



### **Comments of the Regulatory Action Center**

Re: Changes to Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs; Addition of New Categories for Hospital Outpatient Department Prior Authorization Process

Docket ID: CMS-2020-0090-0003

October 2, 2020

The Regulatory Action Center at FreedomWorks Foundation is dedicated to educating Americans about the impact of government regulations on economic prosperity and individual liberty. FreedomWorks Foundation is committed to lowering the barrier between millions of FreedomWorks citizen activists and the rule-making process of government bureaus to which they are entitled to contribute.

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On behalf of over 5.7 million activists nationwide, FreedomWorks Foundation appreciates the opportunity to offer these comments regarding the notice and request for comments on this notice of proposed rulemaking (CMS-2020-0090-0003). This notice seeks comment on revisions to the Medicare hospital outpatient prospective payment system (OPPS) and the Medicare ambulatory surgical center (ASC) payment system for Calendar Year (CY) 2021.

The changes included in this rule change will - as the Centers for Medicare and Medicaid Services (CMS) noted in its fact sheet - increase choice and lower out-of-pocket costs for patients. These are some changes that are long overdue and will also save the Medicare program crucial dollars. More importantly, these savings will be passed on to American taxpayers. Thus, we write today in support of the proposed changes.

This proposal would accomplish the above goals by moving over 1,700 procedures from inpatient settings to outpatient centers. It would also completely phase out the list of procedures that must be completed "inpatient only" (IPO) by the end of 2024. This grants much-needed flexibility to both doctors and patients to decide what is most efficient and safe for them.

In the healthcare sphere, inpatient settings are of highest cost to patients and to the Medicare system. This rule, in shifting these many procedures to a lower cost setting - like outpatient centers - and eliminating the IPO list, physicians have increased ability to determine whether their patients need to be hospitalized for a given procedure or malady. On the other side



of the equation, patients now have added flexibility to determine which outpatient centers might be best for them and are saved from the unnecessary burden of hospitalization where it may not be necessary.

At this point, the free market can work in a way it simply has not been able to in much of the healthcare space. Patients can price shop and find the most innovative outpatient facility or the one that is best able to tailor to them. This creates incentives that have only existed in very limited ways in the healthcare industry. The potential here can and will go far beyond the scope of the rule at hand today.

This rule proposal also removes restrictions on physician-owned hospitals (POH) that qualify as “High Medicaid Facilities.” This includes the cap on the number of additional operating rooms, procedure rooms, and beds that can be approved in an exception and the restriction that the expansion must occur only in facilities on the hospital’s main campus. These restrictions emanated from Sections 6001 and 10601 of the Patient Protection and Affordable Care Act (ACA) and section 1106 of the Health Care and Education Reconciliation Act of 2010 (HCERA).

For POHs that qualify as “Applicable Hospitals,” Congress had historically imposed even more restrictions than they would on High Medicaid Facilities. Despite the law specifically treating Applicable Hospitals and High Medicaid Facilities as different classes of POHs, an HHS rule promulgated in 2012 by the prior administration imposed the excess restrictions on High Medicaid Facilities as well. This functionally treated them the same from a regulatory standpoint.

The Secretary’s actions in this regard essentially wrote regulatory fiat authority into statute where Congress was silent on the matter. Congress has empowered the Secretary to establish a process to carry out the framework it set forth. It did not empower HHS to eliminate the distinction altogether, nor create a different framework.

Congress *was* clear when it established a framework for POHs to apply for grant exemptions to the expansion restrictions. In that very same framework in Section 6001, Congress explicitly decided to implement additional restrictions on Applicable Hospitals and explicitly declined to do the same for High Medicaid Facilities. This is perhaps as clear a signal as Congress could send that there was never the intent for said statutory restrictions to apply to the latter. That these restrictions have persisted until now represents an undue burden on these



outpatient facilities that could have been helping physicians and patients in the manner described above for years.

This is why it is long past time that CMS reverse the wrong that has been done in this space by removing these restrictions. It is both necessary from a legal and constitutional standpoint and from a policy perspective. This proposal embodies the spirit of the “Protecting and Improving Medicare for Our Nation’s Seniors” Executive Order and the administration’s promise to rein in the power of unaccountable bureaucrats. We are glad to have the opportunity to weigh in on this important issue and thank you in advance for the time and attention given to the comments above. We are looking forward to seeing the improvements in our healthcare space that will come as a result.

Respectfully submitted,

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