September 13, 2021

Chiquita Brooks-LaSure, MPP
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Baltimore, MD 21244

Submitted electronically via www.regulations.gov

RE: Medicare Program: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs; Price Transparency of Hospital Standard Charges; Radiation Oncology Model; Request for Information on Rural Emergency Hospitals [CMS-1753-P]

Dear Administrator Brooks-LaSure:

On behalf of the Emergency Department Practice Management Association (EDPMA), we appreciate the opportunity to provide comments on the calendar year (CY) 2022 Hospital Outpatient Prospective Payment System (OPPS) proposed rule. EDPMA represents independent emergency physician groups and their practice partners. Our members serve approximately half of all visits to emergency departments in the nation.

SERVICES THAT WOULD BE PAID ONLY AS INPATIENT SERVICES

EDPMA supports the CMS proposal to halt the elimination of the Inpatient Only List (IOL). As we commented to the Agency last year, we believed the proposal to phase in the elimination of the inpatient only list was of extreme significance. We support the more cautious approach CMS has proposed in this year's proposed rule. We believe this will ensure that CMS policy does not result in unintended consequences that could be harmful to patients and the health care system at large.

While the types of cases that CMS contemplated removing from the list are not the types of procedures that one would expect to be conducted in emergency departments, site of service determinations for observation stays, the IPO list (instituted in 2000), and the 2 Midnight Rule (implemented in 2015) have been intrinsically linked. As providers of care for patients in

observation status, we have always believed that the policy has the potential to have a ripple effect throughout the health care system, hence our recommendation that CMS take a more cautious approach.

Medicare and other payers are direct beneficiaries of the efficient, safe care that is provided to patients who meet the criteria for observation status. Observation stays have proven to be an excellent mechanism for ensuring that patients are not sent home prematurely risking a bad outcome, are provided great care, and helps to ensure that only those patients in need of an inpatient admission are assigned to that level of care. Because of 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, given the linkage of the IOL to the 2 Midnight rule, and the fact that elimination of the IPO list would have meant the elimination of one of the 2 Midnight rule exclusions from site-of-service reviews, we were extremely concerned about increased audit burden across the board as these reviews would have increased***.*** As such, ***EDPMA believes that because of the benefits derived by the health system from observation stays, CMS should finalize its approach to halt the elimination and consider removal of procedures from the IOL on a case-by-case basis as it states is its intention in the proposal***.

As you consider future efforts to potentially move procedures off of the IOL, we reiterate our serious concerns that payers will use the fact that a procedure is removed from IPO list as a tool to force cases that are appropriate for the inpatient setting into other places-of-service. Again, while most of procedures are not procedures that would typically be conducted in emergency departments, if payers were to attempt to shift even a portion of the more than 1,700 cases into other places of service, it is certain to have effects on outpatient departments, emergency departments, and observation units. At a moment in time where we are dealing with tremendous financial and care delivery pressures due to the COVID-19, this type of dramatic shift in care would have affected the resources available to facilities and practitioners that are already navigating a strenuous environment.

CMS also states its intention to enact a 2-year exemption from site-of-service denials, BFCC-QIO referrals to RACs, and RAC reviews for “patient status” for procedures removed from the IPO list. As part of our recommendation for a cautious, thoughtful approach, ***EDPMA supports CMS’ implementation of the 2-year exemption from the 2 midnight rule for cases removed from the IPO list.*** CMS also requests input on whether the exemption should be for a different length of time. As we suggested last year, ***EDPMA believes that CMS should consider a longer exemption, such as 3 years or more to ease administrative burden and ensure that payers do not misappropriate the removal of a procedure from the list***.

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We thank you for the opportunity to comment on these issues. If you have any questions or comments, please do not hesitate to contact Elizabeth Mundinger at emundinger@edpma.org.

Sincerely,

Bing Pao, MD, FACEP
Chair of the Board, EDPMA