Submitter : **Dr. Tania Turbay** **Date: 11/05/2006**

Organization : **Tania C. Turbay, DPM, PA**

Category : **Physician**

Issue Areas/Comments

CY 2008 ASC Impact

CY 2008 ASC Impact

Dr. Tania C. Turbay
2601 SW 37 Ave., Suite 802
Miami, FL 33133

November 5th, 2006

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

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

Dear Ms. Norwalk:

As a practicing interventional pain physician, I am disappointed at CMS s proposed rule for ASC payments. This rule will create significant inequities between hospitals and ASCs, and subsequently beneficiaries access will be harmed. While this may be good for some specialties, interventional pain management will suffer substantially (approximately 20% in 2008 and approximately 30% in 2009 and after). The various solutions proposed in the rule with regards to mixing and improving the case mix, etc., are not really feasible for single specialty centers. CMS should also realize that in general healthcare uses, the topdown methodology or bottom-up methodology used by Medicare is the primary indicator for other payers - everyone following with subsequent cuts. Using this methodology, Medicare will remove any incentive for other insurers to pay appropriately.

Based on this rationale, I suggest that the proposal be reversed and a means be established where surgery centers are reimbursed at least at the present rate and will not go below that rate. We understand there are multiple proposals to achieve this. If none of these proposals are feasible, Congress should repeal the previous mandate and leave the system alone as it is now. However, inflation adjustments must be immediately reinstated.

I hope this letter will assist in coming with appropriate conclusions that will help the elderly in the United States.

Sincerely,

Dr. Tania C. Turbay

Submitter : **Dr. Joseph Mouhanna** **Date: 11/05/2006**

Organization : **Miami Pain**

Category : **Physician**

Issue Areas/Comments

CY 2008 ASC Impact

CY 2008 ASC Impact

Joseph E. Mouhanna, MD, PA
Pain Diagnostics & Treatment

November 5th, 2006

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

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

Dear Ms. Norwalk:

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I hope this letter will assist in coming with appropriate conclusions that will help the elderly in the United States.

Sincerely,

Joseph E. Mouhanna, MD

Submitter : **Mr. Elias Mhanna** **Date: 11/05/2006**

Organization : **Mr. Elias Mhanna**

Category : **Individual**

Issue Areas/Comments

CY 2008 ASC Impact

CY 2008 ASC Impact

Elias F. Mhanna
13500 SW 69th CT.
Miami, FL 33156

11/05/06

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

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

Dear Ms. Norwalk:

As a concerned citizen, I am writing to express my alarm at CMS s proposed rule for ambulatory surgery centers payment system. This rule will create significant inequities between hospitals, ASCs, and ultimately will harm beneficiary access. While this may be good for some specialties, it is clear that interventional pain management will suffer substantially - approximately 20% in 2008 and approximately 30% in 2009 and thereafter. At these reduced reimbursement rates, physicians will not be adequately reimbursed for the services they provide to their Medicare patients and consequently, because all payers follow Medicare, this reduction in ASC reimbursements will affect not only patient access for Medicare patients but all interventional pain management patients.

Given the impact this proposed rule would have on interventional pain physicians practicing in ASCs and their ability to provide services to Medicare patients, I ask that CMS reverse the proposal and that a means be established where surgery centers are reimbursed at least at the present rate and will not go below that rate. If no realistic proposal can be achieved at this time, Congress should repeal the previous mandate and leave the system alone as it is now, with inflation adjustments immediately reinstated.

On behalf of all the patients in the United States and especially the elderly, I thank you for your consideration.

Sincerely,

Elias F. Mhanna

Submitter : **Ms. Joseph Mouhanna** **Date: 11/05/2006**

Organization : **Ms. Joseph Mouhanna**

Category : **Individual**

Issue Areas/Comments

CY 2008 ASC Impact

CY 2008 ASC Impact

Juliette B. Mhanna
13500 SW 69th CT.
Miami, FL 33156

11/05/06

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

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

Dear Ms. Norwalk:

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Given the impact this proposed rule would have on interventional pain physicians practicing in ASCs and their ability to provide services to Medicare patients, I ask that CMS reverse the proposal and that a means be established where surgery centers are reimbursed at least at the present rate and will not go below that rate. If no realistic proposal can be achieved at this time, Congress should repeal the previous mandate and leave the system alone as it is now, with inflation adjustments immediately reinstated.

On behalf of all the patients in the United States and especially the elderly, I thank you for your consideration.

Sincerely,

Juliette B. Mhanna

Submitter : **Dr. Donato Viggiano** **Date: 11/05/2006**

Organization : **Treasure Coast Cosmetic Surgery Center**

Category : **Physician**

Issue Areas/Comments

ASC Ratesetting

ASC Ratesetting

November 3, 2006

RE: CMS proposed Medicare payment rule

Dear Acting Administrator Leslie V. Norwalk:

I am the sole owner of a Florida licensed, Medicare Certified, and American Association for Accreditation of Ambulatory Surgery Facilities accredited ambulatory surgery center which I began in 1987. I am also the sole surgeon in the facility. I sought licensure in order to provide the highest quality care to all of my patients, including my Medicare and Medicaid patients.

As you know, the regulations for an ASC are much more stringent than the regulations for an office surgical facility. These added regulations are costly but are worthwhile for patient safety.

The added cost of providing Medicare and Medicaid patients with an ambulatory surgery center in which to perform surgery is offset by the reimbursement from Medicare, Medicaid, and others. If the proposed ASC payment rates for CY 2007 are implemented, the reimbursement will not justify the added expense of the ASC regulations and I will be forced to abandon my ASC after 19 years of spotless performance. Access by my patients who are Medicare or Medicaid beneficiaries to the safety of an ASC over an office operating room will suffer.

Please consider the effect this drastic reduction in the payment rate will have on American citizens who depend on Medicare and Medicaid for their medical care.

Donato A. Viggiano, M.D., F.A.C.S.
1901 SE Port St. Lucie Blvd.
Port St. Lucie FL 34952-5582

772-335-7477
Fax: 772-335-8379

Submitter : Ms. Cindy Keene **Date:** 11/06/2006

Organization : Lewis

Category : Ambulatory Surgical Center

Issue Areas/Comments

GENERAL

GENERAL

See attachment

CMS-1506-P2-908-Attach-1.DOC

CMS-1506-P2-908-Attach-2.PDF

#908

Lewis & Clark
ORTHOPAEDIC INSTITUTE
LEWISTON ORTHOPAEDIC ASSOCIATES • LEWIS & CLARK OUTPATIENT SURGERY

Bone, Joint & Spine Specialists

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STEVEN R. BOYEA, M.D.
LEROY N. KEENE, PA-C
JEREMY B. OSTERMILLER, PA-C
ANDREW J. SCHUG, PA-C
CINDY L. KEENE, CPA, CMPE
CHIEF EXECUTIVE OFFICER

November 6, 2006

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

This letter is in response to the proposed rules affecting ambulatory surgery centers. Our facility is the only orthopaedic outpatient surgery center for over one hundred miles and serves a 75 mile rural area around Lewiston, Idaho. Our facility experiences a 99% patient satisfaction, and only two infections in over 3,000 cases since opening the facility two and a half years ago. Approximately 30% of our business is Medicare and Medicaid patients, so consequently any changes to the ASC payment system dramatically affects our facility.

The proposed rule establishes a budget neutrality formula which simply is inadequate to cover the cost of performing procedures in an ASC setting. In addition, even though the proposed formula equates to 62% for 2007, the formula is based on budget neutrality which means that ASC's will not receive cost of living increases – we could in fact experience decreases! Secondly, the proposed rule severely limits many procedures that are currently performed safely in an ASC for commercial and private paying patients. The proposed rule needs to include all procedures that can be safely performed in a hospital outpatient department. Thirdly, the same relative weights should be used in ASC's and hospital outpatient departments and the ASC fee schedule should be updated based upon the hospital market basket. The hospital market basket more appropriately reflects inflation in providing surgical services than does the consumer price index.

Our facility is providing a valuable service to Medicare beneficiaries. By aligning the payment systems for ASC's 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.

Thank you,

Cindy L. Keene, CPA, FACMPE, CEO
Lewis & Clark Orthopaedic Institute, LLC

Submitter : Dr. Christopher Chisholm **Date:** 11/06/2006

Organization : San Diego Pain Medicine

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

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 Independenee Avenuc, SW
Washington, DC 20201

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

Dear Ms. Norwalk:

As a practicing interventional pain physician, I am disappointed at CMS s proposed rule for ASC payments. This rule will create significant inequities between hospitals, ASCs, and beneficiaries access will be harmed. While this may be good for some specialties, interventional pain management will suffer substantially (approximately 20% in 2008 and approximately 30% in 2009 and after). The various solutions proposed in the rule with regards to mixing and improving the case mix, etc., are not really feasible for single specialty centers. This could lead to the closure of many specailty clinics and patients access to care would suffer. CMS should also realize that in general healthcare uses, the topdown methodology or bottom-up methodology used by Medicare is the primary indicator for other payers - everyone following with subsequent cuts Using this methodology, Medicare will remove any incentive for other insurers to pay appropriately.

Based on this rationale, I suggest that the proposal be reversed and a means be established where surgery centers are reimbursed at least at the present rate and will not go below that rate. We understand there are multiple proposals to achieve this. If none of these proposals are feasible, Congress should repeal the previous mandate and leave the system alone as it is now. However, inflation adjustments must be immediately reinstated.

I hope this letter will assist in coming with appropriate conclusions that will help the elderly in the United States.

Sincerely,

Christopher Chisholm MD

Submitter : **Dr. Alaa Abousaif** **Date: 11/06/2006**

Organization : **Skagit Valley Medical Center**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1506-P2-910-Attach-1.DOC

#910

Alaa Abousaif, MD
Skagit Valley Medical Center
1400 E. Kincaid Street
Mount Vernon, WA 98274

Mark McClellan, M.D.
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
CMS Docket #: CMS-1506-P

Dear Dr. McClellan:
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 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,

Alaa Abousaif, MD

Submitter : Dr. Edward Singer **Date:** 11/06/2006

Organization : Endoscopy Center of Chula Vista

Category : Physician

Issue Areas/Comments

ASC Ratesetting

ASC Ratesetting

Dear gentlepersons,

The proposed rate of 62% of hospital OP rates would be devastating to our endoscopy center. The proposal made to Congress and the Senate by REp Herger and SEn Crapo would allow ASC's to continue to provideservices and obtain yearly updates. The discount from hosp OPD rates proposed in the bills was not as severe as that proposed and had yearly updates. If access to ASC's is not feasible due to low rates, hospitals will not be able to handle the increased loads leading to long wait times and the government will ultimately pay more for these services in the hospital setting.

Submitter : Mr. Mark Mayo **Date:** 11/06/2006

Organization : ILLINOIS FREESTANDING SURGERY CENTER ASSOCIATION

Category : Ambulatory Surgical Center

Issue Areas/Comments

CY 2008 ASC Impact

CY 2008 ASC Impact

See Attachment

CMS-1506-P2-912-Attach-1.DOC

#912

ILLINOIS FREESTANDING SURGERY CNETER ASSOCIATION
423 East Liberty ~ Wauconda, IL 60084-1961
(p) 847-508-3065 ~ (f) 847-526-2666 ~ (e-mail) mayconsultant@msn.com

Novermber 4, 2006

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

Dear Administrator Norwalk and CMS:

Our Association represents the interests of some 70 licensed Ambulatory Surgery Centers in the State of Illinois and the over 1,200 surgeons who, in 2005, performed over 250,000 outpatient surgical procedures. Our Association is active in both the American Association of Ambulatory Surgery Centers and the Federated Ambulatory Surgery Association, national groups that represent the ASC community. Our Board of Directors includes a member of the Board of Directors of FASA and I serve as a Board Member and Secretary of AAASC. I also benefit from almost twenty years of experience as an administrator of a freestanding ambulatory surgery center, as a consultant to the ASC community, as staff to Symbion Healthcare (one of the leading developers, owners and managers of ASCs in the U.S.) and as a formed Health Systems Agency healthcare planner and Director of Certificate of Need Project Review.

We have appreciated the way in which CMS has approached its dialog with the ASC community and has been willing to address and attempt to correct built-in deficiencies in the decades-old ASC payment system.

We are thankful to CMS for taking a proactive and more positive approach to inclusion of surgical procedures and to the process for determining payments to ASCs for the provision of outpatient surgical procedures to Medicare beneficiaries. ASCs have led in the development of patient-friendly care; have increased patient satisfaction and reduced patient anxiety regarding outpatient surgery; and have led the way in introducing more cost-effective and minimally invasive approaches to performing procedures that until recently required a hospital inpatient admission and a prolonged hospital-based recovery period. I am proud of the accomplishments of the field and the cost-savings that I have witnessed during my almost twenty years in the ASC community.

Our Association and I wish to make the following observations, comments, criticisms and suggestions regarding the proposed changes to the Medicare ASC Payment System as proposed in File Code CMS-4125-P for FY2008 RHQDAM Program Issues (CMS-1506-P):

We support CMS's embracing of the MedPAC recommendations and its work with the ASC community to develop a different approach to the addition of procedures to the ASC list and for revision of the current payment method based upon flawed and incomplete survey data.

Section 5105 of The Deficit Reduction Act of 2005 allowed CMS to implement a 3-year payment transition as a "hold harmless payment protection" for certain OPPS at some smaller hospitals. CMS has not proposed a similar protection for ASCs as you propose only a two-yesr phase in. This failure to protect smaller ASCs (as you have already done for certain smaller hospitals) places ASCs in a disadvantaged and inequitable position when compared to the OPPS and should be corrected in the final CMS rule. CMS has rejected a 4-year phase-in for implementation of the new payment system although such a plan was strongly endorsed by the ASC community and it's ASC Coalition.

The adoption of a hospital 80% utilization threshold is an unfair determinate for whether or not a procedure should fall in only the HOPD list and not appear on the ASC list. If such a determinate were to be strictly enforced, NO PROCEDURE would have ever left the higher cost hospital setting (remember Cataracts took days with sandbags for patients to recover and ether-based anesthesia induced Tonsillectomies took days of inpatient recovery – primarily due to the effects of the ether). The 80% rule is capricious and not supported by data; it is an unfair determinate that protects the inefficiencies of the hospital-based system and is not an indicator of safety. CMS should reject this basic rule, one that it cannot justify.

We agree that the 90 minutes of anesthesia and the 4 hour recovery period are antiquated criteria (as is the above 80% rule) and we applaud CMS for removing such criteria as barriers to including procedures on the ASC-approved list.

The proposed payment methodology of 62% of the HOPD rate for the same surgical procedure is grossly inadequate and will result in unacceptable and significant reductions is Medicare payments for some specialties and specific procedures. The ASC community's own surveys indicated that a 75% payment rate was justified. As it is, Medicare in cross-subsidized at the HOPD and the ASC setting by the private and commercial payors of outpatient surgical services. Medicare is required to cover the cost of care, something neither the current ASC rate nor the proposed 62% of the HOPD payment rate actually covers. As we note below, Medicare payments do not come near adequately covering the costs associated with durable medical equipment and implants.

We also believe that the calculations used by CMS to determine "budget neutrality" are unfair and unsubstantiated. To pick a target and they develop a rationale to defend the target or back-fill the numbers is the wrong approach for CMS to take at the point in time when you are developing the first major change to the ASC payment system in decades. CMS should revisit the methodology and its flawed assumptions. Let's work together to get this important change right rather than move forward with a "guestimate" approach to calculating budget neutrality based on inaccurate and incomplete data and assumptions.

We believe that with the good work and cooperation that CMS has shown in crafting a new approach that the details and attention to further consideration based upon comments to this Proposed Rule can result in a fair and fairly-based final payment system (also see our comments below on a phased-in implementation of the rule).

CMS has already announced your intention to delay implementation of a quality of care factor for hospital outpatient services until 2009. This is a grave disservice to Medicare recipients as hospitals should be required to reduce their unplanned admission rates, their complications rates, their infection rates, their wrong site surgery rates, their medications error rates and their death rates for outpatient surgical procedures. Hospitals should also be mandated by CMS to increase their patient satisfaction rates. These added hospital costs actually increase Medicare payments per episode of care and the added costs are not factored in when CMS compares ASC and HOPD payments.

I disagree strongly with that portion of the proposed rule that continues the five-year freeze on ASC payments. The inequity between hospital outpatient rates receiving an annual 3% increase in 2007 (on top of rate increases granted in 2005 and 2006) and ASCs continuing to receive no rate increase for the CPI-U component of the ASC payment rate in 2008 and in 2009 furthers the inequity in the payment methodologies and greatly increases the cost of providing care to patients in the hospital outpatient setting as compared to the ASC setting. ASCs have endured nursing, supply, implant and other cost increases in 2005, 2006 and will again in 2007, 2008 and 2009 face growing cost of care increases that will not be adequately covered by frozen Medicare rates.

Given the fact that ASC payments are significantly below those CMS pays to HOPDs there is no clear incentive in the proposed rule to move cases from the more costly HOPD setting to the ASC setting. In fact, the proposed rule excludes many procedures that are already safely performed for non-Medicare patients at ASCs that, under the proposed rule, will not be made available to Medicare beneficiaries except at the more expensive HOPD setting.

I support the recommendation to move away from using ASC surveys as the basis for determining payment rates and replacing this system with data already available from hospital Medicare Cost Reports for outpatient surgical services.

I do not agree with the CMS proposal to exclude from the ASC Payment System the following procedures: CPT 27415 Osteochondral Knee Allograft; CPT 47562 Laparoscopic Choleccystectomy; CPT 63030 Low Back Disk Surgery; CPT 63042 Laminotomy, Single Lumbar; and CPT 63041 Removal of Spinal Lamina as these procedures can be effectively performed in the morning and the patient can be discharged to home is a stable period after having met medical discharge criteria in the same day. These procedures are already effectively performed on non-Medicare patients in the ASC setting and there is no increased risk for Medicare patients to be able to also receive such services in the ASC setting. CMS does not provide sufficient data and documentation to exclude these procedures.

CMS allows additional payments to ASC for certain IOLs yet the proposed rule will deny payments to ASCs for durable medical equipment and implants. CMS already allows such additional payments for procedures performed in hospital outpatient settings. This inequity in payment processing is unequal and inherently unfair to ASCs and will result in additional costs to the Medicare payment system. CMS, in its final rule, should allow ASCs to receive pass through for implants and durable medical equipment at the same level and in the same amount as hospital outpatient programs. I disagree strongly with CMS's statement that the cost of such implants is already calculated into the procedure reimbursement. Significant number of non-Medicare Orthopedic and Podiatric procedures involve significant implant costs that exceed $4,000-$6,000 per case and the proposed payment system will not even cover the actual cost of the implant let alone the other time and supply costs associated with these cases. I fear that ASCs will most likely pass on performing these procedures in the ASC setting by making the implants unavailable, thus increasing cost to the Medicare system by forcing these cases to be performed only in the hospital inpatient or the hospital outpatient settings. Such reliance upon hospital settings is only a result of the unfair and inequitable payment system being proposed. I believe that a more rational approach, such as the one CMS is proposing for IOLs (especially the NTIOL) be taken for durable medical equipment and for implants.

In Section XVIII CMS postulates that there are ONLY two components of a surgical procedure cost: the physician component professional cost and the facility cost (supplies, nursing services and overhead). This is far too simplistic an approach and CMS should be called out for its short-sightedness in this analysis. Surgery involves several inter-dependent components from Pre-Operative assessment to Pre-Operative workup and evaluation (including required pre-operative labs, X-Ray and EKG as the patient's condition warrants); to Operative Care (including the above discussion about the use of implants and durable medical equipment); to Post-Operative Care (including the need for unplanned admissions due to error, complication or less-that optimal recovery); to Post-Operative results such as Pathology – all of which add significantly to the TOTAL COST OF AN EPISODE OF CARE. The failure of CMS to adequately document the cost of all components of care and to add the costs associated with unplanned transfers and admissions results in a continued unfair rewarding of hospitals for a significantly higher number of unplanned admissions and the added costs associated with such care.

Expansion of the proposed ASC list and better (higher) reimbursement to the ASCs will save Medicare significant sums when compared to the system that pays hospital outpatient settings more for performing the same surgical procedures.

There are many hospital-owned and hospital joint-venture licensed and Medicare-certified ASCs in the United States. Why should a hospital shift its caseload of outpatient surgical procedures from the more lucrative hospital outpatient setting to the ASC settings when it will receive a 100% HOPD reimbursement at the HOPD while only receiving a 62% reimbursement at the ASC for performing the same surgical procedure? The failure of the proposed rule to adequately reimburse ASCs at their true cost will perpetuate the use of higher-cost HOPDs and will negate any savings to CMS from the potential to shift cases from the HOPD to the lower-cost ASC.

In addition, patients continue to pay a higher co-pay at the HOPD settings, thus increasing the actual cost of care to Medicare beneficiaries. The proposed rule does not adequately address the issue of inequity in patient co-payment amounts.

These draft proposed rules do not take into account, as required by law, the GAO Report that is significantly overdue. I feel that the publication of the proposed rule is not ripe for consideration and should be subject to modification and additional public comment based upon the recommendations of the long-overdue GAO Report.

We understand and accept CMS's proposed definition of midnight as the standard for overnight care. However, we wish to point out that CMS is perpetuating a much more costly system, one without market competition. Illinois passed an Alternative Health Care Delivery Act which allows for up to seventy-two hour care for observation, nursing and pain control for patients undergoing a surgical procedure who subsequently require such care. The only alternative would be for a more costly hospital admission. We have appeared before MedPAC to argue for a change in Medicare laws that would include postsurgical recovery care and we thank the office of The Speaker of the House of Representatives and CMS for encouraging us to meet with MedPAC on this issue. We feel that it is time for such an advance on the federal level as Illinois has clearly demonstrated that patients can receive high quality outpatient-based surgery and the necessary nursing care required for an up-to seventy-two hour recovery period at costs well below the same care provided at an Illinois hospital, with the same or better patient outcomes.

We hope that these proposed rules are actually a starting point, not a final blueprint for continuation of an inequitable payment and procedure system for ASCs. We hope that CMS will carefully consider AND incorporate the serious and significant comments you are bound to receive on these proposed rules from the ASC community and that CMS will craft new and fairer rules that will benefit those we serve.

Respectfully Submitted,
ILLINOIS FRESATNDING SURGERY CENTER ASSOCIATION

Mark Mayo, Executive Director

cc: IFSCA Board of Directors
AAASC
FASA

Submitter : Dr. David Chang **Date:** 11/06/2006

Organization : Altos Eye Physicians

Category : Physician

Issue Areas/Comments

ASC Payable Procedures

ASC Payable Procedures

I work at an ophthalmology only ASC, where we provide excellent care to cataract patients due to our specialization. The proposal to pay ASCs only 62% of the procedural rate for hospital OPDs is unreasonably low. Our biggest costs are nursing staff, and supplies. We pay the same as the hospital OPDs for these items. Inflation of nursing salaries in California is sky high, due to a severe RN shortage. We are already straining to make ends meet without this additional cut. We are dedicated to providing Medicare beneficiaries with excellent care. However, we cannot provide high quality care when our payments are being cut so drastically. You would be forcing all ASCs to cut corners - and it is extremely unfair to pay so much more to a hospital OPD for providing the same service in a less efficient and pleasant manner. CMS should interpret the budget neutrality provision to permit ASCs to be paid at a rate of 75% of the HOPD rate at the very least.

ASC Payable Procedures

ASC Payable Procedures

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

ASC Unlisted Procedures

ASC Unlisted Procedures

CMS proposed reform of the ASC procedures list remains far too restrictive. The decision as to site of surgery should be made by the surgeon in consultation with his patient. ASCs should be permitted to furnish and receive facility reimbursement for any and all procedures that are performed in HOPDs.

ASC Updates

ASC Updates

With our costs spiraling upward - labor and rent especially, the fact that we get no cost of living update for years is very very unfair. 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. We use the same equipment and require the same number of RNs. We actually are providing superior care because we are a single specialty ASC (ophthalmology only).

Submitter : **Dr. Calin Savu** **Date: 11/06/2006**

Organization : **The Pain Center of Jonesboro**

Category : **Physician**

Issue Areas/Comments

CY 2008 ASC Impact

CY 2008 ASC Impact

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

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

Dear Ms. Norwalk:

As a practicing interventional pain physician, I am worried by CMS s proposed rule for ASC payments. This rule will create significant inequities between hospitals and ASCs, with beneficiaries access to timely, cost-effective care being severely hampered.

Interventional pain management will suffer substantially (approximately 20% in 2008 and approximately 30% decreases in reimbursement in 2009 and after). You will agree very few would survive such a hit, especially with the ballooning cost of technology and the more complex cases created by the aging population, to name just 2 of the factors making our discipline increasingly costly and difficult, albeit critical to our patients welfare.

Mixing and improving the case mix are not possible for single specialty centers. Focusing on one type of problem (i.e. chronic painful conditions), while creating strength in terms of expertise, efficiency and timeliness, will become, unjustly, the downfall of our institutions because of the new rule.

CMS should also realize that in general healthcare uses, the topdown methodology or bottom-up methodology used by Medicare is the primary indicator for other payers - everyone following with subsequent cuts. Using this methodology, Medieare will remove any incentive for other insurers to pay appropriately.

We suggest that the proposal be re-examined and a means be established where surgery centers are reimbursed at least at the present rate and will not go below that rate. We understand there are multiple proposals to achieve this. If none of these proposals are feasible, Congress should repeal the previous mandate and leave the system alone as it is now. However, inflation adjustments must be immediately reinstated.

I hope this letter will assist in coming to the appropriate conclusions that will assist us in continuing to provide appropriate care to the growing elderly population in the United States.

Sincerely,

Calin Savu, MD
Medical Director
The Pain Center of Jonesboro
505 E Matthews Avenue, Suite 103
Jonesboro, AR 72401

Submitter : **Dr. Douglas Lundy** **Date: 11/06/2006**

Organization : **Resurgens Orthopaedics**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Please consider these changes and vote for them!

Submitter : Scott Pennington **Date:** 11/06/2006

Organization : Resurgens

Category : Physician

Issue Areas/Comments

ASC Payable Procedures

ASC Payable Procedures

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

Submitter : Scott Pennington **Date:** 11/06/2006

Organization : Resurgens

Category : Physician

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 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 : Michael Doyle **Date:** 11/06/2006

Organization : Lindsay House Surgery Center

Category : Ambulatory Surgical Center

Issue Areas/Comments

GENERAL

GENERAL

"See Attachment"

CMS-1506-P2-918-Attach-1.DOC

Lindsay House Surgery Center is a multi-specialty surgery center serving patients in the 10-12 counties around Monroe country in upstate New York. Of the specialties we service, 55% is orthopedic and 16% is Gastroenterology, 10% is pain management, with the remainder being split amongst several specialties. The patients served are extremely pleased with the services performed as the facility is more friendly accessible than the hospitals they usually go to.

The physicians are pleased with the staff, facility, ability for flexibility to book cases, and outcomes along with the interactions with the patients. A physician is able to add on a case usually the same day. This flexibility allows them to meet the medical concerns of the patients and ensure the patient has the best outcome possible. The physicians have asked several times to be able to perform more services than approved and this is impossible because of the allowed procedures CMS approves for ASC Facilities. The physicians are always concerned about patient safety and would never bring a case where this is compromised.

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

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

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

Overview

The broad statutory authority granted to the Secretary to design a new ASC payment system in the Medicare Modernization Act of 2003 presents the Medicare program with a

unique opportunity to better align payments to providers of outpatient surgical services. Given the outdated cost data and crude payment categories underlying the current ASC system, we welcome the opportunity to link the ASC and hospital outpatient department (HOPD) payment systems. Although the HOPD payment system is imperfect, it represents the best proxy for the relative cost of procedures performed in the ASC. The costs are basically the same for the two facilities due to the major costs of a case being staffing and medical supplies. Hence the payment system for the two settings should be identical. I would imagine that CMS would be more concerned about saving money at the same time meeting patient safety requirements.

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

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

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

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

Alignment of ASC and HOPD Payment Policies

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

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

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

appropriate for the ASC setting. ASC's and HOPD's should be treated the same in that the patient does not require and overnight stay and the procedure is not listed as inpatient only.

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

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

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

- **Different measures of inflation:** CMS updates the OPPS conversion factor for annual changes in inflation using the hospital market basket; however, the agency proposes to update ASC payments using the consumer price index for all urban consumers. The market basket is a better proxy for the inflationary pressures faced by ASCs, as it is the measure used by the agency to update payments to hospitals providing the same services. The CMS market basket should also be utilized for an ASC as the costs are generally the same due to the major costs being nursing staff and medical supplies for the case. With the shortage in nursing, the cost is the same for both at ASC and HOPD.

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

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

appropriate for the ASC, surgery centers should be eligible to receive new technology pass-through payments.

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

Ensuring Beneficiaries' Access to Services

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

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

Establishing Reasonable Reimbursement Rates

Medicare payment rates for ASC services have remained stagnant for nearly a decade. Over time, the industry has identified which services it can continue to offer to Medicare beneficiaries through reductions in cost and improvements in efficiency. In the Medicare Payment Advisory Commission's first review of ASC payments in 2003, ASCs were paid more than the HOPD for eight of the top ten procedures most frequently performed in the ASC. One suggestion by the commission was that services migrated to the ASC because the payment rate was higher than the HOPD. However, a multi-year payment freeze on

ASC services has turned the tables and now the HOPD rate in 2007 will be higher (or the same) for eight of the same ten ASC procedures. The continued growth of ASCs during the payment freeze is a strong testament to their ability to improve their efficiency and the preference of physicians and beneficiaries for an alternative to the hospital outpatient surgical environment.

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

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

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

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

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

Thank you for taking time to review and understand the comments above.

Michael J. Doyle
Administrator
Lindsay House Surgery Center

10 Hagen Drive
Rochester, NY 14625

Submitter : Ms. Julie Greene **Date:** 11/06/2006

Organization : Grand Valley Surgical Center, LLC

Category : Ambulatory Surgical Center

Issue Areas/Comments

GENERAL

GENERAL

See Attachment.

CMS-1506-P2-919-Attach-1.RTF

#616

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

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

Dear Administrator Norwalk:

I am the Executive Director of Grand Valley Surgical Center in Grand Rapids, Michigan. Grand Valley Surgical Center, LLC performs approximately 8,000 surgical procedures per year in a variety of surgical specialties. We have approximately 55% of our case in Orthopedics and Medicare represents 28% of our 2006 patient base to date. I have worked to learn all of the different aspects of the recently proposed Medicare ASC Payment System and ASC List Reform. While I applaud CMS's comprehensive review, I am disappointed with the outcome and feel many aspects of the proposal are inadequate.

In the United States, Ambulatory Surgery Centers are a clear high quality, low cost alternative to hospitals delivering the same types of care. Both hospitals and ASCs are important to their communities, with hospitals providing emergency care and specialized programs, in addition to routine care. Hospitals are able to provide a fair amount of charitable care as a result of their tax exempt status. ASCs also provide a fair amount of community benefit in the form of reduced or free service and the payment of taxes into a wide variety of Local, State, and Federal governments.

One of the most rewarding benefits of having an ASC in the community is that they can provide the community with a lower cost alternative for surgical care. The Medicare beneficiaries we serve benefit from our lower cost surgeries. And of course, because of the Medicare reimbursement being significantly below the hospital, the co-payment for the beneficiary is significantly below the hospital co-payment.

However, the Medicare system is eroding the ability to provide a lower cost alternative by severely disabling the ASC system. In the specialty of Orthopedics, many ASCs have stopped performing surgeries because even the direct costs are not being covered by the Medicare current reimbursement schedule. Fortunately, CMS has addressed part of the orthopedic problem in the 2008 shift of monies to Orthopedics. However, because of CMS' narrow viewpoint of interpretation of the budget neutrality provision enacted by Congress, there is a good chance the recent proposal will simply close many ASCs.

Although I believe all ASCs hold a great amount of pride in using their small size to create an efficiency sometimes not able to be matched by their competitors, there are still the market

factors that affect everyone's ability to do business. In the surgical care area, supplies and staffing are significant factors in being able to provide high quality care. In those areas our costs are rarely, if ever, below the hospital costs. While we can reduce costs in the overhead and administrative areas, the fact is that getting paid 62% of what the hospitals get paid is simply not enough to allow us to stay healthy, across all specialties and by taking this drastic measure, CMS is creating an anti-competitive environment, where hospitals are the winners and everyone else goes out of business or can not provide the same high quality care. Even at the 75% of HOPDs that are own industry supported, there were areas of concern. At 62% CMS will be severely negatively affecting the beneficiary's choices by reducing the number of surgeries available at ASCs and reducing the numbers of ASCs.

I want Medicare to pay ASCs less than Hospitals. However, 62% is too low and will have consequences that are counterproductive to CMS' ultimate goal of providing quality care accessibility at a reasonable cost to their beneficiaries. CMS needs to consider what the cost of the surgeries being done at ASCs now and in the future would cost if done strictly at hospitals before they narrowly interpret the balance budget provision to the point where the high quality, low cost provider goes out of business. Even in Orthopedics, there are still issues:

CPT	Current Rate	New rate (approx. based on 62% of HOPD)
20680	500.67	701
26536	703.88	1,555
29881	618	1005
25620	703.88	1357
23410	703.88	1560
23412	976.80	1560
23420	976.80	1560

These are all specific Medicare procedures done at our ASC where the old rate and the new rate do not meet our costs, although 29881 new rate comes close. 23410, 23412, 23420 represent shoulder cases that many ASCs have stopped doing because they are losing so much money. We are "holding out" in hopes that CMS will fairly reimburse these procedures in the future. In the meantime, we are definitely losing significant money on many CMS cases.

I also think ophthalmology is being severely hit and we will not be able to absorb the losses we will have in this area if the proposed rates go into effect.

In addition to my concern regarding the proposed rate of 62% is the rate at which the conversion factor increases in the future. While CMS ties the hospital reimbursement to the market basket rate, it is proposing to tie the ASC rate to CPI. I will reiterate a previous statement. In two significant areas, cost of supplies and cost of labor, ASCs and Hospitals have similar costs. And even then, one could site the fact that ASCs pay sales tax on all of their supplies and do not get the same GPO deals that hospitals may be able to access.

I find it unfortunate that hospitals who choose to have ASCs are receiving the much higher rate of reimbursement and no cost savings of the alternative environment are going to the beneficiaries.

ASC rates should go up at Market Basket in the future and be tied directly to the hospital rate increases. This is a simpler formula...

I would also like to comment on the proposed additions to the Medicare ASC list. I commend CMS for increasing the list. However, you have made the list so narrow that new technologies and surgeries have to be done in the hospital for a long time in order to get more than 20% of the patients into the outpatient arena before Medicare will consider paying for the procedure in the ASC arena. A good example is the Laparoscopic Cholecystectomy that has been done many times in our surgery center. It would still not be on the ASC list for Medicare beneficiaries. This is not a safe care issue. The 20% or less that had the surgery in an outpatient environment did not all die or have complications because they were outpatients and not inpatients. CMS appears to have taken an arbitrary number (20%) and made that the "magic number". How will that encourage technological advances that bring more patients safely to the lower cost outpatient environment? It will not.

Medicare needs to delete the 20% rule (procedure can not be done in an ASC if 80% or more of Medicare beneficiaries having the procedure were done as inpatients) that is proposed. It does not make sense from a safety point of view and does not promote or encourage advances in lower cost, high quality patient care.

I encourage CMS' desire for transparency and of cost and quality. However, as long as CMS creates more complexity than is needed in the payment system, it will be difficult to attain true transparency. Aligning the Hospital and ASC payment policies will benefit tax payers and Medicare beneficiaries by retaining a low cost high quality alternative for procedures that can be done safely in an ASC environment.

Thank you,

Julie K. Greene
Grand Valley Surgical Center
2680 Leonard St NE
Grand Rapids, MI 49525
616-493-2802

Submitter : Mrs. Julie Greene **Date:** 11/06/2006

Organization : Grand Valley Surgical Center, LLC.

Category : Ambulatory Surgical Center

Issue Areas/Comments

GENERAL

GENERAL

See Attachmcnt.

CMS-1506-P2-920-Attach-1.RTF

#920

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

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

Dear Administrator Norwalk:

I am the Executive Director of Grand Valley Surgical Center in Grand Rapids, Michigan. Grand Valley Surgical Center, LLC performs approximately 8,000 surgical procedures per year in a variety of surgical specialties. We have approximately 55% of our case in Orthopedics and Medicare represents 28% of our 2006 patient base to date. I have worked to learn all of the different aspects of the recently proposed Medicare ASC Payment System and ASC List Reform. While I applaud CMS's comprehensive review, I am disappointed with the outcome and feel many aspects of the proposal are inadequate.

In the United States, Ambulatory Surgery Centers are a clear high quality, low cost alternative to hospitals delivering the same types of care. Both hospitals and ASCs are important to their communities, with hospitals providing emergency care and specialized programs, in addition to routine care. Hospitals are able to provide a fair amount of charitable care as a result of their tax exempt status. ASCs also provide a fair amount of community benefit in the form of reduced or free service and the payment of taxes into a wide variety of Local, State, and Federal governments.

One of the most rewarding benefits of having an ASC in the community is that they can provide the community with a lower cost alternative for surgical care. The Medicare beneficiaries we serve benefit from our lower cost surgeries. And of course, because of the Medicare reimbursement being significantly below the hospital, the co-payment for the beneficiary is significantly below the hospital co-payment.

However, the Medicare system is eroding the ability to provide a lower cost alternative by severely disabling the ASC system. In the specialty of Orthopedics, many ASCs have stopped performing surgeries because even the direct costs are not being covered by the Medicare current reimbursement schedule. Fortunately, CMS has addressed part of the orthopedic problem in the 2008 shift of monies to Orthopedics. However, because of CMS' narrow viewpoint of interpretation of the budget neutrality provision enacted by Congress, there is a good chance the recent proposal will simply close many ASCs.

Although I believe all ASCs hold a great amount of pride in using their small size to create an efficiency sometimes not able to be matched by their competitors, there are still the market

factors that affect everyone's ability to do business. In the surgical care area, supplies and staffing are significant factors in being able to provide high quality care. In those areas our costs are rarely, if ever, below the hospital costs. While we can reduce costs in the overhead and administrative areas, the fact is that getting paid 62% of what the hospitals get paid is simply not enough to allow us to stay healthy, across all specialties and by taking this drastic measure, CMS is creating an anti-competitive environment, where hospitals are the winners and everyone else goes out of business or can not provide the same high quality care. Even at the 75% of HOPDs that are own industry supported, there were areas of concern. At 62% CMS will be severely negatively affecting the beneficiary's choices by reducing the number of surgeries available at ASCs and reducing the numbers of ASCs.

I want Medicare to pay ASCs less than Hospitals. However, 62% is too low and will have consequences that are counterproductive to CMS' ultimate goal of providing quality care accessibility at a reasonable cost to their beneficiaries. CMS needs to consider what the cost of the surgeries being done at ASCs now and in the future would cost if done strictly at hospitals before they narrowly interpret the balance budget provision to the point where the high quality, low cost provider goes out of business. Even in Orthopedics, there are still issues:

CPT	Current Rate	New rate (approx. based on 62% of HOPD)
20680	500.67	701
26536	703.88	1,555
29881	618	1005
25620	703.88	1357
23410	703.88	1560
23412	976.80	1560
23420	976.80	1560

These are all specific Medicare procedures done at our ASC where the old rate and the new rate do not meet our costs, although 29881 new rate comes close. 23410, 23412, 23420 represent shoulder cases that many ASCs have stopped doing because they are losing so much money. We are "holding out" in hopes that CMS will fairly reimburse these procedures in the future. In the meantime, we are definitely losing significant money on many CMS cases.

I also think ophthalmology is being severely hit and we will not be able to absorb the losses we will have in this area if the proposed rates go into effect.

In addition to my concern regarding the proposed rate of 62% is the rate at which the conversion factor increases in the future. While CMS ties the hospital reimbursement to the market basket rate, it is proposing to tie the ASC rate to CPI. I will reiterate a previous statement. In two significant areas, cost of supplies and cost of labor, ASCs and Hospitals have similar costs. And even then, one could site the fact that ASCs pay sales tax on all of their supplies and do not get the same GPO deals that hospitals may be able to access.

I find it unfortunate that hospitals who choose to have ASCs are receiving the much higher rate of reimbursement and no cost savings of the alternative environment are going to the beneficiaries.

ASC rates should go up at Market Basket in the future and be tied directly to the hospital rate increases. This is a simpler formula...

I would also like to comment on the proposed additions to the Medicare ASC list. I commend CMS for increasing the list. However, you have made the list so narrow that new technologies and surgeries have to be done in the hospital for a long time in order to get more than 20% of the patients into the outpatient arena before Medicare will consider paying for the procedure in the ASC arena. A good example is the Laparoscopic Cholecystectomy that has been done many times in our surgery center. It would still not be on the ASC list for Medicare beneficiaries. This is not a safe care issue. The 20% or less that had the surgery in an outpatient environment did not all die or have complications because they were outpatients and not inpatients. CMS appears to have taken an arbitrary number (20%) and made that the "magic number". How will that encourage technological advances that bring more patients safely to the lower cost outpatient environment? It will not.

Medicare needs to delete the 20% rule (procedure can not be done in an ASC if 80% or more of Medicare beneficiaries having the procedure were done as inpatients) that is proposed. It does not make sense from a safety point of view and does not promote or encourage advances in lower cost, high quality patient care.

I encourage CMS' desire for transparency and of cost and quality. However, as long as CMS creates more complexity than is needed in the payment system, it will be difficult to attain true transparency. Aligning the Hospital and ASC payment policies will benefit tax payers and Medicare beneficiaries by retaining a low cost high quality alternative for procedures that can be done safely in an ASC environment.

Thank you,

Julie K. Greene
Grand Valley Surgical Center
2680 Leonard St NE
Grand Rapids, MI 49525
616-493-2802

Submitter : **Dr. Douglas Litchfield** **Date: 11/06/2006**

Organization : **Dakota Eye Institute**

Category : **Ambulatory Surgical Center**

Issue Areas/Comments

CY 2008 ASC Impact

CY 2008 ASC Impact

Dear Congressman: The proposed payment rates for outpatient surgery centers is inadequate. The pay structure should be at least 75% of hospital rates. This will allow Medicare patients to continue to get access to these convenient facilities. Thankyou for your time. Sincerely, Douglas Litchfield M.D.

Submitter : **Dr. David Poer** **Date: 11/06/2006**

Organization : **Vitreo-Retinal Consultants**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1506-P2-922-Attach-1.DOC

#122

November 6, 2006

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

Dear Sir or Madam: **RE: ASC REIMBURSEMENT**

I understand that the comment period is nearly over regarding the lack of ASC reimbursement parity for physician-owned ASCs versus those owned by hospitals. There is no good reason that any ASC, hospital-owned, physician-owned, or otherwise, should not be reimbursed for the same procedure at the same rate and in the same manner. Hospital-owned ASCs often are paid a facility fee for the procedure but also are reimbursed for supplies used. This additional reimbursement is unavailable for physician-owned ASCs, which must compete with hospital-based ASCs, function, and try to profit with less reimbursement.

As participants and owners in a physician-based ASC, my partners and I are committed to maximizing the quality of care at a minimum cost to the patient. A level playing field for all ASCs would be greatly appreciated.

Sincerely,

DVP/jmh
Dictated but not proofread

David V. Poer, M.D.

Submitter : Dr. Jennifer Greger **Date:** 11/06/2006

Organization : Dr. Jennifer Greger

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

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

Submitter : Dr. **Date:** 11/06/2006

Organization : Dr.

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

See attached

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE AND MEDICAID SERIVICES
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Please direct your questions or comments to 1 800 743-3951.

Submitter :

Date: 11/06/2006

Organization :

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

See attached.

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CENTERS FOR MEDICARE AND MEDICAID SERIVICES
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Please direct your questions or comments to 1 800 743-3951.

Submitter : **Date: 11/06/2006**

Organization :

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

See attached

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

Submitter : Ms. Jane G **Date:** 11/06/2006

Organization : Great Plains Ambulatory Surgery Center

Category : Ambulatory Surgical Center

Issue Areas/Comments

ASC Payable Procedures

ASC Payable Procedures

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.