Submitter : Dr. William Fishkind, MD **Date:** 10/29/2006

Organization : Fishkind and Bakewell Eye Care and Surgery Center

Category : Individual

Issue Areas/Comments

ASC Payable Procedures

ASC Payable Procedures

October 29, 2006
Leslie V. Norwalk, Acting Administrator
CMS, Dept. HHS
Washington, DC
Dear Administrator Norwalk,
I am an owner of an ophthalmic ASC. I am writing about the recent CMS rule regarding a new ASC payment system and update of the ASC procedures list. I built my first ASC in 1990 after struggling with our major hospital to allow me to deliver a higher quality of care to my cataract and glaucoma patients. Our patients have been very happy about the more personalized service, the higher quality of care, and the lower costs at the Fishkind and Bakewell Ambulatory Surgery Center.
Linking ASC reimbursement to HOPD allowables at 62% is far too low. Historically, the ratio has been at least 75%; this is more realistic and fair.
Furthermore, the annual update should be linked to the same factor as HOPDs, the hospital market basket, not simply the CPI. Our costs (labor, drugs, and devices) are affected by the identical factors as the HOPD.
Whatever percentage is adopted, it should be uniform across procedures. There is no justification for favoring one specialty over another. Any differences in costs would presumably be reflected in the established HOPD allowables. Justice and simplicity require a single conversion factor for all ASC procedures.
We perform all ophthalmic laser procedures in our ASC. It is not reasonable to reimburse these procedures at the office expense rates. We utilize special anesthesia and nursing care in our ASC for these operations to provide a safer, more comfortable experience for our patients. These services should be included on the ASC list at the same, uniform facility reimbursement rate.
Finally, all procedures allowed in the HOPD should be provided for in the ASC procedure list. Other than the requirement for an overnight stay in the hospital, there is no rationale for any exclusion. This certainly applies to ALL ophthalmic operations.
Thanks very much for your consideration of these changes to the ASC rule under review. I would be happy to reply to any questions you might have.
Yours sincerely,
William J. Fishkind, MD, FACS
Co-Director
Fishkind and Bakewell Eye Care and Surgery Center
Tucson, AZ. 85704
Telephone 520 293-6740 x 109
President, Outpatient Ophthalmic Surgery Society (OOSS)

Submitter : **Dr. Vanessa Vu** **Date: 10/29/2006**

Organization : **ORegon Surgery Center**

Category : **Ambulatory Surgical Center**

Issue Areas/Comments

CY 2008 ASC Impact

CY 2008 ASC Impact

Dear Sir:
Since the 1970s, physiicians have developed ASC to improve patient care and safety. Physicians continue to provide the impetus for the development of new ASCs. In the ASC setting, physicians are able to schedule procedures more conveniently, are able to assemble teams of specially-trained and highly skilled staff, are able to ensure the equipment and supplies being used are best suited to their technique, and are able to design facilities tailored to their specialty.
The CMS Proposal to move the ASC payment system to the HOPD system is laudable. However, the conversion rate of 62% of HOPD rates raises issues of CMS aiding and abetting unfair business influences from the hospitals. In the marketplace, ASCs pay the same wages to their nurses and other employees and more for supplies because of their lower volume. This 62% of HOPD rates for ASCs would put the majority of the ASCs out of business. This would be a tremendous disservice to the patients and to each one of us and our family who eventually will need surgical care, 80% of the times in an ASC. Please ensure beneficiary access to a wide range of surgical procedures that can be safely and efficiently performed in the ASC. Please establish fair and reasonable payment rates to allow beneficiaries and the Medicare program to save money on procedures that can be safely performed at a lower cost in the ASC than the HOPD. In addition, please enact a Procedure list for ASC to include payment for any service not listed on the Inpatient Only List. The present CMS proposal would limit a physician s ability to determine appropriate site of service for a procedure excludes many surgical procedures appropriate for the ASC setting.

Thank you for your attention to this matter.

Sincerely,

Vanessa Vu, M.D.,Ph.D.

Submitter : Dr. Todd Leventhal **Date:** 10/29/2006

Organization : Berkeley Heights Eye Group

Category : Ambulatory Surgical Center

Issue Areas/Comments

GENERAL

GENERAL

My name is Todd Leventhal. I am an ophthalmologist practicing in New Jersey. I have only recently puchased a practice which included an in office Medicare Certified one room operating suite. I perform 95% of my cataract and glaucoma surgery in this setting. I perform 100%of my YAG capsulotomy surgeries here. My practice serves predominantly medicare patients (80-85%). Therefore, any decisions made by CMS regarding reimbursment significantly affects my ability to deliver high quality care. As practice expenses escalate and reimursements remain flat or decline a time will come when I simply will not be able to serve this population. I already have to make tough decisions regarding investment in new technology, including IT, with the steep cuts which are forcast.
The proposed update for ASCs is inadequate to meet the increasing expenses. Please do not continue to increase this pressure by reducing payments to ASCs.
The experience that patients have at my facility is universally preferred to the hospital. I offer patients the choice between the hospital that I have priveleges at and our office. All but one patient has elected to have surgery in my office operating room out of the last 775 patients that I have operated on. The one patient who elected the hospital had a relative who worked in the ambulatory surgery department there. Clearly we have the ability to deliver high quality care in a setting that is preferred and appreciated by patients. Moreover, the cost to CMS is significantly less than delivery of the same care in a hospital. Even with an update of 75% of the HOPD rate, CMS saves significant dollars. The proposed 62% rate simply will not allow ongoing investment in the highest possible care to be delivered to our seniors. Once this new rate is adopted it clearly should be applied equally to all ASC procedures. Please note that I believe that this rate should also apply to office-type procedures as well.
Once again, since current rules do not allow for annual cost-of-living updates for a prolonged period ASCs are constantly being put under escalating financial pressures as effective reimbursement is eroded by increasing cost of delivering care. Please consider this in making any decision regarding the new payment rate.
Thank you for your consideration of my remarks.
Todd Leventhal, M.D.

Submitter : Dr. Stephen Powell **Date:** 10/29/2006

Organization : Regional Eye Associates, Inc

Category : Ambulatory Surgical Center

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1506-P2-527-Attach-1.DOC

#527

P12/29/2006

Centers for Medicare and Medicaid Services
CMS-1506-P
Department of Health and Human Services
Attention: CMS-1506-P
P.O.Box 8011
Baltimore, MD 21244-1850

Dear CMS:

I am writing to you regarding the proposed regulation to establish a new ASC payment system and update of the ASC procedures list (CY 2008 ASC Impact).

Who We Are
Our small facility (Surgical Eye Center of Morgantown), utilizing only one of two ORs, has provided a full range of ophthalmic services to Medicare beneficiaries in our area for almost 10 years. Our estimate is that we have saved Medicare and Medicaid, close to $2,000,000 in payments by using our free standing facility in this ten year period. In addition to being the most cost effective center in the area, we also provide the highest possible quality of care, and are easily accessible to a large area. We have been the most successful joint venture with our community hospital of any physician – hospital cooperative effort in the area. This success is not measured in financial terms, but in the quality of care, efficiency and cost effectiveness of any similar service. Our patients continually rate us superior in various surveys 98% of the time.

Equity in Services Provided
ASCs should be permitted to furnish and receive facility reimbursement for any and all procedures that are performed in HOPDs. Now is the time with this opportunity to allow ASCs equal latitude of performing the same procedures allowed in HOPDs. The savings to Medicare will be very significant.

Outrageous Proposed Rate of 62% of HOPDs
Claiming Budget Neutrality to propose a 62% reimbursement rate will result in shutting down most of the small ASCs (ours included) that have been providing large savings to CMS already. Even at a rate of 75% (recommended by the ASC industry), it will be a stretch for our center to survive. It appears that the Hospital Association is in favor of this new lower rate (62%) as they know many ASCs will close, and they will then be able to provide the services at a much higher rate than ASCs do – and this would be under Part A Medicare, not Part B.

The Reimbursement Shift
If you are looking at Budget Neutrality, you must take the projected dollars saved in Medicare Part A and transfer these dollars into the ASC reimbursement levels – that is in fact in Medicare Part B. Otherwise this will become yet another method of shifting services out of Part A into Part B without the shift of equivalent dollars realized in the savings. Physician providers can simply not absorb any more of this revenue shift that has been occurring for over 10 years.

Facts are Facts
Fact # 1 – Our nurses do not work for 62% of what the hospital pays.

Fact # 2 – We do not get special consideration for our electric bills (or other utilities) at 62% of what hospitals pay (or at any discount).
Fact # 3 – Our construction/facility costs are not 62% of what a hospital pays.
Fact # 4 – Our certification process does not cost 62% of what hospitals pay.
Fact # 5 – Our equipment, instruments, surgical packs and other supplies do not come at 62% of what hospitals are paid, in fact they are much higher due to the low volumes.
Fact # 6 – ASCs are more efficient and proven higher quality than hospitals, and this would seem opposite of the Pay For Performance move in the government.
Fact # 7 – Paying 62% of what hospitals are paid will destroy most small ASCs and severely curtail services for beneficiaries.

Annual Updates of Payment Rates
ASCs currently are not entitled to any cost-of-living updates (2004 – 2009), despite the fact that our costs actually do go up, just like hospitals. CMS is proposing to pay ASCs updates that are going to be less than hospital updates (CPI vs HMB). This will eventually cause a shift of cases back to the hospitals where it is more expensive and does not measure up to the quality provided in ASCs. Additionally, this will result in a dramatic decrease in accessibility for CMS beneficiaries as hospitals are not nearly as efficient as ASCs.

Final Thought
I have practiced Medicine for over 20 years and faced many clinical and practice challenges. I have seen a lot happen in that time. I have always strived to provide the highest quality, cost effective and accessible care to all of my patients. **If this proposal succeeds, I guarantee you that it will result in lower quality, higher cost and less accessible care for those in need.**

My partners and I urge you to consider our comments seriously as we would really like to practice medicine and take care of our patients. Please do not impede our efforts.

Thank you for your consideration,

Sincerely,

Stephen R. Powell, MD
Surgical Eye Center of Morgantown
1299 Pineview Dr.
Morgantown, WV, 26505

Submitter : Mrs. Gina Randolph **Date:** 10/29/2006

Organization : DaVita

Category : Ambulatory Surgical Center

Issue Areas/Comments

ASC Payable Procedures

ASC Payable Procedures

I support CMS' practice of re-examining its policies as technology improves and practice patterns change, especially when supported by recommendations made by the Medicare Payment Advisory Commission (MedPAC) in their March 2004 report to Congress. The report concludes that Clinical safety standards and the need for an overnight stay be the only criteria for excluding a procedure from the approved list.

Please support Patient choice! There is clear scientific evidence that vascular access procedures are safe and can be performed in the Ambulatory Surgical Center setting, and more importantly, patients are extremely satisfied with having the option to secure vascular ccess repair and maintenance care in an outpatient setting. Further, the inclusion of angioplasty codes in the ASC setting would suppotrt CMS' Fistula First initiative by permitting a full range of vascular access procedures to be performed in an ASC setting, a less expensive and more accessible option than the current prevalent hospital setting.

Please treat End Stage Renal Disease patients fairly by ensuring all angioplasty codes, including CPT 35476 are allowed in the ASC setting.

Submitter : **Dr. Jeffrey Hoggard** **Date: 10/29/2006**

Organization : **Eastern Nephrology Associates**

Category : **Physician**

Issue Areas/Comments

ASC Payable Procedures

ASC Payable Procedures

i am interventional nephrologist and perform numerous dialysis access procedures (2000 per year) in an outpatient vascular access center. It is safe and efficient and most importantly improves patient care. The patients prefer an outpatient environment because it is more convenient and it is cheaper than the hospital setting(either inpatient or outpatient). Improving payment for these procedures at an Ambulatory Surgical Center will support better patient care and decrease costs.

Submitter : **Dr. Richard Erdey** **Date: 10/29/2006**

Organization : **East Columbus Surgery Center**

Category : **Ambulatory Surgical Center**

Issue Areas/Comments

CY 2008 ASC Impact

CY 2008 ASC Impact

CMS' proposed payment regulation for cataract surgery (CPT 66984)would pay an ASC $954; This number has not been updated in more than a decade and is not at all realistic, given our costs, particularly RN wages to give only one example that have skyrocketed in recent years. At a minimum, The ASC community HIGHLY recommends a payment methodology that would yield a $1147 fee.
Thank you for your consideration.

Submitter : Dr. Chao Sun **Date:** 10/29/2006

Organization : Nephrology Associates

Category : Physician

Issue Areas/Comments

ASC Payment for Office-Based Procedures

ASC Payment for Office-Based Procedures

In the field of nephrology, there are only few progresses in the past few years. In my opinion, outpatient vascular access center for ESRD patients is clearly one of them. It provides better and cheaper service.

In hospital, both interventional nephrologists and surgeons are frequently saturated with other work and rarely pay full attention to access procedures. As the resul of this, a quick outpatient procedure usualy ends up as admmission. It not only causes more suffering for patients, but it also costs us far more. In order to incentivite nephrologist to continue this wonderful service, cutting payment right now probably is not the imminent thing CMS should do. Once this entity becomes a mature business and supply cost diminishes, it may be more appropriate to reduce reimbursement later.

Submitter : **Dr. Wayne Fleischhacker** **Date: 10/29/2006**

Organization : **Union Anesthesia Associates**

Category : **Physician**

Issue Areas/Comments

ASC Ratesetting

ASC Ratesetting

Rate setting is unfair. The basis for rates should be determined by usual and customary (which should be actual data reflecting what the ASC is getting paid) NOT what the insurance companies 'decide' is usual and customary! We should have an opportunity to gather this information and present it prior to any rate setting. Additionally, rates can NOT be based on a Medicare multiple. You are well aware that Medicare rates are developed based on multiple factors such as balance budgets and should not be a bench mark to work from for private payors!!! The ASC's are cost efficient facilities that provide safe, friendly care to our patients without the expense of visiting a hospital for outpatient procedures. Kindly allow the ASC's to present REAL data which will prove our position and let us work together to continue to provide quality, cost efficient care to our patients.
Thank you.

Submitter : Dr. George Fisher **Date:** 10/29/2006

Organization : Dr. George Fisher

Category : End-Stage Renal Disease Facility

Issue Areas/Comments

GENERAL

GENERAL

I recommend Outpatient procedures for AV Fistula for ERD patients. As a patient that has undergone this procedure as an outpatient I found it very easy, safe and only a short recovery time is needed.

Submitter : Dr. Paul Koch **Date:** 10/29/2006

Organization : St. James Surgery Center

Category : Ambulatory Surgical Center

Issue Areas/Comments

ASC Conversion Factor

ASC Conversion Factor

Proposed percentage rate: In order to be able to provide quality patient services we need funding that adequately reflects our cost of doing business. Historically ASCs have been paid roughly 75% as much as the hospital outpatient department. The recent proposal would reduce that rate to 62%, a percentage that is not nearly adequate to allow us to cover our costs. The agency should interpret the budget neutrality provision to permit ASCs to be paid at 75% of the HOPD rate.

ASC Office-Based Procedures

ASC Office-Based Procedures

Payment rates for office-type procedures: All procedures performed in an ASC should be paid at a rate reflective of the ASC cost of providing service. Under the new rule CMS proposes to pay ASCs at the office fee schedule for some procedures and a percentage of the HOPD rate for other procedures. Whatever percentage is adopted by CMS, it should apply to all services provided in the ASC, regardless of type.

ASC Payable Procedures

ASC Payable Procedures

Uniform percentage for all services: I understand that previous comments have recommended that some ASC facilities receive a different percentage that other ASC facilities. This can only lead to additional problems for CMS and the ASC industry. Whatever percentage is eventually adopted by CMS in the final regulation, it should be applied uniformly to all ASC services regardless of the type of procedure or the specialty of the facility.

ASC Unlisted Procedures

ASC Unlisted Procedures

ASC list: The ASC list remains too restrictive in that some procedures are approved for performance as an outpatient in the HOPD but not as an outpatient in the ASC. CMS should permit ASCs to provide services for the same procedures as are performed in the other outpatient setting, the HOPD. Having one list for the HOPD and a different one for ASCs simply does not make sense. CMS should limit ASC procedures only by a list of exclusive procedures, namely those that are on the inpatient only list. There should not be a policy permitting some outpatient procedures to be performed in a HOPD but not in an ASC.

ASC Updates

ASC Updates

Cost-of-living updates: There should be an annual cost-of-living update for ASCs. Under current law ASCs are provided no COLA from 2004-2009, notwithstanding significant increases in the costs of delivering care. There is no rational for establishing a relative rate at this time, and then providing HOPDs with an annual rate increase and not ASCs. This proposed policy would only widen the differential between payments in the two settings. Furthermore, the update for the ASC should be not be based on the CPI but on the hospital basket market, as are the HOPD rates, because ASC costs are affected by the same inflationary factors.

CMS-1506-P2-534-Attach-1.PDF

#534

I own and operate an ASC dedicated to eye surgery located in Warwick, Rhode Island. We have been in operation since 1985, so my comments regarding the recent CMS rule regarding a new ASC payment system and update of the ASC procedures list reflect 20 years providing patient care in this setting.

Proposed percentage rate: In order to be able to provide quality patient services we need funding that adequately reflects our cost of doing business. Historically ASCs have been paid roughly 75% as much as the hospital outpatient department. The recent proposal would reduce that rate to 62%, a percentage that is not nearly adequate to allow us to cover our costs. **The agency should interpret the budget neutrality provision to permit ASCs to be paid at 75% of the HOPD rate.**

Cost-of-living updates: **There should be an annual cost-of-living update for ASCs.** Under current law ASCs are provided no COLA from 2004-2009, notwithstanding significant increases in the costs of delivering care. There is no rational for establishing a relative rate at this time, and then providing HOPDs with an annual rate increase and not ASCs. This proposed policy would only widen the differential between payments in the two settings. Furthermore, **the update for the ASC should be not be based on the CPI but on the hospital basket market, as are the HOPD rates, because ASC costs are affected by the same inflationary factors.**

ASC list: The ASC list remains too restrictive in that some procedures are approved for performance as an outpatient in the HOPD but not as an outpatient in the ASC. CMS should permit ASCs to provide services for the same procedures as are performed in the other outpatient setting, the HOPD. Having one list for the HOPD and a different one for ASCs simply does not make sense. **CMS should limit ASC procedures only by a list of exclusive procedures, namely those that are on the inpatient only list. There should not be a policy permitting some outpatient procedures to be performed in a HOPD but not in an ASC.**

Uniform percentage for all services: I understand that previous comments have recommended that some ASC facilities receive a different percentage that other ASC facilities. This can only lead to additional problems for CMS and the ASC industry. **Whatever percentage is eventually adopted by CMS in the final regulation, it should be applied uniformly to all ASC services regardless of the type of procedure or the specialty of the facility.**

Payment rates for office-type procedures: All procedures performed in an ASC should be paid at a rate reflective of the ASC cost of providing service. Under the new rule CMS proposes to pay ASCs at the office fee schedule for some procedures and a percentage of the HOPD rate for other procedures. **Whatever percentage is adopted by CMS, it should apply to all services provided in the ASC, regardless of type.**

Thank you for considering my comments on the CMS rule regarding ASC payment system. I will be happy to reply to any questions you or your staff may have.

Sincerely yours,

Paul S. Koch, MD
566 Tollgate Road
Warwick, RI 02886
Vice President, Outpatient Ophthalmic Surgery Society

Submitter : Mrs. Kathy Valentine **Date:** 10/30/2006

Organization : Mrs. Kathy Valentine

Category : Congressional

Issue Areas/Comments

ASC Payable Procedures

ASC Payable Procedures

As a former dialysis patient I speak from experience when I tell you that being chronically ill from kidney disease will never be a cheap way to 'live'.
Fact: If you reveal to any private insurance carrier that you have kidney disease or renal failure issues of any kind for any reason you will never be accepted as 'covered' by any health insurance policy you could ever afford. Kidney disease, in most cases, is completely debilitating.
PERSONAL EXAMPLES;
1) Employment is nearly impossible to find with any reputable employer. They can not fire you for absenteeism
caused by a preexisting condition they were aware of before hiring you. They see you as too much of a high-risk employee, who knows when or how long you could be off due to such a devastating illness.
A]You raise their insurance and no one wants to suffer through that, rates are enough already without trying to insure an employee with 'preexisting' health condition.
FOR EXAMPLE:
B]You may get lucky and actually get the job and even qualify eventually for a pay-rate increase, but no employer is going to be stupid enough to allow you enough hours (usually a 40 hr. week) to qualify for any benefit packages that would include health insurance. Therefore, you never make enough to live on... let alone enough to pay for medical treatments such as dialysis or the procedure in question.

My point is this; Medicare & Medicaid is the only renal patients have for health care coverage. I worked for years paying into S.E.S.S. at a rate of 15.50% and up based on a monthly income of $2800.. Then when I became disabled by kidney failure due to birth defect and I needed what I had paid for and paid into faithfully, sadly, I was told there is a set level of payment for 'end-stage renal disease'. Irregardless of what I made prior to becoming disabled, I was granted a meager $311.@ mth. and without the benefits of Medicaid & Medicare I would have had no chance of survival - let alone the two kidney transplants I have had in the past 25 years.
I have said all of the above to say this - trust me, THIS BILL NEEDS TO PASS!!! Without it the people/patients who NEED 'on-going long term treatment' that varies from patient to patient, depending on each individual physician's plan of treatment, would have no HOPE of any type of 'QUALITY OF LIFE'... let alone the ABILITY to survive.
It is my hope to see this bill passed so others may live.

Thank for your time and cooperation.

Kathy L. Valentine
6498 Logan Dr.
Powell, OH 43065
Home #: (614)761-1271

Submitter : Ms. Angela Bogat **Date:** 10/30/2006

Organization : RMS Lifeline Inc.

Category : Individual

Issue Areas/Comments

ASC Payable Procedures

ASC Payable Procedures

I support CMS practice of re-examining its policies as technology improves and practice patterns change, especially when supported by recommendations made by the Medicare Payment Advisory Commission (MedPAC) in their March 2004 report to Congress. The report concludes that clinical safety standards and the need for an overnight stay be the only criteria for excluding a procedure from the approved list.

Please support patient choice! There is clear scientific evidence that vascular access procedures are safe and can be performed in Ambulatory Surgical Center setting, and more importantly, patients are extremely satisfied with having the option to secure vascular access repair and maintenance care in an outpatient setting. Further, the inclusion of angioplasty codes in the ASC setting would support CMS Fistula First initiative by permitting a full range of vascular access procedures to be performed in an ASC setting, a less expensive and more accessible option than the current prevalent hospital setting.

Please treat End Stage Renal Disease patients fairly by ensuring all angioplasty codes, including CPT 35476 are allowed in the ASC setting.

Submitter : Mrs. Ann Mueller **Date:** 10/30/2006

Organization : DaVita Dialysis

Category : Nurse

Issue Areas/Comments

ASC Payable Procedures

ASC Payable Procedures

I support CMS practice of re-examining its policies as technology improves and practice patterns change, especially when supported by recommendations made by the Medicare Payment Advisory Commission (MedPAC) in their March 2004 report to Congress. The report concludes that clinical safety standards and the need for an overnight stay be the only criteria for excluding a procedure from the approved list.

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Please treat End Stage Renal Disease patients fairly by ensuring all angioplasty codes, including CPT 35476 are allowed in the ASC setting.

GENERAL

GENERAL

Vascular access is one of the greatest sources of complications and cost for dialysis patients. Why, because America uses more surgical grafts and catheters for vascular access than the rest of the developed world, even though there is substantial evidence that they impose higher initial and maintenance costs, lead to greater clinical complications, and result in higher mortality than arterio-venous (AV) fistulae.

The inclusion of CPT codes 35475, 35476, 36205 and 37206 to the list of Medicare approved ambulatory surgical center (ASC) procedures would provide Medicare the opportunity to reduce the cost of, and promote quality outcomes for, end-stage renal disease (ESRD) patients through more thoughtful reimbursement and regulation of vascular access procedures.

Regulatory Action Center
Overview
Sample Comments
How to mail or hand deliver comments
How to submit comments online
Background information
DaVita's Comments to
CMS-1506-P2 (available 11/6/06)
SURVEY:
How can we improve this process?
Comments are due in the CMS Office by 5 p.m. on 11/6/06

Submitter : Mrs. DENISE WILLIAMS **Date:** 10/30/2006

Organization : Mrs. DENISE WILLIAMS

Category : Individual

Issue Areas/Comments

ASC Payable Procedures

ASC Payable Procedures

I support CMS' practice of re-examining its policies as technology improves and practice pattern change, especially when supported by recommendations made by the Medicare Payment Advisory Commission (MedPAC) in their March 2004 report to Congress. The report concludes that clinical safety standards and the need for an overnight stay be the only criteria for excluding a procedure from the approved list.

Please support PATIENT CHOICE! There is clear scientific evidence that vascular access procedures are safe and can be performed in Ambulatory Surgical Center setting, and more importantly, patients are extremely satisfied with having the option to secure vascular access repair and maintenance care in an outpatient setting. Further, the inclusion of angioplasty codes in the ASC setting would support CMS' FISTULA FIRST initiative by permitting a full range of vascular access procedures to be performed in an ASC setting, a less expensive and more accessible option than the current prevalent hospital setting.

Please treat End Stage Renal Disease patients fairly by ensuring all angioplasty codes, including CPT 35476 are allowed in the ASC setting.

If you could see the face of a patient who's been treated at one of these "alternate" sites ... the tears of joy in their eyes. It would bring tears to your eyes, too.

GENERAL

GENERAL

Vascular access in one of the greatest sources of complications and cost for dialysis patients. Why, because America uses more surgical grafts and catheters for vascular access than the rest of the developed world, even though there is substantial evidense that they impose higher initial and maintenance costs, lead to greater clinical complications, and result in higher mortality than arteriovenous (AV) fistulae.

The inclusion of CPT codes 35475, 35476, 36205 and 37206 to the list of Medicare approved ambulatory surgical center (ASC) procedures would provide Medicare the opportunity to reduce the cost of, and promote quality outcomes for, end-stage renal disease (ESRD) patients through more thoughtful reimbursement and regulation of vascular access procedures.

Submitter : **Dr. Anthony Johnson** **Date: 10/30/2006**

Organization : **Jervey Eye Center, LLC**

Category : **Ambulatory Surgical Center**

Issue Areas/Comments

CY 2008 ASC Impact

CY 2008 ASC Impact

October 30, 2006

Leslie V. Norwalk, Esq., Acting Administrator
Center for Medicare and Medicaid Services
Department of Health and Human Services ATT: CMS-1506-P
Room 445-G Hubert H. Humphrey Building
200 Independence Avenue, NW
Washington, DC 20201

Please see attached file.

CMS-1506-P2-539-Attach-1.DOC

#539

October 30, 2006

Leslie V. Norwalk, Esq., Acting Administrator
Center for Medicare and Medicaid Services
Department of Health and Human Services **ATT: CMS-1506-P**
Room 445-G Hubert H. Humphrey Building
200 Independence Avenue, NW
Washington, DC 20201

To Whom It May Concern:

I am writing in hopes of influencing the payment methodology for ambulatory surgery centers being discussed at present. As the Medical Director of Jervey Eye Center, LLC, I have seen an incredibly positive impact on our community with emphasis on the Medicare age group. Our ASC has been in operation since March 1999, and we have performed an average of 3,800 procedures per year which have been primarily cataract surgeries. In addition, we have also performed retinal procedures, ophthalmic plastic procedures, glaucoma procedures, and corneal transplantation procedures. Approximately 70 percent of our patients are Medicare beneficiaries. We take great pride in the incredibly low complication rate of our center, and we have accomplished our success without cutting any corners including anesthesia services. We employ both an anesthesiologist as well as certified registered nurse anesthetists who are involved in every single case. We have been able to save our patient beneficiaries a significant sum of money compared to these same services had they been performed in the outpatient surgery center of either one of our community hospitals. Our community hospitals have benefited by not having their outpatient schedule burdened by these procedures which have not been very fiscally beneficial to them in the past, so they have been able to open their schedule up to other more profitable services. All in all, this has been a win for the patient primarily, and it has also been a win for the community hospitals as well as to the doctors in our practice.

I am also interested in the ASC procedure list remaining too restrictive. The decision for the slightest surgery should be made by the surgeon in consultation with the patient. The ASC should be permitted to furnish and receive facility reimbursement for any procedures that are performed in the hospital outpatient departments as long as deemed safe by the surgeon performing the surgery.

The proposed payment of 62 percent of the hospital outpatient department payment rate is inadequate to meet the costs of providing these services. We compete for the same highly skilled nursing and anesthesia caregivers, and these supply costs are likely greater than the costs at the hospital outpatient departments simply because of their buying power. The agency should interpret the budget neutrality provision to permit ASCs to be paid at a rate of 75 percent of hospital outpatient departments, and this should apply to all ASCs regardless of their specialty type.

The annual update of payment rates should be a consistent index for both hospital outpatient departments as well as ASCs since the rate of cost increases should be similar for both. Therefore, I would propose that both facility types have their payment rates indexed to the hospital market basket (HMB).

Thank you for your interest and willingness to read my above concerns. Please do not hesitate to contact me if you have any questions.

Sincerely yours,

Anthony P. Johnson, M.D.
President and Managing Partner
Jervey Eye Group, P.A.
Medical Director, Jervey Eye Center, LLC

APJ/lmj

Submitter : **Mrs. helen fuller** **Date: 10/30/2006**

Organization : **sylacauga dialysis**

Category : **Nurse**

Issue Areas/Comments

GENERAL

GENERAL

our patients and leaders in the field of kidney car need all the support they can get from all sources; kidney disease and related issues is an expensive and draining endeavor for all concerned.

Submitter : **Dr. James Yegge** **Date: 10/30/2006**

Organization : **Renal Associates.**

Category : **Physician**

Issue Areas/Comments

ASC Payable Procedures

ASC Payable Procedures

This is quite simple: Vascular access procedures for hemodialysis patients done in the out patient setting cost less to perform outside of the hospital. Please review the total cost from hospitals and compare that to the out patient setting for the same procedures. If you cut reimbursement in the out patient setting, the ASC/office based programs will close and the procedures will go back to the hospital and rip-off the tax payers again. Please do the right thing and use logic instead of emotionality.

Submitter : Mrs. Linda Wright **Date:** 10/30/2006

Organization : DaVita

Category : Nurse

Issue Areas/Comments

ASC Payable Procedures

ASC Payable Procedures

I support CMS practice of re-examining its policies as technology improves and practice patterns change, especially when supported by recommendations made by the Medicare Payment Advisory Commission (MedPAC) in their March 2004 report to Congress. The report concludes that clinical safety standards and the need for an overnight stay be the only criteria for excluding a procedure from the approved list.

Please support patient choice! There is clear scientific evidence that vascular access procedures are safe and can be performed in Ambulatory Surgical Center setting, and more importantly, patients are extremely satisfied with having the option to secure vascular access repair and maintenance care in an outpatient setting. Further, the inclusion of angioplasty codes in the ASC setting would support CMS Fistula First initiative by permitting a full range of vascular access procedures to be performed in an ASC setting, a less expensive and more accessible option than the current prevalent hospital setting.

Please treat End Stage Renal Disease patients fairly by ensuring all angioplasty codes, including CPT 35476 are allowed in the ASC setting.

GENERAL

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Vascular access is one of the greatest sources of complications and cost for dialysis patients. Why, because America uses more surgical grafts and catheters for vascular access than the rest of the developed world, even though there is substantial evidence that they impose higher initial and maintenance costs, lead to greater clinical complications, and result in higher mortality than arterio-venous (AV) fistulae.

The inclusion of CPT codes 35475, 35476, 36205 and 37206 to the list of Medicare approved ambulatory surgical center (ASC) procedures would provide Medicare the opportunity to reduce the cost of, and promote quality outcomes for, end-stage renal disease (ESRD) patients through more thoughtful reimbursement and regulation of vascular access procedures.

Submitter : Ms. Teresa Fritter **Date:** 10/30/2006

Organization : InSight Surgery & Laser Center, LLC

Category : Ambulatory Surgical Center

Issue Areas/Comments

GENERAL

GENERAL

Due to the ever increasing building, maintenance, personnel and benefits, and overall cost of doing business, it seems tragic to have this steady decline in ASC (and professional) reimbursements.
We can provide much better and effective care at a much more reasonable price in our ASC setting than in a hospital setting, thereby reducing the cost to CMS.
We are able to offer patients the latest in technology by controlling purchasing options for equipment and supplies. All we ask is to keep the "playing field" on an plane when considering reimbursements to ASCs -vs- hospitals.

Submitter : Mr. Shawn Carroll **Date:** 10/30/2006

Organization : Davita

Category : Health Care Provider/Association

Issue Areas/Comments

ASC Payable Procedures

ASC Payable Procedures

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Submitter : Ms. Barbara Griffin **Date:** 10/30/2006

Organization : DaVita

Category : Social Worker

Issue Areas/Comments

ASC Payable Procedures

ASC Payable Procedures

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Submitter : **Date: 10/30/2006**

Organization : **Davita Dialysis**

Category : **Nurse**

Issue Areas/Comments

GENERAL

GENERAL

I think that declottting,angiograms and minor access revision can be performed in Ambulatory Surgical Centers.

Submitter : Mr. Michael Rucker **Date:** 10/30/2006

Organization : DaVita

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

There is clear scientific evidence that vascular access procedures are safe and can be performed in Ambulatory Surgical Center (ASC) settings. Angioplasty codes should be included to permit a full range of vascular access procedures to be performed in accessible, cost-effective ASC settings.

Submitter : Dr. Michael Shapiro **Date:** 10/30/2006

Organization : Colorado Renal Access and Imaging Center

Category : Ambulatory Surgical Center

Issue Areas/Comments

ASC Payable Procedures

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Submitter : Ms. Susan Kerber **Date:** 10/30/2006

Organization : Illini Renal Dialysis-DaVita

Category : End-Stage Renal Disease Facility

Issue Areas/Comments

ASC Payable Procedures

ASC Payable Procedures

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Submitter : **Ms. Susan Kerber** **Date: 10/30/2006**

Organization : **Illini Renal Dialysis-DaVita**

Category : **End-Stage Renal Disease Facility**

Issue Areas/Comments

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Submitter : **Mrs. Catherine Demmons** **Date: 10/30/2006**

Organization : **Davita Ft. Myers South Dialysis**

Category : **End-Stage Renal Disease Facility**

Issue Areas/Comments

GENERAL

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Submitter : Mrs. Catherine Demmons **Date:** 10/30/2006

Organization : Davita Ft. Myers South Dialysis

Category : End-Stage Renal Disease Facility

Issue Areas/Comments

ASC Payable Procedures

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Submitter : Dr. Douglas Carlson **Date:** 10/30/2006

Organization : Associated Eye Care

Category : Physician

Issue Areas/Comments

CY 2008 ASC Impact

CY 2008 ASC Impact

I am writing with a concern about ASC payments rates. Given our already lower rates than hospitals and our ever increasing costs of delivering eare I am concerned about reductions. Please consider the service we offer to seniors and the pressure to compromise access or quality if payments do not match increasing costs.
Sincerely Doug Carlson

Submitter : Jaime S. **Date:** 10/30/2006

Organization : Orthopaedic Surgery Center

Category : Ambulatory Surgical Center

Issue Areas/Comments

GENERAL

GENERAL

Medicare is making it more and more difficult for our Medicare patient's to have Orthopaedic surgery at our facility. We already have to send all patient's to the hospital if the surgery requires implants/hardware. If Medicare takes off more approved procedures from our list, then that is more we have to send to the hospital. Our doctor's own 49% of our facility and would like to keep the majority of our patient's here at their facility.

Submitter : **Mr. Bradley Harmon** **Date: 10/30/2006**

Organization : **Northern California Surgery Center**

Category : **Ambulatory Surgical Center**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1506-P2-555-Attach-1.DOC

#555

Leslie V. Norwalk, Esq., Acting Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1506-P
Room 445-G
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

Re: CMS-1506-P - Medicare Program; the Ambulatory Surgical Center Payment System and CY 2008 Payment Rates

Dear Ms. Norwalk:

I am writing regarding the proposed payment changes for Ambulatory Surgery Centers. Our center Northern California Surgery Center is located in Turlock, CA and serves hundreds of Medicare recipients each year. We are very concerned that the changes, as currently proposed by CMS, will have a detrimental affect on ASCs and the Medicare program.

Given the outdated cost data and crude payment categories underlying the current ASC system, we welcome the opportunity to link the ASC and hospital outpatient department (HOPD) payment systems. Although the HOPD payment system is imperfect, it represents the best proxy for the relative cost of procedures performed in the ASC.

In the comments to follow, we focus on three basic principles:

- maximizing the alignment of the ASC and HOPD payment systems eliminate distortions between the payment systems that could inappropriately influence site of service selection,
- ensuring beneficiary access to a wide range of surgical procedures that can be safely and efficiently performed in the ASC, and
- establishing fair and reasonable payment rates to allow beneficiaries and the Medicare program to save money on procedures that can be safely performed at a lower cost in the ASC than the HOPD.

Alignment of ASC and HOPD Payment Policies

Aligning the payment systems for ASCs and hospital outpatient departments will improve the transparency of cost data used to evaluate outpatient surgical services for Medicare beneficiaries. The benefits to the taxpayer and the Medicare consumer will be maximized by aligning the payment policies to the greatest extent permitted under the law. While we appreciate the many ways in which the agency proposes to align the payment system, we are concerned that the linkage is incomplete and may lead to further distortions between the payment systems. Many policies applied to payments for hospital outpatient services were not extended to the ASC setting, and these inconsistencies undermine the appropriateness of the APC relative weights, create disparities in the relationship between the ASC and HOPD payment rates, and embed in the new payment system site of service incentives that will cost the taxpayer and the beneficiary more than necessary.

There are many components of the regulation where a more complete alignment of the ASC and HOPD payment systems is appropriate. Below is an overview of the major areas where further refinement of the proposed rule is warranted. These issues are discussed in greater detail under the relevant section heading in the text to follow.

- **Procedure list:** HOPDs are eligible for payment for any service not included on the inpatient only list. The CMS proposal would limit a physician's ability to determine appropriate site of service for a procedure excludes many surgical procedures appropriate for the ASC setting.

- **Treatment of unlisted codes:** Providers occasionally perform services or procedures for which CPT does not provide a specific code and therefore use an unlisted procedure code identify the service. HOPDs receive payment for such unlisted codes under OPPS; ASCs should also be eligible for payment of selected unlisted codes.

- **Different payment bundles:** Several of the policies for packaging ancillary and other procedure costs into the ASC payment bundle result in discrepancies between service costs represented in the APC relative weight. For example, when HOPDs perform services outside the surgical range that are not packaged, they receive additional payments for which ASCs should also be eligible.

- **Cap on office-based payments:** CMS proposes to cap payment for certain ASC procedures commonly performed in the office at the physician practice expense payment rate. No such limitation is applied to payments under the OPPS, presumably because the agency recognizes the cost of a procedure varies depending on the characteristics of the beneficiary and the resources available at the site of service. We likewise believe this cap is inappropriate for the ASC and should be omitted from the final regulation.

- **Different measures of inflation:** CMS updates the OPPS conversion factor for annual changes in inflation using the hospital market basket; however, the agency proposes to update ASC payments using the consumer price index for all urban consumers. The market basket is a better proxy for the inflationary pressures faced by ASCs, as it is the measure used by the agency to update payments to hospitals providing the same services.

- **Secondary rescaling of APC relative weights:** CMS applies a budget neutrality adjustment to the OPPS relative weight values after they are recalibrated with new cost data each year. The agency proposes a secondary recalibration of the relative weights before they are used by ASCs. This secondary recalibration will result in annual and potentially cumulative variation between ASC and HOPD payments without any evidence that the cost of providing services has further diverged between settings.

- **Non-application of HOPD policies to the ASC.** Over the years, CMS has implemented through statutory or administrative authority numerous policies to support services in the HOPD, including additional payment for high-cost outliers, transitional corridor and hold-harmless payments to rural and sole-community hospitals, and payments for new technologies. While not all of these policies are appropriate for the ASC, surgery centers should be eligible to receive new technology pass-through payments.

- **Use of different billing systems:** The HOPD and ASC use the UB-92 and CMS-1500, respectively, to submit claims to the government for services. Use of different forms prevents ASCs from documenting all the services provided to a Medicare beneficiary, therefore undermining the documentation of case mix differences between sites of service. Most commercial payors require

ASCs to submit claims using the UB-92, and the Medicare program should likewise align the payment system at the claim level.

Ensuring Beneficiaries' Access to Services

Ambulatory surgery centers are an important component of beneficiaries' access to surgical services. As innovations in science and technology have progressed, ASCs have demonstrated tremendous capacity to meet the growing need for outpatient surgical services. In some areas and specialties, ASCs are performing more than 50% of the volume for certain procedures. Sudden changes in payments for services can have a significant effect on Medicare beneficiaries' access to services predominantly performed in ASCs.

The implementation of the revised payment system proposed by Medicare will result in significant redistribution of payments for many specialties. Because ASCs are typically focused on a narrow spectrum of services that require similar equipment and physician expertise, they have a limited ability to respond to changes in the payment system other than to adjust their volume of Medicare patients. On the one hand, for procedures such as ophthalmology, there is a limited market for these services in the non-Medicare population. If the facility fee is insufficient to cover the cost of performing the procedure in an ASC, responding to the change may mean relocating their practice to the HOPD. Such a decision would increase expenditures for the government and the beneficiary. On the other hand, the demand for services such as diagnostic colonoscopies is extremely high in the non-Medicare population. If ASCs determine that the payment rates for such services are too low, they may be able to decrease the proportion of Medicare patients they see without reducing their total patient volume. In that case, beneficiaries may experience significant delays accessing important preventive services or treatment. Neither outcome is optimal for the beneficiary of the Medicare program.

Establishing Reasonable Reimbursement Rates

Medicare payment rates for ASC services have remained stagnant for nearly a decade. Over time, the industry has identified which services it can continue to offer to Medicare beneficiaries through reductions in cost and improvements in efficiency. In the Medicare Payment Advisory Commission's first review of ASC payments in 2003, ASCs were paid more than the HOPD for eight of the top ten procedures most frequently performed in the ASC. One suggestion by the commission was that services migrated to the ASC because the payment rate was higher than the HOPD. However, a multi-year payment freeze on ASC services has turned the tables and now the HOPD rate in 2007 will be higher (or the same) for eight of the same ten ASC procedures. The continued growth of ASCs during the payment freeze is a strong testament to their ability to improve their efficiency and the preference of physicians and beneficiaries for an alternative to the hospital outpatient surgical environment.

The impact of HOPD payments eclipsing the ASC rates has had the perverse effect of increasing the "cost" of the budget neutrality requirement imposed by the Medicare Modernization Act on the future conversion factor for ASC payments. The Lewin Group estimates that the inflation updates applied to the HOPD rates since passage of the MMA account for 40 percent of the discount required to achieve budget neutrality under the agency's proposed rule. This, combined with the agency's narrow interpretation of budget neutrality, produce an unacceptably low conversion factor for ASC payments.

- Budget Neutrality: Adopt an expansive, realistic interpretation of budget neutrality. The new payment system and the expansion of the ASC list will result in migration of services from one site of service setting to another. CMS has the legal authority and the fiduciary responsibility to examine the

consequences of the new ASC payment system on all sites of care – the physician office, ASCs, and HOPD.

- ASCs should comment on the possible negative effect on access to services, since the methodology proposed results in ASC payments equaling only 62% of HOPD.

- By setting rates this low, CMS would force doctors to move cases to the more expensive hospital setting, increasing the amount of money paid by Medicare beneficiaries and the government. Rather than paying ASCs a set percentage of HOPD rates, the proposed rule establishes a complicated formula to link ASC payment to HOPD payment but does not link payment in a uniform manner. This will impede Medicare beneficiaries' ability to understand their real costs in alternative settings. In the words of President Bush, Medicare beneficiaries need to be able to make "apples to apples" comparisons in order to increase transparency in the health care sector.

- CMS failed to include on the procedure list many higher complexity services that have for years been safely and effectively performed in ASCs throughout the country. By not creating a truly exclusionary list, CMS is losing an opportunity to increase patient choice and rely on the clinical judgment of the surgeon.

In conclusion, I am asking for a reconsideration of many of the elements of the proposed changes as outlined above. Truly aligning the ASC payment system with that of the HOPDs is the most logical, fair and best policy approach to benefit the Medicare program those served by the program. Should you have any questions regarding any of the issues in this letter, do not hesitate to contact me. My e-mail is bharmon@cancsc.nueterra.com my phone number is (209) 668-9866 and my mailing address is Northern California Surgery Center 3850 Geer Rd. Turlock, CA 95382.

Sincerely,

Brad Harmon
Administrator

Submitter : Dr. JON WESTON **Date:** 10/30/2006

Organization : WESTON EYE CENTER

Category : Physician

Issue Areas/Comments

ASC Payable Procedures

ASC Payable Procedures

There is ongoing concern about how CMS will determine which proceedures will be performed in the ASC setting. The criteria being contemplated are overly complex. All proceedures performed in the HOPD should be allowed in the ASC unless there is clear evidense that an overnight stay may be required or other, rare, codes that might have an increased risk of complications requiring ancilliary services not available in the ASC

Submitter : Mr. Fleet McClamrock **Date:** 10/30/2006

Organization : Palmetto Surgery Center

Category : Ambulatory Surgical Center

Issue Areas/Comments

ASC Conversion Factor

ASC Conversion Factor

The proposed 62% of HOPD rates is inadequate and does not reflect a realistic amount for providing the same service as a HOPD. We provide the same or better service to a similar population of patients as HOPD's and should be paid at least 75% of the HOPD rate to be fair.

ASC Payable Procedures

ASC Payable Procedures

We should be allowed to perform any case deemed safe to be performed as an outpatient procedure. Many HOPD's are at least as far away from a hospital and freestanding, yet they are allowed to receive a significant amount more than we can charge and they are allowed to do procedures we are not allowed to perform. The system needs an overhaul and should allow patients and surgeons to determine where it is best to perform a procedure.

ASC Updates

ASC Updates

We are scheduled to receive no annual cost-of-living updates from 2004-2009, yet we face increased costs every day to provide care. We are seeing equipment and supplies increasing 5% annually, we have "fuel surcharges" added to our invoices at a 10% rate,and utility bills went up 15% last year. I do not understand why ASC's are being penalized for providing quality, efficient services to patients by forcing us to consider limiting the number of cases we can do based on reimbursement levels that are substantially lower than HOPD's. The new system should provide for a reasonable reimbursement to ASC's since they are assisting to hold down the overall cost of surgery.

Submitter : Mrs. Ann S Williford **Date:** 10/30/2006

Organization : DaVita Inc

Category : Social Worker

Issue Areas/Comments

GENERAL

GENERAL

Given the delicate condition of most hemodialysis patients, their fragile physical AND psychological status, and their propensity to bleed easily, I am of the opinion that only a full-service operating room should be used for their vascular procedures. Leaving such patients unattended should not be an option.

Submitter : Martin Winslow **Date:** 10/30/2006

Organization : Nueterra Healthcare

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

Please see attachment regarding reform of ASC payments

CMS-1506-P2-560-Attach-1.DOC

560

Leslie V. Norwalk, Esq., Acting Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1506-P
Room 445-G
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

Re: CMS-1506-P - Medicare Program; the Ambulatory Surgical Center Payment System and CY 2008 Payment Rates

Dear Ms. Norwalk:

I am writing regarding the proposed payment changes for Ambulatory Surgery Centers. I work for Nueterra Healthcare, a management company for ASCs. Through our affiliated centers we serve thousands of Medicare recipients each year. We are very concerned that the changes, as currently proposed by CMS will have a detrimental affect on ASCs and the Medicare program.

Given the outdated cost data and crude payment categories underlying the current ASC system, we welcome the opportunity to link the ASC and hospital outpatient department (HOPD) payment systems. Although the HOPD payment system is imperfect, it represents the best proxy for the relative cost of procedures performed in the ASC.

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Medicare payment rates for ASC services have remained stagnant for nearly a decade. Over time, the industry has identified which services it can continue to offer to Medicare beneficiaries through reductions in cost and improvements in efficiency. In the Medicare Payment Advisory Commission's first review of ASC payments in 2003, ASCs were paid more than the HOPD for eight of the top ten procedures most frequently performed in the ASC. One suggestion by the commission was that services migrated to the ASC because the payment rate was higher than the HOPD. However, a multi-year payment freeze on ASC services has turned the tables and now the HOPD rate in 2007 will be higher (or the same) for eight of the same ten ASC procedures. The continued growth of ASCs during the payment freeze is a strong testament to their ability to improve their efficiency and the preference of physicians and beneficiaries for an alternative to the hospital outpatient surgical environment.

The impact of HOPD payments eclipsing the ASC rates has had the perverse effect of increasing the "cost" of the budget neutrality requirement imposed by the Medicare Modernization Act on the future conversion factor for ASC payments. The Lewin Group estimates that the inflation updates applied to the HOPD rates since passage of the MMA account for 40 percent of the discount required to achieve budget neutrality under the agency's proposed rule. This, combined with the agency's narrow interpretation of budget neutrality, produce an unacceptably low conversion factor for ASC payments.

- Budget Neutrality: Adopt an expansive, realistic interpretation of budget neutrality. The new payment system and the expansion of the ASC list will result in migration of services from one site of service setting to another. CMS has the legal authority and the fiduciary responsibility to examine the

consequences of the new ASC payment system on all sites of care – the physician office, ASCs, and HOPD.

- ASCs should comment on the possible negative effect on access to services, since the methodology proposed results in ASC payments equaling only 62% of HOPD.

- By setting rates this low, CMS would force doctors to move cases to the more expensive hospital setting, increasing the amount of money paid by Medicare beneficiaries and the government. Rather than paying ASCs a set percentage of HOPD rates, the proposed rule establishes a complicated formula to link ASC payment to HOPD payment but does not link payment in a uniform manner. This will impede Medicare beneficiaries' ability to understand their real costs in alternative settings. In the words of President Bush, Medicare beneficiaries need to be able to make "apples to apples" comparisons in order to increase transparency in the health care sector.

- CMS failed to include on the procedure list many higher complexity services that have for years been safely and effectively performed in ASCs throughout the country. By not creating a truly exclusionary list, CMS is losing an opportunity to increase patient choice and rely on the clinical judgment of the surgeon.

In conclusion, I am asking for a reconsideration of many of the elements of the proposed changes as outlined above. Truly aligning the ASC payment system with that of the HOPDs is the most logical, fair and best policy approach to benefit the Medicare program those served by the program. Should you have any questions regarding any of the issues in this letter, do not hesitate to contact me. My e-mail is mwinslow@nueterra.com, my phone number is 913-387-0609 and my mailing address is 11221 roe Ave, Suite 320, Leawood, KS 66211.

Sincerely,

Martin Winslow
Director of Reimbursement
Nueterra Healthcare

Submitter : Mr. Marty Winslow

Date: 10/30/2006

Organization : Mr. Marty Winslow

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

see attachment

CMS-1506-P2-561-Attach-1.DOC

#561

Leslie V. Norwalk, Esq., Acting Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1506-P
Room 445-G
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

Re: CMS-1506-P - Medicare Program; the Ambulatory Surgical Center Payment System and CY 2008 Payment Rates

Dear Ms. Norwalk:

I am writing regarding the proposed payment changes for Ambulatory Surgery Centers. I work for Nueterra Healthcare, a management company for ASCs. Through our affiliated centers we serve thousands of Medicare recipients each year. We are very concerned that the changes, as currently proposed by CMS will have a detrimental affect on ASCs and the Medicare program.

Given the outdated cost data and crude payment categories underlying the current ASC system, we welcome the opportunity to link the ASC and hospital outpatient department (HOPD) payment systems. Although the HOPD payment system is imperfect, it represents the best proxy for the relative cost of procedures performed in the ASC.

In the comments to follow, we focus on three basic principles:

- maximizing the alignment of the ASC and HOPD payment systems eliminate distortions between the payment systems that could inappropriately influence site of service selection,
- ensuring beneficiary access to a wide range of surgical procedures that can be safely and efficiently performed in the ASC, and
- establishing fair and reasonable payment rates to allow beneficiaries and the Medicare program to save money on procedures that can be safely performed at a lower cost in the ASC than the HOPD.

Alignment of ASC and HOPD Payment Policies

Aligning the payment systems for ASCs and hospital outpatient departments will improve the transparency of cost data used to evaluate outpatient surgical services for Medicare beneficiaries. The benefits to the taxpayer and the Medicare consumer will be maximized by aligning the payment policies to the greatest extent permitted under the law. While we appreciate the many ways in which the agency proposes to align the payment system, we are concerned that the linkage is incomplete and may lead to further distortions between the payment systems. Many policies applied to payments for hospital outpatient services were not extended to the ASC setting, and these inconsistencies undermine the appropriateness of the APC relative weights, create disparities in the relationship between the ASC and HOPD payment rates, and embed in the new payment system site of service incentives that will cost the taxpayer and the beneficiary more than necessary.

There are many components of the regulation where a more complete alignment of the ASC and HOPD payment systems is appropriate. Below is an overview of the major areas where further refinement of the proposed rule is warranted. These issues are discussed in greater detail under the relevant section heading in the text to follow.

- **Procedure list:** HOPDs are eligible for payment for any service not included on the inpatient only list. The CMS proposal would limit a physician's ability to determine appropriate site of service for a procedure excludes many surgical procedures appropriate for the ASC setting.

- **Treatment of unlisted codes:** Providers occasionally perform services or procedures for which CPT does not provide a specific code and therefore use an unlisted procedure code identify the service. HOPDs receive payment for such unlisted codes under OPPS; ASCs should also be eligible for payment of selected unlisted codes.

- **Different payment bundles:** Several of the policies for packaging ancillary and other procedure costs into the ASC payment bundle result in discrepancies between service costs represented in the APC relative weight. For example, when HOPDs perform services outside the surgical range that are not packaged, they receive additional payments for which ASCs should also be eligible.

- **Cap on office-based payments:** CMS proposes to cap payment for certain ASC procedures commonly performed in the office at the physician practice expense payment rate. No such limitation is applied to payments under the OPPS, presumably because the agency recognizes the cost of a procedure varies depending on the characteristics of the beneficiary and the resources available at the site of service. We likewise believe this cap is inappropriate for the ASC and should be omitted from the final regulation.

- **Different measures of inflation:** CMS updates the OPPS conversion factor for annual changes in inflation using the hospital market basket; however, the agency proposes to update ASC payments using the consumer price index for all urban consumers. The market basket is a better proxy for the inflationary pressures faced by ASCs, as it is the measure used by the agency to update payments to hospitals providing the same services.

- **Secondary rescaling of APC relative weights:** CMS applies a budget neutrality adjustment to the OPPS relative weight values after they are recalibrated with new cost data each year. The agency proposes a secondary recalibration of the relative weights before they are used by ASCs. This secondary recalibration will result in annual and potentially cumulative variation between ASC and HOPD payments without any evidence that the cost of providing services has further diverged between settings.

- **Non-application of HOPD policies to the ASC.** Over the years, CMS has implemented through statutory or administrative authority numerous policies to support services in the HOPD, including additional payment for high-cost outliers, transitional corridor and hold-harmless payments to rural and sole-community hospitals, and payments for new technologies. While not all of these policies are appropriate for the ASC, surgery centers should be eligible to receive new technology pass-through payments.

- **Use of different billing systems:** The HOPD and ASC use the UB-92 and CMS-1500, respectively, to submit claims to the government for services. Use of different forms prevents ASCs from documenting all the services provided to a Medicare beneficiary, therefore undermining the documentation of case mix differences between sites of service. Most commercial payors require

ASCs to submit claims using the UB-92, and the Medicare program should likewise align the payment system at the claim level.

Ensuring Beneficiaries' Access to Services

Ambulatory surgery centers are an important component of beneficiaries' access to surgical services. As innovations in science and technology have progressed, ASCs have demonstrated tremendous capacity to meet the growing need for outpatient surgical services. In some areas and specialties, ASCs are performing more than 50% of the volume for certain procedures. Sudden changes in payments for services can have a significant effect on Medicare beneficiaries' access to services predominantly performed in ASCs.

The implementation of the revised payment system proposed by Medicare will result in significant redistribution of payments for many specialties. Because ASCs are typically focused on a narrow spectrum of services that require similar equipment and physician expertise, they have a limited ability to respond to changes in the payment system other than to adjust their volume of Medicare patients. On the one hand, for procedures such as ophthalmology, there is a limited market for these services in the non-Medicare population. If the facility fee is insufficient to cover the cost of performing the procedure in an ASC, responding to the change may mean relocating their practice to the HOPD. Such a decision would increase expenditures for the government and the beneficiary. On the other hand, the demand for services such as diagnostic colonoscopies is extremely high in the non-Medicare population. If ASCs determine that the payment rates for such services are too low, they may be able to decrease the proportion of Medicare patients they see without reducing their total patient volume. In that case, beneficiaries may experience significant delays accessing important preventive services or treatment. Neither outcome is optimal for the beneficiary of the Medicare program.

Establishing Reasonable Reimbursement Rates

Medicare payment rates for ASC services have remained stagnant for nearly a decade. Over time, the industry has identified which services it can continue to offer to Medicare beneficiaries through reductions in cost and improvements in efficiency. In the Medicare Payment Advisory Commission's first review of ASC payments in 2003, ASCs were paid more than the HOPD for eight of the top ten procedures most frequently performed in the ASC. One suggestion by the commission was that services migrated to the ASC because the payment rate was higher than the HOPD. However, a multi-year payment freeze on ASC services has turned the tables and now the HOPD rate in 2007 will be higher (or the same) for eight of the same ten ASC procedures. The continued growth of ASCs during the payment freeze is a strong testament to their ability to improve their efficiency and the preference of physicians and beneficiaries for an alternative to the hospital outpatient surgical environment.

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- CMS failed to include on the procedure list many higher complexity services that have for years been safely and effectively performed in ASCs throughout the country. By not creating a truly exclusionary list, CMS is losing an opportunity to increase patient choice and rely on the clinical judgment of the surgeon.

In conclusion, I am asking for a reconsideration of many of the elements of the proposed changes as outlined above. Truly aligning the ASC payment system with that of the HOPDs is the most logical, fair and best policy approach to benefit the Medicare program those served by the program. Should you have any questions regarding any of the issues in this letter, do not hesitate to contact me. My e-mail is mwinslow@nueterra.com, my phone number is 913-387-0609 and my mailing address is 11221 roe Ave, Suite 320, Leawood, KS 66211.

Sincerely,

Martin Winslow
Director of Reimbursement
Nueterra Healthcare

Submitter : **Date: 10/30/2006**

Organization :

Category : **Health Care Professional or Association**

Issue Areas/Comments

GENERAL

GENERAL

scc

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE AND MEDICAID SERIVICES
OFFICE OF STRATEGIC OPERATIONS & REGULATORY AFFAIRS

Please note: We did not receive the attachment that was cited in this comment. We are not able to receive attachments that have been prepared in excel or zip files. Also, the commenter must click the yellow "Attach File" button to forward the attachment.

Please direct your questions or comments to 1 800 743-3951.

Submitter : Mrs. Barbara Mangold **Date:** 10/30/2006

Organization : Davita

Category : Health Care Professional or Association

Issue Areas/Comments

GENERAL

GENERAL

dialysis facilities need to have more support, finacially. the population is getting older and more people are going to dialysis. there is very little money for transportation sevices that is critical for these patients.

Submitter : Ms. Linda Rahm **Date:** 10/30/2006

Organization : MA. Assoc. ASC

Category : Ambulatory Surgical Center

Issue Areas/Comments

CY 2008 ASC Impact

CY 2008 ASC Impact

see attachment

CMS-1506-P2-564-Attach-1.DOC

#561

PIONEER VALLEY SURGICENTER, LLC

PROFESSIONALLY WE SERVE, PERSONALLY WE CARE

October 30, 2006

Leslie V. Norwalk, Esq., Acting Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1506-P
Room 445-G
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

Re: CMS-1506-P - Medicare Program; the Ambulatory Surgical Center Payment System and CY 2008 Payment Rates

Dear Ms. Norwalk:

As CEO of Pioneer Valley Surgicenter in Springfield Massachusetts and as President of the Massachusetts Association of Ambulatory Surgery Centers (MAASC), I have the opportunity to understand the operational needs of 30+ centers though out the state MD. CMS-1506-P will have a severe impact on the operations of all these centers. The physicians who work in my centers do so because they believe in the concept of patients receiving the highest level of care for less money than would be spent if the service was provided in a hospital setting. They are involved in the decisions that affect the care of their patients, and they appreciate the efficiency demonstrated by the surgery center staff.

In the past, reimbursement methodologies have not been equitable for the same services provided in Hospital Outpatient Departments (HOPDs) and Ambulatory Surgery Centers (ASCs). We charge using global fees, and we are paid according to Medicare groupers. There is no reimbursement for implants, unless agreed to as a "carve-out" in a contract. Gaining exception to any insurance contract is difficult and next to impossible to achieve. Orthopedic surgeons across all ASC's in the state use implants, as they do in the HOPD setting which is considered a standard of care. Unlike HOPDs, we frequently are not paid for use these expensive routine implants or the associated fluoroscopy procedures.

I strongly support a payment system that would align payments equitably and reduce the choice of site of service based on reimbursement amounts. The MAASC member base and I are in favor of:

- Payment for CPT codes that is not specific and hence "unlisted". HOPDs are currently reimbursed for these; ASCs are not.

3550 MAIN STREET, SUITE 103 SPRINGFIELD, MA 01107 413-788-9700 OFFICE 413-788-9744 FAX

- Payment for services provided in addition to the procedure, i.e. fluoroscopy, labs. HOPDs are reimbursed for these services; ASCs are not.
- Eliminating the proposed ASC payment based on office-based physician payments. This limitation does not apply to HOPDs.
- Eliminating the proposal for a secondary recalibration for revised cost data each year. The current proposal calls for a secondary recalibration for ASCs, which will result in a cumulative variation between HOPDs and ASCs.
- ASCs should receive all eligible new technology pass-through payments, as currently reimbursed to HOPDs.
- Allow the use of the same forms for filing claims in both the ASC and HOPD settings. Commercial payers require claims to be filed using the UB-92, and I believe Medicare should do the same.
- Reimbursement for any procedures that is not included on the inpatient-only list. HOPDs are currently eligible for payments for these cases.
- Updating the annual increases using the hospital market basket, not the CPI for all urban consumers, as proposed for ASCs. The increases should be based on the same factors.

Patient, the healthcare consumer, should have the ability to have care provided in the location they desire. With the proposed regulations, access may be restricted, as the reimbursement will not cover the cost of performing the procedures.

We believe CMS should adopt the recommendations of the Medicare Payment Advisory Commission (MedPac) and develop a list of excluded services rather than an inclusive services list. The higher costs associated with HOPD reimbursement as compared to ASC reimbursement rates have been well documented by the OIG and MedPac. Medicare ASC's have proven over the past 20 plus years that they are safe performing the same scope of services as an out patient hospital setting while saving the Medicare Program money and providing quality care that should be available to all. Limiting procedures that are safe in an ASC setting increases the cost to Medicare, Medicare beneficiaries and all healthcare beneficiaries since contracting with other insurance providers is based on Medicare's system.

Please consider our concerns. This is so important to the patients, the physicians, and to the ASCs. If you need more information, or if you have any questions, please contact me at 413-788-9700. I would be pleased to speak with you about this important issue.

Respectfully Submitted,

Linda K. Rahm,
CEO of Pioneer Valley Surgicenter, LLC www.pvsurgicenter.com
President of MAASC www.mass-asc.org

Submitter : Mrs. Adriana Moreton **Date:** 10/30/2006

Organization : InterAmerican Dialysis

Category : Nurse

Issue Areas/Comments

ASC Payable Procedures

ASC Payable Procedures

Ambulatory Surgical Center would support Fistula first initiative that CMS support. Patients using this centers are vey happy with results. Tjey do not have to wait long hours to get their access taken care of.

Submitter : Mrs. Angela Fry **Date:** 10/30/2006

Organization : Liberty Cataract Center, LLC

Category : Ambulatory Surgical Center

Issue Areas/Comments

GENERAL

GENERAL

See attachment

CMS-1506-P2-566-Attach-1.DOC

#566

October 29, 2006

Leslie V. Norwalk, Esq., Acting Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1506-P
Room 445-G
Hubert H. Humphrey Building
200 Independence Avenue, NW
Washington, DC 20201

To Whom It May Concern:

The Liberty Cataract Center, an ophthalmic specialty ASC, is committed to delivering high quality cataract and other ophthalmic surgical care at lower costs than HOPDs. Our facility serves approximately 2,000 Medicare patients annually.

It is our belief that the current ASC approved procedures list published by CMS is far too restrictive. The decision on where to perform a patient's surgery should be between the patient and his or her physician. ASCs should be able to furnish and receive facility reimbursement for any and all ophthalmic procedures currently performed in HOPDs. Additionally, the proposed ASC payment of 62% of the HOPD rate does not accurately reflect the difference in expenses incurred in ASC's compared to HOPDs. A 75% rate would be much more acceptable.

Furthermore, ASCs, like HOPDs should absolutely be afforded an annual update of fees based on the hospital market basket since both provide the same services and incur the same costs in delivery high quality surgical care.

Thank you for considering these comments throughout your decision-making process regarding ASC payment reform.

Sincerely,

Angela J. Fry, COT
Administrator
Liberty Cataract Center, LLC
1100 W College St
Liberty, MO 64068

Submitter : Mrs. Terri Olmer **Date:** 10/30/2006

Organization : Medford Kidney Center

Category : End-Stage Renal Disease Facility

Issue Areas/Comments

ASC Payable Procedures

ASC Payable Procedures

I support CMS practice of re-examining its policies as technology improves and practice patterns change, especially when supported by recommendations made by the Medicare Payment Advisory Commission (MedPAC) in their March 2004 report to Congress. The report concludes that clinical safety standards and the need for an overnight stay be the only criteria for excluding a procedure from the approved list.

Please support patient choice! There is clear scientific evidence that vascular access procedures are safe and can be performed in Ambulatory Surgical Center setting, and more importantly, patients are extremely satisfied with having the option to secure vascular access repair and maintenance care in an outpatient setting. Further, the inclusion of angioplasty codes in the ASC setting would support CMS Fistula First initiative by permitting a full range of vascular access procedures to be performed in an ASC setting, a less expensive and more accessible option than the current prevalent hospital setting.

Please treat End Stage Renal Disease patients fairly by ensuring all angioplasty codes, including CPT 35476 are allowed in the ASC setting.

Submitter : Mrs. Terri Olmer **Date:** 10/30/2006

Organization : Medford Kidney Center

Category : End-Stage Renal Disease Facility

Issue Areas/Comments

GENERAL

GENERAL

Vascular access is one of the greatest sources of complications and cost for dialysis patients. Why, because America uses more surgical grafts and catheters for vascular access than the rest of the developed world, even though there is substantial evidence that they impose higher initial and maintenance costs, lead to greater clinical complications, and result in higher mortality than arterio-venous (AV) fistulae.

The inclusion of CPT codes 35475, 35476, 36205 and 37206 to the list of Medicare approved ambulatory surgical center (ASC) procedures would provide Medicare the opportunity to reduce the cost of, and promote quality outcomes for, end-stage renal disease (ESRD) patients through more thoughtful reimbursement and regulation of vascular access procedures.

Submitter : **Ms. Susan Nadolski** **Date: 10/30/2006**

Organization : **Davita**

Category : **Nurse**

Issue Areas/Comments

ASC Office-Based Procedures

ASC Office-Based Procedures

I think vascular access can be done very safely in an ambulatory care center. I also think that fistula creation should receive more reimbursement than graft or catheter insertion.

Submitter : **Mrs. Marcia Ratliff** **Date: 10/30/2006**

Organization : **Nueterra Healthcare**

Category : **Ambulatory Surgical Center**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE AND MEDICAID SERIVICES
OFFICE OF STRATEGIC OPERATIONS & REGULATORY AFFAIRS

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Please direct your questions or comments to 1 800 743-3951.

Submitter : **Mr. Edgardo Marquez** **Date: 10/30/2006**

Organization : **Mr. Edgardo Marquez**

Category : **Individual**

Issue Areas/Comments

ASC Payable Procedures

ASC Payable Procedures

There is clear scientific evidence that vascular access procedures are safe and can be performed in Ambulatory Surgical Center setting, and more importantly, patients are satisfied with having the option to secure vascular access repair and maintenance care in an outpatient setting. Further, the inclusion of angioplasty codes in the ASC setting would support CMS Fistula First initiative by permitting a full range of vascular access procedures to be performed in an ASC setting, a less expensive and more accessible option than the current prevalent hospital setting.

Please help End Stage Renal Disease patients by ensuring that all angioplasty codes, including CPT 35476 are allowed in the ASC setting.

Submitter : **Dr. David George** **Date: 10/30/2006**

Organization : **Physicians Outpatient Surgery Center**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

see attachment

CMS-1506-P2-572-Attach-1.DOC

I am a physician owner of an ASC. In 1999, we started our ASC in a very small town, Belpre Ohio. The the Physicians Outpatinet Surgery Center, Ltd., we now do about 2500 procedures per year and I cannot begin to tell you how much our patient appreciate our center compared to going to a hospital. Our services are high quality and efficient. We have a team that is highly skilled. We charge less than hospitals thus patients save both time and money coming to our ASC for surgery. Having a physician led ASC also better enables me to control the high quality services I demand for my patients. Just survey patients nationally and I'm sure you will find the same story throughout the United States. Patients expect high quality and want efficiency and cost effective care; ASCs meet their needs and thus they are very successful.

The experience of ASCs is a rare example of a successful transformation in health care delivery. Thirty years ago, virtually all surgery was performed in hospitals. Waits of weeks or months for an appointment were not uncommon, and patients typically spent several days in the hospital and several weeks out of work in recovery. In many countries, surgery is still like this today, but not in the United States.

Both today and in the past, physicians have led the development of ASCs. The first facility was opened in 1970 by two physicians who saw an opportunity to establish a high-quality, cost-effective alternative to inpatient hospital care for surgical services. Faced with frustrations like scheduling delays, limited operating room availability, slow operating room turnover times, and challenges in obtaining new equipment due to hospital budgets and policies, physicians were looking for a better way - and developed it in ASCs.

Physicians continue to provide the impetus for the development of new ASCs. By operating in ASCs instead of hospitals, physicians gain the opportunity to have more direct control over their surgical practices. In the ASC setting, physicians are able to schedule procedures more conveniently, are able to assemble teams of specially-trained and highly skilled staff, are able to ensure the equipment and supplies being used are best suited to their technique, and are able to design facilities tailored to their specialty. Simply stated, physicians are striving for, and have found in ASCs, the professional autonomy over their work environment and over the quality of care that has not been available to them in hospitals. These benefits explain why physicians who do not have ownership interest in ASCs (and therefore do not benefit financially from performing procedures in an ASC) choose to work in ASCs in such high numbers.

Overview

The broad statutory authority granted to the Secretary to design a new ASC payment system in the Medicare Modernization Act of 2003 presents the Medicare program with a unique opportunity to better align payments to providers of outpatient surgical services. Given the outdated cost data and crude payment categories underlying the current ASC system, we welcome the opportunity to link the ASC and hospital outpatient department (HOPD) payment systems. Although the HOPD payment system is imperfect, it represents the best proxy for the relative cost of procedures performed in the ASC.

In the comments to follow, we focus on three basic principles:

- maximizing the alignment of the ASC and HOPD payment systems eliminate distortions between the payment systems that could inappropriately influence site of service selection,

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Alignment of ASC and HOPD Payment Policies

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The implementation of the revised payment system proposed by Medicare will result in significant redistribution of payments for many specialties. Because ASCs are typically focused on a narrow spectrum of services that require similar equipment and physician expertise, they have a limited ability to respond to changes in the payment system other than to adjust their volume of Medicare patients. On the one hand, for procedures such as ophthalmology, there is a limited market for these services in the non-Medicare population. If the facility fee is insufficient to cover the cost of performing the procedure in an ASC, responding to the change may mean relocating their practice to the HOPD. Such a decision would increase expenditures for the government and the beneficiary. On the other hand, the demand for services such as diagnostic colonoscopies is extremely high in the non-Medicare population. If ASCs determine that the payment rates for such services are too low, they may be able to decrease the proportion of Medicare patients they see without reducing their total patient volume. In that case, beneficiaries may experience significant delays accessing important preventive services or treatment. Neither outcome is optimal for the beneficiary of the Medicare program.

Establishing Reasonable Reimbursement Rates

Medicare payment rates for ASC services have remained stagnant for nearly a decade. Over time, the industry has identified which services it can continue to offer to Medicare beneficiaries through reductions in cost and improvements in efficiency. In the Medicare Payment Advisory Commission's first review of ASC payments in 2003, ASCs were paid more than the HOPD for eight of the top ten procedures most frequently performed in the ASC. One suggestion by the commission was that services migrated to the ASC because the payment rate was higher than the HOPD. However, a multi-year payment freeze on ASC services has turned the tables and now the HOPD rate in 2007 will be higher (or the same) for eight of the same ten ASC procedures. The continued growth of ASCs during the payment freeze is a strong testament to their ability to improve their efficiency and the preference of physicians and beneficiaries for an alternative to the hospital outpatient surgical environment.

The impact of HOPD payments eclipsing the ASC rates has had the perverse effect of increasing the "cost" of the budget neutrality requirement imposed by the Medicare Modernization Act on the future conversion factor for ASC payments. The Lewin Group estimates that the inflation updates applied to the HOPD rates since passage of the MMA account for 40 percent of the discount required to achieve budget neutrality under the agency's proposed rule. This, combined with the agency's narrow interpretation of budget neutrality, produce an unacceptably low conversion factor for ASC payments.

- Budget Neutrality: Adopt an expansive, realistic interpretation of budget neutrality. The new payment system and the expansion of the ASC list will result in migration of services from one site of service setting to another. CMS has the legal authority and the fiduciary responsibility to examine the consequences of the new ASC payment system on all sites of care – the physician office, ASCs, and HOPD.

- ASCs should comment on the possible negative effect on access to services, since the methodology proposed results in ASC payments equaling only 62% of HOPD.

- By setting rates this low, CMS would force doctors to move cases to the more expensive hospital setting, increasing the amount of money paid by Medicare beneficiaries and the government. Rather than paying ASCs a set percentage of HOPD rates, the proposed rule establishes a complicated formula to link ASC payment to HOPD payment but does not link payment in a uniform manner. This will impede Medicare beneficiaries' ability to understand their real costs in alternative settings. In the words of President Bush, Medicare beneficiaries need to be able to make "apples to apples" comparisons in order to increase transparency in the health care sector.

- CMS failed to include on the procedure list many higher complexity services that have for years been safely and effectively performed in ASCs throughout the country. By not creating a truly exclusionary list, CMS is losing an opportunity to increase patient choice and rely on the clinical judgment of the surgeon.

I hope you will give strong consideration to these concepts. Patients want surgery in an ASC setting. The Medicare program should enable it as every case done in an ASC saves Medicare money compared to a hospital. Change is good. Hospitals need the competition to stay cost effective. America was built on capitalism yet ASCs have never been treated fairly regarding reimbursement. Hospitals lobby to hinder ASC growth and reimbursement as they cannot compete with them in a truly free market. The playing field needs to be leveled thus allowing a surgery done at an ASC to be paid in the same way it is for the same surgery done in a hospital. It is essentially the same product, why should there be such a difference in reimbursement systems and fees?

Please contact me if I can be of any service to you,

David George, MD
Medical Director
Physicians Outpatient Surgery Center, Ltd
Belpre, Ohio
1-800-758-3937

Submitter : **Dr. Jack Rubin** **Date: 10/30/2006**

Organization : **Davita**

Category : **Physician**

Issue Areas/Comments

ASC Payment for Office-Based Procedures

ASC Payment for Office-Based Procedures

I strongly urge you not to reduce payments for out patient angiographic procedures. If this proposal is passed, patients will be forced to wait in inefficient hospital settings and Medicare will be paying more than 3 times the price of the procedure to a hospital when the same procedure could be done for much less cost, more than 2/3 in an out-patient setting

Submitter : **Dr. Jack Rubin** **Date: 10/30/2006**

Organization : **Davita**

Category : **Physician**

Issue Areas/Comments

CY 2008 ASC Impact

CY 2008 ASC Impact

I urge you not to reduce payment for the ambulatory surgical centers taht are threatened with this proposed reduction. By reducing these centers' payments you will force patients back into inefficent hospital settings for them to have their surgical procedures done. Not only is this inconvenient, but hospital procedures are charged more than 300% higher than similar out-patient surgical centers charge.

Submitter : Dr. Eric Fels **Date:** 10/30/2006

Organization : Eastern PA Nephrology Associates

Category : Physician

Issue Areas/Comments

ASC Payable Procedures

ASC Payable Procedures

The inclusion of CPT codes 35475, 35476, 36205 and 37206 to the list of Medicare approved ambulatory surgical center (ASC) procedures would provide Medicare the opportunity to reduce the cost of, and promote quality outcomes for, end-stage renal disease (ESRD) patients through more thoughtful reimbursement and regulation of vascular access procedures.

ASC Payable Procedures

ASC Payable Procedures

I support CMS practice of re-examining its policies as technology improves and practice patterns change, especially when supported by recommendations made by the Medicare Payment Advisory Commission (MedPAC) in their March 2004 report to Congress. The report concludes that clinical safety standards and the need for an overnight stay be the only criteria for excluding a procedure from the approved list.

Please support patient choice! There is clear scientific evidence that vascular access procedures are safe and can be performed in Ambulatory Surgical Center setting, and more importantly, patients are extremely satisfied with having the option to secure vascular access repair and maintenance care in an outpatient setting. Further, the inclusion of angioplasty codes in the ASC setting would support CMS Fistula First initiative by permitting a full range of vascular access procedures to be performed in an ASC setting, a less expensive and more accessible option than the current prevalent hospital setting.

Please treat End Stage Renal Disease patients fairly by ensuring all angioplasty codes, including CPT 35476 are allowed in the ASC setting.

GENERAL

GENERAL

Please support the development of ASC access centers. Despite my practice at a large, nationally recognized tertiary care hospital, dialysis access procedures are always an 'add-on' and are low priority. My patients have to wait and we often have to place temporary catheters to treat the patients emergently, an extra and unnecessary (and uncomfortable) procedure. Nephrologists have little input/control in this setting. ASC models are much more physician friendly, provide faster service which is dedicated purely to dialysis access care. Thank you for your consideration.

Submitter : Mrs. xxx xxx **Date:** 10/30/2006

Organization : davita

Category : End-Stage Renal Disease Facility

Issue Areas/Comments

ASC Payable Procedures

ASC Payable Procedures

it is important for patients to have covered proceedures that are appropriate for safty and and the patient's condition. this should be determined by the nephrologist and the surgeon for ongooing and necessary care. when appropriate out patient care is acceptable in many cases. this should be reimbursed as needed. most esrd patients have little resources of monies or ability to pay outright cost of surgical interventions necessary to sustain their lives. out patient proceedures should be covered when necessary for continued care of the patient.

Submitter : Mr. NIGEL ALVESTON **Date:** 10/31/2006

Organization : Mr. NIGEL ALVESTON

Category : Individual

Issue Areas/Comments

ASC Payable Procedures

ASC Payable Procedures

I support CMS practice of re-examining its policies as technology improves and practice patterns change, especially when supported by recommendations made by the Medicare Payment Advisory Commission (MedPAC) in their March 2004 report to Congress. The report concludes that clinical safety standards and the need for an overnight stay be the only criteria for excluding a procedure from the approved list.

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Please treat End Stage Renal Disease patients fairly by ensuring all angioplasty codes, including CPT 35476 are allowed in the ASC setting.

Submitter : Mr. NIGEL ALVESTON **Date:** 10/31/2006

Organization : Mr. NIGEL ALVESTON

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

Vascular access is one of the greatest sources of complications and cost for dialysis patients. Why, because America uses more surgical grafts and catheters for vascular access than the rest of the developed world, even though there is substantial evidence that they impose higher initial and maintenance costs, lead to greater clinical complications, and result in higher mortality than arterio-venous (AV) fistulae.

The inclusion of CPT codes 35475, 35476, 36205 and 37206 to the list of Medicare approved ambulatory surgical center (ASC) procedures would provide Medicare the opportunity to reduce the cost of, and promote quality outcomes for, end-stage renal disease (ESRD) patients through more thoughtful reimbursement and regulation of vascular access procedures.

Submitter : Ms. Kristine Schede-Don **Date:** 10/31/2006

Organization : DaVita

Category : Nurse

Issue Areas/Comments

ASC Payable Procedures

ASC Payable Procedures

Please support patient choice! There is clear evidence that vascular access procedures are safe and can be performed in Ambulatory Surgical Center setting. Patients are extremely satisfied with having the option to secure vascular access repair and maintenance care in an outpatient setting. It is more convientent for the patients and their families trying to schedule the procedures. It required less waiting time at the facility due to emergency procedures that have to be done in the hospital setting. Further, the inclusion of angioplasty codes in the ASC setting would support CMS Fistula First initiative by permitting a full range of vascular access procedures to be performed in an ASC setting, a less expensive and more accessible option than the current prevalent hospital setting.

Please treat End Stage Renal Disease patients fairly by ensuring all angioplasty codes, including CPT 35476 are allowed in the ASC setting.

Submitter : Mrs. Amy Staples **Date:** 10/31/2006

Organization : Mrs. Amy Staples

Category : Individual

Issue Areas/Comments

ASC Payable Procedures

ASC Payable Procedures

CENTERS FOR MEDICARE & MEDICAID SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES
ATTENTION: CMS-1506-P2
P.O. BOX 8011
BALTIMORE, MD 21244-1850
Dear Sirs/Madams
We support CMS' practice of re-examining its policies as technology improves and practice patterns change, especially when supported by recommendations made by the Medicare Payment Advisory Commission (MEDPAC) in their March 2004 report to Congress. The report concludes that clincal safety standards and the need for an overnight stay be the only criteria for excluding a procedure from the approved list
PLEASE SUPPORT PATIENT CHOICE! There is clear scientific evidence that vascular access procedures are safe and can be performed in Ambulatory Surgical Center setting, and more importantly, patients are extremely satisfied with having the option to secure vascular access repair and maintenance care in an outpatient setting. I personally have had 6 such surgeries in the Ambulatory Surgical Center setting and have been very happy with the entire process. Further, the inclusion of angioplasty codes in the ASC setting would support CMS' Fistula First initiative by permitting a full range of vascular access procedures to be performed in an ASC setting, a less expensive and more accessible option than the curren prevalent hospital setting. I know from personal experience regarding this as I have had approximately 20 angioplasties on my fistulas/grafts and all were required to be in a hospital setting which was far more costly and time consuming than in an ASC setting.
Please treat END STAGE RENAL DISEASE patients (dialyzors/consumers) fairly by ensuring all angioplasty codes, including CPT 35476 are allowed in the ASC setting,
Thank you
Sincerely,
Amy G. Staples
211 SE 75th Ave.
Laredo, MO 64652
660-286-2686

GENERAL

GENERAL

October 31, 2006
CENTERS FOR MEDICARE & MEDICAID SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES
ATTENTION: CMS-1506-P2
P.O. BOX 8011
BALTIMORE, MD 21244-1850

Dear Sirs/Madams:
Please consider the following comments for CMS 1506-P2; The Hospital Outpatient Prospective Payment Systems and CY 2007 payment Rates; FY 2008 ASC Payment.

Vascular access is one of the greatest sources of complications and cost for dialysis patients. Why, because America uses more surgical grafts and catheters for vascular access than the rest of the developed world, even though there is substantial evidence that they impose higher initial and maintenance costs, lead to greater clinical complications, and result in higher mortality than arterio-venous (AV) fistulae.

The inclusion of CPT codes 35475, 35476, 36205, and 37206 to the list of Medicare approved ambulatory surgical center (ASC) procedures WOULD provide Medicare the opportunity to reduce the cost of, and promote quality outcomes for, end-stage renal disease (ESRD) patients through more thoughtful reimbursement and regulation of vascular access procedures.
Thank you
Sincerely,
Amy G. Staples
211 SE 75th Ave.
Laredo, MO
64652
660-286-2586

Submitter : Mr. John Stone **Date:** 10/31/2006

Organization : Three Gables Sugery Center

Category : Ambulatory Surgical Center

Issue Areas/Comments

GENERAL

GENERAL

See attached

CMS-1506-P2-581-Attach-1.DOC

581

Leslie V. Norwalk, Esq., Acting Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1506-P
Room 445-G
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

Re: CMS-1506-P - Medicare Program; the Ambulatory Surgical Center Payment System and CY 2008 Payment Rates

Dear Ms. Norwalk:

I am writing regarding the proposed payment changes for Ambulatory Surgery Centers. Our center, Three Gables Surgery Center, is located in Proctorville, Ohio and serves hundreds of Medicare recipients each year. We are very concerned that the changes, as currently proposed by CMS, will have a detrimental affect on ASCs and the Medicare program.

Given the outdated cost data and crude payment categories underlying the current ASC system, we welcome the opportunity to link the ASC and hospital outpatient department (HOPD) payment systems. Although the HOPD payment system is imperfect, it represents the best proxy for the relative cost of procedures performed in the ASC.

In the comments to follow, we focus on three basic principles:

- maximizing the alignment of the ASC and HOPD payment systems eliminate distortions between the payment systems that could inappropriately influence site of service selection,
- ensuring beneficiary access to a wide range of surgical procedures that can be safely and efficiently performed in the ASC, and
- establishing fair and reasonable payment rates to allow beneficiaries and the Medicare program to save money on procedures that can be safely performed at a lower cost in the ASC than the HOPD.

Alignment of ASC and HOPD Payment Policies

Aligning the payment systems for ASCs and hospital outpatient departments will improve the transparency of cost data used to evaluate outpatient surgical services for Medicare beneficiaries. The benefits to the taxpayer and the Medicare consumer will be maximized by aligning the payment policies to the greatest extent permitted under the law. While we appreciate the many ways in which the agency proposes to align the payment system, we are concerned that the linkage is incomplete and may lead to further distortions between the payment systems. Many policies applied to payments for hospital outpatient services were not extended to the ASC setting, and these inconsistencies undermine the appropriateness of the APC relative weights, create disparities in the relationship between the ASC and HOPD payment rates, and embed in the new payment system site of service incentives that will cost the taxpayer and the beneficiary more than necessary.

There are many components of the regulation where a more complete alignment of the ASC and HOPD payment systems is appropriate. Below is an overview of the major areas where further refinement of the proposed rule is warranted. These issues are discussed in greater detail under the relevant section heading in the text to follow.

- **Procedure list:** HOPDs are eligible for payment for any service not included on the inpatient only list. The CMS proposal would limit a physician's ability to determine appropriate site of service for a procedure, because it excludes many surgical procedures appropriate for the ASC setting.

- **Treatment of unlisted codes:** Providers occasionally perform services or procedures for which the CPT manual does not provide a specific code and therefore the provider uses an unlisted procedure code to identify the service. HOPDs receive payment for such unlisted codes under OPPS; ASCs should also be eligible for payment of selected unlisted codes.

- **Different payment bundles:** Several of the policies for packaging ancillary and other procedure costs into the ASC payment bundle result in discrepancies between service costs represented in the APC relative weight. For example, when HOPDs perform services outside the surgical range that are not packaged, they receive additional payments for which ASCs should also be eligible.

- **Cap on office-based payments:** CMS proposes to cap payment for certain ASC procedures commonly performed in the office at the physician practice expense payment rate. No such limitation is applied to payments under the OPPS, presumably because the agency recognizes the cost of a procedure varies depending on the characteristics of the beneficiary and the resources available at the site of service. We likewise believe this cap is inappropriate for the ASC and should be omitted from the final regulation.

- **Different measures of inflation:** CMS updates the OPPS conversion factor for annual changes in inflation using the hospital market basket; however, the agency proposes to update ASC payments using the consumer price index for all urban consumers. The market basket is a better proxy for the inflationary pressures faced by ASCs, as it is the measure used by the agency to update payments to hospitals providing the same services.

- **Secondary rescaling of APC relative weights:** CMS applies a budget neutrality adjustment to the OPPS relative weight values after they are recalibrated with new cost data each year. The agency proposes a secondary recalibration of the relative weights before they are used by ASCs. This secondary recalibration will result in annual and potentially cumulative variation between ASC and HOPD payments without any evidence that the cost of providing services has further diverged between settings.

- **Non-application of HOPD policies to the ASC.** Over the years, CMS has implemented through statutory or administrative authority numerous policies to support services in the HOPD, including additional payment for high-cost outliers, transitional corridor and hold-harmless payments to rural and sole-community hospitals, and payments for new technologies. While not all of these policies are appropriate for the ASC, surgery centers should be eligible to receive new technology pass-through payments.

- **Use of different billing systems:** The HOPD and ASC use the UB-92 and CMS-1500, respectively, to submit claims to the government for services. Use of different forms prevents ASCs from documenting all the services provided to a Medicare beneficiary, therefore undermining the documentation of case mix differences between sites of service. Most commercial payors require

ASCs to submit claims using the UB-92, and the Medicare program should likewise align the payment system at the claim level.

Ensuring Beneficiaries' Access to Services

Ambulatory surgery centers are an important component of beneficiaries' access to surgical services. As innovations in science and technology have progressed, ASCs have demonstrated tremendous capacity to meet the growing need for outpatient surgical services. In some areas and specialties, ASCs are performing more than 50% of the volume for certain procedures. Sudden changes in payments for services can have a significant effect on Medicare beneficiaries' access to services predominantly performed in ASCs.

The implementation of the revised payment system proposed by Medicare will result in significant redistribution of payments for many specialties. Because ASCs are typically focused on a narrow spectrum of services that require similar equipment and physician expertise, they have a limited ability to respond to changes in the payment system other than to adjust their volume of Medicare patients. On the one hand, for procedures such as ophthalmology, there is a limited market for these services in the non-Medicare population. If the facility fee is insufficient to cover the cost of performing the procedure in an ASC, responding to the change may mean relocating their practice to the HOPD. Such a decision would increase expenditures for the government and the beneficiary. On the other hand, the demand for services such as diagnostic colonoscopies is extremely high in the non-Medicare population. If ASCs determine that the payment rates for such services are too low, they may be able to decrease the proportion of Medicare patients they see without reducing their total patient volume. In that case, beneficiaries may experience significant delays accessing important preventive services or treatment. Neither outcome is optimal for the beneficiary of the Medicare program.

Establishing Reasonable Reimbursement Rates

Medicare payment rates for ASC services have remained stagnant for nearly a decade. Over time, the industry has identified which services it can continue to offer to Medicare beneficiaries through reductions in cost and improvements in efficiency. In the Medicare Payment Advisory Commission's first review of ASC payments in 2003, ASCs were paid more than the HOPD for eight of the top ten procedures most frequently performed in the ASC. One suggestion by the commission was that services migrated to the ASC because the payment rate was higher than the HOPD. However, a multi-year payment freeze on ASC services has turned the tables and now the HOPD rate in 2007 will be higher (or the same) for eight of the same ten ASC procedures. The continued growth of ASCs during the payment freeze is a strong testament to their ability to improve their efficiency and the preference of physicians and beneficiaries for an alternative to the hospital outpatient surgical environment.

The impact of HOPD payments eclipsing the ASC rates has had the perverse effect of increasing the "cost" of the budget neutrality requirement imposed by the Medicare Modernization Act on the future conversion factor for ASC payments. The Lewin Group estimates that the inflation updates applied to the HOPD rates since passage of the MMA account for 40 percent of the discount required to achieve budget neutrality under the agency's proposed rule. This, combined with the agency's narrow interpretation of budget neutrality, produces an unacceptably low conversion factor for ASC payments.

- Budget Neutrality: Adopt an expansive, realistic interpretation of budget neutrality. The new payment system and the expansion of the ASC list will result in migration of services from one site of service setting to another. CMS has the legal authority and the fiduciary responsibility to examine the

consequences of the new ASC payment system on all sites of care – the physician office, ASCs, and HOPD.

- ASCs should comment on the possible negative effect on access to services, since the methodology proposed results in ASC payments equaling only 62% of HOPD.

- By setting rates this low, CMS would force doctors to move cases to the more expensive hospital setting, increasing the amount of money paid by Medicare beneficiaries and the government. Rather than paying ASCs a set percentage of HOPD rates, the proposed rule establishes a complicated formula to link ASC payment to HOPD payment but does not link payment in a uniform manner. This will impede Medicare beneficiaries' ability to understand their real costs in alternative settings. In the words of President Bush, Medicare beneficiaries need to be able to make "apples to apples" comparisons in order to increase transparency in the health care sector.

- CMS failed to include on the procedure list many higher complexity services that have for years been safely and effectively performed in ASCs throughout the country. By not creating a truly exclusionary list, CMS is losing an opportunity to increase patient choice and rely on the clinical judgment of the surgeon.

In conclusion, I am asking for a reconsideration of many of the elements of the proposed changes as outlined above. Truly aligning the ASC payment system with that of the HOPDs is the most logical, fair and best policy approach to benefit the Medicare program those served by the program. Should you have any questions regarding any of the issues in this letter, do not hesitate to contact me. My e-mail is jstone@ohtgsc.nueterra.com or you may contact me at the address/phone number listed below.

Sincerely,

John Stone, RN MBA
Administrator

Three Gables Surgery Center
P.O. Box 490
Proctorville, OH 45669

Submitter : **Date: 10/31/2006**

Organization :

Category : **Physician**

Issue Areas/Comments

ASC Payable Procedures

ASC Payable Procedures

I have been a urologist for over thirty years and have seen the evolution of the services we render our patients. I dare say that the quality of these services have improved considerably since the advent of licensed surgery centers. Our patients attest to it and our meticulous record keeping on outcomes also support that indeed this is tremendous jump in our ability to give quality care to our patients. In any business endeavor we are very much conscious of the cost of health care but at the same time balance that to what it cost to deliver that same quality without compromise to our patients. It seems to me that similar services should be paid the same whether it is done in a hospital setting or in an approved surgery center. It would put us in a tremendous economic hardship if rules are in place to descriminate payment schedules. I strongly urge you to take that into consideration in the formulation of rulings that would adversely affect us.

Submitter : Sharon Adams **Date:** 10/31/2006

Organization : DaVita Dialysis

Category : Nurse

Issue Areas/Comments

ASC Payable Procedures

ASC Payable Procedures

I support CMS practice of re-examining its policies as technology improves and practice patterns change, especially when supported by recommendations made by the Medicare Payment Advisory Commission (MedPAC) in their March 2004 report to Congress. The report concludes that clinical safety standards and the need for an overnight stay be the only criteria for excluding a procedure from the approved list.

Please support patient choice! There is clear scientific evidence that vascular access procedures are safe and can be performed in Ambulatory Surgical Center setting, and more importantly, patients are extremely satisfied with having the option to secure vascular access repair and maintenance care in an outpatient setting. Further, the inclusion of angioplasty codes in the ASC setting would support CMS Fistula First initiative by permitting a full range of vascular access procedures to be performed in an ASC setting, a less expensive and more accessible option than the current prevalent hospital setting.

Please treat End Stage Renal Disease patients fairly by ensuring all angioplasty codes, including CPT 35476 are allowed in the ASC setting.

GENERAL

GENERAL

Vascular access is one of the greatest sources of complications and cost for dialysis patients. Why, because America uses more surgical grafts and catheters for vascular access than the rest of the developed world, even though there is substantial evidence that they impose higher initial and maintenance costs, lead to greater clinical complications, and result in higher mortality than arterio-venous (AV) fistulae.

The inclusion of CPT codes 35475, 35476, 36205 and 37206 to the list of Medicare approved ambulatory surgical center (ASC) procedures would provide Medicare the opportunity to reduce the cost of, and promote quality outcomes for, end-stage renal disease (ESRD) patients through more thoughtful reimbursement and regulation of vascular access procedures.

Submitter : Mr. Steve Kivett **Date:** 10/31/2006

Organization : Iredell Memorial Hospital

Category : Nurse

Issue Areas/Comments

ASC Payable Procedures

ASC Payable Procedures

Our hospital/surgeons insert permcaths and do AVF surgery often on an outpatient/observation basis. We have not had any bad outcomes.

Submitter : Ms. SUE CREWS **Date:** 10/31/2006

Organization : DAVITA DIALYSIS

Category : Nurse

Issue Areas/Comments

ASC Payable Procedures

ASC Payable Procedures

It would improve the care and cost containment for access procedures to be done and payment approved in out patient settings. Please consider allowing the needed surgeries and angioplasties to be performed in an envirnoment that is conducive to efficiency and timeliness for all affected.

I have been a dialysis nurse for 21 years and have seen improvement in the care we deliver, largely due to better accesses which allow for better dialysis. The need to continue to focus on "real"time solutions to the everyday needs will save money and lives. This must be done nationwide to encourage the development of out-patient access centers in as many locations as possible. The lack of AV fistula is related to decreased reimbursement and physicians committment to performing the surgery.

I look forward to seeing improvement in these areas.

Sue Crews, RN, CNN

Submitter : **Beverlee Stemple** **Date: 10/31/2006**

Organization : **DaVita**

Category : **Individual**

Issue Areas/Comments

ASC Payable Procedures

ASC Payable Procedures

I support CMS practice of re-examining its policies as technology improves and practice patterns change, especially when supported by recommendations made by the Medicare Payment Advisory Commission (MedPAC) in their March 2004 report to Congress. The report concludes that clinical safety standards and the need for an overnight stay be the only criteria for excluding a procedure from the approved list.

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Please treat End Stage Renal Disease patients fairly by ensuring all angioplasty codes, including CPT 35476 are allowed in the ASC setting.

Submitter : **Beverlee Stemple** **Date: 10/31/2006**

Organization : **DaVita**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

Vascular access is one of the greatest sources of complications and cost for dialysis patients. Why, because America uses more surgical grafts and catheters for vascular access than the rest of the developed world, even though there is substantial evidence that they impose higher initial and maintenance costs, lead to greater clinical complications, and result in higher mortality than arterio-venous (AV) fistulae.

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Submitter : Ms. Joan Guest **Date:** 10/31/2006

Organization : DaVita

Category : Other Practitioner

Issue Areas/Comments

GENERAL

GENERAL

I Support ESRD Patients' Access to Quality Care. There is clear scientific evidence that vascular access procedures are safe and can be performed in Ambulatory Surgical Center (ASC) settings.

I Support CMS' Fistula First Initiative. Angioplasty codes should be included to permit a full range of vascular access procedures to be performed in accessible, cost-effective ASC settings. Fistulas are the gold standard for ESRD patients. Why does CMS reimburse LESS for Fistula placement and MORE for catheter insertions and graft insertion, when both catheters and grafts have higher incidence of related infections, clotting and hospitalizations? CMS should change its reimbursement practices to reflect current standards of care.

Submitter : **Date: 10/31/2006**

Organization :

Category : **Individual**

Issue Areas/Comments

ASC Payment for Office-Based Procedures

ASC Payment for Office-Based Procedures

As a wife, now widow, of an ESRD patient, I think ASCs are good for the pt. and the government (lower costs). Hospitals have many people to care for that have serious conditions. ASCs offer an alternative to give pts. easier access and quicker appointments under a setting that is designed for their particular needs. And it takes the load off hospital surgical centers. Sounds like a winner for everyone.

Submitter : Ms. La Veta Zhantial **Date:** 10/31/2006

Organization : Nueterra Healthcare

Category : Health Care Industry

Issue Areas/Comments

GENERAL

GENERAL

See Attached

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE AND MEDICAID SERIVICES
OFFICE OF STRATEGIC OPERATIONS & REGULATORY AFFAIRS

Please note: We did not receive the attachment that was cited in this comment. We are not able to receive attachments that have been prepared in excel or zip files. Also, the commenter must click the yellow "Attach File" button to forward the attachment.

Please direct your questions or comments to 1 800 743-3951.

Submitter : **Date: 10/31/2006**

Organization :

Category : **Ambulatory Surgical Center**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE AND MEDICAID SERIVICES
OFFICE OF STRATEGIC OPERATIONS & REGULATORY AFFAIRS

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Please direct your questions or comments to 1 800 743-3951.

Submitter : James Ray **Date:** 10/31/2006

Organization : Timberlake Surgery Center

Category : Other Health Care Professional

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1506-P2-592-Attach-1.DOC

#592

Center for Medicare and Medicaid Services
Washington DC

Dear Sirs:

I wish to submit comments relating to proposed Medicare payment changes that affect Ambulatory Surgery Centers (ASCs). As an administrator of an ASC, I feel I am in a very relevant position to provide you with feedback on the necessity to ensure parity between HOPD payments and ASC payments.

Physicians continue to provide the impetus for the development of new ASCs. By operating in ASCs instead of hospitals, physicians gain the opportunity to have more direct control over their surgical practices. In the ASC setting, physicians are able to schedule procedures more conveniently, are able to assemble teams of specially-trained and highly skilled staff, are able to ensure the equipment and supplies being used are best suited to their technique, and are able to design facilities tailored to their specialty. Simply stated, physicians are striving for, and have found in ASCs, the professional autonomy over their work environment and over the quality of care that has not been available to them in hospitals. These benefits explain why physicians who do not have ownership interest in ASCs (and therefore do not benefit financially from performing procedures in an ASC) choose to work in ASCs in such high numbers.

The broad statutory authority granted to the Secretary to design a new ASC payment system in the Medicare Modernization Act of 2003 presents the Medicare program with a unique opportunity to better align payments to providers of outpatient surgical services. Given the outdated cost data and crude payment categories underlying the current ASC system, we welcome the opportunity to link the ASC and hospital outpatient department (HOPD) payment systems. Although the HOPD payment system is imperfect, it represents the best proxy for the relative cost of procedures performed in the ASC.

In the comments to follow, I focus on three basic principles:

- maximizing the alignment of the ASC and HOPD payment systems eliminate distortions between the payment systems that could inappropriately influence site of service selection,

- ensuring beneficiary access to a wide range of surgical procedures that can be safely and efficiently performed in the ASC, and

- establishing fair and reasonable payment rates to allow beneficiaries and the Medicare program to save money on procedures that can be safely performed at a lower cost in the ASC than the HOPD.

Alignment of ASC and HOPD Payment Policies

Aligning the payment systems for ASCs and hospital outpatient departments will improve the transparency of cost data used to evaluate outpatient surgical services for Medicare beneficiaries. The benefits to the taxpayer and the Medicare consumer will be maximized by aligning the payment policies to the greatest extent permitted under the law. While we appreciate the many ways in which the agency proposes to align the payment system, we are concerned that the linkage is incomplete and may lead to further distortions between the payment systems. Many policies applied to payments for hospital outpatient services were not extended to the ASC setting, and these inconsistencies undermine the appropriateness of the APC relative weights, create disparities in the relationship between the ASC and HOPD payment rates, and embed in the new payment system site of service incentives that will cost the taxpayer and the beneficiary more than necessary.

There are many components of the regulation where a more complete alignment of the ASC and HOPD payment systems is appropriate. Below is an overview of the major areas where further refinement of the proposed rule is warranted. These issues are discussed in greater detail under the relevant section heading in the text to follow.

- **Procedure list:** HOPDs are eligible for payment for any service not included on the inpatient only list. The CMS proposal would limit a physician's ability to determine appropriate site of service for a procedure excludes many surgical procedures appropriate for the ASC setting.

- **Treatment of unlisted codes:** Providers occasionally perform services or procedures for which CPT does not provide a specific code and therefore use an unlisted procedure code identify the service. HOPDs receive payment for such unlisted codes under OPPS; ASCs should also be eligible for payment of selected unlisted codes.

- **Different payment bundles:** Several of the policies for packaging ancillary and other procedure costs into the ASC payment bundle result in discrepancies between service costs represented in the APC relative weight. For example, when HOPDs perform services outside the surgical range that are not packaged, they receive additional payments for which ASCs should also be eligible.

- **Cap on office-based payments:** CMS proposes to cap payment for certain ASC procedures commonly performed in the office at the physician practice expense payment rate. No such limitation is applied to payments under the OPPS, presumably because the agency recognizes the cost of a procedure varies depending on the characteristics of the beneficiary and the resources available at the site of service. We likewise believe this cap is inappropriate for the ASC and should be omitted from the final regulation.

- **Different measures of inflation:** CMS updates the OPPS conversion factor for annual changes in inflation using the hospital market basket; however, the agency proposes to update ASC payments using the consumer price index for all urban consumers. The market basket is a better proxy for the inflationary pressures faced

by ASCs, as it is the measure used by the agency to update payments to hospitals providing the same services.

- **Secondary rescaling of APC relative weights:** CMS applies a budget neutrality adjustment to the OPPS relative weight values after they are recalibrated with new cost data each year. The agency proposes a secondary recalibration of the relative weights before they are used by ASCs. This secondary recalibration will result in annual and potentially cumulative variation between ASC and HOPD payments without any evidence that the cost of providing services has further diverged between settings.

- **Non-application of HOPD policies to the ASC.** Over the years, CMS has implemented through statutory or administrative authority numerous policies to support services in the HOPD, including additional payment for high-cost outliers, transitional corridor and hold-harmless payments to rural and sole-community hospitals, and payments for new technologies. While not all of these policies are appropriate for the ASC, surgery centers should be eligible to receive new technology pass-through payments.

- **Use of different billing systems:** The HOPD and ASC use the UB-92 and CMS-1500, respectively, to submit claims to the government for services. Use of different forms prevents ASCs from documenting all the services provided to a Medicare beneficiary, therefore undermining the documentation of case mix differences between sites of service. Most commercial payors require ASCs to submit claims using the UB-92, and the Medicare program should likewise align the payment system at the claim level.

Ensuring Beneficiaries' Access to Services

Ambulatory surgery centers are an important component of beneficiaries' access to surgical services. As innovations in science and technology have progressed, ASCs have demonstrated tremendous capacity to meet the growing need for outpatient surgical services. In some areas and specialties, ASCs are performing more than 50% of the volume for certain procedures. Sudden changes in payments for services can have a significant effect on Medicare beneficiaries' access to services predominantly performed in ASCs.

The implementation of the revised payment system proposed by Medicare will result in significant redistribution of payments for many specialties. Because ASCs are typically focused on a narrow spectrum of services that require similar equipment and physician expertise, they have a limited ability to respond to changes in the payment system other than to adjust their volume of Medicare patients. On the one hand, for procedures such as ophthalmology, there is a limited market for these services in the non-Medicare population. If the facility fee is insufficient to cover the cost of performing the procedure in an ASC, responding to the change may mean relocating their practice to the HOPD. Such a decision would increase expenditures for the government and the beneficiary. On

the other hand, the demand for services such as diagnostic colonoscopies is extremely high in the non-Medicare population. If ASCs determine that the payment rates for such services are too low, they may be able to decrease the proportion of Medicare patients they see without reducing their total patient volume. In that case, beneficiaries may experience significant delays accessing important preventive services or treatment. Neither outcome is optimal for the beneficiary of the Medicare program.

Establishing Reasonable Reimbursement Rates

Medicare payment rates for ASC services have remained stagnant for nearly a decade. Over time, the industry has identified which services it can continue to offer to Medicare beneficiaries through reductions in cost and improvements in efficiency. In the Medicare Payment Advisory Commission's first review of ASC payments in 2003, ASCs were paid more than the HOPD for eight of the top ten procedures most frequently performed in the ASC. One suggestion by the commission was that services migrated to the ASC because the payment rate was higher than the HOPD. However, a multi-year payment freeze on ASC services has turned the tables and now the HOPD rate in 2007 will be higher (or the same) for eight of the same ten ASC procedures. The continued growth of ASCs during the payment freeze is a strong testament to their ability to improve their efficiency and the preference of physicians and beneficiaries for an alternative to the hospital outpatient surgical environment.

The impact of HOPD payments eclipsing the ASC rates has had the perverse effect of increasing the "cost" of the budget neutrality requirement imposed by the Medicare Modernization Act on the future conversion factor for ASC payments. The Lewin Group estimates that the inflation updates applied to the HOPD rates since passage of the MMA account for 40 percent of the discount required to achieve budget neutrality under the agency's proposed rule. This, combined with the agency's narrow interpretation of budget neutrality, produce an unacceptably low conversion factor for ASC payments.

- Budget Neutrality: Adopt an expansive, realistic interpretation of budget neutrality. The new payment system and the expansion of the ASC list will result in migration of services from one site of service setting to another. CMS has the legal authority and the fiduciary responsibility to examine the consequences of the new ASC payment system on all sites of care – the physician office, ASCs, and HOPD.

- ASCs should comment on the possible negative effect on access to services, since the methodology proposed results in ASC payments equaling only 62% of HOPD.

- By setting rates this low, CMS would force doctors to move cases to the more expensive hospital setting, increasing the amount of money paid by Medicare beneficiaries and the government. Rather than paying ASCs a set percentage of HOPD rates, the proposed rule establishes a complicated formula to link ASC payment to HOPD payment but does not link payment in a uniform manner. This will impede Medicare beneficiaries' ability to understand their real costs in alternative

settings. In the words of President Bush, Medicare beneficiaries need to be able to make "apples to apples" comparisons in order to increase transparency in the health care sector.

- CMS failed to include on the procedure list many higher complexity services that have for years been safely and effectively performed in ASCs throughout the country. By not creating a truly exclusionary list, CMS is losing an opportunity to increase patient choice and rely on the clinical judgment of the surgeon.

In conclusion, CMS now has the opportunity to enhance the delivery of surgical care in our nation in the most favorable manner possible by empowering both surgeons and patients with increased choice.

Please contact me if you have any questions.

Sincerely,

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