March 21, 2008

Patrick Kennedy
Administrator
Office of Data Collection and Quality Assurance
Agency for Health Care Administration
2727 Mahan Drive
Tallahassee, Florida 32308

Re: Comments on Proposed Changes to Rule 59E-7 and 59B-9

Dear Patrick,

Data on hospitals and other health care providers is critical to understanding the current state of Florida's health care system, to help consumers understand cost and quality of specific health care services and to help policy makers in their decisions as to the future direction of health care in the state. The Florida Hospital Association is committed to ensuring that the data that is collected is accurate, useful, consistent, and timely, and has demonstrated that commitment with our involvement in the Agency's data collection and public reporting efforts over the past several years.

We strongly supported, in fact encouraged, the Agency to re-open the two reporting rules, 59E-7 and 59B-9, to incorporate national standards and to eliminate ambiguity in the rule that leads to data reporting inconsistencies.

After providing numerous verbal comments at the workshop on January 29, 2008, and submitting written comments on February 5, 2008 for 59E-7 and February 6, 2008 for 59B-9, we are disappointed that the proposed rule appears to include few of our suggestions and that no explanation was provided for why those suggestions were not included in the second draft of the rules.

Below are additional comments that incorporate some of the broader issues along with specific recommendations for changes to the proposed rules.

**Accuracy and consistency of data**
To maximize the accuracy and consistency of the data, it is important that the rule include clear definitions and instructions, and align with national standards for data reporting.

**Definitions and instructions**
The definitions and instructions in the rule must be complete and unambiguous to ensure that the data submitters and the data users understand exactly what the Agency is expecting the hospital to report. We feel that the current rule does not accomplish this. The definition section (59E-7.011 and 59B-9011) of the rule is incomplete and at times includes instructions for reporting along with the definition. Additionally, the section specifying the data elements (59E-7.018 and 59B-9.019) includes definitions within the description of the data element which might be more effective if included in the definition section. Moreover, if there is a statutory definition of a term, then the statutory definition should be used.

One of the biggest challenges with the 59E-9 rule is clarifying which outpatient visit data should be reported and how it should be reported. Since both hospitals and freestanding ambulatory centers must report data under the same rule, the rule is confusing or unclear in places because the reporting requirements differ for hospitals and the freestanding centers. For ambulatory centers, it should be clear that they are to report data on all patients. For hospitals, the Agency only wants information on certain outpatient visits. Thus, the rule needs to be very specific as to what should be reported. Only using code ranges in the past has lead to confusion and adding the revenue codes helps, but as written the rule needs further clarification. For example, the rule requires that some outpatient cardiac procedures be reported but excludes others such as Percutaneous Transluminal Coronary Angioplasty (balloon angioplasty) or cardiac stents.

***Specific recommendations:***
*1. Separate the reporting requirements for hospital outpatient services from those for freestanding ambulatory surgery, lithotripsy, and cardiac catheterization laboratories.*

*2. Clarify the reporting instructions for outpatient procedures by specifying the category of procedures to be reported, i.e., ambulatory surgical, extra-corporeal shock wave treatment, cardiac catheterization procedures, and endoscopies. The data reporting manual, which the Agency has indicated they are developing, can be used to specify the codes or code ranges and revenue codes that could help the hospital identify those procedures to be reported. For example, "Ambulatory surgery" would include patients with CPT codes in the range of 10000 through 69999 and having charges in the revenue code fields of 36X or 49X.*

*3. Change the definition of "Charity" to be the statutory language.*

*4. Modify the definition of "discharge" to use the national definition ( by the Centers for Medicare and Medicaid Services) which states "a formal release of a beneficiary (patient) from an inpatient hospital. This includes when the beneficiary (patient) is physically discharged from the hospital as well as when the beneficiary remains in the hospital but at a lower level of care".*

*5. Modify the definition for "Inpatient" – delete the sentence "Observation patients are excluded until such time as an order for an inpatient admission is written ordered". This belongs in the reporting section.*

*6. Modify the definition for "Attending practitioner" – delete the sentence "The attending physician may be the operating or performing practitioner. The attending physician may be an emergency room physician or other specialist". This belongs in the reporting section.*

*7. Add a definition for "CMS" since it is referenced in the payer category section.*

*8. Add a definition for "organization name". Current this is only described in 59E-7.017 Header Record.*

**Alignment with national data reporting standards**
The foundation of the data to be reported under this rule is the Uniform Billing System (UB-92 or now the UB-04). This system was chosen because administrative data is readily available and does not require expensive data abstraction to report data to the state. This system is based on data known at the time the patient was discharged from care. Using this system ensures that the Agency is collecting data based on national standards and minimizes any ambiguity in the data since hospitals must report to payers based on the definitions for these code sets. Any modifications to the data elements or the way the data is to be reported that varies from national standards will place a significant financial burden on the hospitals. Thus, we caution and discourage the Agency from implementing any changes that are contrary to how the data is currently being collected based on national guidelines. Anything that differs from this will require manual abstraction and additional programming to capture this data differently for reporting to the Agency.

*Specific recommendations*:

1. *Specify in the rule that the "organization name" is the name of the facility from which the patient is discharged. Currently the rule states that the organization name is the "name of the hospital that performed the inpatient service(s) represented by the data, and which is responsible for reporting the data". If read literally, this means that if a service was provided at two different locations of the licensed hospital, two records must be generated even though the patient was not discharged. This is problematic because (a) it will have to be extracted manually and system revisions will be necessary to capture the data and (b) it will result in double counting of patients, distortions of charge and length of stay data (if the hospital stay is split to reflect services provided at different campuses).*

2. *We strongly encourage the Agency to explore how to reference the UB-04 data code set to minimize the need to re-open the rule each time the data code set is changed or send instructions for re-mapping the data to report in the Agency's format. The UB-04 provides clarity in reporting that is not a part of the Agency's rule. If this violates Florida administrative processes, then we encourage the Agency to use the specific definitions used in the UB-04 manual and provide mapping guidance to the reporting facilities anytime there is a change.*

**Minimize reporting burden**

We believe given the current fiscal crisis, it is now more important than ever to minimize the reporting burden and the data processing burden on each of us. Variations in the data reporting from the source data increases the cost to the hospitals and to the Agency, and also increase the opportunity for error and eliminates the ability to compare Florida data to other states.

If the data is not captured in the administrative data stream or requires manipulation to create a new data element or to re-sequence the data, then the Agency should thoroughly evaluate the cost vs. benefit of the data and whether there is a different way to get the data, such as the Agency manipulating it. While the Agency might incur some minimal costs, those costs are significantly less than what it would cost 279 hospitals individually having to manipulate the data. More importantly, the consistency of the data element would be increased if the Agency assigns the code or sequences the data for public use purposes since the Agency would develop one consistent methodology for these purposes, as opposed to each hospital developing their own.

Two areas of the rule require the data to be manipulated prior to sending to the Agency. These are the "type of service code" and the place of occurrence codes reported in the second e-code field. The Agency is requiring the hospitals to assign a "type of service" code to the inpatient record, which denotes whether it is an "acute inpatient and psychiatric or comprehensive rehabilitation". It is not clear why the Agency wants only two types of service codes. Since the Agency has the diagnosis codes, they can assign a type of service to each record.

External cause of injury codes (e-codes) are reported in the administrative data set but not in any sequencing. Since coding guidelines do not require a specific sequencing of e-codes, the hospitals will have to manually ensure that the place of occurrence code appears in the second position. Thus, requiring hospitals to report the place of occurrence code is in the second e-code field is time consuming and costly since this is not standard reporting formats.

*Specific recommendations*

1. *Delete "type of service code" assignment since the Agency can identify those ICD9 codes that relate to the categories for type of service and assign a code for the public use data set.*

2. *Delete the requirement to sequence the external cause of injury codes such that the place of occurrence codes fall in the second position. Note in the rule that hospitals are required to report external cause of injury codes and, if available, place of occurrence codes for the first encounter for treatment.*

**Data should be meaningful**
Given the costs incurred by both the hospitals and the Agency to collect and report these data, it is crucial to the tax payers of Florida and those paying for health care services that the data be meaningful. While the Agency can collect lots of data, not all data is meaningful. For example, "charity" will not always capture whether a patient qualifies as charity because it can take months to verify that a patient does not qualify for other coverage and/or to obtain the necessary documentation to meet the state's definition of "charity".

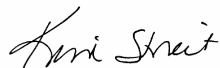
Another data element that is problematic is ED admission hour, ED discharge hour and ED admission date (being reported on the inpatient file). Our understanding is that these data elements will be used to measure ED wait times. Since the Agency is asking for "hour" of admission or "hour" of discharge, it will be difficult to calculate ED wait times without the minutes. The UB-04 only captures the "hour" so reporting minutes will be impossible. There are other problems also, such as when the ED admission time is recorded – some record the hour as the time that the patient is registered and others report it at the time the patient is triaged.
Additionally, some information systems used by hospitals automatically discharge an outpatient so the exact discharge hour might not be known. Also, sometimes patients are placed in observation before being formally admitted to the hospital. Since there is no way to identify observation patients, any wait time (rounded to the hour) will be misleading, inaccurate and not meaningful.

*Specific recommendations*
*1. Delete the category of "charity" in the payer category. If this must be kept in the database, note that it is those patients that were known to have qualified as "charity" at the time of discharge.*

*2. Delete the requirement to report ED admission date and ED discharge hour.*

While Florida leads the country in providing data to consumers on hospital and outpatient care, our goal should be to have the best, most timely data possible. The Florida Hospital Association is committed to working with the Agency on these rules and hopes that the Agency considers the points raised in this letter as constructive suggestions for improving the data that is currently being reported by hospitals.

Sincerely,



Kim Streit
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