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January 31, 2014

Mr. Chuck Braver,
DFO, CMS, CM, HAPG, DOC-HOP Panel
7500 Security Boulevard
C4-05-17
Woodlawn, Md. 21244-1850

Re: CMS-1463-N; Medicare Program; Semi-Annual Meeting of the Advisory Panel on Hospital Outpatient Payment (HOP Panel); March 10-11, 2014

Dear Mr. Braver:

On behalf of the Illinois Hospital Association's (IHA) 88 Small and Rural Hospital Constituency members, we greatly appreciate the opportunity to submit comments to you and the members of the Hospital Outpatient Payment Panel (HOP) regarding the Centers for Medicare & Medicaid Services' (CMS) current regulations governing the direct supervision of hospital outpatient therapeutic services. Per the Dec. 6, 2013 Notice in the *Federal Register*, one of the items on the agenda for the panel's March meeting is "...Recommending the appropriate supervision level (general, direct, or personal) for individual hospital outpatient therapeutic services." IHA is pleased that CMS, following the panel's recommendations in the past, has increased the number of procedures that now qualify for "general" supervision. However, we remain concerned that this number is still too low.

Before we address the specific procedures which should be reclassified to the general supervision category, we must reiterate that, for many of our rural hospital members, the cost of recruiting and employing a physician (oftentimes on a part-time basis) is prohibitive. In order to attract physicians to practice in their communities, our hospitals expend significant budget dollars to first recruit physicians and then offer competitive salaries to hire them. In the case of supervision, the salary costs expended for what is probably a limited hour, part-time position, are high. As a result, if the panel concurs that more procedures can be performed under the auspices of general supervision, not only will patient access be preserved, but costs incurred by the rural health care system will be reduced.

Since the publication of the notice, IHA has solicited comments and recommendations from our member hospitals regarding additional procedures that can appropriately and safely be performed under the general supervision category. After analyzing the responses, IHA submits the following table of procedures for the panel's review. We believe these procedures are more appropriately suited for categorization under the "general supervision" category. Also included is a brief rationale for the general supervision reclassification and possible repercussions if CMS continues to apply the direct supervision criteria:

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HCPCs	Description	Rationale for Change	Consequences of Inaction
93798	Cardiac Rehab / Monitor	Non-physician practitioner can safely perform this activity. Also, would increase the ability to serve more patients prior to the physician's arrival.	Program will be discontinued. Also, in some cases, if patients do not follow through with care, additional treatment costs are incurred.
36600	Withdrawal of arterial blood	This routine test is performed by licensed respiratory therapists and can be safely performed by trained personnel.	Increased cost to the hospital and to patients. Patient access to necessary tests and services in the future may be limited.
86900	Blood Typing ABO	This test can be safely performed by trained personnel.	Reduces patient access; this test cannot be performed if patients need a blood transfusion after regular physician office hours.
86901	Blood Typing Rh Factor		
94640	Airway Inhalation Treatment	This procedure is learned and safely performed by licensed respiratory therapists. It does not require physician supervision.	Reduces patient access and increases costs and limits the ability of offsite clinics to offer this service.
94667 94668	Chest Wall Manipulation	This procedure is routinely performed by licensed respiratory therapists.	Could potentially limit patient access and could increase the cost of care for beneficiaries.
96415	Chemotherapy IV Infusion- Additional HR	This procedure provides cost-effective patient care by reducing travel expenses to receive care in their local community, allowing for the immediate support of family members.	Access would be limited because patients in rural areas would face great travel hardships to receive treatment.
97597	Rmvl Devital tis 20 cm/<	This procedure is safely performed at offsite therapy clinics. Masters or Doctoral-prepared physical, occupational or	Limited access and availability of therapy services in certain areas.

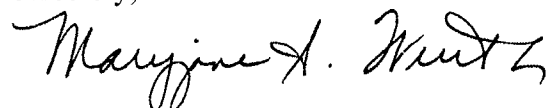
		speech therapists are trained to perform.	
99211	Office/Outpatient Visit	These visits can be safely performed by trained personnel.	Could potentially limit patient access and could increase the cost of care for beneficiaries.
G0176	OPPS/PHP Activity Therapy	This activity can be safely performed by trained personnel.	Could potentially limit patient access and could increase the cost of care for beneficiaries.
97000-97546	Physical, Occupational and Speech Therapy procedures performed on a daily basis	These procedures have been proven to be safely performed at offsite therapy clinics. Masters or Doctoral-prepared physical, occupational or speech therapists are trained to perform.	Limits patient access and availability of therapy services in certain areas.

Currently, many procedures are being performed by non-physician practitioners in rural areas because of a local shortage of physicians. Supervision of these procedures would be performed on a part-time basis. As a result, it is extremely challenging for a rural hospital to recruit and hire a physician willing to supervise on a “part time” basis. The cost to our hospitals would be prohibitive.

In addition, many pathology procedure reviews are done remotely, thereby reducing the costs involved, but still maintaining the integrity and quality of care. In these instances, the application of a direct supervision criterion is moot. The use of telemedicine is another factor to consider when thinking about providing services to rural Medicare patients. Telemedicine is an increasingly growing health care delivery system which also ensures that the quality of patient care in rural areas is not compromised.

Mr. Braver, thank you again for the opportunity to present this information to you and the panel. If you or anyone on the panel has any further questions or comments, please contact Lori Williams, Vice President of Membership, 217-541-1164 or at lwilliams@ihastaff.org.

Sincerely,



Maryjane A. Wurth
President & CEO

Cc

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