



**Association of
American Medical Colleges**
655 K Street, N.W., Suite 100, Washington, D.C. 20001-2399
T 202 828 0400 F 202 828 1125
www.aamc.org

Via Electronic Submission (www.regulations.gov)

February 2, 2015

Andy Slavitt
Acting Administrator
Centers for Medicare & Medicaid Services
ATTN: CMS-1601-P
7500 Security Boulevard
Baltimore, MD 21244-8013

Re: Medicare Inpatient Prospective Payment Systems 0.2 Percent Reduction Notice, File Code CMS-1658-NC.

Dear Mr. Slavitt:

The Association of American Medical Colleges (AAMC or Association) welcomes this opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS' or the Agency's) notice entitled "Medicare Program: Hospital Inpatient Prospective Payment Systems (IPPS); 0.2 Percent Reduction" 80 Fed. Reg. 75017 (December 1, 2015). The AAMC is a not-for-profit association representing all 145 accredited U.S. medical schools; nearly 400 major teaching hospitals and health systems, including 51 Department of Veterans Affairs medical centers; and nearly 90 academic and scientific societies. Through these institutions and organizations, the AAMC represents 148,000 faculty members, 83,000 medical students, and 115,000 resident physicians.

Summary of AAMC's Comments

If the calculations and underlying assumptions of the model developed by the CMS actuary (also referred to as the Actuarial model or the model) were fully disclosed in the FY2014 rulemaking process, as required by the Administrative Procedure Act (5 U.S.C. chapter 5), commenters would have had an opportunity to point out the flaws in the assumptions made by CMS and the Agency would have had no basis on which to reduce FY2014 IPPS rates by 0.2 percent. Therefore, as will be discussed further below, the Agency should restore the 0.2 percent for FY 2014 and subsequent years.

Underscoring the lack of support for the reduction is that the model's assumptions were not supported by actual claims experience in 2014. In 2014 the vast majority of long observation stays remained in outpatient status, contrary to the Actuary's assumption of a 100 percent shift to inpatient. Both surgical and medical inpatient short stays decreased, though far less than the 100 percent reduction assumed by the

Actuary. The number of long medical inpatient stays also decreased in 2014, experiencing a steeper decline than surgical long inpatient stays, the opposite of what the Actuary assumed.

Based on our analysis of the information provided in the December 1 Federal Register Notice and CMS's responses to a memorandum sent jointly by the AAMC and the Federation of American Hospitals (FAH) on December 23, 2015, there never should have been a 0.2 percent reduction. The Agency's inaction to date has resulted in the unjustified payment reduction continuing and must be corrected. Therefore, we ask that CMS restore the reduction to the IPPS rates for FY2014 and also FY2015 and FY2016. Should CMS not restore the reduction for FY2014-2016, the AAMC urges CMS to restore the payment reduction beginning in FY2017.

Our comments focus on the following major areas:

- The Actuary's calculation of the impact of the 2-midnight policy;
- Unreasonable assumptions made by the Actuary in estimating the impact of the 2-midnight policy; and
- Claims experience since the implementation of the 2-midnight policy

The AAMC contracted with Watson Policy Analysis (WPA) to provide an independent review of these issues.

Significant Methodological Issues Raise Concerns about the Reliability of the Actuarial Model and the Justification for the Payment Reduction

In the FY2014 IPPS final rule,¹ CMS finalized a 0.2 percent reduction to IPPS payments to offset an expected net increase of \$220 million in Medicare expenditures resulting from the implementation of the 2-midnight policy. To justify this reduction, CMS stated that its actuaries projected a net increase of 40,000 hospital inpatient encounters. The proposed rule contained very limited discussion to explain the Actuary's methodology and assumptions. Despite repeated requests from the AAMC and other stakeholders for additional information during the comment period, none was provided. While the AAMC welcomes the details provided in the December Notice, and the additional information provided in response to a written request sent to CMS on December 23, we believe that clarification of a series of issues raised in the December 23 request is still needed.

As CMS explained in the Notice, the \$220 million figure was a combined result of the following three actuarial estimates:

- Approximately 400,000 outpatient stays of 2 midnights or more would shift to inpatient, including 350,000 observation stays and 50,000 outpatient major procedures.
- Approximately 360,000 inpatient surgical stays that spanned less than 2 midnights would shift to outpatient.

¹ [2013 IPPS Final Rule](#), 77 Fed. Reg. 53258, 50746 (Aug. 31, 2012).

- The net shift of 40,000 outpatient stays to inpatient would increase inpatient spending by \$290 million and reduce outpatient spending by \$70 million, resulting in a net increase of \$220 million to Medicare expenditures.

In reviewing and replicating the actuarial model, the AAMC in conjunction with WPA, identified the following methodological issues:

- Many inputs and assumptions used in the model are not verifiable and some assumptions are flawed.
- The actuarial model is highly sensitive to different inputs and assumptions. Small changes to inputs and assumptions can lead to significant differences in the projected financial impact of the 2-midnight policy, including directional change switching from increased spending to savings.

In the following sections, we will discuss these issues and their potential impact on the estimated \$220 million which is the basis for the 0.2 percent payment reduction.

Estimate of Shift from Short Inpatient Stays to Outpatient Cannot Be Verified

Among the AAMC's concerns is that the Actuary's original estimate that 360,000 inpatient short stays that span less than 2 midnights would shift to outpatient is not verifiable. The agency's own attempt to replicate its original figure produced significantly different results regardless of whether MedPAR or Integrated Data Repository (IDR) data were used. To allow for verification of the results, it is essential that the Actuary only use data sources that are publically available, such as MedPAR data.

As was disclosed for the first time in the Notice, the Actuary's original estimate of 360,000 inpatient short surgical stays was conducted using the IDR, a database that is constantly refreshed when new claims or updated claim status become available. IDR is not publicly accessible; hence, it is impossible to verify the Actuary's original figures. Even the Agency is unable to replicate its own results published in the 2014 IPSS proposed rule because, as CMS noted in the Notice (80 *Fed. Reg.* 75117), the Agency did not keep a static copy of the data used for its original analysis.

When using MedPAR data, CMS identified 380,000 inpatient short surgical stays, 20,000 more than its original estimate. Holding other actuarial estimates constant, an increase of 20,000 inpatient short surgical stays would reduce the projected net shift to inpatient encounters by half and as a result reduce the projected impact on Medicare expenditures by half.

MedPAR data is a better data source for this analysis as it is publicly available and therefore will allow for verification by the public. Following instructions provided in the Notice and using 2011 MedPAR data, WPA identified 393,000 inpatient short surgical stays, slightly higher than CMS's estimate. For the many reasons stated in this letter the AAMC continues to object to the 0.2 percent reduction in IPSS rates. Nonetheless, if all assumptions had been correct, and if the Actuary used the MedPAR data in the original analysis, the proposed payment reduction would have been 0.1 percent instead of 0.2 percent.

The Method Used To Determine Long Observation Stays Was Inaccurate

A critical distinction between inpatient and outpatient care is that outpatients do not usually remain in a hospital outpatient department continuously to receive outpatient services. To accurately identify long outpatient stays that potentially could become inpatient stays requires first identifying outpatient stays with continuous patient presence in a hospital. The actuarial method failed to sufficiently do so even though CMS was aware of the issue and acknowledged in the Notice that “Hospital OP (outpatient) claims do not readily distinguish between claims based on services provided while the beneficiary physically stayed at the hospital and claims where the beneficiary received recurring services on successive days while leaving the hospital between services.”(80 Fed. Reg. 75116). For example, typically patients who are discharged from observation services are instructed to return immediately when certain symptoms arise, and arrange for follow-up tests at the time of discharge. When follow-up care was continually provided after a patient’s discharge from hospital observation care, the actuarial model would mistakenly include in the length of the outpatient stay calculation the time period from the date a patient was discharged until the “claim through” date (generally the last date on the claim for any service that was provided to the patient).

A more reliable approach to identify long outpatient stays is using observation hours reported on the claim. Following the Actuary’s logic, WPA reviewed observation stays with a length of stay of at least 2 days, and found that approximately 6 percent of these stays (21,000 stays) were in observation for less than 25 hours and 52 percent were in observation for less than 48 hours. Therefore, the AAMC recommends that an additional criteria for identifying long observation stays should be a minimum of 25 continuous observation hours, though 48 hours of continuous observation is preferable.

The methodological flaw in the actuarial model exaggerates the number of long observation stays that would shift to the inpatient setting and therefore overestimates the upward impact on Medicare expenditures. Holding other actuarial estimates constant and assuming the Actuary’s assumptions were reasonable, a decrease of 6 percent would reduce the Actuary’s original projection of a 40,000 net increase to inpatient encounters by half and as a result reduce the originally projected impact on Medicare expenditures by half. **There would be no net increase to inpatient encounters hence no justification for the payment reduction, if the observation hour requirement had been incorporated into the actuarial model and MedPAR data had been used in the Actuary’s original analysis.**

Inpatient Stays Start from the Time of the Inpatient Admission, Not from the First Date of Outpatient Care

In the Notice, CMS suggested the “claim from” date could be more appropriate in determining the starting date of length of outpatient stays. The Agency’s reasoning is that for purposes of determining whether the 2 midnight benchmark was met, the expected duration includes the time the beneficiary spent receiving outpatient services within the hospital. The AAMC disagrees. Even though time spent providing outpatient services should be factored in when determining whether the 2 midnight benchmark was met, the length of an inpatient stay starts from the time of the inpatient admission, not from the first date of outpatient service.

Key Assumptions and Numbers Used to Estimate the Financial Impact of Volume Change Cannot be Verified

The Actuary's approach of converting volume changes into financial impact is a further concern as there was no supporting analysis for the key assumptions and numbers used. A consideration of the cumulative effect of these assumptions would cause a significant revision to the projected financial impact. If the 6 percent decrease in outpatient long observation stays were combined with the increase of 20,000 short inpatient surgical stays (the Actuary's new estimate using MedPAR data), then there would be no net increase to inpatient encounters and no justification for a payment reduction.

One important assumption in estimating the impact of the 2-midnight policy is the payment difference when an inpatient short stay moves to the outpatient setting and vice versa. The Actuary assumes payment under the OPSS would be on average 30 percent of the payment under the IPPS for encounters shifting between the two systems. We requested further details in support of the 30 percent number in our December 23, 2015 memo to CMS. In response, CMS stated the 30 percent was not based on an examination of claims data. In this Notice as well as in CMS' response to our memo, CMS referred to an HHS Office of Inspector General (OIG) report² that found on average Medicare paid nearly three times more for a short inpatient stay than an observation stay. CMS believes that the 30 percent estimate is consistent with OIG's finding. However, the OIG's finding was based on a comparison of average payment between outpatient observation stays, including both long and short observation stays, and short inpatient stays, including both surgical and medical DRGs. Yet, for the purpose of estimating the impact of the 2-midnight rule, the actuarial model only compares payment differences between inpatient surgical short stays and long outpatient stays with either observation or major procedures. No further information or analysis was provided to explain how the OIG's findings informed or influenced the Actuary's assumption. Hence, the accuracy of the Actuary's assumption cannot be verified. To determine whether the 30 percent estimate was accurate, at a minimum a claims-based analysis should have been conducted.

Another factor used in the actuarial model is total inpatient spending, which was not provided in the Notice. In the response to the AAMC's December 23 memorandum, CMS described its projected FY2014 IPPS spending (including capital) as approximately \$138 billion. This figure is nearly 20 percent higher than an estimate released by the Medicare Payment Advisory Commission³ (MedPAC) of 2014 total Medicare IPPS payment which includes both capital and beneficiaries' copayment. If the \$138 billion had been the correct number, and if the \$220 million increase were correct, then the expenditure increase would have been 0.16 percent rather than the 0.20 percent claimed by the Agency. The large variation in spending estimates further undermines the Actuary's estimates used to support the 0.2 percent reduction.

² Department of Health and Human Services Office of Inspector General (July 29, 2013). Memorandum Report: Hospitals' Use of Observation Stays and Short Inpatient Stays for Medicare Beneficiaries, OEI-02-12-00040. <http://oig.hhs.gov/oei/reports/oei-02-12-00040.pdf>.

³ MedPAC's December 10, 2015 presentation on "Assessing payment adequacy and updating payments: hospital inpatient and outpatient services." Slide 3. <http://www.medpac.gov/documents/december-2015-meeting-presentation-assessing-payment-adequacy-and-updating-payments-hospital-inpatient-and-outpatient-services.pdf?sfvrsn=0>.

Small Changes to Model Inputs Can Shift Projected Financial Impact From Increased Spending to Savings

The table below demonstrates that small changes to inputs create a material shift in the projected financial impact of the 2-midnight policy. Our data contractor, WPA, built a spreadsheet model to replicate the Actuary’s financial model using logic described in the Notice. WPA then simulated different scenarios by accumulating small changes to additional input variables one at a time, as shown in the table below. For example, if MedPAC’s estimated 2014 IPPS spending is used, the projected impact on Medicare spending decreases by approximately 20 percent. On top of that, if increasing the outpatient-to-inpatient-payment-difference ratio from the model’s 30 percent to 35 percent, the projected impact would further decline to \$161 million. Likewise, as more variables change slightly, the results vary more significantly, to the point where a more likely outcome is that there would be no increase in Medicare spending and therefore no justification for any payment reduction at all.

Scenarios	Increase to Medicare Spending (\$ Million)	Justified Payment Reduction
Actuarial Projection	\$220M	0.20%
MedPAC’s IPPS Spending of \$110 Billion	\$170M	0.15%
MedPAC’s IPPS Spending of \$110 Billion & Outpatient Payment On Average 35% of Inpatient Payment	\$161M	0.15%
MedPAC IPPS’s Spending of \$110 Billion & Outpatient Payment On Average 35% of Inpatient Payment & 380,000 Inpatient Short Stays	\$81M	0.07%
MedPAC’s IPPS Spending of \$110 Billion & Outpatient Payment On Average 35% of Inpatient Payment & 380,000 Inpatient Short Stays & Decrease Outpatient Long Stays by 6%	0	0%

The Actuary’s Assumptions Are Unreasonable

The Actuary’s assumptions that all the physicians and hospitals would behave universally in a dichotomous way-- either 100 percent complied with the policy or 100 percent did not--depending on the types of patients treated, are unreasonable. The actuarial model assumed that under the 2-midnight policy all surgical short stays would shift to outpatient, while all medical short stays would be extended past 2 midnights because of behavior changes by hospitals and admitting clinicians. Based on the Actuary’s assumptions, all doctors would fully comply with the clinical assessment and protocols for patients receiving surgical procedures, while the same doctors would extend inpatient short stays past 2 midnights. In reality, and as recognized by the rules change that CMS finalized in the FY2016 Outpatient Prospective Payment System final rule (80 Fed. Reg. 70298), physicians use their clinical judgment to determine the best care for the patient, rather than basing decisions on Medicare payment rules.

Small Changes in Assumptions Will Cause Significant Shift to Projected Medicare Spending

Because the number of medical inpatient short stays is twice that of surgical inpatient short stays, a small change to the Actuary’s assumption on medical short inpatient stays will result in a significant change to the projected impact on Medicare spending, contrary to the Actuary’s assumption that the net effect of variations would not have a significant impact on the estimate. As shown in the table below, if 5 percent of medical inpatient short stays shifted to the outpatient setting, the financial impact on Medicare spending would be negative \$17 million, meaning there would be no justification for a payment reduction.

	Actuarial Original Projection	1% of Medical Short Inpatient Stays Shift to Outpatient	5% of Medical Short Inpatient Stays Shift to Outpatient	10% of Medical Short Inpatient Stays Shift to Outpatient
Impact on Medicare Spending (\$ Million)	\$220M	\$173M	(\$17M)	(\$254M)
Justified Payment Reduction Accepting All Other Actuary Assumptions	0.2%	0.15%	0%	0%

CMS Should Restore the 0.2 Percent Reduction in IPPS Rates FY 2014 and Subsequent Years

This letter clearly shows that the FY2014 payment reduction cannot be justified. The AAMC urges CMS to restore the reduction for FY2014 and all subsequent payment years. In the years since 2014 CMS should have reevaluated its assumptions based on actual claims experience in 2014 and made adjustments prospectively as early as FY2016 to reflect the fact that the anticipated shift to the inpatient side did not occur.

Supporting this need for CMS to eliminate the payment reductions are key findings of the WPA analysis, including:

- Compared to 2013, observation stays of 48-hour-or-more long observation decreased by only 15 percent, not the 100 percent assumed by the Actuary.
- Compared to 2013, 2014 medical inpatient short stays decreased by 12 percent, more than an 8 percent decline in surgical inpatient short stays, but far less than the Actuary’s assumptions of nearly 100 percent reduction of short inpatient stays either by shifting to outpatient in terms of surgical cases or being extended to pass 2 midnights for medical cases.
- The data show that the number of medical long inpatient stays decreased in 2014; whereas, if the Actuary had been correct about the behavior change, we would expect to observe a surge of medical long inpatient stays that lasted more than 2 midnights in 2014. More interestingly, medical long inpatient stays experienced a deeper decline than surgical long inpatient stays—a 5% decrease for medical long stays vs. 2% for surgical—the opposite of what the Actuary had assumed. For inpatient stays lasting 2-4 days, in 2014 the number of stays in medical DRGs

decreased by 3% when compared to 2013, while that of surgical DRGs stayed at the same level as 2013.

Together these findings from the actual data show that the Actuary's assumptions about behavior change are unfounded. Given that the 0.2 percent payment reduction was based on the Actuary's assumptions of a net increase in inpatient cases, the adjustment is not justified. Analysis of 2014 MedPAR data by WPA shows that after implementation of the 2-midnight Rule there was a net decline of 4 percent in inpatient encounters and a 10 percent decline in encounters of fewer than two midnights from FY 2013 to FY 2014.

Comparison of FY 2013 and FY 2014 Inpatient Encounters⁴

Length of Stay	FY 2013	FY 2014	% Change
Fewer than 2 days	1,250,437	1,127,934	-10%
2-4 days	4,787,614	4,708,097	-2%
5 or more days	3,847,679	3,650,397	-5%
All Cases	9,885,730	9,486,428	-4%

As we demonstrated in our comments on the CY 2016 OPSS proposed rule⁵, even taking into account the recent downward trend in inpatient volume between 2009 and 2013, there was still a net decrease in inpatient volume in FY 2014 after implementation of the 2-midnight Rule. Further analysis was conducted using FY 2009 - FY 2013 IPPS final rule MedPAR data to calculate counts for stays of less than and greater than 2 midnights. Different compound annual growth rates (CAGRs) were then created and used to project what the numbers would have been in FY 2014 without the 2-midnight rule.⁶ Next, these projected numbers were compared to actual FY 2014 IPPS final rule numbers that take into account the effect of the 2-midnight Rule. The actual case counts for FY 2013 and FY 2014 and the projected case counts without the 2-midnight Rule (using the longer term 2009 - 2013 CAGR) are included in the table below. The data shows a net **decrease** of more than 200,000 inpatient encounters attributable to the 2-midnight rule. The data also shows differences between the actual FY 2014 case counts with the 2-midnight rule in effect and projected FY 2014 inpatient case counts without the 2-midnight Rule. The projected inpatient case counts without the 2-midnight Rule are substantially higher.

⁴ Source: Calculations based on MedPAR data for 2013 and 2014. Includes death and transfers. Excludes Maryland Hospitals and non-IPPS hospitals, as well as HMO-paid cases.

⁵ AAMC comments on the CY 2016 OPSS proposed rule:
<https://www.aamc.org/download/442056/data/cy2016opssrule.pdf>.

⁶ CAGRs were created for each of the following time periods: FY 2009-2013, FY 2009-2011 (the time period used by the Actuary in the FY 2014 final rule); and FY 2011-2013 (a more recent period used for the sake of comparison). Different scenarios were simulated using different CAGRs and no scenario justifies the net increase of 40,000 inpatient cases projected by CMS.

Difference between Actual and Expected Inpatient Cases Using 2009- 2013 CAGR⁷

Length of Stay	Actual FY 2013 Case Counts	Actual FY 2014 Case Counts (With 2 MN Policy in Effect)	2009-2013 CAGR	Projected FY 2014 Case Counts Absent 2-midnight Policy Using 2009-2013 CAGR	Difference between Actual and Projected FY 2014
Less than 2 days	1,250,437	1,127,934	-4.2%	1,197,919	-69,985
2-4 days	4,787,614	4,708,097	-0.8%	4,749,313	-41,216
5 or more days	3,847,679	3,650,397	-2.6%	3,747,639	-97,242
All Cases	9,885,730	9,486,428	-2.0%	9,694,871	-208,443

The AAMC shared its analysis of MedPAR data in multiple comment letters to CMS, all of which showed that the projected increase in inpatient cases was unsubstantiated. The Association has repeatedly urged CMS to restore the 0.2 percent payment reduction. No action has been taken by the Agency to date. As a result, the unjustified payment reduction was carried on in FY2016. **The AAMC again urges CMS to remove the unjustified payment cut without further delay and restore the reduction for FY2014 and all subsequent payment years. At a minimum the 0.2% reduction should be restored for FY2017.**

⁷ Source: FY 2013 – FY 2014 Case Counts by Length of Stay and Expected Cases Projected Using 2009-2013 CAGR (the same time period used by the Actuary’s projection in the FY2014 final rule). After refining our method based on exclusion criteria specified in the Notice, case counts in FY2013 and FY2014 are slightly different than what we provided in our CY 2016 OPSS proposed rule comment letter.

Administrator Slavitt

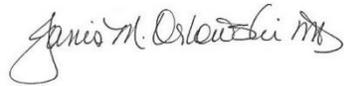
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CONCLUSION

Thank you for the opportunity to present our views. If you need additional information or have questions regarding our comments, please feel free to contact Susan Xu, M.P.A., M.S., at 202-862-6012 or sxu@aamc.org or Ivy Baer, J.D., M.P.H., at 202-828-0499 or ibaer@aamc.org.

Sincerely,



Janis M. Orlowski, MD
Chief Health Care Officer

Attachment

Cc:

Ivy Baer, J.D., AAMC
Merle Haberman, AAMC
Susan Xu, AAMC

Attachment

Sent via e-mail: IngJye.Cheng@cms.hhs.gov; Donald.Thompson@cms.hhs.gov

Date: December 23, 2015

To: Ing Jye Cheng and Don Thompson
Centers for Medicare and Medicaid Services

From: Steve Speil, Federation of American Hospitals
Susan Xu, Association of American Medical Colleges

Re: Two Midnights Calculation Methodology: Key Questions Resulting from Lack of Clarity in CMS-1658-NC

On December 1, 2015 in the Federal Register, CMS published a notice (referred to as the "Notice") with comment period "[i]n accordance with the Court's October 6, 2015 order in *Shands Jacksonville Medical Center, Inc., et al. v. Burwell, No. 14-263* (D.D.C.) and consolidated cases that challenge the 0.2 percent reduction in inpatient prospective payment systems (IPPS) rates to account for the estimated \$220 million in additional FY 2014 expenditures resulting from the 2- midnight policy." In the Notice CMS goes on to say that its purpose is "to facilitate our further consideration of the FY 2014 reduction." 80 Fed. Reg. 75107. In preparing our associations' comments to the Notice we have struggled to understand and replicate the methodology that CMS' has set forth. A full understanding of that methodology and its assumptions are critical to providing CMS with the meaningful comments that are needed by the Agency before it publishes a final notice by March 18, 2016. To meet that goal, we ask that you please respond by January 12, 2016 to the questions and requests for additional information below. Without that information we feel unable to provide you with fully informed comments by the February 2, 2016 comment deadline.

We have divided our questions into three areas, outpatient, inpatient and the overall calculation of impact, as set forth below:

A. Outpatient

1. With regard to outpatient claims, Appendix C states "claims were trimmed to only those whose full span of coverage (the difference of claim-through-date and claim-from-date) was less than 7 days. Claims with longer than a 7 day span were excluded as unlikely to represent continuous overnight stays." **Please describe whether claims equal to exactly 7 days were included or excluded from the OPPS data used on your analysis.**
2. Appendix C states that CMS "remove[d] aberrant claims" from the OPPS data based on each claim's "geometric mean cost." **In your calculation of the geometric mean cost, did CMS use unadjusted cost or standardized cost which has been adjusted for area wage index?** Standardized cost is used in the OPPS rate-setting.

3. CMS states on page 75108 of the Notice "...we identified approximately 350,000 observation care stays of 2 midnights or more using the CY 2011 claims." This statement seems to imply that CMS trimmed OPSS claims to exclude those claims less than 2 midnights, however, this trimming is not described in Appendix C. **How and when is the trimming of claims to those that are less than 2 midnights done? Please describe in detail the logic and process used in this data trimming.**
4. As described in Appendix C, "observation claims" contain either G0378 or G0379 with a medical visit procedure and "surgical claims" contain a significant OPSS procedure code of status indicator equal to "S" or "T" that received Medicare payment. **If a claim has (1) G0378 and/or G0379 and (2) status indicator equal to "S" or "T", does CMS treat this claim as**
 - a. an observation claim,
 - b. a surgical claim, or
 - c. something different?
5. Appendix C states "non-observation claims were trimmed to those where the principal procedure occurs on only a single service date, thus removing any claims that contain major recurring services and ensuring that the stay is initiated with a single instance of the major procedure." Pursuant to this statement, **did CMS make any adjustments for multiple units or multiple lines of the principal procedure?**
6. Appendix C states that "the final list of major procedure APCs used in the development of the -0.2 percent estimate can be found in Appendix B." **In limiting the OPSS data to claims with APCs listed in Appendix B, did CMS:**
 - a. only limit claims with those APCs as the principal procedure,
 - b. limit claims with those APCs as any procedure on the claim,
 - c. do something else?
7. Appendix C states that CMS removed "aberrant claims" with "unreasonable costs" defined as claims with a cost equal to more than 100 times or less than 0.01 times the geometric mean cost. Generally, CMS procedure to remove aberrant claims has been to use the standard statistical trimming method of three standard deviations from the geometric mean. **Please describe why CMS chose to use the method described in Appendix C rather than its established methodology to remove outlier claims.**
8. Appendix C states that non-observation claims where the highest cost coded service on non-observation claims where the highest cost procedure was not (1) C-code, (2) a J-code, (3) a significant OPSS procedure (status indicator equal to S or T), or (4) a medical visit procedure code (status indicator equal to V), then the claim was removed from the analysis. **For claims with G0378, did CMS use Addendum B from the CY2011 OPSS Final Rule to identify V codes or some other means? If Addendum B was used, please describe whether lines with a status indicator of Q3, but not used as a part of a composite APC, would have status indicator equal to "V"? For example, 99205 and 99215 have status indicator Q3, but will be treated as having status indicator "V" if not part of a composite APC.**

9. CMS uses a length of stay for observation claims greater than or less than 7 days (as noted in Q1 above, it is not clear what happens if the claim equals exactly 7 days) as determinative as to whether the claim represents a continuous overnight stay and, therefore, included in the IPPS analysis. According to Appendix C, for non-observation stays, the threshold for inclusion in the analysis is less than or equal to 5 days. **Are there any other trims based on length of stay for observation stays – both for short and long stays?**

10. In the 4th from last paragraph in Appendix C, CMS includes the following sentence: “Each claim’s span of coverage was also calculated as the number of days between the provision of the principal service and the claim’s through-date.” **This information, however, was not used anywhere and seems out of context in this paragraph. Is there text that is missing here and, if so, what is the missing text? If no text is missing, please describe how this “span of coverage” should be utilized in the analysis.**

11. Please clarify the following language from Appendix C: “To remove aberrant claims, each claim’s *non-observation total claim cost* was...” (emphasis added.) **Does this refer to:**
 - a. **Non-observation claims,**
 - b. **Non-observation services on a claim,**
 - c. **Total claim cost, or**
 - d. **Something else?**

12. CMS states on page 75,108 col. 3 of the Notice that: “We identified approximately 50,000 claims containing major procedures with stays lasting 2 midnights or more using the CY 2011 claims. ... Combining the observation care and the major procedures resulted in approximately 400,000 claims for services of 2 midnights or more from the CY 2011 claims data.” **Please provide the definition or characteristics you used to identify which cases were “major” procedures which you included on Appendix B. Please identify the bases for the assumption that 100 percent of claims with major procedures with stays lasting two midnights or more-- the 50,000 claims-- would be considered inpatient claims in your analysis, given that the two midnight policy still required a physician inpatient order and certification before discharge for an inpatient stay. Please also identify the bases for concluding that in 100% of such cases a physician will order an inpatient stay by discharge.**

13. CMS states on page 75109 of the Notice “For the outpatient expenditure estimate, taking 30 percent (based on the assumption that payment under the OPSS would be 30 percent of the payment of under the IPPS)”. **Please provide detail that built up to that assumption. For example:**
 - a. **Was this generated based on the sample of cases expected to be shifting?**
 - b. **Was this based on the total universe?**
 - c. **Was this based on re-pricing inpatient as outpatient and/or outpatient as inpatient?**

14. CMS states on page 75110 of the Notice “Our actuaries assumed that the OPSS cost for services that shift between the OPSS and IPPS was 30 percent of the IPPS cost, and the beneficiary is responsible for 20 percent of the OPSS cost.” **Please explain how and why the 20 percent share of beneficiary copayment was used in computing the cost difference for cases that shift between the IPPS and OPSS, especially given that there was no discussion of beneficiary copay in the inpatient side.**

B. Inpatient

15. CMS states on page 75110 of the Notice that “Our actuaries assumed that those [inpatient stays] spanning less than 2 midnights (other than those stays that were cut short by a death or transfer) would shift from the inpatient setting to the outpatient setting.” **Please define “transfer” as it is used in this context. Specifically, does “transfer” mean:**
 - a. transfers to other short-term acute facilities only,
 - b. transfers to other short-term acute or post-acute setting,
 - c. transfers subject to the transfer policy and payment reduction,
 - d. some combination of these definitions, or
 - e. something different?
16. Appendix C, page 75116 of the Notice details how CMS “remove[d] aberrant claims” from the OPSS data based on each claim’s geometric mean. There is no discussion in Appendix D regarding a similar removal of aberrant claims from the IPPS data. **Please confirm that CMS did not remove outlier claims from the IPPS data. If you cannot provide such confirmation, please describe in detail the logic used to remove aberrant claims from the IPPS data.**
17. **Please confirm that CMS did not remove from the IPPS data hospitals that became Critical Access Hospitals (CAHs) after the data was collected.** That removal is part of the normal IPPS rate-setting process.
18. In Addendum E to the Final OPSS 2015 Rule, CMS provided a list of HCPCS codes that are paid only as inpatient procedures. **Did CMS utilize this list to ensure that claims with procedure codes on the “inpatient only list” were not be shifted to the outpatient setting? If CMS did use a list of “inpatient only” codes, please provide the inpatient only list that was used. Also, please provide the corresponding ICD-9 Procedure codes to each of the CPT/HCPCS codes provided on your inpatient only list that was used.**

C. Calculation of \$220 million impact

19. CMS states on page 75109 of the Notice “Taking 1.2 percent of 17 percent of *total spending* results in the estimate at the time...” (emphasis added). **Please provide the “total spending” figure and source for total spending used in the calculations.**
20. **What did CMS use to calculate the ratio of spending (the 17% figure):**
 - a. FY2011 actual payments,

Administrator Slavitt

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- b. Modeled FY2013 payments based on the FY2011 data, or**
- c. Something else?**

We look forward to your response. Should you have any questions you may contact Susan Xu at sxu@aamc.org or 202-862-6012 and Steve Speil at sspeil@fah.org or 202-634-1529.

Cc: Ivy Baer, J.D., AAMC
Merle Haberman, AAMC