Society of Hospital Medicine
Empowering hospitalists.
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October 5, 2020

Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attn: CMS-1736-P
P.O. Box 8016
Baltimore, MD 21244-8016

Dear Administrator Verma,

The Society of Hospital Medicine, representing the nation's hospitalists, is pleased to offer our comments on the proposed rule entitled: *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 (CMS-1736-P).*

Hospitalists are clinicians whose professional focus is the general medical care of hospitalized patients. Hospitalists are front-line healthcare providers in America's hospitals and care for the nation's hospitalized patients, many of whom are Medicare and Medicaid beneficiaries. They manage inpatient clinical care of their patients while working to enhance the performance of their hospitals and health systems. Due to their focus on the hospital setting, hospitalists have been the backbone of the nation's COVID-19 response, caring for hospitalized COVID patients throughout the country.

It is from this perspective that we issue our comments.

CY 2021 Proposal to Eliminate the IPO List

SHM has concerns about CMS' approach to eliminating the inpatient only (IPO) list and we ask for more data and data transparency to ensure that beneficiary care and out-of-pocket costs will not be negatively impacted. While we are supportive of the concept, CMS needs to provide more information to help stakeholders evaluate whether this move is appropriate. We agree that patients should be able to receive care in the safest, lowest level of care, particularly if it improves outcomes. We also support CMS' efforts to expand physician autonomy and decision making. That said, CMS has not demonstrated in the rule how the proposal achieves these aims. Indeed, prior deletions from the inpatient only list were guided by a transparent, case-by-case analysis.

If CMS moves forward with the proposal, CMS must release comprehensive data demonstrating the impact of this change on patient out-of-pocket costs and any applicable quality of care data. Additionally, CMS should release information about Medicare reimbursement to hospitals and physicians and how this change has impacted them. This information is critical in determining any unintended consequences resulting from the elimination of the inpatient only list and will enable course correction should issues become apparent. This is particularly important for monitoring the care of and resultant cost to Medicare beneficiaries.

The primary reason data transparency is necessary is that we are concerned that elimination of the inpatient-only list could have the unintended consequence of increasing out-of-pocket costs for Medicare beneficiaries. For example, in the Inspector General Report "Vulnerabilities Remain Under Medicare's 2-Midnight Hospital Policy" (https://www.oig.hhs.gov/oei/reports/oei-02-15-00020.pdf), Table F2 shows average beneficiary payments. While this table does not adjust for comorbidities or complexity/severity of a presenting problem, limiting exact comparisons, patients paid the most out-of-pocket costs for the coronary stent insertion category, which is categorized as an outpatient procedure. This example suggests that moving procedures to outpatient status could create new financial liabilities for beneficiaries.

In the proposal, CMS addresses patient out-of-pocket risk by indicating that the C-APC 8011 for observation services should cap out-of-pocket burden for patients. However, this only occurs for patient care that is billable under the C-APC. To our knowledge, CMS has not published data on proportion or types of observation stays eligible for C-APC billing. Some data suggest that only 60% of observation encounters are C-APC eligible, which leaves the remaining 40% vulnerable to uncapped out-of-pocket costs under Part B. **We ask that CMS make publicly available the percent of observation stays billed under the C-APC, as well as the most common clinical indications for those stays.** This information should be made publicly available to allow for more accurate estimation of beneficiaries' out-of-pocket costs. Given the lack of uniformity and transparency associated with APC billing, CMS must proactively create guardrails through rulemaking to prevent beneficiary out-of-pocket costs from ballooning as a result of this proposed change. Patients in CY2021 should not bear greater financial responsibility than those receiving the same services in CY2020.

While some outpatient procedures may move to ambulatory surgery centers, many will not. Ultimately, outpatient (observation) and inpatient status are billing distinctions that may simply amount to two different payment rates for the same medical care delivered in the same physical location. **We hope that CMS' consideration of eliminating the IPO list presents CMS with an opportunity to reconsider this two-tiered billing and reimbursement system altogether**. It is unnecessarily burdensome for both providers and patients, and we have significant concerns that IPO list elimination will further blur this artificial distinction that has no clinical value.

Conclusion

SHM appreciates the opportunity to provide comments on the 2020 Outpatient Prospective Payment System proposed rule. If you have any questions or need more information, please contact Josh Boswell, Director of Government Relations, at jboswell@hospitalmedicine.org or 267-702-2632.

Sincerely,

Danielle Scheurer, MD, MSCR, SFHM
President, Society of Hospital Medicine