

September 2, 2008

Mr. Kerry Weems  
Acting Administrator  
Centers for Medicare & Medicaid Services  
Attention: CMS-1404-P  
Room 445-G  
Hubert H. Humphrey Building  
200 Independence Avenue, SW  
Washington, DC 20201

Re: CMS 1404-P-- 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 Administrator Weems:

The American Society for Gastrointestinal Endoscopy (ASGE) provides the following comments on the proposed changes to the Ambulatory Surgical Center payment system for CY 2009. ASGE is a professional organization representing over 10,000 physicians and surgeons who specialize in the use of endoscopy to diagnose and treat gastroenterological diseases and conditions.

The ambulatory surgical center (ASC) has become an important part of current GI practice, providing a safe, patient friendly and cost effective environment for the provision of medical services, such as colorectal cancer screening for patients of all ages. Typically, these are single specialty centers. According to data from the Ambulatory Surgical Center Association, more than 1200 Medicare certified ASCs provide at least 80 percent of their services in the GI field.

Since the beginning of the transition to a new payment system, ASGE has repeatedly expressed concern that the Centers for Medicare and Medicaid Services (CMS) proposal would pay for endoscopic services at a rate well below the cost of providing those services. This will inevitably lead to a migration of Medicare patients requiring gastrointestinal procedures back to the hospital, increasing the cost to the patient and to the Medicare program. Forcing Medicare patients to endure longer waits and increased costs for essential services, like screening for colorectal cancer, is a disservice to the beneficiaries the agency is obligated to serve. Increasing the costs of care by refusing to adequately reimburse in a more economical setting, is a disservice to the taxpayers who support a substantial portion of the Medicare program, particularly Part B, the source of ASC payments. ASGE is deeply troubled by the agency's apparent unwillingness to examine this issue more carefully and propose a correction that would avoid these consequences.

There is also a serious question about the ability of hospitals in many communities to absorb the shift of GI procedures now performed in ASCs, which can only delay needed diagnostic and therapeutic services. ASGE has been surprised and disappointed that CMS continues to dismiss these concerns.

We are concerned that the response to these issues reflects a lack of understanding about the structure, function and regulation of single specialty GI endoscopy centers. CMS has suggested that ASCs experiencing a decline in revenue in one area simply expand services in another area. This ignores the fact that state licensure and certificate of need regulations often define the limit of the services that a GI ASC can provide. The simple fact is that these facilities usually cannot transform themselves into another type of ASC.

ASGE believes that the proposed rule will accelerate the movement of Medicare patients back into the HOPD, increase costs, decrease patient satisfaction and delay needed medical services. These results are not necessary since CMS has ample authority to make decisions that will preserve the endoscopic ASC as a viable choice for the Medicare beneficiary.

It is also troubling that CMS did not adopt a set of policies that would result in a fixed relationship between ASC and HOPD payment over time. CMS's goal should be a payment system that facilitates Medicare beneficiaries' ability to understand the relative cost of endoscopic services in outpatient settings and enhances their ability to make direct comparisons on the basis of cost and quality. The current proposed rule will not achieve that goal.

The rapidly widening gap between ASC and HOPPS payment rates bears no relationship to actual cost differences between the two settings. It appears that based on the proposed rule aggregate ASC payment in 2009 will be 59 percent of HOPPS expenditures – down from 65 percent this year. If the payment gap continues to grow, certain endoscopic procedures or classes of surgical services will not be viable in the ASC setting. Maintaining the integrity of the connection to the HOPPS relative weights is paramount in ensuring that the payment policies do not influence site of service selection.

We have specific comments on four issues:

- The index used to calculate the annual inflationary update
- Reporting ASC quality data for the annual payment update
- The scaling factor
- Device intensive procedures

#### Annual Inflationary Update

Under the law, the ASC conversion factor is frozen through 2009. In the final rule published August 2, 2007, CMS indicated it was adopting a policy of updating the ASC conversion factor using the CPI-U to adjust ASC payment rates for inflation. This would apply for years beginning with CY 2010. We are requesting CMS to revisit their initial decision of using the CPI-U as the basis for adjusting the ASC payment for inflation. It is

our strong recommendation that the hospital market basket used to adjust the hospital outpatient prospective payment system is a much more appropriate measure of ASC cost inflation than an index measuring changes in the costs of good and services purchased by consumers. This recommendation is universally endorsed by the ASC industry and CMS has complete discretion to adopt a market basket approach. The rationale advanced for maintaining CPI-U as the ASC inflation factor is contrary to the way CMS calculates annual updates for virtually every other provider that is reimbursed by Medicare. In short, there is no justification for maintaining this policy.

The hospital market basket is a much more appropriate measure of ASC cost inflation. First of all, it is necessary if the ASC payment system is to remain tied to payments under the hospital outpatient prospective payment system (HOPPS). The ASC conversion factor was based initially on a percentage of the conversion factor under HOPPS. In addition, under the new ASC payment system, payment for an individual procedure is based directly on the weights assigned to surgical services under HOPPS. Secondly, the hospital market basket measures changes in the costs of goods and services purchased by hospitals. The goods and services purchased by ASCs are very similar. Whether a surgical procedure such as cataract surgery or an endoscopy is performed in a hospital outpatient department or an ASC, very similar supplies, equipment and labor are used to perform the service. When there are inflationary increases in medical or surgical supplies or nursing personnel purchased by hospitals, ASCs experience precisely the same cost increases. For these reasons, we recommend that for 2010 and beyond, CMS modify their earlier decision and use the hospital market basket for ASCs in lieu of the CPI-U which has no relationship to measuring changes in the costs of goods and services purchased by a health care facility.

#### Quality Measures

CMS indicates that the statute authorizes the Secretary to provide for a reduction of 2.0 percent in the annual payment update for failure to report on designated quality measures. This is analogous to the provision currently in effect under HOPPS. CMS indicates that a separate proposed rule will be published to implement quality data reporting. ASGE is supportive of initiatives to improve the quality of care in all settings including ASCs. We welcome the opportunity to review and comment on a future proposal setting out specific quality measures for ASCs. It will be important that the quality measures be applicable to ASCs since some of the hospital quality measures are clearly not appropriate. In addition, since some ASCs specialize in particular types of procedures such as gastroenterology or pain management, we would ask CMS to ensure that all facilities have the opportunity to participate in quality reporting on an equal footing.

#### Scaling Adjustment

Because of increases in the relative HOPPS weights for procedures performed in ASCs, CMS estimates that to preserve budget neutrality a scaling adjustment of 2.47 percent will be needed for 2009 and a 5.88 percent adjustment would be required under the fully implemented system. This will have a very negative impact on payments for ASCs and ASGE strongly urges CMS to abandon the use of scaling in this setting. This use of

scaling will do more to destroy any link between the HOPD and ASC rates than any other part of the proposed rule.

Under the HOPPS system, CMS assures that changes in the hospital relative weights are budget neutral in the aggregate. Since the hospital relative weights have already been scaled to preserve budget neutrality within the HOPPS system, increases in the HOPPS relative weights for services on the ASC list reflect actual increases in the costs for performing these services relative to other services. There is no reason to believe that these cost increases in hospital costs are not equally applicable to ASCS. However, the application of the scaling adjustment to ASCs suggests inappropriately that these increases in relative weights do not reflect legitimate increases in ASC costs and further lessens any logical link in the relationship of hospital and ASC payments for the same set of services. That link between hospital and ASC payments which was tenuous at best at the start of the ASC system will be virtually destroyed over time with the application of the scaling factor each year and the differential update measures.

There will be over a 40 percent differential in payments for 2009 and this will grow over time. Inevitably this is going to lead to reluctance on the part of some ASCs, particularly those providing services taking major reductions in payment, to continue to offer these services to Medicare patients. The result will be that these services will be forced back to the hospital setting at dramatically higher payment rates. Eroding payments for ASC services so they return to the hospital is directly contrary to the need to manage Medicare resources more carefully. Scaling also negatively impacts those surgical services that CMS once indicated would see payment increases under the new ASC rate structure. The use of scaling will discourage the movement of services out of the HOPD into a more cost effective setting and will increase overall program costs. For the sake of the beneficiaries and for the Medicare program, we hope that this does not occur. We strongly urge CMS to reconsider the application of rescaling in calculating ASC payment rates.

#### Covered Surgical Procedures Designated as Device-Intensive

For ASC procedures involving the implantation of a costly device, CMS has established a special payment rule. If a code is identified as “device-intensive” CMS will pay ASCs the full estimated portion of the HOPPS payment associated with the device and then pays the balance or service portion at the lower ASC conversion factor. Thus, hypothetically, if the HOPPS rate for a service is \$2,000 and this includes a device with an estimated cost of \$1,500, the ASC payment will be \$1,825. That is, the payment would include the \$1,500 device cost plus 65 percent of the \$500 service costs. For purposes of this provision, a “device-intensive” procedure is one in which the device represents over 50 percent of the HOPPS rate.

However, under the HOPPS payment system, CMS has a concept of “device-dependent” APCs. As we understand it, this means that for those APCs for which the APC includes a substantial cost for an implanted device, CMS will reject any claim for which there is not a separate charge and code billed for the device. Prior to this change, some hospitals failed to include the costs of the device in their charge for the procedure. This edit assures

that the determination of the median costs for the procedure involving a costly device includes all the costs.

The listing of device-dependent APCs includes a number of codes which are not designated as device-intensive presumably because the 50 percent threshold was not met. For a procedure paid \$2,000 under HOPPS involving a device costing \$900 or 45 percent of the cost, the ASC would be paid only \$1,300 at the 65 percent rate. The device, of course, costs hospitals and ASCs the same \$900. Thus, while hospitals are paid \$900 for the device and \$1,100 for the service portion, effectively the ASC payment covers only \$400 of the service component above the \$900 device cost. We think equity dictates that ASCs receive the same payment for the device since the costs are identical and that only the service portion should be subject to the differential in payment. We therefore urge that CMS to consider all device dependent APCs, including APC 0384, GI Procedures with Stents, to be device-intensive in the ASC setting.

The ASC has been one of the most positive developments in the delivery of services to Medicare beneficiaries in the last 20 years. ASGE is deeply concerned that CMS, when given the opportunity to devise a new payment system for ASCs, continues to make policy choices that clearly undermine the ability of ASCs to serve Medicare beneficiaries. Given strong patient preference for these centers, and the compelling need to manage Medicare expenses more effectively, it is extremely difficult to understand why the agency has chosen this direction. Congress has granted CMS broad authority to establish a new and better payment system for all services provided in the ASC. It is a great disappointment that the agency has failed to exercise that authority in a way that enhances the ability of ASCs to provide services to Medicare beneficiaries.

Thank you for the opportunity to offer these comments.

Sincerely,

John L. Petrini, MD FASGE  
President