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

Organization : **Advanced Endoscopy and Surgical Center**

Category : **Ambulatory Surgical Center**

Issue Areas/Comments

CY 2008 ASC Impact

CY 2008 ASC Impact

see attached

CMS-1506-P2-821-Attach-1.DOC

#821

Advanced Endoscopy and Surgical CENTER

142 Route 35 South
Suite 101
Eatontown, NJ 07724
Tel: (732) 935-0031 Fax: (732) 935-0032

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,

William Basri, MD

Submitter : Anna Barr **Date:** 11/03/2006

Organization : Redmond Surgery Center

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 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

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. Stuart Ackley **Date:** 11/03/2006

Organization : General Surgeons of Western Colorado PC

Category : Physician

Issue Areas/Comments

ASC Payable Procedures

ASC Payable Procedures

I support CMS's proposed addition of CPT 47562 Lap Cholecystectomy to the list of approved surgeries for Ambulatory Surgical Centers in 2008. This permits the surgeon and the patient to determine the setting that is the most clinically appropriate for the specific case. For those cases that are clinically appropriate to be performed in an ASC, the cost savings to the patient and the insurer is significant while still maintaining high quality patient care. This support comes with over 6 years of experience history utilizing the ASC for some of my private insured and self pay patients.

Submitter : Ms. Nancy Franssen **Date:** 11/03/2006

Organization : Oregon Ambulatory Surgery Association

Category : Ambulatory Surgical Center

Issue Areas/Comments

CY 2008 ASC Impact

CY 2008 ASC Impact

We need to give Medicare clients a choice. With the budget neutrality provision enacted by Congress, ASC's will be forced to operate with 62% of revenue received by the hospital for the same procedure. The ASC facilites cannot afford to provide care to the Medicare population with a reimbursement that will not cover costs. Currently, ASC's receive reimbursement for the procedure and additional for implanted DME, with the new HOPD payment system, this is included. This is one of the reasons why the HOPD reimbusement is higher currently at the hospital than the current ASC rates. This drives the Medicare population back to the hospital.

We feel that by aligning the payment system for ASC's and hospital outpatient departments, it will improve the transparency of cost and quality data used to evalutatc outpatient surgical services for Medicare clients. This will decrease confusion and enable the Medicare client to make an informed decision on their surgical care.

With the high quality of care, low infection rates, and family centered care provided by ASC's, we feel that Medicare clients should have a choice.

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

Organization : The Greenwood Endoscopy Center, Inc

Category : Ambulatory Surgical Center

Issue Areas/Comments

GENERAL

GENERAL

Letter attached

CMS-1506-P2-825-Attach-1.DOC

#825

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,

Bryan T. Green, MD

Submitter : Mrs. Kim Jungwirth **Date:** 11/03/2006

Organization : Ambulatory Surgical Center, LLC

Category : Ambulatory Surgical Center

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1506-P2-826-Attach-1.TXT

#928

AMBULATORY ASC
Surgical Center, LLC

November 8, 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

Dear Administrator Norwalk,

Comments on CMS proposed rule 1506-P

I am the facility Manager of a free standing Ambulatory Surgical Center located in Oshkosh, Wisconsin. The ASC currently provides services for Ophthalmology patients requiring surgical interventions due to disease or inability to maintain adequate activities of daily living. The proposed rule if allowed to go through as is will definitely have a negative impact on this facility's ability to continue to provide care to these patients. Approximately 70% of the area population utilizes this center for ophthalmic surgery needs. The main reason for this utilization is lesser charges. Based on 2003 data the area hospital charges $1500 more for routine cataract removal procedures than the ASC. Our outcomes data shows high patient satisfaction, with no major post-operative complications or deaths.

Facility History:

This facility was originally opened in 1999 with one provider, during the intervening years we have grown to 5 physicians with service to 1500 lives per year. Feedback from patients is positive; many patients have indicated that they plan to utilize the facility for all eye care needs in the future. The facility has always made decisions on utilization of supplies and equipment based on several factors: cost, effectiveness, patient safety. To that end the ASC has been able to provide services and keep current with new technology. The reasons this ASC was opened are as follows:
Surgeons had difficulty scheduling surgery at area hospitals, and once scheduled would get bumped to a later time or different day, which caused delays and cancellations in the office appointment schedule.
Staff often were not properly trained to assist on the surgeons cases, which led to improper set-up of equipment and patient complications.
Equipment and instruments were often lost or broken due to improper care

The Future

The concern is that the ASC will not be able to continue to do business after 2008 with the current proposed rule structure. The impact of these changes will not allow the ASC to add new technology in the form of equipment, will take away any staff compensation increases, and will eventually lead to closure of the facility. It is important in the Health Care arena to stay competative in these areas. Most equipment is outdated within 2 years. The ASC does make every attempt to minimize this by making sure equipment is well-maintained and upgrading equipment when indicated rather than purchasing something new. With regard to staff compensation, the ASC needs to be competative in the area market, if wages drop below others in the area, staff recruitment and retention becomes an issue. If closure of the ASC occurs patients will be forced to use the hospital setting for future ophthalmic surgery needs. Most other single specialty ASC's may find themselves in similar circumstances. My concern is that this snowball effect will lead to a significant increase in CMS costs for Medicare rather than achieving budget neutrality.

Thank-you for giving me the opportunity to comment on the impact of the proposed legislation. If you have any additional questions or need additional information feel free to contact me at 920-236-3550 or kmjungwirth@optivisionllp.com.

Sincerely,

Kim Jungwirth, RN, Facility Manager
Ambulatory Surgical Center, LLC
President elect – Association of Wisconsin Surgery Centers, Inc.

501 Doctors Court, Oshkosh, Wisconsin 54901 (920) 236-3550 FAX (920) 236-3548

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

Organization : **Medical Eye Associates**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1506-P2-827-Attach-1.DOC

#827

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

11-03-06

Dear Ms Norwalk:

I am writing to you concerning the Notice of Proposed 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 the Medical Director and a utilizing physician at Medical Eye Associates, an Ophthalmic Ambulatory Surgical Center located in Macon, Georgia.

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. It is with this goal that I submit the following comments.

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. Although the HOPD payment system is imperfect, we believe 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 **alignment of the ASC and HOPD payment** systems to prevent the introduction of new disparities between the payment systems that could drive site of service selection,

- Ensuring **beneficiary access** to a robust 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.

I. Alignment of ASC and HOPD Payment Policies

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.

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 volatility 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 we believe a more complete alignment of the ASC and HOPD payment systems is appropriate. The major areas where we see a need for further refinement are:

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

B. **Treatment of unlisted codes:** When HOPDs perform services or procedures for which the CPT book does not provide specific codes, they use an unlisted procedure code, identify the service and receive payment for which we believe ASCs should also be eligible.

C. **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.

D. **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 us to submit claims using the UB-92, and we suggest that the Medicare program should likewise align the payment system at the claim level.

II. Ensuring Beneficiaries' Access to Services through Fair And Reasonable Payments

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.

If the facility fee is insufficient to cover the cost of performing the procedure in an ASC, responding to the change may mean that we are forced to relocate surgeries to the HOPD. Such a decision would increase expenditures for the government and the beneficiaries.

To remedy this situation and offset future financial losses we strongly recommend that CMS create a final rule that does not make drastic rate cuts and that makes the computation of rates and rate changes the same for both the HOPD and the ASC reimbursement.

In addition, CMS should expand the list of approved procedures to include any and all procedures that can be performed in an HOPD. 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. CMS is losing an opportunity to increase patient choice and rely on the clinical judgment of the surgeon.

In summary, while there are elements of the proposed rule I support, my overreaching concern is that the proposed major overhaul of ASC payment policies contains serious flaws that must be addressed in order to keep the program viable for ambulatory surgery centers. I urge the Agency to give serious attention to the items discussed above. Please contact me to discuss this further:

Malcolm S. Moore, Jr., MD
Medical Eye Associates
1429 Oglethorpe Street
Macon, Georgia 31201
478-743-7061

Thank you for your time and attention in reviewing this correspondence.

Sincerely,

Malcolm S. Moore, Jr., MD

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

Organization : West Shore Endoscopy Center

Category : Physician

Issue Areas/Comments

ASC Conversion Factor

ASC Conversion Factor

I write to speak against the reduction of payment of ASCs mto 62% of that paid to hospitals. This is much less than our costs and will result in severely reducing the number of Medicare patients that we can and will see. ASCs are a dramatic success story and advance in the medical care system. It would be tragic if CMS were to pull the rug on payment this way, and so hurt the very people that you are obligated to help. Please significantly raise this conversion figure.

Frank Jackson MD

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

Organization : Southern Eye Center, PA II

Category : Ambulatory Surgical Center

Issue Areas/Comments

CY 2008 ASC Impact

CY 2008 ASC Impact

Sce Attached

CMS-1506-P2-829-Attach-1.DOC

#829

SOUTHERN EYE CENTER

Lynn B. McMahan, M.D.
Chief-Cataract & Implant

Jamie Jiménez, M.D.
Chief-Retina & Diabetes

Milam S. Cotten, M.D.
Chief-Eyelid & Eye Muscle

C. Byron Smith, M.D.
Chief-Cornea
& Refractive Procedures

Kiper C. Nelson, M.D.
Cataract & Implant

Francis Soans, M.D..
Chief – Glaucoma

John H. Weems, Esq., CPA
Administrator & In-House Counsel

November 3, 2006

Leslie V. Norwalk, Esq., Acting Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue, NW
Washington, D.C. 20201

Attention: CMS—1506-P, Room 445-G

Dear Administrator Norwalk:

I am ophthalmic surgeon who has been practicing over 30 years. During that time I have performed over 35,000 cataract surgeries. I was one of the first surgeons in the world to perform outpatient cataract surgery. I began to do all my cataract surgery without a hospital.

In 1978, I opened the first ASC in Mississippi devoted solely to eye surgery. Today, our eye center has 6 eye surgeons who specialize in retinal, plastics, glaucoma, cornea and refractive procedures. We perform over 4000 surgical cases per year. About 65% of these surgical encounters are from Medicare patients.

Having performed cataract surgery in a hospital environment for many years, I am convinced that cataract surgery and many other types of eye surgery are best performed in an ASC environment that is totally devoted to eyes. Specialty ASC's are more efficient than hospitals and based on my experience have staff who are better trained. Eye surgery is safely performed in ASC's. I have performed over 25,000 cataract surgeries, not once have I ever had to transfer a patient to a hospital. I would like to make the following comments in regard to CMS's proposed regulation to establish a new ASC payment system and update the ASC procedures list.

The proposed ASC List is too restrictive

CMS' proposed reform of the ASC procedures list remains far too restrictive. The surgeon is the best one to decide where surgery should take place. In turn, if an ASC is the preferred surgery sight, it should be permitted to furnish and receive facility reimbursement for any and all procedures.

The Proposed ASC Payment of 62% of the Hospital Outpatient Department (HOPD) Rate is insufficient

CMS, is proposing to pay ASCs only 62% of the procedural rates paid to HOPDs. This percentage rate is wholly inadequate and doesn't reflect a realistic differential of the costs incurred by hospitals and ASCs in providing the same services.

Even though ASC's are more efficient than hospitals, this 62% is not enough to cover overhead, malpractice premiums, maintain equipment and keep trained staff. In order to adequately cover these costs, the agency should interpret the budget neutrality provision to permit ASCs to be paid at a rate of 75% of the HOPD rate, as recommended by the ASC industry.

ASC's provide the same or better service for less money. Unlike many hospitals, privately owned ASC's are not subsidized by the government, freeing up more tax dollars to be used elsewhere.

Please help level the playing field so ASC's can maintain their current high standard of service while reducing the taxpayer's burden on many levels.

Uniform Percentage for All Services

Whatever percentage is eventually adopted by CMS in the final regulation, it should be applied uniformly to all ASC services, regardless of the type of procedure or the specialty of the facility.

The goal for hospitals and ASC's is the same: provide quality healthcare. Why should ASC's be paid less when they are achieving this goal? All available funds set aside for reimbursing healthcare facilities should be equally available to all.

Payment Rates for Office-Type Procedures

Although CMS has added many ophthalmic services to the ASC list, you are proposing to pay for many office-type services, like laser procedures, at the Medicare Professional Fee Schedule practice expense amount. For years, we have subsidized laser fees out of our own pockets. We have

spent hundreds of thousands of dollars on laser equipment to provide this technology to our patients. I am not aware of a single laser in any of our local hospitals that can provide the technology we have. As noted above, whatever percentage is ultimately adopted by CMS, it should be applied uniformly to all services, regardless of type, so we can continue to provide the best technology available to the patient.

Annual Updates of Payment Rates

Under current law, ASCs are provided no annual cost-of-living updates from 2004-2009, notwithstanding significant increases in the costs of delivering care. Commencing in 2010, CMS is proposing to pay ASCs an update equal to the consumer price index (CPI), while HOPDs would be paid an update based on the hospital market basket (HMB), which is typically higher.

Why should hospitals be treated differently when we operate in the same business environment? The new payment system should provide hospital market basket updates to both ASCs and HOPDs since both provide the same services and incur the same costs in delivering high quality surgical care.

In short, ASC's must pay their bills just like hospitals. As noted above, specialty ASC's provide a better service, more efficiently, without government subsidy. However, in order to operate we must cover costs. Unlike the typical business we are unable to pass rising costs to the consumer, we depend on you to be fair and reasonable in your reimbursement practices.

Please keep the playing level, do it the American way...don't play favorites.

Sincerely,

Lynn B. McMahan, M.D.
President

LBM/eal

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

Organization : Ambulatory Surgical Center, LLC

Category : Ambulatory Surgical Center

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1506-P2-830-Attach-1.TXT

#830

November 2, 2006

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

To Whom It May Concern:

I am responding to the recent proposed changes in outpatient ASC reimbursement for 2008. I have been involved in ownership of a physician owed ambulatory surgery center since 1985 both as multi-specialty and single specialty center. I am sure many of my colleagues will respond with many valid reasons why 62% reimbursement level compared to hospital ASC reimbursement is inadequate. I believe there should be equivalency in not only the procedure list but also unlisted procedure codes, payment bundles, elimination of cap on office based payments and unfair and unequal differing measures of inflation.

For the past 21 years I believe we have provided our local community and Medicare substantial reductions in costs based on the lower reimbursement that our ASC's get compared to hospital ASC's. I think the playing field should be level and the reimbursement be the same. Especially annoying is the fact that most hospital outpatient centers are not paying taxes, either business or income, property taxes, nor sales tax, so even if the reimbursement methodology were exactly the same and the payments the same there still would be a leg up advantage by the hospital ASC's.

I would urge you to make this process simple and equalize the payments and eliminate the unfair hospital reimbursement levels, which are just costing Medicare and the system excess money.

Sincerely,

Stephen S. Dudley, M.D
SSD/lr

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

Organization : Central New York Eye Center

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

please see attachment

CMS-1506-P2-831-Attach-1.DOC

CMS-1506-P2-831-Attach-2.DOC

#CC1

November 3, 2006

Leslie V. Norwalk, Esq., Acting Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue, NW
Washington, D.C. 20201

Attention: CMS-1506-P, Room 445-G

Dear Administrator Norwalk:

The Central New York Eye Center is a New York State Article 28 freestanding surgery center. We have been providing high quality, patient centered and cost-effective ophthalmic laser and surgical services since 1987 and we care for more than 1400 patients a year, over 85% of who are Medicare beneficiaries.

This letter is in regard to the Notice of Proposed Rulemaking published on June 12, 2006 regarding updates to the rate-setting methodology, payment rates, payment policies and the list of covered surgical procedures for ambulatory surgery centers. I am submitting the following comments in the interest of creating a healthcare system that delivers excellent clinical outcomes in a cost-efficient environment:

- The decision as to the site of surgery should be made by the surgeon in consultation with his patient. The Centers for Medicare and Medicaid Services' proposal to limit the physician's ability to determine the appropriate site of service for a procedure excludes many surgical procedures appropriate for the ambulatory surgery setting.

- Ambulatory surgery centers should be permitted to furnish and receive facility reimbursement for any and all procedures that are performed in hospital outpatient departments. When hospital outpatient departments perform services or procedures for which specific codes are not provided, they use an unlisted procedure code, identify the service and receive payment. I believe ambulatory surgery centers should also be eligible to utilize this process.

- Proposing to pay ambulatory surgery centers only 62% of the procedural rates paid to hospital outpatient departments does not reflect a realistic differential of the costs incurred by ambulatory surgery centers and hospitals in providing the same services. The budget neutrality provision should be interpreted to permit ambulatory surgery centers to be paid at a rate of 75% of the hospital outpatient department rate as recommended by the ambulatory surgery center industry. Such interpretations should include all hospital outpatient department payments in addition to just ambulatory surgery center payments. Broadly interpreting the budget neutrality requirement imposed by Congress would provide Medicare beneficiaries with access to ambulatory surgery centers, thereby reducing Medicare costs.

- The percentage that is eventually adopted by the Centers for Medicare and Medicaid Services in the final regulation should be applied uniformly to all ambulatory surgery center services, regardless of the type of procedure or the specialty of the facility.

- Although the Centers for Medicare and Medicaid Services has added many ophthalmic services to the ambulatory surgery list, it would pay for many office-type services, like laser procedures, at the Medicare Professional Fee Schedule practice expense amount, i.e., your current reimbursement rate, rather than at the 62% rate. As noted above, whatever percentage is ultimately adopted it should be applied uniformly to all services, regardless of type. Most such services will also be transferred from the hospital outpatient department to the ambulatory surgery center setting thereby reducing Medicare costs and offsetting possible increased costs on the shifting of such services from office to ambulatory surgery center.

- Ambulatory surgery centers should be updated based upon the hospital market basket because it more appropriately reflects inflation in providing surgical services than does the consumer price index. The same relative weights should be used for ambulatory surgery centers and hospital outpatient departments since both provide the same services and incur the same costs in delivering surgical care.

- Aligning the payment systems for ambulatory surgery centers and hospital outpatient departments will improve the transparency of cost and quality 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.

- The cap on office-based payments is inappropriate for the ambulatory surgery center and should be omitted from the final regulation.

- Devices used for surgical procedures should be included in the global fee.

- Ambulatory surgery centers should be eligible to receive new technology pass-through payments.

- The computation of rates and rate changes should be the same for both the hospital outpatient department and ambulatory surgery center reimbursement.

In summary, my firm belief is that the proposed changes to the ambulatory surgery center payment policies contain serious flaws that must be addressed in order to keep the Medicare program viable for ambulatory surgery centers. I urge that your serious attention be given to the items discussed above and I thank you for your time reviewing this correspondence.

Sincerely,

Lawrence K. Fox, M.D.
Medical Director

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

Organization : The Greenwood Endoscopy Center, Inc

Category : Ambulatory Surgical Center

Issue Areas/Comments

GENERAL

GENERAL

Letter attached

CMS-1506-P2-832-Attach-1.DOC

#832

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,

A. A. Ramage, III, MD

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

Organization : The Greenwood Endoscopy Center, Inc

Category : Ambulatory Surgical Center

Issue Areas/Comments

GENERAL

GENERAL

See attached letter

CMS-1506-P2-833-Attach-1.DOC

853

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:
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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.

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Respectfully submitted,

Ralfal Sadurski, III, MD