



September 14, 2007

Kerry Weems, Acting Administrator  
Centers for Medicare and Medicaid Services  
Department of Health and Human Services  
Attention: CMS-1392-P  
P.O. Box 8011, Baltimore, MD 21244-1850  
By electronic submission

***Re: Medicare Program: Proposed Changes to the Hospital Outpatient Prospective Payment System and CY 2008 Payment Rates;  
Proposed Changes to the Ambulatory Surgical Center Payment System and CY 2008 Payment Rates***

Dear Mr. Weems:

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, independent practice associations, and integrated health care delivery systems. AMGA members' 85,000 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 Medicare for the Hospital Outpatient Prospective Payment System and Ambulatory Surgical Center (ASC) payments and related changes.

### **Overview**

In the final rule issued in August, CMS applied its statutory authority to design a new ASC payment system. Although tying ASC payment to the payment system already established for OPPS transfers inherent imperfections to the ASC setting, AMGA believes that the OPPS represents a reasonable basis for the relative cost of procedures performed in the ASC.

For many of the procedures newly eligible for payment in the ASC, the reimbursement that will be available under the fully implemented payment system will provide generally speaking, an economically adequate alternative to allow beneficiaries to receive services outside the hospital. However, the system will not be adequate universally and certain individual and classes of surgical services will not, or will no longer be, reimbursed adequately to allow performance in the ASC setting. Comments below address procedures disadvantaged by provisions in the final ASC or proposed hospital outpatient department (HOPD) rule that could safely and efficiently be performed in the ASC.

Guiding principles that should pertain to policies for the ASC payment system:

- Configuration of the ASC with the HOPD payment systems to eliminate distortions between them that could unsuitably influence site of service selection
- 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
- 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 in the HOPD

### **Ensuring Beneficiaries' Access to Services**

Medicare beneficiaries have diverse needs for surgical services offered in outpatient settings. Ensuring that beneficiaries receive surgical care in the setting best suited for their medical needs, as determined by their physicians, in consultation with the patient and family, should be the primary objective of ambulatory surgery payment policies.

This goal will not be achieved by this rule for several reasons, but primarily because the proposal would limit a physician's ability to determine the appropriate site of service for a procedure by not allowing payment for many surgical procedures that are clinically appropriate in an ASC. We support the proposal to expand access to new procedures in the ASC setting to further choice, convenience and access by Medicare beneficiaries.

### **Establishing Reasonable Reimbursement Rates**

Medicare payment rates for ASC services have remained stagnant for nearly a decade while inflation has driven double-digit increases in the price of many services and supplies used by ASCs. The payment system for ASCs should achieve the following policy goals:

- Achieve savings to the Medicare program and its beneficiaries;
- Promote payment neutrality across sites of service delivery and competition among surgical service providers; and
- Encourage increased transparency of information on Medicare providers.

### **Alignment of ASC and HOPD Payment Policies**

Aligning the payment systems for ASCs and HOPDs will allow Medicare beneficiaries to make better, broader and more informed choices regarding their surgical care alternatives. While the proposal moves towards consistency between the two systems, there are several instances in which alignment of the ASC and HOPD payment systems is incomplete or inconsistent. The following inconsistencies between how the payment system is applied to HOPDs and is proposed for ASCs should be addressed in the final rule:

## **Procedures Covered**

We commend CMS for adopting the recommendations of MedPAC's March 2004 Report to the Congress. We fully support MedPAC's recommendation and CMS's decision that clinical safety standards and the need for an overnight stay be the only criteria for excluding a procedure from payment of an ASC facility fee. This use of an exclusionary, rather than inclusionary, list allows Medicare beneficiaries' access to the broader range of the ASC services currently offered safely to non-Medicare patients. Under this change, as new procedures are developed, Medicare beneficiaries are more likely to be assured timely access to technological advances in ambulatory surgical care. However, we are disappointed in the implementation of these criteria.

## **Definition of Surgical Procedure**

One criterion that needs to be addressed is the definition of a surgical procedure. In the proposed rule revising ASC payment methodology, CMS solicited public comments on this matter, but as finalized, CMS maintains its narrow definition of surgical procedures as any procedure described within the Surgery section of CPT, which corresponds to Category I codes 10000-69999. We are disappointed that CMS did not expand the definition of surgical procedures to be:

- (1) Any procedure described within the range of CPT Category I codes that the AMA defines as "surgery" (CPT codes 10000-69999);
- (2) Any procedure described within the range of CPT Category I codes that the AMA defines as "medicine" that are invasive, that are performed under general anesthesia or that are specifically designated as intraoperative services;
- (3) Any X-ray, fluoroscopy, or ultrasound procedures described within the range of CPT Category I codes that the AMA defines as "radiology" that require the insertion of a needle, catheter, tube, or probe through the skin or into a body orifice;
- (4) Any radiology procedure that is integral to the performance of a non-radiological procedure described in paragraphs (1) or (2) above and performed
  - (i) During the non-radiological procedure, or
  - (ii) Immediately following the non-radiological procedure when necessary to confirm placement of an item placed during the non-radiological procedure; and
- (5) Any procedure described by HCPCS Level II codes or by CPT Category III codes which are clinically similar to the procedures and services described in paragraphs (1)-(4) above.

We are pleased that CMS has finalized a methodology to provide payments to ASCs for these additional procedures and resources associated with performing those services that are surgical procedures as defined by the CPT Editorial Panel. We support CMS'

decision to allow payment for a number of covered ancillary services when they are furnished on the same day as a covered surgical procedure and are integral to the performance of that procedure in the ASC setting including certain radiology and other ancillary services.

### **Excluded Procedures**

**Safety Criteria** –When CMS implemented the OPPS, it used three criteria to determine which procedures required inpatient care: 1) the invasive nature of the procedure, 2) the need for at least 24 hours of postoperative recovery time or monitoring before the patient can be safely discharged, or 3) the underlying physical condition of the patient. These standards remain today and are used to distinguish non-covered inpatient services from covered outpatient services. The OPPS standards have proven sufficient to safeguard patients in the hospital outpatient setting and can be reasonably applied to the ASC setting. Physicians should, in consultation with their patients, retain the ability to determine the site of service for a given procedure.

**Overnight Stay** – We support CMS’s elimination of the four hour recovery time limit when determining what procedures should be payable in ASC setting. Included in the July 2007 proposed final rule was the issue of using midnight as a “defining measure” of overnight stay. In the past, CMS has recognized that midnight is not the only definition of an overnight stay. Given CMS’s historic statements on overnight stays in the ASC, state regulations that allow stays of up to 24 hours and the more extensive length of stay permitted in the HOPD, it is reasonable to allow ASCs to offer either an episode of care or a postoperative recovery period of less than 24 hours. CMS should abide by its previously stated position and continue to define an overnight stay in an ASC as a stay that is less than 24 hours in duration.

**Unlisted Codes** – The final rule excludes unlisted surgical procedure codes from ASC payment under the revised ASC payment system. CMS has indicated that, due to a lack of specific procedural descriptions, it is not possible to determine whether such procedures would pose safety risks to Medicare beneficiaries. This policy is incongruent with the approach CMS takes to reimbursement of unlisted codes under OPPS and is unnecessarily restrictive. CMS should be consistent and evaluate unlisted codes for potential safety risks in both the ASC setting and the HOPD setting.

**Payment Bundles.** Allowing ASCs to bill separately for ancillary services integral to the primary procedure and separately payable under the OPPS is a significant improvement to the alignment of the payment systems. However, discounting the payment to ASCs for many of these ancillary services does not recognize that cost differences vary only slightly between the ASC and HOPD. In principle, we agree that services that are "packaged" under OPPS and therefore not separately payable to HOPDs should not be eligible for payment of a separate ASC facility fee. However, the proposed changes to the OPPS packaging policies will exacerbate problems that arise directly from limiting payment for surgical procedures performed in ASCs to those that fall in the range of CPT codes 10000-69999.

**AMGA Recommendation:** Services should not be newly excluded from the ASC because of changes to the OPPS packaging policies. This policy unnecessarily forces procedures back into the hospital that could be safely performed in less expensive settings. At a minimum, procedures described by CPT Category III codes and Level II HCPCS codes should be exempt from being excluded from the ASC list since CMS will cover these services under the revised ASC payment system. Likewise, if future changes to the OPPS packaging policies result in unbundling, the unbundled services should continue to be included on the ASC list. We agree that the packaging rules applied for services under OPPS should be applied in the same manner to ASCs. However, CMS should alter its current definition of surgical services in order to avoid inconsistencies in its payment policies for the same procedures when provided in different sites of service.

### **Device Related Services**

**AMGA Recommendation:** If CMS does not fix payments for implants to allow for adequate payments during the transition, beneficiaries will be forced back to the higher cost hospital setting. This situation could also result in access issues for beneficiaries. Absent relief from the transition period, it is likely to be several years before the device costs are compensated at a level at which the procedure can be economically viable in the ASC. As a result, these services will continue to be provided primarily in the more expensive hospital setting. During the first period of the transition as the rates are phased in over four years, the payment for the procedure may not adequately cover the costs for the procedure and the cost of the implants. There are a number of these procedures, which for certain procedures, will greatly impact beneficiary access to care if not adequately paid for in the ASC.

### **Payment Limits**

CMS finalized its rule to limit payment for ASC services frequently performed in the physician office. However, the policy was not extended to the OPPS from which the resource requirements necessary to provide procedures of low complexity for patients, varies little. The process used by the agency to identify services for permanent placement on the list of “capped” procedures should also be refined to address the emergence of new technology, the complexity of patient needs, and the annual fluctuations in the volume and location of procedures performed.

The payment limit will force patients who are not appropriately treated in the physician office to go to an HOPD, bypassing the ASC where the service could be done safely and cost-effectively. Physician offices generally treat a less complex and severely ill patient case mix. As such, the office is less likely to have the staff and equipment resources to provide on a regular basis many of the services that a more medically complex patient might require. Capping payment at the physician office rate undermines the stepped reimbursement policies that underlie the level of resources available to the physician and beneficiary at the three sites for outpatient surgical services: the HOPD, ASC, and physician office.

**AMGA Recommendation:** We recommend that CMS drop its policy of designating procedures as “office-based” services. Site of service volume characteristics are arbitrary and without clinical basis and should not be used to determine ASC eligibility. In any case, services should not be designated “office-based services” indefinitely but should be evaluated based solely on whether or not done more than 50% of time in the physician office (using the most recent volume data). CMS should not use clinical information or comparable data for related procedures to determine what should be office-based. If CMS continues to use other data, it should provide that data and rationale that it employed in making that determination.

### **Inflation Update**

CMS continues using the CPI-U inflation update for ASCs despite any evidence that the rate of inflation between the ASC and HOPD varies. The Secretary should implement the new payment system with application of the hospital market basket to the ASC payment system. Absent that adjustment, annual updates will increase the payment gap between ASCs and HOPDs and create incentives for procedures to migrate from the ASC to the hospital when inflation updates fail to keep pace with providers' costs.

### **Secondary Rescaling of APC Relative Weights**

CMS applies a budget neutrality adjustment to the OPPS relative weight values after they are recalibrated with new cost data each year and decided to apply a secondary rescaling of the ASC weights. The relative costliness of surgical services continues to outpace the cost growth of non-surgical services in the OPPS. Applying a secondary recalibration to the ASC, absent evidence that ASC services became relatively less expensive than the HOPD, will create unjustifiable variance in the payment rates between the ASC and HOPD.

### **Physician Payment for Procedures and Services Provided in ASCs**

**AMGA Recommends** that CMS should continue to provide payment under the physician fee schedule for non-covered services that would otherwise be paid if they were performed in a physician office. Beneficiaries should be liable only for the co-payment and deductible associated with the physician fee schedule. We urge CMS to alter its current policy under OPPS and apply this modified policy to the ASC setting. Acknowledging that the course of a planned procedure cannot always be determined in advance and allowing for contractor-based adjudication allows for more equitable treatment of beneficiaries under these circumstances.

When a planned covered procedure is altered by intra-operative findings and becomes a non-covered procedure, the beneficiary should not incur additional financial liability. Under such circumstances, standard cost-sharing formulas should remain in effect. A modifier should be created that allows communication of these circumstances on both ASC and HOPD claims. In these cases, payment would be priced by the contractor based on a review of the operative report. The conversion of a planned covered procedure to an unplanned non-covered procedure occurs infrequently. Allowing contractor review would not impose a significant burden on the adjudication process. Claims of this type could be easily monitored through tracking of the specific modifier created for reporting.

Any concerns regarding billing practices could be readily audited, since scheduling a procedure creates a record of the planned intervention.

### **Reporting Quality Data for Annual ASC Payment Rate Updates**

We concur with CMS's decision not to implement ASC reporting of quality measures prior to January 1, 2009. We request CMS work with outside parties, including AMGA, with interest and expertise in ASCs to develop quality measures. For reporting data, those with advanced capabilities should be able to participate in direct reporting from electronic medical records and data registries rather than using claims-based information. This approach preferable and should be encouraged since it will yield more accurate, clinically meaningful, and overall more reliable data.

AMGA urges CMS to consider the following in future rulemaking regarding publication of quality data collected: Consumers should be able to access quality and cost information on websites organized to allow easy comparisons of information that is correct, current and clearly presented. Information should be presented on all available sites of service so consumers can compare a hospital outpatient department and an ASC for a procedure that could be performed in both locations; there should be a speedy mechanism for corrections or resolving disagreements about any information posted for public presentation; there should be a provider narrative section for each provider-specific item presented to the consumer, that would allow the provider to advise the consumer of any concerns the provider has regarding the reliability or accuracy of the information presented; and in addition to quality measures, other useful information such as accreditation status, state licensure and Medicare certification should be made available.

### **Conclusion**

Inadequate payment will force providers to respond in a variety of ways, some of which may limit patients' ability to have surgical services performed in a safe, convenient and low cost environment. The implementation of the revised ASC payment system will result in significant redistribution of dollars within the ASC payment system with system-wide consequences. Therefore we strongly urge CMS to use its considerable discretionary authority to ensure a smooth transition to the new payment system.

We appreciate the opportunity to opine on these proposed changes and would be happy to work with CMS to assure best access and information on surgical surgery choices for Medicare patients. Feel free to contact George H. Roman, Senior Director, Health Policy, of my staff at [groman@amga.org](mailto:groman@amga.org) or (703) 838-0033 ext. 342, if you have questions or need additional information.

Sincerely,



Donald W. Fisher, Ph.D.  
President and CEO

