Submitted Electronically

December 2, 2014

Daniel R. Levinson
Inspector General
Department of Health and Human Services
330 Independence Avenue, SW
Washington, DC 20201

RE: OIG-403-P3; Revisions to Safe Harbors under the Anti-Kickback Statute and Civil Monetary Penalty Rules Regarding Beneficiary Inducements and Gainsharing

Dear Mr. Levinson:

On behalf of its more than 238member hospitals and health systems, the Florida Hospital Association (FHA) appreciates this opportunity to provide comments on the Office of Inspector General's (OIG) proposed revisions to the anti-kickback statute, beneficiary inducement and gainsharing civil monetary penalty rules. The proposed rules seek to codify into the regulations certain statutory changes made in the Prescription Drug, Improvement and Modernization Act of 2003 and the Patient Protection and Affordable Care Act of 2010, add new protections for certain offerings deemed to present a relatively low risk to federal health care programs if structured properly, and make certain technical corrections to the regulations. FHA comments will focus on OIG proposals to create a safe harbor related to patient transportation.

Hospital responsibility for patient care no longer begins and ends at the inpatient setting or any other site of care provided by the hospital. While discharge planning has long been a condition of participation in the Medicare program, post-discharge monitoring of beneficiary follow-up and treatment plans has become equally important from a patient care and Medicare payment perspective. Medicare readmission penalties, as well as other Medicare payment policies, effectively hold hospitals accountable for the success of the post-discharge treatment plan.

Hospitals need certain tools and flexibility to promote the health of their patients and their communities, while reducing unnecessary health care expenditures. One example is the ability to provide transportation for medically appropriate health care services to a beneficiary, a need that OIG acknowledges has been brought to its attention for years. Transportation can be the difference between a patient receiving or not receiving necessary care. Hospitals also need the ability to provide other types of post-discharge (and post-hospital outpatient care),support to help patients follow through on their post-care plans, whether it is continuing a course of care, electronic monitoring, maintaining a medication regimen or taking other steps to improve/maintain their health status. In addition, transportation for routine care is often difficult because the patient is too infirmed to drive his- or herself, family members are working and cannot always accommodate an appointment schedule, and financial resources are limited and

public transportation is either too costly (taxi) or difficult to maneuver (bus). Providing transportation for these established patients would be beneficial in maintaining the patient's plan of care, reducing readmissions and other setbacks due to failure to receive needed care in the most appropriate setting.

However, allowing transportation for only an "established patient" is too limiting. This limitation would unreasonably prevent a hospital from assisting a beneficiary in keeping the critical first appointment or assisting a beneficiary in completing registration in advance of the visit. Requiring that transportation be limited to a distance no greater than 25 miles will potentially prevent Medicare beneficiaries living in rural areas from accessing needed care. Setting 25 miles as the outer distance limit for a transport would effectively preclude critical access hospitals and sole community hospitals from meeting the transportation needs of those they serve.

We urge the OIG to consider these comments as it undertakes revisions to the anti-kickback statute and work with providers to develop an environment focused on the Triple Aim – improving the patient experience of care, improving the health of populations and reducing the per capita cost of health care. If there are questions on these comments, please do not hesitate to contact me at kathyr@fha.org or at (407) 841-6230.

Sincerely,

Kathy Reep

Kathy Reep
Vice President/Financial Services