Nancy-Ann Min DeParle, Administrator
Health Care Financing Administration
Department of Health and Human Services
Hubert H. Humphrey Building, Room 309-G
200 Independence Avenue, SW
Washington, DC 20201

Attn: HCFA-1885-P; RIN0938–AH81

Subject: Medicare Program; Update of Ratesetting Methodology, Payment Rates, Payment Policies, and the List of Covered Surgical Procedures for Ambulatory Surgical Centers Effective October 1, 1998; Proposed Rule

Dear Ms. DeParle:

The American College of Physicians–American Society of Internal Medicine (ACP–ASIM) appreciates the opportunity to provide comments and recommendations on the above proposed rule related to payment and coverage for services performed in Medicare-certified Ambulatory Surgery Centers (ASCs). Our primary objective is to assure that the quality of patient care is not compromised by allowing payment incentives to influence site of service decisions for outpatient surgical services.

Following is a more detailed discussion of our concerns and related recommendations.

1. <u>HCFA should assure outpatient surgical services are provided in the most medically appropriate setting, eliminating financial considerations as a basis for site of service selection.</u>

ACP–ASIM supports HCFA's goal of achieving a level playing field for outpatient surgical services, and strongly believes that payment rates for different sites of service should not create incentives for patients or physicians to choose one site over another. The decision to use an ASC or hospital outpatient department (HOPD) should be based solely on clinical considerations and the best interest of the patient, without regard to which setting results in the highest Medicare reimbursement or the lowest beneficiary copayment.

The Medicare Payment Advisory Commission (MedPAC), in its June 1998 *Report to Congress: Context for a Changing Medicare Program*, noted that under the present ASC and HOPD payment systems, financial incentives are among the factors that influence where ambulatory care is provided. ACP–ASIM believes this problem will be exacerbated by the magnitude of payment reductions contemplated in the proposed rule, combined with the delayed implementation of the hospital outpatient prospective payment system (PPS), creating even greater financial incentives to shift procedures from ASCs to HOPDs, even when an ASC is clearly the clinically superior choice.

To safeguard against such inappropriate shifts in setting, the MedPAC Report urges HCFA to closely monitor site of service selection among ASCs and HOPDs. ACP–ASIM endorses this recommendation, and considers it a crucial step in the transition to HOPD PPS, especially in light of the fact that most of the cost data used to establish the 105 APCs in the proposed rule is outdated or incomplete, as discussed below.

Most of the facilities which participated in the *Medicare Ambulatory Surgical Center Payment Rate Survey* reported calendar year 1993 data--data which is five years old and which predates significant growth in Medicare spending for ambulatory care services in recent years. Moreover, HCFA had inadequate data for 64 of the 105 APCs in the proposed rule, and thus was forced to extrapolate payment rates for these 64 APCs. This means nearly two-thirds of the payment classifications in the proposed rule are not based on actual data, but simply HCFA's best estimate of the appropriate payment rate. Given this fact, we believe that a delay in the implementation of the proposed rule is warranted in order to allow the medical specialty societies time to evaluate the proposed rule using more reliable HOPD cost report data developed in connection with the outpatient PPS proposed rule, as well as their own independent data sources.

2. <u>HCFA should expand the new criteria for the ASC list to include office-based procedures where clinically appropriate.</u>

ACP–ASIM believes that the physician, in consultation with the patient, is in the best position to determine which setting is most appropriate for performance of a particular procedure. We thus fully support HCFA's decision to remove the 90-minute operating time/four hour recovery time regulation and other site of service criteria for adding or deleting procedures from the ASC list, including its policy of excluding ASC coverage for services which are performed (1) on an inpatient basis 20 percent of the time or less, or (2) in a physician's office 50 percent of the time or more. When first implemented in the 1980s, HCFA no doubt viewed these standards as reasonable interpretations of Section 1833(i)(1) of the Social Security Act (SSA), which limits the Medicare ASC list to procedures which are Aappropriately performed on an inpatient basis "but which also Acan be performed safely on an ambulatory basis" in an ASC. The statutory language is broad enough, however, to permit a more expansive approach to what can be covered in order to reflect the capabilities of the modern ASC.

For example, the 90-minute operating time limit reflects an outdated concept of what "can be safely performed on an ambulatory basis". With the development of short-acting general anesthetics, the length of operating time no longer has any bearing on whether a procedure is appropriately performed in an ASC. Similarly, the 20/50 site-of-service criteria was based on an outdated interpretation of what is "appropriately performed on an inpatient basis". Although surgical procedures historically moved from inpatient settings to outpatient settings, this is no longer the case. Today, certain procedures never need to be performed on inpatients before they can be safely performed on an outpatient basis. Under HCFA's old standards, however, such procedures would never reach the 20 percent inpatient criteria and, thus, would never qualify for inclusion on the ASC list.

ACP–ASIM believes that the statute is broad enough to permit the ASC list to include procedures that are ordinarily performed in an office setting, but that require the more extensive

facilities and services of an ASC to accommodate the special health needs of a patient. The addition of this criterion to Section 416.22(a) of the proposed rule would allow Medicare beneficiaries who are medically unstable, and for whom an office would not be a safe setting for even simple surgery, to have access to an ASC as alternative to the hospital.

3. HCFA should use the CPT Editorial Panel and Relative Value Update Committee (RUC) processes, as well as its own Coverage and Analysis Group, to generate updates to the ASC list.

Section 1833(i)(1) of the SSA requires that HCFA consult with appropriate trade and professional organizations in specifying the procedures that constitute the ASC list. In this regard, ACP–ASIM urges HCFA to rely on the CPT Editorial Panel process and and RUC process for information on new surgical procedures which should be added to the ASC list and the appropriate APC groupings for such procedures. In particular, in connection with the annual updates to the Medicare physician fee schedule, the RUC is proposing to develop practice expense relative value recommendations that will include data collection on the supplies, equipment and other resources required to perform new procedures. We believe that this information will prove helpful in grouping these procedures into the appropriate APCs.

With respect to Section 1833(i)(1)'s requirement for a biennial review and update of the ASC list, ACP–ASIM believes that the addition and deletion of procedures to and from the ASC list essentially involves coverage decisions best performed by HCFA's Coverage and Analysis Group, in consultation with practicing physicians. We understand that this Group is currently developing a new process for making national Medicare coverage decisions. As HCFA develops its plans, ACP–ASIM urges the agency to include decisions about coverage in ASCs as part of this process and to continue its recent efforts to obtain input from practicing physicians, particularly the national medical specialty societies and the AMA, in making Medicare coverage decisions. It also is important HCFA devote sufficient resources to the Coverage and Analysis Group to allow effective implementation and operation of the process under development.

ACP–ASIM greatly appreciates your consideration of the foregoing comments and recommendations. If you should have any questions related to this correspondence, please direct them to our Director of Managed Care and Regulatory Affairs, Mr. John DuMoulin at (202) 261-4535.

Sincerely,

Alan R. Nelson, MD, FACP
Associate Executive Vice President

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