



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

Statement for the Hearing Record:

Office of Inspector General  
U.S. Department of Health and Human Services

Hearing Title:  
"Admitted or Not? The Impact of Medicare  
Observation Status on Seniors"

United States Senate  
Special Committee on Aging

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Good morning, Chairman Nelson, Ranking Member Collins, and other distinguished Members of the Committee. Thank you for inviting the U.S. Department of Health and Human Services (the Department) Office of Inspector General (OIG) to submit a statement for the hearing record about our work in an important area of hospital policy that affects beneficiaries, providers, and taxpayers.

In July 2013, we published a report about hospital observation and short inpatient stays. The Centers for Medicare & Medicaid Services (CMS) subsequently implemented the two-midnight hospital policy. The key takeaways today are: 1) significant issues existed with observation and short inpatient stays in 2012, 2) policymakers must ensure that beneficiaries with similar post-hospital care needs have the same access to and cost-sharing for skilled nursing facility (SNF) services, and 3) careful evaluation of the two-midnight policy and possible alternatives is essential.

### **Many Had Expressed Concerns About Observation and Short Inpatient Stays**

When Medicare beneficiaries enter the hospital, hospital physicians often need to decide whether to admit them as inpatients or to provide observation services. Observation services are short-term treatments and assessments provided to outpatients to determine whether beneficiaries require further treatment as inpatients or can be discharged.

CMS, Members of Congress, industry groups and the public raised concerns about hospitals’ use of observation stays and short inpatient stays. They were concerned about beneficiaries spending long periods in observation stays without being admitted as inpatients. In particular, they were concerned that beneficiaries may pay more as outpatients than if they were admitted as inpatients. Moreover, beneficiaries who were not admitted as inpatients may not qualify under Medicare for needed SNF services following discharge from the hospital. Beneficiaries who did not qualify for SNF services under Medicare may have independently chosen to receive them, but were then responsible for all SNF charges. In addition, CMS was concerned about improper payments for short inpatient hospital stays when the beneficiaries should have been treated as outpatients.

Some of these issues may have arisen because Medicare pays for inpatient and outpatient stays very differently. Inpatient hospital stays are paid under Medicare Part A according to the Inpatient Prospective Payment System (IPPS). The IPPS is designed to reflect the cost of caring

for an average beneficiary, so payments to hospitals generally do not depend on the number of services provided or the beneficiary's length of stay.

Observation and other outpatient stays are paid under Medicare Part B according to the Outpatient Prospective Payment System (OPPS). The OPPS is a hybrid of a prospective payment system and a fee schedule, so payments to hospitals tend to increase as the number of services provided increases.

### **Significant Issues Existed With Observation and Short Inpatient Stays Prior to the Two-Midnight Hospital Policy**

OIG evaluated hospitals' use of observation stays and short inpatient stays in 2012, before the implementation of CMS's new hospital policy.<sup>1</sup> Our findings highlight important issues that require continued attention. They are summarized below.

#### *Beneficiaries in observation stays commonly spent 1 night or more in the hospital*

Beneficiaries had 1.5 million observation stays in 2012. Beneficiaries in these stays were most often treated for chest pain, and the majority of these stays began in the emergency department. In 92 percent of observation stays, beneficiaries spent at least 1 night in the hospital. In 26 percent of stays, beneficiaries spent 2 nights; in 11 percent of stays, beneficiaries spent at least 3 nights.

#### *Short inpatient stays were often for the same reason as observation stays, but Medicare paid nearly three times more for a short inpatient stay than for an observation stay, on average*

Beneficiaries had 1.1 million short inpatient stays in 2012. Similar to beneficiaries in observation stays, those in short inpatient stays were most commonly treated for chest pain. Additionally, 6 of the 10 most common reasons for short inpatient stays were among the 10 most common reasons for observation stays. The areas of overlap were chest pain, digestive disorders, fainting, nutritional disorders, irregular heartbeat, and circulatory disorders.

However, short inpatient stays were far more costly to Medicare than observation stays. Medicare paid an average of \$5,142 per short inpatient stay, but it paid an average of \$1,741 per observation stay. For each of the most common reasons a beneficiary was in the hospital, the average Medicare payment was always higher for short inpatient stays than for observation stays.

#### *Beneficiaries also paid far more for short inpatient stays than for observation stays, on average*

Beneficiaries paid almost two times more for short inpatient stays than for observation stays on average—that is, \$725 per short inpatient stay compared to \$401 per observation stay. For all

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<sup>1</sup> *Hospitals' Use of Observation Stays and Short Inpatient Stays for Medicare Beneficiaries*, OEI-02-12-00040, July 2013, available at <http://oig.hhs.gov/oei/reports/oei-02-12-00040.asp>. Short inpatient stays are inpatient stays that lasted 1 night or less.

but two of the most common reasons for treatment, beneficiaries paid more, on average, for short inpatient stays than for observation stays. The two exceptions were stays for circulatory disorders and for coronary stent insertions. In addition, 6 percent of beneficiaries in observation stays paid more than they would have paid had they been in an inpatient stay.

### *Hospitals varied widely in their use of short inpatient and observation stays*

Some hospitals were far more likely to use short inpatient stays while others were far more likely to use observation stays.<sup>2</sup> Nationally, just over one-quarter of these stays were short inpatient stays. However, some hospitals used short inpatient stays for less than 10 percent of their stays, while others used them for over 70 percent of their stays.

### *A clearer policy was needed*

Our report showed that though observation and short inpatient stays were for similar reasons, reimbursement was very different. The variation in the use of these stays across hospitals suggested that the policy in place at the time was not being implemented consistently. Given that the inpatient-versus-outpatient decision affects how much Medicare pays and how much the beneficiary pays, a clearer policy was needed.

## **Beneficiaries with Similar Post-Hospital Care Needs Should Have the Same Access To and Cost-sharing for SNF Services**

We also found that beneficiaries had almost 618,000 hospital stays that lasted 3 nights or more, but did not include 3 inpatient nights. Because their stays did not include 3 inpatient nights, these beneficiaries did not qualify for SNF services under Medicare. For about 25,000 of the 618,000 hospital stays, beneficiaries received SNF services following discharge from the hospital. Medicare nearly always paid (inappropriately) for these SNF services. However, for about 2,000 of the hospital stays, Medicare did not pay for the SNF services, and the beneficiary was charged an average of about \$11,000.

This result raised concerns about SNF services for beneficiaries. It is important to ensure that beneficiaries with similar post-hospital care needs have the same access to and cost-sharing for SNF services. Allowing nights spent as an outpatient to count toward the 3 nights needed to qualify for SNF services may require additional statutory authority.

## **Careful Evaluation of the Two-Midnight Policy and Possible Alternatives is Essential**

In response to ongoing concerns, CMS implemented a hospital policy—known as the two-midnight policy—in October 2013 to address the issues with observation and short inpatient stays. The new policy provides guidelines for when hospitals should bill for inpatient stays and

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<sup>2</sup> This analysis includes outpatient stays that lasted at least 1 night, but were not coded as observation stays. For some of these stays, hospitals may have provided observation services without coding the claims as observation stays. Hospitals are not always paid a separate amount for coding claims as observation stays.

when they should bill for outpatient services, such as observation. Specifically, the rule states that a hospital stay is appropriately inpatient when the physician admits a beneficiary with the expectation of the stay lasting at least two midnights. CMS expects this policy to reduce the numbers of short inpatient stays and of observation stays lasting 2 nights or longer.

However, the policy has not been evaluated to ensure that it is working effectively. This policy will affect hospitals' use of observation stays and short inpatient stays, which in turn will affect Medicare and beneficiary payments to hospitals. The new policy may also affect beneficiaries' access to SNF services. Because providers have been vocal in their opposition to the two-midnight policy and because CMS and Congress are considering alternatives, a careful evaluation of the two-midnight policy and possible alternatives is essential.

As policymakers move forward, the issues that we highlighted in our prior report continue to be relevant. Information about the impact of the new policy is needed to ensure that policymakers take these issues into account as they move forward.

### **Further Action Is Needed To Ensure that Hospital Payment Policies Are Efficient and Effective**

Ensuring that Medicare's hospital payment policies are effective and efficient for beneficiaries, providers, and taxpayers is of paramount importance. A number of factors must be carefully considered, including clear guidelines for hospitals and contractors; similar payments for similar care; and the overall impact on Medicare payments, hospitals, and beneficiaries. This will continue to require a concerted effort by a number of key players, including CMS, CMS's contractors, providers, OIG, and Congress. Such actions are essential for fighting fraud, waste, and abuse and for protecting Medicare beneficiaries and the Medicare Trust Fund.

New and changing Department programs, including hospital payment policy, offer opportunities to prevent waste and fraud and increase the value realized from prudent Federal investments. They also raise challenges for efficient and effective implementation; therefore, close oversight is essential. Full funding of OIG's fiscal year 2015 budget request would enable us to continue and enhance our focus on hospital payment policy, as well as the Department's other public health and human service programs, the marketplaces, and Medicare.<sup>3</sup>

Thank you for your leadership and interest in these important issues and for the opportunity to discuss some of our work.

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<sup>3</sup> For more details on OIG's impact, the essential work we have planned, and the resources needed to fulfill these mission-critical activities, see OIG's fiscal year 2015 Congressional budget justification, available online at <http://oig.hhs.gov/reports-and-publications/index.asp>.