

The **American Society for Gastrointestinal Endoscopy (ASGE)** is the primary voice on federal legislative and regulatory issues affecting endoscopic practice and patient care. This past year has been full of opportunities to move ASGE's agenda forward in Washington, D.C.

TRANSFORMING ASGE ADVOCACY IN 2008

REDEFINING ASGE ADVOCACY

In 2008, ASGE greatly expanded its federal advocacy program. ASGE has a long history of responding to proposed federal regulations, serving as a trusted resource for key Congressional leaders, lobbying for key issues on behalf of the membership and participating in a number of coalitions to advocate for our patients. However, the increasing complexity of the federal government required a stronger response. Under the leadership of the Health and Public Policy Committee, ASGE redefined its involvement in federal legislative and regulatory advocacy issues related to endoscopic practice and care to be even more proactive. Last year, the Governing Board approved policy statements on colorectal cancer screening, Ambulatory Surgical Centers (ASCs), endoscopic research, eliminating health disparities, electronic prescribing, imaging services, improving healthcare quality and efficiency, obesity, and physician ownership.

CREATING A GRASSROOTS NETWORK & TOOLS TO TAKE ACTION

The Legislative Action Network (LAN) was launched last summer at DDW. To date, more than 700 ASGE members participate in the LAN. The LAN members have already made the voice of ASGE heard on issues impacting endoscopy in 2008, including colorectal cancer screening, ambulatory surgery center payment, and the update in physician payment from Medicare. These members have sent over 2000 letters to members of Congress and made dozens of Hill Visits on behalf of ASGE physicians and patients. To aid ASGE members in their advocacy efforts, ASGE designed a Government and Advocacy Web page at www.asge.org, which provides a one-stop, comprehensive resource for members to learn about ASGE's advocacy positions on the latest legislative and regulatory issues that impact our members and the care they provide. In this new section of ASGE's Web Site, ASGE members can take action, visit the legislation and regulatory issue center, read monthly legislative updates, download grassroots education materials and review ASGE's advocacy agenda and policy statements.

MONITORING CHANGE IN WASHINGTON IN 2008-2009

PROMOTING EQUITABLE REIMBURSEMENT FOR ASCS

Ambulatory Surgical Center payment reform is a priority issue for ASGE. In 2008, the ASGE adopted an Ambulatory Surgical Center policy statement that supports "fair reimbursement for (ASC) facility services."

First Year of New Payment Structure

In January 2008, the Centers for Medicare and Medicaid Services (CMS) implemented a new payment structure for ASCs. This system linked the ASC payment rate to the Hospital Outpatient Department (HOPD) rate. ASCs continue to operate under the freeze on the annual inflation update until 2010. During the first year of the four-year implementation, ASCs were paid at a blend of the old and new payments systems, calculated at 65% of HOPD rates.

Upon implementation, ASGE continued to advocate for improvements to the new payment structure, including calculating the ASC annual inflation updates by the hospital market basket, which is used by all other sectors in health care, instead of the consumer price index. In the 110th Congress, Representative Kendrick Meek (D-FL) introduced the Ambulatory Surgical Center Medicare Payment Modernization Act of 2007 (H.R. 1823, S.2250), which would have set the ASC payment rates at 75% of the HOPD rates and calculated ASC annual updates using the hospital market basket. ASGE supported this legislation, but it expired in committee.

On the regulatory front, ASGE submitted comments to the CMS on the proposed ASC payment rule. In December, ASGE met with the Medicare Payment Advisory Commission (MedPAC) to urge them to recommend a payment update in 2010 for ASCs. MedPAC did recommend an update following that meeting. ASGE will continue to push CMS to adopt MedPAC's recommendation.

Second Year of New Payment Structure

In order to maintain budget neutrality in the Medicare program, in the second year of the payment transition CMS added a secondary "scaler" to the payment calculation. The scaler penalizes increased volume at ASCs, resulting in further reduction in payment for endoscopy services.

If maintaining budget neutrality in Medicare while allowing new procedures to be performed in ASCs is allowed to persist, GI services will continue to see a fall in payments. As a result, it will no longer be cost-effective for ASCs to provide GI services to Medicare patients, who will be shifted back to the more expensive HOPD. This migration will cause higher co-pays for patients and higher facility service fees for Medicare.

In April, Representative Meek introduced the Ambulatory Surgical Center Access Act of 2009 (H.R. 2049), which seeks to set the ASC payment rate at 59% of the HOPD rate. ASGE advocates strongly against this legislation. Currently, Medicare payment for GI services in the ASC is approximately 65% of the HOPD rate. ASCs have already seen a 17% reduction in payment since the 2003 freeze. While ASGE supports some provisions of H.R. 2049, such as the elimination of secondary scaling and moving to the hospital market basket as the annual inflation adjustment, tying ASC payment to 59% of the HOPD rate would exacerbate an increasingly negative situation for ASGE members that practice in an ASC. To date, ASGE has communicated these grave concerns to the primary sponsors of H.R. 2049 and activated its Legislative Action Network to urge other members of Congress not to support this legislation. Hundreds of letters have been sent to the Hill by ASGE members in opposition to H.R. 2049.

ASGE will continue to work with Congress and CMS to find alternative options for addressing the current ASC payment structure, because it is vital that Medicare patients continue to receive the same quality and timely services as private payer patients.

IMPROVING QUALITY IN CARE

Last summer, in coalition with the other GI societies, ASGE provided comments to CMS on the provisions regarding Hospital-Acquired Infections (HAIs) in the proposed FY 2009 Hospital Inpatient Payment System rule. The rule proposed to include *Clostridium difficile associated diarrhea* (CDAD) as a preventable HAI. After reviewing our comments and those of other societies, CMS decided not to include CDAD as an HAI in the final rule. The 2010 hospital inpatient proposed rule is again seeking public comment on adding CDAD as a proposed measure of HAIs. Again, ASGE will comment and recommend not adding a CDAD measure.

In August, the Government Accountability Office (GAO) requested an interview with ASGE experts to help identify data sources that could capture information on HAIs in the ASC setting. This interview was the result of a multi-phase study requested by Congress on Healthcare-Associated Infection (HAI) rates in institutional facilities. The ASC phase of this study was expedited due to the Nevada Hepatitis C incident. The GAO also asked ASGE experts to discuss issues related to infection control in GI endoscopy ambulatory surgical centers. ASGE leaders informed the GAO that the current high standards sufficiently address infection control in ASCs, but funding is insufficient for the reporting systems necessary for existing state and local public health systems. Additionally, ASGE told the GAO that the latent nature of viral infections, in which symptoms can occur weeks after exposure, obscures the identification of where and when the infection originated. ASGE informed the GAO that these infections can only be pinpointed through rapid reporting by providers who later see the infected patient, followed by prompt epidemiological investigation. Appropriate funding and support for these systems needs to be addressed.

The GAO released their ASC report on HAIs earlier this year. Several of ASGE's comments were highlighted in the report including the challenges ASCs face in collecting outcomes data. In conclusion, the GAO recommended that the Secretary of Health and Human Services develop and implement a written plan to use the data collection instrument and methods utilized in an ASC study by CMS, and pilot a plan to conduct periodic surveys of randomly selected ASCs. ASGE will continue to monitor this issue and collection of HAI data as it relates to endoscopy.

INCREASE FUNDING FOR COLORECTAL CANCER SCREENING

In the 110th Congress, ASGE supported a number of legislative vehicles that would increase screening and awareness for individuals within the recommended guidelines through both private payers and Medicare.

In 2008, Medicare increased the window during which Medicare beneficiaries could participate in the "Welcome to Medicare" benefit. The window for beneficiaries to undergo a preventive examination has increased from six months to twelve months.

ASGE wrote several comment letters to CMS and testified at the CMS' Medicare Evidence Development & Coverage Advisory Committee meeting urging Medicare to delay establishing a national coverage decision on CT Colonography (CTC) for colorectal cancer screening until more information has been published. As a result of the advocacy efforts of ASGE and many others, CMS decided to not cover CTC as a Medicare screening benefit at this time.

Tenth Annual National Colorectal Cancer Awareness Month

ASGE began laying the foundation last year to create a ground swell of activity on the Hill during National Colorectal Cancer Awareness Month in March. ASGE kicked off its month of awareness on the Hill by sending educational material on colorectal cancer screening and prevention to members of Congress. Several members of Congress used ASGE's resources to publish articles in their local newspapers. For the first time, ASGE sponsored a Capitol Hill briefing for legislative staff and members of Congress titled, *Colorectal Cancer Screening: Programs that Work*. The briefing highlighted effective programs that increase

screening in local communities to help reduce the incidence and death rates from the disease. ASGE's president, John L. Petrini, MD, FASGE, along with experts from the CDC, New York City Department of Health and Mental Hygiene and the other Gastroenterology societies presented. Colorectal cancer survivor and ARCA REMAX driver, Tim Mitchell, addressed the audience about his own battle with colorectal cancer.

In March, ASGE also announced its support for two colorectal cancer screening and prevention bills, H.R. 1330 and H.R. 1189, currently being considered by Congress.

The Colorectal Cancer Screening and Detection Coverage Act of 2009 (H.R. 1330) requires all health insurance plans to cover colorectal cancer screening for any beneficiary 50 years of age or older, and for those at high risk for colorectal cancer. The Colorectal Cancer Prevention, Early Detection, and Treatment Act of 2009 (H.R. 1189) establishes a national screening program at the CDC and provides states the option to provide medical assistance for those found to have colorectal cancer or colorectal polyps.

After the briefing, Dr. Petrini, other ASGE leaders, and cancer survivor Tim Mitchell participated in Hill visits to advocate in support of these two bills. In addition, ASGE activated its Legislative Action Network (LAN) to participate in call-in and letter writing campaigns in support of H.R. 1330 and H.R. 1189.

ASGE will continue its efforts to advance legislation that will increase colorectal cancer screening access and prevention.

AVERTING PHYSICIAN FEE SCHEDULE CUTS IN 2008-2009

In collaboration with other medical societies, ASGE helped to avert the 10% Medicare physician payment cut that was scheduled to be implemented on July 1, 2008. ASGE members sent more than 1200 electronic letters on this issue to Capitol Hill. ASGE created a Medicare Physician Payment Action Center on its Web site for members.

ASGE SUBMITS APPROPRIATIONS LANGUAGE TO CONGRESS

ASGE submitted proposed appropriations language to Congress that would help to advance patient care in endoscopy. ASGE members sent requests to members of the House and Senate Appropriations committees urging them to include language in their appropriations bills that would:

- direct funding to the Agency for Healthcare Quality and Research (AHRQ) to establish a 5-year demonstration project that provides grant funding to employ various community intervention programs to promote and aid in screening for colorectal cancer in underserved and minority populations;
- assign resources to National Institute of Diabetes and Digestive and Kidney Diseases to fund long-term, multi-center studies comparing bariatric surgery with endoscopic interventions and the durability of outcomes of these procedures to decrease obesity; and
- allocate resources to AHRQ to validate published quality measures relating to procedural services, and to identify procedural practices that are associated with improved patient outcomes.

ASGE will not know if these requests will be incorporated into the final appropriations bills until late summer. Nevertheless, ASGE will continue to advocate for the inclusion of this language with members of the House and Senate Appropriations Committees.

FTC RED FLAG RULE

The ASGE has been working in collaboration with the American Medical Association (AMA) and other medical societies to urge the Federal Trade Commission (FTC) to reverse its decision to view physicians as "creditors" under the Red Flags rule. On November 9, 2007, the FTC issued a final rule which requires financial institutions and "creditors" to develop and implement written identity theft prevention programs, as part of the Fair and Accurate Credit Transactions (FACT) Act of 2003. Although the final rule indicated that the identity theft prevention programs must be in place by November 1, 2008, the FTC has delayed implementation now on two occasions, most recently until August 1, 2009.

During this 3 month deferment, ASGE will continue to work with the AMA and other medical societies to convince the FTC and Congress that physicians are not "creditors" and, therefore, should not be subject to the rule.

PARTICIPATING IN HEALTHCARE REFORM

President Obama and Congress have made it clear that they plan to address healthcare reform during the 111th Congress. Initial healthcare reform proposals address several issues that are important to our members, such as linking payments to quality outcomes through PQRI and Maintenance of Certification (MOC) programs; transparency and appropriateness of imaging services; updating the sustainable growth rate (SGR); implementing health IT; improving quality measures; and comparative effectiveness research. ASGE will continue to follow the healthcare reform debate and monitor the legislative and regulatory priorities of the 111th Congress and the new Administration in order to identify opportunities to advance ASGE's advocacy agenda.

ASGE is working hard to ensure that our members' and patients' interests are being heard. **If endoscopy is your practice, ASGE is your partner** in establishing the value of GI endoscopy on Capitol Hill.

ASGE Advocacy Agenda for the 111th Congress

COLORECTAL CANCER SCREENING

ASGE supports legislation that would improve CRC screening benefits in all health plans.

AMBULATORY SURGICAL CENTER PAYMENT REFORM

ASGE supports legislation to increase Medicare reimbursement and access for endoscopy services performed in ASCs.

FUNDING ENDOSCOPIC RESEARCH

ASGE supports efforts to increase federal funding of basic and applied endoscopic research.

IMAGING SERVICES

ASGE supports legislation that would set appropriate reimbursement levels and allow full patient access for office-based diagnostic imaging services, regardless of specialty.

PATHOLOGY SERVICES

ASGE opposes efforts that would prohibit gastroenterology practices from entering into practice arrangements with pathologists or other specialists that would improve the quality of care given to patients.

COST EFFECTIVE MEDICAL CARE

ASGE supports efforts to identify and eliminate inefficiencies in GI practice.

PAY-FOR-PERFORMANCE

ASGE will work with payors to ensure that valid quality measures are developed with national medical specialty societies.

OBESITY

ASGE will collaborate with other medical societies and the government to combat obesity in the United States.

FOOD AND DRUG ADMINISTRATION

ASGE supports legislative and regulatory initiatives to improve the ability of FDA to review new drugs and devices on a timely basis.

2008-2009 Health & Public Policy Committee



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Join ASGE's Legislative Action Network at www.ASGE.org!