Submitted Electronically

June 24, 2014

Marilyn B. Tavenner
Administrator
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W., Room 445-G
Washington, DC 20201

RE: CMS-1607-P, Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Proposed Fiscal Year 2015 Rates; Quality Reporting Requirements for Specific Providers; Reasonable Compensation Equivalents for Physician Services in Excluded Teaching Hospitals; Provider Administrative Appeals and Judicial Review; Enforcement Provisions for Organ Transplant Centers; and Electronic Health Record Incentive Program(Vol. 79, No. 94), May 15, 2014

Dear Ms.Tavenner:

The Florida Hospital Association (FHA), on behalf of its more than 239 hospital and health system members, appreciates this opportunity to respond to the Centers for Medicare & Medicaid Services' (CMS) proposed rule to update the hospital inpatient prospective payment system (IPPS) for fiscal year (FY) 2105. While FHA's comments will be limited to certain provisions of the proposed rule, we are also supportive of the comments submitted by the American Hospital Association (AHA).

Documentation and Coding Offset

CMS proposes a cut of 0.8 percentage point in FY2015 to fulfill part of the American Taxpayer Relief Act of 2012 (ATRA) requirement that CMS recoup what the agency claims is the effect of documentation and coding changes from FYs 2010, 2011 and 2012 that CMS says do not reflect real changes in case mix. Note that this is in addition to the cut of 0.8 percentage points that was finalized by CMS for FY2014. While we continue to believe these congressionally mandated adjustments are not warranted, we appreciate the Agency's proposal to help mitigate extreme annual fluctuations in payment rates and provide hospitals with additional time to manage these sizeable cuts.

Short Stay Payment Policy

For FY2015, CMS is not proposing any major changes to the two-midnight policy adopted in FY2014, but seeks comments on the development of a short stay payment policy. We believe that such a policy, in conjunction with the existing two-midnight rule, could address a number of

issues surrounding the current "after-the-fact" audits of Medicare short stay claims by Recovery Auditors and Medicare Administrative Contractors. Hospitals are concerned that the current two-midnight policy fails to provide adequate reimbursement for beneficiaries who require an inpatient level of care but who do not meet the two-midnight benchmark for admission. CMS reimburses for this care under the outpatient PPS, which does not cover the cost of the inpatient level of care that is provided and typically results in higher cost-sharing for the beneficiary.

We encourage CMS to adopt a short stay payment policy as soon as possible, with the following guidelines as the basis for its development:

- The short stay payment policy would provide for appropriate and adequate reimbursement for medically necessary inpatient services that span less than two midnights – payment would be higher than the outpatient prospective payment system rate for the service but would not exceed the applicable full inpatient DRG payment.
- The short stay payment policy would not apply to those procedures on the inpatient-only list, regardless of length of stay.
- The short stay payment policy would be budget-neutral to the IPPS with any and all savings redistributed back to the inpatient base DRG rate (i.e., the standard operating rate), thereby allowing those funds to be available for cases that do not qualify for the short stay payment policy.
- For medical DRGs, the short stay payment policy could be designed similarly to CMS' long standing post-acute care transfer policy which reimburses hospitals a graduated per diem rate instead of a full DRG payment rate.
- For surgical DRGs, the policy should pay a minimum of one-half the DRG payment rate due to the majority of cost being incurred on day one of the stay.
- Under the short stay payment policy, hospitals would be eligible on a pro-rata basis for all add-on payments such as disproportionate share and indirect medical education payments that they would otherwise receive.
- Beneficiaries requiring inpatient hospital stays reimbursed under the short stay payment policy should be considered inpatients and cost-sharing obligations should be calculated under Part A.

Pay-for-Performance Programs

The *Patient Protection and Affordable Care Act* included the requirement that CMS establish a number of pay-for-performance programs that carry the potential of rewarding or penalizing hospitals based on their scores on a number of performance measures. FHA urges CMS to revisit the conditions addressed under the value-based purchasing program, the readmissions reduction program, and the hospital-acquired condition reduction program to eliminate overlapping measures across the programs. The overlap of measures across these programs creates the potential for unfair double payment penalties and could send conflicting signals about the true state of hospital performance.

Wage Index Timeline

CMS proposes to issue preliminary wage index data in May of each year rather than September, as was done for the FY2015 date. CMS then proposes to require all hospital proposed

adjustments to wage index and occupational mix data by a deadline of early October. For the 2015 cycle, the deadline was November 21, 2013. For FY2017 data, CMS proposes to further accelerate the deadline for requesting adjustments by individual hospitals to early August 2015.

We support the revision deadlines of early October because it provides for a "level playing field" for June 30 year-end hospitals whose cost report due dates are November 30. Because hospitals have limited cost reporting personnel and resources, many June 30 year-end hospitals likely do not devote sufficient assets to "scrubbing" wage index data and, as a result, may have less accurate data than hospitals with other year ends. Using a May data release and an October deadline eliminates that problem and also allows for more time for hospitals to scrub data and Medicare Administrative Contractors to complete their desk reviews.

The proposed FY2017 deadline of early August seems too soon and we believe that continuing with an early October deadline, or perhaps moving the "scrubbing" deadline to late September, would be preferable to an August date.

Revisions to PRRB Appeal Regulations

The proposed rule appears directed at changing longstanding doctrines related to Provider Reimbursement Review Board (PRRB) jurisdiction and documentation requirements for Medicare cost report appeals. The proposed rule would eliminate the dissatisfaction requirement for PRRB jurisdiction, changing the jurisdictional element of dissatisfaction to a substantive requirement for documenting payment to which a provider is entitled. We encourage the agency to reconsider its proposal as it is an impermissible interpretation of statute and regulation.

The mandate that a provider be dissatisfied with a final determination is integral to the listing of jurisdictional requirements for Board review in 42 U.S.C. § 1395oo(a). It is the first of three requirements for Board jurisdiction, the others being the amount in controversy threshold and the 180-day deadline to file from the date of the disputed final determination. The requirement of a real dispute is a long-standing requirement of judicial and administrative review, and the dissatisfaction requirement is part of the statutory statement of the "real controversy" principle traditionally associated with standing.

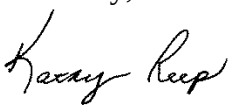
The approach in the proposed rule conflicts with the explicit determination of the United States Supreme Court in *Bethesda Hosp. Ass'n v. Bowen*, in which the Supreme Court instructed that "a provider's dissatisfaction with the amount of its total reimbursement is a condition of Board jurisdiction." If finalized as proposed, the rule would remove a condition for Board jurisdiction that the Supreme Court has expressly ruled is mandated by the statute. Congress created the dissatisfaction element as a condition of appeal to the PRRB, not as a condition for substantive payment, and the Secretary cannot change a statute by mere regulation.

In addition, CMS proposes to move the requirement to include an item on a cost report or protest the item, converting it to a substantive reimbursement requirement rather than a jurisdictional requirement. CMS proposes to move this requirement to various provisions of 42 C.F.R. § 413, the regulations relating to adequately documenting claimed costs. Most PRRB issues, however, do not involve "claimed costs" because the IPPS is not associated with cost-based

reimbursement that is the subject of § 413. Therefore, these regulations are not applicable to payments under the Part A IPPS that are not paid on the basis of a provider's reasonable costs or customary charges.

The FHA appreciates the opportunity to provide these comments for consideration in finalizing the IPPS rule for FY2015. If there are any questions, please do not hesitate to contact me at kathyr@fha.org.

Sincerely,



Kathy Reep
Vice President/Financial Services