August 25, 2009

VIA HAND DELIVERY

Charlene Frizzera, Acting Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1414-P
Room 445-G
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

Re: CMS-1414-P – Medicare Program; Proposed Changes to the Ambulatory Surgical Center Payment System and CY 2010 Payment Rates

Dear Acting Administrator Frizzera:

On behalf of the undersigned members of the ambulatory surgery center (ASC) community, please accept the following comments regarding the payment and quality issues related to ASCs in the proposed rule for CY 2010 payments (74 Fed. Reg. 35232, July 20, 2009). These comments are submitted jointly by the ASC Association and the ASC Coalition, a diverse coalition of national and state associations and companies representing all types of ASCs – single- and multi-specialty, physician-owned, joint ventures between hospitals and physicians, and joint ventures between physicians and management companies. These centers range from the very small to the very large and are located in all parts of the nation.

We appreciate the diligent work of your staff to review and evaluate the proposed changes to the ASC payment system in 2010, and appreciate the opportunity to offer our insights on the impact of the ASC payment system. This is the first opportunity we have had to reflect upon actual claims experience under the revised payment system. We offer our insights on the first year of experience under the revised system as well as our expectations and recommendations for the coming years as we move through the final phases of the transition.

Since the inception of the Medicare benefit in 1982, ASCs have steadily expanded the role they play in meeting the surgical needs of Medicare beneficiaries. A recent study released by the independent health economics and policy firm KNG Health Consulting shows that ASCs have played a pivotal role in moving services into less expensive yet clinically appropriate settings. Most strikingly, the researchers attributed 70 percent of the growth in ASC services between 2000 and 2007 to the migration of services from the hospital outpatient department to the ASC. This finding was buttressed by the fact that ASC market share grew substantially in the primary clinical procedures provided by ASCs. Other key findings from the study, which examined the growth in the number of ASCs and the services provided in this setting between 2000 and 2007, include:

- ASCs are essential Medicare providers of surgical and cancer screening services.
- For gastrointestinal and ophthalmology services—two major types of services ASCs provide—75% and 94% of the growth, respectively, in ASC services over the study period is from the migration of services to the less expensive ASC setting.
- The presence of ASCs does not result in a higher overall surgical volume in their geographic market/area.

The ASC community continues to support CMS's decision to base ASC payments on the ambulatory payment classification (APC) groups and relative weights used in the hospital outpatient prospective payment system (OPPS). However, we remain concerned that CMS did not adopt a set of policies that would result in a fixed relationship between ASC and OPPS payments over time. CMS's policies should facilitate Medicare beneficiaries' understanding of the relative cost of surgical services in outpatient settings and enable them to make direct comparisons on the basis of price and quality.

Although these comments will address a variety of topics of importance to the ASC community, we urge the agency to use its administrative authority to address two elements of the revised ASC payment system that result in a growing and inappropriate separation between ASC and HOPD payment rates.

- Use the same inflation update in both the ASC and HOPD payment systems, the hospital outpatient market basket index.
- Directly apply the OPPS relative weights to ASC services without a second scaling of the relative weights.

Since CMS published the final rule for the revised ASC payment system, aggregate ASC payments as a percent of the OPPS rates have fallen from 65 percent to an estimated 58 percent in 2010. That relationship is down from 86 percent as recently as 2004. Left unchanged, the expanding gap between payments will reverse the decades-long migration of services into the ASCs as certain procedures or classes of surgical services will not remain viable in the ASC setting.

OVERVIEW

In linking the ASC and OPPS payment systems, CMS created an opportunity to ensure that both beneficiaries and the government would save money when patients choose the ASC setting over the HOPD. As MedPAC consistently articulates in its annual reports to Congress, program payments should be adequate to cover the costs of an efficient provider of services. By setting ASC rates below the OPPS rates, Medicare pays more for identical surgical services in the HOPD as compared to the ASC setting for a variety of reasons. However, once that differential is established, as it was in the 2008 rulemaking, payment policies for the two systems should expect both settings to manage costs equally well going forward. Carrying this concept to

implementation means that relative ASC and HOPD rates should not diverge over time, but retain a consistent relationship.

We are concerned that several provisions of this proposed rule perpetuate policies that will reduce, rather than expand, access to surgical care due to the selective and incomplete application of OPPS policies in the ASC setting. Maintaining the integrity of the connection to the OPPS relative weights is paramount in ensuring that the payment policies do not influence site of service selection.

In the sections below, we highlight why the agency should address several design and implementation issues in the revised payment system. These changes will ensure beneficiaries' ability to evaluate their options for outpatient surgery and choose the lowest price setting appropriate for their clinical condition:

- CMS should stop rescaling ASC relative weights as this further exacerbates the gap between ASC and OPPS payments and inappropriately reduces payments to ASCs. The agency's assertions that scaling will not consistently reduce ASC weights and diversification of the industry will diminish the impact of scaling have not been borne out by experience.

- CMS should adopt the hospital market basket as the measure of ASC cost increases, rather than using the CPI-U. The CPI-U does not reflect medical cost inflation and is highly volatile, particularly in response to economic factors unrelated to the delivery of surgical services. The agency's projection of CPI-U is too low and is inconsistent with projections by other federal agencies.

- CMS should use the OPPS wage index for ASC payments to improve the consistency between the payment systems and to limit variation in price at the local level. This change will enhance consumers' ability to compare prices between the two settings.

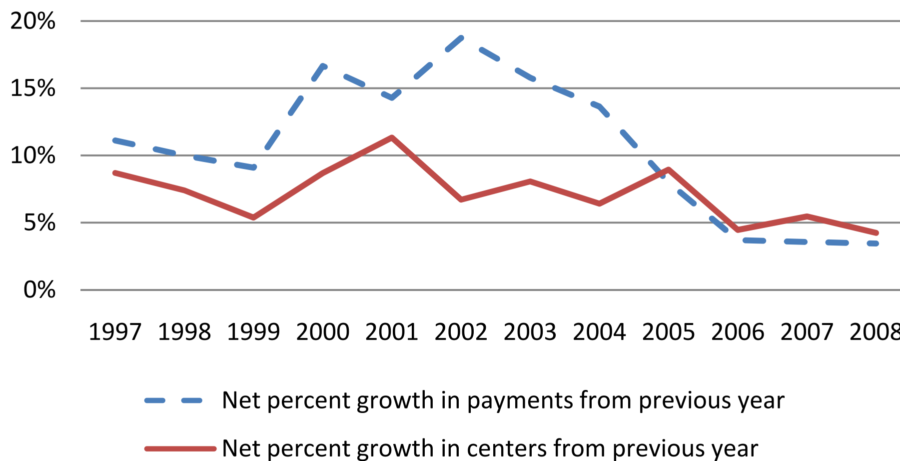
- CMS should continue to expand the ASC procedure list to more closely reflect the spectrum of services covered in the HOPD and already covered by commercial insurers and other private and public payors. In those instances where CMS excludes a procedure from the ASC list, it should disclose the reasoning behind such exclusion.

- CMS should complete its work to design and implement a quality reporting infrastructure for ASCs. We appreciate the challenges of bringing a system online, but we believe that the agency's experience with the existing quality reporting initiatives provide sufficient information to move forward with an ASC reporting initiative. The ASC industry is eager to make quality information available to consumers.

I. ASC conversion factor and scaling of the relative weights

In 2010, ASCs will enter the third year of the transition to a payment system based on the relative weights of services paid under the OPPS. During the transition, the rates for the most common procedures are declining. Calendar year 2010 also marks the end to a 6-year rate freeze imposed by the Medicare Modernization Act of 2003. The effects of the rate freeze can be seen in the slowdown of growth in the number of ASCs as well as aggregate payments to ASCs. As ASC growth slows, so too will the migration of services from the HOPD to the ASC setting, resulting in fewer opportunities to garner additional savings for facility-based outpatient surgical services.

Figure 1. ASC development and spending growth have slowed substantially



Data from some of the largest ASC management companies shows same-store volume growth in 2009 is either flat or negative. It is too early to tell what effects the speed and severity of the payment reductions are having on beneficiary access to ASC services, so we urge CMS to avoid implementing additional policies that will decrease payments. In the discussion below, we describe how

- CMS overestimated the growth in ASC services when establishing the conversion factor for the new payment system, and
- scaling of the ASC relative weights and use of the Consumer Price Index for Urban Consumers is eroding the relationship of ASC to HOPD payments.

Medicare's payment policies should support the continued development of capacity in the industry to move cases into the least intensive setting appropriate to the clinical needs of the patient. Scaling the relative weights and expanding the difference in ASC and HOPD payments is in direct conflict with the goal of ensuring that patients have continued access to surgical care in the lowest priced setting appropriate to their clinical needs.

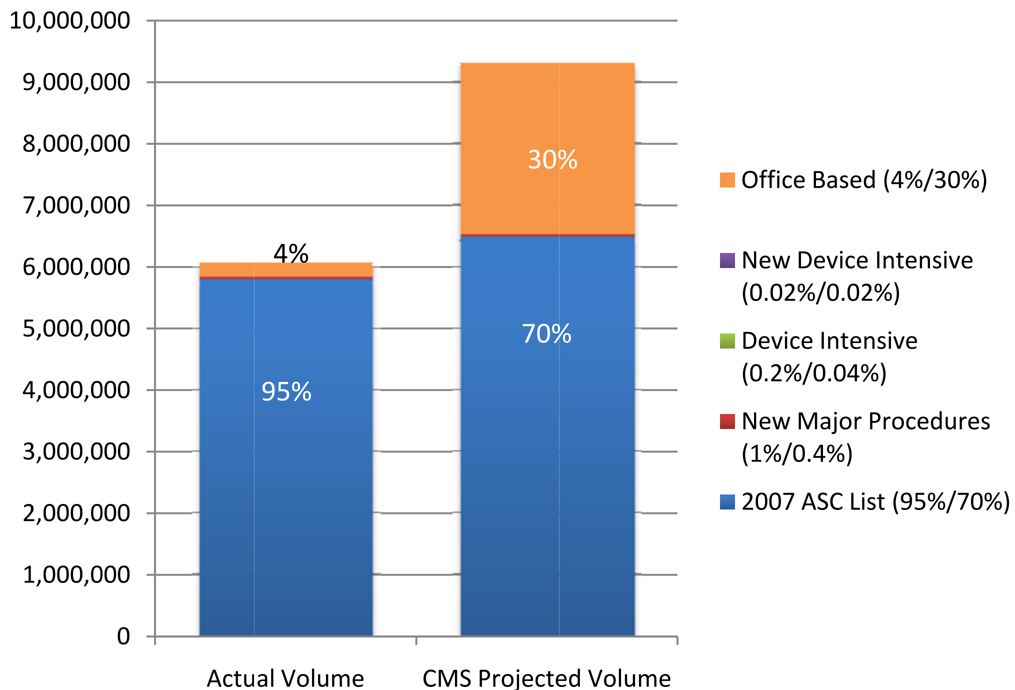
A. ASCs did not grow at the aggressive rate predicted by CMS

When CMS established the payment system in its 2007 rulemaking, the agency used a formula that recognized the migration of services between settings in response to the new payment system. To calculate the conversion factor, CMS used 2005 volume from ASCs, HOPDs, and physician offices to project the volume in 2008. Through improvements or decrements to the conversion factor, the formula credited ASCs for moving volume from the HOPD and penalized them for moving services from the physician office into the ASC. The ASC community firmly embraced including migration in establishing the conversion factor. However, we commented at the time that two primary elements of the formula kept the conversion factor low relative to what we believed was an appropriate payment differential with the HOPD (e.g., a conversion factor at 75% of the OPPS rate). We disagreed with the agency's assertions assumed under the conversion factor formula that ASCs would expand their capacity sufficiently to accommodate a tremendous volume of new services, and that ASCs would begin performing a high volume of low-complexity procedures.

The conversion factor formula assumed ASCs would receive volume from the OPPS and physician office in the first year of the new payment system equal to 12.5% of OPPS and 3.75% of physician office volume for new codes allowed in the ASC setting in 2008. Restricting the migration to new codes excluded previously covered services for which ASCs have moved substantial volume to the most appropriate setting; the model overstated the volume growth and spending in the ASC, and the rule set the conversion factor too low.

Under the migration assumptions in the CMS formula, ASC volume would have nearly doubled between 2005 and 2008. Most of the volume growth assumed by the agency was concentrated in procedures predominately performed in the physician office. The agency assumed that ASCs would perform more than 2.7 million office based procedures in 2008 in its calculation to establish the ASC conversion factor. Using 2008 claims data, we observe fewer than 200,000 instances in which procedures designated as office based were performed in ASCs, more than a third of which were performed secondary to another procedure and were generally low-priced services.

Figure 2. CMS overestimated ASC growth, particularly for office based procedures



In addition to overestimating volume growth, the agency likewise overestimated the level and distribution of spending under the revised system. Using 2008 data on ASC's experience under the new system, we found that CMS' original budget neutrality calculation on the new code range overestimated ASC spending growth and set the conversion factor too low. First, we determined the level of spending which CMS calculated to set the conversion factor. We used 2005 claims and applied the assumptions in CMS's conversion factor formula on

- volume growth in the OPPS and physician offices from 2005 to 2008,
- the migration of volume from those settings to the ASC in 2008,
- the restriction that net migration would only occur in new codes added to the ASC list in 2008, and
- relevant payment policies such as the transition and capped payments for office-based procedures.

This calculation resulted in a projection of ASC payments equal to $285 million over the range of new codes.

Second, we analyzed the actual volume and payments for services in the new code range in 2008; payments for services equaled $67 million. The table below illustrates the CMS estimates and actual 2008 spending by payment indicator for new categories of procedures. The CMS estimates were included in the calculation establishing the ASC conversion factor – estimates

that we argued were too high and which resulted in a lower conversion factor than we believed was appropriate.

Table 1. CMS's method substantially overestimated the migration of volume in new codes

New Code Type	Number of codes	CMS estimate of spending	Actual spending
		(in millions)	
J8: Device-intensive procedure	14	$130	$5
G2: Non office-based surgical procedure	284	$70	$42
P3: Office-based surgical procedure, capped at physician rate	388	$60	$15
P2: Office-based surgical procedure, paid at OPPS rate	147	$20	$4
R2: Office-based surgical procedure, capped at physician rate	42	$5	$1
All new codes	**875**	**$285**	**$67**

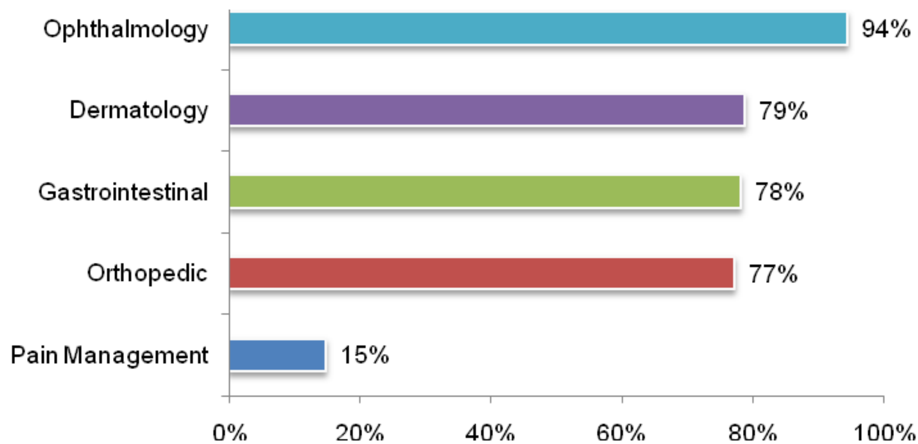
** Spending excludes beneficiary copayments.*

As the table illustrates, CMS's estimate of spending for newly covered procedures was several times higher than the actual spending. If even half as much migration from OPPS and physician offices had occurred, CMS's estimate of spending would still have been twice the actual level of spending.

Since we have no means to attribute the actual volume of new ASC services coming from the HOPD or the physician office, we recalculated CMS's budget neutrality model, using half as much migration from OPPS and physician offices. We applied the same methodology that CMS outlined in the calendar year 2008 final rule, changing only the assumption of migration from OPPS from 12.5% to 6.25% and the assumption of migration from physician offices from 3.75% to 1.5%. This alternative approach yields a conversion factor of 64 percent. In addition, we know that approximately one third of the volume of office-based procedures was secondary, and hence, we discounted 50 percent. Taking into account the discounting of the office-based procedures would have raised the conversion factor further. This analysis, along with the actual spending levels in 2008, confirms that a higher conversion factor would have maintained budget neutrality.

CMS based its migration calculation for the conversion factor on a narrow range of new codes. Though a very small amount of migration did occur to services in those codes, CMS's range excludes codes with a substantial amount of ASC volume and significant amounts of migration to the ASC setting. A recent report by KNG Health Consulting found that ASCs successfully moved thousands of surgeries to the most appropriate setting between 2000 and 2007. The graph below illustrates migration as a portion of growth in ASC volume.

Figure 3. Nearly all growth of ophthalmology services in ASCs is attributable to migration from HOPDs, 78 percent of growth in GI due to migration



We applied KNG's methodology to measure migration into 2008. Our findings were consistent with the KNG research. Among the dominant specialties in ASCs, such as gastroenterology, ophthalmology or dermatology services, migration can be as much as 90 percent of growth since 2005. CMS's exclusion of the services on the 2007 ASC list failed to capture the true extent of migration to ASCs.

B. Scaling the ASC relative weights inappropriately reduces payments

CMS states in the proposed rule that "Today, hospital outpatient and ASC surgical procedures are paid based on the relative weights adopted for the OPPS, and the difference between payments under the two systems is largely a reflection of the differences in capital and operating costs attributable to being an ASC or being an HOPD" (74 Fed. Reg. 35392, July 20, 2009). Scaling of the relative weights is intended to maintain budget neutrality within a payment system; however, CMS' application of scaling in the ASC system is instead creating increasingly large payment differentials between ASC and HOPD payments without evidence of growing differences in capital and operating costs in the two settings.

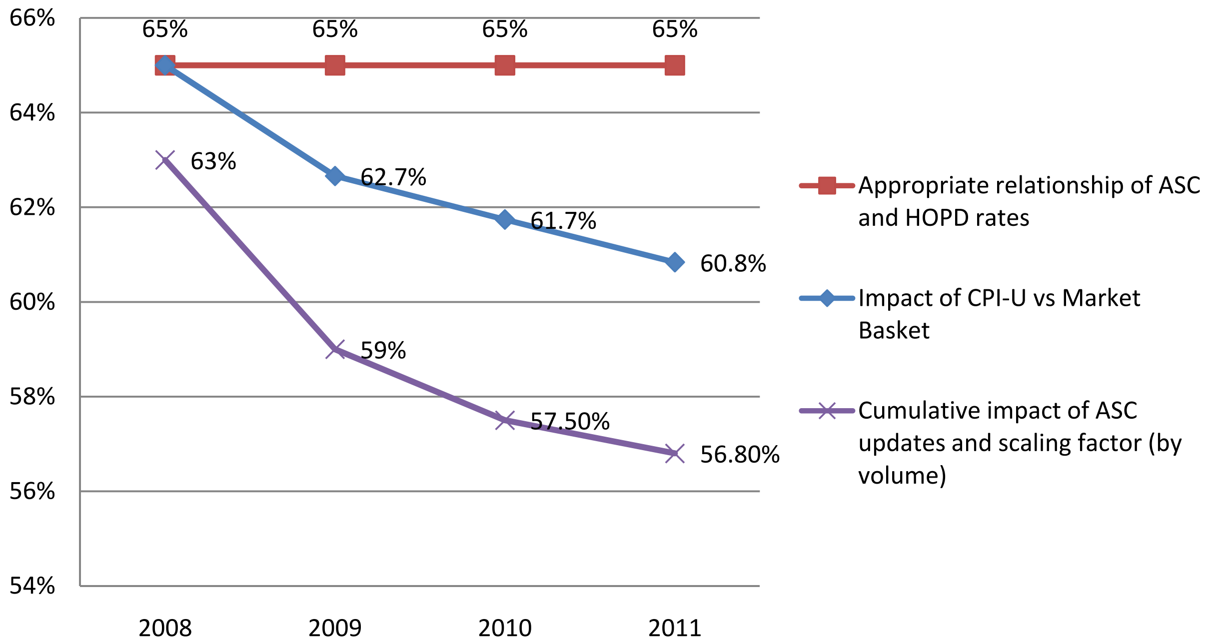
The regulations establishing the revised ASC payment system give CMS the flexibility to scale the OPPS weights "as needed." CMS should use its administrative authority and not apply the secondary scaler to ASC relative weights in 2010. In this section, we will demonstrate that:

- Rescaling is inappropriately eroding the relationship between the OPPS and ASC payment systems.
- The transition to the new payment system is already reducing payments for many ASC services, and rescaling is exacerbating the transition to the new payment system for many common ASC services.
- Rescaling is not required by the statute.

During this critical early implementation period, CMS should continually assess the impact of its decisions on the final payment levels. Scaling of relative weights is a consistent CMS policy in

other Medicare payment systems where the cost and volume data are derived directly from the providers affected by the scaler. However, because CMS bases the ASC system off the OPPS relative weights, the weights should be equal in both settings. The scaler breaks the direct link between ASC and OPPS weights and acts as an unnecessary measurement of volume and case mix. The application of the separate ASC scaling factor as proposed in this rule produces payment differentials that are neither sensible nor good policy.

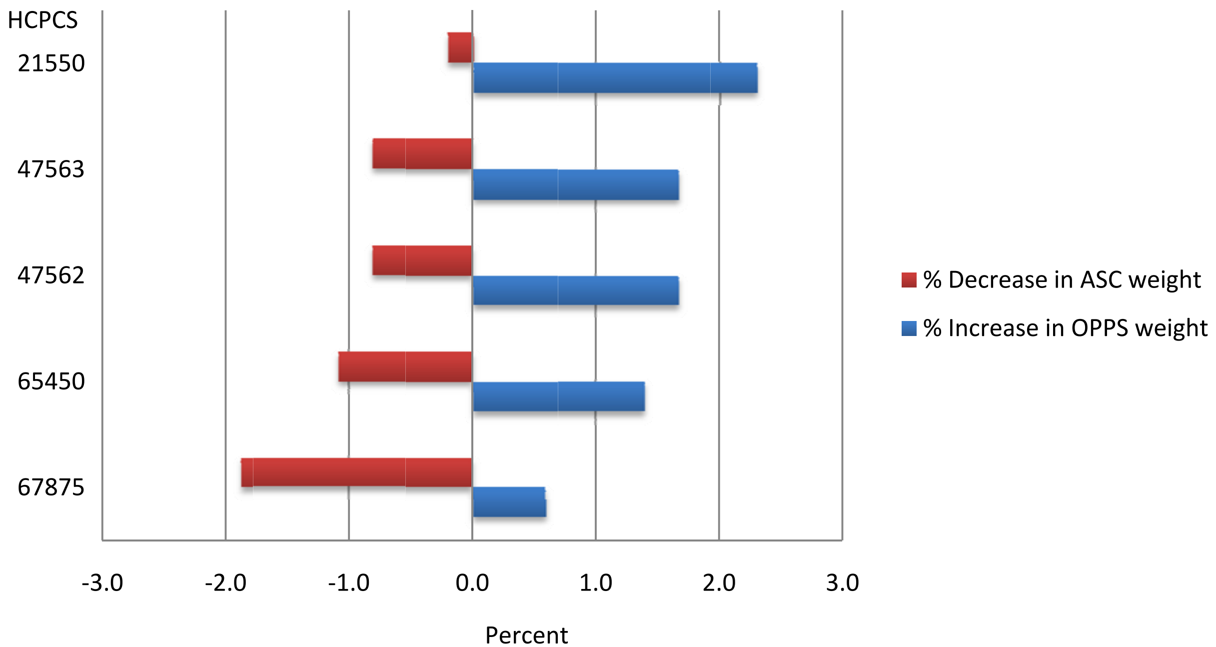
Figure 4. The relationship between ASC and HOPD payment should remain constant



Further, basing the scaler on the full panoply of OPPS relative weights and volume is inconsistent with the principle of rescaling. When CMS transports the OPPS relative weights to ASC payments and then applies a budget neutrality adjustment, the agency's "neutrality" calculation assumes that differences in case mix constitute unanticipated spending increases. Instead, CMS should directly apply the OPPS relative weights to ASC payments after adjusting for the cost of device intensive procedures. The rescaling that currently occurs annually in the OPPS results in a new set of weights and is the best proxy for cost increases at both the APC and HCPCs levels. Absent the transition, scaling the ASC relative weights should not result in a year-to-year decrease in the ASC relative weight when the OPPS relative weight for the same service is rising.

As illustrated in the chart below, the ASC scaling factor can cause the weights for ASC and HOPD services to move in opposite directions. The services represented in this chart were added to the ASC list under the revised payment system and are paid on the basis of the OPPS relative weights. Payment for a service should not increase in one setting and decrease in another solely on the basis of the scaling factor, as is the case for many ASC services.

Figure 5. ASC and OPPS weights for the same procedure can move in opposite directions



At its core, the budget neutrality calculation used to develop the conversion factor was designed to take into account the mix of services ASCs provide and establish a relationship between payments for procedures in the two settings. From that point forward, the relative difference in payments *between* the ASC and HOPD services at the aggregate and procedure level should be driven only by changes in the conversion factor. The 2010 OPPS relative weights reflect real growth in the relative cost of services performed in the HOPD. The ASC scaler should not reclaim dollars from the ASC payment system as there is no reason to believe that there has not been real cost growth for the same surgical services performed in an ASC.

In the final rule establishing the ASC payment system (72 Fed. Reg. 42532, August 2, 2007), CMS suggests that scaling of the relative weights is a design element that will protect ASCs from changes in the OPPS relative weights that could significantly decrease payments for certain procedures. However, the trend in the OPPS relative weights suggests that the scaling factor for ASCs will rarely result in an increase in ASC relative weights. In fact, ASCs would have experienced a negative adjustment to their weights in six of the last eight years if the linkage to the ASC payment system had occurred in 2002 when first contemplated by MedPAC. This historical trend, and the absence of any indication that it is likely to reverse in the future, suggest that the application of scaling in the ASC setting will continue to erode the relationship between ASC and HOPD rates.

C. CMS has the authority to suspend application of the scaling factor

In its regulations at §416.171(e)(2), CMS established a process by which it *may* make annual adjustments to the relative payment weights.

> "(2) For CY2009 and subsequent calendar years, CMS adjusts the ASC relative payment weights under 416.167(b)(2) as needed so that any updates and adjustments made under 419.50(a) of this subchapter are budget neutral as estimated by CMS."

In the first three years under the revised payment system, changes to the OPPS relative weights would have (2008), and did (2009 and 2010) result in the application of an ASC scaling factor that reduces ASC payments relative to the OPPS rates. CMS should use the authority granted it in by the statute and codified in regulations to suspend application of the scaling factor in 2010 to prevent a further divergence in payment between the two systems.

The calculation of budget neutrality CMS used to develop the ASC system and codified at §416.171(e)(1) was designed to take into account the differences in case mix between the two settings and resulted in a conversion factor for ASCs at 63 percent of the OPPS rate. We continue to disagree with the initial budget neutrality conversion factor determined by CMS and articulated our concerns in a previous comment letter[1]. We believed then – and the 2008 claims data confirm – that CMS grossly overestimated the volume of office-based procedures that would migrate into the ASC. We also identified several other methodological issues with the agency's calculation. Using our estimate of how the industry would respond to the new payment system, we produced data indicating that 73% of the OPPS conversion factor was budget neutral (see Addendum A for a summary of the methodology).

We acknowledge that suspending application of the scaler will result in an aggregate increase in spending in the ASC setting in 2010. However, the scaler is forcing procedures for which the OPPS median cost grew from 2009 to 2010 to finance the transitional payment policies implemented by CMS. Unfortunately, the procedures which the transitional payments were intended to aid are the procedures financing the bulk of the scaler.

Our most fundamental objection is that the proposed rescaling results in ASC payments that do not keep pace with rising costs. In this year and in future years, the rescaling process will further erode ASC payments and the relationship between ASC and OPPS rates. Further, altering the ASC weights is contrary to the intent of using the cost-based OPPS measurements to determine the relative payments for the same procedures in the ASC. Rescaling does nothing to maintain the relative weights of procedures that are subject to other payment policies, such as the payment transition or the physician office rate cap.

II. ASC Inflation

When ASC services payment system were added to Medicare's Part B benefit in 1980, the first perspective payment system was created. As a result, the hospital market basket was not yet in existence and the consumer price index for all urban consumers (CPI-U) was adopted as the tool for updating payments for Medicare providers. Since that time, CMS has developed market baskets to better-measure price changes for nearly every one of its provider payment systems.

[1] ASC Coalition Comment Letter "Re: CMS-1506-P - Medicare Program; the Ambulatory Surgical Center Payment System and CY 2008 Payment Rates." November 6, 2006.

We urge CMS to use the market basket used for the OPPS for future ASC payment updates. In the comments below, we describe why the hospital market basket is a more appropriate measure for the ASC payment system. We will also illustrate how there is little government consensus when forecasting the CPI-U and how CMS' own mid-year projection is both inconsistent with other federal projections of CPI-U, and the projection is unlikely to be an accurate measure of inflation for 2010.

In the past, CMS has demonstrated that they have the authority to align payment systems when the Secretary is able to demonstrate the need to do so. In one instance, CMS used this authority in deciding to apply the inpatient hospital wage index to the OPPS even though the statute implementing a variety of adjustments refers only to payments made under the IPPS. CMS acknowledged that it is not required by statute to use the CPI-U for the ASC update in response to comments on the proposed rule for FY2008[2]:

> "[T]he statute gives the Secretary broad authority in designing the specific features of the revised system. In particular, the statute gives the Secretary considerable discretion in determining an appropriate update mechanism for the revised ASC payment system. Section 1833(i)(2)(C)(i) of the Act requires that the Secretary update the payment amounts established under the revised system ''by the percentage increase in the Consumer Price Index for all urban consumers,'' but only if the Secretary has not otherwise ''updated amounts established'' under the revised system for that year. The statute, therefore, does not mandate the adoption of any particular update mechanism, but it does establish the CPI–U as the default update mechanism in the absence of any other update."

The statute's authority clearly allows CMS to use an alternative update mechanism. For the reasons described below, we submit that moving away from the CPI-U to the market basket is not only permissible, but entirely appropriate.

Calendar year 2010 is the first year that CMS will update the ASC payment system for inflation. In the six years since the last inflation update, expansion of the ASC industry has slowed significantly in response to the multi-year Medicare payment freeze and ASCs are under pressure to control their costs. The CPI-U is a poor proxy of the cost inflation facing the ASC industry. The CPI-U is flawed in many ways: it has inherent methodological biases, it is designed to capture household spending rather than healthcare provider spending, there is little consensus on the actual rate of inflation, and its deviation from the hospital market basket adds to the gap between ASC payment and the hospital outpatient department payments. Taking these issues into account, we believe that CMS can and should align ASC payment updates with the OPPS Market Basket.

Compiled and constructed by the Bureau of Labor Statistics (BLS), the CPI-U measures the average change in prices over time of all goods and services purchased by households and covers roughly 87% of the population.[3] Household purchases, however, are significantly different from

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[2] Federal Register**,** Vol. 72, No. 148, Thursday, August 2, 2007 (42518-42519)
[3] CPI-U obtained from the BLS: http://www.bls.gov/cpi/

the basket of goods and services purchased by ASCs. Additionally, the CPI-U has faced criticism from independent researchers and economists, with experts repeatedly documenting biases in the methodology that result in the CPI-U consistently underestimating the rate of inflation.[4]

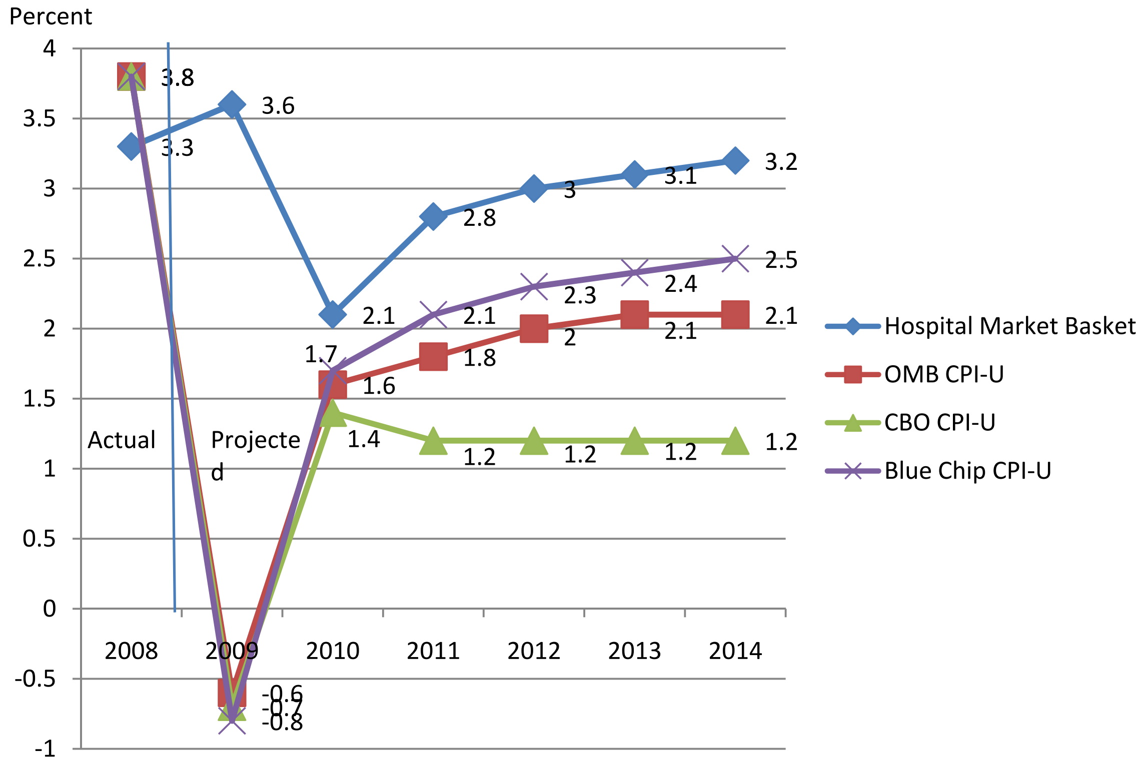
The very construction of the CPI-U limits its ability to predict ASC cost growth. Both the CPI-U and market basket assign weights to categories of goods and the category's proportion of the total budget. However, the CPI-U considers all urban consumers and the market basket analyzes hospital spending. In the market basket, spending on wages and benefits represent nearly 60% of the weight of the index. On the other hand, the CPI-U is dominated by inflation in the housing sector (42% of its weight). Over the past year, we have seen energy prices as a major driver in the decline of the CPI-U.; and in recent months, they have also been responsible for much of the volatility in the index.

Further, CMS uses different proxies for price increases for most of the categories of goods and services in the market basket. As another example, the market basket has assigned a combined weight of 2.84 to food products (Food-direct purchase and Food-away from home); meaning that out of every hundred dollars the hospital spends, $2.84 cents of it is spent on food. The CPI-U, on the other hand, assigns a weight of 14.914 to all food and beverages. The disparity in weights illustrates the inherently different cost pressures faced by the typical U.S. household and the hospital sector. Such discrepancies reveal how unlikely it is that the CPI-U is representative of ASC costs.

Another problem with CMS' usage of the CPI-U is the use a mid-year (June) percent change to determine the payment updates for ASCs, rather than an end-of-year timeframe. The BLS uses mid-year reporting only for current year estimates, not when forecasting. Consequently, the agency's forecast for the 12-month period ending in June 2010 cannot be validated directly with an independent source. In the proposed rule, CMS projects the CPI-U to be 0.6 percent. We find no other federal agency or respected financial publication – Office of Management and Budget (OMB), Congressional Budget Office (CBO), or Blue Chip Consensus FinancialForecast – projecting such low growth in consumer prices for the coming year.

Figure 6. Projections of CPI-U vary widely and remain significantly lower than the hospital market basket

[4] See Greenlees, J.S. "A Bureau of Labor Statistics Perspective on Bias in the Consumer Price Index" (2005); Hausman & Leibtag "CPI Bias from Supercenters: Does the BLS Know that Wal-Mart Exists?" (2004); and Hausman "Sources of Bias and Solutions to Bias in the Consumer Price Index" (2003).



The figure illustrates that all three of the abovementioned forecasters predict the CPI-U for 2010 to hover around 1.5 percent. Additionally, the chart demonstrates we can see how difficult it is to predict the CPI-U: the three authorities in CPI-U forecasting predict a wide range of possibilities. Particularly during the current economic decline, projections of the CPI-U have varied widely Figure 6 also gives us insight into how divergent the OPPS and ASC payment systems are when one is updated using the market basket and the other is updated using the CPI-U. No matter which predictor of the CPI-U CMS uses, the rates paid under two systems will drift further apart in future years.

Quite appropriately, Congress directs Medicate to tie payments in other major payment systems, such as skilled nursing facility and home health services, to market baskets constructed to reflect the change in prices for the items used in each setting. Consequently, CMS has the authority realign ASC payments to the hospital market basket, due to the statute change enacted by Congress in 2003. As a result, we urge the agency to adopt the hospital market basket as the ASC inflation index. Not doing so will widen the differential in the conversion factors for ASC and OPPS payments, far exceeding the original relationship established by rule for the 2008 payment system. This difference cannot be explained by real differences in the growth of the cost of goods and services furnished by ASCs and HOPDs and should not be perpetuated by policies the agency has the administrative authority to correct.

III. ASC Wage Index

Alignment of the ASC and OPPS payment systems is important to ensure that differences in rates do not inappropriately restrict beneficiary access to the most efficient site of surgery appropriate to their clinical needs. The difference in update factors and application of separate ASC scaling causes the national (unadjusted) rates between the two systems to diverge, and applying two different wage indices causes rates between the two systems to diverge at the local level. CMS described the outpatient hospital setting as subordinate to the hospital in its rationale for applying the IPPS wage index and all of its adjustments to the OPPS. The ASC payment system is likewise subordinate to the OPPS and policies applicable under the OPPS should apply to the ASC setting. As such, we urge CMS to adjust ASC payments using the wage index values applied to hospital outpatient payments as published in the Tables 4A and 4B of the inpatient hospital PPS rule. CMS should also apply the out-commuting adjustment to ASCs in qualifying counties, as it does for non-PPS hospitals. Using the pre-floor, pre-reclassification wage index for ASCs is inconsistent with the principle of aligning the two payment systems.

A. Regulatory decisions related to application of the wage index

All of the adjustments to the hospital wage index discussed below are established under section 1886(d) of the Social Security Act, the inpatient hospital section of the statute. No analogous adjustments are provided under the outpatient hospital payment section of the Act, section 1833(t). When CMS proposed rules to implement a prospective payment system for hospital outpatient services in 1998, the agency (then the Health Care Financing Administration) discussed its options for applying an adjustment for geographic variation in local input prices. The agency decided to use the IPPS hospital wage index, rather than another type of geographic adjustor because of the nature of the outpatient department as a unit of the hospital.[5]

If CMS noted in the August 23, 2006 OPPS-ASC proposed rule that there is a "significant overlap between surgical procedures furnished in hospital outpatient setting and those performed in ASCs." In geographic markets with ASCs and hospitals, the two providers compete directly to employ their nurses and administrators, whose functions and skills are applicable to both settings given the significant overlap in the types of services provided. Equitable treatment through the geographic adjustment is necessary to fairly compensate all providers in a market competing for staff qualified to provide services in the hospital outpatient department.

B. Adjustments denied to ASCs and the impact on payments

CMS calculates the "pre-floor, pre-reclassified hospital wage index" using hospital cost report and occupational mix data from the most recent complete year of data available. In establishing the inpatient hospital wage index, Congress has directed CMS to apply several policy adjustments to address market-specific or provider-specific competition for labor. CMS has used its administrative authority to apply these adjustments to the outpatient hospital setting and should likewise apply them to payments made under the ASC payment system. ASCs are not

[5] Health Care Financing Administration, Department of Health and Human Services. 1998. Medicare Program; Prospective Payment System for Hospital Outpatient Services; Proposed Rules. *Federal Register* 63, No. 173: 47551-48036.

seeking a process for reclassification, but believe the following adjustments applied under the IPPS and OPPS systems should likewise be applied to the ASC wage index:

- imputing a statewide rural area wage index for states with no counties outside of an urban area,
- preventing the wage index of any urban area from falling below the statewide rural area wage index (including an imputed floor),
- preventing the wage index of an urban area crossing state lines from falling below the state-specific rural floor, and
- applying an adjustment to the wage index for certain counties where a significant proportion of residents commute to other high wage index counties for work

By applying these policies only to the hospital setting, the agency creates a higher wage index for hospital outpatient services as compared to ASC services in many parts of the country, even though these services are delivered in the same geographic area as ASC services in many parts of the country. These policies keep the hospital payments higher than they would be if the hospital wage index relied solely upon the wage and hour data of providers in their geographic core based statistical area (CBSA).

In all but a few instances, the adjustments applied to the hospital index result in a wage index value for a particular area that is higher than the pre-floor, pre-reclassified wage index used in the ASC payment system and has a substantial impact on the difference in payment between the ASC and the hospital outpatient department. Below is an illustration of how these policies affect payments for services in certain markets where ASCs and hospitals compete for labor.

Table 2. Proposed CY 2010 payment for Arthroscopy biceps tenodesis (29828)

		Wage Index		Payment		Ratio of ASC:HOPD	
Policy Adjustment	Geographic Area	OPPS	ASC	OPPS	ASC	Wage Index	Payment
Rural Floor	Wheeling WV-OH (OH providers)	0.8515	0.6876	$2,987	$1,625	81%	54%
Budget Neutrality	Connecticut	1.2236	1.1201	$3,719	$2,041	92%	55%
Imputed Floor	Wilmington, DE-MD-NJ (NJ providers)	1.1341	0.9641	$3,543	$1,891	85%	53%
Out-Commuting	Pine Co., MN*	1.0078	0.9182	$3,294	$1,847	91%	56%
* Reflects application of out-commuting adjustment of 0.0812 to rural MN index							
Values reflect final FY2010 IPPS wage index and proposed ASC CY 2010 wage index values							

The different wage index values between ASCs and hospital outpatient departments in the same market can create differentials in payments for the same outpatient surgical procedure in excess of 45 percent. These differences do not, however, reflect real differences in the cost of treating a patient in the ASC versus the hospital outpatient department. Using the hospital wage index will largely mitigate these market-level anomalies.

IV. Coverage and payment issues

A. Overview of procedure list issues

We appreciate the significant progress CMS has made in expanding beneficiary access to a broader array of surgical procedures at ASCs. However, we continue to believe that the agency should more fully align the procedure lists under the OPPS and ASC systems. We urge CMS to implement the following improvements:

- ***Addition of procedures to the ASC list.*** CMS should cover additional procedures that would not be excluded based on current ASC criteria.
- ***Coverage of unlisted procedures.*** CMS should eliminate the unlisted codes from the exclusionary criteria for the ASC list and instead provide ASCs an option to supply documentation to facilitate a contractor's review of the procedure consistent with coverage of unlisted procedures under the OPPS.
- ***Transparency in decision-making.*** CMS should identify the exclusionary criterion for all OPPS-eligible services not on the ASC list to enable the ASC community to provide meaningful comments on the agency's decision-making.
- ***Application of OPPS packaging policies on ASC services.*** The application of the OPPS packaging policies should not have the inappropriate effect of excluding procedural services from the ASC when the service otherwise meets CMS's coverage criteria. Further, ASCs should be able to receive payment for services reimbursed under the OPPS through composite APCs.
- ***Treatment of office-based procedures.*** CMS should not finalize new designations of procedures as office-based. The agency has only one year of claims experience and the volume of procedures proposed for new designation is extremely low in all ambulatory settings.
- ***Treatment of procedures with fixed device costs.*** In all services with fixed device costs, CMS's policies should institute policies to shield this portion of the payment from the wage index and the ASC conversion factor.

B. Additions to the ASC list for CY 2010

We applaud the agency's addition of 26 procedures to the ASC list for CY 2010 and concur with its assessment that these can be safely performed in an ASC without the need for an overnight stay. We appreciate the thorough review of the procedure list in the context of capturing relevant codes in each APC that can also be safely performed in the ASC.

For example, we were pleased CMS propose to add two codes for partial thyroid excision (60220, 60210). Neither service requires thrombolytic therapy or involves any major blood vessels. Blood loss as a result of the procedures is minimal. In a review of claims data on approximately 500 centers, we found that roughly 20% of partial thyroid excision cases involve patients over the age of 60. We look forward to the opportunity to offer these services to Medicare beneficiaries.

In addition to the procedures CMS proposes to add in this rule, we have identified several additional procedures that should be included for coverage. For example, we ask CMS to add CPT code 50593 for percutaneous cryoablation of renal tumor(s). This procedure is similar to CPT code 50592, which describes percutaneous radiofrequency ablation of renal tumor(s) and is currently covered in the ASC setting. The principal difference between these two procedures is the modality used for ablation. Both services are included in the same APC (0423), yet CPT 50593 is the only procedure in this APC not covered in the ASC setting. The procedure is compatible with CMS's safety criteria, and would not require medical monitoring beyond midnight.

We are also requesting addition of several codes representing laminectomies in the attached addendum. Many ASCs that specialize in spine procedures are already performing a significant volume of laminectomies on their commercially insured patients. The most common of these procedures are performed on the lumbar and cervical regions of the spine. The procedure generally lasts 60-90 minutes, and our data show that this is followed by a 4-hour recovery period. Patients are carefully screened before the ASC is selected as the appropriate site for their surgical procedure, a practice we would expect to see applied to the Medicare population as well. As the baby boomers age and stay active, we see a significant number of Medicare beneficiaries who are healthy, active, and appropriate candidates for laminectomy procedures in an ASC. Moreover, as technology and surgical techniques continue to improve these services will increasingly migrate to ambulatory settings. We ask the agency to add these procedures to the ASC list to enable patients and physicians to determine the most appropriate setting for their care.

The complete list of procedures we request to have added to the ASC list in 2010 is provided in a compendium at Addendum B.

C. Coverage of unlisted procedures

Under the OPPS, CMS allows providers to perform a procedure that is not described by a particular CPT code. In this instance, the procedure is reported to the Medicare administrative contractor using an unlisted code. The contractor could immediately process payment or request additional documentation from the provider to justify and explain the service provided to a Medicare beneficiary. This process ensures that Medicare does not make payment for a service that would otherwise be excluded from payment and gives physicians in the HOPD the flexibility to utilize an innovative approach or employ new technology to perform a procedure otherwise reimbursed by Medicare. CMS should create an analogous process for ASCs to report and receive payment for unlisted procedures. This change would more closely align the agency's policies with the OPPS as well as ASC coverage policies used by commercial payors and many states, including state workers compensation programs.[6]

[6] For example, the Ohio Bureau of Workers Compensation allows providers to report certain unlisted codes using a modifier "-BR" (by report), signaling that additional documentation must be provided before payment will be made.

We recognize that this change will require CMS to remove unlisted codes from the exclusionary criteria for the ASC list at §416.166(c). We urge the agency to act expeditiously to strike the criterion. Instead, CMS should examine the many subsections of the CPT manual for which the agency has determined that all the specific CPT codes within the clinical group are safely performed in the ASC setting. When this is the case, we submit that the unlisted codes for such sections would not pose a safety risk. We will gladly provide additional documentation to the contractor per request as under the OPPS.

D. Transparency in decision-making

In order to provide meaningful comments to CMS on the agency's decision to exclude certain procedures from the ASC list, CMS must identify its rationale for exclusion. In many instances, clinical experts from the ASC setting believe that procedures would not violate any of the agency's exclusionary criteria. Absent the agency revealing its rationale, we are unable to provide additional information in response to their concerns about the safety of excluded procedures. We urge CMS to publish in this final rule (and in subsequent proposals) an addendum identifying which of the criteria triggers the agency's decision not to add the procedure to the list of covered ASC services.

CMS described several reasons for a procedure to be excluded from the ASC list in the regulations incorporated under §416.166(c). We ask CMS to use the exclusionary criteria from §416.166(c), listed below, to describe why a procedure remains excluded from the ASC setting.

1) Generally results in extensive blood loss
2) Requires major or prolonged invasion of body cavities
3) Directly involves major blood vessels
4) Is generally emergent or life-threatening in nature
5) Commonly requires systemic thrombolytic therapy
6) Typically requires active medical monitoring and care at midnight following the procedure

In addition to using standard criteria in selecting and excluding procedure, we request that CMS explains for each excluded procedure which criteria the agency believes would trigger exclusion from the ASC list. Such transparency will allow the industry to provide meaningful comment to CMS as the agency considers procedures for addition to the list in 2011 and beyond.

E. Application of OPPS packaging policies

i. Procedures bundled into services outside of the CPT surgical code range

As CMS has expanded the payment bundle under the OPPS, the agency has frequently combined surgical and non-surgical procedures that were previously separately payable into a single unit of payment. ASCs are accustomed to operating under a large payment bundle, as was the case prior to 2008, and the expansion of the OPPS bundle does not generally affect the services that can be performed in an ASC. However, when CMS packages a previously "ASC-eligible" procedure

into a non-covered code (e.g. outside CPT 10000-69999) under the outpatient PPS, their OPPS policies have the unintended effect of excluding an ASC covered procedure from payment in the future. This change likely means that the procedure will remain in the HOPD rather than migrate to a less expensive site of care.

We urge the agency to reconsider this policy and allow ASCs to be paid for services outside the CPT surgical range when an ASC-eligible service is reported on the same claim and is integral to that procedure. The application of the OPPS packaging policies should not have the inappropriate effect of excluding procedural services from the ASC when the procedure otherwise meets CMS's coverage criteria. If a procedure was on the ASC list in 2007 or 2008, changes in the packaging policies should not remove that procedure and the other services integral to its performance from coverage under the ASC payment system.

ii. Use of composite APCs for ASC covered services

Under the OPPS, CMS has developed policies to improve the accuracy of payment for services that are frequently performed in a single hospital visit. In these instances, CMS has created composite APCs that correctly establish a median cost and corresponding OPPS relative weight for the services that occur in combination. CMS should establish a parallel process for ASCs to bill Medicare using the composite APC relative weight for these services.

The case of low dose rate (LDR) prostate brachytherapy is an example of two services that are typically performed together and should be paid as a composite. LDR prostate brachytherapy is a treatment for prostate cancer in which hollow needles or catheters are inserted into the prostate (CPT code 55875) followed by permanent implantation of radioactive sources into the prostate through the needles/catheters (CPT code 77778). A correctly coded claim should include, for the same date of service, codes for both needle/catheter placement and application of radiation sources, as well as separately coded imaging and radiation therapy planning services (that is, a multiple procedure claim). An accurate measurement of the cost of LDR prostate brachytherapy should be based on the median cost of the two services together. As a result, the agency created a composite APC (8001) to reflect the median cost of correctly coded claims.

Though the composite is an accurate measure for the cost of LDR prostate brachytherapy, CMS maintains OPPS weights for both services based on claims for the single services so that if they are provided separately hospitals can continue to receive separate payments for the individual services—though CMS acknowledges that most of the single-service claims for the implantation are incorrectly coded. CMS notes in the rule that "[w]e continue to believe that this composite APC contributes to our goal of creating hospital incentives for efficiency and cost containment, while providing hospitals with the most flexibility to manage their resources. We also continue to believe that data from claims reporting both services required for LDR prostate brachytherapy provide the most accurate median cost upon which to base the composite APC payment rate"(74 Fed. Reg. 35281, July 20, 2009).

Under the current system, ASC payments are derived from the OPPS rates for each service based on the single service claims. Basing ASC payments on OPPS rates based on unreliable data has

caused the rates for services like the implantation (CPT code 77778) to fluctuate over the years. Absent the option to bill for a composite code, ASCs can only use what CMS acknowledges to be incorrect coding. For LDR brachytherapy services and other services for which CMS has provided a composite APC, ASCs should have the opportunity to receive payment based on the relative weight of the composite APC to ensure that payments to ASCs represent CMS' most accurate projection of the relative cost of the service.

F. Procedures designated as office-based

CMS designates certain services as office-based and caps ASC payments for those services at the nonfacility practice expense RVU payment available to physicians. In both 2009 and 2010, CMS has proposed to add additional procedures to the list of office-based services. We urge CMS to revise its policies as follows:

- Establish a minimum volume threshold before designating a service as office-based.
- Raise the threshold for designating a service as "office-based" and use multiple years of data.
- Recognize the HOPD median cost data for procedures as the best proxy for relative ASC costs and limit the reduction in payment to ASC services designated as office-based.

We have argued in the past that current policy could prevent migration of services from the office into the ASC, but that ASCs have little interest in providing these low-complexity services. For patients requiring the level of care provided in the ASC, the financial penalty attached to these procedures likely means that many will remain in the higher-priced HOPD.

While physicians routinely perform these procedures on Medicare beneficiaries in the office setting, certain beneficiaries may require the additional infrastructure and safeguards of an ASC to maximize the probability of a good clinical outcome. Even when a procedure is frequently performed in an office there are circumstances when the office is an inappropriate or unavailable setting. These circumstances typically revolve around patient-specific factors and/or co-morbidities causing situations in which, for example, the patient cannot lie still, mental status or language barriers limit the ability to cooperate, anxiety issues cannot be addressed in the office setting, greater sterility is needed, or the surgical site cannot be anesthetized in the office. In other cases, specialized equipment is not available in the office or additional staff requirements preclude the office setting. Unless ASCs are an eligible alternative site of service in such instances, these procedures will have to be performed in a more costly hospital-based setting.

As we expected, the volume of ASC services designated as office-based was very low in 2008. Of the more than $3 billion spent on ASC services in 2008, less than one percent of payments were for services designated as office based. In addition, more than a third of the services designated as office-based were performed secondary to another procedure. As such, "migration" is not occurring, and capped services are often performed in addition to a more major procedure that would not have been done in the office setting. CMS' capping policy is merely a financial penalty to providers delivering care in an appropriate setting.

i. CMS should set a volume threshold before designating office-based procedures

CMS proposes to designate several new procedures as office-based in 2010 and to make permanent the designation of other temporary assignments. In many instances, the volume of the procedures across all three sites of service (ASC, HOPD, and office) is extremely low. As illustrated in the table below, CMS is proposing to newly designate as office-based services that were infrequently, if ever, performed in the ASC in 2008. In addition, the total volume of these procedures in the physician office is extremely low. The designation of extremely low volume services is unnecessary and inappropriate given the inherent volatility in the 50% threshold from year to year when total volume is so low.

Table 3. CMS office-based designation would not have meaningful budgetary impact

HCPCS	Short Descriptor	CY 2009 Payment Indicator	Proposed CY 2010 ASC Payment Indicator*	ASC Volume 2008	MD Office Volume 2008
15852	Dressing change not for burn	G2	R2	11	3444
19105	Cryosurg ablate fa, each	G2	P3	0	48
20555	Place ndl musc/tis for rt	G2	R2	0	142
36420	Vein access cutdown < 1 yr	G2	R2	0	2
50386	Remove stent via transureth	G2	P2	1	63
57022	I & d vaginal hematoma, pp	G2	R2	0	4

ii. CMS should raise the threshold for designating services as office-based and use multiple years of data

We continue to observe significant volatility in the distribution of procedures across the three ambulatory sites of service from year to year, particularly for services with low total volume. The volatility may be explained by other causes which likewise suggest that an inflexible threshold is inappropriate. By their very nature, site of service volume criteria are arbitrary. Past site of service volume criteria have proven problematic, primarily because their static nature has clashed with the dynamic and constantly evolving landscape of outpatient surgical care. The current site of service criterion limiting ASC payment for services performed 50% or more in the physician office fails to recognize the variation in practice patterns across the country, the varying sophistication of physician offices, and the adverse effect on beneficiaries' out-of-pocket costs if the service is performed in the hospital because it is not adequately reimbursed in the ASC setting. In addition, the capping policy uses site of service data that can be unreliable.

CMS uses a 50 percent threshold to determine which procedures should be designated as office-based. However, the agency is not required by the regulations to use 50 percent as the threshold for services "commonly performed" in the physician office. We urge CMS to use the flexibility

afforded by the regulations at section 416.171(d) to increase the threshold for designations in 2010 and beyond.[7]

Finally, we believe CMS should use multiple years of data to set the caps. As CMS considers designations for procedures, particularly low volume services, the review of multiple years of data is important to ensure that data anomalies or changes in practice patterns do not inadvertently affect payments to ASCs, as the difference in the physician office and OPPS rates can be substantial. Provision of these services in the ASCs is generally driven by patient acuity, and the higher acuity level indicates that payment should be made on the basis of the OPPS relative weights.

iii. CMS should recognize the OPPS relative weights as the best proxy for ASC costs

We continue to believe the OPPS median cost calculation is the most accurate assessment of the cost of procedures, particularly given the annual review of hospital cost data. Conversely, some of the RVUs that would apply to procedures designated as office-based have not been reviewed in several years. As more procedures are designated as office-based, the linkage between the ASC and OPPS rate-setting methodology will be eroded, injecting the ASC system with unpredictable inflation updates from the physician fee schedule and confounding relative weight scaling based upon changes in the median cost of hospital outpatient procedures.

In 2006, the GAO concluded that the median cost of most ASC services was strongly correlated to the median cost of HOPD services. In fact, GAO noted that 45 percent of all the procedures they reviewed fell within a 0.10 point range of the ASC-to-APC median cost ratio, and 33 percent of procedures fell within a 0.10 point range of the OPPS-to-APC median cost ratio. Given the absence of cost data from the ASC and physician office setting, GAO further concluded that the hospital data was the best source of relative weight information because it is updated annually.

Finally, CMS is deriving an ASC relative weight from the payment rates under the physician fee schedule. This means that the ASC weight for office-based procedures is subject to fluctuation in both the PE RVU value and the physician conversion factor. The problems with the physician conversion factor are well documented. Absent congressional intervention this year, physicians will face a 21 percent reduction in payments this year. As the policy community widely acknowledges that this is inappropriate, the agency should not subject another category of providers to an inherently flawed payment system. This volatility is unnecessary given the availability of the OPPS median cost data and the agency's wide latitude in determining how the ASC payment system is structured.

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[7] "...[F]or any covered surgical procedure under §416.166 that CMS determines is **commonly performed in physicians' offices** or for any covered ancillary radiology service, the national unadjusted ASC payment rates for these procedures and services will be the lesser of the amount determined under paragraph (a) of this section or the amount calculated at the nonfacility practice expense relative value units under §414.22(b)(5)(i)(B) of this subchapter multiplied by the conversion factor described in §414.20(a)(3) of this subchapter." (emphasis added)

We urge the agency to address the problems created by basing payment for many ASC services on the physician fee schedule in a future rulemaking. GAO demonstrated that the HOPD relative weights are the most appropriate proxy for the cost of ASC services and the linkage to OPPS should be maintained for as many ASC services as possible. In the interim, CMS should not finalize the new designations of procedures as office-based to limit the exposure of the ASC payment system to the vulnerabilities of the physician fee schedule.

G. Treatment of procedures with fixed device costs

CMS generally pays for ASC procedures that have high, fixed device costs using one of four payment methodologies indicated by payment indicator codes H8, J8, A2, and G2. We are concerned that payments using the agency's current methodology are often insufficient to encourage ASCs to provide device-related services, mitigating the amount of migration from the hospital outpatient setting that could save beneficiaries and taxpayers significant dollars. We recommend two adjustments to CMS's policies to improve the likelihood that these procedures will migrate from the HOPD to the lower cost ASC setting. First, CMS should not adjust the device portion of the payment by the wage index. This is consistent with the agency's policy for separately payable drugs and biologics. In addition, CMS should not apply the ASC conversion factor to the device-related portion of the payment for all procedures for which CMS can establish a median device cost regardless of whether they are designated as device intensive.

i. Application of the wage index

The Medicare wage index is intended to adjust the portion of a provider's payment subject to variation in local prices. However, CMS's application of the wage index to 50 percent of ASC rates often adjusts more of the payment for local price variation than is appropriate because devices frequently represent more than 5- percent of the procedure cost. Devices and expensive equipment used in surgical procedures are purchased on a national market. Regardless of the location of the ASC, the price is roughly the same. As such, the agency should not adjust the device-related portion of the payment by the wage index. The rationale is analogous to the agency's policy to not apply the wage index adjustment to payments for items like drugs and biologics. In markets where the wage index is low, CMS is underpaying for the cost of the device; likewise, the agency is likely paying too much in markets where the wage index is above 1.0.

ii. CMS should not apply the discounted conversion factor to the device-related portion of the payment

Like hospitals, ASCs have occasion to use expensive devices and operative supplies during certain surgical procedures. Unlike their general ability to achieve greater operational efficiencies than the HOPD, ASCs are unable to extract greater discounts on devices and expensive operative supplies than their hospital counterparts. Consistent with our discussion of the wage index application, ASCs costs for those devices is generally equal to, if not greater than, the prices paid by hospitals and incorporated in the APC median cost. We ask CMS to

exclude the portion of the ASC payment that is related to equipment and supplies from the conversion factor discount.

Unfortunately, many procedures with high fixed costs are not treated as device-intensive on the ASC list. As a result, the application of the ASC conversion factor sets payments too low for these services. If an ASC-approved procedure has fixed device costs that can be captured in the OPPS median cost data, the procedure should likewise be protected from the full application of the ASC conversion factor to account for the fixed cost of the device.

V. APC Panel Representation

As the ASC payment system uses the same APC assignments as the OPPS, the ASC industry should have input on the APC group and payment weights. The existing charter for the APC Panel requires representatives to be full-time employees of hospitals. However, the statute requiring the Secretary to consult with an outside group, Section 1833(t)(9)(A)[8], does not require that panel members be hospital employees. Since the charter for the APC Panel was first developed, ASCs have begun to use the APC groups and their relative weights for payment purposes.

The APC Panel is the advisory body responsible for recommendations to revise the APCs, evaluate procedures proposed for removal from the inpatient-only list, and review the packaging of device, drug, and procedure costs. As such, the industry has a keen interest in participating in panel discussions. We urge CMS to revise the APC Panel's charter and include representation from the ASC industry on the APC Panel as permitted by the statute. We believe it is appropriate to have ASC representation on this body to provide clinical and operational expertise on all of the settings that will be responsible for providing services paid on the basis of the APC groups and relative weights.

For example, we note that the APC panel considered issues related to neurostimulator implantation earlier this year. ASCs offer these services to Medicare beneficiaries, and could have provided valuable insight regarding clinical and cost considerations, particularly with regard to newer technologies such as rechargeable neurostimulators.

VI. ASC Cost Reports

We appreciate the agency's discussion of cost reporting in the proposed rule and concur with its statement "that a new Medicare requirement for ASCs to submit cost data to the Secretary could be administratively burdensome for ASCs" (74 Fed. Reg. 35391, July 20, 2009).

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[8] Section 1833(t)(9)(A) Periodic review and adjustments components of prospective payment system.—
(A) … The Secretary shall consult with an expert outside advisory panel composed of an appropriate selection of representatives of providers to review (and advise the Secretary concerning) the clinical integrity of the groups and weights. Such panel may use data collected or developed by entities and organizations (other than the Department of Health and Human Services) in conducting such review.

In addition to being administratively burdensome, ASC cost reports are also unnecessary. The use of OPPS relative weights removes the need for resource use measurement in ASCs. A similar conclusion was reached in 2006 by GAO, which they determined that the OPPS relative weights were a good proxy for relative ASC costs. Further, since the ASC conversion factor was established on the basis of budget neutrality rather than an estimate of the difference in costs between the two systems, cost reporting would be burdensome to providers and CMS without producing any policy-relevant findings.

VII. Quality

Reliable quality information enables transparency and performance improvement. The ASC industry has historically used quality information for internal use, accreditation, and licensure and has sought to engage CMS to develop a quality reporting system for outpatient surgical services. The foundation for a national, voluntary quality reporting system is strong. The ASC Quality Collaboration gathered clinicians, measurement experts, and industry leaders together to review the evidence base, identify best practices, and develop relevant quality measures. We fully support the comments submitted by the ASC Quality Collaboration and the measures they have developed. We echo its comments and attach them to our letter in Addendum C.

We are seeking a system that incorporates facility-level quality measures appropriate to the ASC setting and empowers consumers to consider all of their options for outpatient surgery with ASC-hospital outpatient department comparisons. We encourage CMS to take the necessary steps to expeditiously implement a quality reporting system by 2010.

In order to achieve maximum participation, CMS should ensure that any quality reporting system implemented does not create significant administrative burden on the ASC community. We strongly recommend the use of administrative claims as a means for quality reporting. Both chart abstraction and internet-based reporting would impose major disadvantages for ASCs, most of which are classified as small businesses. Instead, we recommend that the agency include HCPCS Level II G codes and AMA Category II CPT codes in the quality reporting system. This will allow the ASC community to use existing systems to meet the new requirements.

Finally, public reporting supports consumers. We recommend that CMS ensure the availability of fair and accurate quality data to consumers. The agency should report quality information in a way that enables consumers to compare data across settings. Providers should have the opportunity to address issues with any information prior to publication. For validity and thorough context, providers of surgical services should also have the opportunity to provide further information regarding each measure. We also recommend that CMS make other information, such as facility licensure and accreditation, available in the public reports.

* * *

We appreciate the agency's consideration of our comments on behalf of the ASC community. Throughout our comments, we urge the agency to make every effort to fully align the ASC and HOPD payment systems. The most important elements of this alignment are the application of the OPPS market basket adjustment and the elimination of the second scaling of ASC relative weights. Continuing policies that permit ASC and HOPD rates to drift further apart erodes the integrity of the connection between the two systems and will inhibit migration of services into the less expensive ASC setting.

Thank you for considering our comments. If you have any questions or need additional information, we would be happy to assist you.

Sincerely,

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President

AmSurg Corp.
Christopher A. Holden
President & Chief Executive Officer

David Shapiro, M.D.
Florida Society of Ambulatory
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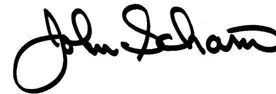

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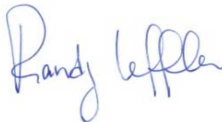

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President & Chief Executive Officer

ADDENDUM A

PREVIOUSLY PROPOSED ADJUSTMENTS TO CMS ALTERNATIVE BUDGET NEUTRALITY CALCULATION

Proposed Adjustments to CMS Alternative Budget Neutrality Calculation		
Starting Point	62.90	CMS's Calculation (This includes migration of HOPD at 25% for new procedures and migration from physician offices at 15% for new procedures.)
Change 1	+0.11	To accurately reflect ASC payment rates for procedures capped at HOPD rate if no new payment system in 2008
Subtotal	=63.01	
Change 2	+ 0.41	To include in the 2007 device costs that were paid to ASCs in addition to facility fees.
Subtotal	=63.42	
Change 3	+ 3.11	Net savings of reducing movement from physician offices; CMS assumed 15%; Coalition reduced to 2%
Subtotal	=66.53	
Change 4	+ 0.43	Correction to exclude beneficiary copayments for procedures subject to the physician office limit
Subtotal	=66.96	
Change 5	+1.04	Adjust for variable co-insurance in hospital by using total payment rates or by applying 20% co-insurance discount to all 2007 services in formula.
Subtotal	=68.00	
Change 6	+ 5.57	Net savings of positive migration from HOPDs for procedure on the ASC list. Assume that for every 10% increase in reimbursement rate, 1.5% of HOPD volume moves subject to maximum of 25% of HOPD volume or 25% increase in ASC volume if more than 4,600 procedures are performed in ASCs annually.
Subtotal	=73.57	
Change 7	-0.51	Net cost for negative migration from ASC to HOPD. Assume that for every 10% decrease in ASC reimbursement, 1.5% of ASC volume moves from ASC to HOPD.
Total	=73.06	Final conversion percentage after seven changes made to original CMS alternative model

ADDENDUM B

PROPOSED ADDITIONS TO THE ASC PROCEDURE LIST

HCPCS	Description
27485	Arrest, hemiepiphyseal, distal femur or proximal tibia or fibula (eg, genu varus or valgus)
29867	Arthroscopy, knee, surgical; osteochondral allograft (eg, mosaicplasty)
29868	Arthroscopy, knee, surgical; meniscal transplantation (includes arthrotomy for meniscal insertion), medial or lateral
35470	Transluminal balloon angioplasty, percutaneous; tibioperoneal trunk or branches, each vessel
35474	Transluminal balloon angioplasty, percutaneous; femoral-popliteal
35493	Transluminal peripheral atherectomy, percutaneous; femoral-popliteal
35495	Transluminal peripheral atherectomy, percutaneous; tibioperoneal trunk and branches
50593	Ablation, renal tumor(s), unilateral, percutaneous, cryotherapy
52649	Laser enucleation of the prostate with morcellation, including control of postoperative bleeding, complete (vasectomy, meatotomy, cystourethroscopy, urethral calibration and/or dilation, internal urethrotomy and transurethral resection of prostate are included if performed)
63001	Laminectomy with exploration and/or decompression of spinal cord and/or cauda equina, without facetectomy, foraminotomy or discectomy (eg, spinal stenosis), 1 or 2 vertebral segments; cervical
63005	Laminectomy with exploration and/or decompression of spinal cord and/or cauda equina, without facetectomy, foraminotomy or discectomy (eg, spinal stenosis), 1 or 2 vertebral segments; lumbar, except for spondylolisthesis
63020	Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc, including open and endoscopically-assisted approaches; 1 interspace, cervical
63030	Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc, including open and endoscopically-assisted approaches; 1 interspace, lumbar
63035	Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc, including open and endoscopically-assisted approaches; each additional interspace, cervical or lumbar (List separately in addition to code for primary procedure)
63040	Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc, reexploration, single interspace; cervical
63042	Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc, reexploration, single interspace; lumbar

ADDENDUM B, continued

63045	Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s], [eg, spinal or lateral recess stenosis]), single vertebral segment; cervical
63047	Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s], [eg, spinal or lateral recess stenosis]), single vertebral segment; lumbar
63048	Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s], [eg, spinal or lateral recess stenosis]), single vertebral segment; each additional segment, cervical, thoracic, or lumbar (List separately in addition to code for primary procedure)
0213T	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with ultrasound guidance, cervical or thoracic; single level (released 7/1/09, implemented 1/1/10)
0214T	second level. (List separately in addition to code for primary procedure) (released 7/1/09, implemented 1/1/10)
0215T	third and any additional level(s) (List separately in addition to code for primary procedure) (released 7/1/09, implemented 1/1/10)
0216T	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with ultrasound guidance, lumbar or sacral; single level. (released 7/1/09, implemented 1/1/10)
0217T	second level. (List separately in addition to code for primary procedure) (released 7/1/09, implemented 1/1/10)
0218T	third and any additional level(s). (List separately in addition to code for primary procedure) (released 7/1/09, implemented 1/1/10)

ADDENDUM C

COMMENTS SUBMITTED BY THE ASC QUALITY COLLABORATION