

October 5, 2020

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The Honorable Seema Varma
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8013
Baltimore, MD 21244-1850

**RE: CMS-1736-P: 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.**

Dear Administrator Verma:

The National Health Council (NHC) appreciates the opportunity to provide comments on the Centers for Medicare and Medicaid Services' (CMS) request for comments on the Hospital Outpatient Prospective Payment System.

Created by and for patient organizations 100 years ago, the NHC brings diverse organizations together to forge consensus and drive patient-centered health policy. We promote increased access to affordable, high-value, sustainable health care. Made up of more than 140 national health-related organizations and businesses, the NHC's core membership includes the nation's leading patient organizations. Other members include health-related associations and nonprofit organizations including the provider, research, and family caregiver communities; and businesses representing biopharmaceutical, device, diagnostic, generic, and payer organizations.

While many of the proposed changes in this rule affect the relationship between providers and Medicare, there are some proposals that will directly affect patient access to care. Specifically, we are offering comments on two issues:

1. New requirements for prior authorization; and
2. Phasing out of the inpatient-only list.

New Requirements for Prior Authorization

In the proposed rule, CMS proposes to add two new service categories that are subject to prior authorization process. We ask CMS to reconsider this proposal by setting a very high bar for adding services to the prior authorization list and taking a patient-centered approach by engaging with patient organizations to determine the value and importance of services to patients before instituting new barriers to care. We still do not have information about whether and how prior authorization has affected access. We ask that CMS not move forward on new requirements for prior authorization unless there is a process for engagement and an oversight and analysis mechanism for the existing services subject to prior authorization.

For 2020, prior authorization requirements were added to the program for the first time. However, these requirements were largely applied to services that are typically performed for cosmetic purposes rather than due to medical necessity and are, therefore, often outside a Medicare benefit category.

The proposed expansion of prior authorization requirements in 2021 marks a significant policy shift, as it involves procedures to treat patients who are likely in severe pain, and decisions to manage this type of pain are typically made after thorough discussions between patients and providers. As CMS has stated¹, the prior authorization process can take up to 10 days unless expedited to a two-day process because the patient's condition is such that delay **“may jeopardize the beneficiary's life, health, or ability to regain maximum function.”** This could result in patients being left in situations where they are experiencing significant unnecessary pain or risking further injury while waiting for treatment authorization. Further, CMS has consistently touted its efforts to reduce paperwork burden for providers to allow them to spend more time treating their patients. Policies that create access hurdles such as prior authorization present additional burdens on both providers and patients.

While we recognize the ongoing need to make sure that all services are necessary and effective, prior authorization inserts a barrier between the patient-provider relationship. It means that patients will face longer waits and is ultimately likely to lead to patients being denied necessary care.

Phasing Out of the Inpatient-Only List

CMS also proposes to eliminate, over three years, the inpatient-only lists. While we appreciate this effort to remove unnecessary restrictions on where patients can receive care, we urge CMS to make sure that certain supports and protections are put in place.

Patients, in consultation with their providers, are in the best position to determine the most appropriate care, including the most appropriate setting. We appreciate that ending this list would result in more choice and flexibility for patients. As the list is

eliminated, we need to work together to assure that patients can pursue both inpatient and outpatient options, depending on what they and their providers agree will produce the best outcome for the patient.

The guiding principle of deciding whether procedures are done in an inpatient or outpatient setting is that the decision must be made on a patient-specific basis, considering the clinical outcomes, potential lack of available support from caregivers in the home during recovery, or adequate transportation from the clinic while still impacted by anesthesia. The NHC also urges CMS to ensure that patients have access to the services they need post-surgery, especially if they are sent home quickly. This includes home health services that they would be eligible for if procedures were performed in an inpatient setting, rehabilitation services (including rehab hospital stays if needed), and more.

Finally, we urge CMS to ensure that its Medicare Advantage (MA) plans do not implement setting-specific prior authorization processes. Permitting site-specific prior authorization would create de facto “outpatient only” lists that would not address the patient-specific factors that may make inpatient care most appropriate for some patients.

Conclusion

We appreciate the opportunity to provide input on this important issue. Please do not hesitate to contact Eric Gascho, Vice President of Policy and Government Affairs, if you or your staff would like to discuss these issues in greater detail. He is reachable by phone at 202-973-0545 or via e-mail at egascho@nhcouncil.org.

Sincerely,

A handwritten signature in black ink, appearing to read 'MBoutin', with a long horizontal stroke extending to the right.

Marc Boutin, JD
Chief Executive Officer
National Health Council