billion for these stays in FY 2014.
- Medicare pays more for some short inpatient stays than for short outpatient stays, although the stays are for similar reasons.
- Hospitals continue to bill for a large number of long outpatient stays.
- An increased number of beneficiaries in outpatient stays pay more and have limited access to SNF services than they would as inpatients.
- Hospitals continue to vary in how they use inpatient and outpatient stays.

CMS needs to address these continuing vulnerabilities by improving oversight of hospital billing under the 2-midnight policy and increasing protections for beneficiaries.

What OIG Recommends and Agency Response

We recommend that CMS (1) conduct routine analysis of hospital billing and target for review the hospitals with high or increasing numbers of short inpatient stays that are potentially inappropriate under the 2-midnight policy; (2) identify and target for review the short inpatient stays that are potentially inappropriate under the 2-midnight policy; (3) analyze the potential impacts of counting time spent as an outpatient toward the 3-night requirement for SNF services so that beneficiaries receiving similar hospital care have similar access to these services; and (4) explore ways of protecting beneficiaries in outpatient stays from paying more than they would have paid as inpatients.

CMS concurred with all four recommendations.

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OBJECTIVES

1. To assess the changes in hospital inpatient and outpatient stays since the implementation of Medicare's 2-midnight policy.
2. To identify remaining vulnerabilities since the implementation of the 2-midnight policy.
3. To determine the extent to which hospitals' use of inpatient and outpatient stays vary.

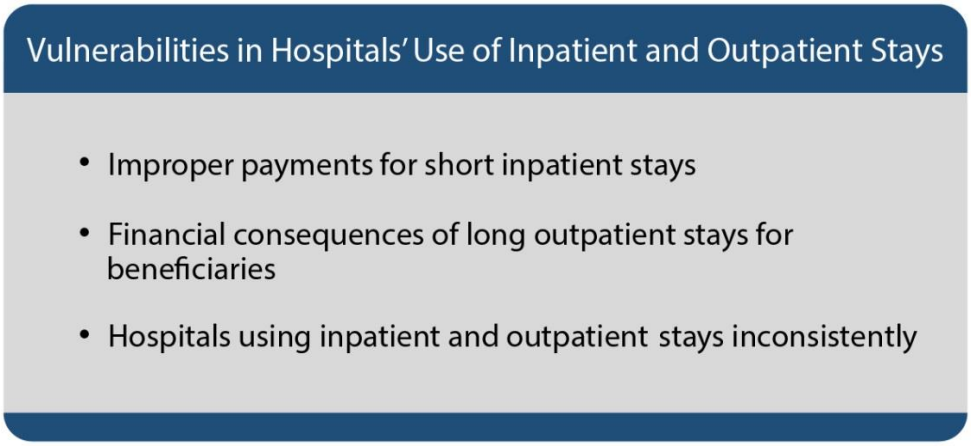
BACKGROUND

In fiscal year (FY) 2014, the Centers for Medicare & Medicaid Services (CMS) implemented "the 2-midnight policy" to clarify the appropriateness of inpatient hospital admissions.[1] Specifically, the policy establishes that inpatient payment is generally appropriate if physicians expect beneficiaries' care to last at least 2 midnights; otherwise, outpatient payment would generally be appropriate.

CMS implemented the 2-midnight policy to address vulnerabilities in hospitals' billing of short inpatient stays and long outpatient stays and the associated cost to Medicare and beneficiaries. Before the policy was implemented, CMS found that a significant portion of payments for short inpatient stays—i.e., stays lasting less than 2 midnights—were improper because the services should have been billed as outpatient services.[2]

In addition, CMS, Members of Congress, and others were concerned about long outpatient stays—those lasting 2 midnights or longer. In particular, they were concerned that beneficiaries may pay more as outpatients than they would as inpatients. This could happen because of differences in payments by beneficiaries for inpatient and outpatient stays. Moreover, they were concerned that beneficiaries who are not admitted as inpatients may not qualify under Medicare for skilled nursing facility (SNF) services following discharge from the hospital. Another concern leading to the 2-midnight policy was that hospitals were using inpatient and outpatient stays inconsistently—some hospitals were more likely to use short inpatient stays, while others were more likely to use outpatient stays.

[1] 78 Fed. Reg. 50506 (Aug. 19, 2013).
[2] CMS, Comprehensive Error Rate Testing, *Medicare Fee-for-Service 2014 Improper Payment Report*, July 2015. Accessed at https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/CERT/CERT-Reports-Items/Medicare-FeeforService-2014-Improper-Payments-Report.html on May 10, 2016.



The text box above summarizes these known vulnerabilities prior to the implementation of the 2-midnight policy.

In previous work, the Office of Inspector General (OIG) provided data related to these concerns.[3] Before the 2-midnight policy was implemented, OIG found that Medicare paid hospitals more for short inpatient stays than for outpatient stays, on average, and that some hospitals were far more likely to use short inpatient stays rather than outpatient stays. We concluded that hospitals have a financial incentive to use short inpatient stays. In addition, we found that, on average, beneficiaries paid twice as much for a short inpatient stay than for an outpatient stay that included observation services. However, some beneficiaries in outpatient stays paid more than they would have if they had been admitted as inpatients. Also, some beneficiaries were responsible for SNF charges after they were discharged from hospitals.

This report follows up on our previous work and compares data from the year before and the year after the implementation of the 2-midnight policy. It identifies remaining vulnerabilities and provides recommendations to address them.

The 2-Midnight Policy

The decision to admit a beneficiary as an inpatient is made by the treating physician, who must consider several clinical factors including the beneficiary's medical history, the severity of the beneficiary's symptoms, and the expected care.[4]

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[3] OIG, *Hospitals' Use of Observation Stays and Short Inpatient Stays for Medicare Beneficiaries*, OEI-02-12-00040, July 2013.

[4] CMS, *Medicare Benefit Policy Manual* (MBPM), Pub. No. 100-02, ch. 1, § 10. Prior to FY 2014, CMS guidance stated that physicians should consider whether the beneficiary would require at least 24 hours of care.

At the beginning of FY 2014, CMS implemented the 2-midnight policy to clarify the appropriateness of payments for inpatient stays. The policy establishes that Medicare will generally pay for an inpatient stay if physicians reasonably expect beneficiaries' care to last at least 2 midnights; otherwise, payment would generally be made for treatment as outpatients.

Anticipated Outcomes of the 2-Midnight Policy

- Decrease use of short inpatient stays
- Decrease use of long outpatient stays
- Promote more consistent and appropriate use of inpatient and outpatient stays

CMS anticipated that the 2-midnight policy would decrease hospitals' use of short inpatient stays and long outpatient stays. CMS also anticipated that the policy would provide hospitals with some clarity that would promote the consistent, appropriate use of inpatient and outpatient stays.[5] The consistent, appropriate use of these stays would also result in more consistent payments by Medicare and beneficiaries. The text box above summarizes these anticipated outcomes.

The policy also establishes that inpatient stays lasting at least 2 midnights from the date of inpatient admission will be presumed appropriate for payment.[6] Those lasting less than 2 midnights may be reviewed by CMS for compliance with the policy. CMS identified several circumstances under which a stay—though short—would nevertheless be appropriate and consistent with the policy. These circumstances include stays with:

1. inpatient-only procedures;
2. mechanical ventilation initiated during the visit;
3. an unforeseen circumstance, such as the beneficiary's death, transfer to another hospital, or leaving against medical advice; or

[5] 78 Fed. Reg. 50948 (Aug. 19, 2013).
[6] This guidance is for CMS's contractors as they review inpatient claims for compliance.

4. 2 midnights or longer in the hospital when outpatient time prior to admission is added to inpatient time.[7]

Limited Enforcement

In the first 2 years of the policy, CMS engaged in limited reviews of short inpatient stays. During this time—FY 2014 and FY 2015—CMS's Recovery Auditors were prohibited from reviewing short inpatient stays to determine whether the admissions were appropriate under the 2-midnight policy. Instead, CMS's Medicare Administrative Contractors reviewed medical records for small samples of each hospital's short inpatient stays. If the results of the sample indicated poor compliance with the policy, the contractors educated the hospital and conducted further reviews.

Recent Changes

CMS has made two recent revisions to the 2-midnight policy.[8] First, beginning in 2016, it allowed for case-by-case exceptions to the policy in which a physician determines that an inpatient stay is necessary absent an expected length of stay of at least 2 midnights. The physician's decision must be documented in the medical record and is subject to review by CMS's contractors. Second, CMS changed its enforcement policy so that CMS's Quality Improvement Organizations first review small samples of medical records to determine whether hospitals are complying with the 2-midnight policy. If they find deficiencies, these organizations educate the hospitals to promote compliance. If deficiencies continue, they refer the hospitals to the Recovery Auditors for further reviews.

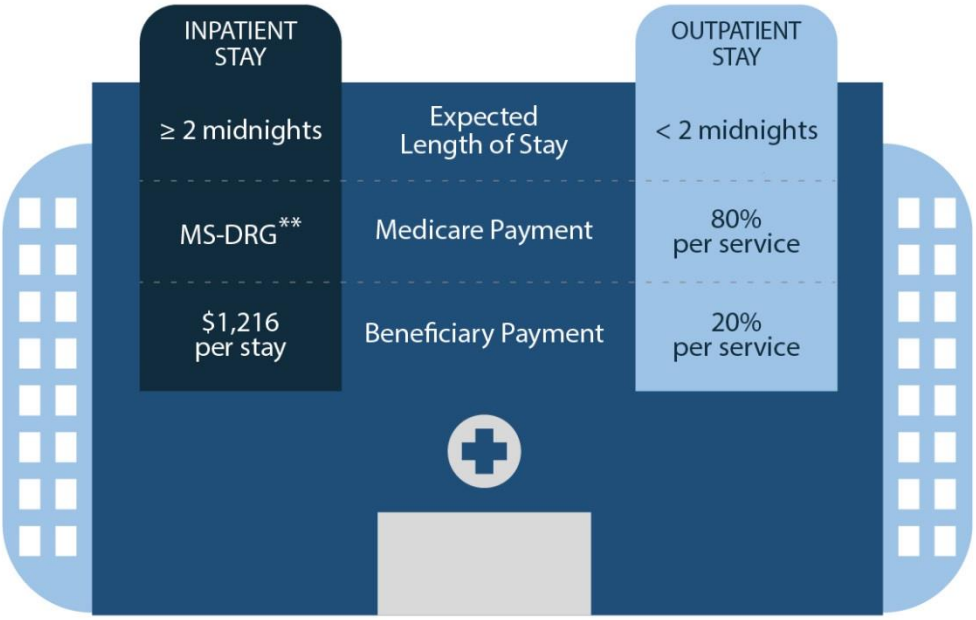
Medicare and Beneficiary Payments for Hospital Stays

Medicare and beneficiary payments to hospitals differ for inpatient and outpatient stays. Under the 2-midnight policy, stays expected to last at least 2 midnights are generally appropriate for inpatient payment; other stays are generally appropriate for outpatient payment (see Figure 1).

[7] See 80 Fed. Reg. 70540–70541 (July 8, 2015) and CMS, *Frequently Asked Questions: 2 Midnight Inpatient Admission Guidance & Patient Status Reviews for Admissions on or after October 1, 2013*. Accessed at https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Medical-Review/InpatientHospitalReviews.html on November 5, 2013.

[8] 80 Fed. Reg. 39206 (July 8, 2015).

Figure 1: Comparison Between Payments for Inpatient and Outpatient Stays, FY 2014*



* While the information in this table applies generally to inpatient and outpatient stays in FY 2014, there are some circumstances under which different payment rules would apply.
** Stays are classified into Medicare severity diagnosis related groups (MS-DRGs), each of which has an associated payment rate.

Inpatient Stays

Medicare Part A pays hospitals for inpatient stays under the Inpatient Prospective Payment System (IPPS).[9] Each stay is classified into a Medicare severity diagnosis related group (MS-DRG). These groups are based on the beneficiary's primary and secondary diagnoses and the procedures the hospital performed, as well as other factors.[10] Medicare pays hospitals a different payment rate for each MS-DRG.[11] Beneficiaries

[9] Social Security Act, § 1886(d); 42 CFR pt. 412.
[10] Each MS-DRG generally falls into one of three severity levels, depending on the beneficiary's secondary diagnoses. For example, a beneficiary with no secondary diagnoses that increase the complexity of care would be in a low-severity MS-DRG, a beneficiary with asthma would be in a medium-severity MS-DRG, and a beneficiary with pneumonia would be in a high-severity MS-DRG.
[11] Payment rates are adjusted by a variety of facility-level factors, such as a geographic factor to account for differences in labor costs.

are responsible for an inpatient deductible; in 2014, the deductible was $1,216.[12]

Outpatient Stays

Medicare Part B pays hospitals for outpatient stays under the Outpatient Prospective Payment System (OPPS).[13] When a hospital bills Medicare, the claim typically includes many services. Under the OPPS, each service has an associated Medicare payment rate. For most services, Medicare pays 80 percent of this rate, while the beneficiary is responsible for the remaining 20 percent.[14] Beneficiary copayments are capped so beneficiaries do not pay more than the inpatient deductible for any individual outpatient service, but there is no policy to prevent the payments for multiple services from adding up to more than the inpatient deductible.[15] Beginning in 2015, CMS began implementing "comprehensive ambulatory payment classifications," which are designed to provide a single payment rate for a primary service and any secondary services related to it.[16] In these circumstances, beneficiaries would be responsible for 20 percent of the single payment amount rather than for 20 percent of the payment amount for each individual service.[17]

In addition, beneficiaries may be charged for self-administered drugs taken during their outpatient stays because Medicare Part B generally does not cover them.[18]

SNF Services After a Hospital Stay

Medicare Part A pays SNFs under the SNF Prospective Payment System.[19] To qualify for SNF services, a Medicare beneficiary must have had an

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[12] Beneficiaries are responsible for paying the deductible once per benefit period, even though a benefit period may include multiple inpatient hospital stays. A benefit period ends when the beneficiary has not received Medicare-covered hospital or SNF services for 60 consecutive days.

[13] Social Security Act, § 1833(t); 42 CFR part 419.

[14] Social Security Act, § 1833(t); 42 CFR § 419.40(b); CMS, *Medicare Claims Processing Manual*, Pub. No. 100-04, ch. 4, § 30.

[15] See Social Security Act, § 1833(t)(8)(C) and 42 CFR § 419.40(c).

[16] 78 Fed. Reg. 74861 (Dec. 10, 2013).

[17] The beneficiary's 20 percent of the single payment amount may not exceed the inpatient deductible.

[18] Self-administered drugs are not covered unless they are required for the outpatient services that beneficiaries receive. Even if they are not covered, hospitals may not always bill beneficiaries for the self-administered drug charges. In some cases, beneficiaries may choose to request reimbursement from their Part D plan; however, if the Part D plan reimburses the beneficiary, it may be at a rate lower than that charged by the hospital. Beneficiaries would be responsible for the difference.

[19] Social Security Act, § 1886(e)(4); 42 CFR part 413.

inpatient stay in a hospital for at least 3 nights.[20] Outpatient stays and time spent as an outpatient prior to inpatient admission do not count toward this requirement.[21] Beneficiaries may choose to receive SNF services when they do not qualify for them under Medicare, but the beneficiaries are then responsible for the full SNF charges.

METHODOLOGY

We based this study on an analysis of paid Medicare Part A and Part B hospital claims and Part B noninstitutional provider claims from the National Claims History file with dates of service in FY 2013 and FY 2014. We excluded claims from hospitals that were not paid under both the OPPS and the IPPS, such as long-term care hospitals, critical access hospitals, and hospitals in Maryland.

For this study, inpatient stays were identified using Part A hospital claims, and outpatient stays were identified using Part B hospital claims. We defined a "short stay" as one that lasted less than 2 midnights and a "long stay" as one that lasted 2 midnights or longer.[22]

For short inpatient stays, we determined whether information on the hospital claims met CMS's criteria for inpatient payment under the 2-midnight policy. If so, we considered the stay "appropriate" for payment under the 2-midnight policy; if not, we considered the stay to be "potentially inappropriate" for payment. We based this analysis on claims and did not do a medical record review. Information on the claim can indicate only whether the stay was *potentially* inappropriate under the policy. A medical record review would be needed to make a final and complete determination of whether a stay was in fact appropriate.[23]

See Appendix A for more detailed information about the methodology and Appendix B for descriptions of the reasons for the inpatient and outpatient stays presented in this report.

Limitations

This study was based on hospital claims and did not include a medical record review. We did not determine whether each claim met all of Medicare's requirements, including whether services billed were medically necessary. In addition, we did not isolate the effect of the

[20] This qualifying hospital stay typically must occur within the 30 days prior to the SNF admission. See Social Security Act § 1861(i) and 42 CFR § 409.30.
[21] MBPM, ch. 8, § 10.
[22] For inpatient stays, this definition is based on the date of the inpatient admission and includes only time spent as an inpatient.
[23] For example, a medical review may show that some short inpatient stays were appropriate because the beneficiary experienced clinical improvement after the physician documented an expectation of a 2-midnight stay.

2-midnight policy; instead, we looked at the differences in types of stays before and after the implementation of the policy. Some of these differences could be related to factors other than the 2-midnight policy.

Standards

This study was conducted in accordance with the *Quality Standards for Inspection and Evaluation* issued by the Council of the Inspectors General on Integrity and Efficiency.

FINDINGS

Hospital inpatient stays decreased and outpatient stays increased since the implementation of the 2-midnight policy

Overall, the number of hospital inpatient stays decreased and the number of outpatient stays increased in FY 2014, the year the 2-midnight policy was implemented. Specifically, inpatient stays decreased by 262,794 stays, and outpatient stays increased by a similar number—259,908. These changes represent a 2.8 percent decrease in inpatient stays and an 8.1 percent increase in outpatient stays (see Table 1). Despite these changes, vulnerabilities remain and raise concerns about the cost to Medicare and beneficiaries.

Table 1: Change in Stays From FY 2013 to FY 2014

Setting	FY 2014	Change From FY 2013	Percentage Change From FY 2013
Inpatient	9,083,804	-262,794	-2.8%
Outpatient	3,458,234	259,908	8.1%
Total	**12,542,038**	**-2,886**	

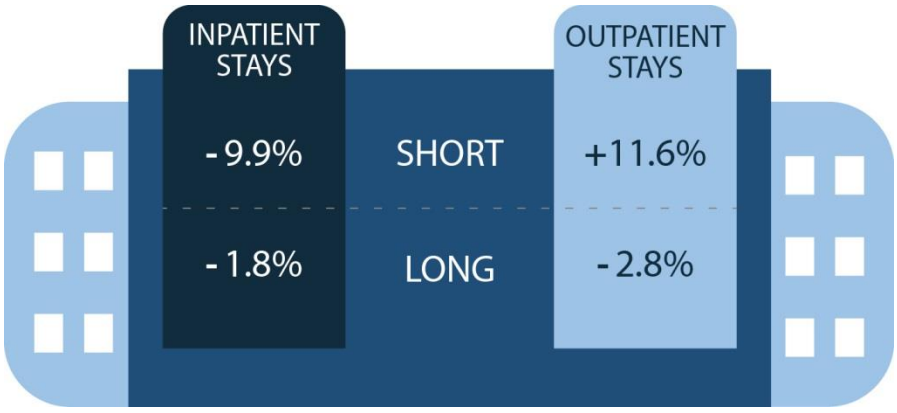
Source: OIG analysis of CMS data, 2016.

Short inpatient stays decreased more than long outpatient stays

CMS anticipated that the 2-midnight policy would decrease the number of short inpatient stays (those lasting fewer than 2 midnights). In FY 2014, short inpatient stays decreased by almost 10 percent.

CMS anticipated that the policy would also decrease the number of long outpatient stays (those lasting 2 midnights or longer). In FY 2014, long

Figure 2: Changes in Types of Hospital Stays, FY 2013 to FY 2014



Source: OIG analysis of CMS data, 2016.

outpatient stays decreased only slightly, by about 3 percent (see Figure 2 and Appendix C).

Despite changes, vulnerabilities remain and raise concerns about the cost to Medicare and beneficiaries

Despite the changes in hospital billing, vulnerabilities still exist. Hospitals are billing for many short inpatient stays that are potentially inappropriate under the 2-midnight policy and some of them indicate that Medicare—and beneficiaries—may be paying differently for similar care. Moreover, hospitals continue to bill for a large number of long outpatient stays. An increased number of beneficiaries in outpatient stays pay more and have limited access to SNF services than they would as inpatients.

Hospitals are billing for many short inpatient stays that are potentially inappropriate under the 2-midnight policy

Hospitals were paid for a total of 1,074,267 short inpatient stays in FY 2014. Of these, 39 percent were potentially inappropriate for payment under the 2-midnight policy because the claims did not appear to meet any of CMS's criteria for an appropriate short inpatient stay.[24] Short inpatient stays that were potentially inappropriate under the policy decreased by almost one-third from the previous year, yet there were still 423,544 of them in FY 2014. See Table 2, and for more information about the short inpatient stays that were appropriate under the 2-midnight policy, see Appendix D.

Medicare paid almost $2.9 billion for short inpatient stays that were potentially inappropriate under the policy in FY 2014. Medical record reviews are necessary to make a final and complete determination of whether these stays are appropriate or not.[25] However, these stays cannot be reviewed by CMS contractors for this purpose because CMS's enforcement during this time period was limited to medical record reviews of small samples of each hospital's short inpatient stays, and additional medical record reviews are prohibited.[26]

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[24] We identified stays with the following characteristics: inpatient-only procedures; mechanical ventilation; an unforeseen circumstance such as the beneficiary's death, transfer to another hospital, or departure against medical advice; or a duration of 2 midnights or longer in the hospital when outpatient time prior to admission is added to inpatient time (see Appendixes B and D).

[25] For example, a medical review may show that some are appropriate because the beneficiary experienced clinical improvement after the physician documented an expectation of a 2-midnight stay.

[26] 80 Fed. Reg. 70540 (July 8, 2015).

Table 2: Change in Short Inpatient Stays From FY 2013 to FY 2014

Short Inpatient Type	FY 2014	Change From FY 2013	Percentage Change From FY 2013
Appropriate under the 2-midnight policy	650,723	72,669	12.6%
Potentially inappropriate under the 2-midnight policy	423,544	-190,729	-31.0%
Total	**1,074,267**	**-118,060**	**-9.9%**

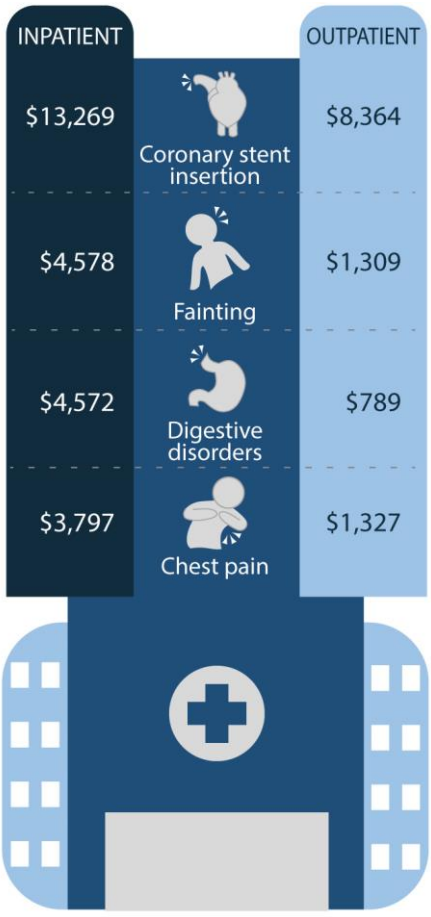
Source: OIG analysis of CMS data, 2016.

Medicare pays more for some short inpatient stays than for short outpatient stays, although the stays are for similar reasons

The most common reasons for short inpatient stays were similar to the most common reasons for short outpatient stays, though all of these stays lasted fewer than 2 midnights.[27] For example, four of the six most common reasons for short inpatient stays were also the four most common reasons for short outpatient stays. See Appendix E for the most common reasons for each type of stay.

Although reasons for the stays were similar, Medicare payments were not. On average, Medicare paid three times as much for a short inpatient stay than for a short outpatient stay. Further, for all of the 10 most common reasons for short inpatient stays, Medicare paid more for short inpatient stays than for short outpatient stays (see Appendix F). For example, for digestive disorders, Medicare paid an average of $4,572 for short inpatient stays but $789 for short outpatient stays (see Figure 3). These payment

Figure 3: Average Medicare Payments for Short Inpatient Stays and Short Outpatient Stays for Most Common Reasons in FY 2014



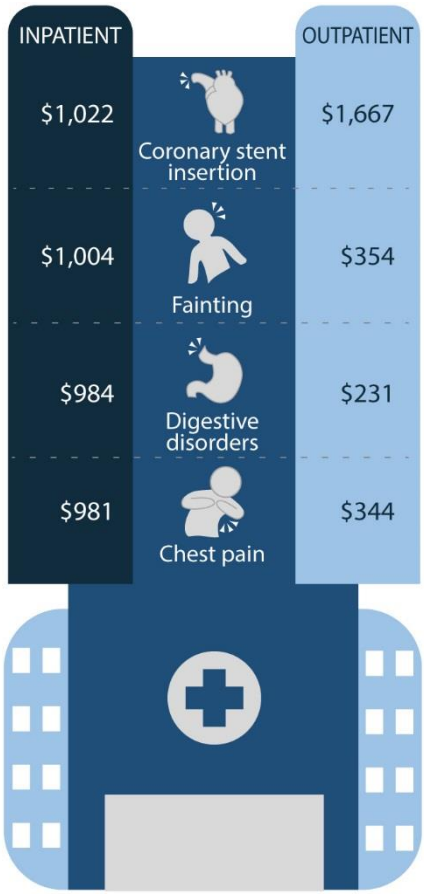
Source: OIG analysis of CMS data, 2016.

[27] For this analysis, we included only short inpatient stays that were potentially inappropriate under the 2-midnight policy.

differences raise concerns that Medicare is paying differently for similar care.

Beneficiaries, too, typically paid more for short inpatient stays than for short outpatient stays. On average, beneficiaries paid almost two times as much for a short inpatient stay than for a short outpatient stay. Further, for nine of the most common reasons for short inpatient stays, beneficiaries paid more for short inpatient stays than for short outpatient stays (see Appendix F). For example, beneficiaries with digestive disorders paid an average of $984 for short inpatient stays but an average of $231 for short outpatient stays, a notable exception being for coronary stent insertions (see Figure 4).

Figure 4: Average Beneficiary Payments for Short Inpatient Stays and Short Outpatient Stays for Most Common Reasons in FY 2014



Source: OIG analysis of CMS data, 2016.

Hospitals continue to bill for a large number of long outpatient stays

Long outpatient stays decreased only slightly in FY 2014—by about 3 percent. Hospitals continued to bill a significant number—748,337—despite the 2-midnight policy. A large number of long outpatient stays is somewhat unexpected because these stays likely met the 2-midnight policy's expected-length-of-stay requirement for inpatient admission, and providers have a financial incentive to admit beneficiaries as inpatients when possible. That providers did not admit these beneficiaries may indicate that other factors caused them to continue to bill for a large number of long outpatient stays. These factors may include an inability to safely discharge beneficiaries, delays in care, or confusion about the 2-midnight policy.

An increased number of beneficiaries in outpatient stays pay more and have limited access to SNF services than they would as inpatients

Some beneficiaries in outpatient stays—both short and long—faced financial consequences that they would not have faced had they been in

inpatient stays. These consequences include paying more for hospital and SNF services because Medicare policies differ for inpatient and outpatient stays.

On average, beneficiaries paid more for inpatient stays than for outpatient stays, but in some instances the reverse was the case. In FY 2014, beneficiaries in 352,940 outpatient stays paid more than the inpatient deductible.[28] This is an increase of almost 50,000 in such outpatient stays, or 16 percent, from FY 2013. The most common reason for these stays was coronary stent insertion, accounting for just over one-quarter of such stays. See Appendix G for more information about how these stays increased beneficiaries' payments. Beneficiaries in outpatient stays generally pay 20 percent of Medicare's rate for each service, and there is no cap on the total amount they can be responsible for paying.[29]

In addition, an increased number of beneficiaries in outpatient stays had charges for self-administered drugs.[30] In FY 2014, beneficiaries in 1,628,628 outpatient stays had charges for such drugs, an increase of 13 percent from FY 2013. When the charges were present on a claim, the average amount was $207, essentially the same as in FY 2013.[31] This amounted to more than $337 million in charges.

For some beneficiaries, time spent as an outpatient could mean facing substantial charges after they leave the hospital. Medicare covers SNF services only if a beneficiary had a hospital stay that included at least 3 nights as an inpatient. An increased number of beneficiaries in FY 2014 did not qualify for SNF services after their hospital stays. In that fiscal year, beneficiaries had 633,148 hospital stays that lasted at least 3 nights but did not include 3 *inpatient* nights. This number of stays reflects a 6 percent increase from FY 2013. These beneficiaries did not qualify for SNF services under Medicare and, therefore, would have been responsible for any SNF charges incurred following their hospital stays.[32]

For most of these stays (432,740), beneficiaries spent some nights in the hospital as outpatients and then were admitted as inpatients for additional nights. This type of stay increased by 20 percent from FY 2013. For the

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[28] The inpatient deductible was $1,216 in calendar year 2014.

[29] In circumstances involving comprehensive ambulatory payment classifications, beneficiaries may be responsible for a single payment rather than for payments for each individual service.

[30] Beneficiaries in inpatient stays typically do not pay for these drugs.

[31] Hospitals may not always bill beneficiaries for these charges.

[32] For this study, we did not determine the extent to which beneficiaries who had hospital stays of at least 3 nights but not 3 *inpatient* nights needed SNF services. However, prior OIG work found that 4 percent of these beneficiaries in 2012 went to a SNF following discharge from the hospital. See OIG, *Hospitals' Use of Observation Stays and Short Inpatient Stays for Medicare Beneficiaries*, OEI-02-12-00040, July 2013.

other stays (200,408), beneficiaries spent 3 or more nights as outpatients and were never admitted. This type of stay decreased from FY 2013 (see Table 3).

Table 3: Change From FY 2013 to FY 2014 in Hospital Stays That Lasted at Least 3 Nights but Did Not Include 3 Inpatient Nights

Type of Stay	FY 2014	Change From FY 2013	Percentage Change From FY 2013
3 or more nights as outpatient and never admitted as inpatient	200,408	-36,163	-15.3%
Began as outpatient and admitted as inpatient	432,740	72,342	20.1%
Total	**633,148**	**36,179**	**6.1%**

Source: OIG analysis of CMS data, 2016.

Hospitals continue to vary in how they use inpatient and outpatient stays

CMS anticipated that the 2-midnight policy would promote the consistent, appropriate use of inpatient and outpatient stays. However, hospitals continued to vary in how they used short inpatient stays and long outpatient stays in FY 2014.[33] For example, nationally, approximately 3 percent of all stays were short inpatient stays. However, this percentage varied among hospitals, ranging from about 1 percent to more than 5 percent (see Table 4). For comparison, these same values were approximately 2 and 8 percent in FY 2013. While the variation decreased in FY 2014, hospitals' use of short inpatient stays remained inconsistent.

Similarly, 6 percent of all stays were long outpatient stays in FY 2014. Again, this percentage varied among hospitals, ranging from about 2 percent to almost 11 percent, essentially unchanged from FY 2013.

Table 4: Distribution of the Use of Stays Among Hospitals in FY 2014

Setting	Length of Stay	Percentage of All Stays – National	Distribution Among Hospitals		
			10th Percentile	50th Percentile	90th Percentile
Inpatient	Short	3.4%	1.1%	3.1%	5.4%
Outpatient	Long	6.0%	2.1%	5.7%	10.8%

Source: OIG analysis of CMS data, 2016.

Furthermore, while use of short inpatient and long outpatient stays decreased in FY 2014 nationally, some hospitals increased their use of

[33] For this analysis, we included only short inpatient stays that were potentially inappropriate under the 2-midnight policy.

these stays, which is inconsistent with the stated goals of the 2-midnight policy. Specifically, 18 percent of hospitals increased their use of short inpatient stays. Similarly, 51 percent of hospitals increased their use of long outpatient stays.

This pattern was even more pronounced for certain reasons for stays. For example, nationally, the use of short inpatient stays for chest pain decreased substantially in FY 2014. At some hospitals, use decreased to zero. However, 29 percent of hospitals actually increased their use of short inpatient stays for chest pain.

For stays involving chest pain, Medicare and beneficiaries paid hospitals more for short inpatient stays than for short outpatient stays. Medicare paid hospitals an average of $3,797 for a short inpatient stay and $1,327 for a short outpatient stay. As a result, hospitals that had a high or increasing use of short inpatient stays for chest pain received larger payments than hospitals that had a low or decreasing use of short inpatient stays for chest pain.

CONCLUSION AND RECOMMENDATIONS

Overall, we found that the number of inpatient stays decreased and the number of outpatient stays increased since the implementation of the 2-midnight policy. Short inpatient stays decreased more than long outpatient stays. Despite these changes, vulnerabilities still exist.

Hospitals are billing for many short inpatient stays that are potentially inappropriate under the 2-midnight policy, and some of these stays are for similar reasons as short outpatient stays. This raises concerns that Medicare is paying differently for similar care and may reflect hospitals' financial incentives to use inpatient stays. Hospitals also continue to bill for a large number of long outpatient stays. Moreover, an increased number of beneficiaries in outpatient stays pay more and have limited access to SNF services than they would as inpatients. Finally, hospitals continue to vary in how they use inpatient and outpatient stays, even though the policy was intended to promote consistency among hospitals.

CMS needs to address these vulnerabilities by improving oversight of hospital billing under the 2-midnight policy and increasing protections for beneficiaries.

Specifically, we recommend that CMS:

Conduct routine analysis of hospital billing and target for review the hospitals with high or increasing numbers of short inpatient stays that are potentially inappropriate under the 2-midnight policy

Since the 2-midnight policy was implemented, enforcement has been limited. We found that hospitals billed for a large number of potentially inappropriate short inpatient stays; for these stays, Medicare paid a total of almost $2.9 billion. We also found that hospitals may have financial incentives to use short inpatient stays, and that some hospitals increased their use of these stays, which is inconsistent with the stated goals of the 2-midnight policy.

CMS should routinely conduct analysis to identify hospitals that have high or increasing numbers of short inpatient stays that are potentially inappropriate under the 2-midnight policy. CMS should use this analysis to inform its auditing and enforcement strategies. Such oversight is even more important given the change made in 2016 to allow for case-by-case exceptions to the 2-midnight policy. This policy change has the potential for abuse and should be monitored closely.

CMS should use the analysis to instruct the Quality Improvement Organizations to target the identified hospitals for larger samples or more

frequent medical record reviews. If warranted, these hospitals should be referred to the Recovery Auditors for further audits and possible recoupments. In addition, we will refer to CMS the list of hospitals that we identified as having high or increasing numbers of short inpatient stays for appropriate followup.

Identify and target for review the short inpatient stays that are potentially inappropriate under the 2-midnight policy

We found that about 40 percent of all short inpatient stays were potentially inappropriate under the 2-midnight policy. CMS should routinely use claims information to identify such stays and target these potentially inappropriate stays for medical review to determine whether they are appropriate. Using medical reviews in this way would be a more efficient use of Medicare resources than a strategy that looks at all short inpatient stays.

CMS should develop tools to effectively identify these short inpatient stays for review. For example, CMS should develop a list of inpatient procedure codes associated with inpatient-only procedures.[34] In addition, CMS should encourage and expand hospitals' use of an existing code that allows them to indicate on Medicare claims a beneficiary's time spent as an outpatient prior to inpatient admission. CMS should use this code to add together the beneficiary's time as an outpatient and time as an inpatient to determine whether the beneficiary spent at least 2 midnights in the hospital in total. By using this code, the inpatient-only procedure codes, and discharge codes on claims, CMS could distinguish stays that are potentially inappropriate under the policy from those that are appropriate.

Analyze the potential impacts of counting time spent as an outpatient toward the 3-night requirement for SNF services so that beneficiaries receiving similar hospital care have similar access to these services

Under current Medicare policy, beneficiaries with similar post-hospital care needs have different access to and cost sharing for SNF services depending on whether they were hospital outpatients or inpatients. CMS should analyze the potential impacts of counting time spent as an outpatient toward the 3-night requirement to qualify for SNF services, which would provide equitable access to SNF services for Medicare beneficiaries regardless of whether they are inpatients or outpatients.

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[34] Currently, CMS has only a list of outpatient procedure codes associated with inpatient-only procedures to ensure that these codes are not used on outpatient claims. There is no corresponding list of the inpatient procedure codes associated with inpatient-only procedures.

CMS should closely review and weigh the financial implications of any proposed policy change for both the Medicare program and its beneficiaries.

Explore methods for protecting beneficiaries in outpatient stays from paying more than they would have paid as inpatients

Beneficiaries generally pay for each Part B service they receive.[35] As a result, beneficiaries in outpatient stays may pay more than they would as inpatients because they may receive many services and their payments may add up to more than the inpatient deductible. CMS should assess the extent to which Medicare beneficiaries in outpatient stays continue to pay more than they would as inpatients. It should also explore methods, including statutory or other policy changes as necessary, for ensuring more equitable cost sharing for beneficiaries with similar care needs regardless of whether they are inpatients or outpatients. For example, CMS could consider capping beneficiary payments for the entire outpatient hospital stay at the level of the inpatient deductible.

In addition, many beneficiaries in outpatient stays incur charges for self-administered drugs. Hospitals may choose whether or not to bill beneficiaries for these charges, which means that some beneficiaries have to pay for them while others do not. CMS should assess the extent to which hospitals bill beneficiaries for these charges. CMS should consider covering self-administered drugs in certain circumstances, such as when the beneficiary has been an outpatient for 24 or more hours, so that beneficiaries' payments are not dependent on the hospital at which they seek treatment.

For any potential change in policy, CMS should conduct an analysis of the potential implications for Medicare and beneficiaries. CMS should use the results of these analyses to develop legislative proposals, as appropriate, to seek the authority to implement changes that would further the goal of more equitable beneficiary cost sharing.

[35] In circumstances involving comprehensive ambulatory payment classifications, beneficiaries may be responsible for a single payment rather than for payments for each individual service.

AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

CMS concurred with all four of our recommendations.

First, CMS concurred with our recommendation to conduct routine analysis of hospital billing and target for review the hospitals with high or increasing numbers of short inpatient stays. CMS stated that it will instruct its Quality Improvement Organizations, which review medical records to determine whether hospitals are complying with the 2-midnight policy, to conduct such analysis.

Second, CMS concurred with our recommendation to identify and target for review the short inpatient stays that are potentially inappropriate under the 2-midnight policy. CMS stated that its Quality Improvement Organizations are currently conducting initial patient status reviews of short stays in hospitals to determine the appropriateness of Part A payment for short stay hospital claims.

Third, CMS concurred with our recommendation to analyze the potential impacts of counting time spent as an outpatient toward the 3-night requirement to qualify for SNF services. CMS noted that while it will analyze the potential impacts of such a policy change, it currently lacks the statutory authority to make the policy change.

Finally, CMS concurred with our recommendation to explore methods for protecting beneficiaries in outpatient stays from paying more than they would have paid as inpatients. CMS noted that it has already explored its existing statutory authority to protect beneficiaries in these situations. The current statutory requirements are fairly prescriptive surrounding beneficiary cost-sharing liabilities under the IPPS and the OPPS. CMS has taken several steps within its statutory authority to reduce beneficiary cost sharing. For example, it established Comprehensive Ambulatory Payment classifications under the OPPS, which establishes a single copayment and helps protect beneficiaries from paying a copayment for each service furnished in an encounter.

For the full text of CMS's comments, see Appendix H.

APPENDIX A

Detailed Methodology

We based this study on an analysis of paid Medicare Part A and Part B hospital claims and Part B noninstitutional provider claims from the National Claims History file with dates of service in FY 2013 and FY 2014. We excluded claims from hospitals that were not paid under both the OPPS and IPPS, such as long-term care hospitals, critical access hospitals, and hospitals in Maryland.

We used the Medicare claims to identify hospital stays relevant to the analysis of the 2-midnight policy.[36] For outpatient stays, we identified all Part B hospital claims that (1) included observation services or (2) lasted at least 1 night and included emergency department services or a major procedure.[37] We used Part A hospital claims to identify all inpatient stays.[38] We then calculated the length of each stay. We considered stays "short" if they lasted fewer than 2 midnights and "long" if they lasted 2 midnights or longer.[39]

We used this information to calculate the number and percentage of stays by setting (i.e. inpatient and outpatient) and length of stay (i.e. short and long) in FY 2013 and FY 2014. We calculated the difference and the percentage change between FY 2013 and FY 2014. We also calculated the average Medicare and beneficiary payment in FY 2014 by setting and length of stay.

We then determined the reason for each stay. For inpatient stays, we used the MS-DRG on the claim as the reason for the stay. For outpatient stays, we calculated what the MS-DRG would have been if the beneficiary had been admitted. We used information on the hospital and noninstitutional provider claims regarding the beneficiaries' primary and secondary

[36] For the purposes of this report, we considered each hospital claim to be a hospital stay.
[37] Observation services are short-term treatments and assessments to determine whether a beneficiary should be admitted as an inpatient or discharged. Claims with observation services were identified as those with a claim line item with a revenue center code of 0760 or 0762. For claims that lasted at least 1 night, we did not include claims for repetitive and recurring services, such as physical therapy and chemotherapy. The dates on these claims may indicate, for example, a 30-day stay; however, the beneficiaries did not spend those nights in the hospital, instead returning periodically (e.g., once a week) for the same services.
[38] Stays that included time spent as an outpatient prior to inpatient admission are counted as inpatient stays in this report.
[39] For inpatient stays, this definition is based on the date of the inpatient admission and includes only time spent as an inpatient. In determining the length of stay for outpatient stays, we attempted to include only continuous nights spent in the hospital.

diagnoses, procedures, age, and gender.[40] We ran this information through CMS's grouping software to determine the reason for the stay.[41] We tested our method on a subset of inpatient claims. We used the results of this testing to correct the number of outpatient stays associated with each reason.

We then determined the top 10 reasons for stays in FY 2014 by setting and length of stay. See Appendix B for descriptions of the reasons for these stays. We also calculated the average Medicare and beneficiary payment for each reason in FY 2014 by setting and length of stay.[42]

Analysis of short inpatient stays. For short inpatient stays, we determined whether the information on the claim indicated that the stay met CMS's criteria for an inpatient stay under the 2-midnight policy[43] (see Appendix D). For example, we used codes on the Part B noninstitutional provider claims to determine if inpatient-only procedures were provided. We also used discharge codes on the claims to determine whether beneficiaries died, were transferred, or left against medical advice.[44] We used the MS-DRG on claims to determine whether mechanical ventilation was provided. Finally, we used information on the hospital and noninstitutional provider claims to calculate the total nights spent in the hospital, including outpatient time prior to inpatient admission. If the total number of nights spent in the hospital was 2 or greater, we determined that the stay was appropriate under the 2-midnight policy.

We then summed the number of short inpatient stays that were appropriate and potentially inappropriate under the policy in FY 2013 and FY 2014. We calculated the difference and the percentage change between the two fiscal years. We also calculated the total Medicare payments in FY 2014 for the short inpatient stays that were potentially inappropriate under the 2-midnight policy.

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[40] We converted the Current Procedural Terminology procedure codes on the noninstitutional provider claims to ICD-9 procedure codes using information from MediRegs and other sources. (ICD-9 is the International Classification of Diseases, Ninth Revision, Clinical Modification.)

[41] *Medicare Severity Grouper with Medicare Code Editor Software, Installation and User's Manual*, October 2014.

[42] For outpatient stays, these average payments are estimates because of the method we used for determining the reasons for these stays.

[43] Information on the claim can indicate only whether the stay was potentially inappropriate under the policy. A medical record review would be needed to determine whether these stays were appropriate under the 2-midnight policy.

[44] We were unable to use claims information to identify short inpatient stays during which the beneficiary experienced clinical improvement after the physician documented an expectation of a 2-midnignt stay.

We compared in several ways the short inpatient stays that were potentially inappropriate under the 2-midnight policy and short outpatient stays. First, we compared the most common reasons for the two types of stays. We determined the overlap among the top reasons for the two types of stays. Second, we compared average Medicare and beneficiary payments for the two types of stays.

Analysis of beneficiary payments for outpatient stays and SNF access. For all outpatient stays, we determined how often beneficiaries paid more than the inpatient deductible in FY 2013 and FY 2014. We calculated the difference and percentage change between the two fiscal years. We also determined the most common reason for stays for which beneficiaries paid more than the inpatient deductible in FY 2014.

Next, we calculated the number of outpatient stays in FY 2013 and FY 2014 that included charges for self-administered drugs. We calculated the difference and percentage change between the two fiscal years. We also calculated the average charge amount when charges were present on the claims for each of the fiscal years and the total charges in FY 2014.

Finally, we identified all hospital stays in FY 2013 and FY 2014 in which beneficiaries spent at least 3 nights in the hospital but had fewer than 3 nights as inpatients. These stays included both long outpatient stays and short or 2-midnight inpatient stays for which beneficiaries spent time as outpatients prior to admission.[45] We calculated the difference and percentage change between the two fiscal years.

Analysis of short inpatient and long outpatient stays by hospital. For each hospital, we calculated the percentage of all stays that were short inpatient and long outpatient in FY 2013 and FY 2014.[46]

We calculated the distribution of these percentages. Next, we calculated the percentage of hospitals that increased their use of short inpatient and of long outpatient stays from FY 2013 to FY 2014.

[45] We excluded from this analysis the hospital stays with discharge codes that indicated that the beneficiaries died, were transferred, or were still in the hospital.

[46] We conducted this analysis using provider numbers. We excluded from this analysis the hospitals that did not have at least 50 claims in both FY 2013 and FY 2014. We also excluded short inpatient stays that were appropriate under the 2-midnight policy.

APPENDIX B

Description of Reasons for Stay*

Reason for Stay	Detailed Description
Back problems	Medical back problems
Chest pain	Chest pain
Chronic obstructive pulmonary disease (high severity)	Chronic obstructive pulmonary disease (high severity)
Circulatory disorders	Circulatory disorders except acute myocardial infarction, with cardiac catheterization
Coronary stent insertion	Percutaneous cardiovascular procedures with stent
Digestive disorders	Esophagitis, gastroenteritis, and miscellaneous digestive disorders
Dizziness	Dysequilibrium
Fainting	Syncope and collapse
Heart failure and shock (high severity)	Heart failure and shock (high severity)
Heart failure and shock (medium severity)	Heart failure and shock (medium severity)
Injuries to the skin or tissue	Trauma to the skin, subcutaneous tissue, and breast
Irregular heartbeat	Cardiac arrhythmia and conduction disorders
Irregular heartbeat (medium severity)	Cardiac arrhythmia and conduction disorders (medium severity)
Joint replacement of lower extremity	Major joint replacement or reattachment of lower extremity
Kidney and urinary tract infections	Kidney and urinary tract infections
Loss of blood flow to the brain	Transient ischemia
Nutritional disorders	Nutritional and miscellaneous metabolic disorders (e.g., vitamin deficiency)
Pneumonia (high severity)	Simple pneumonia and pleurisy (high severity)
Pneumonia (medium severity)	Simple pneumonia and pleurisy (medium severity)
Red blood cell disorders	Red blood cell disorders (e.g., anemia, sickle-cell disease)
Renal failure (medium severity)	Renal failure (medium severity)
Respiratory signs and symptoms	Respiratory signs and symptoms (e.g., coughing, shortness of breath)
Septicemia (high severity)	Septicemia or severe sepsis (high severity)
General signs and symptoms	Signs and symptoms (e.g., general pain, malaise)

* Unless noted otherwise, throughout this report, all of the reasons for stays were for beneficiaries at the low-severity level—i.e., without secondary diagnoses that can increase the complexity of care.

Source: Adapted from CMS, FY 2014 IPPS Final Rule, Table 5.

APPENDIX C

Change in Stays from FY 2013 to FY 2014

Setting	Length of Stay	FY 2014	Change From FY 2013	Percentage Change From FY 2013
Outpatient	Short	2,709,897	281,156	11.6%
	Long	748,337	-21,248	-2.8%
Inpatient	Short	1,074,267	-118,060	-9.9%
	Long	8,009,537	-144,734	-1.8%
Total		**12,542,038**	**-2,886**	

Source: OIG analysis of CMS data, 2016.

APPENDIX D

Short Inpatient Stays That Were Appropriate Under the 2-Midnight Policy in FY 2014

CMS provided several circumstances under which inpatient stays lasting or expected to last fewer than 2 midnights are appropriate for inpatient payment and consistent with the 2-midnight policy.[47] These circumstances include stays with:

1. inpatient-only procedures;
2. mechanical ventilation initiated during the visit;
3. an unforeseen circumstance, such as the beneficiary's death, transfer to another hospital, or leaving against medical advice; or
4. 2 midnights or longer in the hospital when outpatient time prior to admission is added to inpatient time.

The first two types of stays are appropriately inpatient even if the treating physician does not expect care to last 2 midnights. The latter two types of stays are appropriately inpatient, even though they are short, only if the treating physician documented a reasonable expectation of a stay lasting 2 midnights or longer. As discussed in the detailed methodology, we used claims information to identify these short inpatient stays that were appropriate under the 2-midnight policy.

Characteristic of Stay	FY 2014*	Percentage of Short Inpatient Stays That Were Appropriate Under the 2-Midnight Policy With This Characteristic*
Stay lasted 2 midnights when outpatient time prior to the inpatient admission is included	367,870	56.5%
Stay involved an inpatient-only procedure	158,137	24.0%
Stay in which beneficiary died	75,237	11.6%
Stay in which beneficiary transferred to another hospital	57,673	8.9%
Stay in which beneficiary left against medical advice	33,797	5.0%
Stay involved mechanical ventilation	8,298	1.3%
Total	**650,723**	**100%**

* Columns do not sum to totals because a stay may have more than one characteristic.
Source: OIG analysis of CMS data, 2016.

[47] See 80 Fed. Reg. 70540–70541 (July 8, 2015) and CMS, *Frequently Asked Questions: 2 Midnight Inpatient Admission Guidance & Patient Status Reviews for Admissions on or after October 1, 2013*. Accessed at https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Medical-Review/InpatientHospitalReviews.html on November 5, 2013.

APPENDIX E

Most Common Reasons for Certain Types of Hospital Stays

Table E.1: Most Common Reasons for Short Inpatient Stays That Were Potentially Inappropriate Under the 2-Midnight Policy, FY 2014*

Most Common Reasons for Short Inpatient Stays	Number of Short Inpatient Stays	Percentage of Short Inpatient Stays
Irregular heartbeat	16,235	3.8%
Chest pain	14,766	3.5%
Digestive disorders	13,544	3.2%
Loss of blood flow to the brain	10,146	2.4%
Coronary stent insertion	9,846	2.3%
Fainting	9,158	2.2%
Nutritional disorders	8,924	2.1%
Irregular heartbeat (medium severity)	8,881	2.1%
Circulatory disorders	8,677	2.0%
Red blood cell disorders	7,752	1.8%

* Short inpatient stays that were appropriate were removed for this analysis.

Source: OIG analysis of CMS data, 2016.

Table E.2: Most Common Reasons for Short Outpatient Stays, FY 2014

Most Common Reasons for Short Outpatient Stays	Number of Short Outpatient Stays	Percentage of Short Outpatient Stays
Chest pain	356,625	13.2%
Digestive disorders	185,202	6.8%
Fainting	84,596	3.1%
Coronary stent insertion	81,966	3.0%
General signs and symptoms	63,330	2.3%
Injuries to the skin or tissue	58,963	2.2%
Kidney and urinary tract infections	52,817	1.9%
Back problems	50,393	1.9%
Respiratory signs and symptoms	47,232	1.7%
Circulatory disorders	46,448	1.7%

Source: OIG analysis of CMS data, 2016.

APPENDIX E (CONTINUED)

Table E.3: Most Common Reasons for Long Inpatient Stays, FY 2014

Most Common Reasons for Long Inpatient Stays	Number of Long Inpatient Stays	Percentage of Long Inpatient Stays
Joint replacement of lower extremity	392,292	4.9%
Septicemia (high severity)	389,076	4.9%
Heart failure and shock (high severity)	183,088	2.3%
Heart failure and shock (medium severity)	170,813	2.1%
Digestive disorders	149,417	1.9%
Kidney and urinary tract infections	138,350	1.7%
Pneumonia (medium severity)	132,808	1.7%
Renal failure (medium severity)	128,034	1.6%
Pneumonia (high severity)	125,649	1.6%
Chronic obstructive pulmonary disease (high severity)	123,512	1.5%

Source: OIG analysis of CMS data, 2016.

Table E.4: Most Common Reasons for Long Outpatient Stays, FY 2014

Most Common Reasons for Long Outpatient Stays	Number of Long Outpatient Stays	Percentage of Long Outpatient Stays
Chest pain	85,535	11.4%
Digestive disorders	47,019	6.3%
Fainting	42,115	5.6%
General signs and symptoms	27,293	3.6%
Nutritional disorders	18,756	2.5%
Circulatory disorders	18,301	2.4%
Back problems	15,793	2.1%
Dizziness	15,691	2.1%
Kidney and urinary tract infections	14,375	1.9%
Coronary stent insertion	13,068	1.7%

Source: OIG analysis of CMS data, 2016.

APPENDIX F

Average Medicare and Beneficiary Payments for Certain Most Common Reasons for Stays

Table F.1: Average Medicare Payments for Short Inpatient and Short Outpatient Stays for Most Common Reasons for Short Inpatient Stays in FY 2014

Most Common Reasons for Short Inpatient Stays	Short Outpatient Stay	Short Inpatient Stay
Coronary stent insertion	$8,364	$13,269
Circulatory disorders	$2,463	$6,706
Irregular heartbeat (medium severity)	$1,905	$4,801
Loss of blood flow to the brain	$1,575	$4,039
Irregular heartbeat	$1,559	$3,069
Chest pain	$1,327	$3,797
Fainting	$1,309	$4,578
Red blood cell disorders	$1,150	$5,119
Nutritional disorders	$924	$4,226
Digestive disorders	$789	$4,572

Source: OIG analysis of CMS data, 2016.

Table F.2: Average Beneficiary Payments for Short Inpatient and Short Outpatient Stays for Most Common Reasons for Short Inpatient Stays in FY 2014

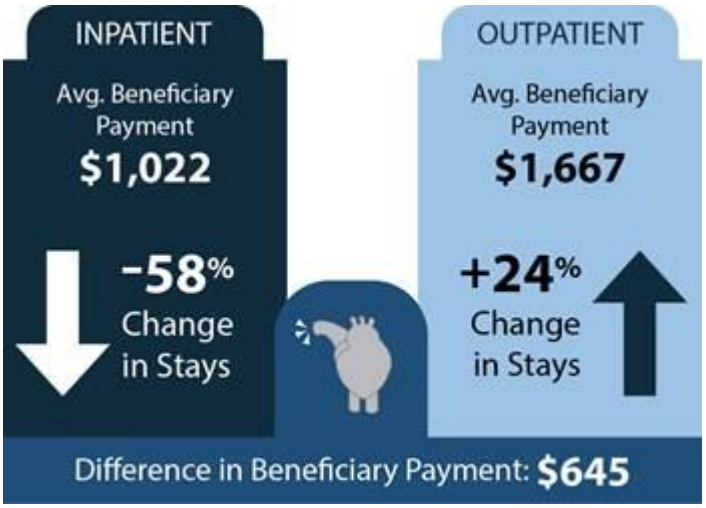
Reason for Stay	Short Outpatient Stay	Short Inpatient Stay
Coronary stent insertion	$1,667	$1,022
Circulatory disorders	$903	$1,011
Loss of blood flow to the brain	$461	$1,079
Irregular heartbeat (medium severity)	$374	$936
Fainting	$354	$1,004
Chest pain	$344	$981
Irregular heartbeat	$326	$1,050
Red blood cell disorders	$293	$832
Nutritional disorders	$244	$898
Digestive disorders	$231	$984

Source: OIG analysis of CMS data, 2016.

APPENDIX G

Beneficiary Payments for Coronary Stent Insertions

Changes in stays for coronary stent insertions illustrate how an increase in the use of outpatient stays also increased beneficiary payments. From FY 2013 to FY 2014, short inpatient stays for coronary stent insertions decreased significantly, while short outpatient stays increased. Because beneficiaries tended to pay more for short outpatient stays, the increase in this type of stay also increased beneficiary payments.



Source: OIG analysis of CMS data, 2016.

APPENDIX H
Agency Comments

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

OCT 27 2016

200 Independence Avenue SW
Washington, DC 20201

To: Daniel R. Levinson
Inspector General
Office of the Inspector General

From: Andrew M. Slavitt
Acting Administrator
Centers for Medicare & Medicaid Services

Subject: Vulnerabilities Remain Under Medicare's 2-Midnight Hospital Policy (OEI-02-15-00020)

The Centers for Medicare & Medicaid Services (CMS) appreciates the opportunity to review and comment on the Office of the Inspector General's (OIG) draft report. CMS strives to provide Medicare beneficiaries with access to high quality health care while protecting taxpayer dollars.

CMS recognizes the importance of continuing to provide Medicare beneficiaries with access to essential services and, at the same time, working to improve appropriate billing and payment. To provide greater clarity to hospital and physician stakeholders regarding appropriate billing and payment, and to address the long outpatient stays receiving observation services for extended periods of time, CMS adopted the 2-Midnight rule for admissions beginning on or after October 1, 2013. This rule establishes that an admission is generally appropriate for payment under Part A if the admitting physician reasonably expects the beneficiary to require hospital care that lasts at least 2 midnights; otherwise, the care should generally be billed as outpatient services under Part B. When considering this rule, CMS sought to balance principles shared by a variety of stakeholders, including beneficiaries, hospitals, and physicians. These principles include the need for payment criteria that are clear and consistent with sound clinical practice, reflect the beneficiaries' medical needs, respect a physician's judgment, and are consistent with the efficient delivery of care to protect the Trust Funds.

CMS has taken a collaborative approach to the education about and enforcement of the 2-Midnight rule. Since October 2015, CMS has used the Quality Improvement Organizations (QIOs) to conduct initial medical reviews of providers who submit inpatient claims. The QIOs have history of collaborating with hospitals and other stakeholders to ensure high quality care for beneficiaries. Under this enforcement strategy, claims for inpatient admissions that are determined not to be appropriate pursuant to the 2-Midnight rule will be denied, and the QIOs will provide one-on-one provider education regarding the policy. As of January 2016, QIOs may refer to the Recovery Audit Contractors those providers exhibiting persistent noncompliance with Medicare payment policies, including, but not limited to: consistently failing to adhere to the 2-Midnight rule, or failing to improve their performance after QIO educational intervention.

OIG Recommendation
The OIG recommends that CMS conduct routine analysis of hospital billing and target for review hospitals with high or increasing numbers of short inpatient stays that are potentially inappropriate under the 2-midnight policy.

CMS Response
CMS concurs with the recommendation. CMS will instruct the QIOs to conduct routine analysis of hospital billing for inpatient stays and target for review hospitals with high or increasing numbers of short inpatient stays.

OIG Recommendation
The OIG recommends that CMS identify and target for review short inpatient stays that are potentially inappropriate under the 2-midnight policy.

CMS Response
CMS concurs with the recommendation. QIOs are currently conducting initial patient status reviews of short stays in acute care inpatient hospitals, long-term care hospitals, and inpatient psychiatric facilities to determine the appropriateness of Part A payment for short stay hospital claims.

OIG Recommendation
The OIG recommends that CMS analyze the potential impacts of counting time spent as an outpatient towards the 3-night Skilled Nursing Facility (SNF) requirement so that beneficiaries receiving similar hospital care have similar access to SNF services.

CMS Response
CMS concurs with this recommendation. CMS will analyze the potential impacts of counting time spent as an outpatient towards the 3-day inpatient hospital stay requirement for Medicare SNF coverage. However, CMS lacks statutory authority to count time spent as an outpatient towards the 3-day inpatient hospital stay requirement for Medicare SNF coverage and such a proposal is not included in the Fiscal Year 2017 President's Budget.

OIG Recommendation
The OIG recommends that CMS explore methods for protecting beneficiaries in outpatient stays from paying more than they would as inpatients.

CMS Response
CMS concurs with this recommendation. CMS has explored our existing statutory authority to protect beneficiaries in outpatient stays from paying more than they would as inpatients. The current statutory requirements are fairly prescriptive surrounding beneficiary cost-sharing liabilities under the Inpatient Prospective Payment System (IPPS) and the Outpatient Prospective Payment System (OPPS). In general, the OPPS copayment is 20 percent of the Medicare-approved amount and is capped per procedure at the inpatient deductible amount that applies under the IPPS. CMS has taken several steps within its statutory authority to reduce beneficiary cost sharing. In 2014, CMS established Comprehensive Ambulatory Payment classifications (C-APCs) under the OPPS. This establishes a single copayment (which is capped at the inpatient deductible) and helps protect beneficiaries from paying a copayment for each service furnished

in a comprehensive encounter. Further, in 2016, CMS established a C-APC for Comprehensive Observation Services.

ACKNOWLEDGMENTS

This report was prepared under the direction of Jodi Nudelman, Regional Inspector General for Evaluation and Inspections in the New York regional office, and Nancy Harrison and Meridith Seife, Deputy Regional Inspectors General.

Rachel Bryan served as team leader for this study. Other Office of Evaluation and Inspections staff from the New York regional office who conducted the study include Kari-Anna Adrian, Marissa Baron, Judy Bartlett, and Daniel S. Song. Central office staff who provided support include Clarence Arnold, Evan Godfrey, Althea Hosein, Christine Moritz, Berivan Demir Neubert, and Jessica Swanstrom.

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