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February 2, 2016

Andrew M. Slavitt
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1658-NC
P.O. Box 8013
Baltimore, MD 21244-1850

RE: CMS–1658-NC, Medicare Program; Inpatient Prospective Payment Systems; 0.2 Percent Reduction

Dear Mr. Slavitt:

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, and our 43,000 individual members, the American Hospital Association (AHA) is responding to the Centers for Medicare & Medicaid Services' (CMS) Dec. 1 Notice (Notice) regarding the 0.2 percent reduction to hospitals' payments under the Inpatient Prospective Payment System (PPS).

As the AHA has previously explained, we believe that CMS unlawfully implemented the 0.2 percent payment reduction to the inpatient PPS standardized amount to offset $220 million in additional inpatient expenditures that CMS estimated would occur as a result of the "two-midnight" policy adopted in fiscal year (FY) 2014. CMS has continually failed to reveal critical data and methodology, as well as many of the key and basic assumptions, it used to justify this payment cut. Now, in response to the Court's October 6, 2015 order in a consolidated federal challenge to the payment reduction, *Shands Jacksonville Medical Center, Inc., et al. v. Burwell, No. 14-263*, CMS has provided some limited additional information in the Notice. The agency believes this information is sufficient to establish the basis for its assumptions related to the 0.2 percent reduction and the methodology its actuaries used in making their estimates. We disagree.

Despite offering some additional details, CMS's explanation still fails to establish a rational and lawful basis for the imposition of the 0.2 percent reduction. The AHA continues to believe that: (1) CMS has failed to disclose key data and methodological assumptions, which prevents our being able to comment on the agency's assumptions and estimates; and (2) a number of the methodological and data choices made were arbitrary and capricious because they

were not explained and/or because they were unreasonable on their face. As a result, the actuaries' estimates were severely flawed and, in some instances, baseless.

CMS's Notice has failed not only to provide critical factual information underlying the methodology behind the reduction but also to provide a reasoned explanation for the many assumptions made in its modeling. In addition, even where CMS has provided such explanation, the assumptions made by the actuaries are completely unreasonable. **This continued absence of a full and transparent explanation of the data, methods and assumptions behind the actuaries' calculations undermines their estimate and renders the 0.2 percent reduction unfounded.**

Moreover, actual inpatient claims data demonstrate that the actuaries' predictions of increased inpatient admissions have not materialized – a reality that provides further evidence of the lack of a reasoned basis to impose the 0.2 percent reduction. The two-midnight policy has not resulted in an increase in inpatient cases. In fact, it has had precisely the opposite result: a net decrease in inpatient stays since the two-midnight policy was implemented.

Consequently, we believe strongly that the agency must reverse its 0.2 percent reduction in full. The payment rates (the standardized amount, hospital-specific rate, Puerto Rico-specific standardized amount and capital rate and capital federal rate) for FY 2014 and subsequent years must be revised accordingly, and hospitals should be reimbursed for the shortfall in Medicare payments they received for hospital discharges on or after Oct. 1, 2013 that have resulted from CMS's unlawful imposition of the 0.2 percent payment reduction.

Our detailed comments follow. If you have any questions, please contact me or Priya Bathija, senior associate director of policy, at (202) 626-2678 or pbathija@aha.org.

Sincerely,

/s/

Thomas P. Nickels
Executive Vice President

Attachments

AMERICAN HOSPITAL ASSOCIATION DETAILED COMMENTS

BACKGROUND

As part of the FY 2014 inpatient PPS final rule, CMS unlawfully imposed a *permanent* prospective 0.2 percent reduction to the operating PPS standardized amount, the Puerto Rico-specific standardized amount and capital rate, the hospital-specific payment rates and the capital federal rate to offset what the agency claimed would be an increase of $220 million in inpatient PPS expenditures resulting from implementation of the two-midnight policy. This reduction was based, CMS claimed – without further explanation or analysis – on an Office of the Actuary (OACT) estimate of an anticipated net increase in hospital inpatient encounters that would result from the implementation of the two-midnight policy.

Specifically, without setting forth its actuaries' assumptions, reasoning, calculations or the data on which the actuaries relied, CMS asserted that approximately 400,000 encounters would shift from the outpatient to inpatient setting and approximately 360,000 encounters would shift from the inpatient to outpatient setting, causing a net *increase* of 40,000 inpatient encounters. The agency stated that this shift would increase inpatient PPS expenditures by approximately $220 million and necessitated the 0.2 percent reduction.

The AHA, along with four hospital associations and four hospital organizations, challenged the 0.2 percent reduction because CMS relied on indefensible assumptions when making this arbitrary and capricious cut. Other hospitals also filed suit and the cases were consolidated. In September 2015, the court rejected CMS's arguments that it met all of the procedural legal requirements for rulemaking when it made the payment cut. The court ordered the agency to provide further justification for the payment reduction and permit additional opportunity for hospitals to comment. CMS's Dec. 1 Notice responds directly to the October court order.

CMS'S NOTICE HAS FAILED TO PROVIDE INFORMATION RELATED TO ITS METHODOLOGY, INCLUDING EXPLANATIONS OF CRITICAL ASSUMPTIONS MADE BY ITS ACTUARIES AND DATA ON WHICH ITS ACTUARIES RELIED

Although CMS has provided some additional information in the Notice, and in response to additional follow up questions submitted by the AHA during the comment period, there is still critical factual information related to the agency's methodology that it has not made available to the public for comment, including explanations of critical assumptions made by its actuaries and data the actuaries used in making their estimates. Without this information and data, it remains impossible for hospitals to replicate CMS's methodology with certainty or offer a thorough critique of the actuaries' estimate. We have highlighted below those areas in which CMS has failed to provide the necessary information, appropriate explanations and data. Where applicable, we also have provided responses to the areas in which CMS has specifically requested additional comment in the Notice.

Claims Data Used by the Actuaries. CMS has failed to provide the claims data that the actuaries used for purposes of their inpatient estimates. In the Notice, CMS indicates that it used data from its Integrated Data Repository (IDR) – an internal and proprietary CMS data source – when it originally presented its justification for the 0.2 percent reduction in the final inpatient PPS rule for FY 2014. The IDR data that CMS used in its analysis were not made available to the public. In the Notice, CMS indicates that it cannot now make the IDR data available because the IDR is a dynamic database that is constantly updated, and the agency did not retain a static version of the data it used at the time the original analysis was completed. **As a result, it is impossible for hospitals to replicate CMS's analysis and comment on the reasonableness of the agency's approach. In addition, it is impossible for CMS itself to replicate the analysis it performed to support its estimate that 360,000 inpatient admissions would move to outpatient stays.**

CMS did not explain why it used the IDR data rather than the Medicare Provider Analysis and Review (MedPAR) data to calculate its estimate of inpatient stays that would shift to the outpatient setting. We believe that decision was unreasonable for the following reasons:

- MedPAR is a publicly available database that might allow hospitals to attempt to replicate CMS's analysis;
- CMS has always used MedPAR data to set inpatient rates, and CMS's analysis should have been done consistent with that standard process; and
- Using MedPAR would have been consistent with the agency's use of the publicly available outpatient standard analytical file (SAF) to calculate its outpatient estimate in this same analysis (i.e., the outpatient cases that could potentially shift to the inpatient setting).

Moreover, CMS also appears to think that it is appropriate to use MedPAR data. In the Notice, the agency indicates that it assumed the data available to the public in MedPAR would have led to similar results as the IDR, the data set CMS itself used; however, the agency acknowledges that it did not verify this when developing its original estimate. Given that CMS had access to MedPAR data, it was unreasonable for the agency simply to assume the results would be similar without actually verifying that result using these publicly available data.

Using MedPAR data rather than the IDR actually yields significantly different results. Table 1 below demonstrates the impact of using the MedPAR estimate instead of the IDR estimate, *all other things being equal*. **This would cut the actuaries' projected net increase in inpatient stays by 50 percent, from 40,000 to 20,000, and result in a reduction of the actuaries' projected impact from $220 million to $110 million.**

Table 1: Impact of Using MedPAR Estimate Instead of IDR Estimate

1. Inpatient to outpatient: CMS estimate based on proprietary IDR data (surgical cases only)	360,000
2. Inpatient to outpatient: CMS estimate based on publicly available MedPAR data (surgical cases only)	380,000
3. Total shift of outpatient cases to inpatient cases: CMS's original estimate	400,000
4. Net Shift to Inpatient using MedPAR data: (3) - (2)	**20,000**

No Basis for Estimating the Percentage of Total Medicare Inpatient Expenditures Attributable to Short Inpatient Stays Used to Estimate the Financial Impact of the Purported Net Increase in Inpatient Cases. CMS has not provided the basis for estimating the percentage of total Medicare inpatient PPS expenditures that are attributable to short inpatient stays. In the Notice, CMS assumes that 28 percent of cases are short-stay cases, which accounts for approximately 17 percent of total inpatient PPS spending. This figure, however, is dependent upon a number of assumptions which CMS has not provided.

In addition, CMS indicated that it looked at data from 2008 through 2010, which had inpatient spending percentages of 17.65 percent, 16.86 percent and 17.10 percent. But this explanation results in more questions than answers, making it impossible to determine whether the percentage CMS used is a reasonable assumption. For example:

- What is the baseline number from which that percentage was derived?
- What were the total inpatient PPS expenditures in each of those years?
- Was the 17 percent of inpatient expenditures number that CMS calculated based on actual claims experience, modeled projections or some combination?

No Basis for Estimating that Payment Under the Outpatient PPS Is 30 Percent of the Payment Under the Inpatient PPS. CMS has offered no explanation for its estimate that payment under the outpatient PPS would be equal to 30 percent of the payment under the inpatient PPS if a case is reclassified from inpatient to outpatient. When the AHA specifically asked for such an explanation in questions we submitted during the comment period, CMS indicated that it will not be able to provide any additional information pertaining to the figure because our request was not related to "a technical clarification of its methodology." However, CMS also stated that this assumption was "not based on an examination of the claims data." The only explanation CMS offered is that the HHS Office of Inspector General (OIG) had found that, on average, Medicare paid nearly three times more for a short inpatient stay than an observation stay.[1] The OIG report has defined "short inpatient stays" and "observation stays" in a different manner than CMS, which calls into question CMS's use of the OIG figure to validate its assumption since CMS's and OIG's calculations of spending on such stays would not be comparable.[2] **CMS's failure to offer anything further renders it impossible to address the appropriateness of its assumption.**

CMS conducted its analysis using claims data, and accordingly, the agency should have examined these data to confirm that its assumption about outpatient payment was in fact valid. CMS has explicitly stated, however, that it did not do so.

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[1] CMS cites the OIG report, ''Hospitals' Use of Observation Stays and Short Inpatient Stays for Medicare Beneficiaries'' (OEI– 02–12–00040).

[2] Page 6 of the OIG report defines short stay stays as "claims that were 1 night or less" while p. 75108 of the Notice, where CMS estimates spending on inpatient short stay discharges, defines short stay discharges as "same day discharges and discharges crossing one or two midnights" which translates into stays with a length of stay of 2 nights or less. Page 5 of the OIG report defines observation stays as claims that had a claim line item with a revenue center code of 0760 or 0762, while CMS defines observation stays using HCPCS codes G0378 and G0379. In addition CMS includes non-observation outpatient stays with major procedures.

In fact, there are a number of possible approaches CMS could have taken to better estimate outpatient payments as a percentage of inpatient payments. For example, CMS could have used a sample of cases that it would have expected to shift under the two-midnight policy. Alternatively, CMS could have calculated the average expenditures for certain lengths of stay. Or, the agency could have re-priced outpatient claims as inpatient, or re-priced inpatient claims as outpatient. Despite having numerous alternatives, CMS has chosen arbitrarily, without further explanation, to use this number. **CMS's approach is extremely troubling given that a slight shift in this 30 percent estimate could have a large impact on the estimated financial impact.**

Explanation for Using the Midsession Review of the FY 2013 President's Budget to Estimate Inpatient PPS expenditures. In the original FY 2014 inpatient PPS proposed rule and in subsequent rules and this Notice, CMS continually failed to provide the estimate of total inpatient spending (as well as the source of this estimate) that it used to arrive at its $220 million impact estimate. During the comment period for this Notice, we specifically asked CMS for such information. In response, CMS stated that the total spending number used was approximately $139 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."

However, the AHA has not been able to locate this estimate in the source explicitly cited by CMS. We were able to find expenditure numbers in the 2014 Medicare Trustees Report and, in comparison, CMS's number appears to be unduly high, likely including more than inpatient hospital spending at short-term acute care hospitals paid under the inpatient PPS. For example, the number used by CMS appears to include payments made to other types of inpatient hospitals, including psychiatric, rehabilitation, long-term care, cancer, and children's hospitals and units that should not be included in the analysis here. Our conclusion that CMS's estimate of inpatient PPS expenditures includes unrelated hospital expenditures is supported by the data AHA has found in the Medicare Payment Advisory Commission (MedPAC) document, *A Data Book: Health care spending and the Medicare program, June 2015*, as well as statements in the 2014 Medicare Trustees Report. We have attached the relevant information from these resources as Appendix 1. **CMS's failure to provide more information about the source of this estimate renders its decision to use the number from the President's Budget arbitrary and capricious. Moreover, the estimate seems unreasonable on its face.**

The more appropriate total spending number to use as a starting point, before taking into account the beneficiary portion (described below) would be total spending on only short-term acute care inpatient PPS hospitals. As seen in the attached chart from the March 2015 MedPAC Report to Congress (also included in Appendix 1), total fee-for-service spending on inpatient services in 2013 was $118 billion.[3] But even that $118 billion figure would need to be adjusted downward, as the MedPAC data book makes clear that this number includes not only Medicare program spending, but also beneficiary cost-sharing. **We ask that CMS verify whether the total spending number it used includes spending for hospitals other than short-**

[3] MedPAC notes that this figure includes critical access hospitals so payments to inpatient PPS hospitals should be slightly lower.

term acute care hospitals paid under the inpatient PPS. We also ask that CMS explicitly address whether it excluded – as it should have – the amount of inpatient spending that is attributable to beneficiary cost-sharing.

To attempt to verify the $139 billion in inpatient spending offered by CMS, we examined the MedPAC Report to Congress and accompanying databook. Based on that analysis, our best guess is that CMS: (1) incorrectly included inpatient expenditures for non-PPS hospitals, which obviously should have been excluded from any estimated impact on *IPPS* expenditures; but (2) correctly excluded the portion of inpatient spending that is the beneficiaries' responsibility. Of course, without access to the specific source used by CMS, it is impossible to be sure. The MedPAC data book explains that in 2013, total inpatient hospital spending was $137 billion (which is the closest number we could find to CMS's $139 billion figure), and that figure includes payments made to other types of inpatient hospitals, including psychiatric, rehabilitation, long-term care, cancer, and children's hospitals and units not reimbursed under the inpatient PPS, but it also reflects Medicare program spending only and does not include beneficiary cost sharing. MedPAC's $118 billion estimate of total inpatient hospital spending, cited above as the more appropriate starting point for the expenditure analysis, includes only inpatient PPS expenditures, but is composed of both Medicare program spending and beneficiary cost-sharing expenditures. AHA analysis of 2011-2014 MedPAR data shows that Medicare program spending is consistently only about 89-93 percent of total inpatient spending, depending on the category of cases being used.[4] Thus, even the $118 billion should be further adjusted downward so that only the program spending portion is used. Doing so would reduce the net impact even further, *all other things being equal*.

MANY OF CMS'S ACTUARIES' ASSUMPTIONS WERE UNREASONABLE

As the AHA again attempted to replicate CMS's financial modeling, it remained clear that many of the assumptions made by CMS's actuaries were unreasonable. Had CMS taken a more reasonable approach in its assumptions, its estimates of both a net increase in inpatient cases and a negative financial impact on the Medicare program would have been eliminated.

For example, CMS explained in the Notice that, when examining the number of claims that shifted from the inpatient setting to the outpatient setting, medical MS-DRGs were excluded from the analysis because the agency assumed medical cases would not be affected by the two-midnight policy. **There is no reasonable basis for CMS to exclude medical MS-DRGs, since the two-midnight policy applies to all inpatient admissions. It also is unreasonable to assume that no medical case will shift to outpatient or, in other words, that every single short-stay medical case will remain an inpatient admission under the two-midnight policy. CMS's estimates would have been significantly different had the agency not relied on this faulty assumption.**

[4] As stated earlier, since it is unclear what baseline numbers CMS has used to estimate its spending percentages, we can only estimate possible ranges.

In its analysis, CMS should have made some allowance to account for the possibility that a certain percentage of medical short-stay cases could shift. AHA's analysis of the 2011 MedPAR data reveals that medical short-stay cases (spanning less than two midnights) constitute approximately 800,000 discharges and are 67 percent of all short-stay cases that are less than two midnights.[5] To get a sense for the magnitude this has on CMS's estimates, each 1 percent of short-stay medical DRG cases that shifts from inpatient to outpatient would result in approximately 8,000 additional outpatient cases. Even if just 5 percent of the short medical MS-DRG cases shifted from inpatient to outpatient, the entire net increase in inpatient stays identified by CMS would be eliminated. If a greater proportion of the medical cases shifted from inpatient to outpatient, there would be a net decrease in inpatient cases, which, using CMS's logic, would require an increase in inpatient PPS rates.

We believe that even the 5 percent estimate is very conservative and that a more reasonable assumption at the time would have been for CMS to assume that 10 percent, or even 20 percent of the medical short stays would have shifted to outpatient. But even assuming that only 5 percent of the medical cases shift to outpatient, the following table compares the net shift in cases when we use CMS's reported IDR-based estimate and its more appropriate reported MedPAR-based estimate. Using the IDR estimate and including just 5 percent of medical short-stay cases, the net shift is zero, while using the MedPAR data and making the same assumption leads to a net shift in the opposite direction.

Table 2: Impact of Using MedPAR Estimate and a Portion of Medical Cases – *All Other Things Equal*

1. Inpatient to Outpatient: CMS Estimate Based On Proprietary IDR - Surgical Cases Only	360,000
2. Add 5% of Medical Cases: 5% x Total Count of 800,000 Medical Cases	40,000
3. Total Inpatient to Outpatient Including Medical Cases: (1) + (2)	400,000
4. Total Outpatient to Inpatient Per CMS's Estimate	400,000
5. Net Shift to Inpatient: (4) - (3)	**0**
6. Use MedPAR Estimate Instead - Surgical Cases Only	380,000
7. Total Inpatient to Outpatient Using MedPAR Estimate and Including Medical Cases: (2) + (6)	420,000
8. Total Outpatient to Inpatient Per CMS's Estimate (same as (4))	400,000
9. Net Shift to Inpatient: (8) - (7)	**-20,000**

The OIG report that CMS itself cites in its recent Notice states that "short inpatient stays were often for the same reasons as observation stays. Similar to beneficiaries in observation stays, those in short inpatient stays were most commonly treated for chest pain." Of course, chest pain is a medical MS-DRG (DRG 313). It obviously makes no sense to assume that medical inpatient stays treated for the same conditions in the outpatient setting would not shift. According to AHA analysis, the 2011 MedPAR data contain approximately 58,000 short-stay cases in MS-DRG 313. If these cases were to shift to outpatient, the net shift of 40,000 cases that CMS estimated would be eliminated and the shift would actually be in the other direction – to a net decrease in

[5] These counts are calculated excluding transfer and deaths.

inpatient stays that, once again, using CMS's logic, would require an increase in inpatient PPS rates.

We note that CMS also has been inconsistent about its assumptions regarding medical cases at two different sections of the Notice. On p. 75111, CMS states: "Under the original 2-midnight policy, our actuaries did not expect that … every single medical MS–DRG encounter would remain in the inpatient setting." Yet, on p. 75110, CMS states that "[c]laims containing medical MS–DRGs were excluded because, as stated in the August 2013 memorandum, 'it was assumed that these cases would be unaffected by the policy change.'''

In addition, CMS assumed that in estimating the shift of cases from the outpatient setting to the inpatient setting, outpatient stays spanning seven days were continuous. Basic testing of that assumption, however, reveals obvious flaws. CMS acknowledges these flaws on page 75116 of the print version of the Notice, stating:

> Hospital OP 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. Since only continuous stays apply for this analysis, certain assumptions had to be made to indirectly estimate the body of claims for continuous services.

Yet, CMS still fails to account for this in its analysis. Had CMS taken this into account, the number of cases shifting from the outpatient setting to the inpatient setting would have been significantly lower by approximately six percent or 21,000 cases, according to AHA's analysis. In fact, had CMS's actuaries properly accounted for the portion of observation stays that were not continuous, the net change in the number of cases shifting from outpatient to inpatient would have been zero (or even a small net decrease in inpatient stays). In other words, even before taking into account medical MS-DRGs – arguably the most significant flaw in CMS's approach – making only a few minor corrections to CMS's actuaries' assumptions would entirely negate the net increase in inpatient stays predicted by CMS.

ACTUAL CLAIMS EXPERIENCE SHOWS A NET *DECREASE*, NOT INCREASE, IN INPATIENT STAYS

Despite the two-midnight rule having been in effect for more than two fiscal years, the actuaries' predictions are not at all reflective of hospitals' actual behavior in response to the new policy. The AHA attempted to analyze CMS's data in considering the agency's proposed changes to the two-midnight policy as part of the outpatient PPS proposed rule for CY 2016. Although it was difficult to undertake, given the lack of a full explanation of the actuaries' data and methodology, **the AHA's analysis clearly demonstrates that, in the first full year of implementation, the two-midnight policy *did not* result in a net increase in inpatient encounters, as CMS's actuaries estimated.**

We previously provided the data below as part of our letter on the outpatient PPS proposed rule; and those remain the most recent data available for analysis. As Table 3 demonstrates, a straightforward comparison of FY 2014 and FY 2013 cases continues to show a decrease, not an increase, in the number of inpatient encounters. Specifically, total inpatient encounters declined by four percent and total inpatient encounters of less than two midnights declined by 10 percent.

Table 3: Percent Change in Inpatient Encounters, FY 2013 to FY 2014

Length of Stay	FY 2013	FY 2014	% Change
Less than 2 days	1,173,783	1,059,254	-10%
2-3 days	3,376,510	3,356,805	-1%
4 or more days	5,016,479	4,773,975	-5%
All Cases	9,566,772	9,190,034	-4%

Source: FY 2013-2014 MedPAR (March (final rule) updates).

Our analysis explicitly accounts for, and recognizes that, total inpatient encounters were decreasing even prior to implementation of the two-midnight policy. Specifically, our analysis examined case counts for those stays that were less than two midnights and those that were greater than two midnights from FY 2009 through FY 2013, using publicly available MedPAR data sets from the final inpatient rules for each year. We looked at different compound annual growth rates (CAGRs) and created one for each of the following time periods:

1. FYs 2009-2013;
2. FYs 2009-2011 (the time period used by OACT in the FY 2014 final rule); and
3. FYs 2011-2013 (a more recent time period for comparison purposes).

We then used these numbers to calculate projected inpatient encounters for FY 2014 absent the two-midnight policy, and compared these projections to the actual inpatient encounters for FY 2014, which include the effect of the two-midnight policy. The difference in encounters can be deemed as the two-midnight effect.

Under no scenario do the numbers support OACT's estimate that the two-midnight policy would cause a net increase of 40,000 inpatient encounters. In fact, as shown in Table 4, using the longer term FY 2009-2013 CAGR, the two-midnight policy actually resulted in a net decrease of almost 200,000 inpatient encounters.[6]

[6] It was unclear, at the time, whether CMS used 2-3 and 4 or more days (as opposed to 2-4 and 5 or more days) when breaking down its analysis. For purposes of this letter, we are breaking down the data using 2-3 and 4 or more days. Regardless, the result would be similar if we had chosen 2-4 and 5 or more days for the breakdown.

Table 4: Inpatient Encounters by Length of Stay and Difference between Actual and Expected Cases Using 2009-2013 CAGR

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 MN Policy Using 2009-2013 CAGR	Difference between Actual and Projected FY 2014
Less than 2 days	1,173,783	1,059,254	-4.2%	1,124,831	-65,577
2-3 days	3,376,510	3,356,805	-0.5%	3,359,537	-2,732
4 or more days	5,016,479	4,773,975	-2.4%	4,895,893	-121,918
All Cases	9,566,772	9,190,034	-2.0%	9,380,261	-190,227

Source: FY 2009-2014 MedPAR (March (final rule) updates).

This claims experience data calls into serious question the assumptions, data and methodology used by CMS's actuaries to justify the 0.2 percent reduction. The significant increases in inpatient encounters expected as a result of the two-midnight policy did not occur. In fact, the result was precisely the opposite – a decrease in inpatient encounters during the period when the two-midnight policy applied. **This is precisely what the hospitals predicted and told CMS would occur. And while the actual experience confirms that the payment cut was unwarranted, it is for the reasons set forth above that the AHA believes CMS must reverse the 0.2 percent reduction in full and revise the payment rates (the standardized amount, hospital-specific rate, Puerto Rico-specific standardized amount and capital rate and capital federal rate) for FY 2014 and subsequent years accordingly. In addition, we urge CMS to reimburse hospitals for the shortfall in Medicare payments they received for hospital discharges on or after Oct. 1, 2013 that have resulted from CMS's unlawful imposition of the 0.2 percent payment reductions.**

As part of the Notice, CMS asked specifically for comments on whether it should await the completion of its own actuaries' analysis of FY 2014 and FY 2015 data before resolving the issues related to the 0.2 percent reduction. The AHA believes there is no reason to await the completion of the actuaries' analysis of FY 2014 and FY 2015 data in order to resolve fully the 0.2 percent issues. CMS has taken the position that its actuaries' estimates regarding the impact of the two-midnight rule are reasonable projections. However, even if actual claims experience confirmed CMS's projections, the agency legally cannot rely on those data to justify its decision to impose the 0.2 percent reduction. And in any event, as demonstrated above, our analysis of the publicly available FY 2014 data does not confirm the shifts that the actuaries projected – actual claims experience shows the opposite. **In short, nothing stands in the way of CMS resolving these issues now.**

Furthermore, as demonstrated elsewhere in this letter, not only has CMS continued to withhold critical factual material that the AHA and other stakeholders would need to test – and comment on – the reasonableness of the agency's methodology, but also the limited additional information

provided in the Notice confirms that CMS has made unreasonable assumptions and relied on inappropriate data sources (such as its proprietary IDR database) in order to calculate its 0.2 estimate. By correcting even a few of these assumptions (such as including even a portion of short stay cases in medical MS-DRGs that would be expected to shift to outpatient) and utilizing more appropriate data sources (such as the publicly available 2011 MedPAR database), we have shown that CMS's estimate of a potential 40,000 net increase in inpatient discharges is unjustified: The shifts from inpatient to outpatient essentially net each other out, necessitating no need, and providing no basis, for the 0.2 percent cut.

For all of these reasons, we strongly urge CMS to reverse the 0.2 percent payment cut and restore the amounts that hospitals would have received for their inpatient admissions in FYs 2014, 2015 and 2016 absent that cut. CMS also must eliminate the 0.2 percent cut going forward. CMS already has made significant modifications to the two-midnight policy in the outpatient PPS final rule, effective Jan. 1, 2016, as a result of urging from AHA. Specifically, under the revised policy, the decision to admit a patient for inpatient services will no longer be based solely on the arbitrary two-midnight time-based benchmark. Instead, the admission decision will be based on the judgment of the admitting physician – even if, in some cases, as determined on a case by case basis, the physician does not expect the patient to need care for a period spanning two midnights but still reasonably concludes that a patient needs inpatient care. As a result of CMS reverting to a policy much closer to its previous standard, there is no reason to continue imposing the 0.2 percent cut moving forward.

RESPONSES TO CMS'S EXPLICIT REQUESTS FOR COMMENTS IN THE NOTICE

Definition of Observation Services. In the Notice, CMS seeks comments on whether it would be more appropriate to define observation services using revenue center codes 0760 and 0762 rather than HCPCS codes G0378 and G0379.

We believe that it would not be more appropriate to define observation services using revenue center codes 0760 and 0762 rather than HCPCS codes G0378 and G0379. Rather than providing a thorough rationale for the methodology it already employed for purposes of the 0.2 percent reduction, CMS appears to be seeking comments on the use of revenue center codes in place of the G-codes in an attempt to change its methodology. But we believe that, in recognizing the procedural defects in adopting the 0.2 percent cut for FY 2014 and remanding the matter to the agency to issue a new notice, the *Shands* court was asking the agency to provide adequate notice and an opportunity to comment on the methodology that the agency *used at the time*. The court was not granting license to CMS to invent a new methodology and apply it retroactively.

In addition, however, the revenue center codes are less specific as to the duration of observation services being performed – 0760 denotes *Treatment or observation room—general classification,* and 0762 denotes *Treatment or observation room—observation room* – which makes them inappropriate for use here. Not only are the G-codes more specific – G0378 denotes *Hospital observation service, per hour,* and G0379 denotes *Direct admission of patient for*

hospital observation care – but G0378 even specifies the number of hours of observation which addresses the length of stay issue that is central to the appropriate analytical methodology. As the attached report from Watson Policy Analysis shows, 6% of the observation claims have 24 hours − the absolute minimum for two midnights − or less reported and hence the count of such claims that could potentially shift to inpatient should be reduced by at least six percent. Table 5 demonstrates that, starting with the more appropriate MedPAR estimate of inpatient surgical claims, if one properly reduces the volume of observation claims by six percent, the net shift to inpatient is close to zero, if not in fact negative. While not shown in the table below, again starting with the MedPAR estimate of inpatient surgical claim in row 1, and including only 5% (or 40,000) of the inpatient medical claims that the actuaries assumed would not shift, the net effect would be even more negative.

Table 5: Impact of Reducing Outpatient by 6% − *All Other Things Equal*

1. Inpatient to Outpatient: MedPAR Estimate - Surgical Cases Only	380,000
2. Outpatient to Inpatient: CMS's Estimate of Observation Claims Only	350,000
3. 6% of Observation Claims: (2) * 6%	21,000
4. Revised Estimate of Observation Claims: (2) - (3)	329,000
5. Outpatient to Inpatient: CMS's Estimate of Claims with Major Procedure	50,000
6. Revised Total Outpatient Claims Shifting to Inpatient: (4) + (5)	379,000
7. Net Shift to Inpatient: (6) - (1)	**-1,000**

Claim from Date versus Date of First Observation Service. CMS seeks comments on whether it would be more appropriate to have used the claim from date rather than the first date that observation services were provided in order to determine when claims containing observation services spanned two midnights or more.

We believe that it would not be more appropriate to have used the claim from date rather than the first date that observation services were provided in order to determine when claims containing observation services spanned 2 midnights or more. Rather than providing additional details on the methodology it already employed for purposes of the 0.2 percent reduction, CMS appears once again to be attempting to introduce a change in its methodology by seeking comments on the claim from date versus the date of first observation service. Again, we believe that the *Shands* court was asking CMS to provide adequate notice and an opportunity to comment on the methodology that the agency used at the time that it adopted the 0.2 percent cut more than two years ago, and, thus, that it would be inappropriate for CMS to change its methodology at this time.

As CMS clearly acknowledges, hospital outpatient claims do not readily distinguish between claims based on services that were 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. Assume the following scenario. A patient presents to the Emergency Department with right upper quadrant abdominal pain. The patient is diagnosed with cholecystitis (inflammation of the gallbladder) and thought to have gallstones. A possible course of action would be surgical treatment to remove the gallstones. However the patient is on anticoagulant medication so surgery is not an immediate option. Hence the patient needs to be

monitored carefully – repeated blood draws, put on a low-fat diet at home, need for cardiac evaluation, etc. This could take 3, 4, 5 or more days. In this case, these services are performed to optimize peri-operative care to minimize risk to the patient. There is no need for the patient to be an inpatient during this time, but the situation requires prolonged non-continuous outpatient care before the surgery. The patient eventually comes back to the outpatient department for the surgery. After surgery, the patient is then placed in observation status and is eventually discharged. Since the previous services were related to the surgery, they can be placed on one claim with the claim from date being the date of the ED visit, or even one of the dates on which the patient received any of the other outpatient services like the blood draws; and the claim through date being the discharge date after the surgery. Using the claim from date would count services which clearly are not delivered during a continuous stay in the hospital outpatient department. Since, as CMS itself acknowledges, "only continuous stays apply for this analysis," using the claim from date rather than the date of first observation service would result in CMS over counting outpatient claims that could shift to inpatient.

Outpatient Data Source and Data Trims/Claims Selection Criteria. CMS seeks comments on the appropriate outpatient data source to use for the 0.2 percent reduction and any data trims and claims selection criteria that it should apply to the data.

Data source: CMS used the 2011 outpatient standard analytical file SAF in its analysis. However, the SAF does not include the cost information which is needed to establish what the primary procedure on the claim is. CMS, however, did acknowledge that similar analysis could be undertaken by analyzing the outpatient PPS limited data set (LDS). We feel that the outpatient LDS is a more appropriate set to use because it does identify the primary procedure on the claim and the AHA used the LDS for analysis.

Data Trims/Claims Selection Criteria: CMS has used 7- and 5-day cutoffs when deciding whether to include outpatient stays in its analysis of such stays that could potentially shift to the inpatient setting. The scenario described above shows that since different outpatient claims could contain non-continuous services that could vary in length, the 7- and 5-day cutoffs used by CMS are arbitrary, and CMS has offered no rationale for its choice of these numbers.

Source: 2014 Medicare Trustees Report

B. MEDICARE DATA FOR CALENDAR YEAR 2013

HI (Part A) and SMI (Parts B and D) have separate trust funds, sources of revenue, and categories of expenditures. Table II.B1 presents Medicare data for calendar year 2013, in total and for each part of the program. For fee-for-service Medicare, the largest category of Part A expenditures is inpatient hospital services, while the largest Part B expenditure category is physician services. Payments to private health plans for providing Part A and Part B services currently represent roughly 30 percent of total A and B benefit outlays.

Table II.B1.—Medicare Data for Calendar Year 2013

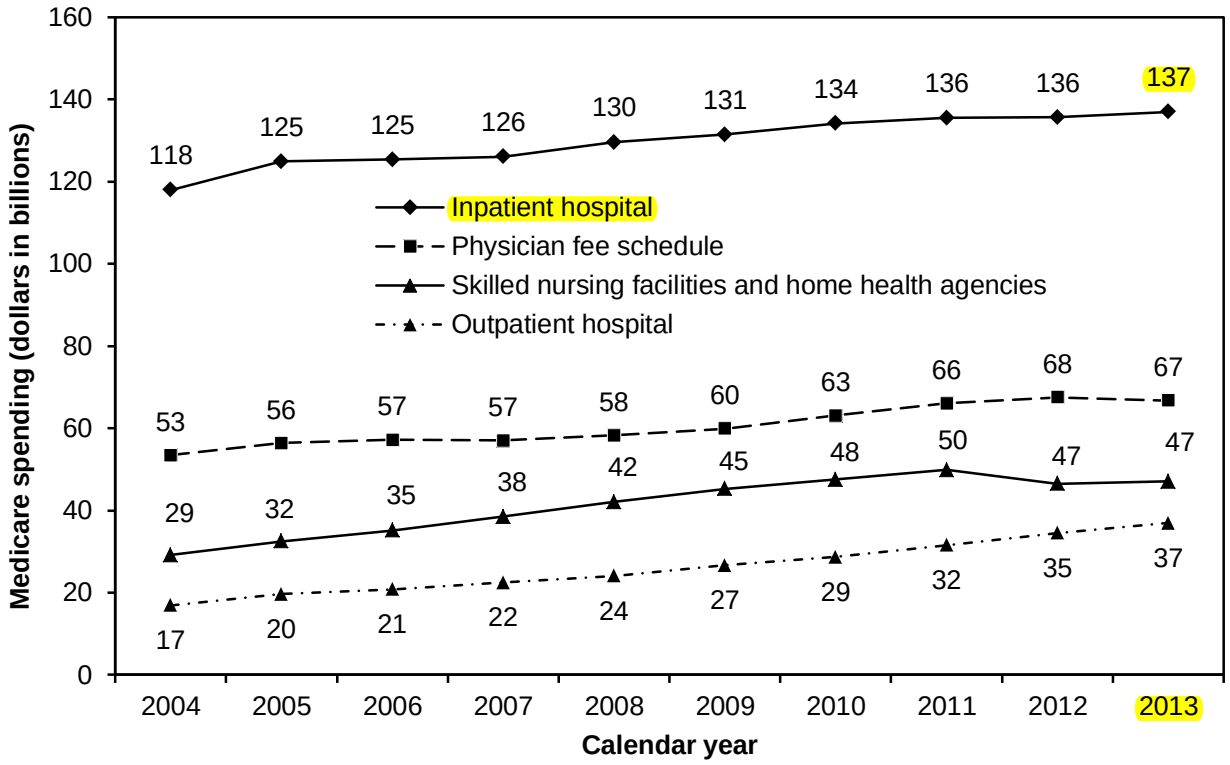
		SMI		
	HI or Part A	Part B	Part D	Total
Assets at end of 2012 (billions)	$220.4	$66.2	$1.0	$287.6
Total income	$251.1	$255.0	$69.7	$575.8
Payroll taxes	220.8	—	—	220.8
Interest	9.3	2.4	0.0	11.7
Taxation of benefits	14.3	—	—	14.3
Premiums	3.4	63.1	9.9	76.4
General revenue	0.9	185.8	51.0	237.7
Transfers from States	—	—	8.8	8.8
Other	2.4	3.7	—	6.1
Total expenditures	$266.2	$247.1	$69.7	$582.9
Benefits	261.9	243.8	69.3	575.0
Hospital	136.8	41.8	—	178.6
Skilled nursing facility	28.4	—	—	28.4
Home health care	6.8	11.5	—	18.4
Physician fee schedule services	—	68.6	—	68.6
Private health plans (Part C)	73.2	72.7	—	145.9
Prescription drugs	—	—	69.3	69.3
Other	16.7	49.2	—	65.8
Administrative expenses	$4.3	$3.3	$0.4	$7.9
Net change in assets	−$15.0	$7.9	−$0.0	−$7.1
Assets at end of 2013	$205.4	$74.1	$1.0	$280.5
Enrollment (millions)				
Aged	43.1	40.0	n/a	43.5
Disabled	8.8	7.9	n/a	8.8
Total	51.9	47.9	39.1	52.3
Average benefit per enrollee	$5,045	$5,092	$1,773	$11,910

Notes: 1. Totals do not necessarily equal the sums of rounded components.
2. n/a indicates data are not available.

For HI, the primary source of financing is the payroll tax on covered earnings. Employers and employees each pay 1.45 percent of a worker's wages, while self-employed workers pay 2.9 percent of their net earnings. Starting in 2013, high-income workers pay an additional 0.9-percent tax on their earnings above an unindexed threshold ($200,000 for single taxpayers and $250,000 for married couples). Other HI revenue sources include a portion of the Federal income taxes that Social Security recipients with incomes above

Source: A Data Book: Health care spending and the Medicare program, June 2015, MedPAC

Chart 1-1. Aggregate Medicare spending among FFS beneficiaries, by sector, 2004–2013



Note: FFS (fee-for-service). "Physician fee schedule" includes spending on services provided by physicians and other health professionals such as nurse practitioners, physician assistants, and physical therapists. Dollar amounts are Medicare spending only and do not include beneficiary cost sharing. Spending for Medicare Advantage enrollees is also not included.

Source: CMS Office of the Actuary, based on the FY 2016 President's budget and on the annual report of the Boards of Trustees of the Medicare trust funds 2014.
AT THE TIME THIS DATA BOOK WAS PREPARED, THE MEDICARE TRUSTEES' REPORT (WHICH IS THE CUSTOMARY SOURCE OF DATA FOR THIS CHART) HAD NOT YET BEEN RELEASED FOR 2015. THIS CHART REFLECTS DATA FROM THE 2014 MEDICARE TRUSTEES' REPORT. THE READER IS ADVISED TO CONSULT THE 2015 TRUSTEES' REPORT DIRECTLY, WHEN AVAILABLE, FOR THE MOST CURRENT VERSION OF THESE DATA.

- Medicare spending among FFS beneficiaries has increased significantly since 2004 across all sectors, even though spending growth has slowed recently. The slowdown in spending growth is partly attributable to a decline in the growth of FFS enrollment since the number of Medicare Advantage enrollees has increased.

- Spending growth for inpatient hospital services, the sector with the highest level of spending, averaged 2 percent per year from 2004 to 2010. It declined to about 1 percent per year from 2010 to 2013. The decline in the last three years is partly attributable to a shift in service volume from the inpatient setting to the outpatient setting and to the decline in the growth of FFS enrollment, but it may also reflect broader economic conditions. Despite the slowdown, spending on inpatient hospital services increased, on aggregate, 16 percent from 2004 to 2013.

- Spending growth for outpatient hospital services remained strong throughout the period, averaging 10 percent per year from 2004 to 2007 and 9 percent per year from 2007 to 2013. Aggregate spending on outpatient hospital services increased 118 percent from 2004 to 2013.

providers, to verify these reports, and to perform audits (where appropriate), final settlements have lagged behind the original costs by as much as several years for some providers. Additional complications arise from legislative, regulatory, and administrative changes, the effects of which cannot always be determined precisely.

The process of allocating the various types of HI payments made to the proper incurred period—using incomplete data and estimates of the impact of administrative actions—presents difficult problems, and the solutions to these problems can be only approximate. Under the circumstances, the best that one can expect is that the actual HI incurred cost for a recent period can be estimated within a few percent. This process increases the projection error directly by incorporating any error in estimating the base year into all future years.

b. Fee-for-Service Payments for Inpatient Hospital Costs

Payment for almost all inpatient hospital services for fee-for-service beneficiaries occurs under a prospective payment system. The law stipulates that the annual increase in the payment rate for each admission relate to a hospital input price index (also known as the hospital market basket), which measures the increase in prices for goods and services purchased by hospitals for use in providing care to hospital inpatients. For fiscal year 2014, the prospective payment rates have already been determined. For fiscal years 2015 and later, the statute mandates that the annual increase in the payment rate per admission equal the annual increase in the hospital input price index (for those hospitals submitting required quality measure data), minus a specified percentage. For this report, the Trustees assume that all hospitals will submit these data.

Increases in aggregate payments for inpatient hospital care covered under HI can be analyzed in six broad categories, presented in table IV.A1:

(1) Labor factors—the increase in the hospital input price index attributable to increases in hospital workers' hourly compensation (including fringe benefits);

(2) Non-labor factors—the increase in the hospital input price index attributable to factors other than hospital workers' hourly compensation, such as the costs of energy, food, and supplies;

Source: 2014 Medicare Trustees Report

The average complexity of hospital admissions (case mix) is expected to increase by 0.5 percent annually in fiscal years 2014 through 2038 as a result of an assumed continuation of the current trend toward treating less complicated cases in outpatient settings, ongoing changes in DRG coding, and the overall impact of new technology. This assumption is based on the recommendation of the 2010-2011 Medicare Technical Review Panel.

Hospital payments are also affected by other factors, as reflected in the "other sources" column of table IV.A1. A complicating factor is the advent of the new MS-DRG system, which led to significant increases in case mix as a result of claims coding. Statutory budget neutrality adjustments have offset much of the MS-DRG impact. Although the law limited the size of these adjustments in 2008 and 2009, it allows subsequent recovery of any extra payments that resulted. The "other sources" column reflects all of these actual and anticipated effects and adjustments. In addition, one can attribute part of the increase from "other sources" to the increase in payments for certain costs, not included in the DRG payment, that are generally growing at a rate slower than the input price index. These other costs include capital, medical education (both direct and indirect), disproportionate share (DSH) payments, and payments to hospitals not included in the prospective payment system. A particularly important change affecting these costs is the reduction in Medicare DSH payments under the ACA. This change reflects the major coverage expansions beginning in 2014 that will result in significantly fewer uninsured hospital patients.

Additional possible sources of changes in payments include (i) a shift to higher-cost or lower-cost admissions due to changes in the demographic characteristics of the covered population; (ii) changes in medical practice patterns; and (iii) adjustments in the relative payment levels for various DRGs, or addition/deletion of DRGs, in response to changes in technology.

The "other sources" column reflects, as appropriate, the impact of certain enacted legislation, including the sequestration process which requires a reduction of about 2 percent for April 2013 through September 2024. Also reflected in this column is the impact of the estimated bonus payments and penalties for hospitals due to the health information technology incentive provisions of the American Recovery and Reinvestment Act of 2009.

The increases in the input price index (less any intensity allowance specified in the law), units of service, and other sources are

Source: Report to the Congress: Medicare Payment Policy, March 2015, MedPAC

TABLE 3–1 **Growth in Medicare inpatient and outpatient spending**

Hospital services	2006	2012	2013	Average annual change 2006–2013	Change 2012–2013
Inpatient services					
Total FFS payments (in billions)	$110	$119	$118	1.3%	–0.9%
Payments per FFS beneficiary	3,084	3,232	3,192	0.8	–1.3
Outpatient services					
Total FFS payments (in billions)	29	46	49	7.8	5.9
Payments per FFS beneficiary	884	1,395	1,471	7.9	5.5
Inpatient and outpatient services					
Total FFS payments (in billions)	139	165	167	2.9	1.0
Payments per FFS beneficiary	3,968	4,627	4,663	2.6	0.8

Note: FFS (fee-for-service). Reported hospital spending includes all hospitals covered by Medicare's inpatient prospective payment system along with critical access hospitals. Maryland hospitals are excluded. Fiscal year 2013 payments include partial imputation to account for hospitals that typically do not submit their cost reports to CMS before CMS makes the most recent year available to the public. The combined inpatient and outpatient services per capita are based on a weighted average of Part A and Part B beneficiaries.

Source: MedPAC analysis of CMS Medicare hospital cost reports and Medicare Provider Analysis and Review files.

Background

Medicare spending on hospitals

In 2013, Medicare paid acute care hospitals nearly $118 billion for fee-for-service (FFS) inpatient care and nearly $49 billion for FFS outpatient care (Table 3-1). Acute inpatient and outpatient services represented 92 percent of Medicare FFS spending on acute care hospitals. From 2012 to 2013, Medicare inpatient spending per FFS beneficiary decreased by 1.3 percent, and outpatient spending per FFS beneficiary grew by 5.5 percent (Table 3-1).[1] The decline in inpatient payments reflects a 4 percent drop in discharges per capita, which was partly offset by increases in case complexity and Medicare payment rates. The increase in outpatient spending reflects a 4 percent increase in service volume and an increase in Medicare payment rates. On a combined basis, total payments per beneficiary increased by 0.8 percent.

Medicare's payment systems for inpatient and outpatient services

Medicare's inpatient and outpatient prospective payment systems have a similar basic structure. Each has a base rate that is modified for the differences in type of case or service, as well as geographic differences in input prices. However, each prospective payment system (PPS) has different units of service and a different set of payment adjustments.

Acute inpatient prospective payment system

Medicare's acute inpatient prospective payment system (IPPS) pays hospitals a predetermined amount for most discharges. The payment rate is the product of a base rate and a relative weight that reflects the expected costliness of cases in a particular clinical category compared with the average of all cases. The labor-related portion of the base payment rate is adjusted by a hospital geographic wage index to account for differences in hospital input prices among market areas. Payment rates are updated annually.

To set inpatient payment rates, CMS uses a clinical categorization system called Medicare severity–diagnosis related groups (MS–DRGs). The MS–DRG system classifies each patient case into 1 of 749 groups, each of which contains cases with similar principal diagnoses, procedures, and severity levels. The severity levels are determined according to whether patients have a complication or comorbidity (CC) associated with the base MS–DRG (the categories are no CC, a nonmajor CC, or a major CC). A more detailed description of the acute IPPS, including payment adjustments, can be found at http://www.medpac.gov/documents/payment-basics/hospital-acute-inpatient-services-payment-system-14.pdf?sfvrsn=0.

CMS's Two Midnight Rule: Data and Methodological Issues Lead to an Improper Result

Date: February 1, 2016

WATSON POLICY ANALYSIS

Introduction

In the FY 2014 Inpatient Prospective Payment System (IPPS) Proposed Rule, the Centers for Medicare & Medicaid Services (CMS) proposed new policies to clarify when a patient would be treated as an inpatient versus as an outpatient for Medicare payment purposes. This is known colloquially as the "Two-Midnight Rule" (or "Two Midnights") since the rule proposed that generally a patient who is expected to be in the hospital over the course of two or more midnights would be presumed an inpatient, and otherwise would be treated as an outpatient.

As a part of this rule, CMS assumed some shifts in admitting patterns with some patients currently classified as outpatients moving to inpatient status and some inpatients shifting to outpatient status. CMS estimated that with more patients shifting to inpatient status, Medicare Part A expenditures would increase, and the agency would need to remove $220 million (0.2%) from the IPPS aggregate payments to balance those assumed shifts. CMS accomplished this by reducing the standard payment rate by 0.2 percent.

The American Hospital Association (AHA) contracted with Watson Policy Analysis (WPA) to attempt to replicate the CMS analysis that led to the $220 million figure and analyze the appropriateness of the assumptions, methodology and findings.

Executive Summary

The CMS methodology contains numerous questionable and potentially erroneous assumptions which serve to inflate the estimated dollar impact of the Two-Midnight Rule on Medicare payment to IPPS hospitals which was the basis for the 0.2 percent reduction. Correcting just two of the key elements of the CMS methodology leads to *no net impact* on IPPS expenditures as opposed to the $220 million impact that CMS computed based on an estimated net 40,000 cases shifting from outpatient to inpatient.

WPA calculated a net impact of $0 by correcting for only two of the assumptions made by CMS to well-supported values:

1) **Inpatient Counts: Use MedPAR Data for Consistency with Rule-Making. CMS's inpatient counts were derived from a dataset not available to the public.** If CMS would have used its own publicly available (MedPAR) data (as opposed to the internal data CMS used which were not available for public examination, testing, or comments) to compute the number of inpatient surgical short-stay cases, the number of cases shifting from inpatient status to outpatient status increases by 20,000. This reduces the net change by half: from 40,000 to 20,000 cases.

2) **Outpatient Counts: Account for Non-Continuous Stays. CMS failed to back-out non-continuous outpatient stays, thereby inflating the number of cases that could potentially shift to inpatient status.** By using the "claim from" and "claim through" dates for outpatient observation stays to compute the length of stay, CMS

inappropriately captures a significant number of non-continuous outpatient encounters—that is, a patient who made separate trips to the hospital on non-consecutive days for outpatient services (including observation services) and did not stay continuously in the hospital. CMS failed to account for these encounters in its estimate of cases that would shift claims from outpatient to inpatient status, thus overstating the number of cases expected to shift to inpatient status. One way to have appropriately accounted for the non-continuous outpatient cases would have been to examine the number of hours in outpatient observation care reflected on the outpatient claim and to shift only those claims with 24 hours or more of observation care—the bare minimum for a continuous stay that might be expected to span two midnights—from outpatient to inpatient. WPA performed that analysis and found that if CMS had reduced the number of observation cases by a conservative 6 percent (based on the number of outpatient cases with 24 hours or less of reported observation care), the net number of cases shifting from outpatient status to inpatient status would be reduced by 20,000.

Correcting for these two issues in CMS's analysis alone would result in a zero net shift in cases and a resulting zero net financial impact. In addition, however, there are numerous other issues of concern in the CMS analysis. Correcting these would also reduce the impact that CMS estimated and could even result in a shift in the other direction which, under that agency's interpretation, would mean that money should be *added* to the IPPS system. We have identified three of the major issues below. We note that this list is not exhaustive but is intended to focus on the main shortcomings of CMS's analysis.

- **Medical DRG cases were assumed to not shift to outpatient.** CMS assumed that inpatient short-stay cases in medical diagnosis related groups (DRGs) would not shift to outpatient. Given that the majority of inpatient short stay cases are assigned to medical DRGs, even a small proportion of medical DRG cases shifting could have a dramatic impact on the net number of cases shifting

    - If just 5 percent of the short-stay medical DRG cases shifted to outpatient, that shift by itself would completely eliminate the net increase in inpatient cases CMS estimated. If more than 5 percent of the short-stay medical DRG cases were to shift to outpatient stays, there would be a reduction in inpatient stays requiring an increase in IPPS payments under CMS's interpretation.

- **Small changes in assumptions have a huge impact on results.** As CMS acknowledged, the model is highly sensitive to small changes in inputs or assumptions. Small changes can lead to significant differences in the estimate of change, including changing the direction of the impact. We similarly found this in our replication of the CMS model, and based on our examination of the data and CMS's assumptions, believe there should be changes to more accurately reflect expected provider and beneficiary behavior. These refinements may and can shift numbers dramatically. As a result, clear explanations of the agency's assumptions and inputs would have provided us with a better framework to more accurately test the model.

- **CMS failed to adequately document its assumptions and data sources**. The most recent CMS Notice with Comment Period (80 FR 75107, the "Shands Notice") is still lacking in sufficient detail. The AHA sent CMS a list of questions via email on December 23, 2015 (the "December 2015 Questions"). CMS responded to these questions on January 13, 2016, but in certain instances still did not provide sufficient detail to allow WPA to discern the specific path that CMS took to arrive at its final adjustment factor even through all of the documents. For example:

    - CMS either ignored or failed to document a number of logical steps that are essential to the development of its analysis. It is not possible to tell if this is just a lack of proper documentation or if the analysts at CMS failed to take these issues into account.

    - CMS failed to provide sufficient information for outside analysts to replicate the agency's analysis based on its underlying assumptions with a reasonable degree of confidence. Of particular significance, CMS – at times – failed to provide enough information for outside analysts to understand the CMS inputs and results.

- **CMS used data that were not publicly available.** In its original inpatient analysis, when estimating inpatient short stay cases that could potentially shift to the outpatient setting, CMS used data from its Integrated Data Repository (IDR), which is not publicly available. CMS assumed that the publicly available MedPAR data would yield similar results, but expressly stated in the Shands Notice that they did not verify this assumption. A static version of the data used was also not retained at the time the original analysis was completed making it impossible to replicate and validate the CMS methodology.

Background on the Two-Midnight Rule

The Two-Midnight Rule was originally proposed in the FY2014 Proposed IPPS Rule and adopted in the FY2014 Final IPPS Rule (collectively, the "FY14 Proposed and Final IPPS Rule"). As stated in the FY14 Proposed and Final IPPS Rule, CMS adopted the Two-Midnight Rule in an effort to clarify what is required for Medicare Part A payment of hospital inpatient services based on the beneficiary's length of stay. Specifically, CMS observed that from 2006 to 2011, the number of cases of Medicare beneficiaries receiving observation services for more than 48 hours increased from 3 percent to 8 percent. Concerned that Medicare beneficiaries may not fully understand the potential financial impact that this trend could have on them, CMS attempted to provide additional details regarding what constitutes an inpatient stay.

The FY14 Proposed and Final IPPS Rules focused significantly on the physician's certification of inpatient status for a patient, the requirements for physician orders and the role and presumptions of Medicare's external medical reviews. There was also a limited discussion in both the FY2014 Proposed and Final IPPS Rules of the actuarial assumptions that contributed to the determination that the Two-Midnight policy would result in an additional $220 million in

IPPS expenditures. In terms of replicating the analysis, the FY2014 Proposed and Final IPPS Rules provide very little detail regarding CMS's assumptions.

On August 19, 2013, after release of the Final Rule, the Office of the Actuary at CMS issued a memorandum entitled "Estimated Financial Effects of Two Midnight Policy".

In April 2014 and August 2014, CMS promulgated the FY2015 Proposed and Final IPPS Rules (collectively, the "FY15 Proposed and Final IPPS Rule"), which provided a very limited discussion of the Two-Midnight policy. The FY2015 rules speak to the "inpatient only list" and the other "rare and unusual circumstances" in which a hospital stay expected to last less than 2 midnights would nonetheless be appropriate for inpatient hospital admission and payment under Part A. There is no discussion in either the FY15 Proposed or Final IPPS Rule of the logic or methodological assumptions adopted by CMS with respect to the accompanying 0.2 percent payment cut.

This most recent Shands Notice provides limited additional background information as well as two appendices with information about CMS's assumptions. While this Notice provides more detail than the FY2015 and the original FY2014 rules, there are still significant omissions that make it nearly impossible to accurately replicate CMS's analysis.

In an effort to address some of these omissions and to clarify some of the outstanding issues, the AHA and others submitted a series of questions to CMS following the publication of the Shands Notice. CMS responded to most of the questions. However, CMS declined to answer some questions based on its determination that certain questions focused on "assumptions" rather than methodology. Other questions were not answered in a meaningful way. Thus even after receiving answers sought by WPA, it was still impossible to fully understand and replicate with certainty the path that led CMS to institute the 0.2% reduction to IPPS payment.

Replication

For purposes of our analysis, WPA divided the replication into three core components:

1. Inpatient analysis
2. Outpatient analysis
3. Financial modeling

The following sections provide a discussion of the different issues and methodological questions that we have identified with the CMS analysis. We also describe the potential impacts that a more reasoned and supportable analysis could have on the agency's estimate that the Two-Midnight Rule would increase IPPS expenditures by $220 million.

<u>Inpatient Analysis</u>

Based on an internal actuarial analysis, a summary of which was published in various rules, CMS estimated that approximately 360,000 short stay inpatient cases with a length of stay of

less than two (2) midnights assigned to surgical DRGs would shift to the outpatient setting as a result of the Two-Midnight Rule.

Appendix D of the Shands Notice contains a description of this methodology. The description contains a number of questionable methodological decisions and raises additional questions about the reasonableness of the assumptions.

Key issues with CMS's logic and methodology include:

- **CMS did not account for the potential shifting of short-stay medical DRG cases.** CMS assumed that no cases assigned to DRGs would shift from inpatient to outpatient status. This assumption was not described in the original FY2014 IPPS proposed rule but was present in the discussion sections of later published rules and additional notices. Not until the Shands Notice, did CMS provide an explanation. While the inpatient or outpatient status of a patient is determined at the time the patient is first treated at the hospital, the DRG assignment is made at the time the patient is discharged (based on all of the patient's diagnoses and treatments received during his/her hospital stay). While we believe it is safe to assume that physicians have a sense of (1) what treatment a patient will need and (2) if the patient will require a stay of more than two midnights, it seems unlikely that every admitting physician would have perfect foresight to be able to know both of these factors in every situation. It is far more likely that some proportion of medical cases for patients admitted as inpatients ultimately require less than two midnights and assigned to a medical DRG and, therefore, could potentially have been assigned an outpatient status.
    - Impact: CMS excluded all short-stay medical DRG cases when estimating the number of short-stay cases that would shift from inpatient to outpatient status. Using the 2011 MedPAR data, WPA estimates that there are slightly more than 800,000 short-stay medical cases. Each 1 percent of short-stay medical DRG cases shifting would move approximately 8,000 cases to outpatient status. Just 5 percent of the medical DRG cases shifting would completely eliminate the net change that CMS estimated. A shift greater than 5 percent would move the change in the other direction. However, for purposes of this modeling, we have not estimated a percentage that would shift as this is potentially a clinical/treatment issue and requires more specialized knowledge.

- **CMS failed to use a publicly available data set.** In the recent Shands Notice, CMS for the first time described the exact data set (the IDR) that it used for its inpatient analysis. *This data set is not publicly available.* In fact, CMS admitted it merely assumed that the publicly available data – MedPAR which is used in most of its inpatient rate-setting activities – would yield a similar result. On page 75116 of the Shands Notice, CMS wrote "At the time the original -0.2 percent estimate was developed, we believed similar conclusions regarding the -0.2 percent estimate could be drawn using either the IDR or the publicly available inpatient data files. However, we did not verify this at the time."
    - Impact: Outside analysts are unable to review and replicate the CMS analysis. Even by CMS's own calculations using the MedPAR data would drop the net

impact of cases shifting by 50 percent. Using the MedPAR data, CMS estimated that 380,000 cases would shift from inpatient to outpatient, which would cut the projected net increase in inpatient stays from 40,000 to 20,000. Use of public data that outside analysts can analyze is a key tenet of the public's right to comment. WPA has tested CMS's analysis using the MedPAR data and finds an even higher number of stays (393,000) would shift from inpatient to outpatient than CMS estimated (380,000). However, being conservative, WPA has used the published CMS estimate from the MedPAR data for its analysis.

- **The initially published analysis can no longer be replicated even by CMS.** In the Shands Notice, CMS acknowledged that the data its actuaries used in their analysis is not "static" and has been changed and updated over time. In fact, CMS cannot even replicate its published results with the same data set because, according to CMS in the Shands Notice, it appears that a static copy of the data was not saved at the time of the original analysis.
    - Impact: This compounds the problem that outside analysts confront in trying to replicate CMS's results.

- **Shifting and Multiple Disclosures of Information.** CMS's gradual and incomplete release of information about its assumptions and methodology contained inconsistencies and left many unanswered questions. This behavior generated confusion with respect to understanding and replicating CMS's analysis that led to the 0.2 percent payment reduction.
    - Impact: CMS creates undue challenges for analysts to replicate the agency's analysis to inform comments to each new proposal. Many of the multiple disclosures provide conflicting (or, at best, confusing) information.

Based on the issues described above and suggested corrections, WPA believes that the most appropriate figure to use for the number of surgical short-stay inpatient cases potentially shifting to outpatient should be the 380,000 cases that CMS reported based on the agency's analyses using the publicly available MedPAR data. This count is 20,000 cases higher than the number CMS reported it calculated with the IDR data that cannot be currently replicated either by CMS or the public. The MedPAR data are used in the annual rate-setting process, and so for consistency should be used here as well.

Outpatient Analysis

In contrast to the inpatient analysis, the outpatient analysis was far more complicated and subject to misunderstanding. CMS's descriptions of its outpatient analysis are unclear and there are other policy and logical concerns. The CMS actuarial analysis estimated that 400,000 outpatient cases would become inpatient cases under the Two-Midnight Rule. CMS estimated that there would be 350,000 observation cases shifting to inpatient status and 50,000 major procedure cases shifting to inpatient status. Some of the issues related to CMS's logic include the following:

- **CMS could not accurately determine which patients had continuous stays in the outpatient setting.** CMS acknowledged that the data do not allow for analysts to know whether an outpatient claim represents a continuous time period in the hospital or whether the claim reflects a beneficiary leaving the hospital and returning on a later day within a 30-day period. CMS admitted this was an issue, writing on P. 75116 of the Shands Notice, "Hospital OP 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. Since only continuous stays apply for this analysis, certain assumptions had to be made to indirectly estimate the body of claims for continuous services." But while CMS acknowledged this issue, it failed to account for it in its analysis.
    - Impact: CMS may have dramatically overestimated the number of outpatient claims that could potentially shift to inpatient.

- **Measurement of Observation Status.** CMS defined observation claims by the presence of certain codes (namely, G0378 and G0379) and then measured the length of the outpatient claim based on dates of service. It is unclear, since CMS never discussed it in any of the published rules or additional notices, why CMS did not define the length of observation services based on the number of hours of observation services reported on the claim. Using this data would have been a far more direct and appropriate way to measure the length of observation time and the length of time in the hospital while receiving observation services.
    - Impact: CMS may have dramatically overestimated the number of outpatient claims that could potentially shift to inpatient.

In order to review CMS's logic on the outpatient side, WPA examined the number of hours of observation care reported on each claim. Based on our review of the number of observation hours reported on claims where the length of time between the start of the observation and the end of the claim was at least 2 days (following the CMS logic), WPA found nearly 6 percent of observation cases with 24 or fewer hours (the bare theoretical minimum for 2 midnights) and 52 percent of observation claims with 47 or fewer hours (the theoretical maximum). In order to be conservative in estimation, WPA used 6 percent as the estimate for the proportion of observation claims that did not meet the two-midnight benchmark – although the true figure may be higher.

> Reducing the observation cases by 6 percent in order to account for likely claims that did not span two midnights reduces the number of outpatient claims shifting to inpatient by approximately 20,000 claims.
>
> Combined with the previous shift based on using the MedPAR data, this would lead to a **zero** net change in cases.

Financial Modeling

The inpatient and outpatient modeling provide two of the key inputs into the modeling of the estimated financial impacts; but as CMS explains, there is additional analysis needed to estimate the impact of the Two-Midnight Rule. Based on the results of CMS's previous modeling and the agency's associated assumptions, CMS determined that the Two-Midnight Rule would have an estimated $220 million impact in additional IPPS spending. Changes in these assumptions, however, can lead to dramatically different results, including the financial impacts.

WPA believes that this estimate of financial impact is overstated. WPA also has reservations and questions about a number of the assumptions that the agency made, including but not limited to the following:

- **Short Stays.** CMS assumed that 28 percent of cases are short stay cases, accounting for approximately 17 percent of total spending for total discharges. These figures depend on a number of assumptions, most importantly, the definition of "short stay cases."
    - Impact: The impact of different percentages could alter the financial impact asserted by CMS.

- **Cost.** CMS assumed that payment under the OPPS system is equal to 30 percent of the payment under the IPPS system if a case is reclassified from inpatient to outpatient. The published rules and additional notices lack a detailed description of how this number was calculated. CMS was asked about it and asserted that it was an assumption, not a methodological question, and did not provide any additional information pertaining to the figure. The agency noted that an Office of the Inspector General (OIG) report had found inpatient costs to be close to three times outpatient costs without providing any more comment. CMS should provide a basis for this assumption that can be validated by commenters and outside analysts. There are a multitude of different ways to calculate this, which may provide different results. Understanding what underlies the CMS assumption is necessary for commenting.
    - Impact: An improper assumption with regard to the relationship of outpatient to inpatient costs could shift the dollar impact estimated by CMS in either direction.

- **Total Inpatient Spending.** In response to the AHA's December 2015 Questions, CMS reported using a total spending figure equal to "…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." We have attempted to validate this figure, but our search proved unsuccessful. Furthermore, CMS has not provided any explanation for what types of inpatient spending are included in this number, which appears unusually high when compared with other data sources. It is likely that this amount includes spending for other types of inpatient facilities not covered by the IPPS, such as psychiatric, rehabilitation, long term care, etc. For example, this figure is approximately 18 percent higher than the $118 billion figure reported by MedPAC in its "Report to the Congress: Medicare Payment Policy, March 2015", P. 53, Table 3-1. The

amount reported by MedPAC is consistent with total spending amounts found in the MedPAR data sets based on modeling of later years.

- Impact: If CMS were to use a figure for IPPS payment that excluded other types of inpatient facilities in accordance with the MedPAC estimate, the financial impact of the Two-Midnight Rule would be reduced significantly.

While each of these issues, and others not documented here, are of concern to us, the potential for all of these different issues to have a cumulative, layering effect is particularly troubling. This cumulative impact can lead to even greater variability and uncertainty than the impact of just one issue.

Conclusion

WPA concludes that the CMS published figure of $220 million as the financial impact of the Two-Midnight Rule is questionable. A more likely figure is zero net change or a change in the other direction, resulting in a positive rather than negative adjustment.

Other changes in assumptions or inputs could further change the results, as CMS's actuaries wrote: "While we believe that these assumptions are reasonable, relatively small changes have a disproportionate effect on the estimated net costs. For this reason, these estimates are subject to a much greater degree of uncertainty than usual, and actual results could different significantly from these estimates." (Page 75114 of Federal Register Vol. 80, No. 230).

Appendix A: Data sources

Inpatient

The data used for the inpatient analysis were the MedPAR final data for federal fiscal year 2011. These are the data used in the FY 2013 IPPS rate-setting.

Outpatient

The data used for the outpatient analysis w the Outpatient Prospective Payment System (OPPS) final data from calendar year 2011. These are the data used in the CY 2013 OPPS rate-setting.

Contact information

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