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.**

   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.

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.

   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.

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 OPPS 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.**

   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."

4. As described in Appendix C, "observation claims" contain either G0378 or G0379 with a medical visit procedure and "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) 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?**

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.

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?**

   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.

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 OPPS 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?**

   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.

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.**

   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.

8. Appendix C states that non-observation claims where the highest cost coded service on non-observation claims was not (1) 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), then the claim was 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.

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?**

   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.

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.**

    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.

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?**

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

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.**

Response: This request is not asking for a technical clarification of the methodology for purposes of replication. We have provided the rationale for the estimate in the notice. Comments on that rationale can be submitted as described in the notice.

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 OPPS 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?**

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.

14. CMS states on page 75110 of the Notice "Our actuaries assumed that the OPPS cost for services that shift between the OPPS and IPPS was 30 percent of the IPPS cost, and the beneficiary is responsible for 20 percent of the OPPS 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 OPPS, especially given that there was no discussion of beneficiary copay in the inpatient side.**

Response: The actuaries assumed that the beneficiary is responsible for 20 percent of the OPPS cost in order to be able to calculate the share that Medicare pays. On the inpatient side, because these cases are all short stay, the actuaries estimated no copayments. The actuaries made no assumptions regarding Part A and Part B deductibles.

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?**

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

16. Appendix C, page 75116 of the Notice details how CMS "remove[d] aberrant claims" from the OPPS 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.**

Response: CMS did not remove outlier 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.

Response: CMS did not remove IPPS data from hospitals that later became critical access hospitals. As noted in our response to question #7, the purpose of this exercise was not to establish relative weights, an important aspect of IPPS rate setting.

18. In Addendum E to the Final OPPS 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.**

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.

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.**

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.

20. **What did CMS use to calculate the ratio of spending (the 17% figure):**
    a. **FY2011 actual payments,**
    b. **Modeled FY2013 payments based on the FY2011 data, or**
    c. **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.