

Inpatient

1. What is the definition of “transfer”? The definition of “transfer” could significantly affect the number of cases counted as shifting from the inpatient to the outpatient setting.

CMS states: “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.” 80 Fed. Reg. at 75,110. For this purpose, does “transfer” mean:

- a. transfers to other short-term acute facilities only, regardless of whether they received a payment reduction under the IPPS transfer policy at 42 C.F.R. § 412.4
- b. transfers to other short-term acute or post-acute setting, regardless of whether they received a payment reduction under the IPPS transfer policy at 42 C.F.R. § 412.4,
- c. transfers subject to the transfer policy, but only those transfers for which received the payment reduction, or
- d. something different?

Response: Transfers were determined as those discharges whose status code was not home, home health, left against medical advice, or died.

2. Did CMS remove aberrant (outlier) claims from the IPPS data as it did from OPDS data?

In Appendix C, CMS states that it “remove[d] aberrant claims” from the OPDS data based on each claim’s geometric mean. 80 Fed. Reg. at 75,116. There is no discussion in Appendix D regarding a similar removal of aberrant claims from the IPPS data.

- a. Did CMS remove aberrant (outlier) claims from the IPPS data? If so, please describe in detail the logic used to remove such aberrant claims from the IPPS data.
- b. If CMS did not remove aberrant claims, why not?

Response: CMS did not remove outlier claims from the IPPS data. The purpose of this exercise was to get a reasonable estimate of the number of cases that might shift between inpatient and outpatient, not to establish relative weights. Claims that might skew the establishment of an average relative weight may be appropriate to include in a count of cases that are likely to shift. As stated in the notice, we seek comment on any data trims and claims selection criteria that we should apply to the data.

3. Did CMS remove, from the IPPS data, hospitals that subsequently became Critical Access Hospitals (CAHs) after the data were collected? This removal is part of the normal IPPS rate-setting process. If CMS did not follow the normal IPPS rate-setting process, please explain why not. The failure to follow the normal IPPS rate-setting process could result in overestimating the number of inpatient stays affected by the two-midnight rule.

Response: CMS did not remove IPPS data from hospitals that later became critical access hospitals. As noted in our response to question #2, the purpose of this exercise was not to establish relative weights, an important aspect of IPPS rate setting.

4. CMS recognized that claims on the “inpatient only” list would not shift to the outpatient setting under the two-midnight rule. 78 Fed. Reg. 50,495, 50,952 (Aug. 19, 2013). In Addendum E to the 2015 OPPS final 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” would not be shifted to the outpatient setting in estimating the financial impact of the two-midnight rule? If not, 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 the inpatient only list that was used.

Response: CMS did not remove claims on the inpatient only list. As stated in the notice, we seek comment on any data trims and claims selection criteria that we should apply to the data.

Outpatient

5. The manner in which CMS handled claims spanning exactly 7 days could significantly affect the universe of outpatient cases and total expenditures considered for purposes of estimating the shift of cases from the outpatient to inpatient setting. In Appendix C, CMS states: “[Outpatient] 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.” 80 Fed. Reg. at 75,116. Please describe whether claims equal to exactly 7 days were included or excluded from the OPPS data used in the actuaries’ analysis.

Response: Claims with thru-date minus from date = 7 (Full claim span of coverage of exactly 7 Medicare days) were assumed to have physical spans of greater than 7 days (7x24hrs) and were excluded. Thus claims with a 7 day span of coverage were excluded and the span for included claims ranged from 0 days thru 6 days.

6. Did CMS follow its established OPPS rate-setting methodology in calculating geometric mean cost? In Appendix C, CMS states that it “remove[d] aberrant claims” from the OPPS data based on each claim’s “geometric mean cost.” In the calculation of the geometric mean cost, did CMS use unadjusted cost or standardized cost which has been adjusted for area wage index? CMS uses standardized cost in OPPS rate-setting.

Response: Unadjusted costs were used to develop the geometric mean costs in this study; standardization of claim costs using provider wage indices was not applied. Geometric mean cost of a service was not used to set rates for specific services but only to create an ordinal ranking of principal procedures for the purpose of claim assignment based on total claim cost. Either standardized cost or unadjusted cost could be used for this purpose with no significant change in the outcome. This is not a computation that is used in OPPS rate setting, which is based on service cost not claim cost.

7. CMS states that it “identified approximately 350,000 observation care stays of 2 midnights or more using the CY 2011 claims.” 80 Fed. Reg. at 75,108. This statement implies that CMS trimmed OPPS claims to exclude those claims less than 2 midnights; however, this trimming is not described in Appendix C. How and when did the actuaries trim claims to those that are less than 2 midnights? Please describe in detail the logic and process used in this data trimming process. If too few claims were trimmed, it would overstate the number of outpatient cases the actuaries assumed would shift to inpatient.

Response: This is an incorrect inference as no trimming was implied. Within the final set of claims, CMS identified those subsets for which the estimated continuous length of stay (LOS) was less than 2 days (0 or 1 midnights) and for which the estimated LOS was 2 or more days (2 or more midnights). The estimated continuous LOS, referred to as the span of coverage, was calculated as defined in Appendix C: "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."

8. As described in Appendix C, "observation claims" contain either HCPCS code G0378 or G0379 with a medical visit procedure. "Surgical claims" contain a significant OPPS procedure code of status indicator equal to "S" or "T" that received Medicare payment. If a claim has (1) code G0378 and/or G0379 and (2) status indicator equal to "S" or "T", does CMS treat this claim as
- an observation claim,
 - a surgical claim, or
 - something different?

Response: As described in Appendix C, observation claims are those claims that meet the G0378 and G0379 inclusion criteria, while surgical claims are all drawn from non-observation claims. For non-observation claims, the principal procedure was identified as the claim's significant OPPS procedure code (status indicator of "S" or "T") with the highest line-item cost. Since the query specifies the presence of G0378/G0379 criteria, the claim in question would be considered an observation claim and assigned to the "medical" category.

9. 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." 80 Fed. Reg. at 75,116. In light of this statement, did CMS make any adjustments for multiple units or multiple lines of the principal procedure?

Response: CMS did not make any adjustments for multiple units or multiple lines of the principal procedure. As stated in Appendix C ("removing any claim that contains major recurring services"), the purpose of this step was to remove recurring services, i.e. those services in which separate outpatient visits on multiple days can be reported on the same claim because the services are considered to be "recurring services." Multiple units or lines for the same date of service would not be relevant to that exercise.

10. 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." 80 Fed. Reg. at 75,116. In limiting the OPPS data to claims with APCs listed in Appendix B, did CMS:
- only limit claims with those APCs as the principal procedure,
 - limit claims with those APCs as any procedure on the claim,
 - something else?

The actuaries' decision to limit the outpatient claims using this list of APCs could significantly affect the universe of outpatient cases that were considered for purposes of estimating the shift of outpatient cases to the inpatient setting.

Response: The principal procedure process as discussed led to “one claim one APC”, that is, the highest cost or “principal” APC. Therefore this subsequent step was performed on the principal APC, as exclusion of non-principal APCs would not change the claim list.

11. 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 a statistical trimming method of three standard deviations from the geometric mean? Please explain why CMS chose to use the method described in Appendix C rather than the agency’s established methodology to remove outlier claims.

Response: The purpose of this exercise was to get a reasonable estimate of the number of cases that might shift between inpatient and outpatient, not to establish relative weights. Claims that might skew the establishment of an average relative weight might be appropriate to include in a count of cases that are likely to shift. As stated in the notice, we seek comment on any data trims and claims selection criteria that we should apply to the data.

12. Appendix C states that non-observation claims where the highest cost coded service was not (1) a C-code, (2) a J-code, (3) a significant OPPS procedure (status indicator equal to S or T), or (4) a medical visit procedure code (status indicator equal to V), were removed from the analysis. For claims with G0378, did CMS use Addendum B from the CY2011 OPPS 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.

Response: The cited algorithm specifies that the assessment for the presence of a code with the Status Indicator=V occurs only for non-observation claims. Therefore, for claims with G0378, no SI=V codes were identified.

13. How claims are trimmed could significantly affect the universe of outpatient cases that were considered for purposes of estimating the shift of outpatient cases to the inpatient setting. In Appendix C, CMS uses a length of stay for observation claims greater than or less than 7 days (and it is not clear what happens if the claim equals exactly 7 days) to determine whether the claim represents a continuous overnight stay and is, 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?

Response: As indicated above, claims where the estimated claim span date equals 7 are excluded. The 5 day “trim” is an additional step that estimates an actual continuous stay span using the date of the principal service as the initial DOS for non-observation stays. All trims are described in Appendix C.

14. 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 in the analysis 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.

Response: This is a reference to the estimated (i.e. derived) span of coverage that represents an estimate of the length of a continuous stay as described and is also used in the paragraph that precedes the cited paragraph.

15. Please clarify the following language from Appendix C: “To remove aberrant claims, each claim’s *non-observation total claim cost* was...” 80 Fed. Reg. 75,116. (emphasis added.) Does this refer to:
- Non-observation claims,
 - Non-observation services on a claim,
 - Total claim cost, or
 - Something else?

Response: This describes the total claim cost of the non-observation claims.

Calculation of \$220 million impact

The data source used to calculate the ratio of total spending could significantly affect the estimated total financial impact of the two-midnight rule.

16. CMS states: “Taking 1.2 percent of 17 percent of *total spending* results in the estimate at the time...” 80 Fed. Reg. at 75,109 (emphasis added). Please provide the “total spending” figure and source for that figure used in the calculations.

Response: The total spending number used was approximately \$138.761 billion which was the estimate of IPPS spending (including capital) in FY 2014 based on the Midsession Review of the FY 2013 President’s Budget.

17. What did CMS use to calculate the ratio of spending (the 17% figure):
- FY2011 actual payments,
 - Modeled FY2013 payments based on the FY2011 data, or
 - Something else?

Response: The 17% figure was determined after looking at data from 2008-2010. The 2008 number was 17.65%, the 2009 number was 16.86% and the 2010 number was 17.10%. Since the last two years of these numbers were fairly close and bracketed 17%, it was decided to use 17% for the projection.

18. CMS states: “For the outpatient expenditure estimate, taking 30 percent (based on the assumption that payment under the OPDS would be 30 percent of the payment of under the IPPS)...” 80 Fed. Reg. at 75,109. Please provide the factual basis for that assumption. Unless we understand the factual basis for that assumption, it is impossible for us to test the validity of that assumption or the sensitivity of the results to variation in that assumption. For example:
- Was this generated based on the sample of cases expected to shift?
 - Was this based on the total universe?
 - Was this based on repricing inpatient as outpatient and/or outpatient as inpatient?

Response: This request is not asking for a technical clarification of the methodology for purposes of replication. As stated in the notice, this was an assumption. It was not based on an examination of the claims data. However, as also stated in the notice, we note that when the OIG examined the payment differential between short inpatient stays and observation stays it found that on average Medicare paid nearly three times more for a short inpatient stay than an observation stay. This is consistent with the 30 percent estimate.