Submitter : **Mrs. Lisa Williams** **Date: 11/06/2006**

Organization : **Davita**

Category : **Nurse**

Issue Areas/Comments

ASC Payable Procedures

ASC Payable Procedures

November 6, 2006

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1506-P2
P.O. Box 8011
Baltimore, MD 21244-1850

Dear Sirs:

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

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

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

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

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

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

Thank you.
Sincerely,
{Lisa Williams,RN Davita Redford}

Submitter : Ms. ROSE PANTOJA **Date:** 11/06/2006

Organization : IDAHO 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

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A 62 % conversion factor is unacceptable and often does not cover the cost of the procedure potentially forcing facilities not to perform these procedures forcing the Medicare patient back into the more expensive hospital setting. 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 of a 73% conversion factor.

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

ASC Ratesetting

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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.

ASC Unlisted Procedures

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

ASC Updates

ASC Updates

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

Submitter : Ms. Carolyn Scanlan **Date:** 11/06/2006

Organization : HAP

Category : Health Care Professional or Association

Issue Areas/Comments

GENERAL

GENERAL

"See Attachment"

CMS-1506-P2-957-Attach-1.PDF

#957

HAP

THE HOSPITAL & HEALTHSYSTEM ASSOCIATION OF PENNSYLVANIA

November 6, 2006

Leslie V. Norwalk, Esquire
Acting Administrator
Centers for Medicare & Medicaid Services
Attention: CMS-1506-P
Room 445-G, Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Washington, DC 20201

RE: CMS-1506-P, Medicare: Hospital Outpatient Prospective Payment System and Calendar Year 2007 Payment Rates; Proposed Rule & Proposed Medicare Ambulatory Surgical Center Rule for Calendar Year 2008.

Dear Ms. Norwalk:

On behalf of our more than 225 member hospitals and health care systems, The Hospital & Healthsystem Association of Pennsylvania (HAP) welcomes this opportunity to comment on the proposed rule: **"Medicare: Hospital Outpatient Prospective Payment System and Calendar Year 2007 Payment Rates; Proposed Rule"** as published in the August 23, 2006, *Federal Register.*

The Centers for Medicare & Medicaid Services (CMS) has proposed significant changes to the Medicare outpatient prospective payment system and, while the proposed rule has many components, these comments specifically address concerns centered on **proposed changes to the Ambulatory Surgical Center (ASC) for Calendar Year (CY) 2008.**

HAP commends the Centers for Medicare & Medicaid Services for working toward the refinement of the outpatient prospective payment system to ensure equal opportunity for return across the areas of reimbursement, as well as to afford equal incentive to treat all types of patients and conditions.

HAP would like to share the following summary positions on potential revisions to the ASC payment system for CY 2008.

The expansion of ASCs comes under the CMS proposal to replace the current criteria used to determine which procedures may be safely performed in a freestanding ASC.

4750 Lindle Road
P.O. Box 8600
Harrisburg, PA 17105-8600
717.561.9200 Phone
717.561.5334 Fax
www.haponline.org

In 2008, under the CMS proposal, expansion of the list of allowable ASC procedures by including all surgical procedures except those that are determined to pose a significant safety risk or that generally require an overnight stay. In addition, the CMS proposal intends to replace the ASC payment system in CY 2008 with a methodology based on the Ambulatory Payment Classifications (APCs) used to group procedures under the Outpatient Prospective Payment System (OPPS). Distinct ASC rates would be established based on the lower costs incurred in the ASC setting. CMS estimates that the ASC rates would be 62 percent of the corresponding OPPS rates in CY 2008.

Changes under the proposed rule include:

- The list of surgeries payable in a freestanding ASC would expand by 763 procedures in 2008.
- The proposal would add 216 procedures that are performed in hospital outpatient departments but are not currently allowed in freestanding ASCs.
- It would add 547 procedures that are primarily performed in physician offices and are currently excluded from the ASC list.

Given the extensive nature of this change and the regulatory process surrounding it, **HAP does not believe there has been adequate review time for Pennsylvania hospitals, and we urge CMS to delay this expansion to allow the hospital community adequate time to assess the full clinical and financial implications, as well as the overall impact.** Analysis that has been done has shown that even the slightest of changes in the proposed method results in potentially large changes to a hospital outpatient payment.

Again, HAP appreciates the opportunity to submit these comments and recommendations. If you have any questions regarding our comments, please feel free to contact me or Michael Lane, HAP's director, health care finance and policy, at (717) 561-5317 or mlane@haponline.org.

Sincerely,

Carolyn F. Scanlan

CAROLYN F. SCANLAN
President and Chief Executive Officer

CFS/
Attachment

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

Organization : **Effingham Surgical Partners, LLC**

Category : **Ambulatory Surgical Center**

Issue Areas/Comments

CY 2008 ASC Impact

CY 2008 ASC Impact

Please consider the following points when deciding on the final rule for Ambulatory Surgery Centers payment methodology.

1. To assure Medicare beneficiaries access to ASCs, CMS should broadly interpret the budget neutrality provision enacted by Congress. 62% is not adequate.
2. ASC list reform is too limited. CMS should expand the list to include all procedures that can be performed in an HOPD.
3. ASCs should be updated based on the hospital market. This is a better way that reflects inflation in providing surgical services rather than the CPI.
4. The benefits to the taxpayer by aligning the payment systems for ASCs and HOPD will be maximized.

Thank you,
Brenda Lustig
Effingham Surgical Partners, LLC
dba Effingham Ambulatory Surgery Center

Submitter : **Mrs. Jade Lovgren** **Date: 11/06/2006**

Organization : **Nueterra Healthcare**

Category : **Other Health Care Provider**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1506-P2-959-Attach-1.DOC

#959

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

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

Dear Ms. Norwalk:

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

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

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

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

Alignment of ASC and HOPD Payment Policies

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

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

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

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

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

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

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

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

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

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

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

Ensuring Beneficiaries' Access to Services

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

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

Establishing Reasonable Reimbursement Rates

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

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

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

Submitter : **Mr. Jim Davidson** **Date: 11/06/2006**

Organization : **Nueterra Healthcare**

Category : **Other Health Care Provider**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1506-P2-960-Attach-1.DOC

CMS-1506-P2-960-Attach-2.DOC

#960

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

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

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

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

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

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

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

In conclusion, I am asking for a reconsideration of many of the elements of the proposed changes as outlined above. Truly aligning the ASC payment system with that of the HOPDs is the most logical, fair and best policy approach to benefit the Medicare program those served by the program. Should you have any questions regarding any of the issues in this letter, do not hesitate to contact me. My e-mail is jdavidson@nueterra.com. My phone number is (913) 387-0507. And my mailing address is 11221 Roe Avenue, Ste 320 Leawood, KS 66211.

Sincerely,

Jim Davidson

Submitter : **Miss. Amanda Tidmore** **Date: 11/06/2006**

Organization : **Saint Thomas Outpatient Neurosurgical Center**

Category : **Ambulatory Surgical Center**

Issue Areas/Comments

GENERAL

GENERAL

Our ASC specializes in Pain Management therapies. It will make a dramatic difference in our facility to know that the payment amount of an implantable medical device for an ASC will be 38% less than that of an outpatient hospital setting. The 'procedure' is still the same if it is done in an ASC or in an outpatient hospital setting. This reduction in payment may impact our ability to perform this type procedure for Medicare patients in our facility. Therefore, please consider that the payment rates should be the same in an ASC and an outpatient hospital setting based on clinical appropriateness not based on the facility it is performed in.

Thank you for your attention in this matter.

Amanda Tidmore

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

Organization :

Category : **Ambulatory Surgical Center**

Issue Areas/Comments

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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.

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Submitter : Mr. James Jackson **Date:** 11/06/2006

Organization : Mr. James Jackson

Category : Health Care Professional or Association

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

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A 62 % conversion factor is unacceptable and often does not cover the cost of the procedure potentially forcing facilities not to perform these procedures forcing the Medicare patient back into the more expensive hospital setting. 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 of a 73% conversion factor.

ASC Inflation

ASC Inflation

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

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.

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ASC Payable Procedures

ASC Payable Procedures

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

ASC Payment for Office-Based Procedures

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

ASC Updates

ASC Updates

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

ASC Wage Index

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Submitter : **Patrick O'Leary** **Date: 11/06/2006**

Organization : **Kirby Surgical Center**

Category : **Ambulatory Surgical Center**

Issue Areas/Comments

CY 2008 ASC Impact

CY 2008 ASC Impact

Medicare ASC Payment System and ASC List Reform

Submitter : Mrs. Wendy Tribbett **Date:** 11/06/2006

Organization : Unity Surgical Arts

Category : Ambulatory Surgical Center

Issue Areas/Comments

GENERAL

GENERAL

See attachment

CMS-1506-P2-965-Attach-1.DOC

#1165

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

Date: November 2, 2006

Dear Sir/Madam:

I would like to express my thoughts on the proposed rule that CMS has developed. These provisions mark the wholesale reform of the ASC payment system by eliminating the grouper payments and adopting the APC relative weights used in the hospital outpatient prospective payment system. The following are my concerns relating to this change:

1. I feel there has not been adequate time to study the methodology used to understand the possible impact of the proposed changes. This could have a negative effect on services since the proposed results in ASC payments equals only 62% of HOPD.
2. By setting rates this low, physicians would be forced to move cases to the hospital which would be more expensive to Medicare beneficiaries and the government.
3. ASC's should have the same annual updates as hospitals. ASC's should be entitled to the inflationary costs, such as nursing, medial devices, and other related healthcare costs in the same way as hospitals. Since we have not had an increase in payments since 2003 it is difficult to be competitive in the labor market.
4. We are a small business with less than 20 employees, because of this a move to a new system must be phased in over several years as changes in reimbursement for specific procedures and specialties may disproportionately impact our surgery center.
5. The use of specific criteria should be eliminated and use only safety and the lack of need for overnight stay as the criteria to determine what procedures are reimbursable in the ASC setting.
6. I suggest that CMS develop a reasonable process that evaluates criteria in determining the safety of performing surgical procedures in the ambulatory surgical center setting. Medical technology has made incredible advances over the past 30 years and will continue to improve. For this reason, utilizing the current criteria to determine what can or can not be done in the ASC does not offer patients a cost-effective choice to their healthcare.

I appreciate your time and thought in this sensitive area of reform. As we strive to keep health costs competitive and offer patients an excellent choice to their health care we need to offer a fair system.

Sincerely,

Wendy Tribbett
Executive Director

Submitter : **Ms. Marlis Raney** **Date: 11/06/2006**

Organization : **Ms. Marlis Raney**

Category : **Individual**

Issue Areas/Comments

CY 2008 ASC Impact

CY 2008 ASC Impact

11/6/06

http://www.cms.hhs.gov/erulemaking

RE: Comments on CMS -1506-P

Ladies and Gentlemen:

Thank you for the opportunity to comment on the Proposed Rule CMS-1506-P.

It is inaccurate to assume that ASC costs are less than that of hospital outpatient departments. In the case of implantable medical devices such as spinal cord stimulators and infusion pumps, the proposed methodology of payment omits the cost of the device, thus, resulting in payments to ASCs that do not cover the cost of the device. Device costs should be factored into the calculation.

As a result of the proposed methodology, procedures which include implantable medical devices will no longer be preformed in an ASC, and in my particular practice, that means the procedures will no longer be accessible to Medicare beneficiaries. It is simply an inefficient use of physician time to perform these procedures at a hospital.

Payment amounts for implantable medical devices should be equivalent in both the hospital and outpatient ASC settings as acquisition costs of the devices vary very little between these facility types.

Sincerely,

Marlis Raney
Office Manager

Submitter : **Mr. Sean Boyette** **Date: 11/06/2006**

Organization : **USPI Memorial Hermann Surgery Center Southwest**

Category : **Ambulatory Surgical Center**

Issue Areas/Comments

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

Organization :

Category : **Ambulatory Surgical Center**

Issue Areas/Comments

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

Organization : **Medical Group Management Association**

Category : **Health Care Professional or Association**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1506-P2-969-Attach-1.PDF

#967

MGMA

MGMA Center for Research
American College of Medical Practice Executives
Medical Group Management Association

November 6, 2008

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, S.W.
Washington, DC 20201

Re: 42 CFR Parts 410, 414, et al. Medicare: Hospital Outpatient Prospective Payment System and CY 2007 Payment Rates; Proposed Rule

Dear Ms. Norwalk:

The Medical Group Management Association (MGMA) appreciates the opportunity to comment on the Proposed Revised Ambulatory Surgical Center (ASC) Payment System for Implementation January 1, 2008 contained in Section XVIII of the above-referenced proposed rule.

MGMA is the nation's principal voice for medical group practice. MGMA's 20,000 members manage and lead more than 12,000 organizations in which more than 242,000 physicians practice. MGMA's membership reflects the full range of physician organizational structures and includes group practices that perform surgical procedures in free standing offices, those structured as part of hospital outpatient departments and those that own ASCs. Consequently, MGMA has consistently supported efforts by Congress and the Centers for Medicare & Medicaid Services (CMS) to seek greater equity in facility payment amounts across the various sites of service so that patient needs, rather than payment amounts, are the basis for determining the appropriate surgical setting. To that end, MGMA appreciates CMS' efforts to implement a new ASC payment system and offers the following critiques and recommendations related to this proposed rule.

HEADQUARTERS
104 Inverness Terrace East
Englewood, CO 80112-5306
phone: 303.799.1111
fax: 303.643.4439

GOVERNMENT AFFAIRS
1717 Pennsylvania Avenue
North West, Suite 600
Washington, DC 20006
phone: 202.293.3450
fax: 202.293.2787

www.mgma.com

ASC Payable Procedures

MGMA supports CMS' goal of expanding the number of procedures that may be reimbursed in an ASC setting. In previous comments to CMS, MGMA has urged CMS to adopt recommendations from the Medicare Payment Advisory Commission (MedPAC) to develop a list of excluded ASC services and allow ASCs to provide services not otherwise excluded by CMS. MGMA supports this change and commends CMS for recognizing that ever-changing technologies and capabilities increasingly expand the services that may be safely performed in an ASC. By focusing on appropriate exclusion of procedures from ASCs, physicians and patients will be able to choose the setting that best fits the circumstances of each unique case, based on patient needs and the

capacity of local health care facilities. MGMA disagrees, however, with CMS' decision to exclude procedures from payment of an ASC facility fee if the CY 2005 Part B Extract Summary System data indicates that the procedures were performed in a hospital inpatient setting 80 percent or more of the time. This proposal would exclude from an ASC setting procedures that are not listed on the Outpatient Prospective Payment System (OPPS) inpatient list and that are performed currently in an outpatient setting up to 20 percent of the time. The 80/20 threshold is an arbitrary distinction that does not adequately reflect procedures that may be performed safely in an ASC setting, particularly given the fact that Medicare does pay for such services performed in an outpatient setting. Furthermore, as technology advances, it will be safe to provide more and more surgical procedures in an outpatient setting. By linking allowable ASC procedures to 2005 data, CMS is building in a bias against certain procedures that may be more commonly performed in outpatient settings in future years. If CMS maintains this restriction, MGMA asks that CMS continue to review current data on hospital inpatient procedures.

ASC Payment for Office-Based Procedures

CMS has proposed to limit payment for procedures that are performed in physician offices more than 50 percent of the time. Payment for such services would be limited to the lesser of the ASC rate or the Medicare Physician Fee Schedule (PFS) amount. This policy suggests that the PFS payment amount for a particular procedure is an appropriate amount of reimbursement for a given procedure. MGMA data indicates that reimbursement under the PFS amount falls far short of physicians' actual costs. MGMA has collected data on physician practices for over 50 years, and the data has continually shown that Medicare reimbursement for physician procedures does not cover the costs of performing those procedures in an office setting. The PFS currently reimburses physicians at less than they were reimbursed in 2001. As long as the PFS relies on the sustainable growth rate, which is tied to performance of the nation's economy instead of the actual costs of providing care, payment for services under the PFS will continue to fall far short of the actual costs of performing the services. This shortfall in payment is devastating in the physician office setting. Applying the same payment amount to an ASC, where costs can often exceed those in an office setting, would be economically infeasible.

As a result of this payment shortfall, services that CMS has determined are "office-based" services may not be performed in an ASC setting. In situations where a physician determines that a patient's specific needs require a higher level of care than can be provided in an office setting for a procedure that CMS has determined is "office-based," the shortfall in the payment amount means that the only viable option may be to receive care in a hospital. This option increases costs to both the patient and the Medicare program and deprives the patient of access to care in a more convenient and less expensive setting.

ASC Wage Index

MGMA objects to CMS' proposal to apply the Inpatient Prospective Payment System (IPPS) pre-reclassification wage index values to adjust the national ASC payment rates for geographic wage differences. As CMS admits in its proposed rule, CMS is relying on data that is 12 years old to determine the appropriate labor adjustment factor. 71 Fed. Reg. 49,506, 49,655 (Aug. 23, 2006). MGMA data show that for 2005, ASCs spent 26.55 percent of medical revenue on support staff. Given the significance of labor expenditures in ASCs, CMS must collect new data on the costs of delivering services in the ASC setting. In addition, CMS has not yet published regulations to explain how this proposal will be implemented.

ASC Inflation

MGMA is also concerned about the proposal to use the Consumer Price Index for All Urban Consumers (CPI-U) to calculate annual updates to the ASC conversion factor for inflation. The CPI-U measures the cost of consumer goods and does not specifically measure the cost of items used in the medical profession. MGMA has conducted extensive surveys of ASC costs. MGMA-collected data indicate that the cost of operating an ASC rose by an average 13.4 percent between 2003 and 2005. During that same period, the CPI-U fell 36 percent short of meeting these increased costs. If Medicare reimbursement rates continue to fall far short of the increased cost of delivering quality services to Medicare patients, providers will face difficult decisions as they evaluate the economic practicability of caring for Medicare beneficiaries. The economic viability of practices is further undermined by the widespread use of the Medicare reimbursement rate as a benchmark for private insurance reimbursement rates for ASCs.

The OPPS rates are measured against a market basket of items that hospitals use in practice. When the price of those items increases, the payment rate increases. The CPI-U is not tied to the highly inflationary nature of operating a health care facility. MGMA strongly urges CMS to base the annual updates of the ambulatory payment classification conversion factor to the market basket method used for hospitals or to develop another method that would more closely approximate the rising cost of operating an ASC.

ASC Phase In

CMS has proposed to phase in the new ASC payment system over two years. This two-year phase in does not give ASCs enough time to adjust to the revised payment rates. A four-year phase in would allow a more gradual and less disruptive transition to the new system. MGMA strongly urges CMS to extend the phase in to a four-year transition period.

ASC Conversion Factor

MGMA supports CMS' decision to link the payment rate for ASCs to the payment rate for hospital outpatient departments. In developing the ASC formula, CMS reduces the ASC conversion factor to 62 percent of the OPPS conversion factor for 2008. MGMA disagrees with CMS' use of this 62 percent budget neutrality adjustment to calculate the ASC conversion factor. This calculation is based on unfounded assumptions made by CMS and does not reflect the actual cost of providing services to Medicare beneficiaries in an ASC. CMS is not bound by Congress to adopt the 62 percent adjustment.

CMS' proposal to further scale back ASC payments for years after 2008 goes beyond Congress' requirement for budget neutrality in the new ASC system. CMS' interpretation that Congress intended ASCs to receive less money each year than they did the year before is absurd. It is a market assumption that services cost more money each year due to changes in overhead costs. Health care is even more inflationary in nature due to rapid changes in technology and increasing costs of clinical support staff. MGMA urges CMS to reconsider this interpretation of the budget neutrality provision.

The combination of a substantially lower ASC conversion factor relative to that for HOPDs, and the prospect of less than adequate inflation updates in the years ahead, could well undermine the goal of achieving a more level playing field across the various sites in which procedures may be performed. If CMS proceeds with these aspects of the proposed rule, it will need to adjust the

system in future years to narrow the disparity. Otherwise, payment considerations will inevitably trump clinical judgment and patient convenience.

MGMA appreciates the opportunity to comment on these important maters. If you should have any questions or would like to discuss these matters further, please feel free to contact Amy Nordeng at MGMA at 202.293.3450.

Sincerely,

William F. Jessee, MD, FACMPE
President and Chief Executive Officer

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

Organization : NovaMed, Inc.

Category : Ambulatory Surgical Center

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1506-P2-970-Attach-1.DOC

#910

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

Dear. Ms. Norwalk,

I am writing regarding the proposed changes to the ASC Payment system. I'm a Regional Vice President for NovaMed, Inc, and as such work with six surgery centers located throughout the Midwest (Nebraska, Kansas, Missouri and Western Illinois). At these centers we perform a wide variety of surgical procedures, including ophthalmology, urology, orthopedics, podiatry, pain management, ENT and plastics. Each one of these centers was originally started by forward-thinking, patient-focused, conscientious surgeons dedicated to providing the best in patient care. They were risk-takers who intuitively knew that there was a better, safer and more efficient surgical environment. And each one of these centers qualitative and quantitative outcomes bear this out.

Significantly fewer complications and infections occur at these centers and others like them, than at hospital-based surgery centers. Due to the above, and personal, compassionate care, patient satisfaction at these centers is very high as well. Not only do these centers deliver the best in patient care, they do so while saving Medicare, private insurance, and the patients billions of dollars per year.

The current proposed changes to the ASC payment system threatens the above "win, win, win" for patients, surgeons and third-party payers.

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

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

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

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

Alignment of ASC and HOPD Payment Policies

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

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

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

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

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

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

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

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

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

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

Ensuring Beneficiaries' Access to Services

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

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

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

Establishing Reasonable Reimbursement Rates

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

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

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

- 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.

Ambulatory surgical centers have made a dramatic difference in healthcare over the past 20+ years, by delivering outstanding patient care while saving patients, government and private insurers billions of dollars. Please make the appropriate changes to the proposal to ensure that this will not only continue, but that additional procedures can be performed as well.

Please feel free to contact me if you have any questions or comments at 913-491-3040.

Sincerely,

John P. Blanck,
Regional Vice President
NovaMed, Inc.
Suite 200
5520 College Blvd
Overland Park, KS 66211

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

Organization : Rush University Medical Center

Category : Ambulatory Surgical Center

Issue Areas/Comments

GENERAL

GENERAL

See attachment

CMS-1506-P2-971-Attach-1.DOC

#971

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Karen S. Sable, MD
Claire S. Smith, MD
Daniel H. Winship, MD
Lijuan Zhang, PhD

Section of Hepatology
Stanley Martin Cohen, MD
Director

Tanya Gilbert
Fellowship Coordinator

November 1, 2006

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

Dear Dr. McClellan:
I am an academic practicing gastroenterologist 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,

Submitter : **Mrs. Frances Blocker** **Date: 11/06/2006**

Organization : **Augusta Urology Surgicenter, LLC**

Category : **Health Care Industry**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1506-P2-972-Attach-1.DOC

#972

Augusta Urology Surgicenter, L.L.C.

James J. Carswell, III, M.D.
Mark L. Cain, M.D.
Charles H. Coleman, Jr., M.D.
Richard B. Sasnett, Jr., M.D.
Henry N. Goodwin, Jr., M.D.
Michael F. Green, M.D.
J. Douglas Quarles, Jr., M.D.

November 1, 2006

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

Re: Ambulatory Surgicenter Reimbursement

Dear Administrator Norwalk:

I currently work for a single specialty urology surgery center that is owned by seven-physicians in Augusta, Georgia. We obtained a letter of non-reviewability (LNR) from Georgia's Department of Community Health in 1998 to open our center. We serve patients covered by private health insurance as well as an ever-growing Medicare/Medicaid and indigent population in the physician offices as well as our surgery center. I am writing because there is current legislation pending that will drastically reduce Medicare ASC payments and I oppose this proposition

Augusta Urology Surgicenter is a high quality, cost effective alternative to the surrounding hospitals. We play an important role in holding down the costs of medical care in the Augusta area. Therefore, I was disturbed to learn that Congress is considering proposals to cut our Medicare payments. Urology is expected to be the third hardest hit specialty in reductions to ASC Medicare payments. Mostly, this is due to the large reduction in the payment of the second most frequently performed Medicare ASC urologic procedure, prostate biopsy (CPT 55700). Payments for this procedure are expected to be reduced by 39% in 2007 and even further in 2008.

I understand elected officials want to limit our facility fees to that of the hospital's outpatient department rate (HOPD). On paper a few of the ASC rates appear to be higher than the hospital rate, but this is very misleading. Our facility fee has to cover all the costs of our surgery, including radiology services. The hospital gets to bill separately for each of these as well as many services. They also get to pass through the costs of supplies and new technology, but we cannot. By any standard, the hospital always gets paid much more for the same procedure in the same outpatient setting.

University Professional Center III
811 13th Street, Suite 17
Augusta, GA 30901
Phone: (706) 724-4111 Fax: (706) 823-0533

As the actual impact of these reductions will vary among the different specialties, ultimately the financial viability of these enterprises will be negatively impacted. Instead of accomplishing the goal of more competition within the healthcare arena this will result in still fewer choices for Medicare recipients. This reimbursement philosophy greatly discourages the efficiency and excellence exhibited by a majority of surgery centers and does nothing to realistically reduce costs.

The proposal to reimburse surgery centers somewhere between 60-65% of hospital outpatient department rates is simply not adequate. Surgery centers must pay competitive wages to nurses and other staff the same as hospitals. The increase in the cost for liability insurance coupled with the difficulty of obtaining coverage in some states has had a huge financial impact on surgery centers just as hospitals have experienced. Rent, taxes and operating supplies probably consume more of most surgery centers budgets than those of hospitals. Most surgery centers have 20-25 employees and are small businesses. They don't have the political clout and resources of large hospital organizations. If this were not so, this entire discussion and proposal would never had occurred.

Aligning the payment systems for ASCs with those of the hospital outpatient departments will improve the transparency of cost. In addition, improving the quality of the data generated by ASCs and hospital outpatient departments could only be a positive 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.

In closing, we also believe the ASC list reform proposed by CMS is simply too limited. CMS should expand the list of procedures to mirror that of the HOPDs. ASCs are state licensed and Medicare approved facilities. Additionally, a substantial number of ASCs are accredited by AAAHC and other respected accrediting bodies just as hospital outpatient departments. To allow HOPDs to perform any outpatient procedure but then restrict many of the same procedures from being performed in an ASC frankly makes no sense. The same physicians performing these procedures in the hospital outpatient suites are also owners and practitioners in ASCs. There is no deterioration in their surgical skills between facilities. CMS should exclude only those procedures that are on the inpatient list.

Since ASCs must compete for labor, pay substantial sums for liability insurance and taxes, maintain all of the regulations mandated by CMS in addition to providing a safe, efficient and highly professional environment for Medicare patients, it is only equitable that CMS consider ASCs as equal partners in the medical services delivery system and not substandard enterprises.

Respectfully,

Frances L. Blocker

Frances L. Blocker
Business Manager

Submitter : **Mr. Jonathan West** **Date: 11/06/2006**

Organization : **Beach SurgiCenter for Eyes**

Category : **Other Health Care Professional**

Issue Areas/Comments

GENERAL

GENERAL

November 6, 2006

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

To Whom It May Concern:

My name is Jonathan West and I am the administrator for Beach SurgiCenter for Eyes in Virginia Beach, Virginia. We are a one room single specialty Ophthalmic ambulatory surgery center with four surgeons operating in our facility. We perform primarily eataract procedures do approximately 600-700 cases per year. We also perform some limited glaucoma and oculoplastics procedures. Our patient volume is 70% Medieare as the cataract procedure tends to follow a particular demographic due to the nature of this condition.

The CMS proposed reform list of ASC procedures is still too restrictive and does not allow for ambulatory surgery centers to provide care for patients demanding a higher level of care via specialized nurses and technicians and more advanced technology. An ASC should receive reimbursement for the same procedures as those performed in an Hospital Outpatient Department Rate (HOPD) setting as there is no difference in either facility providing the care. ASCs do a better job at containing costs while providing a higher level of care. There are a number of supporting cases documenting this statement.

The proposed ASC Payment of 62% of the HOPD rate is not sufficient to support the operations of an ASC. The recommended 75% figure has been proposed by the ASC industry as a reasonable compromise. It is interesting how an ASC is able to contain costs but is penalized via the proposal of 62% for its efforts. The ASC industry is already willing to take a reduction of 25% to be able to cover costs and provide a reasonable return on investment. CMS should consider changing this proposal to 75% from the 62% proposal as anything less than 75% would impact the quality of service that ASCs have worked hard to create. It is important that when the percentage is adopted that it is adopted equally across all ASC services.

In conclusion, I think a program of annual updates should be in effect commencing in 2010 where the ASCs and HOPDs should follow the same method of increases since both provide the same services and incur the same costs in delivering care. Thank you for your consideration on these items and I look forward to a favorable conclusion.

Sincerely,

Jonathan West

Submitter : Mrs. Larissa Ottinger **Date:** 11/06/2006

Organization : USPI

Category : Individual

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

A 62 % conversion factor is unacceptable and often does not cover the cost of the procedure potentially forcing facilities not to perform these procedures forcing the Medicare patient back into the more expensive hospital setting. 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 of a 73% conversion factor.

ASC Inflation

ASC Inflation

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

ASC Office-Based Procedures

ASC Office-Based Procedures

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

ASC Packaging

ASC Packaging

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

ASC Payable Procedures

ASC Payable Procedures

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

ASC Payment for Office-Based Procedures

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ASC Phase In

ASC Phase In

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

ASC Ratesetting

ASC Ratesetting

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

ASC Unlisted Procedures

ASC Unlisted Procedures

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

ASC Updates

ASC Updates

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

ASC Wage Index

ASC Wage Index

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

Organization : Rush University Medical Center

Category : Ambulatory Surgical Center

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1506-P2-975-Attach-1.DOC

#975

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November 1, 2006

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

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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,