



August 31, 2010

Donald Berwick, MD, MPP, FRCP
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1503-P
P.O. Box 8013
Baltimore, MD 21244-8013

CMS 1504-P – Medicare Program; Proposed Changes to the Hospital Outpatient Prospective Payment System and CY 2011 Payment Rates; Proposed Changes to the Ambulatory Surgical Center Payment System and CY 2011 Payment Rates; Proposed Rule

Dear Dr. Berwick:

On behalf of the American College of Gastroenterology (ACG), the American Gastroenterological Association (AGA), the American Society for Gastrointestinal Endoscopy (ASGE) and our 18,000 physician members specializing in digestive diseases, we are pleased to comment on CMS's proposed rule CMS-1504-P, published on Aug. 3, 2010 in the *Federal Register*, regarding proposed changes to the hospital outpatient prospective payment system (HOPPS) and ambulatory surgical center (ASC) payment system for CY 2011.

Background

The ASC is an important part of the practice of gastroenterology, providing a safe, patient friendly and cost effective environment for the provision of medical services, such as colorectal cancer screening, for patients of all ages. The majority of ASCs in which gastroenterologists practice are single specialty centers. According to a 2009 study prepared by KNG Health Consulting, LLC, of the more than 5,000 ASCs in the United States, 24 percent specialize in just gastrointestinal procedures. Because of their single specialty structure, gastrointestinal ASCs are particularly sensitive to changes in Medicare payments.

The same study showed that gastrointestinal services continue to migrate from the hospital outpatient department (HOPD) to ASCs. ASCs increased their market share for gastrointestinal services to almost 37 percent in 2007, an increase of 19.4 percentage points from 2000, with most of the growth coming from HOPDs. If Medicare reimbursement for gastrointestinal services in the ASC setting continues to lag behind the true costs of care, it is predictable that cases will shift back to the hospital at a greater cost to patients and to the Medicare program. While the Patient Protection and Affordable Care Act (ACA) waives the coinsurance for diagnostic colonoscopies, the taxpayers who fund the Medicare program shoulder the nearly \$250 price difference when a colonoscopy is performed in the HOPD versus the ASC.

Colonoscopy has historically been an important factor in the growth in ASC gastrointestinal services. In some states, more than half of all colonoscopies are performed in ASCs. Growth in colonoscopies for the purposes of colorectal cancer screening is important from a public health perspective since colorectal cancer is preventable, yet remains the second leading cause of cancer deaths in the United States. According to the Centers for Disease Control and Prevention (CDC), the prevalence of up-to-date colorectal cancer screening in the United States continues to increase, but 22 million adults who meet the recommended guidelines for screening have not yet been screened. According to the CDC, there are notable geographic differences in colorectal cancer screening prevalence. While the exact reasons for these geographic differences are unknown, screening capacity and lack of physician availability have been proposed as reasons. It is critical that the ASC remain a viable setting for Medicare patients to receive colonoscopies and other gastrointestinal services, especially given the demand for screening colonoscopies that is expected to follow the preventive services benefits included in the ACA. For ASCs to remain a viable health care delivery setting, costs must be appropriately recognized and reimbursed.

There are a number of provisions in the proposed rule that impact practicing gastroenterologists and the Medicare beneficiaries they treat. Our comments will focus on the following issues:

- Upper GI CPT code reassignment within the APC system (APC 0141/0422)
- Reassignment of 43240 (Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with transmural drainage of pseudocyst from APC 0141 to APC 0384, GI Procedures with Stent)
- Wage Index
- Secondary Rescaling of APC Relative Weights for ASCs
- ASC Conversion Factor and Productivity Adjustment
- Extension of Waiver of Deductible to Services Furnished in Connection with or in Relation to a Colorectal Cancer Screening Test that Becomes Diagnostic or Therapeutic
- Cost Reporting
- Reporting ASC Quality Data

Upper GI CPT code reassignment within the APC system (APC 0141/0422)

In this proposed rule, CMS is proposing a change in APC category for several upper GI CPT codes affecting APCs 0141 and 0422. Specifically, CMS proposes to reassign CPT code 43242 “Upper gastrointestinal endoscopy with transendoscopic ultrasound-guided intramural or transmural fine needle aspiration/biopsy(s) (includes endoscopic ultrasound examination of the esophagus, stomach, and either the duodenum and/or jejunum as appropriate)” from APC 0141 to APC 0422. In addition, three other codes - 43216 (Esophagoscopy, rigid or flexible; with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps or bipolar cautery), 43510 (Gastrotomy; with esophageal dilation and insertion of permanent intraluminal tube (eg, Celestin or Mousseaux-Barbin)), and 43870 (Closure of gastrotomy, surgical) were also moved from APC 0141 to APC 0422. These three codes are of much lower claim volume than 43232.

We believe CMS’s proposal is inconsistent with its own imperative to maintain resource and clinical homogeneity in the APC categorization of services. Therefore, our societies are recommending creation of a new Upper GI APC. As a result, there would be three levels of GI APCs for the consideration of CMS.

It is essential that APCs are structured appropriately so procedures may be performed in the hospital outpatient setting with adequate reimbursement without large losses on items such as catheters and other devices. Hospitals that continue to take losses on certain procedures cannot sustain providing these procedures, which will likely result in access problems to medically necessary procedures for Medicare beneficiaries. We feel the restructuring of the current APCs to three upper level GI APCs provides an appropriate solution that will allow appropriate reimbursement for gastroenterology procedures and will allow CMS to protect beneficiary access to medically beneficial procedures. Our proposal is also in line with CMS's intention of properly structuring APCs; namely, resource homogeneity, clinical homogeneity, provider concentration, frequency of service, and minimal opportunities for upcoding and code fragmentation.

The result of the 2011 proposed rule reassigning one of the six upper endoscopic ultrasound (EUS) procedures (code 43242) from APC 0141 to APC 0422 would be a higher facility payment for CPT 43242. Yet, it would leave the other five similar EUS codes (CPT codes 43231, 43232, 43237, 43238 and 43259) in APC 0141 with a lower payment because these remaining codes do not meet the two-times rule, although they have high median cost compared to the remainder of the APC codes. This creates a potential and inappropriate opportunity for upcoding for the remaining five EUS procedures in APC 0141, which CMS states it wishes to avoid.

Therefore, we recommend the creation of a new Upper GI APC as described below. Creation of this new APC would bridge the significant cost gap between APC 0141 and APC 0422, segregate the upper GI endoscopy code family by resource utilization (median cost data, using CMS methodology) and determine appropriate natural breaks in the data in order to differentiate codes between level I (APC 0141), level II (new), and level III (APC 0442).

Further, all EUS codes are moved to the new level II APC category, achieving more resource homogeneity and clinical homogeneity for this group and eliminating the opportunity for upcoding in EUS services.

UPPER GI LEVEL I (APC 0141)

CPT	Proposed APC	Single Frequency	Mean Cost	Median Cost
43999	0141	1319	\$608.56	\$349.44
43761	0141	363	\$559.42	\$505.32
43235	0141	69,833	\$580.35	\$509.47
43200	0141	995	\$800.06	\$558.99
43239	0141	251,792	\$667.02	\$603.77
43234	0141	414	\$706.88	\$623.31
43248	0141	17,095	\$713.91	\$623.35
43247	0141	4,928	\$727.06	\$623.52
43236	0141	2,983	\$708.61	\$636.14
43202	0141	433	\$915.71	\$642.76
43241	0141	156	\$882.45	\$650.09
43600	0141	7	\$986.47	\$668.95
43243	0141	199	\$795.52	\$684.52
43204	0141	3	\$811.01	\$691.27
43499	0141	464	\$2,304.74	\$1,915.67

UPPER GI LEVEL II (new APC)

CPT	Proposed APC	Single Frequency	Mean Cost	Median Cost
43250	0141	1,055	\$847.14	\$725.40
43201	0141	72	\$1,092.75	\$726.68
*43240	0141	29	\$1,244.99	\$746.10
43251	0141	3,039	\$865.61	\$747.05
43458	0141	154	\$919.14	\$754.16
91111	0141	85	\$853.81	\$756.21
43231	0141	281	\$940.57	\$760.14
43259	0141	11,923	\$869.21	\$762.20
43237	0141	422	\$903.09	\$769.45
43205	0141	99	\$856.53	\$769.68
43246	0141	14,755	\$903.85	\$799.65
43215	0141	188	\$1,025.77	\$803.83
44100	0141	5	\$573.69	\$825.31
43255	0141	3,959	\$906.00	\$832.23
49446	0141	279	\$1,116.25	\$843.25
43244	0141	4,551	\$904.83	\$844.69
43249	0141	17,911	\$927.99	\$848.74
43217	0141	38	\$1,035.81	\$894.71
49440	0141	1,558	\$1,094.69	\$902.98
43245	0141	2,266	\$1,013.42	\$905.53
43220	0141	582	\$1,134.04	\$921.75
43226	0141	737	\$1,239.73	\$927.30
49441	0141	126	\$1,221.92	\$944.37
43238	0141	365	\$1,112.77	\$986.79
43232	0141	273	\$1,115.97	\$995.19
43258	0141	4,919	\$1,284.80	\$1,000.70
43227	0141	27	\$1,187.54	\$1,047.13
43242	0422	10,216	\$1,205.13	\$1,073.96

* CPT Code 43240- would be removed if reassigned to APC 0384 as proposed in the following section.

UPPER GI LEVEL III (APC 0422)

CPT	Proposed APC	Single Frequency	Mean Cost	Median Cost
43228	0422	1,602	\$1,976.58	\$1,823.53
43830	0422	168	\$1,866.46	\$1,868.20
43870	0422	108	\$1,594.24	\$1,509.17
43257	0422	57	\$1,511.43	\$1,367.73
43216	0422	16	\$1,506.87	\$1,328.88
C9724	0422	7	\$4,360.09	\$4,451.92
43510	0422	1	\$1,471.40	\$1,471.40

Creating a new Level II APC allows aggregation of codes according to resource homogeneity. The natural breaks are present in the median cost data for the upper GI codes as follows:

	APC	Median Cost (lowest)	Median Cost (highest)
Level I	0141	\$505	\$691
Level II	New	\$725	\$1,073
Level III	0422	\$1,329	\$1,868

Although we believe that the option presented above is preferable, a second option for CMS's consideration is to create a new APC category exclusively for the six upper endoscopy EUS codes (CPT codes 43231, 43232, 43237, 43238, 43242 and 43259).

Creating an APC for the upper endoscopy EUS codes satisfies a CMS imperative to achieve resource and clinical homogeneity and would also prevent upcoding of the five EUS codes that reside in APC 0141. The downside, however, is that this scenario permits significant resource heterogeneity within APC 0141, as there are a number of high cost codes that would remain in APC 0141. When those codes meet the two-times rule in the next few years, they would move to APC 0422 or to the new APC which would have an adverse impact on patients, limiting access for other codes in APC 0422 due to a lower facility payment that will result. In addition, an EUS-only option 2 was previously considered by CMS and rejected in the 2005 Final Rule. Therefore, we believe that an EUS-only option is less preferable than the proposal as described above.

Our societies recommend that CMS adopt the proposal to create a new APC for Upper GI Procedures which would bridge the significant cost gap between APC 0141 and APC 0422, segregate the upper GI endoscopy code family by resource utilization (median cost data, using CMS methodology), and determine appropriate natural breaks in the data in order to differentiate codes between level I (APC 0141), level II (new), and level III (APC 0442). We request that this change be implemented in the 2011 final HOPD/ASC rule.

Reassignment of code 43240 from APC 0141 to APC 0384

As discussed above, it is essential that APCs are structured appropriately so procedures may be performed in the hospital outpatient setting with adequate reimbursement without large losses on items such as catheters, devices, etc. Hospitals that continue to take losses on certain procedures cannot sustain providing these procedures, which will likely result in access problems to medically necessary procedures for Medicare beneficiaries.

In the performance of code 43240, *Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with transmural drainage of pseudocyst*, once a suitable site has been selected, a needle knife is used to burn through the gastrointestinal wall and enter the pseudocyst cavity. Under combined fluoroscopic and endoscopic visualization, a guidewire is advanced through the needle knife catheter and coiled into the pseudocyst cavity. The catheter is withdrawn leaving the wire in place. A biliary dilation balloon is then advanced over the guidewire and the tract between the gastrointestinal lumen and pseudocyst cavity is dilated, with the degree of dilation monitored by fluoroscopy. The balloon is deflated and then withdrawn leaving the guidewire in place. A stiffener tube is then advanced over the guidewire into the pseudocyst cavity. Under fluoroscopic and endoscopic guidance, a 10 French double pigtail stent is then placed across the gastrointestinal wall into the pseudocyst cavity carefully ensuring that the stent does not migrate completely into the pseudocyst

when released. To allow insertion of the stent, the guidewire and catheter must be removed. The catheter is then flushed with contrast material and the pseudocyst cavity is recannulated. Entry is confirmed by monitoring of contrast injection under fluoroscopy. When this is confirmed, a decision is made regarding placement of a second 10 French double pigtail stent or insertion of a nasocystic lavaging catheter.

Both pigtail and expandable metal stents, deployed under endoscopic and fluoroscopic guidance as described above, are used to achieve drainage of the pseudocyst.

APC 0384, GI Procedures with Stents, includes the following procedures:

CPT	Single Frequency	Mean Cost	Median Cost
43219	83	2,985.41	2,681.11
43256	764	3,322.75	3,124.51
43268	1,516	2,317.59	1,978.57
43269	4,608	2,006.59	1,726.90
44370	3	2,520.57	2,539.20
44379	1	1,523.36	1,523.36
44383	9	2,745.86	2,577.58
45327	2	5,363.28	5,363.28
45345	53	3,269.49	2,992.02
45387	72	4,077.84	3,633.07

Similar to the other procedures in APC 0384, performance of CPT code 43240 involves the placement of stents to achieve drainage of a pancreatic pseudocyst. Based on CMS’s intention of properly structuring APCs-- namely, resource homogeneity, clinical homogeneity, provider concentration, frequency of service, and minimal opportunities for upcoding and code fragmentation-- our societies recommend that code 43240 should be reassigned to APC 0384.

Our societies recommend that CMS adopt the proposal to reassign code 43240 from APC 0141 to APC 0384. We request that this change be implemented in the 2011 final HOPD/ASC rule.

Wage Index

We are disappointed that CMS continues to propose using the most recent available raw pre-floor and pre-reclassified hospital wage indices to adjust the labor portion of ASC costs. As has been requested in the past by the gastrointestinal community and other ASC stakeholders, **we ask that CMS use the same “adjusted” hospital wage indices for calculating ASC payments as it uses for the hospital outpatient prospective payment system (HOPPS) payments.**

Because ASCs and HOPDs provide the same types of services and compete in any given locality for the same nursing and professional staff, they should be paid using the same adjustment for geographic differences in costs. By continuing to use the pre-floor, pre-reclassified hospital wage indices to calculate individual ASC payments, it exacerbates at the local level the growing variation between ASC and HOPD payments – variation that will be more profound in some markets beginning next year due to a change in ACA that sets the hospital wage index at 1.0 for inpatient and outpatient services in “frontier states.”

Secondary Rescaling of APC Relative Weights for ASCs

For 2011, CMS proposes to again create relative weights for use in setting ASC payments through a secondary rescaling of the HOPPS relative weights. This rescaling occurs even though the APC relative weights are rescaled once for budget neutrality under the HOPPS rules. Because the relative weights for surgical services are increasing, the proposed secondary rescaling would provide a 9 percent cut in ASC reimbursement for 2011. Annual increases in ASC relative weights reflect real changes in the costs of providing surgical services to Medicare beneficiaries. However, the secondary rescaling process suggests inappropriately that these increases in relative weights do not reflect legitimate increases in ASC costs. The result is the further erosion of any logical link in the relationship of HOPD and ASC payments for the same set of services.

For 2011, ASC payments could fall below 57 percent of the HOPD payment if CMS implements the rule as proposed. Inevitably, this growing disparity will result in ASCs ceasing to provide those services for which Medicare no longer adequately reimburses. **We strongly urge CMS to use its administrative authority and not apply secondary rescaling to ASC relative weights in 2011.**

ASC Conversion Factor and Productivity Adjustment

Our societies are dismayed that CMS has again decided to use the consumer price index for urban consumers (CPI-U) as the update factor for calculating CY2011 ASC payments. We are particularly disappointed because there appears to be no strong policy rationale for continuing to use CPI-U and because continuing to use CPI-U is a significant factor to the growing divergence between ASC and HOPD Medicare payments. In fact, the Medicare Payment Advisory Commission (MedPAC) in its March 2010 report to Congress stated its concern that CPI-U may not reflect ASC cost structures and, therefore, the use of CPI-U may not be a reasonable proxy to measure changes in ASC costs. Replacing the CPI-U with the hospital market basket index would be good first step in more closely aligning ASC and HOPD payments as intended when the ASC payment system underwent revision. Furthermore, CMS provides no justification for maintaining its policy to use CPI-U as the update factor.

The hospital market basket is a much more appropriate measure of ASC cost inflation than an index measuring changes in the costs of goods and services purchased by consumers. The hospital market basket is used to adjust the hospital outpatient prospective payment system, and reflects the same types of operating costs faced by ASCs.

We believe the hospital market basket is a much more appropriate measure of ASC cost inflation based on two fundamental reasons:

1. Using the hospital market basket is necessary if the ASC payment system is to remain tied to payments under the hospital outpatient prospective payment system (HOPPS). ASC payment for an individual procedure is based directly on the weights assigned to surgical services under HOPPS.
2. The hospital market basket measures changes in the costs of goods and services purchased by hospitals. The goods and services purchased by ASCs are very similar. Whether an endoscopy is performed in a hospital outpatient department or an ASC, very similar supplies, equipment and labor are used to perform the service. When there are inflationary increases in medical supplies or nursing personnel purchased by hospitals, ASCs experience precisely the same cost increases.

For these reasons, we recommend that for 2011 and beyond, CMS modify its proposal and use the hospital market basket for ASCs in lieu of the CPI-U, which has no relationship to measuring changes in the costs of goods and services purchased by a health care facility.

When the 1.6 percent multifactor productivity (MFP) adjustment is applied to the 1.6 percent update, the result is a zero percent update for ASCs in 2011. The MFP adjustment, as defined in statute, is to be equal to the 10-year moving average of changes in annual economy-wide private nonfarm business MFP. The 10-year period should end with the applicable fiscal year, year, cost reporting period, or other annual period. **We believe transparency is needed concerning the assumptions underlying the projection of MFP and ask that CMS address this in the final rule so a better understanding can be gained about how CMS arrived at an MFP adjustment of 1.6 percent.**

MedPAC has recommended an ASC update of 0.6 percent for 2011. With the application of the MFP adjustment, the proposed update will fall below this recommended update. If CMS were to use the hospital market basket index and applied the MFP adjustment of 1.6 percent, ASCs would at least receive a small positive update of 0.8 percent. **We therefore urge CMS to update ASC payments beginning in 2011 using the hospital market basket index.**

Extension of Waiver of Deductible to Services Furnished in Connection with or in Relation to a Colorectal Cancer Screening Test that Becomes Diagnostic or Therapeutic

Our societies are pleased that certain cost barriers to colorectal cancer screening for Medicare beneficiaries have been lifted due to efforts by Congress. We hope that relieving beneficiaries of the financial responsibility of obtaining a colorectal cancer screening test will result in increased utilization beyond the current screening rate of 52 percent for this patient population. We also realize that to increase colorectal cancer screening rates, continued efforts are needed to educate providers about screening options and how they can increase patient compliance, such as through patient reminder systems.

Sec. 4104 of the ACA requires that effective Jan. 1, 2011, the deductible for colorectal cancer screenings be waived for Medicare patients regardless of the code that is billed for the establishment of a diagnosis as a result of the test, or for the removal of tissue or other matter or other procedure that is furnished in connection with, as a result of, and in the same clinical encounter as a screening test. However, as CMS notes in the proposed rule, “coinsurance would continue to apply to the diagnostic test and to other services furnished in connection with, as a result of, and in the same clinical encounter as the screening test.” The continued coinsurance requirement will impact a substantial number of Medicare beneficiaries who will be subjected to a post-procedure “shock” of learning that they must pay a coinsurance simply because they were responsible in getting screened and had a precancerous polyp removed.

We are frustrated with the inconsistent cost-sharing requirements for colorectal cancer screenings that become diagnostic or therapeutic. We believe it is confusing to Medicare beneficiaries and continues to serve as a deterrent to screening colonoscopy.

Sec. 4104 waives the beneficiary coinsurance for covered preventive services that have a grade “A” or “B” from the USPSTF. Colorectal cancer screening by colonoscopy or flexible sigmoidoscopy, which have a grade “A” from the USPSTF, are unique preventive services because when pre-cancerous polyps are detected they are removed at the same time, thus *preventing* colorectal cancer as opposed to detecting cancer at an early stage. **We believe that CMS should seek authority under Sec. 4104 of the ACA to waive coinsurance for a colorectal cancer screening regardless of the code that is billed for the establishment of a diagnosis as a result of the test, or for the removal of tissue or other matter or other procedure that is furnished in connection with, as a result of, and in the same clinical encounter as a screening test.**

At a minimum, we believe that CMS should reduce the financial burden on Medicare beneficiaries by waiving the coinsurance requirement for the increment of the procedure that is screening in nature. As a result, coinsurance would only apply to the diagnostic test and to other services furnished in connection with, as a result of, and in the same clinical encounter as the screening test.

Cost Reporting

While MedPAC continues to recommend that ASCs be required to submit cost data to CMS, we support CMS's decision in the proposed rule to not require ASCs to submit cost data in 2011. Furthermore, we agree with CMS that requiring ASCs to routinely submit cost data would be administratively burdensome because many ASCs are small and lack the personnel to perform the reporting. As our organizations have commented in the past, if ASCs were required to report cost data, the accuracy of the data could be questionable because of the varying types of services (single specialty, multispecialty) and cost structures among ASCs. Furthermore, the type of information that CMS might need to calculate costs for payment purposes is not likely to be maintained by the ASC in the format needed by the agency.

Reporting ASC Quality Data

We recognize that CMS has the authority to require ASCs to submit quality data and to impose a payment penalty for non-compliance. We appreciate that CMS is sensitive to the potential burden on ASCs associated with chart abstraction, particularly at a time when many ASCs, especially gastrointestinal ASCs, are adjusting to the negative financial impact resulting from the transition to a revised ASC payment system. We, therefore, support CMS's proposal to defer quality reporting for ASCs.

Our societies support quality measures that are both actionable and meaningful to gastrointestinal ASCs, and we want to be included in the development of those measures. We believe that by suggesting non-specialty specific measures as "starter" measures for ASC quality reporting (*patient fall in the ASC; patient burn; hospital transfer/admission; wrong site, side, patient, procedure, implant; prophylactic IV antibiotic timing; appropriate surgical site hair removal; surgical site infection; medication administration variance; medication reconciliation; and VTE measures: outcome/assessment/prophylaxis*), CMS recognizes the importance of a gradual and step-wise approach to ASC quality reporting. However, to apply these measures, many of which are surgical measures, to endoscopic services provided in the ASC setting is not only burdensome but unlikely to reflect quality or correlate with outcomes. Rather, more meaningful and relevant measures for gastrointestinal ASCs are needed. For example, such a measure could be one pertaining to sedation safety (rescue required, delayed recovery).

In addition to process and outcomes measures, we also believe that patient experience/satisfaction measurement is important to assessing the overall quality of care delivered in the ASC setting and will be most useful and understandable to Medicare beneficiaries when deciding where to receive care.

With respect to measure reporting, like hospitals and physicians, ASCs should be given more than one way to report quality data. Claims-based reporting will remain an important option in the near term, especially since ASCs are still limited in their use of electronic health records (EHR), and, in the future, registry-based reporting will become a reporting option for ASCs.

Conclusion

Many of the issues raised in these comments have been stated by our societies and other organizations since the beginning of the new ASC payment system. In the case of the gastrointestinal single specialty ASC, we fear there may be misconceptions about the structure, function and regulation of single specialty endoscopy centers. In the past, it has been suggested that ASCs experiencing a decline in revenue in one

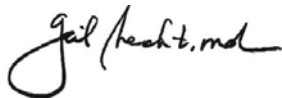
area simply expand services in another area. This may be an option for multispecialty centers, but this statement ignores the reality that state licensure and certificate of need regulations often define a limit on the services that a gastrointestinal ASC can provide.

We believe policies of this proposed rule will accelerate the migration of Medicare patients back into the HOPD, increase costs, decrease patient satisfaction, and delay or deny needed medical services, including life-saving colorectal cancer screening. These results are unnecessary since CMS has ample authority to make decisions that will continue to make GI ASCs viable and a choice for Medicare beneficiaries.

The ASC has been one of the most positive developments in the delivery of services to Medicare beneficiaries in the last 20 years. We are deeply concerned that CMS continues to make policy choices that clearly undermine the ability of ASCs to serve Medicare beneficiaries, particularly given strong patient preference for these centers and the compelling need to manage Medicare expenses more effectively. Congress granted CMS broad authority to establish a new and better payment system for all services provided in the ASC. We hope that CMS will utilize its authority in a way that enhances the ability of ASCs to provide services to Medicare beneficiaries.

Thank you for the opportunity to offer these comments. If we may provide any additional information, please contact Anne Marie Bicha, Director of Regulatory Affairs, AGA, at 240-482-3223, or abicha@gastro2.org; Brad Conway, Vice President of Public Policy, ACG, at 301-263-9000, or bconway@acg.gi.org; or Camille Bonta, consultant to ASGE at 202-320-3658 or cbonta@asge.org.

Sincerely:



Gail A. Hecht, MD, AGAF
Chair, American Gastroenterological Association



Philip O. Katz, MD, FACP
President, American College of Gastroenterology



M. Brian Fennerty, MD, FASGE
President, American Society for Gastrointestinal Endoscopy