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Missouri ASC Association

12639 Old Tesson Road
St. Louis, MO 63128

November 3, 2006

Leslie V. Norwalk, Esq.
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attn: CMS -4125 – P and CMS – 1506 - P
Mail stop C5-11-24
7500 Security Boulevard
Baltimore, Maryland 21244-1850

RE: Medicare Program: Ambulatory Surgery Centers PPS Proposed Rule for 2008

Dear Ms. Norwalk:

I am an administrator of four (4) ambulatory surgery centers and I also act as the President of Missouri's ASC Association. Our four ASC's see Orthopedic, Gastroenterology, Gynecology, General Surgery, and Urology patients. Between 12% and 25% of the patients treated at these ASC's have Medicare insurance.

Generally, the goal to pay ASC's some percentage of the hospital reimbursement appears to be sound. However, I am writing to express my concern with CMS's recent proposal to change the way the agency pays for specific procedures performed in ambulatory surgery centers (ASC's). If Medicare does not address the attached procedures, then ASC managers like me will ask physicians to perform these procedures at the hospital where reimbursement will adequately cover hospital costs. My concerns with certain procedures in each specialty are addressed below:

Orthopedics — Medicare currently does not reimburse ASC's for orthopedic procedures that require implants. Based on the attached analysis, our surgery centers will continue to require physicians who wish to perform cases requiring implants (which are expensive!) back to the hospital where reimbursement for implants can be passed through and reimbursed by Medicare.

General Surgery — Like Orthopedics, hernias require an expensive implant – mesh – which is not adequately covered by CMS' proposed rates. Again, we will continue to require physicians to bring such cases to the hospital where reimbursement is sufficient to cover the costs as well as some excess revenues.

Gynecology — Endometrial Ablation (58563) is not a common procedure for Medicare patients but is for younger women. The levels of payment established for an ASC do not recognize the significant costs of 90% of the market that uses a certain expensive technology/supply (Novasure) which is much more effective for women with these problems. Even the office visit levels of reimbursement are much higher although our gynecologists think that the office is a dangerous setting in which to use anesthesia and would prefer the ASC to the hospital, where these patients must currently be cared for.

Gastroenterology — Although there are no implants, if payments for GI patients drop to the levels that CMS proposes, then it is likely that our ASC's would exit the GI line of business as it would otherwise be unprofitable to stay in the GI business. These cases would go back to the hospital and CMS expenditures would increase.

Budget Neutrality — CMS's concept of budget neutrality in this proposal is in error and unfair for many reasons. The agency is correct in proposing to increase markedly the number of procedures, from a variety of different specialties that are performed in the ASC. Raising reimbursement to ASC's for

certain services is a sound economic strategy to incent ASC's to perform more cases. But my understanding is that in computing budget neutrality, every new service/procedure that is added to the ASC list forces CMS to reduce the ASC facility fees for GI and Ophthalmology. This public policy does not make good sense.

The reality is that for nearly all cases that move from the HOPD to the ASC under this expansion of the ASC approved list, the Medicare program will save money. And the more cases that move from the hospital to the ASC, the more money that Medicare will save!

In summary, CMS's perspective on budget neutrality is wrongly-applied. CMS 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. The most 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.

Questions There are three questions that CMS must ask itself:

1. Does Medicare achieve more savings at an ASC or at a Hospital Outpatient Department (HOPD)? Is the less expensive provider the HOPD or ASC?

2. If CMS underpays for certain procedures (see attached), then will ASC's continue providing these unprofitable services?

3. If Medicare really does save money in ASC's, then how can CMS incent physicians and ASC's to bring more surgeries/ procedures to the ASC?

Solution — The best way to avoid an unintended outcome is to modify this proposal in order to increase the facility fees for the attached procedures, especially those procedures requiring implants. If CMS insists on pegging ASC payments to a percentage of HOPD payments, then it should adopt either much higher payment levels or institute a multi-level approach relative to ASC procedures in specialties like Orthopedics, General Surgery, Gynecology, GI, Pain Management and Ophthalmology so that these specialties can cover their costs. Adjusting certain procedures upward will not only help ASC's meet their costs but also will avoid the closure of single specialty ASC's (e.g. GI or Ophthalmology). In summary, more procedures can be performed in the least costly setting: the Ambulatory Surgery Center.

Regards,

M. R. Ladevich

Michael R. Ladevich, President

Missouri Ambulatory Surgery Center Association (MASCA)

Attachment

Implant Analysis
2008 Medicare Reimbursement for ASC's

CPT	Description	Ave. Base Cost	Ave. Implant Cost	Total Cost	Proposed Payments @ 62%	Net Income	
	Orthopedics						
29880	Arthroscopy, Meniscus Rpr	$ 1,100	$ 320	$ 1,420	$ 1,136	$ (284)	
29882	Arthroscopy, Meniscus Rpr	$ 1,100	$ 600	$ 1,700	$ 1,136	$ (564)	
29883	Arthroscopy, Meniscus Rpr	$ 1,100	$ 600	$ 1,700	$ 1,136	$ (564)	
29827	Arthoscopy, Rotator Cuff	$ 1,100	$ 900	$ 2,000	$ 1,787	$ (213)	
29807	Arthroscopy, Shoulder (SLAP)	$ 1,100	$ 900	$ 2,000	$ 1,788	$ (212)	
29888	Arthroscopy, Knee (ACL Repair)	$ 1,100	$ 3,300	$ 4,400	$ 1,788	$ (2,612)	
27792	Distal Fibular Frxt, Open	$ 1,100	$ 462	$ 1,562	$ 1,491	$ (71)	
28485	Metatarsal Frx, Open	$ 1,100	$ 379	$ 1,479	$ 1,491	$ 12	
25620	Distal Radial Frx, Open	$ 1,100	$ 1,500	$ 2,600	$ 2,239	$ (361)	
28296	Hallux Valgus Correction	$ 1,100	$ 400	$ 1,500	$ 1,115	$ (385)	
27650	Achilles Rupture Rpr	$ 1,100	$ 560	$ 1,660	$ 1,637	$ (23)	
27829	Distal Tib Fib Joint, Open	$ 1,100	$ 320	$ 1,420	$ 1,491	$ 71	
28322	Metatarsal Nonunion Rpr	$ 1,100	$ 550	$ 1,650	$ 1,636	$ (14)	
	General Surgery						
49650	Laparoscopy, Repair Ingu Hernia	$ 1,100	$ 850	$ 1,950	$ 1,727	$ (223)	
	Gynecology						
57461	Colposcopy	$ 1,190	$ 30	$ 1,220	$ 183	$ (1,037)	
58563	Hysteroscopy, Ablation Rollerball	$ 1,190	$ 300	$ 1,490	$ 1,322	$ (168)	
58563	Hysteroscopy, Ablation Novasure	$ 1,190	$ 950	$ 2,140	$ 1,322	$ (818)	*
58563	Hysteroscopy, Ablation (Office)				$ 2,299	*	
	GI						
45380	Colonoscopy and Biopsy	$ 395	$ -	$ 395	$ 335	$ (60)	
43235	Upper GI	$ 355	$ -	$ 355	$ 315	$ (40)	

Mays & Schnapp
PAIN CLINIC AND REHABILITATION

November 2, 2006

Via Federal Express

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:

Let us give you some background so that you will better understand the point of view we represent. We developed an ambulatory surgery center 15 years ago to improve patient access to interventional pain procedures. Prior to having an ASC for chronic pain patients, we had to schedule time in local hospital outpatient departments to perform needed procedures for return to function and pain relief. Patients living with chronic pain were not considered priority and so these cases were not scheduled on a priority basis. In the ensuing 13 years, the understanding of pain and the benefits of treatment have been more widely understood and access to care in ASCs has been a lauded benefit for our aging population. In 2005 our ASC treated 4087 patients, 35% of whom were Medicare beneficiaries. We care deeply about this population and CMS-1506-P and CY 2008 Payment Rates puts their access to quality care at risk.

- We agree that the HOPD methodology for payment is more developed than the ASC payment schedules. We strongly disagree with the assumption that the cost factors for hospitals are significantly higher than for ASCs and cite as a single example the cost of staffing. There are no studies that show nursing costs lower in the ASC setting. We base our salary scales on hospital data and must do so to compete in an HR market with an acknowledged shortage. Although we submit several federal survey forms a year, none ask for supply and salary information. Hard studies need to be done to either validate the assumption that ASC services to Medicare recipients cost less or to prove it without merit. The 38% discount in payment proposed for ASCs is premature and any methodology ultimately implemented must be transparent, appropriately measuring costs and efficiencies in both settings. The findings of a recent report funded by MedPac entitled ***Further analyses of Medicare procedures provided in multiple ambulatory settings: An Introduction*** show that, in fact, costs are very similar in both settings.
- The good foundation on which CMS-1506-P was based, achieving budget neutrality, was flawed in its implementation. Budget neutrality is a sound idea.

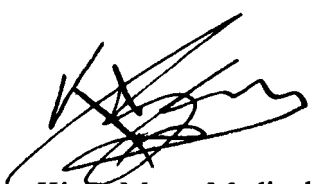
Reaching it by creating a disparity among ASCs, where some settings such as urology, pain and gastroenterology, suffer greater payment reductions and others such as orthopedics, see increases, is not. Medicare has seen its share of over utilization; however, to make the assumption that the most used services are the most overused is to misunderstand the population. For example, without citing any studies one can say with the certainty of common sense that pain in the elderly is a greater problem than in any other age group and one that increases as this population grows. Additionally, implementing the suggestions that the losses that single specialty ASCs will suffer would be mitigated by expanding to include the specialties with greater reimbursement may address the income concerns to ASC ownership but certainly harms the beneficiary the rule is intended to help and will lead to limited access for the most at risk. Should some single specialty ASCs be forced to closed because of reduced reimbursement, costs to Medicare will rise dramatically when doctors are forced to utilize HOPD settings again.

- The index used to update payment scales for HOPDs and ASCs must be the same. The current plan, to use the Hospital Market Basket for HOPDs and the Consumer Price Index for Urban Consumers for ASC, will increase the payment gap between HOPDs and ASCs and instead of accomplishing the goal of eliminating disparities between the two settings, will increase them. It will effectively over time reinstitute the site of service differential the rule strove to eliminate.

To conclude, we believe the rule as it is written is not ready for implementation. Further study should be done to confirm its methodology. We consider the proposed 62% of HOPD payment to ASCs to be disastrously low and feel certain that the unintended consequences of the cuts will be worse for both beneficiaries and the Medicare bottom line. Our hope is that implementation will be delayed, more studies will be done and true parity will achieved.

Thank you for your time and for the work you do.

Sincerely,



Kit S. Mays, Medical Director

Moacir Schnapp, Medical Director

cc: Hon. Lamar Alexander
Hon. William Frist
Hon Harold Ford Jr.

123.

John Ledbetter, M.D.
Vincent Forte, M.D.
Board Certified
Pain Medicine
Anesthesiology

November 1, 2006

Centers for Medicare and Medicaid Services
Department of Health and Human Services
ATT: CMS-1506-P or CMS-4125-P
P. O. Box 8011
Baltimore, MD 21244-1850

To Whom It May Concern:

I am a board certified anesthesiologist and pain management specialist in Monroe, Louisiana. We have a very busy practice providing interventional pain management services for both Medicare and privately insured patients. Our practice and those of similarly trained physicians all over the country specialize in non- surgical interventions for patients who have all types of acute and chronic pain problems, especially spinal pain. Modern technology has allowed specialists such as myself and my partner to very effectively diagnose and treat spinal pain problems in a cost effective manner. Over the past two decades, lumbar spinal surgeries have become one of the most common types of surgery done in this county. In a large number of cases, patients who have traditionally undergone lumbar spinal surgery can now be treated via non-surgical means. This can help minimize the cost of caring for these patients and also prevent the dreaded "postlaminectomy syndrome" by which patients who do not respond to their first, second, or third spinal surgeries continue to have severe unrelenting pain and disability.

There are, on the other hand, many cases of patients for whom surgical intervention is appropriate and necessary. Interventional pain management specialists do diagnostic procedures which can help direct a surgeon to the specific structure within the spine that is the source of the patients' pain, thereby increasing the chance of a successful surgical procedure the first time. Interventional pain management diagnostic and therapeutic procedures are traditionally done in an efficient ASC (Ambulatory Surgical Center) setting whereas spinal surgical procedures are necessarily done in a hospital. It has come to my attention that CMS has proposed drastic changes to the regulations by which ASC's are paid. In fact, it has been proposed that a facility fee for a procedure done in an ambulatory surgical setting should be no more than 62% of what a hospital outpatient department is paid. An ASC is, at the current time, paid more for an interventional pain management procedure than a hospital outpatient department, which has been an incentive to have these done in the most efficient and cost-effective setting. It makes no sense whatsoever to incentivize a physician to schedule such procedures in a hospital setting, which by nature is more expensive and less efficient, both for the physician and for the patient. The amount Medicare pays an ambulatory surgical center for a basic pain management procedure is currently about $300, which is barely enough money to cover the significant overhead of even an ASC. The CMS recommendation is to dramatically decrease the ASC payments by about 50%, which would be financially devastating, and also a big step in the wrong direction from an efficiency-of-care standpoint.

210 Layton Avenue, Suite 20
Monroe, Louisiana 71201
318-323-6405
fax 318-325-8232

Besides being financially disastrous for those of us who are trying to efficiently and effectively care for, Medicare patients pain problems, such drastic cuts will also inevitably impede Medicare beneficiaries' access to these very necessary procedures. Already Medicare pays ASCs, as well physicians, a minimal fee to care for these patients. Through the efficiencies that we have worked into our practice, we can at this time, continue to justify treating Medicare patients. If these ASC fees are cut as predicted, it may be extremely difficult for those with Medicare coverage to find interventional pain management specialists who can afford to care for them.

It also makes no sense for CMS to financially incentivize physicians to do these elegant, but minimally invasive procedures in a hospital, as opposed to an ASC setting. This will inevitably lead to increased cost to the Medicare program. ASCs are the ideal setting for these procedures due to their efficiency and lower overhead, and can currently make a financial go of it if facility fees are not cut as proposed by CMS.

It is my opinion as a pain management specialist that the proposed change in ASC fee schedules for interventional pain management will be a disaster for our specialty and our Medicare patients. I agree with the American Society of Interventional Pain Physicians that CMS should establish a fair and reasonable conversion factor that appropriately reflects the cost effectiveness associated with an ASC for interventional techniques. I would respectfully urge those with the power to effect CMS policy to strongly reconsider such drastic cuts in an area of medicine that provides so much good to so many Medicare beneficiaries in a cost-effective manner.

Sincerely,

John Ledbetter, M.D.

cc: David Vitter
U.S. Senator
1217 North 19th Street
Monroe, La. 71201

Mary Landrieu
U.S. Senator
US Courthouse
300 Fannin Street
Room 2240
Shreveport, La. 71101

Rodney Alexander
5th District Congressman
1900 Stubbs Avenue, Suite B
Monroe, La. 71201

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J. Patrick Couch, M.D., FAAPM

Diplomate, American Board Of Pain Medicine
Diplomate, American Board Of Anesthesiology
Fellowship Trained Pain Medicine

Xiulu Ruan, M.D.

Physical Medicine and Rehabilitation
Fellowship Trained Pain Medicine
Diplomate, American Board of Physical Medicine and Rehabilitation

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Thomas S. Bennett, Ph.D

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Pam A. Porter, P.T.
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- Shingles Pain
- Reflex Sympathetic Dystrophy
- Spasticity Treatment
- Phantom Limb Pain
- Spinal Degenerative Disorders

November 2, 2006

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

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 would like to share with you my concerns surrounding CMS's proposed rule for ASC payments. Additionally, I would like to point out factors that should be considered before a final decision is made.

Looking at the new rates that are proposed, 62% of HOPD is insufficient to cover my costs of performing the procedures. In order to offset the proposed cuts in the ASC payment rates, physicians will most likely shift their procedures to the outpatient facilities of their local hospitals. As a result, Medicare will actually pay more for these procedures than they would by leaving the current ASC rates alone. Additionally, physicians not utilizing a hospital's outpatient facility may tend not to provide such services to Medicare recipients, thus lowering access to Medicare beneficiaries.

I do not believe that sufficient time has been given to the evaluation of all factors surrounding the proposed rate change–especially the negative consequences that will result should these changes take place. The CMS must establish a reasonable conversion factor that accurately reflects the cost effectiveness associated with an ASC for interventional techniques. Consider also the efficiencies associated with performing procedures in the ASC setting. Lastly, keep in mind that the changes you make will affect the actions of other payors as

well since Medicare is used as a benchmark. Subsequent cuts from other payors will only multiply the potential problems for both physicians like me and the patients who need treatment.

Based on these observations, I implore that you reconsider the proposed changes and establish the means whereby surgery centers are reimbursed at least at the current rate. Also take note that inflation adjustments must be immediately reinstated.

I hope this letter helps the CMS come to the appropriate conclusion that will also help this nation's elderly population.

Sincerely,

Xiulu Ruan, M.D.

HEALTHSOUTH
SurgeCenter of Louisville

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November 2, 2006

Centers for Medicare and Medicaid Services
Department of Health and Human Resources
ATTN: CMS-4125-P
P.O. Box 8011
Baltimore, MD 21244-1850

Dear Sir/Madam,

I am writing on behalf of SurgeCenter of Louisville. I have been an administrator in ASC's for 10 years. The purpose of this letter is to briefly explain why I feel that CMS should develop a new ASC payment system as well as expansion of the allowed procedure listing for ambulatory surgical facilities.

During the time of my employment I have witnessed explosive growth in medical technology. I respectfully point out the current system has not been able to keep pace with the new technology available. This technology allows us to offer our patients many procedures that could not have been safely performed in the out-patient surgical setting 20 years ago. Examples include new laser technology which reduces trauma to surrounding tissue and allows smaller incisions, also new laparoscopic technology allowing procedures which, in the past required major incisions, extended hospital stays and painful recoveries to be preformed safely in the out–patient setting.

We provide high quality healthcare at a cheaper rate than hospital outpatient departments. The quality is demonstrated by our extremely low infection rates. These rates run less than .01%. Of further importance our patient satisfaction rates are above 95%. Unfortunately we are currently limited from caring for some patients who would benefit from our out-patient surgical care. Due to current restrictions within the Medicare system, many procedures we perform are not available to the Medicare patient. These same procedures are performed in HOPD's increasing your cost, the patient cost and unnecessary exposures and inconvenience. Of further consideration are implantable DME's. HOPD's do receive reimbursement for the devices where as free standing surgery centers do not, forcing patients to receive their care in the HOPD at a higher procedure rate. Our patients (many of whom live on fixed incomes) save money on their co-pays, the government saves money on the patient care provided, it really seems like a win/win situation.

HEALTHSOUTH
SurgeCenter of Louisville

Please consider creating a parallel system to HOPD's. The services mirror services they provide as should not only regulatory requirements but reimbursement as well. Hospitals have claimed that specialty providers are "skimming" the most profitable patients. I would like to point out that many providers, my center included have attempted, or are working directly with hospitals to provide a community a system. In cases were there is competition please recognize that the competition improves care and services available to patients as well as keeps the cost down.

There are additional benefits such as a free standing out-patient surgical facility that have less exposure to viruses and airborne organisms simply by walking in the door. Due to the age and/or the fragile condition of many of the Medicare patients we feel that this is a clinical benefit to our patients. Additionally, the physical layout of our facility is in itself much easier for the fragile patients to access. Parking is just outside the front door, once inside there are not different departments to navigate through the halls to reach.

We are more than the latest craze in healthcare but true providers of quality care. I am proud of the service that we provide to our patients, community and respectfully request your consideration in aligning our payment system to mirror the services provided in a hospital out-patient department.

Thank you for your time and consideration.

Sincerely,

Vicki Burns

Vicki Burns
Administrator

4005 Dupont Circle • Louisville, KY 40207 • 502 897-7401

HERMANN EYE CENTER

November 1, 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 Ave., 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 a physician practicing in the Hermann Eye Center in the Memorial Hermann Hospital, in Houston, Texas. We all appreciate the effort extended by the Centers for Medicare and Medicaid (CMS) in developing proposals for the new ASC payment system to be implemented in 2008.

I write to express my concern about the proposed fee schedule. The favored treatment given hospital outpatient departments in my opinion is not fair. The efficiency and success in ambulatory surgery centers reducing costs while at the same time delivering superior service is well documented. With individual physicians as partners in many of the ASCs the effectiveness increases further. Physicians become much more aware of costs and waste when working in ASCs as partners. Outcomes are significantly better than in the acute care hospital settings, costs are lower, patients are more satisfied and physician owner referral patterns are no different than non-owners. Maintaining the status quo of protecting hospitals from market forces only leads to higher costs and more waste.

I urge that CMS consider the following changes to the 2008 ASC fee schedule rule.

- The ASC list of procedures should be expanded to include any and all procedures that can be performed in an HOPD, only those procedures that are on the inpatient list should be excluded.

6411 Fannin, 7 Jones, Houston, Texas 77030-1697
(713) 704-1777 • (713) 704-0617 FAX

Hermann Eye Center • Memorial Hermann Hospital
The University of Texas - Houston Medical School • Department of Ophthalmology and Visual Science

- The ASC fee schedule should be updated based upon the hospital market basket which more appropriately reflects inflation in providing surgical services than does the consumer price index.

- The same relative weights should be used in ASCs and HOPDs.

CMS should appreciate that the benefit to the tax-payer and the Medicare consumer will be maximized by aligning the payment policies to encourage moving expensive procedures out of HOPDs and into ASCs when appropriate. Aligning the payment systems for ASC and HOPD will improve transparency of costs and quality data allowing you to evaluate outpatient surgical services for Medicare beneficiaries.

Medicare patients deserve the best medical care possible, I urge you not to prohibit access by differentiating between the hospital and a convenient, efficient and low-cost ASC.

Thanks again for your work on behalf of all citizens. Feel free to contact me at 713-470-0509 if you have any questions about my comments.

Sincerely,

Richard S Ruiz

Richard S. Ruiz, M.D.
John S. Dunn Distinguished University Chair
Professor and Chairman

RSR/sm

ANESTHESIA ASSOCIATES OF NORTHWEST DAYTON, INC. 127
3180 KETTERING BOULEVARD
DAYTON, OHIO 45439-1924
937-297-6072 (FAX) 937-293-0960

September 27, 2006

Mark B. McClellan, M.D., Ph.D.
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1512-PN
PO Box 8014
Baltimore, MD 21244-8014

Dear Dr. McClellan:

I am writing to express my concern as an anesthesiologist over upcoming changes to the physician fee schedule. I've been advised that the proposed practice expense methodology and changes in work values will result in a 10 percent cut in payments to anesthesiologists over the next 4 years. This only compounds the problems with the standard growth rate formula, adversely affecting all Medicare Part B physicians. Experts are projecting an alarming 34 percent reduction in reimbursement over the next 10 years based on the proposed 4.6 percent reduction to the fee schedule in 2007.

These cuts stand to have a dire impact on access to vital medical care for America's seniors. Medicare's failure to keep pace with the cost of delivering patient care is disturbing. Costs continue to increase while reimbursements decrease at an alarming rate. This is particularly troubling because the proposed practice expense methodology changes stand to adversely affect anesthesiologists more than any other specialty.

I am urging both CMS and Congress to address this issue immediately and make significant changes to the current methodology used to reimburse providers. I feel it would be in CMS' best interest to take advantage of the American Society of Anesthesiologists and other physician organizations' offer to financially support a comprehensive, multi-specialty practice expense survey. By collecting and using new practice expense data, CMS can take major steps towards improving the basis and accuracy of practice expense payments for all providers. Likewise, Congress needs to take action by supporting legislation that eliminates the unrealistic sustainable growth rate formula and replaces it with a more market-sensitive system based on positive changes to the Medicare Economic Index.

The ever-increasing gap between physician reimbursement and the costs incurred to provide care cannot be allowed to continue. My concern is that our nation's most vulnerable populations face a shortage of anesthesia care in operating rooms, pain clinics and critical care facilities throughout the country, unless action is taken. I greatly appreciate your time and consideration in this matter.

Sincerely,

Carla R. Hightower

Carla R. Hightower, M.D.

Cc: Senator Mike DeWine
Senator George Voinovich
Congressman Michael R. Turner

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MD: Indiana University School of Medicine

Member: American Medical Association, American Academy of Physical Medicine & Rehabilitation, Association of Academic Physiatrists, Indiana State Medical Association

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10-27-06

Mark B. McClellan, M.D., Ph.D.
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
CMS-1321-P
P.O. Box 8015
Baltimore, MD 21244-8017

Re: CMS 1321-P

Dear Dr. McClellan:

As a healthcare consumer, I have watched with alarm the increasing number of doctors who have not been able to take on new Medicare patients due to the inadequate reimbursement rate they receive for their services. Doctors want to serve seniors and we need a system put in place that adequately keeps track with inflation and helps ensure that doctors can care for their patients.

The proposed global cuts and unfair methodology for some specialists will have devastating effect on access to care magnified by the fact that all other payers follow Medicare. Please replace the 5.1% cut with a positive update that reflects increases in practice costs and stabilizes Medicare physician payments, and tell CMS to hold off on using inappropriate methodology.

Please take immediate action to prevent these scheduled cuts to Medicare reimbursement for physicians and protect beneficiary access to healthcare. Your positive action will preserve access to quality physician services for millions of patients.

Sincerely,

Lance Coons R.T.(R)

Lance Coons, Radiology Technician
Indiana Pain & Spine Care, P.C.

Southwest Center For Gastroenterology

Thomas Arndt, M.D.
Charles Berkelhammer, M.D.
Brian Blumenstein, M.D.
Douglas Lee, M.D.
Wayne Lue, M.D.
Vincent Muscarello, M.D.
Samir Patel, M.D.
Jeffrey Port, M.D.
Stephen Sittler, M.D.

October 28, 2006

Dr. Mark McClellan
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attn: CMS-1506-P
P.O. Box 8014
Baltimore, MD 21244-8014

RE: Medicare Program and Ambulatory Surgical Center PPS Proposed Rule

Dear Dr. McClellan:

I am a private practice gastroenterologist who treats Medicare patients in my practice.

Medicare patients undergoing screening colonoscopies are evaluated either at the hospital, or at ambulatory surgery centers. The proposed pay cuts to the Ambulatory Surgical Center would reduce the number of patients undergoing colon cancer screening and divert the flow to hospitals, which would increase costs.

The proposed CMS action, if implemented, to cut ASC colonoscopy GI procedure rates would result in a rise in Medicare costs because of diversion to hospitals rather than ambulatory surgical centers, available access to Medicare beneficiaries will decline, and Medicare beneficiaries may experience a rise in colon cancer because of reduced screening.

Please prevent this proposed rule from being implemented.

Thank you,

Charles Berkelhammer, M.D., FACG
Clinical Professor, University of Illinois

CB:amg

HEALTHSOUTH
Gadsden Surgery Center

130

October 30, 2006

Leslie V. Norwalk, Esq., Acting Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS – 4125-P
P.O. Box 8011
Baltimore, MD 21244-1850

Dear Administrator Norwalk:

I am encouraged by the Department of Health and Human Services efforts to reform the ASC payment system by aligning more closely to the hospital outpatient department (HOPD) payment system; however there still remain important concerns that are not included in the proposal, which should be addressed.

You are aware, ASCs provide patients with a high-quality, convenient and less expensive option for their outpatient surgery. When Medicare patients choose to have their outpatient surgery performed at an ASC, the patient and Medicare save money. Knowing that the proposed payment plan must be budget neutral, I believe the proposed 62% of HOPD rates is low and a budget neutral percentage could be substantially higher than this proposal.

The proposal includes a list of ASC approved procedures with an additional 750 new procedures. There are still limitations to the procedures that can be performed in an ASC as compared to an HOPD. Choices should be maximized by expanding the list to include all procedures that can be performed in a HOPD. It would seem logical for a procedure that is classified as "safe" to perform in an HOPD be classified the same for an ASC. The difference would be in the cost savings related to the use of an ASC versus HOPD.

HOPDs are allowed market basket updates on their pricing. The proposed ASC payment system limits the ASCs to consumer price index updates. The difference in these two inflation rates is a full percentage differential each year. Knowing that ASCs face the same inflationary pressures as HOPDs, including nursing costs and medical goods, the pricing updates should be reflective of this pattern.

Your department's thoughtful consideration of the above points when making a final proposal for ASC payment reform will be necessary and appreciated. As stated above, ASCs provide an excellent cost savings opportunity for all involved. The cases being performed in HOPDs are all appropriate for the ASC setting and are already being

performed on patients covered by other payers. This proposal has the potential to upgrade the services available to Medicare patients and create exponential savings and benefits.

Respectively,

Harriet H. Willoughby
Administrator
HealthSouth Gadsden Surgery Center

Albany Gastroenterology Consultants, P.C.
1375 Washington Avenue, Suite 101
Albany, New York 12206
Phone 518-438-4483
518-482-8377
Fax 518-482-0090
www.albanygi.com
office@albanygi.com

Satellite Offices:

Latham Medical Bldg., Latham, N.Y.

William M. Notis, M.D.
Edward S. Orris, M.D.
Nina F. Sax, M.D.
Richard G. Clift, M.D.
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John Buhac, M.D.
Sean Sheehan, M.D.

Karen Brimmer, R.N.
Practice Administrator

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October 30, 2006

Mark McClellan, MD
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS - 1506 - P PO Box 8014
Baltimore, Maryland 21244-8014

RE: MEDICARE PROGRAM AMBULATORY SURGERY CENTERS PPS PROPOSED RULE

Dear Dr. McClellan:

I am in a large private practice group of 12 physicians and 4 nurse practitioners who have always been actively involved in caring for Medicare patients. I wanted to express my concern regarding the new CMS's recent proposal to change the way the agency reimburses ambulatory surgery centers for their services by a facility fee payments.

As you know, colon cancer screening has been proven to be of significant benefit in the early identification and treatment of colon cancer by the removal of polyps preventing colon cancer in the future. It is clear that the cost benefit of such screening is of significant value both in patient health, well being, and cost to society.

As such, I do not understand why CMS would want to reduce the reimbursement for screening of colon cancer and other GI diseases in ambulatory surgical centers where the cost to perform these services are already less than that in the hospital setting. If the goal is to reduce the cost of providing endoscopic services and to increase the number of patients who are screened, it would seem illogical to push patients from a low cost center to a cost center which is two to five times greater in cost as the CMS proposal suggests.

My simple understanding of the change would be to drive patients from a low cost ambulatory surgical center to a high cost outpatient hospital center. This would clearly raise the cost of providing this service and significantly increase the cost if screening is to be applied to additional patients in the future.

I understand that budget issues need to be addressed but paying two to five times as much for the same quality of service seems to have negative effects. Those effects would be either higher cost or less patients screened. It would certainly be more appropriate, I believe, to add incentives to move outpatient procedures from the hospital to an ambulatory center where the cost is less, providing high quality care at a lower cost to more patients in the future.

Respectfully submitted.

Edward S. Orris, M.D
ALBANY GASTROENTEROLOGY CONSULTANTS, PC
EO:ia

Consultants In
Gastroenterology, L.L.C.

Michael N. Eppel, M.D., F.A.C.G.
David D. Lee, M.D.
Denise L. Speich, APRN

132

10/31/2006

The Honorable Ben Nelson
Rm 287 Federal Building
100 Centennial Mall North
Lincoln, NE 68508

Dear Ben:

I am writing to draw your attention to a recent proposed rule change by the Centers for Medicare and Medicaid Services concerning reimbursement for gastroenterology procedures at Ambulatory Surgery Centers. This proposal makes no fiscal or medical sense.

As you know, endoscopic procedures are being done at ASC's safely and cost-effectively every day across the country. Compared to the costs incurred at a hospital outpatient department this has resulted in significant savings to the taxpayer. Right now CMS pays 89% of the facility fee to an ASC that they would pay for the same GI service performed in the hospital outpatient department. They are now proposing to pay instead 62% of the HOPD payment. I gather that the rationale for this cut is that more procedures by various other specialties have been approved for performance at ASC's and that CMS wants to maintain "budget neutrality". Therefore they are splitting the same ASC pie amongst more specialties. What they should be measuring is the total ASC/HOPD pie and the amount of dollars that will be saved by performing all these newly approved procedures at an ASC compared to a hospital outpatient department. This total pie should be the basis for reimbursement calculations.

CMS has consistently reduced reimbursement for various GI procedures over the years. At a time when the colonoscopy screening benefit is underutilized by Medicare beneficiaries this change would significantly impact that even more. It doesn't take a genius to figure out that there will be a shift of Medicare patients to hospital outpatient departments since it is going to be impossible to provide services at an ASC to this population at this level of payment. Thus the overall effect of this would be to significantly *raise* the costs to the taxpayer!

As a great supporter of colorectal cancer screening for Medicare patients I know you will be concerned that this step will result in even less utilization of that procedure.

1730 South 70th Street, Suite 110 • Lincoln, Nebraska 68506 • 402-441-5600 • FAX 402-441-5606
www.consultantsingastro.com

Once again CMS is being shortsighted and frankly irrational.

Regards,

Michael N. Eppel, M.D.
Copy to Mark McClellan, M.D.
Centers for Medicare and Medicaid Services

Florence Surgery Center, L.P.
A HEALTHSOUTH FACILITY

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October 30, 2006

Leslie V. Norwalk, Esq., Acting Administrator, CMS
Department of Health and Human Services
Attention: CMS-4125-P
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, Maryland 21244-1850

Dear Administrator Norwalk:

I write to share my concerns regarding the recently announced Medicare Ambulatory Surgery Center (ASC) Payment System and ASC list reform. As Administrator of an ASC facility in North Alabama, I have full awareness of the convenient, safe, fiscally beneficial care we as an industry provide to many Medicare patients each day. Our goals for the long awaited changes to the ASC Payment System would be: to receive at least some parity with the reimbursement that the HOPD facilities are currently receiving; to expand the list of procedures allowed to be performed in an ASC to a truly exclusionary list specifically for ASC services as suggested by MedPAC and Secretary Leavitt.

We have endured the same increases in our supply/equipment costs along with the expense of staffing our facilities with skilled nurses and other healthcare workers. While I am acutely aware of the requirement of budget neutrality for the proposed payment plan, I believe the proposed 62% of HOPD rates is too low and a budget neutral percentage could be substantially higher than this proposal.

The Medicare Modernization Act requiring that ASC's be transitioned from the current Medicare payment system to a new payment system by 2008 provides an opportunity to provide more transparency across sites of service and permit ASC's to be a vital and viable competitive alternative to more expensive outpatient hospital departments. In today's healthcare, there is a place for both HOPD's and ASC's.

103 Helton Court • Florence, AL 35630 • 256 760-0672 • Fax 256 766-4547

Please do not widen the already unfair gap between HOPD and ASC reimbursements. ASC's provide a cost effective alternative to the hospital setting for outpatient surgery and should be allowed the same benefits of reimbursement as the HOPD's receive. It should be the goal of the CMS to create a truly parallel system to HOPD in all aspects. The CMS proposed rule continues to treat HOPD's and ASC's differently in certain key respects. These differences should be eliminated and ASC and HOPD payments made on the same basis.

Thank you for your consideration of the above issues.

Sincerely,

Pam Watson, RN

Pam Watson, RN
Administrator
Florence Surgery Center

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ASHEVILLE GASTROENTEROLOGY ASSOCIATES, P.A.

PRACTICE LIMITED TO GASTROINTESTINAL AND LIVER DISEASES
Main Location: 191 BILTMORE AVENUE • ASHEVILLE, NC 28801
PHONE: 828 254-0881 • FAX 828 253-7841 (Clinical) 828 258-1614 (Business)
East Location: 136 Creekview Court • Marion, NC 28752 • PHONE: 828 659-8065
North Location: 125 Hospital Drive • Spruce Pine, NC 28749 • PHONE: 828 765-7865 ext. 366

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October 31, 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: Ambulatory Surgery Center Proposed Rule

Dear Dr. McClellan:

Asheville Gastroenterology Associates, P.A. is a sixteen physician singe-specialty gastroenterology practice located in Asheville, North Carolina. While located in a rural setting we are the second largest group in North Carolina and are the sole suppliers of high quality tertiary care in our region. Because of our size, setting, and ethic for many we have become the gastroenterologists of last resort as we have never turned patients away. We cared for many of our patients when the paper mills and sewing factories were thriving and we have always felt we should care for these same patients after the mills have closed. We see patients from as far away as North Georgia, Tennessee, and South Carolina; many have driven past three or four small GI practices on their way to an appointment. The Buncombe County Medical Society maintains a program called Project Access which provides a healthcare safety net for those with no insurance at no cost to the patient and while physicians typically limit their participation we have never posted limits on our free care.

We have a physician owned four room endoscopic ambulatory surgery center which was the first in North Carolina and has been the low cost site of service for screening colonoscopy since its inception in 1991. The manager of my Insurance Department unfortunately has a condition that requires frequent endoscopic procedures which must be done in the hospital and from her reports what we charge the patient is half to two-thirds less than that charged by the hospital. We try to be very aware of the financial impact to our patients and

schedule outpatient procedures in the hospital if the patient has a medical condition that might warrant the higher cost, or when our ASC fills to capacity.

In a healthcare system that sometimes appears mercenary, we have always felt we were the good guys and frankly the Rule as proposed has us up against a wall. In 2005 we were able to provide lower cost care to 4,500 Medicare patients and keep them out of the hospital outpatient department. This year it looks like that number will be around 5,000. If I maintain the same level of Medicare cases under the Proposed Rule my receipts for that book of business will drop somewhere between $220,000 to $250,000 per year. That is roughly what we offer a new gastroenterologist out of fellowship when we can find one.

As a former Chief Financial Officer of a 62-bed rural hospital I can say tagging ASC colonoscopy reimbursement to 62% of hospital outpatient colonoscopy reimbursement is too deep; at least by half. As a physician owned private operation I don't have the buying power exercised by a hospital so I pay more for all of my supplies and equipment and I am held by the state of North Carolina to the same building standards as that of a hospital.

Five years ago clinical labor was 48% of my total expense. Last year it was 51% and this year it will be more than that. We are held by the state of North Carolina to maintain RNs in the procedure room and recovery. I don't know how things are in Baltimore and Washington, DC but in rural North Carolina the competition for RNs is intense. My wife is a nursing professor at Western Carolina University, the only BS RN program in the region, and she would tell you the pipeline in Western North Carolina is no where near matching the pace of retirement and job abandonment. If I want to keep talented clinical labor, and I do, I can't afford to pay my RNs at a significant discount to what is being offered in the endo units at the hospital. My discount in clinical salary to the hospital is small and is constantly eroding as the pool of new RNs continues to shrink.

I also don't have the ability to shift clinical labor to meet demand as they do in the hospital setting. To maintain my clinical staff I must provide them a normal work week regardless of the number of cases I have in the unit. In the hospital as demand fluctuates they can shift nursing from inpatient to outpatient and even from endo to recovery or med-surg which makes them more efficient and lowers their effective labor cost. I'm stuck and that increases my overall cost in ways that are not accounted for in your calculations. In my own estimation, from working in both settings, I feel the small discount I have in clinical salary is consumed by my inability to shift labor on demand as in the hospital setting.

While I realize the Proposed Rule is in reaction to legislation, it is hard to review transcripts from MEDPAC and not come away with the conclusion that a component of the deep discount to outpatient reimbursement comes in reaction to a perception of ASCs as a monolithic corporate environment providing assembly line heath care at some fabulous rate of return. I can not speak to that but as a past president of MGMA's GI Assembly I can say the private GI physician owned ASC environment is a tapestry of providers with varying capacity and cost who together provide an integral component of screening

colonoscopy capacity to the Medicare community. Endoscopic ASC start-up operations and one and two room centers with moderate volumes often have average cost per case that exceeds Medicare reimbursement. I am aware of two of my colleagues in North Carolina that run one or two room "boutique" endoscopy centers with 100% commercial payers. While I do not agree with the ethics, if we wish to remain privately owned this is the direction in which you are pushing the community. Ironically the mandate of such deep discounts is likely to result in the "Wal-Mart" effect and drive the small independently owned ASCs either into "boutique" operations which exclude the Medicare population or to transfer ownership to a corporate entity.

My state CON covenants state that we can only provide endoscopic services. We can not expand into a multi-specialty center. Providing screening colonoscopy access and capacity is my only avenue. In my own case I can't afford to absorb an annual reduction in the neighborhood of $220,000 to $250,000. I have to be able to recruit new physicians as they become available, to buy new equipment, and to give my staff a raise.

If the Proposed Rule is implemented as written we are faced with three options: sell the ASC to a corporation, sell the ASC to the local hospital, or reduce the Medicare mix of patients in the ASC and move them to the hospital outpatient department opening ASC capacity for better paying commercial clients. For now, we don't want to sell the ASC; reducing our options to, for the first time, saying "no" to certain patient populations.

Realistically such cuts will force us to limit our Project Access patients and the amount of indigent care we provide. We will probably need to shift 25% to 50% of our Medicare capacity to the hospital but as we already maintain a three physician "hospitalist" operation we will be unable to shift additional gastroenterologists to the hospital to absorb the extra capacity. The result is higher cost to the patient, higher cost to CMS, and extended wait times for the next available outpatient colonoscopy slot.

There are no winners in the Proposed Rule and as a single specialty ASC our best hope is to pay strict attention to payer mix so that we tread water with reimbursement while our cost continues to rise; sliding slowing into the realm of "boutique" colonoscopy. If this Proposed Rule is adopted you are delivering the private single-specialty ASCs into the hands of corporate medicine or driving them from the Medicare market. In either case the Medicare population will suffer and in Western North Carolina screening capacity for Medicare patients will be reduced.

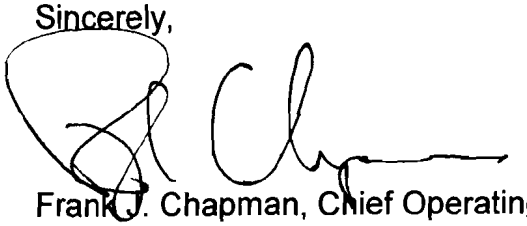
One of the first things I noticed in moving from the hospital setting to the physician setting is that the reimbursement for outpatient procedures has no "relative" relationship to the same procedures performed in the ASC. While tagging ASC reimbursement to the hospital outpatient department is easy, it has no underlying relative foundation on which to build an equitable compensation model.

The Proposed Rule applies a definition of budget neutrality which ignores the significant site of service shift that will be driven largely by the reduction in reimbursement for some procedures and the increase in reimbursement for others. It is reckless to ignore such a fundamental business principle and it is a policy that is needlessly punitive to single specialty ASCs with no where else to go.

This Proposed Rule is policy based on ease of implementation ungrounded by logic or data. Year after year we spend needless energy battling the outcome of the bad policy we call the SGR. Most agree it is a problem. Most disagree with the proper solution. This Proposed Rule creates the same problem: a flawed calculation to be passed along until fixed at some point in the future. If there is anything to be learned from the agony we call the SGR is that policy should begin with a solid foundation and we should never implement policy with the expectation that it will be fixed at some point in the future.

My hope is that CMS will have the strength of leadership to pull back from such a flawed system early enough to be able to still meet its deadline. The mark of good leadership is to be able to sometime pull the plug on a bad decision and to begin again.

Sincerely,



Frank J. Chapman, Chief Operating Officer
Asheville Gastroenterology Associates, P.A.
The Endoscopy Center
191 Biltmore Avenue
Asheville, North Carolina

cc: The Honorable Richard Burr
The Honorable Elizabeth Dole
The Honorable Charles Taylor

ber 30, 2006

lie V. Norwalk, Esq., Acting Administrator
nters for Medicare and Medicaid Services
epartment of Health and Human Resources
Attention: CMS-4125-P
Room 445-G
Hubert Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

RE: ASC Payment Reform

Dear Administrator Norwalk:

My name is Sam Martinez and I am the Administrator of the Antelope Valley Surgery Center in Lancaster, California. Our center, which is located in the northern part of Los Angeles County, provides important and cost effective services to a large and increasing number of Medicare Beneficiaries. I am writing to express some concerns I have regarding the pending CMS proposal for Ambulatory Surgery Center (ASC) payment reform.

Over the past 30 years, ASCs have proven that the services provided to patie are of at least equal quality as those provided by Hospital Outpatient Departments (HOPDs). In most cases, the quality of care is much higher a patients are taken care of in a timelier manner and more efficiently. Under new proposal, the ability for ASCs to continue to provide this exceptional greatly compromised.

The new proposal provides for ASCs to be reimbursed at 62% of wha are reimbursed, for providing the exact same service. By setting the reimbursement rates this low, CMS would force doctors to move ca more expensive hospital setting, increasing the amount of money Medicare beneficiaries and the government. Furthermore, by lim reimbursement to 62% of the HOPD rate, CMS will be drastical availability of the quality services provided by ASCs to benefic the United States.

ASCs confront the same operational and budgetary hurdle and retaining qualified OR staff, purchasing medical supp

maintenance, ability to keep up with technological advances, etc. Yet CMS has proposed updating ASC payments by the consumer price index, a general measure of inflation of the economy rather than the hospital market basket update. 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. By utilizing the consumer price index, over time, the disparity in payments will create deeper divisions between prices paid in the HOPD and the ASC without evidence that different payment rates are warranted.

The ASC proposed Procedure List reform is too limited. While the proposed ruling adds some 750 procedures that could be performed in an ASC, most are low complexity procedures that can be done in a physician's office and are capped at the much lower physician fee schedule rate, not paid using a percentage of HOPD rates. Additionally, CMS failed to include on the list many higher complexity services that for years have 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.

By implementing these measures that I have addressed, and those that I have not, CMS is placing dubious limitations on beneficiaries and providers of care, rather than creating a more viable and stronger system for the delivery of medical care. Inasmuch as reform is needed in the reimbursement process, this approach falls well short of aligning the ASC and HOPD payment policies as mandated by the Medicare Modernization Act.

In closing, I ask that CMS re-evaluate the proposed ASC Payment Plan and reconsider its position to develop a more aligned payment plan that is fair to both the ASC and HOPD communities. Thank you for taking the time to read my letter and allowing me to share my concerns with CMS.

With Best Regards,

Sam Martinez
Administrator

VNS VAGUS NERVE STIMULATION

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November 6, 2006

Honorable Mark B. McClellan, M.D., Ph.D., 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-P2 - Medicare Program; The Ambulatory Surgical Center Payment System and CY 2008 Payment Rates

Dear Dr. McClellan:

As the sole manufacturer of the VNS Therapy System, Cyberonics, Inc. is pleased to submit these comments regarding the August 23, 2006 proposed rule to revise the ASC facility payment system and update the payment rates for CY 2008.

The VNS Therapy implant procedure is typically performed on an outpatient basis. Surgery is performed under general anesthesia and lasts approximately 1 to 2 hours. Historically, neurosurgeons, otolaryngologists, as well as general and vascular surgeons have been trained to competently perform the implant procedure. No special operating room equipment is required.

This procedure can easily be performed in an outpatient department or an ambulatory surgical center. Based on reimbursement issues, ASCs are currently providing this procedure for private-pay patients only.

We would like to offer comments on the following provisions of the proposed rule:

- The 62% conversion percentage will be a particular problem for ASCs performing device implantation procedures for APC Codes 0039 and 0225. While the hospital OPPS payment weights include an allowance for the cost of implanted devices, this cost provision is known to be inadequate even when hospitals are paid 100% of the OPPS rate.

- We would like to recommend that Medicare reimburse the ASCs 100% of the device acquisition rate portion of the APC rates and apply 62% to the procedure portion of the APC rates. The only efficiencies will be achieved in the procedure costs, and not in the acquisition cost.

We appreciate the considerable effort CMS has put into these proposals to ensure that patients have equal access to care in the setting that best serves the patient. Inappropriate reimbursement will definitely hinder access to the facilities.

Sincerely,

Max Gill

Max Gill, MBA
Senior Director, Reimbursement
Cyberonics, Inc.
MGill@Cyberonics.com

137

Gulf Coast Endoscopy Center South

7152 Coca Sabal Lane,
Fort Myers, FL 33908

(239) 985-0215 *FAX: (239) 985-0394* 113

Joint Commission on Accreditation of Healthcare Organizations

ANDREE A. DADRAT, MD JUAN G. HERRERA, MD MARK S. O'KONSKI, MD JAMES W. PENUEL, Jr., MD PAUL L. YUDELMAN, MD

Board Certified Gastroenterologists

October 31, 2006

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

2006 NOV -6 PM 1:46

Dear Administrator Norwalk:

As a Center Director of a busy ambulatory surgery center in Florida, I wish to comment on your CMS rule.

Our center has a 50% + Medicare population. Your proposed rule will reduce the center's profitably by over 40%, making it impossible to invest in capital improvements and maintain the high standards which JCAHO requires.

The physicians who utilize this facility intend to shift their Medicare patients to the hospital and they are already in discussions with the hospital to increase their capacity for this increase. Our center will continue to service non-Medicare patients, which will require us to reduce our operating hours and our staffing levels to accommodate this change. There is little or no choice if we stay open and maintain our high standards.

The net effect of your proposed ruling is to create in Florida (and other high Medicare locations) a two-tier system of one set of patients having access to a state of the art outpatient facility, while Medicare patients are shifted to the hospital with all its inherent problems. This is particularly troublesome in that ambulatory surgery centers have a lower complication rate compared to hospitals. Also, the local hospital system is unable to accommodate this large volume shift which I am concerned will lead to delays in diagnosis and treatment.

While many discussion letters are abstract, I would be happy to share real numbers should you desire. 62% of the current hospital outpatient charges is not viable options for outpatient surgery centers.

Yours truly,

Sue Oakley, RN.

Sue Oakley RN
Center Director

CC: Senator Bill Nelson
716 Hart Senate Office Building
Washington, D.C. 20510

ASCOA
ambulatory surgical
centers of america℠

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November 2, 2006

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

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

Dear Ms. Norwalk:

I am the CEO of ASCOA, a private company that develops outpatient surgery centers in partnership with physician groups. Over the past decade we have partnered with physicians in developing over 30 outpatient surgery centers.

I am concerned that the proposed rule is not setting reimbursements high enough to ensure the continued growth of ambulatory surgery center industry. Privately developed ASCs have directly saved CMS billions of dollars, improved care, improved convenience, and saved Medicare beneficiaries sizable amounts in lower copays. Additionally, the profits derived from these privately owned facilities are taxed; whereas, surpluses generated by not-for-profit hospitals, from which most ASC cases are migrating, are not taxed.

The report published in 2005 entitled "Study of Physician-owned Specialty Hospitals Required in Section 507(c)(2) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003" by Michael O. Leavitt, Secretary of Health and Human Services, details how physician owned hospitals provide societal benefits that exceed those of not-for-profit hospitals because of the taxes they pay.

With physician owned surgery centers, society not only gets the same tax benefits but also gets the added benefit of lower direct costs to CMS and to Medicare beneficiaries. CMS should be encouraging ASC development by providing adequate reimbursements to ASCs.

For example:

1) The proposed rule should not penalize the ASC industry by using a non-medical based CPI adjustment factor. ASC costs are medical costs and ASCs should be protected from inflationary cost increases in the same way hospitals are.

2) ASCs should be eligible for new technology pass through reimbursement as hospitals are.

124 Washington Street, Suite 4 / Norwell, MA 02061 / Tel: 781.871.3311 / Fax: 781.871.3314 / www.ascoa.com

3) ASCs should not be subjected to reimbursement caps based on what the procedure would pay in an office. Hospitals aren't subject to caps so why should ASCs?

4) ASCs should be able to bill on the same form, UB92, that hospitals use. Using the CMS 1500 limits the information that CMS gets from ASCs.

Additionally, CMS should seek long term savings for the Medicare program by setting the rates high enough to continue to encourage further ASC development. Every additional ASC creates a stream of long-term savings for CMS. CMS should not be short sighted in merely striving for budget neutrality in the short term. CMS should be striving for savings in the long term. I would think setting the rates at a higher rate of 75% of hospital rates would go a long way towards encouraging ASC development and generating future savings for the Medicare program.

I am concerned that at the proposed 62% of hospital reimbursement rates many surgery centers, focused on those specialties adversely impacted, may go undeveloped. Indeed, many centers that are only breaking even in specialties of ophthalmology, GI, and pain could close, driving some cases back to the higher cost hospital environment. You can see in the dramatic sell off of the publicly traded ASC companies over the past year that investors see greatly diminished prospects for growth based on threats to reimbursement. The three leading public ASC companies are down 25 – 40% from their highs even while the broader equity indexes are hitting historic highs.

Paying hospitals more for the same services that ASCs can safely provide is a waste of tax payer dollars and a detriment to our society's welfare. Regardless of what ASC rates are ultimately determined to be, rates should be transitioned over time such that hospitals and ASCs are paid the same for the same services.

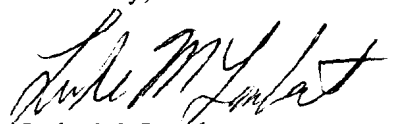
With a level playing field cases would naturally flow to those providers that can best deliver those services. With a majority of state level regulatory environments being heavily biased towards protecting the legacy incumbents from competition, we cannot afford at the federal level to be further subsidizing inefficient providers.

I welcome discussing my thoughts with you further and can be reached at:

Ambulatory Surgical Centers of America
124 Washington St., Suite 4
Norwell, MA 02061
Phone: 781-871-3311 ext. 200

Thank you for your consideration.

Sincerely,



Luke M. Lambert
Chief Executive Officer

November 6, 2006

VIA HAND DELIVERY

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 the Surgery Division of HealthSouth Corporation, please accept the following comments regarding Section XVIII of the proposed rule, which would revise the ambulatory surgical center (ASC) payment system for CY 2008. 71 Fed. Reg. 49505 (August 23, 2006). We appreciate the careful consideration and significant work that has gone into developing these proposals.

With interests in 143 ASCs in 34 states, HealthSouth is the one of the largest operators of ASCs in the United States. ASCs offer a convenient, safe environment characterized by superior care, which is highly valued by Medicare beneficiaries and their physicians.

We support the comments which have been submitted under separate cover from the ASC Coalition, of which we are a member. Those comments provide detailed recommendations regarding the implementation of the revised ASC payment system. While we support many of the general principles underlying the changes CMS has proposed, we believe that by failing to fully conform the ASC and HOPD reimbursement systems and by setting the proposed conversion factor too low, CMS is missing an important opportunity to achieve additional permanent savings to both the Medicare program and to Medicare beneficiaries. In particular, we draw your attention to the following key points:

ASC conversion factor: We support the use of CMS's proposed "alternative formula" for the calculation of the ASC conversion factor. This approach allows consideration of the dynamic forces that will drive shifts of services between outpatient surgical settings. However, we agree with other members of the ASC Coalition that the estimated 15% migration of services from the physician office to the ASC is significantly overstated. ASCs have little interest in using their specialized physical plant, personnel, and equipment to perform minor procedures on a routine basis and physicians have no reason to move cases from the office to the ASC setting

unless it is medically necessary to do so. Moreover, the proposed rule makes no allowance for migration of currently eligible ASC procedures as a result of expected reimbursement changes. Using what we believe to be more reasonable migration assumptions and correcting certain oversights in the calculation results in a more reasonable ASC conversion factor of 73.06%. Within the constraint of Part B budget neutrality, CMS should seek to establish a conversion factor that maximizes the cost-saving opportunities for both the Medicare program and Medicare beneficiaries for services that are appropriately performed in ASCs.

Alignment of HOPD and ASC payment systems: Unless there is a compelling reason to do so, CMS should consistently apply OPPS reimbursement policies to the revised ASC payment system. A cost-based analysis is needed to determine if there is a significant difference between the costs of delivering specific services in the ASC and the median costs for the same services in the HOPD. Without a relative cost analysis, there is no basis for the proposed secondary rescaling of ASC relative weights in 2009 and beyond, which will result in variation between ASC and HOPD payments without evidence that the cost of providing services has diverged between the two settings. Similarly, the manner in which services are provided in the ASC does not vary significantly from the HOPD, and thus the same policies regarding packaging and separately payable services should be used to determine ASC reimbursement. Further, ASC adjustments for inflation should be made using the hospital market basket rather than the CPI-U in reflection of the similar inflationary pressures facing ASCs and HOPDs.

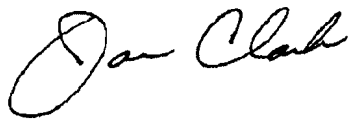
Reimbursement of implanted devices: The current HOPD reimbursement system packages implantable device costs into the APCs for the related surgical service. This recognizes that the device represents a fixed cost to the HOPD and assures adequate reimbursement. By contrast, the conversion factor described in the proposed rule discounts the full ASC payment, including the fixed cost of the device. In many cases, this will yield a reimbursement rate below the total cost for furnishing services requiring the use of implantable devices. We believe that this must have been an oversight as it would divert procedures that could be performed at less expense to the Medicare program and to Medicare beneficiaries in an ASC to the more costly HOPD setting. In order to allow access to these services in the ASC setting, CMS should allow full payment to ASCs for the portion of the APC related to the device, while still applying the ASC conversion factor to the non-device related portion of the APC reimbursement.

Impact on selected high volume ASC services: The proposed ASC conversion factor will have a profound effect on certain gastroenterology, pain management, and other services commonly performed in the ASC setting. The magnitude of the financial impact may have undesired consequences on Medicare beneficiary access, particularly for the already underutilized screening colonoscopy benefit. We believe that these effects are caused by a misalignment of APC cost relatives for these services. Data being presented in other comment letters indicate that the proposed reductions to GI procedures will cause payments to drop below the cost of furnishing the service. To mitigate the potential effect on access to services or for reverse migration to the more costly HOPD setting, CMS should consider options, such as an extended transition period. This would allow time for adjustment of the APC cost relatives so that reimbursement in all settings is more aligned with the costs of providing these services.

Coverage policies for ASCs: We support the proposal to expand the range of procedures eligible to be performed in an ASC. However, we believe expanding the definition of surgical services as described in the ASC Coalition comments would promote beneficiary access to a broader range of the outpatient procedures safely offered in the ASC setting. Any coverage exclusions should be made on the basis of well-defined clinically based criteria established in consultation with the medical community, in order to allow physicians to determine the site of service best suited to a patient's needs.

Thank you for considering the comments we have submitted here and under the auspices of the ASC Coalition. We appreciate the opportunity to share our views on these important changes to the ASC payment system.

Sincerely,



Joe Clark
President, Surgery Division
HealthSouth Corporation
One HealthSouth Parkway
Birmingham, AL 35243

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Joseph G. Feghali, M.D., Inc. 11/01/2006
Glaucoma Consultation and Surgery

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

Dear CMS:

I am writing to you regarding the proposed regulation to establish a new ASC payment system and update of the ASC procedures list (CY 2008 ASC Impact).

Who We Are
Our small facility (Surgical Eye Center of Morgantown), utilizing only one of two ORs, has provided a full range of ophthalmic services to Medicare beneficiaries in our area for almost 10 years. Our estimate is that we have saved Medicare and Medicaid, close to $2,000,000 in payments by using our free standing facility in this ten year period. In addition to being the most cost effective center in the area, we also provide the highest possible quality of care, and are easily accessible to a large area. We have been the most successful joint venture with our community hospital of any physician – hospital cooperative effort in the area. This success is not measured in financial terms, but in the quality of care, efficiency and cost effectiveness of any similar service. Our patients continually rate us superior in various surveys 98% of the time.

Equity in Services Provided
ASCs should be permitted to furnish and receive facility reimbursement for any and all procedures that are performed in HOPDs. Now is the time with this opportunity to allow ASCs equal latitude of performing the same procedures allowed in HOPDs. The savings to Medicare will be very significant.

Outrageous Proposed Rate of 62% of HOPDs
Claiming Budget Neutrality to propose a 62% reimbursement rate will result in shutting down most of the small ASCs (ours included) that have been providing large savings to CMS already. Even at a rate of 75% (recommended by the ASC industry), it will be a stretch for our center to survive. It appears that the Hospital Association is in favor of this new lower rate (62%) as they know many ASCs will close, and they will then be able to provide the services at a much higher rate than ASCs do – and this would be under Part A Medicare, not Part B.

The Reimbursement Shift
If you are looking at Budget Neutrality, you must take the projected dollars saved in Medicare Part A and transfer these dollars into the ASC reimbursement levels – that is in fact in Medicare Part B. Otherwise this will become yet another method of shifting services out of Part A into Part B without the shift of equivalent dollars realized in the savings. Physician providers can simply not absorb any more of this revenue shift that has been occurring for over 10 years.

Facts are Facts
Fact # 1 – Our nurses do not work for 62% of what the hospital pays.

(304) 599-6627 • 800-333-6627 • FAX (304) 599-1437
2000 Hampton Center • Suite D • Morgantown, WV 26505

Fact # 2 – We do not get special consideration for our electric bills (or other utilities) at 62% of what hospitals pay (or at any discount).
Fact # 3 – Our construction/facility costs are not 62% of what a hospital pays.
Fact # 4 – Our certification process does not cost 62% of what hospitals pay.
Fact # 5 – Our equipment, instruments, surgical packs and other supplies do not come at 62% of what hospitals are paid, in fact they are much higher due to the low volumes.
Fact # 6 – ASCs are more efficient and proven higher quality than hospitals, and this would seem opposite of the Pay For Performance move in the government.
Fact # 7 – Paying 62% of what hospitals are paid will destroy most small ASCs and severely curtail services for beneficiaries.

Annual Updates of Payment Rates
ASCs currently are not entitled to any cost-of-living updates (2004 – 2009), despite the fact that our costs actually do go up, just like hospitals. CMS is proposing to pay ASCs updates that are going to be less than hospital updates (CPI vs HMB). This will eventually cause a shift of cases back to the hospitals where it is more expensive and does not measure up to the quality provided in ASCs. Additionally, this will result in a dramatic decrease in accessibility for CMS beneficiaries as hospitals are not nearly as efficient as ASCs.

Final Thought
I have practiced Medicine for over 20 years and faced many clinical and practice challenges. I have seen a lot happen in that time. I have always strived to provide the highest quality, cost effective and accessible care to all of my patients. **If this proposal succeeds, I guarantee you that it will result in lower quality, higher cost and less accessible care for those in need.**

My partners and I urge you to consider our comments seriously as we would really like to practice medicine and take care of our patients. Please do not impede our efforts.

Thank you for your consideration,

Sincerely,

J. Feghali, MD

Joseph G. Feghali, MD
Surgical Eye Center of Morgantown
1299 Pineview Dr.
Morgantown, WV, 26505

SOUTHWEST
SURGICAL SUITES

7920 West Jefferson Blvd., Suite 210, Fort Wayne, IN 46804 ph 260.434.2022 fx 260.434.2023

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November 2, 2006

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

Dear Administrator Norwalk:

I am responding to the Centers for Medicare and Medicaid Services (CMS) proposed rule that targets the wholesale reform of the ASC payment system by eliminating the historic grouper payments and adopting the APC relative weights used in the hospital outpatient prospective payment system.

As Director of Surgical Services, I have some concerns about the negative affects this proposed rule would have on the operations of our ASC. I ask that you consider the following in regards to the proposed rule:

- CMS should broadly interpret the budget neutrality provision enacted by Congress, to assure Medicare beneficiaries' access to ASCs. 62% is simply not adequate. Southwest Surgical Suites actively gives care to Medicare beneficiaries and maintains a 97% customer satisfaction rating. I believe the care and service we provide is superior to the care provided by the hospital system.
- 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. The same, if not higher, levels of care are being provided by ASCs as HOPDs. Our main focus is on patient safety; and because we are smaller we are able to enact and uphold effective safety measures. CMS should exclude only those procedures that are on the inpatient only list.
- ASCs should be updated based upon the hospital market basket because this more appropriately reflects inflation in providing surgical services than does the consumer price index. Also, the same relative weights should be used in ASCs and hospital outpatient departments. ASCs are providing the same services at reduced reimbursements.

- 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. In 2005, the Morgan Company documented that Medicare spent $1.1 bilion less for surgical services furnished in ASCs than had such services been preformed in HOPDs. I 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.

I strongly ask that you consider the above concerns and/or issues that I have when debating this proposed rule. If you have any further questions or would like me to explain my position further, please do not hesitate to contact me at (260) 434-2022.

Sincerely,

Anne Haddix, RN
Director of Surgical Services

AH/tmr

SEATTLE SURGERY CENTER

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

Dear Administrator Norwalk:

Seattle Surgery Center is located on the crest of First Hill A.K.A. "Pill Hill" in Seattle Washington between Seattle's two biggest non State hospitals.

The reasons surgeons from these two hospitals bring their patients here is that Seattle Surgery Center has lower infection rates than the hospitals, higher patient satisfactions rates that the hospitals, and faster room turnovers between the surgery cases so the surgeons can be more efficient.

Seattle Surgery Center pays the same high rent as the hospitals, the same high wages to the same nurses as the hospitals, and our building recently raised our parking rates because the hospitals raised their rates.

Since the Seattle Surgery Center is a for profit corporation we pay taxes that the not for profit hospitals are exempted from.

To assure Medicare beneficiaries' access to ASCs, CMS should broadly interpret the budget neutrality provision enacted by Congress. 62% is simply not adequate. Seattle Surgery Center is a hospital without any beds. We should be paid the same rate for the same surgery as a hospital with beds.

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.

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. Why shouldn't all Medicare beneficiaries' have an opportunity to have an outpatient procedure in a safer (lower infection rate) friendlier (higher patient satisfaction) setting?

Respectfully,

David R Weber
Executive Director

PROLIANCE SURGEONS

SEATTLE SURGERY CENTER—PROLIANCE, LLC
900 TERRY AVENUE, THIRD FLOOR
SEATTLE, WA 98104

PHONE 206-382-1021
FAX 206-382-1026
WWW.SEATTLESURGERYCENTER.COM

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Surgery Center of Beaufort

November 3, 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 Administrator Norwalk:

This letter concerns the purposed changes to the payment methodology and other issues for Ambulatory Surgery Center. Please let me identify myself as a concerned physician and one who has been intimately involved with the ambulatory surgery center in my locality. I am a board member, as well as the medical director of our facility. We have been operational for approximately 6 years. We are a multi-specialty ambulatory surgery center, including the specialties of ENT, orthopaedics, jaw surgery, gynecology, oral surgery, gastroenterology, and ophthalmology. We are in partnership with our sole community hospital, with physicians owning 60% and the hospital owning 40%. We are not a freestanding center in opposition to our local hospital.

I am sure you are aware of the many permit issues, which have been presented to you by the ASC Industry Group. The main ones that I am concerned with are as follows: 1) alignment of the ASC and HOPD parent policies, 2) development of an exclusionary list for eligible procedures similar to the HOPD, 3) tying inflationary adjustments to the hospital market basket and not the consumer priced index.

The main issue, as I see it, is the conversion factor that is applied to Ambulatory Surgery Center. At the present time, my understanding is that CMS is purposing a 62% conversion factor. This would mean that Ambulatory Surgery Center would receive 62% for identical procedure that is performed in a hospital Outpatient

Department. It is my understanding, from our research, that if this 62% conversion factor is applied, that the specialties of gastroenterology and ophthalmology will more than likely be money losing procedures in our surgery center. We are a broad-based surgery center, and we do provide services to both Medicare and Medicaid patients, as well as an indigent care program. It is my strong suspicion that if this 62% conversion factor is applied, that we will no longer be able to offer the gastroenterology and ophthalmology procedures at our surgery center, and that these will therefore be shifted to the more expensive setting of our local hospital outpatient department. This will adversely affect our ability to treat Medicare and Medicaid patients in general, and will certainly harm our indigent care program. If this low conversion factor is applied, I think you will have the perverse affect of increasing cost to the Medicare program, as well as to Medicare beneficiaries, and this is again due to the shifting of these patient's to a more expensive health care setting.

I understand the merits of the purposed changes and the Surgery Center agrees that we need to find a way to tie our payment to that of the hospital Outpatient Department. I think it is paramount that a fair conversion factor is agreed upon, and the intent of CMS is to not drive the ambulatory surgery center business out of business. If there are any questions related to points I have brought up, I remain available to discuss these, as I am a very concerned physician, and our surgery center has been a benefit to our local community, and we have the full support of our hospital in our local market.

Thank you for your consideration.

Sincerely,

Kenneth A. Brown, MD

Kenneth A. Brown, M.D.

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MED EL CORPORATION

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

RE: CMS-1506-P, The Hospital Outpatient Prospective Payment System and CY 2007 Payment Rates and the Ambulatory Surgical Center Payment System and CY 2008 Payment Rates

"ASC Conversion Factor"

I am writing to submit public comment on the proposed ruled indicated above on behalf of MED-EL Corporation, one of the world's three cochlear implant manufacturers. I appreciate CMS' willingness to create a more comparable payment system to promote the delivery of quality, health care services performed in ambulatory surgical centers (ASC). As I am sure you are aware, providers often do not consider ASC as a viable option when performing procedures that require use of a high-cost implantable device, due to significant underpayment for the device and the financial loss to the facility. Consequently, cochlear implantation (69930) is rarely performed in the ASC setting because of poor reimbursement for the device. Currently, the cochlear device (L8614) is reimbursed an average payment of $15,500.00 under the DMEPOS fee schedule and since the hospital's acquisition cost for the cochlear device is approximately 68% higher than the payment rate, cochlear implantation is rarely performed in the ASC setting. If CMS' objective is to increase beneficiaries access to outpatient care in the most appropriate setting by eliminating payment differences that influence one outpatient setting over another, the ASC 2008 proposed payment for APC 259 cannot be adopted.

Based on CMS' projected conversion factor and relative weights for 2008, payment for APC 259 under HOPPS is estimated at **$26,078.00**; while payment under the "revised" APC payment system is estimated at **$8,500.00**, a stark difference. Further, the estimated 2008 ASC payment for APC 259 represents an approximate **$9,000.00** decrease from the current payment. If the proposed payment for 2008 is adopted, it will only serve to broaden the gap between cochlear implant procedures performed in ambulatory surgery centers versus hospital outpatient departments. Therefore, further analysis is required for device-dependent procedures, such as cochlear implantation, that result in significant payment differences when compared to payment under the hospital outpatient prospective payment system.

To mitigate this payment shortfall, please consider the following:

1. Use 2005 OPPS claims data to determine device costs for APC 259 when establishing the 2008 ASC payment rate and adjust any device-dependent APC with greater than 50% disparity in payment between the ASC and HOPPS payment systems.

MED-EL CORPORATION • 2222 E. HWY 54, SUITE B-180 • DURHAM • NORTH CAROLINA • 27713 USA
TOLL FREE 1-888-MED-EL-CI (633-3524) V/TDD • PHONE (919) 572-2222 • FAX (919) 484-9229
EMAIL: implants@medelus.com • www.medel.com

2. Require mandatory use of device codes for device-dependent APCs to ensure greater accuracy in device costs.
3. Veto the proposed 2008 ASC payment methodology that calculates payment based on use of a 50/50 payment blend. This methodology is flawed in that it does not consider the facility's "fixed" cost for the device, which represents greater than 85% of the total procedure cost. Instead, CMS should employ a methodology that determines payment based on the OPPS payment rate, adjusted by a reasonable percentage to account for the difference in operating costs. Since the cost for the device is a fixed amount, regardless of the site of the service, special consideration should be granted to device-dependent APCs such as cochlear implants. Otherwise, the ASC site of service for APC 259 will be of no use.

MED-EL Corporation welcomes the opportunity to work with CMS and other stakeholder groups to develop a more equitable payment methodology for device-dependent APCs (with device costs greater than 85% of total procedure costs) paid under the ASC payment system, to allow Medicare beneficiaries' greater access to cochlear implants.

Sincerely,

Barbara Carter
MED-EL Corporation

MED-EL CORPORATION • 2222 E. HWY 54, SUITE B-180 • DURHAM • NORTH CAROLINA • 27713 USA
TOLL FREE 1-888-MED-EL-CI (633-3524) V/TDD • PHONE (919) 572-2222 • FAX (919) 484-9229
EMAIL: implants@medelus.com • www.medel.com

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CITRUS SURGICAL CENTER

2861 SOUTH DELANEY AVENUE, SUITE B • ORLANDO, FLORIDA 32806
TELEPHONE (407) 472-5095 • FAX (407) 999-2226

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

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

Dear Ms. Norwalk:

I am a Gastroenterologist in private practice in Orlando, Florida. I currently work at Citrus/Central Florida Surgery Center, where approximately 27% of my patients are Medicare beneficiaries. I appreciate the opportunity to submit the following comments to the Centers for Medicare and Medicaid Services ("CMS") proposed refinements to the ambulatory surgical center ("ASC") payment system for calendar year 2008.

I am concerned that the revised ASC payment system, if finalized as proposed, would have a detrimental effect on my ability to continue providing care to Medicare beneficiaries. Several provisions in the proposed rule seem to promote a policy that favors the hospital outpatient department ("HOPD") at the expense of fair competition from ASCs and may actually increase Medicare spending. The rule, as it is announced, disproportionately impacts two specialties negatively. These two specialties are gastroenterology and pain management. CMS proposes to reimburse ASC procedures at 62% of the HOPD rate for the same procedure. This arbitrary percentage will lower ASC payments for gastroenterology procedures overall by approximately 30%. This severe cut would detrimentally affect the ability of a single-specialty GI ASC to continue providing care to Medicare beneficiaries.

I have seen Medicare reimbursement for ASC procedures hold steady for several years while HOPD payment rates have increased. During that period of time, our costs for personnel and equipment have escalated just as they have at hospitals. It is unclear whether I would be able to continue providing such services if the payment rate were reduced to 62% of the HOPD rate for the same service. This could force Medicare beneficiaries to seek care from the hospitals, where costs are typically higher and patient satisfaction is lower. I believe that Congress and President Bush wish to promote a level playing field between HOPDs and ASCs in order to foster greater competition and lower costs. CMS should not drive ASCs out of the Medicare business, increasing Medicare spending in the process and reducing access to necessary care.

CMS proposes to add 750 procedures to the list of ASC-covered procedures. While I welcome this expansion of the list, CMS has not done enough. CMS should create an exclusionary list of non-Medicare reimbursable ASC procedures. With the advancement of technology and safety, many outpatient surgical procedures can be safely effectively performed

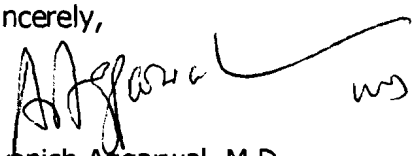
in ASCs, yet are not currently covered by Medicare. Only through the adoption of an exclusionary list will Medicare beneficiaries have full access to multiple settings. This will also serve the ultimate goals of fair competition and lower costs.

CMS proposes to update the payment rates for ASC services annually by the increase in the consumer price index, while HOPD rates would continue to be updated by the hospital market basket. The consumer price index is not an accurate reflection of the annual increase in health care costs. In a few short years, the CMS proposed update for ASCs would create a system where ASC payments rates were significantly underpaid compared with their HOPD counterpart. Patients would be forced to seek care at the hospital due to the lack of a viable, less-costly alternative. This would significantly reduce beneficiary access to care and greatly increase Medicare spending.

I provide outpatient surgical services to hundreds of patients at an ASC because it is an efficient, convenient, and responsive venue for me to provide better care for my patients. I believe that Medicare beneficiaries choose to receive care in an ASC because of their convenience, higher quality and lower costs than hospitals. I appreciate CMS' consideration of my comments and hope that you recognize the value ASCs provide to Medicare beneficiaries and the Medicare Program.

I am happy to answer any questions you may have regarding my comments. I can be reached at 813-872-9310.

Sincerely,



Avanish Aggarwal, M.D.