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

Organization : Garland Surgery Center LP

Category : Health Care Professional or Association

Issue Areas/Comments

ASC Coinsurance

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Submitter : **Ms. Michele Page** **Date: 11/06/2006**

Organization : **DaVita East Wichita Dialysis**

Category : **Nurse**

Issue Areas/Comments

ASC Payable Procedures

ASC Payable Procedures

Vascular access is one of the greatest sources of complications and cost for dialysis patients. America uses more surgical grafts and catheters for vascular access than the rest of the developed world, even though there is evidence showing that the higher initial costs lead to greater clinical complications and result in higher mortality than AV fistulae. The inclusion of CPT codes 35475, 35476, 36205 and 37206 to the list of Medicare approved ambulatory surgical center procedures would provide Medicare the opportunity to reduce the cost of and promote quality outcomes for ESRD patients through more thoughtful reimbursement and regulation of vascular access procedures.

Please support patient choice! There is clear scientific evidence that vascular access procedures are safe and can be performed in Ambulatory Surgical Center setting, more importantly, patients are extremely satisfied with having the option to secure vascular access repair and maintenance care in an outpatient setting. 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.

Thank you.

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

Organization : **Regional Eye associates**

Category : **Physician**

Issue Areas/Comments

ASC Conversion Factor

ASC Conversion Factor

The proposal to pay hospitals more money to do the same job and obtain less favorable outcomes, as has been clearly shown in the case of cataract surgery, is a step BACKWARD for your parents and mine. The goal should be to get the best outcomes possible, in the most efficient way. If, as is the case, ASC's benefit from increased efficiency should they be penalized. Equal pay for equal work has been well-documented in our heritage.

ASC Payable Procedures

ASC Payable Procedures

We are a large practice with affiliations with community hospitals in many of our locations and our own surgery center at our central location. We support our hospitals at every juncture, and try to help them become more efficient. Paying a hospital more, to do the same thing less effeciently may outwardly appear to provide cost savings, but does not make any sense, financially or otherwise. Limiting the procedures which can safely be done in an ASC setting exacerbates the first poor decision, to pay less money for the same job done. Does it not make more sense to provide the service at the most efficient mechanism available? Handcuffing ASC's opens the door for INCREASED inefficiency, and will limit access, making excellent services less availble to the patients, through decreased efficiency. How could we NOT want to provide the best care, with increased effeciency, cleary documented BETER OUTCOMES, and better patient access and ease? Please do not do this to my parents and your parents.

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

Organization : Garland Surgicare Partners LP

Category : Ambulatory Surgical Center

Issue Areas/Comments

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

Organization : Consultants in Pain Medicine

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1506-P2-994-Attach-1.TXT

#994

November 6, 2006

Leslie V. Norwalk, Acting Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
ATTN: CMS-1506-P, Rm 445-G
Hubert H. Humphry Bldg
200 Independence Ave, SW
Washington, DC 20201

RE: CMS-1506-P Medicare Program, Ambulatory Surgery Center Payment System and CY 2008 Payment Rules

Dear Ms. Norwalk:

I am writing as a practicing interventional pain physician regarding CMS proposed rule for ACS payments. I hope that this letter will assist you and your department in making appropriate conclusions and decisions that will help my elderly patients who suffer with pain in our country. The proposed rule will create significant inequities between hospitals, ASCs, and beneficiaries' access to interventional pain care will be harmed. The various solutions that are proposed in this rule change with regards to mixing and improving the case mix, etc., are not feasible for single specialty centers or for ASCs. While this change might be good for some specialties, interventional pain management will suffer substantially and ultimately costs will increase as patient load is shifted to hospital outpatient settings.

It is inadequate to assume that ASC costs are on average 38% less than that of hospital outpatient departments, especially with my patients who have implantable devices for control of their pain. One of the most important shortcomings in hospital outpatient patient methodology, as you know, is the phenomenon of charge compression. It underestimates the cost of more expensive items, such as medical devices, resulting in payment rates that do not reflect the true cost. CMS should and could remedy this issue by applying a decompression factor rather than allowing inaccurate rates to be carried over to the revised ASC payment system. The proposed payment methodology will inappropriately impact site of service decisions. These decisions should be based on clinical considerations and not on inaccurate payment methodology as proposed. Accuracy should be included as a goal of any new payment system to avoid site of service decisions which are based on financial factors rather than clinical appropriateness.

Based on this rational, I would suggest that your current proposal be reversed and further study be imposed to establish where surgery centers are reimbursed at least at the present rate and at least assure that they will not go below that rate. I understand that there are multiple proposals to achieve this. My contention is that the current proposal will change access for my patients and ultimately will increase cost to the system. If I can be of further help in this matter, please feel free to write or call me.

Sincerely,

C. William Murphy, M.D.

CWM/mp
dd: 11/06/06
dt: 11/06/06

Submitter : Mrs. IRIS BROWN **Date:** 11/06/2006

Organization : GARLAND SURGERY CENTER LP

Category : Ambulatory Surgical Center

Issue Areas/Comments

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Submitter : Mr. Richard Spires **Date:** 11/06/2006

Organization : Augusta Urology Surgicenter, LLC

Category : Health Care Industry

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1506-P2-996-Attach-1.DOC

#996

November 01, 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

Dear Administrator Norwalk:

I am currently the administrator of a seven-physician urology practice in Augusta, Georgia. We have a freestanding ambulatory surgery center as well as three clinic offices in the surrounding area. We serve patients covered by private health insurance as well as an ever-growing Medicare/Medicaid and indigent population in our clinics as well as our surgery center. I am writing because there is current legislation pending that will drastically reduce Medicare ASC payments.

Augusta Urology Surgicenter is a high quality, cost effective alternative to the hospital. 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 will be reduced by 39% in 2007 and even further in 2008.

I understand elected officials want to limit our facility fees to the hospital outpatient department rate (HOPD). While on paper a few of our rates appear to be higher than the hospital rate, 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 other services. They also get to pass through the costs of new technology, but we cannot. By any standard, the hospital almost always gets paid much more for this and other procedures performed in this setting (outpatient).

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 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 that we are aware. 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,

Richard O. Spires, Jr.
Augusta Urology Associates Surgicenter, LLC

Submitter : Ms. Anne Glaser **Date:** 11/06/2006

Organization : Ms. Anne Glaser

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

see attached letter

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

Please note: We did not receive the attachment that was cited in this comment. We are not able to receive attachments that have been prepared in excel or zip files. Also, the commenter must click the yellow "Attach File" button to forward the attachment.

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

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

Organization : **Baylor Surgicare at Heath**

Category : **Ambulatory Surgical Center**

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

Organization : Naples Day Surgery

Category : Ambulatory Surgical Center

Issue Areas/Comments

ASC Payable Procedures

ASC Payable Procedures

Please consider ASC reimbursement for the Interstim procedure, a sacral nerve root stimulator by Medtronic. This simple, effective treatment for overactive bladder, urgency/frequency symptoms, and non-obstructive urinary retention has become the most promising procedure to date for the treatment of the above symptoms. This procedure is fast, effective, and associated with little side effects. The dissection and placement of the implant causes minimal pain, is performed under flouroscopy (which is readily available in ASC settings), and is always performed under same-day surgery guidelines at the hospital. It would be logical to offer this procedure at ASCs around the country:
1) costs at ASC's are significantly less than that of a hospital-based procedure, leading to major savings to CMS and to the patient
2) the procedure can be performed in facilities specifically designed to handle outpatient procedures, with greater patient satisfaction and known and accepted protocols for patient follow-up
3) most of these procedures are reimbursed at ASCs by the private insurers anyway with excellent results. These same excellent results can be offered to the patients if they had a choice of facilities.
Thank you for your consideration, Joseph Gauta, MD

Submitter : Mrs. Deborah Mack **Date:** 11/06/2006

Organization : National Surgical Hospital, Inc

Category : Ambulatory Surgical Center

Issue Areas/Comments

CY 2008 ASC Impact

CY 2008 ASC Impact

see attached letter

CMS-1506-P2-1000-Attach-1.DOC

1000

National
Surgical Hospitals

Date: November 1, 2006

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

Dear Ms. Norwalk:

This letter serves as my comments on the Proposed Rule for Ambulatory Surgery Centers, which will be effective in 2008. I oversee the management of five surgery centers in the East Bay area of California. We provide quality outpatient service to over 17,000 patients annually and approximately 26% of those patients are Medicare beneficiaries.

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.

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

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

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

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

Alignment of ASC and HOPD Payment Policies

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

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

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

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

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

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

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

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

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

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

Ensuring Beneficiaries' Access to Services

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

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

Establishing Reasonable Reimbursement Rates

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

the payment freeze is a strong testament to their ability to improve their efficiency and the preference of physicians and beneficiaries for an alternative to the hospital outpatient surgical environment.

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

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

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

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

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

Thank you for your consideration of my comments. I look forward to continuing to provide high quality outpatient services to the Medicare beneficiaries.

Sincerely,

Deborah L. Mack, MSN, CASC
Area VP of Operations, NSH

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

Organization : Elmwood Park Same Day Surgery

Category : Ambulatory Surgical Center

Issue Areas/Comments

ASC Coinsurance

ASC Coinsurance

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

ASC Conversion Factor

ASC Conversion Factor

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 Payable Procedures

ASC Payable Procedures

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

ASC Phase In

ASC Phase In

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

ASC Unlisted Procedures

ASC Unlisted Procedures

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

ASC Updates

ASC Updates

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

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

Organization : New England Anesthesiologists

Category : Physician

Issue Areas/Comments

ASC Payment for Office-Based Procedures

ASC Payment for Office-Based Procedures

November 6, 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, 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. 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. Especially in Rhode Island, I am concerned that access to pain physicians will suffer.

Sincerely,

Timothy G. Connelly, D.O.

Submitter : **Ms. Kelly Guest** **Date: 11/06/2006**

Organization : **Ms. Kelly Guest**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

ESRD Patients' Access to Quality Care should be a priority. There is clear scientific evidence that vascular access procedures are safe and can be performed in Ambulatory Surgical Center (ASC) settings. As a dialysis patient of 7 years I feel that it is upto Medicare to see to it this is taken care of in a proper manner..

Submitter : Ms. Carol Hinrichs **Date:** 11/06/2006

Organization : The Outpatient Surgery Center

Category : Ambulatory Surgical Center

Issue Areas/Comments

CY 2008 ASC Impact

CY 2008 ASC Impact

Please see attached

CMS-1506-P2-1004-Attach-1.DOC

CMS-1506-P2-1004-Attach-2.DOC

#1004

The Outpatient Surgery Center
101 Academy Ave.
Greenwood, SC 29646

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

Dear Ms Norwalk:

I am concerned about the Notice of Proposed Rulemaking published on June 12, 2006, regarding updates to rate-setting methodology, payment rates, payment policies, and the list of covered surgical procedures for ambulatory surgical centers. I am the administrator at *The Outpatient Surgery Center*, a multi-specialty facility located in Greenwood, SC.

The ASC community is and has been focused on providing excellent clinical outcomes in a cost efficient environment.

Antiquated cost data and payment can now be better aligned to provide payment to ASCs. HOPD payment systems, although not perfect, represent the best model for relative costs for procedures done in ASCs. To follow are three principles that need to be focused upon:

- Maximizing **alignment of the ASC and HOPD payment** systems to prevent the introduction of new disparities between the payment systems that could drive site of service selection,

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

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

I. Alignment of ASC and HOPD Payment Policies

Aligning the payment systems for ASCs and hospital outpatient departments will improve the transparency of cost and quality data used to evaluate outpatient surgical services for Medicare beneficiaries. We believe that the benefits to the taxpayer and the Medicare consumer will be maximized by aligning the payment policies to the greatest extent permitted under the law.

While we appreciate the many ways in which the agency proposes to align the payment system, we are concerned that the linkage is incomplete and may lead to further distortions between the payment systems. Many policies applied to payments for hospital outpatient services were not extended to the ASC setting, and these inconsistencies undermine the appropriateness of the APC relative weights, create volatility in the relationship between the ASC and HOPD payment rates, and embed in the new payment system site of service incentives that will cost the taxpayer and the beneficiary more than necessary.

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

A. **Procedure list:** HOPDs are eligible for payment for any service not included on the so-called inpatient only list. The CMS proposal to limit physician's ability to determine appropriate site of service for a procedure excludes many surgical procedures appropriate for the ASC setting. Examples of this include but are not limited to: CPT Code 66761 Laser Iridotomy, CPT Code 11603 Excision of Malignant skin lesion; excised diameter 2.1 to 3.0 cm.

B. **Treatment of unlisted codes:** When HOPDs perform services or procedures for which the CPT book does not provide specific codes, they use an unlisted procedure code, identify the service and receive payment for which we believe ASCs should also be eligible. Examples of this include but are not limited to: CPT Code 47562, 47563, 47564 Laparoscopic Cholecystectomy, CPT Code 19361 Latissimus Flap Reconstruction of Breast W/ or WO Implant, CPT Code 61795 Stereotactic computer assisted volumetric (navigational) procedure .

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

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

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

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

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

Examples of procedures that we perform in our ASC that will have more than a 15% decline in reimbursement under the proposed regulations are:

21310 Treatment clsd/opn nasal fracture w/o manipulation 66% decrease in rate
21315 Manipulation treatment nasal bone fracture 66% decrease in rate
25565 Treatment closed radial/ulnar shaft fx.+ manipulation 76% decrease in rate
28193 Excision Foreign Body foot complicated 33 % decrease in rate
30903 Control nasal hemorrhage ant, complex 78% decrease in rate
31233 nasal.sinus endo, Dx with sinuscopy 80% decrease in rate
31511 laryngoscopy with removal foreign body 80 % decrease in rate
55700 Prostate biopsy any approach 22% decrease in rate

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

In addition, CMS should expand the list of approved procedures to include any and all procedures that can be performed in an HOPD. CMS failed to include on the procedure list many higher complexity services that have for years been safely and effectively performed in ASCs throughout the country. CMS is losing an opportunity to increase patient choice and rely on the clinical judgment of the surgeon.

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

Carol Hinrichs, Administrator
The Outpatient Surgery Center
101 Academy Ave.
Greenwood, SC 29646
(864)725-7520
carolhinrichs@earthlink.net

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

Sincerely,

Carol Hinrichs, RN, Administrator
The Outpatient Surgery Center

Submitter : Mr. Abraham Lindman **Date:** 11/06/2006

Organization : Surgery Center of Scottsdale

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.

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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.

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Submitter : **Mrs. Suzanne Broome** **Date: 11/06/2006**

Organization : **Blue Ridge Surgery Center**

Category : **Ambulatory Surgical Center**

Issue Areas/Comments

ASC Ratesetting

ASC Ratesetting

see attachcd

CMS-1506-P2-1006-Attach-1.DOC

#1006

BLUE RIDGE SURGERY CENTER

"We'll get you back in the game, quickly and safely."

October 30, 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:

On behalf of Blue Ridge Surgery Center, we appreciate the opportunity to submit comments to the Centers for Medicare and Medicaid Services ("CMS") proposed refinements to the ambulatory surgical center ("ASC") payment system for calendar year 2008. At our Center approximately 36% of our patients or 1,200 patients, are Medicare beneficiaries. Our facility performs a full range of orthopaedic, musculoskeletal surgeries, as well as cataract extractions performed by our ophthalmologist. Our facility is obviously greatly dependent on the Medicare program.

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. Two physicians who saw an opportunity to establish a high-quality, cost-effective alternative to inpatient hospital care for surgical services opened the first facility in 1970. 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

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PHONE (864) 482-5100 FAX (864) 482-9100
E-MAIL sbroome@broa.com

and highly skilled staff, are able to ensure the equipment and supplies being used are best suited to their technique, and are able to design facilities tailored to their specialty. Simply stated, physicians are striving for, and have found in ASCs, the professional autonomy over their work environment and over the quality of care that has not been available to them in hospitals. These benefits explain why physicians who do not have ownership interest in ASCs (and therefore do not benefit financially from performing procedures in an ASC) choose to work in ASCs in such high numbers.

Overview

The broad statutory authority granted to the Secretary to design a new ASC payment system in the Medicare Modernization Act of 2003 presents the Medicare program with a unique opportunity to better align payments to providers of outpatient surgical services. Given the outdated cost data and crude payment categories underlying the current ASC system, we welcome the opportunity to link the ASC and hospital outpatient department (HOPD) payment systems. Although the HOPD payment system is imperfect, it represents the best proxy for the relative cost of procedures performed in the ASC.

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

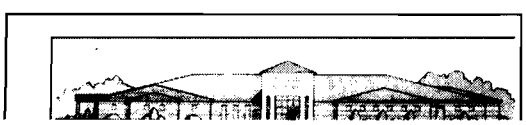
- Maximizing the alignment of the ASC and HOPD payment systems eliminate distortions between the payment systems that could inappropriately influence site of service selection,

- 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.



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BLUE RIDGE SURGERY CENTER

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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.

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- **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.

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- **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

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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 achieving budget neutrality under the agency's proposed rule. These, 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 the proposed rates at 62% of HOPD, 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.

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If you have comments or questions regarding this correspondence, please feel free to contact me.

Sincerely,

Suzanne Broome, RN

Suzanne Broome, RN
Center Director
Blue Ridge Surgery Center
Seneca, South Carolina
864-482-5100

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Submitter : Ms. Rory Qualls **Date:** 11/06/2006

Organization : Baylor Surgicare at Garland

Category : Ambulatory Surgical Center

Issue Areas/Comments

ASC Coinsurance

ASC Coinsurance

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

ASC Conversion Factor

ASC Conversion Factor

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 Office-Based Procedures

ASC Office-Based Procedures

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

ASC Payable Procedures

ASC Payable Procedures

We support CMS s decision to adopt MedPAC s recommendation from 2004 to replace the current inclusive list of ASC-covered procedures with an exclusionary list of procedures that would not be covered in ASCs based on two clinical criteria: (i) beneficiary safety; and (ii) the need for an overnight stay.

ASC Payable Procedures

ASC Payable Procedures

However, the ASC list reform proposed by CMS is too limited. CMS should expand the ASC list of procedures to include any and all procedures that can be performed in an HOPD. CMS should exclude only those procedures that are on the inpatient only list and follow the state regulations for overnight stays.

ASC 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.

Submitter : Mrs. Barbara Watson **Date:** 11/06/2006

Organization : Urology Surgery Center

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1506-P2-1008-Attach-1.RTF

#1008

October 30, 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:

I am writing this letter on behalf of the Urology Surgery Center. We are a single specialty ASC with two operating rooms and 2 procedure rooms. Our facility has been in existence since 1999. We are accredited by Medicare and by AAAHC. The facility is owned by Dr. Bruce H. Truesdale and Dr. David H. Lamb. We perform on average more than 200 cases/ surgeries and /or procedures per month. We have maintained a 98% patient satisfaction rate for the last four years.

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

Physicians continue to provide the impetus for the development of new ASCs. By operating in ASCs instead of hospitals, physicians gain the opportunity to have more direct control over their surgical practices. In the ASC setting, physicians are able to schedule procedures more conveniently, are able to assemble teams of specially-trained and highly

skilled staff, are able to ensure the equipment and supplies being used are best suited to their technique, and are able to design facilities tailored to their specialty. Simply stated, physicians are striving for, and have found in ASCs, the professional autonomy over their work environment and over the quality of care that has not been available to them in hospitals. These benefits explain why physicians who do not have ownership interest in ASCs (and therefore do not benefit financially from performing procedures in an ASC) choose to work in ASCs in such high numbers.

Overview

The broad statutory authority granted to the Secretary to design a new ASC payment system in the Medicare Modernization Act of 2003 presents the Medicare program with a unique opportunity to better align payments to providers of outpatient surgical services. Given the outdated cost data and crude payment categories underlying the current ASC system, we welcome the opportunity to link the ASC and hospital outpatient department (HOPD) payment systems. Although the HOPD payment system is imperfect, it represents the best proxy for the relative cost of procedures performed in the ASC.

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

- Maximizing the alignment of the ASC and HOPD payment systems 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.

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Sincerely,

Barbara Watson, CMM
Administrator