

October 5, 2020

Seema Verma, MPH
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
PO Box 8013
Baltimore, MD 21244-1850

Re: CMS-1736-P

Re: Medicare Program: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs; New Categories for Hospital Outpatient Department Prior Authorization Process; Clinical Laboratory Fee Schedule: Laboratory Date of Service Policy; Overall Hospital Quality Star Rating Methodology; and Physician-owned Hospitals Proposed Rule

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Dear Administrator Verma:

On behalf of our 42,000 members, the American College of Emergency Physicians (ACEP) appreciates the opportunity to comment on the major price transparency proposal included in the Calendar Year (CY) 2021 Medicare Hospital Outpatient Prospective Payment System (OPPS) Proposed Rule.

CMS is proposing to eliminate the Inpatient Only (IPO) list over a three-year transitional period with the list completely phased out by CY 2024. This is a list of procedures which currently can only be performed in a hospital inpatient setting. CMS will begin with the removal of nearly 300 musculoskeletal-related services, which would make these procedures eligible to be paid by Medicare in the hospital outpatient setting in addition to the inpatient setting. Procedures removed from the IPO list will eventually become subject to the “two-midnight rule.”

ACEP has long expressed concerns about the two-midnight rule. Under the two-midnight rule, patients that spend less than two midnights in a hospital are treated as an outpatient, while patients that spend more than two midnights in a hospital are treated as an inpatient. The difference between having an “inpatient” and “outpatient” status on patients could potentially be significant, as beneficiaries generally face a 20 percent coinsurance for most outpatient services. Unfortunately, many beneficiaries do not know that they are actually outpatients. If they are in the hospital, they assume they are inpatients and subject to the inpatient Medicare rules. Hospitals are required to provide a Medicare Outpatient Observation Notice (MOON) to Medicare beneficiaries

informing them that they are outpatients receiving observation services and are not inpatients. However, it is still confusing for beneficiaries, and this new IPO policy in the OPPS proposed reg will only add to that confusion. All in all, we believe that CMS to must ensure that Medicare beneficiaries clearly understand their cost-sharing obligations if they receive one of these procedures being removed from the IPO list.

We also have concerns about the effects eliminating the IPO list will have on observation stay reimbursement policies. Observation stays have proven to be an excellent mechanism for ensuring that patients are not unnecessarily admitted to the hospital or prematurely sent home. Due to the safety and efficiency benefits of observation status, we have found that these claims are not subject to heavy audits for site-of-service review. However, the removal of the IPO list could result in an increased audit burden across the board as two-midnight case reviews increase. CMS should therefore more carefully consider the potential auditing and documentation burden on health care practitioners prior to finalizing any policy as significant as the complete elimination of the IPO list.

We are also concerned that other healthcare payors will use the lack of an IPO list as a tool to force cases that are appropriate for the inpatient setting into other places-of-service. While these are not procedures that would typically be conducted in emergency departments, if payors were to attempt to shift even a portion of the more than 1,700 cases into other places of service, the potential effects on outpatient departments, emergency departments, and observation units could be debilitating. At a moment in time where we are dealing with tremendous financial and care delivery pressures due to the novel coronavirus (COVID-19), this type of dramatic shift in care could add to the mounting resource strains that facilities and practitioners are already navigating.

Related to this proposal, CMS stated its intention to retain its existing two-year exemption from site-of-service denials, Beneficiary and Family Centered Care-Quality Improvement Organizations (BFCC-QIOs) referrals to recovery audit contractors (RACs), and RAC reviews for “patient status” for procedures removed from the IPO list, even in the event that it finalizes the proposal to eliminate the IPO list, for CY 2021 and subsequent years. CMS also requests input on whether the two-year period is appropriate or whether a different time frame may be more appropriate in order for providers to gain experience with applying the two-midnight rule to these services. If CMS were to finalize the proposal to eliminate the IPO list, in order to address any unintended consequences, ACEP believes that CMS should maintain at least the two-year exemption from the two midnight rule for cases removed from the IPO list and should consider a longer exemption, such as three years or more given the current state of affairs in which the elimination of the IPO list would begin.

We appreciate the opportunity to share our comments. If you have any questions, please contact Jeffrey Davis, ACEP’s Director of Regulatory Affairs at jdavis@acep.org.

Sincerely,

A handwritten signature in black ink that reads "William P. Jaquis". The signature is written in a cursive, flowing style.

William P. Jaquis, MD, MSHQS, FACEP
ACEP President