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September 2, 2008

Kerry N. Weems
Acting Administrator
Centers for Medicare and Medicaid Services
Department of Health & Human Services
Attention: CMS-1404-P
P.O. Box 8013
Baltimore, Maryland 21244-1850

Re: *Medicare Program: Proposed Changes to the Hospital Outpatient Prospective Payment System and CY 2009 Payment Rates; Proposed Changes to the Ambulatory Surgical Center Payment System and CY 2009 Payment Rates*

Dear Mr. Weems:

The American College of Gastroenterology is pleased to provide these comments with respect to CMS' proposed rule, published in the *Federal Register* on July 18, 2008, on Proposed Changes to the Ambulatory Surgical Center Payment System and CY 2009 Payment Rates and other related topics. Our comments will focus on the payment rates and rate-setting methodology, quality reporting for ASCs' and concept of extending CMS' non-payment policy for healthcare acquired infections to the ambulatory surgery center (ASC) and hospital outpatient department (HOPD) settings.

INTRODUCTION

The American College of Gastroenterology is a physician organization representing gastroenterologists and other gastrointestinal specialists. Founded in 1932, the College currently numbers nearly 11,000 physicians among its membership of health care providers of gastroenterology specialty care. Although the vast majority of these physicians are gastroenterologists, the College's membership also includes surgeons, pathologists, hepatologists, and other specialists in various aspects of the overall treatment of digestive diseases and conditions. The College has chosen to focus its activities on clinical gastroenterology – the issues confronting the gastrointestinal specialist in treatment of patients. The primary activities of the College have been, and continue to be, educational efforts directed at promoting and optimizing quality care including education.

ASCs are a key source of GI care and many ASCs are GI-focused, making CMS' ASC policies of essential concern to the GI community. Specifically, according to an ASC Association analysis of the 2007 CMS ASC limited data set file, in 2007, 1,256 ASCs had more than 80% of their volume in GI.

Rate-Setting Methodology and Conversion Factor

CMS has professed a desire to increase utilization of Medicare's colorectal cancer

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screening benefit and has spoken often about the importance of it. Unfortunately, the agency's payment policies –particularly for ambulatory surgery centers -- are likely to make reaching this goal harder to achieve. This is a sad outcome, particularly when data from CMS's sister agency, the Agency for Healthcare Research and Quality (AHRQ) indicate that only 57.5% of persons aged 65 and older have ever had a screening colonoscopy—the gold standard for colorectal cancer prevention and detection. (See http://www.meps.ahrq.gov/mepsweb/data_files/publications/st188/stat188.pdf). Further, a January 2008 study in *Cancer* confirmed under-use of the benefit and found that just a quarter of Medicare beneficiaries received a complete colorectal cancer screening by any method during the recommended follow-up period after their last screening.

In 2007 in 72 *Federal Register* 42470, CMS finalized a policy of linking ambulatory surgery center (ASC) payments to the hospital outpatient department (HOPD) rate. In that rule, CMS set the payment rates for ASCs at 65% of the HOPD rate and established a four-year transition for procedures already permitted in the ASC setting. As the proposed rule states, ASC payment rates are calculated by multiplying the ASC conversion factor by the ASC relative payment weight and applying an ASC "scaler" of 0.9753. The proposed conversion factor of $41.384 is grossly inadequate.

As we have noted in the past, GAO's statutorily-mandated report *Payment for Ambulatory Surgical Centers Should Be Based on the Hospital Outpatient Payment System*, (GAO-07-86), played a key role in informing CMS' decision to use the HOPD payment methodology as the basis for the new ASC payment system. Further, the College respectfully disagrees with the GAO/CMS conclusion that a uniform percentage of the HOPD payment rate is appropriate in the ASC setting. CMS provides scant evidence at best on the relation between actual ASC costs relative to HOPD rates, and hence any justification for a single payment across specialties and/or procedures. Indeed, for GI, as indicated in our 2006 and 2007 comments, the HOPD payment clearly does not reflect costs in the ASC setting as to GI services. Our previous comments and that of other key GI stakeholders, as well as presentation to the agency in a November 2006 meeting prior to the close of the comment period, all showed that HOPD is not a relative cost proxy for GI ASCs costs. For example, as we stated in 2006, a study of hospital costs, derived from HOPD costs and payment data, shows that among eighteen 40000 series GI CPT codes, four codes [45378 (diagnostic colonoscopy), 43239 (EGD with biopsy), 43247 and 43450 (two much lower volume codes)] had HOPD payments in excess of the hospitals reported costs, while for the remaining fourteen GI procedures Medicare payments were less than the hospital's reported costs. Based on this-- 77% of GI cases have a negative margin *even* when paid at 100% of the HOPD facility fee payment. Therefore, the rule's 65% of HOPD rate results in these procedures being severely underpaid, projected by the Lewin Group at Medicare GI ASC payments to be approximately 22% below actual costs. It is not just the GI community that has sounded the alarm. An independent Deutsche Bank analysis found that under the proposed version of the new payment system – which is not significantly different from the final system -- any GI ASC that provided fewer than 3,500 procedures per year would be put out of business.

Making this entire situation even worse, we are very concerned that the gap between ASC and OPPS payment rates is widening, without any basis whatsoever in actual cost differences between ASCs and HOPD. When one runs the actual numbers, aggregate ASC payment in 2009 would be just 59% of HOPD payments for the same volume of services. So the "conversion factor" as it were has dropped, without justification from 65% in the final ASC rule last year, to 63% when CMS integrated that with the OPPS (outpatient prospective payment system) rule last year, and now down to 59% this year. This is an unfair, unjustified and devastating result that will only hasten the bankruptcy and closing of multiple GI ASCs.

Relative Weight Rescaling

Given that the agency is about to enter the second year of the transition to a new payment system that has harsher effects on GI than any other medical specialty, we urge the agency in the strongest possible terms to avoid the adoption of any other policies that further decreases payments to GI ASCs. The idea behind the GAO analysis and the new CMS ASC payment system is that the relative weights in the HOPD setting should be used in the ASC setting and should therefore be equivalent. However, in this rule, CMS introduced a "rescaler" – CY 2009 relative payment weights would be multiplied by the ASC scaler of 0.9753 -- to take away the budgetary effects of the new hospital outpatient prospective payment system (OPPS) weights. This rescaler disrupts this nexus and produces undesirable payment differentials. The revised relative weights reflect real growth in the relative cost of services performed in the HOPD. A rescaler should not reclaim from the ASC payment system dollars reflecting cost growth in the relative weights for the surgical services performed in the ASC.

The rescaler is inappropriately based on the range of weights used in the HOPD setting. This calculation assumes that differences in case mix between the two settings represent unanticipated spending increases and that the resulting spending must be eliminated from the ASC setting. Instead, CMS should use the rescaling that is used in the HOPD setting with the OPPS methodology. This set of new weights is a far better proxy for cost increases at the APC and HCPCs level. Unfortunately, the faulty proposed rescaler, while problematic across the board, has even more detrimental effects on GI where the weights for GI procedures decline over time if their OPPS weight gains do not stay aligned with the size of the rescaler. Rescaling in future years erodes the funds spent on GI services over time, depressing payment beyond what even budget neutrality as interpreted by CMS would yield under the 2003 Medicare Modernization Act.

Rescaling exacerbates the ASC's payment system's failure to keep up with increasing costs, owing to the freeze in the base payment, by eliminating measurable growth in ASC procedure costs. An analysis by the ASC Coalition contained in their separately submitted comment letter shows that seven of the highest volume ASC procedure costs bear much of the brunt of rescaling. Of these, four GI codes 43239, 45378, 45380 and 45385, collectively finance 17.25% of the rescaling and will face decreased payment of $13,717,234 in 2009 alone. This is inequitable and especially poor policy in light of the massive cuts already faced by gastroenterologists participating in the Medicare program.

The methodology for linking of the ASC and OPPS systems fails in its very premises (because HOPD costs are not a valid cost indicator for GI ASC costs, as demonstrated above), and CMS would now exacerbate this deficiency since several provisions of this proposed rule would almost certainly serve to reduce, rather than expand, access because of inconsistent application of OPPS policies to ASC payments. Remarkably, the premise of CMS' ASC rule was that maintaining the integrity of the connection of ASC payments with OPPS is indispensable in trying to assure that payment policies do not influence site of service decisions.

ASC Member Survey Confirms Fears

The deleterious effects of the new payment system are born out by new data. In the first quarter of this year, the ACG surveyed its membership to determine the effects of the new CMS payment policy for ASCs. The responses bore out our concerns about continuing Medicare beneficiary access to ASCs for GI procedures. Once the new payment system is fully implemented, seven out of ten respondents (69.5%) expect Medicare beneficiaries to face longer waiting times to schedule procedures. By contrast, over 93% expect that private-pay patients will face the same or shorter waiting times than they do today.

An overwhelming majority (85.2%) expects that their ASCs will see fewer Medicare beneficiaries in an average week when the new system is fully implemented, but very few (7.9%) expect to see fewer private pay patients in an average week.

Once the new system is fully implemented, 69.4% of respondents would be more likely to recommend the HOPD to their Medicare patients; 3.8% would be more likely to recommend the ASCs to their Medicare patients, and 26.8% anticipate no change. This pattern is reversed with non-Medicare patients, where only 7.2% of respondents said they would be more likely to recommend the HOPD, 54.3% would be more likely to recommend the ASC and 38.5% anticipate no change. The ASC policy clearly is wrong-headed, as it will push up overall Medicare costs by creating incentives to see patients in the HOPD, which is a more expensive setting for both Medicare and for beneficiaries, who pay higher co-payments there.

Overwhelming majorities (90.5%) expect the number of GI ASCs serving Medicare beneficiaries to decrease. 14.3% of respondents said they expected that their ASCs would shut down and 58.2% expect to reduce the total number of employees at their ASCs. Another 43.5% expect a reduction in average compensation for their ASC employees.

Anecdotally, we have heard from a number of our members that this is the last year that they will see Medicare beneficiaries in their endoscopy centers. By next year, when the payment blend is 25% of the old system rates, and 75% of the new system rate, they will not be able to afford to continue to offer endoscopic services to Medicare beneficiaries in the ASC setting.

Budget Neutrality

Reverse Migration

The ACG continues to be mystified by CMS' budget neutrality calculations, whose shortcomings will result in higher costs to the Medicare Part B Trust Fund and to Medicare beneficiaries. As the College argued in its 2006 and 2007 comments, CMS limited its analysis to new ASC procedures. It did not recognize savings that will accrue to Medicare with procedures already on the ASC list when large payment shifts trigger volume moves from the HOPD to the ASC for many non-GI procedures, or costs that will be incurred when volume in GI procedures – as confirmed by our member survey -- move back to the HOPD from the ASC when payment is too low, and does not cover the costs of the procedure. In an alternative analysis in the proposed rule, CMS did consider the effect of migration but analyzed the migration that could occur only as to the 14 new codes that CMS proposed to implement. This analysis is baffling and does not at all reflect a real world scenario. ACG has maintained that if CMS defined budget neutrality to include all outpatient sites, as the most reasonable reading of the legislation by Congress would permit, this could generate savings to the Medicare system and still maintain a reasonable revised ASC facility fee cost structure for GI procedures. The extensive Lewin Group analysis that is already in the record confirms that many non-GI cases would migrate from the HOPD to the less expensive ASC, thereby creating savings to Medicare, for which CMS is not accurately accounting in its rulemaking proposal.

In the final 2007 rule, while CMS did a more expansive analysis of case migration and chose to estimate budget neutrality using case migration, it explicitly failed to reference the Lewin data, or that submitted by others on reverse/negative migration. Instead, the agency appears to have instead simply stated that the phenomena would be offset by positive migration, but provides no evidence for this conclusion.

Also in the final 2007 rule, CMS specifically concentrated its migration analysis for the 793 new procedures added to the ASC list, assuming that any shift in site traceable to the wide shift in payment rates for procedures such as colonoscopy and EGD and other procedures already on the ASC list would be negligible. (The final combined HOPD/ASC rule actually added several more procedures to the ASC list.) CMS' actuaries also concluded, and factored into the agency budget neutrality calculations, that it would incur costs when eventually 15% of cases now done in physician offices move over to the ASC, even though the final rule assures that the payments would essentially be cost-neutral, since the new facility fee for cases now done 50% in the office would never exceed the practice expense component under the Medicare physician fee schedule. These two conclusions appear to be logically inconsistent. Finally, as stated above, the 2007 final rule stated that agency actuaries determined that any negative migration will be offset by positive migration but provides no evidence or detailed analysis to support this conclusion or to counter the Lewin analysis. In fact, the agency makes no mention whatsoever of the Lewin analysis, a substantial body of evidence which the agency, despite the fact that it was delivered to the agency during the comment period, including

a briefing for CMS staff on November 6, 2006, by Lewin personnel who conducted the study, by all appearances was completely ignored.

The budget neutrality baseline was established based on 2003 law. Subsequently, interpreting P.L. 109-71, CMS extracted significant early savings (i.e., mandating that the ASC facility could never exceed the facility fee in the HOPD). CMS's budget neutrality calculation should have been interpreted to consider this early savings installment in ASC payment reform. Those savings should have been considered as part of the pool for computing budget neutrality (and not excluded just because after MMA 2003 CMS undertook ASC payment reform in two steps—one through interpretation of P.L. 109-71, and the second step via the adoption of the ASC payment reform rulemaking first published in August 2006) and a higher conversion factor would have resulted. This year's proposed rule exacerbates this problem by proposing to add nine new procedures to be paid for out of the same budget pie.[1]

As our survey evidence noted above indicates, whatever the actuaries calculations and reasoning, they have has missed what is happening in the real world, where these unwarranted cuts to endoscopy centers will force beneficiaries back to the HOPD, if in fact there is even capacity to treat them there. ***Therefore, we urge the agency to take reverse migration into account in formulating the final rule before we enter further into the transition to the new system, and it is too late to undue all the damage caused by the pernicious underpayment to GI inherent in the new system.***

Rescaler and Budget Neutrality

We discuss our concerns with CMS' implementation of a "rescaler" into the ASC setting above. In the context of budget neutrality, we understand that foregoing application of the rescaler would cause an increase in ASC spending in 2009. However, it is important to note that these funds represent a true change in the costs of providing ambulatory surgical services and thus these funds are appropriately spent on Medicare beneficiaries. Without these funds, the relationship between aggregate ASC and HOPD expenditures at the level envisioned by the original budget neutrality adjustor is further broken.

CMS' proposal to rescale the relative weights of the ASC payment system is consistent with the manner in which this policy is applied in other settings, but inconsistent with the construction and intent of the ASC payment system. Instead of maintaining budget neutrality within the ASC payment system, the rescaler would mandate budget neutrality as if its volume and case mix were the same as the HOPD, causing the inappropriate removal of millions of dollar from ASC payment system. ***Therefore, we urge CMS to withdraw its proposal to rescale ASC relative weights. Doing so further exacerbates the gap between ASC and HOPD payments.***

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[1] Specifically, the preamble of the proposed rule states "For CY 2009 budget neutrality adjustments, we assume that there would be no significant change in the weight scaler or wage adjustment attributable to new covered surgical and covered ancillary services." (See p. 41538.)

Annual Updates

Under current law, CMS is required to annually adjust ASC payments by the consumer price index for urban areas (CPI-U), although inflation adjustments were suspended under the MMA through 2009. The same law requires CMS to inflate HOPD payments by the hospital market basket index, a separate inflation adjustment. This hospital market basket is traditionally higher than the CPI-U, and, if the two differing methodologies are applied each year, the gap between ASC and hospital payments would continue to diverge because of this disparity. This is likely to result in further significant underpayments to ASCs, compared to hospitals and exacerbate the underpayment to endoscopy centers. ***ACG urges CMS to instead use a hospital market basket update for ASC payments.***

Case Mix and the Transition Period to the New System

As the agency itself notes in this proposal, "the combined effect on an individual ASC of the update to the CY 2009 payments will depend on a number of factors including, but not limited to, the mix of services the ASC provides, the volume of specific serviced provided by the ASC, the percentage of its patients who are Medicare beneficiaries, and the extent to which an ASC will choose to provide different services in the coming year." (p. 41563) The agency's own data in Tables 47 and 48 shows that the rule will have the greatest negative effect on GI with most other specialties experiencing positive effects. The agency is also correct in noting that the four-year transition to the new system is better than no transition at all or a shorter one. However, many ASCs that perform endoscopic procedures are GI only. Indeed, according to an ASC Association analysis of the 2007 CMS ASC limited data set file, about half of ASCs have more than 80% of their volume in a single specialty.

For the reasons noted below, we believe that many ASCs specializing in providing colonoscopies will not be able to modify their business practices to change the services provided and /or the patient case mix. Furthermore, even if an ASC and the physicians affiliated with that ASC were able to make such changes, this would not be a desirable outcome for Medicare beneficiaries or the Medicare program.

Single specialty ASCs are able to deliver high quality efficient care to the patients receiving care largely due to the highly specialized nature of the ASCs and the physician practices they are associated with. The types of procedures performed dictate the size and setup of the operating rooms, the type of equipment used, and the personnel assisting the physicians. These ASCs are most often located adjacent to, and are contiguous to, the physician practices. They are designed to provide the most efficient work flow between the ASC and the practice and between the physicians and staff. We believe this structure contributes to the high quality care delivered. This is consistent with the growing trend in the quality arena to reduce medical error by routinizing as many aspects that affect the safety and quality of the procedures whenever possible. Introducing the performance of other types of procedures (e.g., orthopedic procedures) will significantly reduce the ability to routinize the provision of services. The performance of multiple types of

procedures in one ASC introduces the need for varied and expensive equipment as each type of procedure requires its own type of equipment. Purchasing multiple types of equipment may not be feasible for many ASCs due to the volume and type of patients they see. Also, the physicians that are affiliated with the ASC are not general surgeons, but, rather practicing gastroenterologists who provide the services that their patient base needs. The types of procedures performed in a single specialty GI ASC are dictated by the types of patients seen by the gastroenterologists.

We believe CMS has failed to recognize how the legal and regulatory environment is likely to affect the ability of ASCs to modify the range of services provided to patients. For example, most state licensing requirements and/or certificate of need (CON) laws would not permit an ASC currently providing solely GI services to provide other types of services and/or allow other specialties to perform procedures at that ASC.

Finally, even if an ASC that is currently providing only GI services was able to reduce the number of GI procedures performed and replace those procedures with other higher paying procedures, this behavioral change could significantly reduce the number of Medicare beneficiaries utilizing the colorectal caner screening benefit. This is a dangerous public health risk as this important preventive benefit is already significantly underutilized. We believe CMS should be looking for ways to improve beneficiary access, not reduce it.

As our survey data discussed above indicates, many will instead simply switch their case mix *away from* Medicare beneficiaries and encourage Medicare beneficiaries to seek care in HOPDs rather than in ASCs. At a recent AMA briefing on the proposed rule, CMS officials stated that GI should deal with this challenge by lobbying states to change their certificate-of-need laws. Such a suggestion demonstrates that the agency has little understanding of how ASCs operate and ignores current realities as well as the fact that such legislative changes are unlikely to be achievable in sufficient time to blunt the negative effects of the new payment regime.

CMS also states in the proposed rule that the new payment system “represents a major stride towards encouraging greater efficiency in ASCs.” (page 41566) The College vociferously disagrees and notes that all the new system would do is allow GI ASCs to lose money faster on all the services they provide. If each procedure loses money, doing more of them in a shorter amount of time just results in facilities losing money at a faster rate.

Reporting of ASC Quality Data

The College is dedicated to the provision of high-quality care and evidence-based medicine. Our journals further the dissemination of such research. The ACG is a member of the National Quality Forum (NQF), the Physician Consortium for Performance Improvement and has participated in the AQA. With our sister society, the American Society for Gastrointestinal Endoscopy (ASGE), we are piloting an endoscopy benchmarking project that is designed to gather and use evidence to improve the quality

of endoscopic procedures. The tool will provide individual endoscopists the necessary data to help them improve their technique and ultimately result in improved patient outcomes. While this project was recently profiled in a major newspaper (the *Wall Street Journal*), it is still in its early stages. It is our hope that participation in this program as it moves from the pilot stage to a broader roll-out can provide a source for endoscopy center quality measures. In the meantime, we agree with CMS that the transition to the revised payment system is a significant enough challenge that implementation of a pay-for-reporting system in ASCs would be inadvisable at this time. We urge the agency to continue to exercise its discretion in not implementing the MIEA-TRHCA (Medicare Improvements and Extension Act- Tax Relief and Health Care Act of 2006) requirement to submit ASC quality data.

To date, such systems have been costly and burdensome for practioners. Endoscopy centers cannot afford to implement such pay-for-reporting databases at the same time they are losing money. New expensive requirements will simply accelerate the exodus of endoscopy centers from the Medicare program. Furthermore, most gastroenterologists are still learning the Physician Quality Reporting Initiative (PQRI) system and having endured measure "whiplash" in that system where measures have not been stable and they will need to learn how to participate in that program before they can be expected to implement an ASC quality reporting system.

Healthcare-Associated Conditions (HACs)

As we, in conjunction with our sister societies, the American Gastroenterological Association (AGA) and the ASGE, commented on the inpatient prospective payment system (IPPS) hospital-acquired condition payment policy, we have significant concerns with the application of this policy in both the inpatient setting <u>and</u> other settings. Nosocomial infections of the gastrointestinal tract are an important clinical challenge for gastroenterologists. However, as our comments on the potential addition of *Clostridium difficile* to the list of hospital-acquired conditions for which CMS would deny payment indicate, it is not always easy to determine which conditions are <u>reasonably</u> preventable. We commend CMS for carefully considering our comments regarding *Clostridium difficile* infections and recognizing that this condition is not reasonably preventable and therefore did not meet CMS' criteria for inclusion.

Denying payment also presupposes that it can be determined when and how a particular patient acquired a particular pathogen. Depending on the pathogen, its incubation period and the sensitivity and specificity of the tests used to detect it; this may not always be possible in a timely way. We certainly support CMS' efforts to improve the quality of care provided to Medicare beneficiaries across all settings. However, it is not reasonable to hold one setting of care liable for a condition acquired in a different setting and it may be difficult to detect in which setting or under whose care a particular pathogen was acquired.

Lastly, such a payment policy can create incentives to avoid caring for certain at-risk populations. Specifically, patients who are older, are immuno-compromised, or are

medically underserved are more susceptible to infection and other complications. Broader application of this policy could exacerbate existing disincentives for healthcare providers and facilities to provide care to these populations by encouraging these providers and facilities to erect barriers to such patients' admission or care.

The concept of not paying for complications that may be unavoidable despite safe practice is discriminatory and could end up hurting vulnerable patients. In the Medicare population, it is not uncommon for beneficiaries to suffer from multiple chronic conditions. Such patients may be more susceptible to infection and other complications or because of the drug regime for one of these conditions be more susceptible to various pathogens.

We agree completely with the agency that the ASC setting does not have the infra-structure to support nonpayment for healthcare acquired conditions in the setting. It would be equally if not more challenging and burdensome to develop a coding algorithm analogous to "present on admission" in the hospital setting for non-hospital care. As the proposed rule states, the agency notes that "the OPPS currently has neither the infrastructure to currently identify POA [Present on Admission] indicator data nor the ability to stratify by CC [Complicating Condition] or MCC [Major Complicating Condition] for differential payments under the present APC payment methodology. OPPS claims report an 'admitting diagnosis' which identified the reason for the encounter prior to the establishment of the principal diagnosis, but the admitting diagnosis cannot be presumed to be equivalent to a diagnosis that is present on admission as reporting on an inpatient claim." (p. 41550)

Our concerns about applying the HAC policy to the ASC or HOPD setting are practical ones. Nonetheless, they do nothing to diminish the fact that we take safety in all settings, including endoscopy centers very seriously. The College has been working collaboratively with the CDC to educate gastroenterologists about standard precautions for infection control generally and safe injection procedures specifically. We have emphasized in numerous College publications the need to ensure compliance with CDC injection guidelines and are distributing injection safety cards – based on the CDC guidelines—to the thousands of our members expected to attend our annual scientific meeting in October. We have emphasized that all our members have a responsibility to ensure compliance with standard injection safety procedures and other infection control measures and that any lapse can deter patients from seeking lifesaving colorectal cancer screening, including colonoscopy. We want our patients to feel confident that the use of endoscopy for the diagnosis and treatment of digestive diseases is safe. We would be happy to discuss our efforts in this arena further with CMS and to work with the agency to prevent any such incidents in the future.

Conclusion

We are deeply concerned that the cumulative cuts of almost 34% in professional fees for life-saving colonoscopies over the past ten years, new cuts from the SGR, and the implementation of the new ambulatory surgery payment system will drive many

gastroenterology practices and ASCs out of the Medicare system and/or out of business and compromise their ability to continue to provide gastroenterology specialty care to Medicare beneficiaries. As demonstrated by our 2008 survey data, the potential negative implications for patient access to quality gastroenterologic services are frighteningly apparent. If this policy is not changed **this** year, patient care and outcomes will be threatened, and it will be too late to put the proverbial genie back in the bottle.

No one in the ASC field can afford to allow the announced 65% of HOPD to be further diminished to 59%, nor can they endure a system of annual updates which assures further losses against the HOPD payment threshold which was, after all, the basis (misguided as it was in the case of GI ASCs where HOPD costs are **NOT** a proxy for GI ASC costs) for the new payment system announced last year. This is even more dramatically the case for GI ASCs having taken the biggest hit in the new ASC payment system, in addition to huge antecedent and concurrent reductions in GI professional fees. This proposed rule is antithetical to colorectal cancer screening as a public health priority, and its economic dismemberment which forces GI ASCs to close their doors to Medicare beneficiaries (or completely) will stand as a major cause for inadequate screening rates among Medicare beneficiaries, for which CMS will be solely responsible.

The College urges the agency to go back to the drawing board to develop a new system as it applies to gastroenterology services. These changes should be made in a way that will not impair beneficiary access to colorectal screening and accounts more accurately for the real picture on case migration for procedures that have been on the ASC list, including the fact that projected reverse migration (from ASC to HOPD) in GI would run counter to the objective of budget neutrality. We appreciate the opportunity to submit our comments on this proposal, and we would be pleased to answer questions or otherwise engage in dialogue with the agency about how to revise the proposal in a way that protects taxpayers and Medicare beneficiary access and does not penalize physicians and ASCs and the patients who need these services.

Respectfully Submitted,

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Chair, National Affairs Committee