Submitter : Dr. Stephen Michigan **Date:** 11/02/2006

Organization : Urological Associates of Savannah, PC

Category : Physician

Issue Areas/Comments

ASC Payable Procedures

ASC Payable Procedures

As a urologist who operates both in the hospital (inpatient and outpatient) and in the ASC setting as well, I have a number of concerns about the proposed regulatory changes. There is no question in my mind that, for appropriately selected patients and procedures, outpatient surgery in the ASC setting can be accomplished with effectiveness and safety equal to that of the hospital setting but can also be carried out more efficiently, often more economically, and in more pleasant surroundings that seemed to be preferred by a majority of patients. Any regulatory changes which make it economically difficult to run a successful ASC, which may therefore result in the closing of some ASC's or at least limit patient access to ASC treatment, do so to the detriment not only of physicians but also to the patients they serve and to the health care delivery system as a whole. With regards to 'office-based' procedures, often procedures which may have been performed in the office in the past can be done more safely in the ASC setting, particularly in complex patients. However, performing such procedures in the ASC does add additional complexity which must be reimbursed at a reasonable level in order for the ASC to be able to keep its doors open. It is essential that procedures on the 2007 ASC list, such as but not limited to cystoscopy, prostate biopsy and urodynamics, remain exempt from the office-based classification or urological ASC's will disappear. With regards to the '62% conversion factor', it is true that some procedures can be performed in the ASC at lower cost than in the hospital outpatient department but this is certainly not always the case. It is not clear why ASC's should be penalized for providing more efficient service when in fact this should be encouraged. Furthermore, for some ASC procedures, such as implantable devices (such as impotence or anti-incontinence surgery) or procedures requiring high cost sophisticated medical technology which is either leases or is supplied on a case by case basis by a third party vendor (such as ESWL, laser procedures, cryotherapy, and heat based treatments for BPH), the great majority of the cost of such procedures is fixed and is dictated by the cost of the implantable device or the medical technology and is identical whether the procedure is performed in the ASC or at the hospital. Such procedures should be reimbursed the same amount regardless of where they are performed. I appreciate the opportunity to comment on the pending regulatory changes.

Submitter : Dr. Doug Holmes **Date:** 11/02/2006

Organization : Same Day Surgery

Category : Ambulatory Surgical Center

Issue Areas/Comments

ASC Payable Procedures

ASC Payable Procedures

We support CMS s decision to adopt MedPACs recommendation from 2004 to replace the current inclusive list of ASC-covered procedures with an exclusionary list of procedures that would not be covered in ASCs based on the two clinical criteria of beneficiary safety and the need for an overnight stay.
However, the ASC list reform proposed by CMS is too limited. CMS should expand the ASC list of procedures to include any and all procedures that can be performed in an HOPD. CMS should exclude only those procedures that are on the inpatient only list and follow the state regulations for overnight stays.

ASC Payable Procedures

ASC Payable Procedures

We support CMS s proposal to extend the new ASC payment system to cover procedures that are commonly performed in physician offices. While physicians may safely perform many procedures on healthy Medicare beneficiaries in the office setting, sicker beneficiaries may require the additional infrastructure and safeguards of an ASC to maximize the probability of a good clinical outcome. There is a known increase in 30-day mortality rates and in adverse events during procedures on ASA II and ASA III patients done in the office versus an ASC. In other words, for a given procedure, the appropriate site of service is dependent on the individual patient and his specific condition.

Submitter : Dr. Doug Holmes **Date:** 11/02/2006

Organization : Same Day Surgery

Category : Ambulatory Surgical Center

Issue Areas/Comments

ASC Addenda

ASC Addenda

We support retaining the Medicare beneficiary coinsurance for ASC services at 20 percent. For Medicare beneficiaries, lower coinsurance obligations will continue to be a significant advantage for choosing an ASC to meet their surgical needs. Beneficiaries will save significant dollars each year under the revised ASC payment system because ASC payments will in all cases be lower than the 20-40 percent HOPD coinsurance rates allowed under the OPPS.

ASC Coinsurance

ASC Coinsurance

We support retaining the Medicare beneficiary coinsurance for ASC services at 20 percent. For Medicare beneficiaries, lower coinsurance obligations will continue to be a significant advantage for choosing an ASC to meet their surgical needs. Beneficiaries will save significant dollars each year under the revised ASC payment system because ASC payments will in all cases be lower than the 20-40 percent HOPD coinsurance rates allowed under the OPPS.

ASC Office-Based Procedures

ASC Office-Based Procedures

Sicker beneficiaries may require the additional infrastructure and safeguards of an ASC to maximize the probability of a good clinical outcome. In other words, for a given procedure, the appropriate site of service is dependent on the individual patient and his specific condition or co-morbid illnesses. For example, procedures might be considered safe (on the inclusion list) on children in the office setting, but there is a known increased incidence of adverse events if this child has sleep apnea and is sent home.

ASC Phase In

ASC Phase In

Given the size of the payment cuts contemplated under the proposed rule for certain procedures and specialties; especially GI, pain and ophthalmology, one year does not provide adequate time to adjust to the changes. Thus, we believe the new system should be phased-in over several years

ASC Unlisted Procedures

ASC Unlisted Procedures

At a minimum, when all the specific codes in a given section of CPT are eligible for payment under the revised ASC payment system, the associated unlisted code also should be eligible for payment.

ASC Updates

ASC Updates

We support retaining the Medicare beneficiary coinsurance for ASC services at 20 percent. For Medicare beneficiaries, lower coinsurance obligations will continue to be a significant advantage for choosing an ASC to meet their surgical needs. Beneficiaries will save significant dollars each year under the revised ASC payment system because ASC payments will in all cases be lower than the 20-40 percent HOPD coinsurance rates allowed under the OPPS

CY 2008 ASC Impact

CY 2008 ASC Impact

We urge CMS to maximize alignment of the ASC and HOPD payment systems by adopting in the final rule the same packaging policies, the same payment caps for office-based procedures, the same multiple procedure discounts, the same wage index adjustments and the same inflation updates for ASCs and HOPDs.

These facilities exist in the same communities and often in partnership with the community hospital. Aligning the payment systems for ASCs and hospital outpatient departments will improve the transparency of cost and quality data used to evaluate outpatient surgical services for Medicare beneficiaries. We believe that 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

GENERAL

GENERAL

By forcing specific procedures to be done in certain settings, you increase the chance of an adverse event. For example a patient, with sleep apnea, going home after a procedure has an increased risk of respiratory complications independent of the procedure. By forcing that these patients go home, you make it unsafe to perform the procedure in the outpatient setting, forcing covered patients to come up with the cash or increase their risk of dying.

We urge CMS to maximize alignment of the ASC and HOPD payment systems by adopting in the final rule the same packaging policies, the same payment caps for office-based procedures, the same multiple procedure discounts, the same wage index adjustments and the same inflation updates for ASCs and HOPDs.

Submitter : Ms. Cindy Mitchell **Date:** 11/02/2006

Organization : Resurgens

Category : Ambulatory Surgical Center

Issue Areas/Comments

ASC Payable Procedures

ASC Payable Procedures

We support CMS s decision to adopt MedPAC s recommendation from 2004 to replace the current inclusive list of ASC-covered procedures with an exclusionary list of procedures that would not be covered in ASCs based on two clinical criteria: (i) beneficiary safety; and (ii) the need for an overnight stay. However, the ASC list reform proposed by CMS is too limited. CMS should expand the ASC list of procedures to include any and all procedures that can be performed in an HOPD. CMS should exclude only those procedures that are on the inpatient only list and follow the state regulations for overnight stays.

ASC Ratesetting

ASC Ratesetting

We urge CMS to maximize alignment of the ASC and HOPD payment systems by adopting in the final rule the same packaging policies, the same payment caps for office-based procedures, the same multiple procedure discounts, the same wage index adjustments and the same inflation updates for ASCs and HOPDs. These facilities exist in the same communities and often in partnership with the community hospital. Aligning the payment systems for ASCs and hospital outpatient departments will improve the transparency of cost and quality data used to evaluate outpatient surgical services for Medicare beneficiaries. We believe that 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.

ASC Unlisted Procedures

ASC Unlisted Procedures

At a minimum, when all the specific codes in a given section of CPT are eligible for payment under the revised ASC payment system, the associated unlisted code also should be eligible for payment.

Submitter : Mrs. Victoria Hertko **Date:** 11/02/2006

Organization : Lakeview Surgery Center

Category : Ambulatory Surgical Center

Issue Areas/Comments

ASC Inflation

ASC Inflation

This is another area of discrepancy that I do not understand. Secondary rescaking does not appear to based on any cost evidence supporting difference between settings and will lead to divergnet setting payments with no basis.

Again using different inflation factors when the hosptial and ASC's hire from the same employment pool and purchase the same supplies and equipment does not make sense and will only complicate future eomaprisons . the market basket is a better estimate of the inflation that impact ASC's

ASC Office-Based Procedures

ASC Office-Based Procedures

I would agree with you that we do not want to encourage the movement of office based proeedures to ASC's. However, this is another example of you applying different rules to HOPD's and ASC's. By capping the rates at the offiee rate you are disregarding the fact that costs vary by patient and setting resources. You do not cap hospitals and should remove this for ASC's also.

ASC Payable Procedures

ASC Payable Procedures

I am concerned that the majority of codes added are office proceudre codes. If you adopt a criteria that only limits cases to the inpatient only list and eliminate other outdated guidelines, you will not only increase access to high quality cost effect services for your clients you will save dollars because these procedures will be reimbursed at a lower rate. I routinely get questions from physicians (some owners, but many non-owners) regarding why they can't bring their Medicare patients here for procedures like lap chole's that they perform on other payor patients. They beleive strongly that jsut like they do with all thier other patients they should have the option to use screening criteria to determine what is the appropriate procedure setting for each individual patient. This should not be based on who the payor happens to be.

ASC Ratesetting

ASC Ratesetting

I would encourage you to expand your diffintion of budget neutrality. If you consider the hosptial and ASC as the pool of resources Medicare is spending and you apply common rules with a reasnabe discounted payments to ASC's you will move patients from the hospital setting and save overall dollars. You could also save administative overhead if you were continuing different rules for each setting.

62% payment level will actully drive some case back the hospital and end up costing Medicare overall.

ASC Unlisted Procedures

ASC Unlisted Procedures

Your current proposal provides for inconsistent payment procedures between HOPD rates and ASC's for unlisted procedures. If the intent is to move awat from an inclusionary list to an exclusionary one why would you deny payment to an ASC for service provied, but pay the HOPD for that same code. I believe that continuing the disparate practices on limit you and the rest od the industry from truly comparing care accross paractice settings.

CY 2008 ASC Impact

CY 2008 ASC Impact

The assessment of the impact of these rules is very difficult because instead of truly aligning HOPD's and ASC's you have proposed many complex rules that differ based on setting. Most of us in the industry understand that ASC's have a different overhead struture than hospitals and will then we paid at a lower rate.

However, the rule will add to the complexity of ASC's billing and possibly overhead. We will still not have an apples to applies system that can be expained to patients or phyiscians. We are asked regularly to explain the variations in billing by setting. The nation is calling for more consumer price shopping, but is not possible when every set of billing rules in different. You have a chance to lead the way in simplifying things for yourself and consumers and providers by standerdizing the HOPD and ASC's rules. I don't think you have accomplished this. I fact instead of inceasing access and savings by moving cases from the hospital to ASC's you may have the opposite effect and drive cases to a more expensive setting.

GENERAL

GENERAL

I am very concerned that the proposal continues the practice of different billing procedures between ASC's and hospitals. Other payors have standardized on the UB-92 form and so should Medicare.

ASC's should also be able receive pass through payments for new technology and bundling of procedure cost should be standard between settings. Failing to do this will again limit the number and types of Medicare cases an ASC can perform and will cost Medicare more money.

While I personally have not experienced a problem with transfer agreements with local hospitals, I am concern with what I am hearing from other parts of the country. The practice of hospitls refusing to sign transfer agreements endangers patients and has the potential to limit competition and reduce cost savings.

Submitter : **Ms. Anne Marie Bicha** **Date: 11/02/2006**

Organization : **American Gastroenterological Association**

Category : **Health Care Provider/Association**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1506-P2-764-Attach-1.DOC

#7121

4720 Montgomery Lane
Suite 430
Bethesda, MD 20814-5320

PH 240.482.3220
FX 301.652.9405

www.gastro.org

November 2, 2006

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1506-P
P.O. Box 8011
Baltimore, MD 21244-1850

Re: Medicare Program; Proposed Revised Ambulatory Surgical Center (ASC) Payment System for Implementation January 1, 2008

Dear Ms. Norwalk:

The American Gastroenterological Association (AGA) is the nation's oldest not-for-profit medical specialty society, and the largest society of gastroenterologists, representing more than 14,000 physicians and scientists who are involved in research, clinical practice, and education on disorders of the digestive system. We appreciate the opportunity to comment on the proposed changes to the Ambulatory Surgical Centers proposed rule for 2008.

ASC Rates at 62% of Hospital Outpatient Department Rates

We are extremely concerned about CMS' proposal to set the ASC facility fee payments at 62% of the hospital outpatient department (HOPD) rates, effective January 1, 2008. Paying for procedures performed in ASCs at 62% of HOPD rates will jeopardize Medicare beneficiary access to many surgical services in the more efficient and cost-effective ASC setting. CMS needs to have more accurate data to determine the cost differences between the hospital and ASC setting.

In 2006, the overall ASC facility fee for GI procedures represents approximately 83.8% of HOPD rates, a substantial reduction from the proposal of 62% of HOPD rates. Two surgical specialties, gastroenterology and pain management, will suffer unsustainable losses under this proposed rule with gastroenterology being

the highest losses of any clinical group. ASCs tend to be small businesses; 64% have 20 or fewer full time employees. A drop in reimbursement to 62% of HOPD rates is too drastic a reduction for any small business to absorb. No business can operate with this amount of loss while also dealing with increased business expenses such as overhead and staff salaries.

CMS' assumptions on moving everyone to a single level are based on the supposition that the costs of each specialty bear a comparable relationship to the relative payment structure for each specialty/procedure in the HOPD payment system. We question this assumption and recommend that CMS obtain data to determine the legitimate cost differences between the hospital and the ASC setting and validate its assumption that a uniform proportion of HOPD payment is appropriate for all services. We hope that CMS can structure an ASC payment system that prevents these dramatic shifts in payments for different specialties.

If enacted as proposed, the rule will have a negative impact on many ASCs that provide gastrointestinal endoscopic services. Under the fully implemented system, the proposed ASC reimbursement rate will not cover the costs incurred in providing common endoscopic procedures, such as colonoscopy and polypectomy or endoscopy with biopsy. In addition, this will have a negative impact on Medicare efforts to increase colorectal cancer screening. The precipitous drop in reimbursement will mean that ASCs providing GI endoscopy services will be unable to meet their expenses and may lead to the closing of many GI single specialty ASC facilities or restricting their services to non-Medicare patients. A uniform rate of 62% of HOPD results in unsustainable losses for GI and the inability for the ASC to cover costs for medical devices such as luminal stents for gastrointestinal neoplasms. The unintended consequence of shifting many endoscopic procedures back to the more costly HOPD setting will result in higher costs to the Medicare program and higher coinsurance for beneficiaries.

We are concerned that CMS has not considered in their analysis the potential impact of shifting services to the more expensive HOPD setting. Not only is the hospital outpatient department less convenient, but in many areas of the country, hospitals may not have the capacity to accommodate all beneficiaries requiring colorectal cancer screening and other GI procedures resulting in substantial delays in care.

Two-year transition

The AGA is concerned that CMS has proposed only a two-year transition for such a major change to a payment system. Clearly, a two-year transition period would seriously threaten the viability of many GI ASCs and affect beneficiary access to many GI procedures including colorectal cancer screening.

A transition of two years is not consistent with prior major changes to CMS payment programs. Past precedent for major policy changes that result in a substantial redistribution effect have typically been implemented over a minimum of a four-year time frame. This would allow blending of old and new payments over a longer time period and allow additional time for ASCs to prepare for the new system. Two such examples of a four-year transition were the change to a resource-based practice expense methodology, and CMS' recent practice expense proposal for the 2007 physician fee schedule which proposed a new bottom-up methodology.

Regardless of the transition period, CMS' proposal to pay ASCs at 62% of HOPD is not a sufficient payment rate for our specialty. We are hopeful that a better payment solution will be developed prior to implementation.

Budget neutrality

We understand that CMS is mandated under the Medicare Modernization Act of 2003 to revise the current ASC payment system by January 1, 2008 in a budget neutral manner. However, CMS' budget neutrality results in significant swings in specialties since GI payments drop to 62% of HOPD while rates for other specialties simultaneously increase, some of whom have current payments as low at 36% of HOPD rates. The AGA is extremely concerned with CMS' narrow interpretation of budget neutrality as it applies to this rule. We note that Gastroenterology represents approximately 25 percent of all surgical cases across all specialties that perform procedures in an ASC setting.

Under the fully implemented system, CMS essentially proposes to pay ASCs 38% less than what they pay a hospital for the exact same surgical procedure. This price differential is unrelated to the costs that ASCs actually incur in delivering services. It is driven entirely by the CMS' narrow interpretation of budget neutrality requirements and will jeopardize the ability of many ASCs to continue to provide high quality surgical care to Medicare beneficiaries. The direct costs related to clinical labor, equipment, and supplies, as well as the costs of the facility suite, should be similar in both settings and in our judgment, the cost differential between these setting is substantially less than 38% of the HOPD rate.

CMS limited its analysis to the migration of new procedures, but migration of underrepresented services already on the ASC list is very likely if the rate structure is adequate and should be considered in the calculation. The measure of migration should be the total universe of covered procedures not a small percentage of the services.

The AGA supports the collection and review of data that identifies potential migration patterns under the new system and the associated costs and savings. In the rule, CMS estimated that 25% of procedures would move to the ASC and that 15% of procedures would move from the office setting. We request that CMS conduct additional data analysis in the final rule that model different scenarios and migration assumptions.

We also recommend that CMS define budget neutrality across the entire Part B system for outpatient services which would enable ASC payments to be at a higher percentage of HOPD rates. A broader application of the mandated budget neutrality adjustment that includes savings effects resulting from case migration out of the higher cost hospital setting and into the lower cost ASC is an essential modification that must occur before a final rule is issued.

Office-based procedures

CMS is proposing to substantially increase the ASC list, by allowing office-based procedures to be performed and reimbursed in an ASC setting. However, CMS is proposing to cap the payment for these office-based procedures at the lower of the office rate or the ASC rate, in order to limit movement from the physician office to the ASC. We are concerned how the addition of these office-based procedures contributed to the CMS methodology for calculating the proposed

ASC reimbursement and low estimate of 62% of HOPD rates. As this portion of the proposal will not improve beneficiary access to services, we do not encourage the movement of office-based procedures to a more complex setting. We recommend that CMS revisit the expansion of this list on how it effects the budget neutrality calculations, and that these office-based procedures are excluded from CMS' final rule.

Device Issues

Appropriate and adequate reimbursement for medical device-related procedures is a critical issue that must be addressed. Given CMS' proposal to link ASC reimbursement to the HOPD system, it needs to make uniform policy decisions between these two payment systems. Those items covered as part of the OPPS APC payment rate should be included in the ASC bundled rate. Items not included in the APC rate should likewise be excluded from the ASC rate. ASC payment rates should have an explicit mechanism to take into account the cost of new technology such as new technology pass-through payments.

For services that involve costly disposable or implanted devices like the dependent APCs, the ASC rate should be set to assure full payment for the device since any differential between the costs in an ASC and HOPD would be in overhead and not in direct costs or the cost of devices. These devices generally cost the same regardless of whether they are used or implanted in the ASC or HOPD setting; therefore, CMS needs to ensure appropriate device payments in both settings.

ASC Payment Updates

CMS proposes to use the Consumer Price Index for Urban consumers (CPI-U) to annually update ASC payment rates, beginning in 2010. In comparison, rates paid to hospital outpatient departments are updated by the hospital market basket, which is typically at least a full percentage point higher. Inflationary costs for nursing services and medical device costs affect ASCs no differently than they affect hospitals. This part of the proposal will create greater disparity in the reimbursement for services performed in the hospital outpatient and ASC settings without any evidence that hospital costs increase at rates in excess of those of ambulatory surgery centers. AGA recommends that CMS adopt the hospital market basket methodology for updating the ASC conversion factor for inflation since that is a better measure of changes in the cost of providing ASC services than the CPI-U.

We note that the HOPD setting has enjoyed 3% or higher annual updates since the implementation of the Medicare Modernization Act of 2003, while ASC rates have been frozen during the same period. It makes little sense to artificially and arbitrarily widen the gap between ASC and HOPD payment rates by an inflation factor update that is unrelated to the relative costs incurred by each setting in providing surgical services.

Delay in Implementation of Final Rule

We have heard that the Government Accountability Office (GAO) recently provided to CMS its comparison study of ASCs to the HOPD setting. We are concerned that the comment period on the ASC rule ended prior to the release of the GAO report to the public for review and that the GAO report had information that may have assisted us in providing comments to CMS.

We are also concerned about the 90-day comment deadline for this rule and the lack of data provided by CMS to allow specialties to conduct an appropriate analysis on this impact of the changes. This time-frame was not adequate for our specialty to gather cost comparison data between the ASC and HOPD settings to determine in greater detail the impact of setting ASC rates at 62% of HOPD rates.

The American College of Gastroenterology, the American Society for Gastrointestinal Endoscopy and the American Gastroenterological Association contracted with the Lewin Group to conduct an analysis of the CMS proposal. One component of this ASC Case Migration analysis was to model CMS' assumptions that resulted in a uniform payment rate of 62%. The Lewin data identified some shortcomings in CMS' baseline that affects the number being proposed in the rule. As commented on earlier, we request that CMS revisit its assumptions about cost differentials and migration of services in the final rule.

Due to the lack of data and assumptions as released by CMS, the lack of access to the GAO report, and the short comment period deadline, we request that the effective date of the rule be delayed until at least January 1, 2009, in order to allow the development of a fair and equitable ASC reimbursement methodology. Again, we also recommend a minimum of a four-year transition period.

Thank you for consideration of our comments. If we may provide any additional information, please contact Anne Marie Bicha, AGA Director of Regulatory Affairs at 240-482-3223 or abicha@gastro2.org.

Sincerely,

David A. Peura, M.D.
Chair, American Gastroenterological Association

Submitter : Mrs. MARYJANE DIAZ **Date:** 11/02/2006

Organization : MEMORIAL HERMANN SURGERY CENTER NW

Category : Ambulatory Surgical Center

Issue Areas/Comments

ASC Coinsurance

ASC Coinsurance

We support retaining the Medicare beneficiary coinsurance for ASC services at 20 percent. For Medicare beneficiaries, lower coinsurance obligations will continue to be a significant advantage for choosing an ASC to meet their surgical needs. Beneficiaries will save significant dollars each year under the revised ASC payment system because ASC payments will in all cases be lower than the 20-40 percent HOPD coinsurance rates allowed under the OPPS.

ASC Conversion Factor

ASC Conversion Factor

62 % conversion factor is unacceptable and often does not cover the cost of the procedure. We understand that budget neutrality is mandated in the MMA of 2003; however, we believe that CMS made assumptions in order to reach budget neutrality with which we differ, most especially the migration of cases from and to the ASC. The ASC industry has worked together with our physicians and established a migration model that is being provided to CMS along with the data in an industry comment letter. We encourage CMS to accept this industry model.

ASC Office-Based Procedures

ASC Office-Based Procedures

We support CMS s proposal to extend the new ASC payment system to cover procedures that are commonly performed in physician offices. While physicians may safely perform many procedures on healthy Medicare beneficiaries in the office setting, sicker beneficiaries may require the additional infrastructure and safeguards of an ASC to maximize the probability of a good clinical outcome. In other words, for a given procedure, the appropriate site of service is dependent on the individual patient and his specific condition.

ASC Payable Procedures

ASC Payable Procedures

We support CMS s decision to adopt MedPAC s recommendation from 2004 to replace the current inclusive list of ASC-covered procedures with an exclusionary list of procedures that would not be covered in ASCs based on two clinical criteria: (i) beneficiary safety; and (ii) the need for an overnight stay. However, the ASC list reform proposed by CMS is too limited. CMS should expand the ASC list of procedures to include any and all procedures that can be performed in an HOPD. CMS should exclude only those procedures that are on the inpatient only list and follow the state regulations for overnight stays.

ASC Phase In

ASC Phase In

Given the size of the payment cuts contemplated under the proposed rule for certain procedures and specialties; especially GI, pain and ophthalmology, one year does not provide adequate time to adjust to the changes. Thus, we believe the new system should be phased-in over several years.

ASC Ratesetting

ASC Ratesetting

We urge CMS to maximize alignment of the ASC and HOPD payment systems by adopting in the final rule the same packaging policies, the same payment caps for office-based procedures, the same multiple procedure discounts, the same wage index adjustments and the same inflation updates for ASCs and HOPDs.. These facilities exist in the same communities and often in partnership with the community hospital. Aligning the payment systems for ASCs and hospital outpatient departments will improve the transparency of cost and quality data used to evaluate outpatient surgical services for Medicare beneficiaries. We believe that 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.

ASC Unlisted Procedures

ASC Unlisted Procedures

At a minimum, when all the specific codes in a given section of CPT are eligible for payment under the revised ASC payment system, the associated unlisted code also should be eligible for payment.

ASC Updates

ASC Updates

We are pleased that CMS is committing to annual updates of the new ASC payment system, and agree it makes sense to do that conjunction with the OPPS update cycle so as to help further advance transparency between the two systems. Regular, predictable and timely updates will promote beneficiary access to ASCs as changes in clinical practice and innovations in technology continue to expand the scope of services that can be safely performed on an outpatient basis.

CY 2008 ASC Impact

CY 2008 ASC Impact

Submitter : **Date: 11/02/2006**

Organization :

Category : **Ambulatory Surgical Center**

Issue Areas/Comments

CY 2008 ASC Impact

CY 2008 ASC Impact

See Attachment

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 : **Mr. John Schario** **Date: 11/02/2006**

Organization : **Nueterra Healthcare**

Category : **Health Care Professional or Association**

Issue Areas/Comments

GENERAL

GENERAL

see attached

CMS-1506-P2-767-Attach-1.DOC

CMS-1506-P2-767-Attach-2.DOC

CMS-1506-P2-767-Attach-3.TXT

#767

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.

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 jschario@nueterra.com; my phone number is 913-387-0504, and my mailing address is 11221 Roe, Leawood, KS 66211.

Sincerely,

John Schario

Submitter : **Date: 11/02/2006**

Organization :

Category : **Ambulatory Surgical Center**

Issue Areas/Comments

CY 2008 ASC Impact

CY 2008 ASC Impact

See Attachment

CMS-1506-P2-768-Attach-1.DOC

#768

The Eye Depot

426 Manatee Avenue West
Bradenton, FL 34205
941-708-9000

October 31, 2006

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

Dear Sir or Madam:

I am writing to comment on the proposed 2007 and 2008 changes to the ambulatory surgical center payment system. I would like to make sure that all Medicare beneficiaries have access to ambulatory surgical centers (ASCs). I am hoping that CMS will broadly interpret the budget neutrality provision enacted by Congress. I feel that offering to reimburse ASCs 62% of the hospital outpatient department (HOPD) fee schedule is simply not adequate for us to provide quality, safe care.

I also feel the ASC list reform proposed by CMS is too limited. I hope that CMS will expand the ASC list of procedures to include any and all procedures that can be performed in a HOPD. CMS should exclude only those procedures that are on the inpatient only list.

ASC reimbursements should be updated based upon the hospital market basket because this more appropriately reflects inflation in providing surgical services than does the consumer price index. I feel the same relative weights should be used in ASCs and hospital outpatient departments.

Aligning the payment systems for ASCs and hospital outpatient departments will improve the transparency of cost and quality data used to evaluate outpatient surgical services for Medicare beneficiaries. I believe that 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.

For these reasons, I respectfully request CMS revise the proposed 2007 and 2008 ambulatory surgical center payment system and increase the reimbursement percentage to at least 75%.

Sincerely,

Daniel B. Pope, M.D.

Submitter : Mr. Robert Mangeot **Date:** 11/02/2006

Organization : DaVita Inc.

Category : Individual

Issue Areas/Comments

ASC Payable Procedures

ASC Payable Procedures

I would like to thank CMS for taking on the review of such a critical issue as vascular access services for dialysis patients. Maintaining proper access is critical to excellent clinical outcomes in dialysis. That includes the ability of the physician to quickly and safely respond when problems with that access develop.

Allowing vascular access services in the ASC setting has great clinical benefits, a tremendous gift to dialysis patients. Patient access problems can be quickly and safely corrected, allowing the patient to return more quickly to their dialysis schedule. This has the further benefits of avoiding more costly hospital stays and minimizing stress and disruption on the patient and their family.

CMS should also review its payment methodology to ensure consistency with its Fistula First Initiative. The clinical benefits of a fistula over a surgical graft or catheter are well documented: lower complications and lower patient mortality. CMS could further promote these benefits by permitting the full range of vascular access services in the ASC setting, including all the necessary angioplasty codes.

Thank you again taking on this effort and providing a chance for the dialysis community to comment.

Submitter : Mrs. ZORAIDA CHOWDHURY **Date:** 11/02/2006

Organization : MEMORIAL HERMANN SURGERY CENTER NORTH WEST

Category : Ambulatory Surgical Center

Issue Areas/Comments

ASC Coinsurance

ASC Coinsurance

We support retaining the Medicare beneficiary coinsurance for ASC services at 20 percent. For Medicare beneficiaries, lower coinsurance obligations will continue to be a significant advantage for choosing an ASC to meet their surgical needs. Beneficiaries will save significant dollars each year under the revised ASC payment system because ASC payments will in all cases be lower than the 20-40 percent HOPD coinsurance rates allowed under the OPPS.

ASC Conversion Factor

ASC Conversion Factor

62 % conversion factor is unacceptable and often does not cover the cost of the procedure. We understand that budget neutrality is mandated in the MMA of 2003; however, we believe that CMS made assumptions in order to reach budget neutrality with which we differ, most especially the migration of cases from and to the ASC. The ASC industry has worked together with our physicians and established a migration model that is being provided to CMS along with the data in an industry comment letter. We encourage CMS to accept this industry model.

ASC Office-Based Procedures

ASC Office-Based Procedures

We support CMS s proposal to extend the new ASC payment system to cover procedures that are commonly performed in physician offices. While physicians may safely perform many procedures on healthy Medicare beneficiaries in the office setting, sicker beneficiaries may require the additional infrastructure and safeguards of an ASC to maximize the probability of a good clinical outcome. In other words, for a given procedure, the appropriate site of service is dependent on the individual patient and his specific condition.

ASC Payable Procedures

ASC Payable Procedures

We support CMS s decision to adopt MedPAC s recommendation from 2004 to replace the current inclusive list of ASC-covered procedures with an exclusionary list of procedures that would not be covered in ASCs based on two clinical criteria: (i) beneficiary safety; and (ii) the need for an overnight stay. However, the ASC list reform proposed by CMS is too limited. CMS should expand the ASC list of procedures to include any and all procedures that can be performed in an HOPD. CMS should exclude only those procedures that are on the inpatient only list and follow the state regulations for overnight stays.

ASC Phase In

ASC Phase In

Given the size of the payment cuts contemplated under the proposed rule for certain procedures and specialties; especially GI, pain and ophthalmology, one year does not provide adequate time to adjust to the changes. Thus, we believe the new system should be phased-in over several years.

ASC Ratesetting

ASC Ratesetting

We urge CMS to maximize alignment of the ASC and HOPD payment systems by adopting in the final rule the same packaging policies, the same payment caps for office-based procedures, the same multiple procedure discounts, the same wage index adjustments and the same inflation updates for ASCs and HOPDs.. These facilities exist in the same communities and often in partnership with the community hospital. Aligning the payment systems for ASCs and hospital outpatient departments will improve the transparency of cost and quality data used to evaluate outpatient surgical services for Medicare beneficiaries. We believe that 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.

ASC Unlisted Procedures

ASC Unlisted Procedures

At a minimum, when all the specific codes in a given section of CPT are eligible for payment under the revised ASC payment system, the associated unlisted code also should be eligible for payment.

ASC Updates

ASC Updates

We are pleased that CMS is committing to annual updates of the new ASC payment system, and agree it makes sense to do that conjunction with the OPPS update cycle so as to help further advance transparency between the two systems. Regular, predictable and timely updates will promote beneficiary access to ASCs as changes in clinical practice and innovations in technology continue to expand the scope of services that can be safely performed on an outpatient basis.

Submitter : **Ms. Susan Stroman** **Date: 11/02/2006**

Organization : **Dallas Endoscopy Center**

Category : **Ambulatory Surgical Center**

Issue Areas/Comments

CY 2008 ASC Impact

CY 2008 ASC Impact

My name is Susan Stroman, CPA and I currently serve as the Administrator of Dallas Endoscopy Center in Dallas, Texas. Our ambulatory surgery center offers endoscopy services and has been providing high quality, patient centered, and cost effective interventional procedures and surgery since 2005. Our 18 employees and over 13 surgeons care for approximately 6,600 patients a year (this includes approximately 2,640 Medicare beneficiaries) at our surgery center. It is for these reasons that I ask you to add your name as a cosponsor to The Ambulatory Surgical Center Payment Modernization Act (HR 4042, S 1884).

I would like to share with you the costs that are involved in running our surgery center and how CMS's proposed cut in fees to surgery centers will be detrimental not only to ASC's but to CMS and Medicare patient's in particular.

CMS now reimburses the hospital for a diagnosic colonoscopy done in the hospital outpatient surgery setting $542.53 and they reimburse ASC's $446.00. The proposed CMS rule states that it is trying to achieve transparency and neutrality between ASC and hospital reimbursement yet instead of proposing an increase in fees to the surgery center to meet the hospital reimburesement, they are proposing a cut to $349.82 for a colonoscopy performed at an ASC.

As you can see this is not a move towards neutrality or transparency and further more the amount of reimbursement that is being proposed is less than our cost to perform a proccdure. If CMS moves our fee to their proposed $349.82 for a colonoscopy our physicians will be forced to do the procedure in the hospital setting which, as you can see from the numbers, costs' CMS more money since they reimburse the hospital at a much higher level.

In the proposed rule by CMS, CMS spends a lot of time describing its reasoning for the methodology used to determine that hospital APC (procedure code) coding and rates would be used to set ASC reimbursement. The argument is that there has been many years of study going into all the factors that make up the relative value of each APC. While this may be a fair assessment, they do not follow thru with proposing the same reimbursement for the ASC as the hospital.

If CMS feels that the hospital needs to be reimbursed more because it runs an emergency room and many other services that they do not get sufficient funds from then, they need to reimburse these areas at a greater amount and reimburse other procedures at their true relative value, if they truly want to be transparent and fair.

I would really like to be involved in helping you understand the issues involved with this matter and how large of an impact to Medicare and Medicare patients it would be if ASCs had to shut down and all procedures be performed in the hospital. We do patient satisfaction surveys at our center and have found that 90% or better, of our patients, would choose again to have their procedure performed in the surgery center setting. Surgery centers are safe and convenient for the patient and also saves the patient and the healthcare system money.

Please let me know if I could meet with you to discuss this issue further. Thank you for your time and consideration

Submitter : Carol BLANAR **Date:** 11/02/2006

Organization : The Indiana Federation of Ambulatory Surgical Ctrs

Category : Ambulatory Surgical Center

Issue Areas/Comments

CY 2008 ASC Impact

CY 2008 ASC Impact

"See Attachment"

CMS-1506-P2-772-Attach-1.DOC

#772

INDIANA FEDERATION OF AMBULATORY SURGICAL CENTERS INC.

P.O. BOX 3183
CARMEL, IN
46082

November 02, 2006

Leslie V. Norwalk, Esq., Acting Administrator
Centers for Medicare & 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: MEDICARE ASC PAYMENT SYSTEM AND ASC LIST REFORM

Dear Administrator Norwalk:

The Federation of Ambulatory Surgical Centers (IFASC) is taking this opportunity as representatives of a majority of Indiana ambulatory surgical centers to address concerns regarding the CMS-1506-P2 – Medicare Program; The Ambulatory Surgical Center Payment System and CY 2008 Payment Rates.

The experience of ASCs is a rare example of a successful transformation in health care delivery. Thirty years ago, virtually all surgery and diagnostic testing required admission to the hospital. 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 eliminates 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.

You may contact me for further information at 765-474-7854 or via e-mail at exeedir@ifasc.com.

Respectfully submitted,

Carol Blanar
Executive Director
The Indiana Federation of Ambulatory Surgical Centers, Inc.

Submitter : Mrs. Geri Gracey **Date:** 11/02/2006

Organization : DaVita

Category : Nurse

Issue Areas/Comments

ASC Payable Procedures

ASC Payable Procedures

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.

ASC Payable Procedures

ASC Payable Procedures

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.

GENERAL

GENERAL

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.

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.

Submitter : Mr. David Gross **Date:** 11/02/2006

Organization : Surgery Center of Duncanville

Category : Ambulatory Surgical Center

Issue Areas/Comments

ASC Conversion Factor

ASC Conversion Factor

I am the administrator of an ASC in Duncanville, Texas. We serve 4,000 patients and year with 1200 of them being Medicare beneficiaries. We provide a wide spectrum of multi-s[specialty services which include a large number of High cost implant procedure for orthopedics, podiatry, pain management and Neurosurgery. In reviewing the proposed changes several areas are of great concern.

It is inaccurate to assume that ASC costs are on average 38% less than that of hospital outpatient departments, especially in the case of high cost implantable devices.

One of the most important shortcomings in the hospital outpatient payment methodology is the known phenomenon of charge compression. It underestimates the cost of more expensive items such as medical devices, resulting in payment rates that do not reflect true costs. CMS should remedy this issue by applying a decompression factor or other methodology rather than allowing inaccurate rates to be carried over to the revised ASC payment system.

The proposed transition payments appear to include errors in the calculations for implantable devices for which separate payment has historically been made. Device costs appear to have been inadvertently omitted from the calculation.

The proposed payment methodology will inappropriately impact site of service decisions. These decisions should be based on clinical considerations. Payment accuracy should be included as a goal of any new payment system to avoid site of service decisions based on financial factors rather than clinical appropriateness.

These payment issues will impede the transition of procedures associated with devices or other technologies to the ASC setting when appropriate and will limit beneficiary access to needed procedures because ASCs will not receive adequate payment to cover their costs.

Payment amounts for implantable medical devices should be equivalent in both the hospital outpatient and ASC settings as acquisition costs of the device do not vary between these facility types. Thank you for the opportunity to provide comment on this import issue sincerely. Please feel free to contact me if we can assist in providing additional information on these issues.

David Gross
Surgery Center of Duncanville

Submitter : Ms. Ann Deters **Date:** 11/02/2006

Organization : Physician Surgery Center

Category : Ambulatory Surgical Center

Issue Areas/Comments

CY 2008 ASC Impact

CY 2008 ASC Impact

ASC: Physician Surgery Center
1500 Highway 72 East
Rolla, MO 65401

Dear Ms Norwalk:

CMS-1506-P2-775-Attach-1.DOC

#775

Physician Surgery Center

PROVIDING PREMIERE PATIENT CARE

Leslie V. Norwalk, Esq., Acting Administrator
CMS
Dept of Health and Human Services
ATTN: CMS-1506-P
Room 445-G
Hubert H. Humphrey Bldg.
200 Independence Avenue, SW
Washington, DC 20201

Dear Ms Norwalk:

For the past 4 years, Physician Surgery Center has provided multi-specialty surgical services to patients in a 60 mile radius to Rolla, MO. We have seen substantial growth in our patient base each year since inception, both in new clients as well as repeat patients. According to our patient surveys, the main reason our patients chose the surgery center environment over the hospital outpatient surgery department is due to the fact that the quality of service is at or above the hospital, ability to "get in and out quicker", family members like being able to see loved ones sooner after surgery, and it's a "much more friendly environment" than the hospital setting.

Consumers and healthcare professionals will agree that the experience of ASCs is a rare example of a successful transformation in health care delivery - thanks to physicians, who 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.

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.

PHYSICIAN
SURGERY CENTER

Surgery Center:
1500 Hwy 72 East
Rolla, MO 65401
Phone: (573)426-6301
Fax: (573)426-6304

Corporate Office:
1901 S. 4th Street. Suite 221
PO Box 1294
Effingham, IL 62401
Phone: (217)342-0801
Fax: (217)342-0804
Email: info@7d.bz

Physician Surgery Center

PROVIDING PREMIERE PATIENT CARE

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,
- 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.

PHYSICIAN SURGERY CENTER

Surgery Center:
1500 Hwy 72 East
Rolla, MO 65401
Phone: (573)426-6301
Fax: (573)426-6304

Corporate Office:
1901 S. 4th Street. Suite 221
PO Box 1294
Effingham, IL 62401
Phone: (217)342-0801
Fax: (217)342-0804
Email: info@7d.bz

Physician Surgery Center

PROVIDING PREMIERE PATIENT CARE

- **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

PHYSICIAN SURGERY CENTER

Surgery Center:
1500 Hwy 72 East
Rolla, MO 65401
Phone: (573)426-6301
Fax: (573)426-6304

Corporate Office:
1901 S. 4th Street. Suite 221
PO Box 1294
Effingham, IL 62401
Phone: (217)342-0801
Fax: (217)342-0804
Email: info@7d.bz

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.

I am happy to discuss any of these points as well as our experience in operating a surgery center in rural America. You can reach me at 573-426-6301 or 217-342-2255 x222.

Sincerely,

Ann S. Deters, President

PHYSICIAN SURGERY CENTER

Surgery Center:
1500 Hwy 72 East
Rolla, MO 65401
Phone: (573)426-6301
Fax: (573)426-6304

Corporate Office:
1901 S. 4th Street. Suite 221
PO Box 1294
Effingham, IL 62401
Phone: (217)342-0801
Fax: (217)342-0804
Email: info@7d.bz

Submitter : Dr. Ronald Holweger **Date:** 11/02/2006

Organization : Northwest Kansa Surgery Center

Category : Ambulatory Surgical Center

Issue Areas/Comments

GENERAL

GENERAL

It is well known that an ASC can provide affordable healthcare with great safety and efficiency with state-of-the art services to patients in the community where the ASC is located. These services can often be provided at a substantial cost savings to the consumer, private insurance companies and Medicare. These savings provide an opportunity to decrease healthcare costs paid for by government.

Because of cost savings along with safety and efficiency provided by ASCs every effort should be made to remove road blocks from ASC development. Hospitals are trying to prevent ASC growth and development, especially in rural areas, by refusing to provide transfer agreements between the ASC and the hospital. Current regulations (CFR 416.41) require that a transfer agreement be in place prior to receiving CMS licensure. This attempt by hospitals to limit ASC development can be removed by the government by allowing transfer of patients from ASCs to hospitals following EMTALA guidelines or a similair regulation {Medicare Regulation Section 483.75, (n) transfer agreement (1) in accordance with section 1861(1)}that allows nursing homes to transfer patients to hospitals. The above mentioned guidelines and regulations protect the rights of patients to receive continuity of care if their medical condition warrants a transfer to a hospital.

Patients should have choice when it comes to the when-and-where of their healthcare. This is especially important when it could mean substantial savings of their already limited financial resources. ASCs are win-win proposition. Patients will win with increased access to quality healthcare within their community and the Federal Government will realize substantial cost savings related to outpatient surgery.

Submitter : Mrs. Susan Jackson **Date:** 11/02/2006

Organization : Physicians Alliance

Category : Ambulatory Surgical Center

Issue Areas/Comments

ASC Payable Procedures

ASC Payable Procedures

See attachment

CMS-1506-P2-777-Attach-1.DOC

Submitter : Dr. Thad Bartell **Date:** 11/02/2006

Organization : Maricopa Ear, Nose,

Category : Physician

Issue Areas/Comments

ASC Coinsurance

ASC Coinsurance

The Medicare benficiary coinsurance rate for ASC serviees should be kept at 20%. Our Medicare patients appreciate that we are able to do their procedures in an ASC with a lower coinsurance obligation to them.

ASC Conversion Factor

ASC Conversion Factor

The recommended ASC conversion factor of 62% is rediculous and completely unacceptable. At that rate, the reimbursement for nearly every procedure would be less than the cost of performing it. Subsequently, we would find it necessary to move our surgical procedures to the hospital inpatient facility. This would end up costing much more to CMS and to the patients. I also believe that there is a considerbly increased danger to these paients from hospital-acquired infections, which currently does not exist in the smaller ASC facilities. I understand that the ASC industry and the physicians who use many ASC facilities have developed a model of case migration which differs significantly from the assumptions used by CMS to reach their unrealistic conversion factor. The ASC industry model should be adopted instead.

ASC Office-Based Procedures

ASC Office-Based Procedures

It would be most appropriate for the physician to determine the safest location for a given surical procedure. I perform many small procedures in my office, but only if it is safe to do it there, and I have all the necessary equipment to perform the procedure. Often, I will schedule a procedure at the local ASC to take advantage of certain equipment or monitoring capabilities which I may not have in my office. My primary concern is the safety of the patient.

ASC Payable Procedures

ASC Payable Procedures

MedPAC's 2004 recommendation to replace the "inclusive" list of procedures approved at ambulatory surgery centers with an "exclusionary" list was appropriate and should be adopted. The list should be developed based on the need to stay in a hospital overnight following the procedure and the overall safety risk to the patient. The list needs to include all procedures currently performed in hospital outpatient surgery facilities, and exclude only those procedures which can only be safely performed in an inpatient setting.

ASC Phase In

ASC Phase In

The scheduled date for implementation of the recommendations needs to be set later to allow a more gradual phase-in of the new rules. As it is, the new rules are scheduled to be in place in only one year.

ASC Ratesetting

ASC Ratesetting

The payment systems adopted for ambulatory surgery centers and hospital outpatient surgery departments should be equalized as much as possible. The types of procedures performed at these two types of facilities is very similar, and alligning the payment policies would be fairest to the Medicare patients and the facilities.

ASC Unlisted Procedures

ASC Unlisted Procedures

If all the specific codes in a section of the CPT manual are allowed to be performed in an ASC, and eligible for reimbursement, then the corresponding "unlisted" codes from the same CPT section should also be approved by simple logic.

ASC Updates

ASC Updates

CMS needs to continue annual updates of the new ASC reimbursement system. In all fairness, this needs to be coordinated with the OPPS update cycle.

Submitter : **Date: 11/02/2006**

Organization :

Category : **Nurse**

Issue Areas/Comments

GENERAL

GENERAL

I am the Facility Administrator for a outpatient dialysis center and would like very much for you to add outpatient surgical sites for vascular access work. These centers work so well for patients and are much more efficient when it comes to procedures. They save money in the long run, as the pt is not hospitalized. I have almost 50% of my patients with a catheter and know that if these patients could have procedures done on an outpatient basis they would appreciate it and so would we. Think of how much money would be saved and how much more streamlined this is for the patients. Linda

Submitter : Mr. Stuart Hackworth **Date:** 11/02/2006

Organization : United Surgical Partners International

Category : Ambulatory Surgical Center

Issue Areas/Comments

ASC Coinsurance

ASC Coinsurance

We support retaining the Medicare beneficiary coinsurance for ASC services at 20 percent. For Medicare beneficiaries, lower coinsurance obligations will continue to be a significant advantage for choosing an ASC to meet their surgical needs. Beneficiaries will save significant dollars each year under the revised ASC payment system because ASC payments will in all cases be lower than the 20-40 percent HOPD coinsurance rates allowed under the OPPS.

ASC Conversion Factor

ASC Conversion Factor

62 % conversion factor is unacceptable and often does not cover the cost of the procedure. We understand that budget neutrality is mandated in the MMA of 2003; however, we believe that CMS made assumptions in order to reach budget neutrality with which we differ, most especially the migration of cases from and to the ASC. The ASC industry has worked together with our physicians and established a migration model that is being provided to CMS along with the data in an industry comment letter. We encourage CMS to accept this industry model.

ASC Inflation

ASC Inflation

We urge CMS to maximize alignment of the ASC and HOPD payment systems by adopting in the final rule the same packaging policies, the same payment caps for office-based procedures, the same multiple procedure discounts, the same wage index adjustments and the same inflation updates for ASCs and HOPDs.. These facilities exist in the same communities and often in partnership with the community hospital. Aligning the payment systems for ASCs and hospital outpatient departments will improve the transparency of cost and quality data used to evaluate outpatient surgical services for Medicare beneficiaries. We believe that 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.

ASC Office-Based Procedures

ASC Office-Based Procedures

We support CMS s proposal to extend the new ASC payment system to cover procedures that are commonly performed in physician offices. While physicians may safely perform many procedures on healthy Medicare beneficiaries in the office setting, sicker beneficiaries may require the additional infrastructure and safeguards of an ASC to maximize the probability of a good clinical outcome. In other words, for a given procedure, the appropriate site of service is dependent on the individual patient and his specific condition.

ASC Packaging

ASC Packaging

We urge CMS to maximize alignment of the ASC and HOPD payment systems by adopting in the final rule the same packaging policies, the same payment caps for office-based procedures, the same multiple procedure discounts, the same wage index adjustments and the same inflation updates for ASCs and HOPDs.. These facilities exist in the same communities and often in partnership with the community hospital. Aligning the payment systems for ASCs and hospital outpatient departments will improve the transparency of cost and quality data used to evaluate outpatient surgical services for Medicare beneficiaries. We believe that 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.

ASC Payable Procedures

ASC Payable Procedures

We support CMS s decision to adopt MedPAC s recommendation from 2004 to replace the current inclusive list of ASC-covered procedures with an exclusionary list of procedures that would not be covered in ASCs based on two clinical criteria: (i) beneficiary safety; and (ii) the need for an overnight stay. However, the ASC list reform proposed by CMS is too limited. CMS should expand the ASC list of procedures to include any and all procedures that can be performed in an HOPD. CMS should exclude only those procedures that are on the inpatient only list and follow the state regulations for overnight stays.

ASC Payment for Office-Based Procedures

ASC Payment for Office-Based Procedures

We urge CMS to maximize alignment of the ASC and HOPD payment systems by adopting in the final rule the same packaging policies, the same payment caps for office-based procedures, the same multiple procedure discounts, the same wage index adjustments and the same inflation updates for ASCs and HOPDs.. These facilities exist in the same communities and often in partnership with the community hospital. Aligning the payment systems for ASCs and hospital outpatient departments will improve the transparency of cost and quality data used to evaluate outpatient surgical services for Medicare beneficiaries. We believe that 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.

ASC Phase In

ASC Phase In

Given the size of the payment cuts contemplated under the proposed rule for certain procedures and specialties; especially GI, pain and ophthalmology, one year does not provide adequate time to adjust to the changes. Thus, we believe the new system should be phased-in over several years.

ASC Ratesetting

ASC Ratesetting

We urge CMS to maximize alignment of the ASC and HOPD payment systems by adopting in the final rule the same packaging policies, the same payment caps for office-based procedures, the same multiple procedure discounts, the same wage index adjustments and the same inflation updates for ASCs and HOPDs.. These facilities exist in the same communities and often in partnership with the community hospital. Aligning the payment systems for ASCs and hospital outpatient departments will improve the transparency of cost and quality data used to evaluate outpatient surgical services for Medicare beneficiaries. We believe that 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.

ASC Unlisted Procedures

ASC Unlisted Procedures

At a minimum, when all the specific codes in a given section of CPT are eligible for payment under the revised ASC payment system, the associated unlisted code also should be eligible for payment.

ASC Updates

ASC Updates

We are pleased that CMS is committing to annual updates of the new ASC payment system, and agree it makes sense to do that conjunction with the OPPS update cycle so as to help further advance transparency between the two systems. Regular, predictable and timely updates will promote beneficiary access to ASCs as changes in clinical practice and innovations in technology continue to expand the scope of services that can be safely performed on an outpatient basis.

ASC Wage Index

ASC Wage Index

We urge CMS to maximize alignment of the ASC and HOPD payment systems by adopting in the final rule the same packaging policies, the same payment caps for office-based procedures, the same multiple procedure discounts, the same wage index adjustments and the same inflation updates for ASCs and HOPDs.. These facilities exist in the same communities and often in partnership with the community hospital. Aligning the payment systems for ASCs and hospital outpatient departments will improve the transparency of cost and quality data used to evaluate outpatient surgical services for Medicare beneficiaries. We believe that 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.

Submitter : Dr. James Hays **Date:** 11/02/2006

Organization : NovaMed

Category : Physician

Issue Areas/Comments

ASC Ratesetting

ASC Ratesetting

I do not understand the logic of linking payment to ASC's to payment to hospitals. It is illogical. The cost structures are totally different. Why should a cataract surgery cost more in a hospital outpatient department than in a ASC? That indicates a tremendous amount of waste, bill padding, and extra expense for surgeons working in hospitals. You should pay the same for the surgery regardless of the location. If ASC's can do it cheaper, just don't do cataract surgery in hospitals any more! Why penalize the ASC's who are trying to be efficient? Your ruling is poorly thought out and is bad policy. Let the market decide...pay the same for the surgery and see who wants to do it. This sounds like a hospital lobby got to you and is having way too much influence on policy. Jim Hays, M.D. M.H.S.A.
Atlanta, Ga

Submitter : Dr. richard westmark **Date:** 11/02/2006

Organization : Dr. richard westmark

Category : Physician

Issue Areas/Comments

ASC Payable Procedures

ASC Payable Procedures

I would like to see an expansion of allowed procedures to include lumbar laminectomy/discectomy. I am a neurosurgeon and currently do this procedure on non-medicare patients as an outpatient at a local ASC. It is commonly accepted to do these procedures as outpatients assuming no significant comorbidities exist. The ASC setting I believe is safer for this type of patient as my work at the local hospital would attest. In the ASC setting it is an unhurried environment absent the triage that necessarily takes place in a hospital with larger and emergent cases getting the greater attention.
I can asure you my patients feel more important and better cared for in the ASC and tell me this often. I get mostly complaints on the hospital side. The basis for the bulk of these complaints is understandable and I believe has more to do with trying to integrate healthy outpatients with sicker inpatients than with poor management per se.
I would love to be able to offer my medicare patients the same level of care I offer all my other patients.

Submitter : Dr. Thomas Merchant **Date:** 11/03/2006

Organization : Roseville Orthopedic Surgery and Sports Medicine

Category : Physician

Issue Areas/Comments

ASC Conversion Factor

ASC Conversion Factor

The 62% conversion factor is unreasonable and untenable. Many proceedures are already under-reimbursed through medicare as medicare does not cover costly implants for ASC's which are an important part of many neccssary surgeries today (especially orthopedic). Once again this imparts an unfair advantage to hospitals and HOPD's and may simply result in medicare recipients not having access to ASC's which often have lower complication rates and other superior performance measures. If other insurers follow medicare's lead, the valuable resource that I believe ASC's are may be in jeapordy.

Thank you very much for reviewing and considering my comments.

ASC Office-Based Procedures

ASC Office-Based Procedures

I agree with the plan to cover office based proceedures in an ASC setting both because, for some of the patients with more complex medical problems, it would be safer; and because many physician's offices are not set up for minor proceedures making an ASC the next most cost effective alternative.

ASC Packaging

ASC Packaging

Please see my comments in Ratesetting.

ASC Payable Procedures

ASC Payable Procedures

I support the conversion to an "exclusionary list" but feel it should result in a broadening of the surgeries that can be properly performed in an ASC which should include all proceedures performed in an HOPD. Excluded procedures should be only those that are on the in patient stay list. This is logical because, at least regarding the HODP's I have worked in, HOPD's and ASC's are essentially identical in terms of personel and equipment present.

ASC Payment for Office-Based Procedures

ASC Payment for Office-Based Procedures

Please see my comments for Ratesetting.

ASC Phase In

ASC Phase In

If the changes are enacted as written, a one-year phase in my be catestrophic for ASC's and major changes (cost reduction measures) would be required. One year would not be sufficient time to implement these and continue to optimize patient safety. A three year period would be more resonable if this has to occur.

ASC Ratesetting

ASC Ratesetting

Rates, program packaging, multiple proceedure discounts, wage indexing and office based proceedure caps should be identical for ASC's and HOPD's. These entities require the same personell and equipment, and the same training and support for both. Therefore overhead costs are the same. Reimbursement rules favoring HOPD's would create an unfair competitive advantage for the HOPD's. This may neccssitate cost cutting measures or spending limits in ASC's that would force a reduction in quaility of service provided to medicare insureds who tend to be sicker and in need of greater intensity and quality of service. My biggest fear is production of a less safe environment for surgery but I also fear increased difficulty for ASC's to remain in business. I feel ASC's provide and excellent avenue for patient care as well as competition for hospitals that helps keep rates down for both providers.

ASC Unlisted Procedures

ASC Unlisted Procedures

Ulisted codes associated with listed codes that are covered should also be covered. It is unfair to arbitrarily restrict payment for many legitimate proccedures that simply were not included on original code lists or were developed after the codes were established.

ASC Wage Index

ASC Wage Index

Please see my comments in Ratesettng.

Submitter : Mrs. WINIFRED CHEUNG **Date:** 11/03/2006

Organization : DAVITA GARFIELD DIALYSIS CENTER

Category : End-Stage Renal Disease Facility

Issue Areas/Comments

ASC Payable Procedures

ASC Payable Procedures

THIS IS AN EXCELLENT CHOICE TO HAVE THE VASCULAR ACCESS PROCEDURE BEING DONE IN AN AMBULATORY SURGICAL CENTRER.IT WILL SAVE A LOT OF EXPENSES FROM GETTING IT DONE IN THE HOSPITAL SETTING. THE SCHEDULE WILL BE EASIER TO OBTAIN INSTEAD OF MAKING IT FROM THE HOSPITAL, & IT MIGHT SHORTEN THE WAITING TIME FOR THE PATIENTS. PATIENT CAN ALSO HAVE IT DONE & RETURN TO THE DIALYSIS CENTER FOR THEIR TREATMENT THE SAME DAY WITHOUT MISSING THEIR TREATMENT OR TO GET IT DONE IN THE HOSPITAL DUE TO THEIR CHEMISTRY INBALANCE. IT WILL BE COST EFFECTIVE FOR THE MEDICARE PROGRAM OR OTHER INSURANCE COMPANY. OF COURSE THE SETTING UP OF THE CENTER SHOULD BE GORVERNED FOR THE SAFETY OF THE PATIENTS & THE PROCEDURES TO BE DONE. I WILL DEFENITELY SUPPORT FOR THIS PROGRAM & I HOPE IT WILL BE SUPPORTED BY THE MEDICARE PROGRAM.