Submitted Electronically

September 6, 2016

Andrew M. Slavitt
Acting Administrator
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W., Room 445-G
Washington, D.C. 20201

RE: CMS-1656-P, Medicare Program; Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs; Payment to Certain Off-campus Outpatient Departments of a Provider; Proposed Rule (Vol. 81, No. 135), July 14, 2016.

Dear Mr. Slavitt:

On behalf of our over 200 member hospitals and health systems, the Florida Hospital Association (FHA) appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) calendar year (CY) 2017 hospital outpatient prospective payment system (OPPS) proposed rule. Our comments will focus on the proposals that would implement the site-neutral provisions contained in Section 603 of the Bipartisan Budget Act of 2015 (BiBA).

Section 603 of BiBA enacted site-neutral payment reductions for Medicare services that are furnished in newer off-campus provider-based hospital outpatient departments (HOPDs) that are not dedicated emergency departments (EDs). A "new" HOPD is defined as an off-campus provider-based department of a hospital that first furnished and billed for Medicare hospital outpatient services on or after the date of BiBA's enactment (Nov. 2, 2015), but is not a dedicated ED. CMS refers to these HOPDs, as well as the items and services they furnish, as "nonexcepted." BiBA states that such nonexcepted HOPDs would not be eligible for OPPS reimbursements beginning Jan. 1, 2017, and instead would be paid under another applicable Part B payment system.

The FHA is extremely concerned about CMS's implementation of the BiBA site-neutral provisions, which we fear will result in hospitals being unable to continue to provide the current level of necessary, innovative and high-quality health care in their communities. More than half of the U.S. House and Senate this spring urged CMS to provide reasonable flexibility when implementing the BiBA site-neutral provisions in order to ensure that Medicare patients have continued access to the highest quality hospital outpatient care in their communities. Instead, CMS has proposed a short-sighted and unworkable set of policies that provide no reimbursement directly to hospitals in CY2017 for the services they provide to Medicare beneficiaries. CMS must delay these site-neutral policies until it can adopt much-needed changes in order to provide fair and equitable payment to hospitals.

Payment Policy for Nonexcepted Hospital Outpatient Departments (HOPDs). CMS proposes to make no payment to newer "nonexcepted" off-campus HOPDs for the services they provide to Medicare beneficiaries in 2017. In other words, the agency would not provide any reimbursement to HOPDs for the nursing, laboratory, imaging, chemotherapy, surgical and many other reasonable and necessary services they provide to Medicare beneficiaries. Such a payment policy is completely unreasonable and unsustainable.

Medicare's PFS payment is higher in the nonfacility setting and lower in the facility setting so as to recognize that when a physician/practitioner furnishes a service in the office, the physician/practitioner incurs the cost of the clinical staff, equipment and supplies. In the facility setting, the physician/practitioner does not incur these direct costs and Medicare makes a lower payment. In this circumstance, Medicare also makes payment to the hospital for its direct costs and its institutional indirect costs that are associated with providing services in a HOPD.

However, under its proposal, not only does CMS provide no payment at all for the hospital's costs associated with providing a service, but also it is paying the physician/practitioner for the hospital's direct costs – costs that the physician does not actually incur. Expecting hospitals to then obtain reimbursement from the physician/practitioner raises a multitude of issues such as reassignment, anti-markup, self-referral and anti-kickback, making this proposed policy infeasible to implement at all, much less by Jan. 1, 2017.

The FHA also believes that the agency's basis for its "non-payment" policy is not sound. That is, CMS claims that the agency cannot pay hospitals directly under a non-OPPS Medicare Part B payment system in 2017 because "at a minimum, numerous complex systems changes would need to be made to allow an off-campus provider-based department to bill and be paid as another provider or supplier type." However, CMS currently pays hospitals, on the hospital UB04/837I claim, at the Medicare Physician Fee Schedule (PFS) rate for hospital outpatient therapies and mammography services. It also reimburses hospitals via the Critical Access Hospital (CAH) Optional Payment Method (Method II) at PFS rates using the institutional claim. While it may not be simple, CMS clearly has a mechanism at its disposal that it could use to pay hospitals directly for nonexcepted services under the PFS.

Requiring hospitals to bill using the CMS 1500 (professional claim) for nonexcepted off-campus HOPDs creates many extremely difficult operational issues. Hospital billing systems are designed to generate the institutional claim, referred to as the UB04/837I, and not the CMS 1500 claim. Billing on the CMS 1500 claims requires entirely different software and processes. It is critical that CMS's site-neutral payment regulations continue to allow nonexcepted services in off-campus HOPD to be billed on the UB04/837I. In addition, as noted earlier, CMS already requires hospitals to bill using a UB04/837I for certain services that are only paid at the PFS rate, such as therapy and preventive services.

The FHA believes that, in the statutory language included in BiBA, Congress signaled its intent that hospitals bill on the institutional claim, rather than the professional claim, when it referenced another "applicable payment system" being used to pay for nonexcepted items and services in off-campus provider-based HOPDs. That is, BiBA adds language to the Social Security Act at 1833(t)(21)((D) to implement site-neutral payment, stating, "Each hospital shall provide to the Secretary such information as the Secretary determines appropriate to implement this paragraph

and paragraph (1)(B)(v) (which may include reporting of information *on a hospital claim* using a code or modifier."

Further, as CMS itself notes, nonexcepted HOPDs would remain provider-based departments of the hospital and there are important implications of having their charge and cost data flow to the hospital cost report as it does today. The FHA is concerned that if the billing for these non-excepted off-campus HOPDs is on CMS 1500 claims, the information on hospital services and encounters performed in these provider-based HOPDs would be completely lost for purposes of cost allocation, settlement and other policies. This information is crucial for proper cost reporting and reconciliation to hospital ledgers for all services and departments, not just for excepted services that are paid via the OPPS and for inpatient services. It is important that the revenue for these nonexcepted off-campus HOPDs flow through the Provider Statistical and Reimbursement (PS&R) report, even if that revenue is not paid via the OPPS.

There are additional concerns and complexities that would arise if CMS were to require hospitals to bill under its provider number using the CMS 1500 professional claim for nonexcepted items and services furnished in a provider-based off-campus HOPD. For instance:

- Every hospital with off-campus provider-based HOPDs would need to run dual billing systems for its excepted and nonexcepted outpatient services, one using the UB04 claim and one using the CMS 1500. The hospital's IT system would have to be altered in order to differentiate between the two. This would be even more complex for those individual patient encounters in excepted HOPDs that involve both excepted and nonexcepted services, in which case, the IT system would need to differentiate those services that would have to be billed on the CMS 1500 and those that would be billed on the UB04. Furthermore, this creates a dual billing system for Medicare only, which makes this approach unwieldy, bureaucratic and very costly.

- Medicare beneficiaries would receive two different bills from the hospital, which would include different copayment amounts; one for services billed on a UB04 and one for services billed on a CMS 1500. Further, if the patient encounter involved physician services, there would be a third bill with a third patient copay.

- Claims for Medicare outpatient hospital services provided within 72 hours of admission are rolled into the inpatient claim. Currently, CMS looks for an overlap of hospital claims under the same provider number. How would CMS be able to find such overlap between the inpatient UB04 and the outpatient CMS 1500 claims? How would CMS combine the claims if the CMS 1500 service was billed with physician's billing number? Would the payment window apply if the physicians are not employed by the hospital?

- There would be downstream effects for secondary supplemental payers, including Medicaid and commercial insurers. We are concerned that state Medicaid agencies would not be able to handle cross-over claims for beneficiaries who are dually eligible. We have similar concerns about secondary supplemental payers being able to handle hospital outpatient services being billed on both institutional and professional claims.

- There may be implications for the Health Insurance Portability and Accountability Act (HIPAA) transaction standards. In particular, the 837P, the professional claim, is not intended to be used for institutional services, such as facilities enrolled as provider-based departments of a hospital. Rather, institutional services, such as HOPD services, are intended to be billed on the 837I claim.

Additional Considerations for 2018 and Beyond. As CMS considers how to establish a more reasonable and workable payment policy for 2018 and beyond, the FHA urges the agency to further examine its other proposals related to site-neutrality. In particular, the agency's proposal to limit flexibility in relocation, expansion and change of ownership, in combination with its proposal to withhold hospital payments altogether, would mean that hospitals and health systems that have planned to provide or expand much-needed hospital-level outpatient care in urban and rural communities with limited access to care would not be able to do so.

We firmly believe that Congress did not intend that the site-neutral provisions of BiBA be implemented so inflexibly. In fact, the plain language of Section 603 does not mention relocation, expansion or change of ownership. Had Congress intended to prohibit the relocation, expansion or change of ownership of excepted HOPDs, it could easily have included that in Section 603; however, it did not.

We recommend that CMS:

- Allow excepted HOPDs to relocate and rebuild without triggering payment cuts;
- Protect hospitals' ability to offer expanded lines of services without experiencing a loss of reimbursement; and
- Allow individual HOPDs to be transferred from one hospital to another and maintain their excepted status.

Again, we reiterate that CMS must delay these site-neutral policies until it can adopt much-needed changes in order to provide fair and equitable payment to hospitals. Thank you for the opportunity to share our comments on the proposed rule. If there are any questions, please do not hesitate to contact me at (407) 841-6230 or via email at kathyr@fha.org.

Sincerely,

Kathy Reep
Vice President/Financial Services