Submitter : Mrs. Winnie Cheung **Date:** 11/03/2006

Organization : Davita

Category : End-Stage Renal Disease Facility

Issue Areas/Comments

GENERAL

GENERAL

see attachment

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

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 : **Dr. Todd Brandt** **Date: 11/03/2006**

Organization : **Individual**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

I am a physician who utilizes an independent ASC for a number of the surgical procedures that I perform for my urology practice. I am concerned with the proposed legistlation that my local ASC will not be able to compete for patients if reimbursement drops below an appropriate reimbursement for outpatient procedures performed in an ASC. Currently patients benefit from the ASC experience with improved efficiency and decreased cost for their procedures. As medicine changes I believe we will become more dependent on quality ASCs within our local medical community as more and more procedures move towards outpatient care with improved technologies. We need to encourage and support this innovation. I believe your current proposed legislation and rate cuts are contrary to helping me care for my patients.

Todd D. Brandt MD

Submitter : Mrs. Gayle Harman **Date:** 11/03/2006

Organization : Day-Op Center of Long Island

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 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 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.

CMS-1506-P2-787-Attach-1.DOC

#787

November 3, 2006

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

Re: 2007 OPPS Proposed Rule (CMS-1506-P) – Comments on Proposed Revised Ambulatory Surgical Center Payment System for Implementation January 1, 2008 (Section XVIII)

Dear Administrator Norwalk:

I am writing to you concerning the above Rulemaking published on June 12, 2006, regarding updates to rate-setting methodology, payment rates, payment policies, and the list of covered surgical procedures for ambulatory surgical centers. I am Day-Op Center of LI's Director of Nursing. Day-Op is a multi-specialty Ambulatory Surgical Center, located in Mineola, NY.

The goal for all of us--providers, physicians, and payors--is to create a health care system that delivers excellent clinical outcomes in a cost efficient environment.

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 antiquated 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. The following comments focus on three principles:

- maximizing **parity between the ASC and HOPD payment systems** to prevent differences between the payment systems

- 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.

1. ASC Payable Procedures (Section XVIII.B.1)

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.

2. ASC Unlisted Procedures (Section XVIII.B.2)

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.

3. ASC Office-Based Procedures (Section XVIII.B.3)

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.

4. ASC Ratesetting (Section XVIII.C.2); ASC Packaging (Section XVIII.C.3); ASC Payment for Office-Based Procedures (Section XVIII.C.5); ASC Multiple Procedure Discounting (Section XVIII.C.6); ASC Wage Index (Section XVIII.C.7); ASC Inflation (Section XVIII.C.8)

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.

5. ASC Coinsurance (Section XVIII.C.9)

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.

6. ASC Phase-In (Section XVIII.C.10)

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.

7. **ASC Conversion Factor (Section XVIII.C.11)**

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.

8. ASC Updates (Section XVIII.C.12)

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.

If you have questions or would like to visit me regarding my comments, I can be reached at *(telephone number)* and again my sincere appreciation for the work and commitment of CMS to the patients each of us serves.

Sincere regards,

Gayle F. Harman, RN, MSN, CNOR
Director of Nursing

Submitter : Dr. Shariq Afridi **Date:** 11/03/2006

Organization : Hamilton Endoscopy and Surgery Center

Category : Ambulatory Surgical Center

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1506-P2-788-Attach-1.DOC

#788

HAMILTON ENDOSCOPY AND SURGERY CENTER, LLC

1235 Whitehorse – Mercerville Road, Suite 310 Hamilton, NJ 08619 Tel: (609) 581-6610 Fax: (609) 581-6620

November 3, 2006

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

Dear Administrator Norwalk:

I am a private practice physician who presently treats Medicare beneficiaries in my practice. I am writing to express my grave concern with CMS's recent proposal to change the way the agency pays ambulatory surgery centers for their services, via facility fee payments.

In my practice, we see a large number of Medicare patients. Treatment for a substantial percentage of these patients includes performing screening colonoscopies for those who are at average risk for colorectal cancer, as well as colonoscopies for high risk individuals and surveillance colonoscopies for those who have already been detected as having either polyps, or who have had cancerous lesions excised previously. Additionally we see a very significant number of patients with other conditions—GI bleeding, inflammatory bowel disease, gastroesophageal reflux disease (GERD), and/or Barrett's esophagus for whom ready access to an appropriate, safe, cost-efficient site for GI endoscopy is critical to either restoring them to good health, or sustaining them in good health.

Because of these reasons it is imperative that the current reimbursement payment system remain in effect. We can ill afford a reduction in the current rate in order to continue providing the highest quality of care to our Medicare beneficiaries.

The following points should be taken into consideration:

- To assure Medicare beneficiaries' access to ASCs, CMS should broadly interpret the budget neutrality provision enacted by Congress. 60% is simply not adequate.

- 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 a HOPD. CMS should exclude only those procedures that are on the inpatient only list.
- ASCs should be updated based upon the hospital market basket because this more appropriately reflects inflation in providing surgical services than does the con summer price index. Also, the same relative weights should be used in ASCs and hospital outpatient departments.

- Aligning the payment systems for ASCs the 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.

Having dealt a death-blow to many GI ASCs by draconian reductions in payment, the access of Medicare beneficiaries to GI ASCs will be markedly reduced. CRC screening colonoscopies will be reduced, but the volume of diagnostic colonoscopies and endoscopies will not decline.

With fewer ASCs, a larger proportion of all GI procedures will need to be performed in the HOPD, where the facility fees CMS pays will be higher.

So, the inevitable result of this proposed CMS action, if implemented will be: (a) total Medicare costs for GI facility fees will rise (although the per unit facility fee for decreased number of these performed in the ASC may well decline); (b) available access by Medicare beneficiaries for GI colonoscopies and other endoscopic procedures will decline; and (c) more Medicare beneficiaries will die unnecessarily from colorectal cancer will increase as screening rates decline.

It is hard to believe that these are the results the CMS is seeking, but the only way to avoid this outcome is to modify this proposal so as to increase, not decrease, the facility fees to GI ASCs. This will avoid the closure of GI ASCs, and thus avoid a reduction in access and CRC screening rates. It will also prevent an increase in the number of GI procedures performed in the more costly HOPD setting.

Respectfully submitted,

Shariq Afridi, MD

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

Organization : Hamilton Endoscopy and Surgery Center

Category : Ambulatory Surgical Center

Issue Areas/Comments

GENERAL

GENERAL

See Attachments

CMS-1506-P2-789-Attach-1.DOC

CMS-1506-P2-789-Attach-2.DOC

CMS-1506-P2-789-Attach-3.DOC

CMS-1506-P2-789-Attach-4.DOC

#789

HAMILTON ENDOSCOPY AND SURGERY CENTER, LLC

1235 Whitehorse – Mercerville Road, Suite 310 Hamilton, NJ 08619 Tel: (609) 581-6610 Fax: (609) 581-6620

November 3, 2006

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

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- Aligning the payment systems for ASCs the 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.

Having dealt a death-blow to many GI ASCs by draconian reductions in payment, the access of Medicare beneficiaries to GI ASCs will be markedly reduced. CRC screening colonoscopies will be reduced, but the volume of diagnostic colonoscopies and endoscopies will not decline.

With fewer ASCs, a larger proportion of all GI procedures will need to be performed in the HOPD, where the facility fees CMS pays will be higher.

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It is hard to believe that these are the results the CMS is seeking, but the only way to avoid this outcome is to modify this proposal so as to increase, not decrease, the facility fees to GI ASCs. This will avoid the closure of GI ASCs, and thus avoid a reduction in access and CRC screening rates. It will also prevent an increase in the number of GI procedures performed in the more costly HOPD setting.

Respectfully submitted,

Imran Fayyaz, MD

#789 - 2

HAMILTON ENDOSCOPY AND SURGERY CENTER, LLC

1235 Whitehorse – Mercerville Road, Suite 310 Hamilton, NJ 08619 Tel: (609) 581-6610 Fax: (609) 581-6620

November 3, 2006

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

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It is hard to believe that these are the results the CMS is seeking, but the only way to avoid this outcome is to modify this proposal so as to increase, not decrease, the facility fees to GI ASCs. This will avoid the closure of GI ASCs, and thus avoid a reduction in access and CRC screening rates. It will also prevent an increase in the number of GI procedures performed in the more costly HOPD setting.

Respectfully submitted,

Zahid Baig, MD

#789-3

HAMILTON ENDOSCOPY AND SURGERY CENTER, LLC

1235 Whitehorse – Mercerville Road, Suite 310 Hamilton, NJ 08619 Tel: (609) 581-6610 Fax: (609) 581-6620

November 3, 2006

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

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Respectfully submitted,

Shivaprasad Marulendra, MD

#189-4

HAMILTON ENDOSCOPY AND SURGERY CENTER, LLC

1235 Whitehorse – Mercerville Road, Suite 310 Hamilton, NJ 08619 Tel: (609) 581-6610 Fax: (609) 581-6620

November 3, 2006

Leslie V. Norwalk, Esq., Acting Administrator
Center for Medicare & Medicaid Services
Dept. of Health and Human Services
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Room 445-G
Hubert H. Humphrey Building
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Respectfully submitted,

Zafar Zamir, MD

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

Organization : Mt. Laurel Endoscopy Center

Category : Ambulatory Surgical Center

Issue Areas/Comments

GENERAL

GENERAL

See Attachments

CMS-1506-P2-790-Attach-1.DOC

CMS-1506-P2-790-Attach-2.DOC

CMS-1506-P2-790-Attach-3.DOC

#790

MT LAUREL ENDOSCOPY CENTER, LP
15000 MIDLANTIC DRIVE, SUITE 110 MT LAUREL, NJ 08054 TEL: (856) 996-4001 FAX: (856) 996-4002

November 3, 2006

Leslie V. Norwalk, Esq., Acting Administrator
Center for Medicare & Medicaid Services
Dept. of Health and Human Services
Attention: CMS-1506-P
Room 445-G
Hubert H. Humphrey Building
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- Aligning the payment systems for ASCs the 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.

Having dealt a death-blow to many GI ASCs by draconian reductions in payment, the access of Medicare beneficiaries to GI ASCs will be markedly reduced. CRC screening colonoscopies will be reduced, but the volume of diagnostic colonoscopies and endoscopies will not decline.

With fewer ASCs, a larger proportion of all GI procedures will need to be performed in the HOPD, where the facility fees CMS pays will be higher.

So, the inevitable result of this proposed CMS action, if implemented will be: (a) total Medicare costs for GI facility fees will rise (although the per unit facility fee for decreased number of these performed in the ASC may well decline); (b) available access by Medicare beneficiaries for GI colonoscopies and other endoscopic procedures will decline; and (c) more Medicare beneficiaries will die unnecessarily from colorectal cancer will increase as screening rates decline.

It is hard to believe that these are the results the CMS is seeking, but the only way to avoid this outcome is to modify this proposal so as to increase, not decrease, the facility fees to GI ASCs. This will avoid the closure of GI ASCs, and thus avoid a reduction in access and CRC screening rates. It will also prevent an increase in the number of GI procedures performed in the more costly HOPD setting.

Respectfully submitted,

John Kravitz, MD

MT LAUREL ENDOSCOPY CENTER, LP
15000 MIDLANTIC DRIVE, SUITE 110 MT LAUREL, NJ 08054 TEL: (856) 996-4001 FAX: (856) 996-4002

November 3, 2006

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

Dear Administrator Norwalk:

I am a private practice physician who presently treats Medicare beneficiaries in my practice. I am writing to express my grave concern with CMS's recent proposal to change the way the agency pays ambulatory surgery centers for their services, via facility fee payments.

In my practice, we see a large number of Medicare patients. Treatment for a substantial percentage of these patients includes performing screening colonoscopies for those who are at average risk for colorectal cancer, as well as colonoscopies for high risk individuals and surveillance colonoscopies for those who have already been detected as having either polyps, or who have had cancerous lesions excised previously. Additionally we see a very significant number of patients with other conditions—GI bleeding, inflammatory bowel disease, gastroesophageal reflux disease (GERD), and/or Barrett's esophagus for whom ready access to an appropriate, safe, cost-efficient site for GI endoscopy is critical to either restoring them to good health, or sustaining them in good health.

Because of these reasons it is imperative that the current reimbursement payment system remain in effect. We can ill afford a reduction in the current rate in order to continue providing the highest quality of care to our Medicare beneficiaries.

The following points should be taken into consideration:

- To assure Medicare beneficiaries' access to ASCs, CMS should broadly interpret the budget neutrality provision enacted by Congress. 60% is simply not adequate.

- 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 a HOPD. CMS should exclude only those procedures that are on the inpatient only list.
- ASCs should be updated based upon the hospital market basket because this more appropriately reflects inflation in providing surgical services than does the con summer price index. Also, the same relative weights should be used in ASCs and hospital outpatient departments.

- Aligning the payment systems for ASCs the 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.

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It is hard to believe that these are the results the CMS is seeking, but the only way to avoid this outcome is to modify this proposal so as to increase, not decrease, the facility fees to GI ASCs. This will avoid the closure of GI ASCs, and thus avoid a reduction in access and CRC screening rates. It will also prevent an increase in the number of GI procedures performed in the more costly HOPD setting.

Respectfully submitted,

David Salowe, MD

#1510-3

MT LAUREL ENDOSCOPY CENTER, LP
15000 MIDLANTIC DRIVE, SUITE 110 MT LAUREL, NJ 08054 TEL: (856) 996-4001 FAX: (856) 996-4002

November 3, 2006

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

Dear Administrator Norwalk:

I am a private practice physician who presently treats Medicare beneficiaries in my practice. I am writing to express my grave concern with CMS's recent proposal to change the way the agency pays ambulatory surgery centers for their services, via facility fee payments.

In my practice, we see a large number of Medicare patients. Treatment for a substantial percentage of these patients includes performing screening colonoscopies for those who are at average risk for colorectal cancer, as well as colonoscopies for high risk individuals and surveillance colonoscopies for those who have already been detected as having either polyps, or who have had cancerous lesions excised previously. Additionally we see a very significant number of patients with other conditions—GI bleeding, inflammatory bowel disease, gastroesophageal reflux disease (GERD), and/or Barrett's esophagus for whom ready access to an appropriate, safe, cost-efficient site for GI endoscopy is critical to either restoring them to good health, or sustaining them in good health.

Because of these reasons it is imperative that the current reimbursement payment system remain in effect. We can ill afford a reduction in the current rate in order to continue providing the highest quality of care to our Medicare beneficiaries.

The following points should be taken into consideration:

- To assure Medicare beneficiaries' access to ASCs, CMS should broadly interpret the budget neutrality provision enacted by Congress. 60% is simply not adequate.

- 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 a HOPD. CMS should exclude only those procedures that are on the inpatient only list.
- ASCs should be updated based upon the hospital market basket because this more appropriately reflects inflation in providing surgical services than does the con summer price index. Also, the same relative weights should be used in ASCs and hospital outpatient departments.

- Aligning the payment systems for ASCs the 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.

Having dealt a death-blow to many GI ASCs by draconian reductions in payment, the access of Medicare beneficiaries to GI ASCs will be markedly reduced. CRC screening colonoscopies will be reduced, but the volume of diagnostic colonoscopies and endoscopies will not decline.

With fewer ASCs, a larger proportion of all GI procedures will need to be performed in the HOPD, where the facility fees CMS pays will be higher.

So, the inevitable result of this proposed CMS action, if implemented will be: (a) total Medicare costs for GI facility fees will rise (although the per unit facility fee for decreased number of these performed in the ASC may well decline); (b) available access by Medicare beneficiaries for GI colonoscopies and other endoscopic procedures will decline; and (c) more Medicare beneficiaries will die unnecessarily from colorectal cancer will increase as screening rates decline.

It is hard to believe that these are the results the CMS is seeking, but the only way to avoid this outcome is to modify this proposal so as to increase, not decrease, the facility fees to GI ASCs. This will avoid the closure of GI ASCs, and thus avoid a reduction in access and CRC screening rates. It will also prevent an increase in the number of GI procedures performed in the more costly HOPD setting.

Respectfully submitted,

Craig Barash, MD

Submitter : Dr. Paul Ajamian **Date:** 11/03/2006

Organization : Novamed

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

see attachment

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

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 : Dr. Charles & Jason Jones **Date:** 11/03/2006

Organization : CJ Elmwood Partners, LP & Jones Eye Clinic

Category : Ambulatory Surgical Center

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1506-P2-792-Attach-1.DOC

#792

October 31, 2006

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

Dear Administrator Norwalk:

Regarding the Medicare ASC Payment System and ASC list reform, we feel as an ASC that in order to assure Medicare beneficiaries' access to ASCs, CMS should broadly interpret the budget neutrality provision enacted by Congress because 62% is simply not adequate.

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.

ASCs 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. Also, 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. 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.

Thank you for your attention to our concerns regarding the proposed ASC payments and structure for allowed services. Our hope is to continue to provide the same high quality surgical services to Medicare beneficiaries that we have done since 1987.

Sincerely,

Charles E. Jones, M.D.
Medical Director

Jason J. Jones, M.D.
Assistant Medical Director

C.J. Elmwood Partners, L.P.
Jones Eye Clinic and Surgery Centers
4405 Hamilton Blvd.
Sioux City, IA 51104

3801 So. Elmwood Ave.
Sioux Falls, SD 57105

Submitter : **Dr. Roberto Rodriguez** **Date: 11/03/2006**

Organization : **Dallas Endoscopy Center**

Category : **Ambulatory Surgical Center**

Issue Areas/Comments

CY 2008 ASC Impact

CY 2008 ASC Impact

My name is ROBERTO RODRIGUEZ, and I currently serve as Medical Director and also provide services at 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).

The Medicare drug benefit legislation enacted in 2003 requires the Centers for Medicare and Medicaid Services (CMS) to implement a new ambulatory surgical center (ASC) payment system by 2008. HR 4042, introduced by Representative Herger, and S 1884, introduced by Senator Crapo, would provide necessary guidance to CMS as it develops the new system. The legislation adopts the recommendation of the Medicare Payment Advisory Commission that ASCs should be allowed to perform and receive Medicare facility payments for any outpatient surgical service, except for those that the HHS Secretary designates, after consultation with specified organizations, as unsafe to beneficiary safety when furnished in an ASC. Further, the bill would pay ASCs at 75 percent of the fee schedule amount provided to hospitals for the same covered services, as well as the same annual payment updates.

This legislation would accomplish a number of important Medicare program objectives. It provides necessary guidance from Congress to CMS as the agency modernizes a reimbursement system which was established a quarter-century ago. Under current law, there is no correlation between the coverage and payment rules applicable to hospitals and ASCs that perform the same surgical services; the legislation appropriately expands the array of procedures that can be safely and effectively performed in ASCs and links payments for these services to the rates paid to HOPDs. Because each service provided in the ASC would be discounted below the hospital rate, program costs would be reduced annually by hundreds of millions of dollars. Moreover, beneficiaries would be subject to lower out-of-pocket obligation when care is furnished by an ASC.

This legislation will enable centers like ours to continue to offer to Medicare beneficiaries the highest quality surgical care at lower cost in a patient-friendly environment. Please sign on as a co-sponsor to The Ambulatory Surgical Center Payment Modernization Act (HR 4042, S 1884). If I can provide you with any further information about this legislation or about ambulatory surgery centers, please do not hesitate to let me know.

Roberto Rodriguez Ruesga MD

Dallas Endoscopy Center
214-520-8235
214-520-8236 fax

Submitter : George H. Roman **Date:** 11/03/2006

Organization : American Medical Group Association

Category : Other Association

Issue Areas/Comments

GENERAL

GENERAL

See attachment

CMS-1506-P2-794-Attach-1.DOC

#794

AMGA
American Medical Group Association

November 3, 2006

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

Re: *Medicare Program; Ambulatory Surgical Center Payment System and CY 2008 Payment Rates*

Dear Ms Norwalk:

The American Medical Group Association (AMGA) is an association that represents medical groups, including some of the nation's largest, most prestigious multi-specialty practices and integrated health care delivery systems. AMGA members' 65,000 physicians deliver health care to more than 50 million patients in 40 states, including 15 million capitated lives. Thank you for the opportunity to comment on the proposed rule regarding revisions to the payment policies under the Medicare for Ambulatory Surgical Center (ASC) payments and related changes.

The Medicare Modernization Act of 2003 presents an opportunity to better align Medicare payments to providers of outpatient surgical services. There are three key elements for ASC payment changes that would comport with Congressional intent, produce an equitable system, and assure development of beneficiary access through sound public policy.

The first is the configuration of the ASC with the HOPD payment systems to eliminate distortions between them that could unsuitably influence site of service selection. Secondly, changes should facilitate maximal conveyance of the benefits of surgery done at ASCs to Medicare patients for services that can be safely and efficiently performed in the ASC. Finally, CMS should establish fair and reasonable payment rates to allow beneficiaries and the Medicare program to save money on procedures that can be safely performed at a lower cost in the ASC than the HOPD.

The current ASC payment system has for its underpinnings outdated cost data and imprecise payment categories. Although the HOPD payment system suffers from its own blemishes, we favor linkage of the ASC with the hospital outpatient department (HOPD) payment system since it is the most analogous basis for determination of the relative cost of procedures performed in ASCs. However, there should be parity in all matters where appropriate and equitable adjustment where that is not the case.

The methodology proposed in the rule results in ASC payments equaling only 62% of HOPD levels. 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 program. Rather than paying ASCs a set, fair percentage of HOPD rates, as has been suggested by the industry, and a notion we support, the proposed rule establishes a complicated methodological linking of ASC payment to HOPD payment but does not do it in a uniform manner. This will impede Medicare beneficiaries' ability to understand their real costs in alternative settings and does nothing to advance the idea of transparency in pricing, a much heralded objective of current public policy.

We agree with and cite MedPAC's perspectives on ASC rate setting as noted in its letter of October 10, 2006 to CMS on these matters:

> "The current ASC payment system is outdated and should be replaced by a system based on the OPPS. The current system classifies services into only nine payment groups of clinically-unrelated procedures and sets rates based on 1986 cost data. Because these rates are based on old cost data, they are probably no longer consistent with ASCs' costs. The broad ASC payment groups make it difficult for CMS to classify new services and increases the likelihood that many services are over- or underpaid. In addition, the ASC rates are not aligned with rates for surgical procedures provided in other ambulatory settings. If payment variations among settings are unrelated to differences in underlying costs, there could be financial incentives to shift services to the most profitable setting. To remedy these problems, in our March 2004 report to the Congress, we recommended that the Secretary revise the ASC payment system so that its relative weights and procedure groups are aligned with those in the OPPS."
>
> ..." Ideally, the ASC conversion factor would be based on either ASCs' costs or the lowest-cost safe alternative setting for ambulatory surgical procedures. Because CMS has not collected recent ASC cost data, we are not able to estimate ASCs' costs or determine which surgical setting has the lowest costs. Thus, the Commission is unable to judge whether an ASC conversion factor that equals 62 percent of the OPPS conversion factor is appropriate."

The proposed rule includes several key differences between the HOPD and the ASC payments that will perpetuate the unnecessary use of higher cost settings and may make it impossible for ASCs to offer surgical services.

Rate-setting Methodology

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 program.

Annual Rate Updates
ASCs should receive the same annual updates as hospitals. Inflationary costs, such as nursing and medical device cost affect ASCs in the same way as hospitals. ASCs have not had an increase in payments since 2003 which makes it hard to compete in an aggressive labor market. ASCs should also get the same market basket updates as hospitals and not the CPI-U update.

Transition
CMS has proposed to phase in the new payment system over two years. Most payment changes of this scale and scope have a 3-4 year transition period. That has certainly been the case in changes affecting the HOPD. We strongly urge CMS to be consistent with prior actions and phase-in the final rule changes over a 4 year term.

ASC List: Safety and No Overnight Stay should be Sole Criteria
This proposal should eliminate the use of specific ASC list criteria and instead use only safety and the absence of a required overnight stay as the criteria to determine what procedures are reimbursable in the ASC setting.

We suggest that CMS develop a reasonable process the agency can use to gather and evaluate reliable information about the safety of performing surgical procedures in the outpatient and ASC settings upon which to make subsequent decisions about the safety of allowing those procedures in ASCs. The rate of technology transfer is phenomenally fast and medical technology will continue to advance in the future. By using many of the same limitations on what is permissibly performed in ASCs, problems in providing cost-effective care to patients in the future will be simply be carried forward. For example, Medicare does not allow procedures done more than 80% of the time on an inpatient basis to be performed in an ASC. This makes little sense since because the program already pays for such procedures, done on an out patient basis, 20% of the time. The standard is arbitrary and contradicts itself.

Predictable, Rational Responses: Shifts in Types of Procedures Done
For ophthalmology procedures such as cataract surgery, there is limited demand in the non-Medicare population. If the facility fee is insufficient to cover the cost of performing the procedure in an ASC, a predictable, business oriented response of physicians may mean relocating their practices to the hospital outpatient department (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 high in the non-Medicare population. If ASCs find that the Medicare payments for such services are inadequate, they may seek, through various outreach, marketing and conscious choices, to decrease their share of Medicare patients without reducing their total patient volume, in business parlance, change the payor mix

If implemented, the revised payment system proposed by Medicare will result in significant redistribution of payments for many specialties. Because ASCs typically undertake a narrowly focused range of services that require similar capabilities in terms of equipment and surgical specialty, they have at their disposal few responses to changes in the payment system beyond their ability to adjust their volumes of Medicare patients. . If this happens broadly, Medicare beneficiaries may experience significant delays accessing important preventive services or treatment.

Conclusion

We urge you to reevaluate the assumptions used in defining budget neutrality and to broaden your views allowing you to set a conversion factor that will more realistically set payments for ASCs in order to preserve the many patient care and financial benefits that inure to Medicare beneficiaries and the program; allow any payment changes to be phased-in over 4 years; and allow procedures permissible in ASCs to be determined by two criteria: First, those that can be done safely and secondly, procedures that do not require an overnight stay.

Next year is slated to be difficult for our member group practices and the physicians who work there. With the 5.1% Sustainable Growth Rate reductions anticipated in the Medicare physician fee schedule; the imaging payment reductions of the Deficit Reduction Act; the uncertain outcomes of realignment of payments and changes resulting from the Medicare Five year review; and now the draconian payment cuts proposed for ASCs, our members stand to see noteworthy reductions in Medicare revenues.

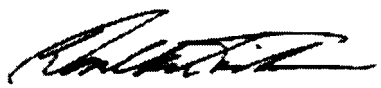
We hesitate to wave the caution flag of impeded or reduced patient access to care for Medicare beneficiaries because this warning has been sounded many times in the past, luckily not supported by manifestations of significant access problems. However, we fear that the stage has been set to relegate mention of access issues to the realm of crying "wolf". However we are certain that our members and many other physicians in the country will respond rationally to the financial circumstances in which they find themselves.

In a recent poll of our members we asked them about actions they might take if the physicians' fee schedule were dropped by 5.1% in 2007. Fully 68% replied that they would in some way limit acceptance of new Medicare patients. Of the respondents to our survey, 95% reported that their Medicare payor mix was between 40-60% of their overall volume.

We do feel that the proposed ASC payment cuts, coupled with the other upcoming payment declines, will have negative consequences for Medicare patients over the next several years. Newly eligible Medicare beneficiaries in particular, may encounter difficulties in finding physicians and in getting timely care. If this proves to be correct, among the hardest hit will be those living in underserved areas, already part of the most vulnerable in our society.

In closing we thank you for the opportunity to present our perspectives about the new ASC payment system and would be pleased to work with you on this important matter. Should you have questions or require additional information, please contact George Roman, Director of Regulatory Affairs at (703) 838-0033 extension 342 or by email at groman@amga.org.

Sincerely,



Donald W. Fisher, Ph.D.
President and Chief Executive Officer

Submitter : Dr. Alfred Rosche **Date:** 11/03/2006

Organization : Advanced Pain Intervention

Category : Physician

Issue Areas/Comments

ASC Conversion Factor

ASC Conversion Factor

Please don't tell me that the biggest insurance organization in the U.S. is trying to limit access to medical pain care for its aging and needy baby boomer population AGAIN. By decreasing the conversion factor for ASC pain care hospitals will be the next available venue and that will dramatically increase costs but not care availability. In essence Medicare would be again subsidizing the hospital system at the expense of those who need care and those providing care. Sounds backward to me. A.P. Rosche M.D.

Submitter : **Ms. Ellie Tabar** **Date: 11/03/2006**

Organization : **Spinal Injection Institute**

Category : **Ambulatory Surgical Center**

Issue Areas/Comments

ASC Payable Procedures

ASC Payable Procedures

Certain procedures are not reimbursed appropriately, especially when it comes to multiple levels.

Submitter : Dr. Matthew Bachinski **Date:** 11/03/2006

Organization : The Greenwood Endoscopy Center, Inc

Category : Ambulatory Surgical Center

Issue Areas/Comments

GENERAL

GENERAL

See attached letter

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

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

Submitter : Dr. William Gilchrist **Date:** 11/03/2006

Organization : The Greenwood Endoscopy Center, Inc

Category : Ambulatory Surgical Center

Issue Areas/Comments

GENERAL

GENERAL

See attached letter

CMS-1506-P2-798-Attach-1.DOC

#798

Mark McClellan, M.D.
Leslie V. Norwalk, Esq., Acting Administrator
Centers for Medicare and Medicaid Services
Department of Health & Human Services
Attention: CMS-1506-P
P.O. Box 8014
Baltimore, Maryland 21244-8014

Re: Medicare Program: Ambulatory Surgery Centers PPS Proposed Rule

Dear Dr. McClellan and Administrator Norwalk:
I am a private practice physician who presently treats Medicare beneficiaries in my practice. I am writing to express my grave concern with CMS's recent proposal to change the way the agency pays ambulatory surgery centers for their services, via facility fee payments.

In my practice, we see a large number of Medicare patients. Treatment for a substantial percentage of these patients includes performing screening colonoscopies for those who are at average risk for colorectal cancer, as well as colonoscopies for high-risk individuals and surveillance colonoscopies for those who have already been detected as having either polyps, or who have had cancerous lesions excised previously. Additionally we see a very significant number of patients with other conditions—GI bleeding, inflammatory bowel disease, gastroesophageal reflux disease (GERD), and/or Barrett's esophagus for whom ready access to an appropriate, safe, cost-efficient site for GI endoscopy is critical to either restoring them to good health, or sustaining them in good health.

Both the GAO and CMS itself have stated that the Medicare colorectal cancer screening benefit is underutilized. MEDPAC has repeatedly endorsed the concept that medical procedures and services should be site neutral. So, on its face, a proposal such as this one, which institutionalizes the concept of paying significantly more to the hospital than to the ASC, and which will likely reduce the capacity to provide GI screening colonoscopies and other GI endoscopic procedures by forcing a significant number of ASCs to close their doors to Medicare beneficiaries, if not to all patients, because Medicare's payment level will drop so precipitously that these ASCs can no longer meet their expenses and render a reasonable return on investment, seems foolish and counterproductive.

Medicare seems to be ignoring both the stated priorities of the current Administration as well as the lessons of cost management in the private sector. President Bush and his staff are on record, on multiple occasions, stating that ASCs are a more cost-effective environment than the hospital to receive key medical services. When private sector insurers have sought to reduce total health care costs, they have actively sought to

encourage patients to receive their services in the ambulatory surgery center, instead of in the hospital outpatient department. In a recent example, Blue Cross of California has announced that it will pay a 5% premium to physicians for every GI endoscopy that is performed in the ASC, rather than in the HOPD. This CMS proposal, which would always pay more to HOPDs and always pay less to ASCs, is directly antithetical to the direction adopted by the private sector insurers.

The agency's concept of budget neutrality in this proposal is incorrect, unfair and shortsighted, for multiple reasons. First and foremost, the agency proposes to increase markedly the number of procedures, from a variety of different specialties that are performed in the ambulatory surgery center. By raising, markedly, the reimbursement for vascular, orthopedic and urologic services, much larger numbers of these services will be performed in ASCs. But in computing budget neutrality, CMS appears to believe that exactly the same pool of dollars should cover in full the payment, even if, because of expansion of the ASC approved list, millions of procedures that once were performed in the HOPD are now reimbursed under the ASC payment policy. Congress could never have intended that CMS would secure twice as many services for the same number of dollars. Every new service that is added to the ASC list, under this interpretation, forces the facility fee payment for a GI endoscopy performed in an ASC that much lower. This approach is unfair, nonsensical and bad health policy.

The reality is that for every single case that moves from the HOPD to the ASC under this expansion of the ASC approved list, the Medicare program will save money. This is so because at the current rates, ASC payments are always lower than, or at least never greater than the facility fee that CMS pays to HOPDs. Again, if the pool of dollars for ASC payments were fixed despite a large increase in the number of cases done in the ASC (because of expansions to the ASC list), then the pool of dollars paid out to HOPDs will decline, because fewer cases are likely to be done there. So, the only accurate approach to budget neutrality is to consider the impact on the total pool of BOTH ASC facility fee payments and HOPD facility fee payments. In summary, the agency currently has budget neutrality completely wrong—(1) you cannot expect the same pool of funds to cover all costs when the expansion of the ASC approved list will likely result in millions of additional cases moving to the ASC; and (2) CMS must take into account, and not ignore, the savings that are generated in HOPD payments because many cases will likely move from HOPD to the ASC setting.

In the gastroenterology area, CMS's proposed policy virtually assures results inimical to the public health. Today, when a GI procedure, such as a screening colonoscopy is performed in an ASC, that ASC receives a facility fee, which on the average amounts to 89% of the facility fee CMS pays to the HOPD if that same procedure is performed there. We need to provide a bit of background relating to the effectiveness of the Medicare colorectal cancer screening benefit. Congress did the right thing in 1997 when it enacted the Medicare colorectal cancer screening benefit, and again in 2000 when it added the average risk colonoscopy benefit. Sadly, and whether intentionally or inadvertently, CMS has done everything possible to emasculate the effectiveness and utilization of that benefit. Since 1997, CMS has cut the physician fee schedule payment for

screening/diagnostic colonoscopies by almost 40%--from a little over $300, to the current level of just around $200, and trending downward (these are raw dollars—if inflation were factored in the reduction would almost certainly be in excess of 50%). According to information from the American College of Gastroenterology, no other Medicare service has been cut this much. Now, CMS issues a new proposal, which would further undercut and devastate the prospects for Medicare beneficiaries to receive a colorectal cancer screening colonoscopy. In terms of the specialty that would be hurt the most by the current proposal, once again, CMS foolishly has placed gastroenterology and colonoscopies for colorectal cancer screening in its cross hairs, as by far the biggest potential loser, with the prospect of cuts from 89% of the HOPD payment to 62%.

If CMS is bound to peg ASC payments at a percentage of HOPD, it must adopt a bi-level approach, with ASCs in groups like GI and pain management at a higher tier of payment that is at or higher than the current 89% we now receive, and then a second, lower tier as the facility fee percentage for ASCs in other specialties, which are not involved in life-saving preventive services like colorectal cancer screening tests.

It is clear what will happen if this CMS proposal is adopted in anything close to its current form:

For Patients:

Utilization of the Medicare colorectal cancer screening benefit, already anemic, will be further devastated—the collision of false payment "savings" vs. sound preventive public health policy will be dramatic. Utilization of CRC screening will decline still further, cancers will go undetected, and in life and death terms, many Medicare beneficiaries will die unnecessarily because the access to sites where colonoscopies can be performed will be reduced as GI ASCs close, waiting times for screening will increase, and the overall rate of CRC screening will plummet farther.

For the Medicare System:

Medicare facility fee payments for GI services will increase, rather than decrease. Having dealt a deathblow to many GI ASCs by draconian reductions in payment, the access of Medicare beneficiaries to GI ASCs will be markedly reduced. CRC screening colonoscopies will be reduced, but the volume of diagnostic colonoscopies and endoscopies will not decline.

With fewer ASCs, a larger proportion of all GI procedures will need to be performed in the HOPD, where the facility fees CMS pays will be higher.

So, the inevitable result of this proposed CMS action, if implemented will be: (a) total Medicare costs for GI facility fees will rise (although the per unit facility fee for decreased number of these performed in the ASC may well decline); (b) available access by Medicare beneficiaries for GI colonoscopies and other endoscopic procedures will

decline; and (c) more Medicare beneficiaries will die unnecessarily from colorectal cancer will increase as screening rates decline.

It is hard to believe that these are the results the CMS is seeking, but the only way to avoid this outcome is to modify this proposal so as to increase, not decrease, the facility fees to GI ASCs. This will avoid the closure of GI ASCs, and thus avoid a reduction in access and CRC screening rates. It will also prevent an increase in the number of GI procedures performed in the more costly HOPD setting.

Respectfully submitted,

William J. Gilchrist, MD, FACP,FACG,AGAF

Submitter : Mrs. Charlotte Bellantoni **Date:** 11/03/2006

Organization : USPI and Ga. Society of ASC

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 recomendation from 2004 to replace the current "inclusive" list of ASC-covered procedures with an "exclusionary" list of procedures that would not be covered in ASC's based on two clinical criteria: (i)beneficiary safety; and (ii)the need for an overnight stay.

ASC Payable Procedures

ASC Payable Procedures

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.

CY 2008 ASC Impact

CY 2008 ASC Impact

no comment

Submitter : Dr. Matthew Bachinski **Date:** 11/03/2006

Organization : The Greenwood Endoscopy Center, Inc

Category : Ambulatory Surgical Center

Issue Areas/Comments

GENERAL

GENERAL

Disregard Comment #95898, attachment failed. See attached letter

CMS-1506-P2-800-Attach-1.DOC

#800

Mark McClellan, M.D.
Leslie V. Norwalk, Esq., Acting Administrator
Centers for Medicare and Medicaid Services
Department of Health & Human Services
Attention: CMS-1506-P
P.O. Box 8014
Baltimore, Maryland 21244-8014

Re: Medicare Program: Ambulatory Surgery Centers PPS Proposed Rule

Dear Dr. McClellan and Administrator Norwalk:
I am a private practice physician who presently treats Medicare beneficiaries in my practice. I am writing to express my grave concern with CMS's recent proposal to change the way the agency pays ambulatory surgery centers for their services, via facility fee payments.

In my practice, we see a large number of Medicare patients. Treatment for a substantial percentage of these patients includes performing screening colonoscopies for those who are at average risk for colorectal cancer, as well as colonoscopies for high-risk individuals and surveillance colonoscopies for those who have already been detected as having either polyps, or who have had cancerous lesions excised previously. Additionally we see a very significant number of patients with other conditions—GI bleeding, inflammatory bowel disease, gastroesophageal reflux disease (GERD), and/or Barrett's esophagus for whom ready access to an appropriate, safe, cost-efficient site for GI endoscopy is critical to either restoring them to good health, or sustaining them in good health.

Both the GAO and CMS itself have stated that the Medicare colorectal cancer screening benefit is underutilized. MEDPAC has repeatedly endorsed the concept that medical procedures and services should be site neutral. So, on its face, a proposal such as this one, which institutionalizes the concept of paying significantly more to the hospital than to the ASC, and which will likely reduce the capacity to provide GI screening colonoscopies and other GI endoscopic procedures by forcing a significant number of ASCs to close their doors to Medicare beneficiaries, if not to all patients, because Medicare's payment level will drop so precipitously that these ASCs can no longer meet their expenses and render a reasonable return on investment, seems foolish and counterproductive.

Medicare seems to be ignoring both the stated priorities of the current Administration as well as the lessons of cost management in the private sector. President Bush and his staff are on record, on multiple occasions, stating that ASCs are a more cost-effective environment than the hospital to receive key medical services. When private sector insurers have sought to reduce total health care costs, they have actively sought to

encourage patients to receive their services in the ambulatory surgery center, instead of in the hospital outpatient department. In a recent example, Blue Cross of California has announced that it will pay a 5% premium to physicians for every GI endoscopy that is performed in the ASC, rather than in the HOPD. This CMS proposal, which would always pay more to HOPDs and always pay less to ASCs, is directly antithetical to the direction adopted by the private sector insurers.

The agency's concept of budget neutrality in this proposal is incorrect, unfair and shortsighted, for multiple reasons. First and foremost, the agency proposes to increase markedly the number of procedures, from a variety of different specialties that are performed in the ambulatory surgery center. By raising, markedly, the reimbursement for vascular, orthopedic and urologic services, much larger numbers of these services will be performed in ASCs. But in computing budget neutrality, CMS appears to believe that exactly the same pool of dollars should cover in full the payment, even if, because of expansion of the ASC approved list, millions of procedures that once were performed in the HOPD are now reimbursed under the ASC payment policy. Congress could never have intended that CMS would secure twice as many services for the same number of dollars. Every new service that is added to the ASC list, under this interpretation, forces the facility fee payment for a GI endoscopy performed in an ASC that much lower. This approach is unfair, nonsensical and bad health policy.

The reality is that for every single case that moves from the HOPD to the ASC under this expansion of the ASC approved list, the Medicare program will save money. This is so because at the current rates, ASC payments are always lower than, or at least never greater than the facility fee that CMS pays to HOPDs. Again, if the pool of dollars for ASC payments were fixed despite a large increase in the number of cases done in the ASC (because of expansions to the ASC list), then the pool of dollars paid out to HOPDs will decline, because fewer cases are likely to be done there. So, the only accurate approach to budget neutrality is to consider the impact on the total pool of BOTH ASC facility fee payments and HOPD facility fee payments. In summary, the agency currently has budget neutrality completely wrong—(1) you cannot expect the same pool of funds to cover all costs when the expansion of the ASC approved list will likely result in millions of additional cases moving to the ASC; and (2) CMS must take into account, and not ignore, the savings that are generated in HOPD payments because many cases will likely move from HOPD to the ASC setting.

In the gastroenterology area, CMS's proposed policy virtually assures results inimical to the public health. Today, when a GI procedure, such as a screening colonoscopy is performed in an ASC, that ASC receives a facility fee, which on the average amounts to 89% of the facility fee CMS pays to the HOPD if that same procedure is performed there. We need to provide a bit of background relating to the effectiveness of the Medicare colorectal cancer screening benefit. Congress did the right thing in 1997 when it enacted the Medicare colorectal cancer screening benefit, and again in 2000 when it added the average risk colonoscopy benefit. Sadly, and whether intentionally or inadvertently, CMS has done everything possible to emasculate the effectiveness and utilization of that benefit. Since 1997, CMS has cut the physician fee schedule payment for

screening/diagnostic colonoscopies by almost 40%--from a little over $300, to the current level of just around $200, and trending downward (these are raw dollars—if inflation were factored in the reduction would almost certainly be in excess of 50%). According to information from the American College of Gastroenterology, no other Medicare service has been cut this much. Now, CMS issues a new proposal, which would further undercut and devastate the prospects for Medicare beneficiaries to receive a colorectal cancer screening colonoscopy. In terms of the specialty that would be hurt the most by the current proposal, once again, CMS foolishly has placed gastroenterology and colonoscopies for colorectal cancer screening in its cross hairs, as by far the biggest potential loser, with the prospect of cuts from 89% of the HOPD payment to 62%.

If CMS is bound to peg ASC payments at a percentage of HOPD, it must adopt a bi-level approach, with ASCs in groups like GI and pain management at a higher tier of payment that is at or higher than the current 89% we now receive, and then a second, lower tier as the facility fee percentage for ASCs in other specialties, which are not involved in life-saving preventive services like colorectal cancer screening tests.

It is clear what will happen if this CMS proposal is adopted in anything close to its current form:

For Patients:

Utilization of the Medicare colorectal cancer screening benefit, already anemic, will be further devastated—the collision of false payment "savings" vs. sound preventive public health policy will be dramatic. Utilization of CRC screening will decline still further, cancers will go undetected, and in life and death terms, many Medicare beneficiaries will die unnecessarily because the access to sites where colonoscopies can be performed will be reduced as GI ASCs close, waiting times for screening will increase, and the overall rate of CRC screening will plummet farther.

For the Medicare System:

Medicare facility fee payments for GI services will increase, rather than decrease. Having dealt a deathblow to many GI ASCs by draconian reductions in payment, the access of Medicare beneficiaries to GI ASCs will be markedly reduced. CRC screening colonoscopies will be reduced, but the volume of diagnostic colonoscopies and endoscopies will not decline.

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Respectfully submitted,

Matthew S. Z. Bachinski, MD