September 2, 2014

Ms. 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-1613-P, Medicare Program: Proposed Changes to the Hospital Outpatient Prospective Payment System and 2015 Payment Rates

Dear Ms. Tavenner:

On behalf of its more than 238 member hospitals and health systems, the Florida Hospital Association (FHA) appreciates this opportunity to provide comments to the Centers for Medicare & Medicaid Services (CMS) regarding the proposed rule to update the Medicare hospital fee-for-service (FFS) Outpatient Prospective Payment System (OPPS) for 2015. FHA comments will focus on CMS proposals to track services in off-campus provider-based departments and physician certification.

Tracking Services in Off-Campus Provider-Based Departments

Building on a concept suggested by CMS in the 2014 OPPS rule, CMS is proposing to collect data on the type and frequency of hospital and physician services provided in off-campus provider-based clinics. Currently, CMS does not have access to data that differentiates between outpatient services provided directly in a hospital and services provided in these clinics. CMS cites the growing trend toward hospital acquisition of physician offices and subsequent treatment of those locations as off-campus provider-based departments along with the current Medicare reimbursement differentials between the two settings as the rationale for this data collection. The Medicare Payment Advisory Commission (MedPAC) has also raised concerns about this issue and has put forward recommendations to Congress to pay for Evaluation/Management (E/M) services and other select outpatient services performed in off-campus provider-based clinics at the rates under the Physician Fee Schedule or Ambulatory Surgical Center prospective payment system, rather than the OPPS payment rate.

To obtain this data, CMS proposes to create a HCPCS modifier to be reported with every code for outpatient hospital services and physicians' services provided in an off-campus provider-based clinic. Specifically, CMS seeks comments regarding whether the use of the HCPCS modifier is the best mechanism for collecting service-level data in the hospital outpatient department.

While we understand CMS's interest in analyzing this rapidly changing environment, we are concerned that the information collected could be used as a means to justify implementing "site

neutral" payment reductions, such as the policies that MedPAC and Congress have pursued in recent years in the context of federal budget cuts. Instead, we urge policymakers to recognize that the growing trend of hospitals to acquire physician practices and integrate those practices as hospital outpatient departments (HOPDs) likely reflects efforts to provide more integrated and comprehensive care while improving care coordination that focuses on appropriate utilization, efficiency and outstanding measurable outcomes. This trend may also reflect physicians' inability to maintain financially viable practices at current Medicare payment rates.

In addition, implementation of a HCPCS modifier would create an added administrative burden for hospitals since a single Medicare outpatient claim can include up to 30 days of services. The claim may also include many services provided in various locations both on and off the hospital's main campus. Hospital billing processes currently do not provide a manner to distinguish the specific location where a particular service is provided. Therefore, implementing a site-specific HCPCS modifier to track off-campus provider-based services would require investing significant resources to modify the hospital billing system. Given the limited number of billing systems vendors, the ability for hospitals to implement system changes in a short period of time is almost impossible. The industry would need at least six months' notice and that may not be enough for some. It is also likely that the Medicare Administrative Contractors (MACs) would not be ready to adopt this change in such a short timeframe and would need additional time to make required changes to their claims processing systems. Furthermore, additional staff training would be required for both hospitals and the MAC. This would be a complex and costly endeavor and could potentially involve hospitals submitting multiple claims for the same patient encounter representing different sites of service. This is not currently permitted in the MAC claims processing system.

The FHA urges CMS not to finalize the proposed modifier. Instead, we encourage CMS to work with stakeholders from the hospital and physician communities to better identify what specific questions CMS is attempting to answer. We believe this would allow CMS to find a less burdensome approach to collecting the desired information and result in a better outcome for hospitals, patients and CMS.

Physician Certification of Hospital Inpatient Services

Under the Social Security Act, Medicare Part A payments are only made for services that are furnished over a period of time if a physician certifies that such services are required to be given on an inpatient basis. CMS previously interpreted this to require a physician certification for all inpatient admissions. The American Hospital Association (AHA) challenged this interpretation in litigation on the inpatient "two midnight" policy, arguing that the physician certification should be required only for certain long-term stays. In an attempt to address the litigation, CMS proposes to alter its previous interpretation and require a physician certification only for cases that are 20 inpatient days or more, or are considered outlier cases.

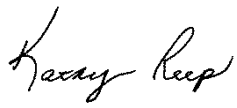
While the FHA supports the proposed change to the requirement for physician certification to only those with lengths of stay of 20 days or longer, we also ask that you address the requirement for certification of cost outlier claims. Many providers are not able to determine that a particular claim will be paid as a cost outlier and they are unable to obtain physician certification for what is essentially an uncertainty. Current requirements in § 424.13(f)(2) state

that for cost outlier cases, certification is required no later than the date on which the hospital requests cost outlier payment, or 20 days into the hospital stay, whichever is earlier. If possible, certification must be made before the hospital incurs costs for which it will seek cost outlier payment. This is outside the knowledge of the physician, charges are often late in posting to an account, and the requirement is an administrative burden on hospitals that should be eliminated.

In addition, we oppose any action by CMS to require a signed physician order for all inpatient admissions prior to the discharge order as a condition of payment. In order for a hospital to have a complete medical record and to be in compliance with the Conditions of Participation, orders must be signed within a timeframe set by state law or hospital bylaws. CMS cannot use its general rulemaking authority under Section 1871 to require a physician order for each inpatient admission, and if finalized, this change would conflict with the Social Security Act.

Again, the FHA appreciates this opportunity to provide input to CMS and urges you to modify the OPPS proposed rule based on these comments. We believe that these changes would result in a positive outcome for our hospitals and the patients they serve. If you have questions or require additional information, please contact me at (407) 841-6230 or kathyr@fha.org.

Sincerely,



Kathy Reep
Vice President/Financial Services