



November 3, 2006

Leslie Norwalk, Acting Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1506-P
P.O. Box 8011, Baltimore, MD 21244-1850
By electronic submission

Re: *Medicare Program; Ambulatory Surgical Center Payment System and CY 2008 Payment Rates*

Dear Ms Norwalk:

The American Medical Group Association (AMGA) is an association that represents medical groups, including some of the nation's largest, most prestigious multi-specialty practices and integrated health care delivery systems. AMGA members' 65,000 physicians deliver health care to more than 50 million patients in 40 states, including 15 million capitated lives. Thank you for the opportunity to comment on the proposed rule regarding revisions to the payment policies under the Medicare for Ambulatory Surgical Center (ASC) payments and related changes.

The Medicare Modernization Act of 2003 presents an opportunity to better align Medicare payments to providers of outpatient surgical services. There are three key elements for ASC payment changes that would comport with Congressional intent, produce an equitable system, and assure development of beneficiary access through sound public policy.

The first is the configuration of the ASC with the HOPD payment systems to eliminate distortions between them that could unsuitably influence site of service selection. Secondly, changes should facilitate maximal conveyance of the benefits of surgery done at ASCs to Medicare patients for services that can be safely and efficiently performed in the ASC. Finally, CMS should establish fair and reasonable payment rates to allow beneficiaries and the Medicare program to save money on procedures that can be safely performed at a lower cost in the ASC than the HOPD.

The current ASC payment system has for its underpinnings outdated cost data and imprecise payment categories. Although the HOPD payment system suffers from its own blemishes, we favor linkage of the ASC with the hospital outpatient department (HOPD) payment system since it is the most analogous basis for determination of the relative cost of procedures performed in ASCs. However, there should be parity in all matters where appropriate and equitable adjustment where that is not the case.

The methodology proposed in the rule results in ASC payments equaling only 62% of HOPD levels. By setting rates this low, CMS would force doctors to move cases to the more expensive hospital setting, increasing the amount of money paid by Medicare beneficiaries and the program. Rather than paying ASCs a set, fair percentage of HOPD rates, as has been suggested by the industry, and a notion we support, the proposed rule establishes a complicated methodological linking of ASC payment to HOPD payment but does not do it in a uniform manner. This will impede Medicare beneficiaries' ability to understand their real costs in alternative settings and does nothing to advance the idea of transparency in pricing, a much heralded objective of current public policy.

We agree with and cite MedPAC's perspectives on ASC rate setting as noted in its letter of October 10, 2006 to CMS on these matters:

“The current ASC payment system is outdated and should be replaced by a system based on the OPSS. The current system classifies services into only nine payment groups of clinically-unrelated procedures and sets rates based on 1986 cost data. Because these rates are based on old cost data, they are probably no longer consistent with ASCs' costs. The broad ASC payment groups make it difficult for CMS to classify new services and increases the likelihood that many services are over- or underpaid. In addition, the ASC rates are not aligned with rates for surgical procedures provided in other ambulatory settings. If payment variations among settings are unrelated to differences in underlying costs, there could be financial incentives to shift services to the most profitable setting. To remedy these problems, in our March 2004 report to the Congress, we recommended that the Secretary revise the ASC payment system so that its relative weights and procedure groups are aligned with those in the OPSS.”

...“ Ideally, the ASC conversion factor would be based on either ASCs' costs or the lowest-cost safe alternative setting for ambulatory surgical procedures. Because CMS has not collected recent ASC cost data, we are not able to estimate ASCs' costs or determine which surgical setting has the lowest costs. Thus, the Commission is unable to judge whether an ASC conversion factor that equals 62 percent of the OPSS conversion factor is appropriate.”

The proposed rule includes several key differences between the HOPD and the ASC payments that will perpetuate the unnecessary use of higher cost settings and may make it impossible for ASCs to offer surgical services.

Rate-setting Methodology

By setting rates this low, CMS would force doctors to move cases to the more expensive hospital setting, increasing the amount of money paid by Medicare beneficiaries and the program.

Annual Rate Updates

ASCs should receive the same annual updates as hospitals. Inflationary costs, such as nursing and medical device cost affect ASCs in the same way as hospitals. ASCs have not had an increase in payments since 2003 which makes it hard to compete in an aggressive labor market. ASCs should also get the same market basket updates as hospitals and not the CPI-U update.

Transition

CMS has proposed to phase in the new payment system over two years. Most payment changes of this scale and scope have a 3-4 year transition period. That has certainly been the case in changes affecting the HOPD. We strongly urge CMS to be consistent with prior actions and phase-in the final rule changes over a 4 year term.

ASC List: Safety and No Overnight Stay should be Sole Criteria

This proposal should eliminate the use of specific ASC list criteria and instead use only safety and the absence of a required overnight stay as the criteria to determine what procedures are reimbursable in the ASC setting.

We suggest that CMS develop a reasonable process the agency can use to gather and evaluate reliable information about the safety of performing surgical procedures in the outpatient and ASC settings upon which to make subsequent decisions about the safety of allowing those procedures in ASCs. The rate of technology transfer is phenomenally fast and medical technology will continue to advance in the future. By using many of the same limitations on what is permissibly performed in ASCs, problems in providing cost-effective care to patients in the future will be simply be carried forward. For example, Medicare does not allow procedures done more than 80% of the time on an inpatient basis to be performed in an ASC. This makes little sense since because the program already pays for such procedures, done on an out patient basis, 20% of the time. The standard is arbitrary and contradicts itself.

Predictable, Rational Responses: Shifts in Types of Procedures Done

For ophthalmology procedures such as cataract surgery, there is limited demand in the non-Medicare population. If the facility fee is insufficient to cover the cost of performing the procedure in an ASC, a predictable, business oriented response of physicians may mean relocating their practices to the hospital outpatient department (HOPD). Such a decision would increase expenditures for the government and the beneficiary.

On the other hand, the demand for services such as diagnostic colonoscopies is high in the non-Medicare population. If ASCs find that the Medicare payments for such services are inadequate, they may seek, through various outreach, marketing and conscious choices, to decrease their share of Medicare patients without reducing their total patient volume, in business parlance, change the payor mix

If implemented, the revised payment system proposed by Medicare will result in significant redistribution of payments for many specialties. Because ASCs typically undertake a narrowly focused range of services that require similar capabilities in terms of equipment and surgical specialty, they have at their disposal few responses to changes in the payment system beyond their ability to adjust their volumes of Medicare patients. If this happens broadly, Medicare beneficiaries may experience significant delays accessing important preventive services or treatment.

Conclusion

We urge you to reevaluate the assumptions used in defining budget neutrality and to broaden your views allowing you to set a conversion factor that will more realistically set payments for ASCs in order to preserve the many patient care and financial benefits that inure to Medicare beneficiaries and the program; allow any payment changes to be phased-in over 4 years; and allow procedures permissible in ASCs to be determined by two criteria: First, those that can be done safely and secondly, procedures that do not require an overnight stay.

Next year is slated to be difficult for our member group practices and the physicians who work there. With the 5.1% Sustainable Growth Rate reductions anticipated in the Medicare physician fee schedule; the imaging payment reductions of the Deficit Reduction Act; the uncertain outcomes of realignment of payments and changes resulting from the Medicare Five year review; and now the draconian payment cuts proposed for ASCs, our members stand to see noteworthy reductions in Medicare revenues.

We hesitate to wave the caution flag of impeded or reduced patient access to care for Medicare beneficiaries because this warning has been sounded many times in the past, luckily not supported by manifestations of significant access problems. However, we fear that the stage has been set to relegate mention of access issues to the realm of crying “wolf”. However we are certain that our members and many other physicians in the country will respond rationally to the financial circumstances in which they find themselves.

In a recent poll of our members we asked them about actions they might take if the physicians’ fee schedule were dropped by 5.1% in 2007. Fully 68% replied that they would in some way limit acceptance of new Medicare patients. Of the respondents to our survey, 95% reported that their Medicare payor mix was between 40-60% of their overall volume.

We do feel that the proposed ASC payment cuts, coupled with the other upcoming payment declines, will have negative consequences for Medicare patients over the next several years. Newly eligible Medicare beneficiaries in particular, may encounter difficulties in finding physicians and in getting timely care. If this proves to be correct, among the hardest hit will be those living in underserved areas, already part of the most vulnerable in our society.

In closing we thank you for the opportunity to present our perspectives about the new ASC payment system and would be pleased to work with you on this important matter. Should you have questions or require additional information, please contact George Roman, Director of Regulatory Affairs at (703) 838-0033 extension 342 or by email at groman@amga.org.

Sincerely,

A handwritten signature in black ink, appearing to read "Donald W. Fisher".

Donald W. Fisher, Ph.D.
President and Chief Executive Officer