HEALTHSOUTH
Surgery Center of B.R.A.S.S.

146

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

Dear Sir or Madam:

The physicians and staff of our multispecialty ambulatory surgery center have served the Baton Rouge Metropolitan Area for more than 25 years. As the first ASC in this area, we have had the privilege of providing top quality outpatient surgical services to more than 75,000 residents of this community with a record of safety, efficiency and top notch clinical care which would be the envy of any hospital setting. We serve more than 3500 patients annually.

We have witnessed the growth of ambulatory procedures throughout these three decades as surgeons have continued to pursue performing ever greater numbers of procedures which have been tested and proven to be safe for their patients, and in response to patient demands for more convenient, responsive surgical care which allowed them to return to home and family as soon as they were medically able. We have an outstanding safety record and have consistently recorded far lower infection rates than occur in hospital settings. Our patient satisfaction ratings consistently exceed averages for the ASC healthcare industry. We believe the freestanding ambulatory surgery facility is a highly desirable model for providing outpatient surgery to CMS patients which needs to be encouraged and supported for the results it has produced and for the cost savings it offers for the CMS program.

We write today to voice our comments regarding the proposed new CMS rule to create a new ASC payment system. While we laud efforts to update the existing ASC payment system which has been far too long ignored, we have very serious concerns over the proposed new payment system and would like to bring these concerns to your attention.

1) **The proposed rule fails to tackle the problem of maintaining budget neutrality in a comprehensive fashion, wherein all expenditures for Medicare outpatient surgical services are considered** . Outpatient surgical services continue to constantly evolve as a safe, practical alternative to overnight inpatient care. Freestanding ambulatory surgery centers must be allowed the opportunity to expand in the proportionate volume of CMS outpatient patients they serve because they offer a more cost effective delivery model which patients and surgeons have shown they endorse. We have seen many hospitals acknowledge this evolving growth trend, as they open their own freestanding centers in response to crowded hospital surgical departments, unending, unplanned delays and the surgeon and patient attrition which always results. Why are the hospitals choosing to own and construct their own freestanding ASC facilities? **It is precisely because they know the setting is SAFE, the model is more efficient and cost effective and is what patients and physicians find more desirable**. CMS must abandon its **artificial** budget construct of trying to maintain the overall same level of payments to ASC's without considering its expenditure levels in hospital based outpatient surgery. CMS must approach development of an equitable ASC payment system recognizing the flow of procedures away from hospital outpatient settings is a continuing process for many valid reasons. The total expenditures on outpatient surgery should be the basis of any budget neutral payment proposal. If not, hospitals will continue to hold on to Medicare budget dollars for outpatient services which patients are rejecting in favor of freestanding ASC alternatives. To base a new payment system on a decision to maintain the historical distribution of expenditures between hospital outpatient and freestanding ambulatory treatment alternatives is shortsighted and fails to acknowledge the validity of the reasons why the ASC service delivery model has succeeded and can offer even more advantages to CMS patients if allowed to grow. .

2) **The ASC payment rule continues to utilize a proposed listing of PERMITTED PROCEDURES which is not sufficiently extensive and reflective of the level of complexity of outpatient procedures which are routinely, safely performed by ASC's on their patients with non-Medicare insurance coverage.** CMS moreover ,proposes to allow many procedures currently performed in offices to move to the ASC for the same office reimbursement fee. This is of course redundant logic in reversing the trend of moving care to the least expensive SAFE setting. If those procedures were safe in an office before now, why try to encourage their movement back to an ASC? Why not move them back to a hospital? Of course this would wreak havoc on hospital overcrowding and would be contrary to logic. Similarly, to offer to " allow" office procedures to return to the ASC at office rates does nothing to promote ASC's as it only injects greater volumes of low or "no " margin cases where costs have been frozen for years.

We have long favored the abandonment of the CMS PERMITTED listing. Why have insurance carriers consistently recognized far more reimbursed procedures in their managed care contracts with ASC's? They know safety precautions are not the true concern, as accredited, licensed ASC facilities can safely triage the patients they treat. The reason is they are forced by sound business principles to consider avoiding UNNECESSARY COSTS when selecting a safe surgical venue. CMS should recognize **cost savings are readily achievable while maintaining patient safety by more fully using the ASC outpatient setting**. The PERMITTED LIST is again another arbitrary mechanism to maintain the status quo of procedures historically performed in hospitals. **Every procedure which is relegated to the hospital, simply due to the Medicare coverage of the patient and NOT THE ACTUAL HEALTH STATUS OF THAT PATIENT is an arbitrary decision to spend more dollars when this is not always justified. Health Status as evaluated by the physician should more directly influence where the patient may be admitted for treatment.** Simply because the patient qualifies for MEDICARE COVERAGE should not LUMP ALL MEDICARE patients into a high risk category for every outpatient surgical procedure. This is totally at odds with the truth .Many older patients are far more healthy than younger patients routinely handled in an ASC .Why can't CMS allow greater physician discretion to evaluate their own patient and choose where procedures can safely be performed? If any list is to be utilized, then publish a list of WHAT PROCEDURES CANNOT BE DONE ON ANY MEDICARE PATIENT FOR SAFETY REASONS and allow physicians more latitude to treat healthy candidates in an ASC.

3)The proposed payment system must include provisions to reimburse ASC facilities for implant costs as hospital outpatient facilities receive. As prosthetics evolve in the frequency they are used to replace injured joints, bones, breasts lost to cancer, and cataract filled eyes among a constantly evolving list of technology available to ease pain, disease and injury, ASC's cannot be expected to absorb the cost of the implants within a fee structure much smaller than that received by the hospital outpatient center. Our facility has more than a few times been forced to pay 1500-2000 for the implants used for a medicare patient which far exceeded the fee paid to the facility for the procedure. This is another unfair arbitrary determination to penalize the ASC in favor of hospital based treatment of the same patient. We have witnessed hospital owned freestanding surgery centers refuse to treat these Medicare cases and refer them to the hospital. What better evidence can be provided that this is simply a punitive provision designed to maintain patient flow to the hospital?

4) The ASC payment system must remain proportionate to the payment system used for hospitals. We have endured years of frozen payment levels from CMS while costs have risen greatly throughout the healthcare industry. When a payment system is finally created it should be rooted in the same mechanism for updating cost increases to the hospital outpatient surgery sector. It must not allow disparity in rates of payment to increase each year by virtue of using differing means to update the reimbursements to each. Permitting hospital outpatient rates to update at higher annual percentage rates will rapidly escalate the rates paid in that setting compared to the ASC. Not only is this another unfair attempt to favor the hospital based setting over time, but there is no logic to using different rates

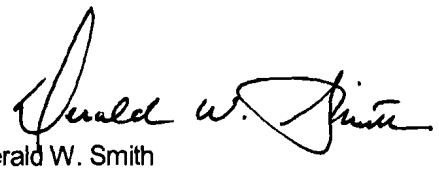
of increase when both pay the same expenses .ASC's compete for nurses and pay supply expenses equal to or greater than hospital day surgery. The mechanism to update payments must be the same for both.

We believe CMS must realize the valuable role that ASC's perform in caring for their patients in a safe, efficient, highly caring setting. The opportunities to provide the many ASC's that proudly serve the CMS patient population with the adequate means to do so is now at hand and must seriously be examined. We urge the arbitrary and unfair measures we have identified be addressed in revisions to the proposed rule for a new ASC payment system. We must have serious improvements to our CMS rates to continue to perform a vital role in the care system serving CMS. CMS must truly use this opportunity to maximize the return on its budgeted dollar by permitting ASC's to serve more CMS patients with the expectation of receiving a reasonable, fair reimbursement of its services as compared to hospital outpatient treatment rates.

The proposed Regulation as drafted will not address our vital concerns. We urge revisions to address the issues we have identified. We would welcome the opportunity to respond to any specific questions you desire to raise in response to these comments.

We thank you for the opportunity to have our concerns be heard.

Sincerely,



Derald W. Smith
BRASS SURGERY CENTER
ADMINISTRATOR

HEALTHSOUTH
Surgery Center of Wauwatosa

147

November 1, 2006

Centers for Medicare and Medicaid Services
Department of Health and Human Resources
Attention: CMS-4125-P
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

Dear Sirs,

I am the administrator of the Wauwatosa Surgery Center in Wauwatosa, WI. This letter is in regard to the CMS proposed rule on the new ASC payment system. My facility is a small one which serves the public with high quality care for lower cost both to Medicare and to Medicare beneficiaries.

This period of time before the required transition of the current Medicare payment system to the new payment system by 2008 gives all ASCs an opportunity to be the competitive alternative to the more expensive outpatient hospital departments.

I and ASCs as a whole support moving to the Hospital Outpatient Payment System. The six year payment freeze for ASC payments and other reductions resulted in significantly lower payments to ASCs compared to identical outpatient hospital surgical services which did not have freezes or reductions during the same time period. In fact, they have had significant increases which widened the gap even more. The new proposed rule states that ASCs should be paid at only 62% of HOPD for providing identical surgical services. The cuts that are proposed will result in significant decreases to many commonly performed procedures in ASCs.

I am suggesting that CMS adopt an expansive and realistic interpretation of budget neutrality that examines total Medicare spending on outpatient surgery. The ASC industry is working with respected Medicare payment experts in order to provide CMS with an analysis of the impact on ASCs, CMS and Medicare beneficiaries. I believe the results will show a need to go beyond the 62% of HOPD.

There is a need to create an exclusionary list for ASC services. Only ASCs are tied to a list of permitted procedures. CMS failed to include many higher complexity procedures that have been performed at ASCs for many years. CMS is losing an opportunity to increase patient choice and should rely on the judgment of the surgeon.

10900 W. Potter Road • Wauwatosa, WI 53226-3424 • 414 774-9227 • Fax 414 774-0957

As an administrator of an ASC, I see inflationary hits to supplies, services and payroll on a regular basis. ASCs and HOPDs experience the same inflation, however, the CMS proposal does not take this into account with the different method of updating payments between ASCs and HOPDs. I take pride in hiring experienced and qualified Registered Nurses and support staff. In order to retain quality staff and maintain quality supplies and equipment, ASCs should see the same methodology for determining payment updates as do the outpatient hospital departments. Using differing methods will only increase the disparity in payments.

The CMS proposed rule continues to treat ASCs and HOPDs differently. I would like to see this turned around and eliminated. For example, prosthetic implants are added in such a manner that HOPDs are reimbursed at rates that cover the cost of the implant. ASC payments should be set at similar levels to allow for full reimbursement of these implants. This would make it possible for Medicare beneficiaries to have procedures in ASCs for those procedures requiring prosthetic implants. This in turn will be cost efficient for both Medicare and Medicare beneficiaries. Otherwise it seems that many procedures which can and have been routinely done in an ASC for years will not be available to Medicare beneficiaries due to the payments remaining below cost and in turn Medicare will be paying higher amounts to HOPDs.

All ASC facilities like mine look forward to the positive changes in Medicare reimbursements. We respect our patients and their needs. We desire the changes that will improve their choices for quality care in settings such as ours. In conclusion, my facility and other ASCs provide safe, high quality, low cost care and we welcome the chance to provide expanded services to our Medicare patients.

Thank you for considering the above mentioned points.

Sincerely,

Cathy L. Logue

Cathy L. Logue
Administrator
Wauwatosa Surgery Center

HEALTHSOUTH
Surgery Center of Sarasota

148

11-3-06

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

To Whom It May Concern:

I am writing this letter on behalf of the HealthSouth Surgery Center of Sarasota as the facility administrator. I have been in my position for less than a year. I have learned these last few months, that my surgery center and the employees, patients and doctors that use the facility may be adversely affected by the proposed CMS ruling for ASC payment. I am discouraged by what this means for the future survival of this facility because at this time, competition for doctors and cases with other ASCs and HOPDs in this area of Florida has intensified dramatically as our community grows and demands more of these outpatient services. Our facility has struggled over the last few years to continue to provide the same multispecialty focus for outpatient surgery although expenses continue to incline (implants and prosthetics) and competition with other ASCs and HOPDs demands paying higher wages to our employees to retain them. In addition, the expense of upgrading technology or maintaining aged equipment is unavoidable.

Despite the reality of this scenario, 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. This will result in a full percentage differential each year. Over time, the disparity in payments will create deeper divisions between prices paid in the ASC and HOPD without any evidence that different payment rates are warranted. I have spent much time this year going out into the medical community, marketing to surgeons to use our center. Recently, my discussions with the medical professional community have included this CMS rule. Surgeons who prefer working in the ASC are discouraged from becoming likely investors in limited partnership arrangements when the mix of services offered are close to 70% Medicare and will become limited in reimbursement by this new proposal. This would be an enormous roadblock to centers like ours that are attempting resyndication as a means to bring in more surgeons and their patients and sustain the interest of our surgery center against the enormous challenges that already exist in this market.

The CMS proposed rule continues to treat HOPD and ASCs differently in certain key respects. These differences should be eliminated and ASCs and HOPD payments made

HEALTHSOUTH
Surgery Center of Sarasota

on the same basis. For example, as I mentioned above, implants and prosthetic expense continues to erode reimbursement to the surgery center. These are bundled in HOPD payments as rates that allow a full pass through of the implant cost. Payment levels for ASCs should be set at similar levels to allow full reimbursement for implant costs. (ei: whatever discount factor is used to determine ASC payments relative to HOPD should not apply to the portion of the payment related to implant cost). Otherwise, many procedures that could be safely performed in an ASC more conveniently for patients and at less cost to the Medicare program will not be available because payments will remain below cost.

In conclusion, the ASCs provide patients with high-quality, convenient and less expensive option for their outpatient surgery. When Medicare beneficiaries choose ASCs for their outpatient surgery, they and Medicare save money. CMS can help Medicare and beneficiaries save money by making ASCs a viable, competitive alternative to outpatient hospitals by fixing the payment system in a logical, realistic methodology that recognizes the benefits of its outcome.

Sincerely,

Christine H. Orsini RN, BSN, ONC
Administrator
HeathSouth Surgery Center of Sarasota

Metro Anesthesia
Pain Management

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1479

November 3, 2006

Centers for Medicare and Medicaid Services
Department of Health and Human Resources
Attn: CMS-4125-P
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

Dear Sir or Madam:

My name is Dr. Clay Ransdell. I am an anesthesiologist and pain management physician practicing in Des Moines, Iowa. The CMS Proposed Ruling is of great importance to me as it impacts the livelihood of my practice.

The majority of my pain patients are treated at Surgery Center of Des Moines. I have chosen to treat my patients in an ASC environment due to the fact that the surgery center consistently provides my patients with high-quality care in a convenient and less expensive center. My patients, many of whom happen to be Medicare beneficiaries, choose the ASC for their outpatient surgery, both Medicare and the patient save money. The patient is happy, I am happy and the payor saves money.

I do not want to see this opportunity diminish due to the proposed decrease in the rate changes with my pain procedures. The Surgery Center is a well established option to the HOPD's. I want to continue utilizing their services and do not want to take my patients to the HOPD's in the market.

I feel the differences should be eliminated and ASC's payments should be made on the same basis as HOPD's. An ASC can perform the same exact service that the HOPD performs and therefore it is my belief payment structure should reflect the services rendered on a more parallel level. With the proposal as it currently stands, this is not the case. Therefore, without change, many of the procedures I perform will be re-routed to a less convenient more costly HOPD. I am strongly opposed to this outcome.

Thank you for allowing me to express my views and contribute my thoughts on the proposed ruling. I am anxiously awaiting the final ruling and am hopeful it will be favorable to the beneficiaries, CMS and Medicare as well as ASCs and HOPD's. There is certainly a need for each of these entities in our aging market.

Respectfully submitted,

Clay E. Randsell, DO

Indian River Surgery Center

150

Thursday, 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

Dear Ms. Norwalk:

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

This letter is written to express dismay and disappointment in the proposed CMS rules for allotting payments to the Ambulatory Surgery Centers (ASCs). The new rules would, in effect, place the ASCs in a significantly less competitive position and paradoxically increase the costs to Medicare/Medicaid as it gives incentives for participants to utilize the more expensive Hospital setting.

There is an increase in the allowed number of procedures for the ASCs but at the substantially reduced rate of 62% of the Hospital Outpatient Department rates for the same services. If an exclusionary list were to be implemented between the two settings, more equitable distribution of both services and payments could be the result. As it stands, the gap in the payment structures forces the ASCs to focus on the best paying and least costly procedures to the detriment of the patient and the CMS in the long term. It is unlikely that the ASC will continue to provide the necessary services that patients have grown to expect for below cost.

As time moves forward, it becomes increasingly clear that the ASC setting provides a safe and cost effective alternative to the Hospital Outpatient setting. It would be a shame to force the ASCs to restrict their role in their respective communities for lack of an even playing field. We respectfully submit to you that it is time to reconsider the proposed CMS rule changes.

Thank you for your time and attention to this matter.

Albert Morgan, MD
Medical Director, IRSC

Barbara Narenkivicius, RN
Administrator

1200 37th Street Vero Beach, Florida 32960 (772) 770-5600 Fax (772) 770-1793

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November 3, 2006

Centers for Medicare and Medicaid Services
Department of Health and Human Resources
Attn: CMS-4125-P
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

Dear Sir or Madam:

As an anesthesiologist and pain management physician practicing in Des Moines, Iowa, and the CMS Proposed Ruling is of great importance to me.

More than 80% of my pain patients are treated at Surgery Center of Des Moines. I have worked with the center for the past ten years. Why? It's simple; center consistently provides my patients with high-quality care in a convenient and less expensive environment. The surgery center is a cost effective means which not only saves my patients money but also saves Medicare money. My patients are comfortable in the center, I enjoy a competent staff, quick turn over times and an efficient system and payor saves money.

I do not want to change the way in which I practice. If the proposed decrease in the ASC rates occurs, I will be forced to look at other options. The Surgery Center has been in the market for 25 years, has a stellar reputation as is truly a viable option to the HOPD's. It is my desire to continue my long standing relationship.

An ASC can perform the same service as the HOPD performs and therefore it is my opinion the payment structure should reflect the services rendered equally. I am strongly opposed to this the 62% HOPD rate as it impacts pain in that it not permit the surgery centers to continue to accommodate my cases without a tremendous loss.

Thank you for allowing me to express my views on the proposed ruling. I am anxiously awaiting the final ruling and am hopeful it will be favorable to the beneficiaries, CMS and Medicare as well as ASCs and HOPD's.

Sincerely,

Daniel J. Baldi DO

Daniel J. Baldi, DO

October 31, 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 VP of Operations for Ambulatory Surgical Centers of America (ASCOA), I oversee the operations of 4 multispecialty surgery centers located in FL, MA, PA, and MD. CMS-1506-P will have a significant negative impact on the operations of these centers. The physicians who work in my centers do so because they believe in the concept of patients receiving the highest level of care for less money than would be spent if the service was provided in a hospital setting. They are involved in the decisions that affect the care of their patients, and they appreciate the efficiency demonstrated by the surgery center staff. Spending is carefully monitored, both for staffing and supplies, so no money is wasted.

In the past, reimbursement methodologies have not been equitable for the same services provided in Hospital Outpatient Departments (HOPDs) and Ambulatory Surgery Centers (ASCs). We charge using global fees, and we are paid according to Medicare groupers. There is no reimbursement for implants, and in 3 of my centers, we do a lot of orthopedics, using expensive implants. These are considered standard of care, yet we cannot be paid for them. We also cannot charge for the use of fluoroscopy, and the equipment alone costs over $100,000 to purchase. C-arms are used for pain management and orthopedics, and hospitals are reimbursed for fluoroscopy procedures.

I strongly support a payment system that would align payments equitably and reduce the choice of site of service based on reimbursement amounts. I am favor of:

- Reimbursement for any procedures that are not included on the inpatient-only list. HOPDs are currently eligible for payments for these cases.
- Payment for CPT codes that are not specific and hence "unlisted". HOPDs are currently reimbursed for these; ASCs are not.
- Payment for services provided in addition to the procedure, i.e. fluoroscopy, labs. HOPDs are reimbursed for these services; ASCs are not.

- Eliminating the proposed ASC payment based on office-based physician payments. This limitation does not apply to HOPDs.
- Updating the annual increases using the hospital market basket, not the CPI for all urban consumers, as proposed for ASCs. The increases should be based on the same factors.
- Eliminating the proposal for a secondary recalibration for revised cost data each year. The current proposal calls for a secondary recalibration for ASCs, which will result in a cumulative variation between HOPDs and ASCs.
- ASCs should receive all eligible new technology pass-through payments, as currently reimbursed to HOPDs.
- Allow the use of the same forms for filing claims in both the ASC and HOPD settings. Commercial payers require claims to be filed using the UB-92, and I believe Medicare should do the same.

ASC patients should have the ability to have care provided in the location they desire, and especially in sites that have lower costs for the patients. With the proposed regulations, access may be restricted, as the reimbursement will not cover the cost of performing the procedures.

Costs of providing services in the ASCs have continued to rise, yet reimbursements have been frozen for several years. A significant factor that affects both ASCs and HOPDs has been the nursing shortage. It is difficult to attract nurses and surgical technicians, and salary costs have risen significantly. When reimbursement rates are set differently, the cost of hiring clinical employees does not change. Thus, the impact on ASCs is serious.

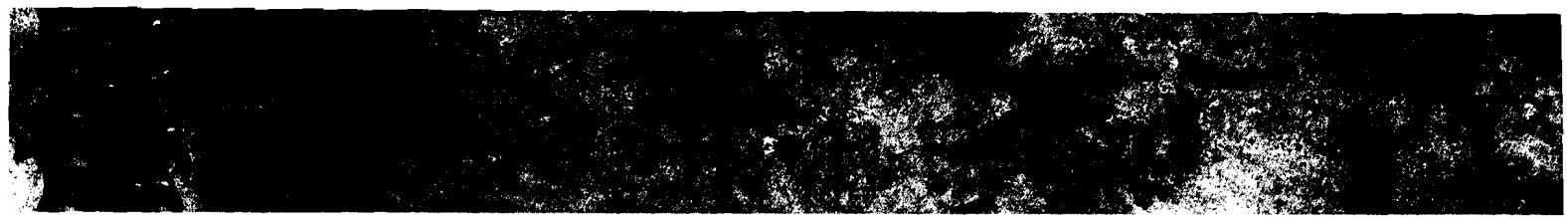
The physicians utilizing my centers are already concerned with the proposed rule and are considering shifting cases back to the hospital. They are angry about this, as they feel that the decision on where to perform cases should be theirs and the patients' – not the government's. By paying the ASCs less than the cost of performing the procedure, they will be forced to make that decision.

Please consider my concerns. This is so important to the patients, the physicians, and to the ASCs. If you need more information, or if you have any questions, please contact me at 843-216-2432 VM or 843-303-0008. I would be pleased to speak with you about this important issue.

Respectfully,

Ann Geier

Ann Geier, RN, MS, CNOR, CASC
VP of Operations
ASCOA
22 Frogmore Road
Mt. Pleasant, SC 29464-6651



Spinal Diagnostics, PLLC
nterventional Pain Management & Diagnosis

Arthur S. Watanabe, M.D.
Medical Director

153

Friday, November 03, 2006

Centers for Medicare & Medicaid Services
Department of Health & Human Services
ATTN: CMS-1506-P or CMS-4125-P
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

Dear Sirs:

This is to express my concern and disappointment in the recent reimbursement cuts to physicians and increases to hospitals.

1. I am a physician in solo practice with six employees and a large overhead. I provide personalized care to my Medicare patients which represent 70% of my patient population. I am an interventional pain physician and my work significantly and in many cases dramatically improve the quality of my Medicare patients with various causes of back pain. Your cuts will hurt me severely and could jeopardize my practice which is financed heavily by bank loans.
2. Medicare rewards the inefficiency and bureaucracy of hospitals by increasing their outpatient reimbursement fees. This is unfair. Hospitals are increasingly impersonal and have excessive costs for visits and procedures and tests which can be performed at lower cost in outpatient office. I fail to understand why Medicare rewards inefficiency and punishes solo practice physicians.
3. Corporate practices of medicine with large physician groups are able to absorb the costs of you cuts without threatening the viability of their business. Many corporate practices of medicine and large doctor groups based on business decisions limit Medicare access to their services. Solo practicing physicians such as my self rarely behave in such an antisocial manner towards our elderly.

It is beyond me why Medicare rewards the big, bureaucratic and inefficient hospitals and corporate practices of medicine. Medicare should reward efficiency and physicians who can save money for Medicare by providing services in their offices.

Respectfully yours,

Arthur S. Watanabe, M.D., Pharm.D.

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Spinal Diagnostics, PLLC
Interventional Pain Management & Diagnosis

Arthur S. Watanabe, M.D.
Medical Director

Friday, November 03, 2006

153

Dana (2)
Jean
Alberta

Centers for Medicare & Medicaid Services
Department of Health & Human Services
ATTN: CMS-1506-P or CMS-4125-P
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

Dear Sirs:

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It is beyond me why Medicare rewards the big, bureaucratic and inefficient hospitals and corporate practices of medicine. Medicare should reward efficiency and physicians who can save money for Medicare by providing services in their offices.

Respectfully yours,

Arthur S. Watanabe, M.D., Pharm.D.

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153

November 3, 2006

2006 NOV -6 PM 2:27

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 Ave, SW
Washington, DC 20201

To Whom It May Concern:

RE: Reform of CMS Ambulatory Surgery Center payment structures

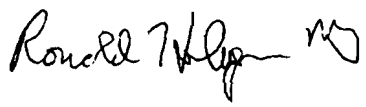
As a medical director of an ASC, I have been following the CMS reimbursement reform for ASC quite closely. It is my understanding that ambulatory surgery center reimbursements will be based as a percentage of those reimbursements established for HOPDs. It seems as though the current discussion is to set that rate at approximately 62% of HOPDs, however this does not adequately cover the cost and expenditures incurred in an ASC. It also seems reasonable that ASC reimbursement updates should be based on a hospital market basket as opposed to the consumer price index because the hospital market basket more appropriately reflects inflationary changes and expenditures and cost providing surgical services. If HOPDs are to be the standard on which to base reimbursements, it seems only fair that the same relative weights should be used in the ASC reimbursement structure as those used in HOPDs.

Another benefit aligning the payment structures between the ASCs and HOPDs will be the ability to more adequately evaluate outpatient surgical services for Medicare beneficiaries because there will be transparency of both the cost and quality data used to evaluate patient outcomes.

Finally, major reform regarding reimbursements to ASCs is imperative, it is also, in my opinion, that the list of surgical services that can be provided at ASCs is much too limited. The ambulatory surgery procedure list should include any and all procedures that can be performed in a hospital outpatient department. Procedures should be excluded from the list only if they are on the hospital inpatient services list.

As a medical director of an ASC, I'm looking forward to improvement in the payment and reimbursement structures of ASCs. However, I do think that if the new system is to work there must be adequate parity between the ASC and the HOPD.

Sincerely yours,



Ronald Holweger, MD
Medical Director

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HEALTHSOUTH

October 23, 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 Surgical Center of Elizabethtown. I have been an employee here for 18 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 that 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 performed 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 the 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 the 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.

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 care 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.

108 Financial Drive • Elizabethtown, KY 42701
270-737-5200
robin.boles@healthsouth.com

There are additional benefits such as a free standing out-patient surgical facility 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.

I am enclosing a picture of our facility inside and out. This will show you that 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 and 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.

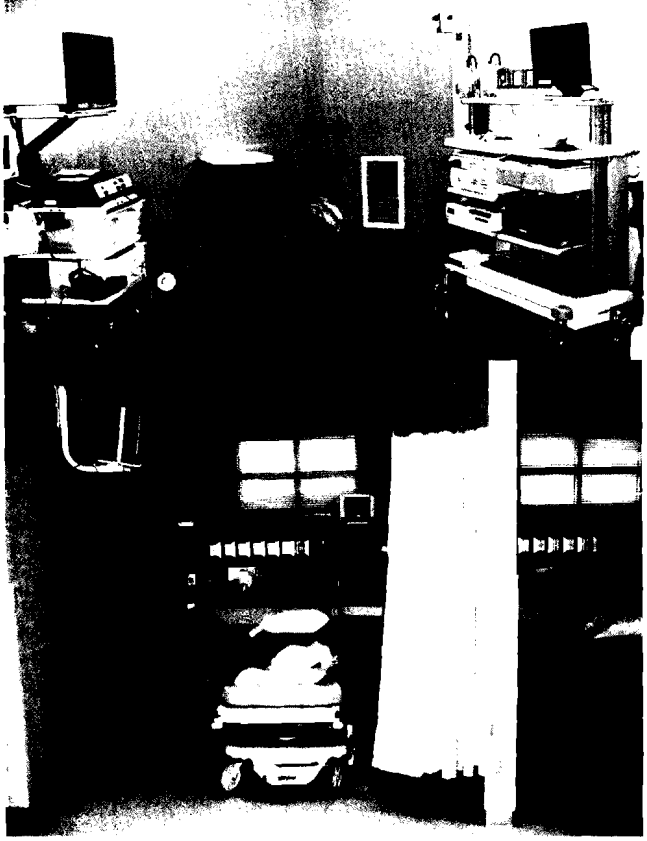
Sincerely,

Robin Boles

Robin Boles
Administrator

Center first opened in 1983. Relocated to a larger building in 2004. The center has provided surgical and special procedure services to over 70,000 patients. The center employs directly and indirectly approximately 60 people. 47 physicians participate in the limited partnership. The center is licensed by the state and maintains Joint Commission Accreditation.

One of 5 operating rooms in the center. It boasts ceiling mounted state of the art equipment enabling physicians to perform GYN, Orthopedic, General Surgery, Urology, Otolaryngology, Podiatry, Oral, Ophthalmology, and Plastic surgery as well as pain management services.



One of two special procedure rooms. Procedures performed include upper and lower gastroenterology procedures.

One of 23 bays provided for patient pre-op and post-op care. The bays were located with nursing care and ease of patient access of up-most importance.

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Telephone (270) 737-5200 E-mail Robin.boles@healthsouth.com

WOMEN'S WELLNESS CENTER

PROFESSIONAL ASSOCIATION

2950 Village Drive
Fayetteville, North Carolina 28304
Telephone (910) 323-3301 • (910) 483-1400
Fax (910) 323-4207

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Arnold B. Barefoot, Jr. M.D.
Gerianne C. Geszler, M.D.
Stuart H. Jordan, M.D.

R. Earl Meeks, M.D.
Anessa J. Lewis, M.D.
Wendy P. Jones, M.D.

October 31, 2006

Centers for Medicare and Medicaid Services
Department of Health and Human Resources
Attn: CMS-4125-P
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

Re: CMS proposed rulings affecting ambulatory surgery centers

To Whom It May Concern:

Excellent care to every patient is the current mission statement of our local ambulatory surgery center. We (OB/GYN physicians) understand that when Medicare beneficiaries choose Fayetteville Ambulatory Surgery Center, they receive exemplary care while Medicare saves money.

The six year payment freeze to ambulatory surgery centers is threatening to close the open door policy that our local center provides to Medicare, Medicaid and Tri-Care and indigent patients.

In our own specialty, laparoscopic procedures are valued 400% more at our local hospital outpatient care center as compared to the same procedure being performed more efficiently at our local surgery center. Hysteroscopic procedures are valued 275% more at our local hospital outpatient center as compared to the same procedure being performed at our local surgery center. This represents the discrepancy in (HOPD and ASC) rates.

The current HOPD rates and the proposed increases do not allow our local outpatient surgery center to continue to operate. Please allow physicians to create the exclusionary list for services, don't widen the HOPD/ASC payment gap and create a level playing field for Medicare patients in their choices for surgical services.

Respectfully,

Dr. R. Earl Meeks, M.D.

(continued...)

Dr. Arnold B. Barefoot, Jr., MD

Dr. Stuart H. Jordan, MD

Dr. Anessa J. Lewis, MD

Dr. Gerianne C. Geszler, MD

Dr. Wendy P. Jones, MD

Women's Wellness Center of NC
2950 Village Drive
Fayetteville, NC 28304
(910) 323-3301

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FAYETTEVILLE AMBULATORY SURGERY CENTER
1781 Metromedical Drive
Fayetteville, NC 28304

October 30, 2006

Centers for Medicare and Medicaid Services
Department of Health and Human Resources
Attention: CMS-4125-P Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

Dear Sirs:

I am writing to comment upon the CMS proposed rule regarding the implementation of the new ASC payment system. I am the Administrator and Medical Director of the Fayetteville Ambulatory Surgery Center (FASC) in Fayetteville, NC. This freestanding ambulatory surgery center is a multi-speciality center with approximately 100 physicians on its medical staff representing all surgical specialities. More than 14,000 patients will undergo procedures at FASC in 2006. Approximately 57% of the patients having procedures at FASC are covered by the Medicare, Medicaid, and Tricare programs. Therefore, the proposed rule will have a great impact regarding patient access to and the fiscal viability of our facility.

At the present time, as Medical Director and Administrator of our facility, I am seeing more and more instances where physicians are requesting approval to perform certain procedures at FASC on Medicare, Medicaid, and Tricare patients that we can no longer perform here because the cost of supplies alone for a given procedure are not covered by the reimbursement from those federal programs. An example would be an arthroscopic anterior cruciate ligament repair which is reimbursed by the Medicare program at $510. The average cost of supplies in an ACL repair procedure is in the excess of $1,100 and, if a cadaver tendon is used for the repair, the allograft costs an additional $2,000. Virtually any procedure that requires an implant such as ossicular chain reconstruction, rotator cuff repairs, breast reconstruction following mastectomy for breast cancer, etc. can no longer be performed in freestanding ambulatory surgical facilities because reimbursement for these procedures is inadequate.

In many other cases, physicians call to schedule procedures at FASC and we are unable to do so because the procedure is "not on the ASC list". These procedures are not performed in the physician's office but rather are performed in the outpatient setting at Cape Fear Valley Medical Center (CFVMC), approximately one block from our facility. Because of this, the Medicare program certainly incurs more expense even through the planned procedure is performed by the same physician using identical supplies and equipment on the same patient.

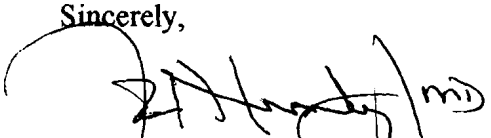
It makes no sense to me that CMS should allow this to occur. I strongly recommend that CMS adopt an expansive realistic interpretation of budget neutrality that examines total Medicare spending on outpatient surgery. In our community, there will definitely be a migration of outpatient procedures from CFVMC to FASC and with a resultant decrease in Medicare costs. It should be noted that CFVMC is a partner in FASC limited partnership.

In addition, CMS and the ASC community must work together to create a means to effectively add significant numbers of procedures that are of higher complexity that have for years been safely and effectively performed in ASC's throughout the country but have not yet been added to the Medicare approved list. A truly exclusionary list for ASC services must be created in a way that allows Medicare, Medicaid, and Tricare patients to have a true choice in where they prefer to have their surgical procedures safely performed.

In most of the larger cities in North Carolina, local hospitals have developed a true freestanding ASC which usually is still reimbursed under Medicare Part A. Ambulatory surgical facilities in North Carolina may only be developed after submitting a certificate of need to the North Carolina Department of Human Resources for approval. Hospital outpatient departments and ASC's are virtually identical in operating at this time in larger urban areas. To recommend that ASC's only receive 62% of the reimbursement currently allowed at HOPD's results in certain procedures not being performed at ASC's because of inadequate reimbursement. It is important to realize that the same supplies, implants, and other resources are used in both places since the procedure is performed by the same surgeon. It is absolutely essential that prosthetic devices and implantable DME should be reimbursed by the Medicare program when used during procedures on Medicare patients. In addition, payment levels for ASC's for these prosthetic devices and implantable DME should allow full reimbursement for their cost. Whatever discount factor is used to determine ASC payments relative to HOPD's should not apply to the portion of payment related to DME cost. In addition, the new rule, when implemented, should ensure that ASC payments are increased annually using the hospital market basket update rather than the general consumer price index as is currently done since the inflation of medical supplies and equipment at ASC's is identical to competitor hospitals. In addition, ASC's compete with hospitals for experienced, well-trained nursing staff espically in the operating room and recovery room areas. I again urge the same inflationary index be used for both ASC's and HOPD's.

I appreciate the effort of CMS in developing a proposed rule that is fair and equitable. The ASC industry has revolutionized surgery in the United States over the last 25 years and fairness requires that Medicare and other federal program patients have reasonable access to ASC's and that reimbursement for those procedures is fair and adequate as well.

Sincerely,



John T. Henley, Jr. MD
Medical Director/Administrator

FAYETTEVILLE
UROLOGY
ASSOCIATES

1786 METROMEDICAL DRIVE
FAYETTEVILLE, N.C. 28304
910-485-8151

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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 Sirs:

I am writing in regards to the recent proposed CMS rule. It is my understanding that this will continue the marked disparity in reimbursements for surgery performed at ambulatory surgery centers and that performed at hospitals. Ambulatory surgery centers have proven to be the most cost-effective site for out-patient surgery. I have performed surgery on hundreds, if not thousands, of my patients at our local surgery center since 1982. My patients uniformly have received a higher level of care than the local hospital has been able to deliver. In addition, the savings to the patient and the insurance carriers have been significant.

Even with the proposed changes, there will be an unjustifiable discrimination against the ambulatory surgery centers. In many cases, reimbursement will be only 60 percent of the hospital payment system. While this is an improvement, it still falls far short of being equitable. In addition, the discrepancy between payments will widen due to inflation. The cost of personnel, medical equipment, medical supplies, and employee benefits will continue to rise just as it will for hospitals. Therefore, any rule changes should be indexed to inflation using the same formula that the hospitals have. I believe this is referred to as the "hospital market basket update." Finally, there are the many surgical procedures excluded from the list of approved procedures for the ambulatory surgery centers. In many cases, this is not based on sound medical principles and should be modified. Only those operations that require in-hospital stay as determined by each surgical specialty's certifying organization should be excluded from the surgery centers.

Thank you for your time and consideration in addressing these issues.

Sincerely,

H. E. Parfitt, M.D., F.A.C.S.

HEP/cpm

Birth & Women's Care, P.A.
OBSTETRICS & GYNECOLOGY
3601 Cape Center Drive
Fayetteville, North Carolina 28304

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October 31, 2006

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

Andre' F. Hall, MD, FACOG
Birth and Women's Care, PA
Obstetricians & Gynecologists
3601 Cape Center Drive
Fayetteville, NC 28304

To whom it may concern:

I am an Obstetrician/Gynecologist in Fayetteville, North Carolina. I have been in practice for 10 years and am writing to request your consideration of a very serious matter.

I currently have surgical privileges at our local hospital, Cape Fear Valley Medical Center and our local ambulatory surgical center, Fayetteville Ambulatory Surgical Center. It is my understanding that CMS over the years have instituted policies that have led to a significant discrepancy in the payment to hospitals and freestanding surgical centers for the same exact procedure. Unfortunately, this has resulted in a large number of procedures that would normally be performed in an outpatient surgical center setting that now have to be performed in the hospital.

Birth & Women's Care, P.A.
OBSTETRICS & GYNECOLOGY
3601 Cape Center Drive
Fayetteville, North Carolina 28304

The unintended results of these policies have been several fold. First, due to the significant lower reimbursement for the same exact procedure, our ambulatory surgical center has been forced to prevent surgeons from performing procedures in which the cost of the equipment and supplies for the surgery is more than the anticipated reimbursement. This increases costs for our patients and is clearly more inconvenient. As a physician as well as a father, I have had the opportunity to utilize both the hospital and ambulatory surgical center outpatient facilities from a physician's standpoint as well as a father of a patient. From a quality of care standpoint as well as from a cost standpoint; I would choose the ambulatory surgical center every time.

Please fix this problem so that I can care for my patients in the setting that they wish to be cared for in. I am asking that you adopt an interpretation of your budget that examines total Medicare spending on outpatient surgery. Second, please do not widen the gap between hospital outpatient payments and ambulatory surgical centers over time. Finally, create a parallel system between hospital outpatient facilities and ambulatory surgical centers that increases not decreases options for our patients. Thank you.

Cordially,

Andre F. Hall, MD, FACOG

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Frank Lancellotti, M.D.
Gastroenterology- Internal Medicine
164 Canal Street
P.O. Box 335
Ellenville, N.Y. 12428

Tel(845)647-1122; Fax(845)647-6654

November 3, 2006

Mark McClellan, M.D.
Centers for Medicare and Medicaid Services
Department of Health & Human Services
Attention: CMS-1506-P
P.O. Box 8014
Baltimore, Maryland 21244-8014

Re: Medicare Program: Ambulatory Surgery Center PPS Proposed Rule

Dear Dr. McClellan:

Although I do endoscopic procedures only in a hospital setting I am writing to tell you that I think you are making a major mistake by cutting reimbursements for these procedures that are done at ASC facilities.

Hospitals at present can not handle all the volume of procedures required and to make it less attractive to have an ASC facility is not a good idea. Also, at present reimbursement rates there is some savings to insurers including CMS when doing the procedures at ASC facilities.

I urge you not to be penny-wise and pound-foolish.

Sincerely,

Frank Lancellotti

Frank Lancellotti, M.D.

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Charles W. Everhart, JR., M.D., F.A.C.G.
Rocco J. Volpe, M.D., F.A.C.P., F.A.C.G.
Joel B. Haight, M.D., F.A.C.P., F.A.C.G.
Juniata Valley Gastroenterology Associates, P.C.
310 Electric Avenue
Lewistown, PA 17044
(717) 242-2531
Fax (717) 242-1028

November 3, 2006

Mark McClellan, M.D.
Centers for Medicare and Medicaid Services
Department of Heath and Human Services
Attn: CMS-1506-P
P.O. Box 8014
Baltimore, Maryland 21244-8014

Dear Mr. McClellan:

I am a private practice physician who treats many Medicare beneficiaries in my practice. I have grave concerns with the recent proposal by the Centers for Medicare and Medicaid Services (CMS) agency to change the way ambulatory surgery centers are paid for their services. Simply stated, the proposal as put forth would quickly result in us failing to remain financially viable in our current situation. We are the only facility of our kind that provides endoscopic services for Mifflin and Juniata Counties and the surrounding area. Besides eliminating 20 jobs from the workforce, the local economy would lose $300-400,000 in benefits. Medicare patients would have the hardship of traveling long distances and longer waits for endoscopic procedures not to mention the non-medicare patients that would also lose access to our services.

Our options would be to 1) close down, 2) stop seeing Medicare patients, or 3) sell our center to the hospital. Obviously, the first two options are unsatisfactory so we will probably sell our Endoscopy Center to the hospital to keep it open and continue to provide endoscopy services to the area. The end result will be that Medicare will be paying higher fees to the hospital than what they are paying us now. Doesn't this sound like a stupid idea?

I hope you have the wisdom to think this through and do the right thing. Cutting fees for medial services will not reduce health care costs. It will just make it harder for us to keep our business viable (all our costs continue to rise) or eventfully backfire. Medical care in the US is the best in the world and an essential national resource. Don't jeopardize the future by putting a band-aid on it today.

Sincerely,

Joel B. Haight, MD

Joel B. Haight, MD
JBH/cc

Gastr enterology Associates, PC

Ronald D. Joseph, M.D. Suzanne M. Daly, M.D. Holly B. Clark, M.D.
Peder J. (P.J.) Pedersen, M.D. D. Brad Trowbridge, M.D. Jason C. Wills, M.D.

October 30, 2006

Mark McClellan, M. D.
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attn: CMS-1506-P
P.O. Box 8014
Baltimore Maryland 21244-8044

Re: Medicare Program:Ambulatory Surgery Centers PPS Proposed Rule

Dear Dr. McClellan:

I am writing to express my deep concern with CMS' recent proposal to change the way the agency pays ambulatory surgery centers for their services.

I am one of six gastroenterologists who currently see a large number of Medicare patients. Unlike many of our contemporaries we have not "opted out" of caring for Medicare patients. Many of our Medicare patients undergo screening colonoscopies for the detection and removal of colon polyps and colon cancer, or surveillance colonoscopy due to their high risk of developing colon cancer due to a history of colon polyps. We also treat a significant number of Medicare patients with conditions such as GI bleeding, gastroesophageal reflux disease (GERD), dysphagia, inflammatory bowel disease, and Barrett's esophagus. Many of these patients will require colonoscopy or upper endoscopy for diagnosis and/or treatment. We perform the vast majority of these procedures in a single specialty ambulatory surgery center. This center is a safe, cost-effective site for GI endoscopy which provides excellent care to patients. It is critical that Medicare patients continue to have ready access to centers such as ours in order to sustain them in good health.

Both the current administration and the private sector insurers have recognized the cost savings of key medical services received in an ASC. The current CMS proposal threatens to severely limit or end Medicare patients receiving endoscopic procedures in an ASC. Under the current schedule of facility fees, performing endoscopic procedures in an ambulatory surgery center rather than a hospital outpatient department saves Medicare 11%--the difference between the 100% HOPD payment vs. and 89% current ASC payment level. The current CMS proposal of 62% HOPD payment of endoscopic

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www.womensdigestivehealth.com

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Salt Lake City, UT 84124-1362
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Gastr enterology Associates, PC

Ronald D. Joseph, M.D. Suzanne M. Daly, M.D. Holly B. Clark, M.D.
Peder J. (P.J.) Pedersen, M.D. D. Brad Trowbridge, M.D. Jason C. Wills, M.D.

procedures performed in ASC is not sustainable. Many ASCs will refuse to see Medicare beneficiaries or limit the number of beneficiaries who undergo endoscopic procedures if the current CMS proposal is adopted. The tragic results will be longer waiting times for endsoscopic procedures due to limited access, unnecessary suffering and deaths from colon cancer and higher costs in the treatment of colon cancer detected at a later stage. It will also result in higher costs to Medicare as a result of these endoscopic procedures moving to hospital outpatient departments from ASCs.

The CMS's proposal will be disastrous not only to the strides made for colon cancer screening by Congress in the Medicare colorectal cancer screening acts, but also to our senior citizens' health. In an environment where the utilization of the Medicare colon cancer screening benefit is poor, this proposal is likely to result in further reduction of this utilization.

MEDPAC has repeatedly endorsed the concept that medical procedures and services should be site neutral. Therefore it makes no sense that there would be such a descrepancy between HOPD and ASC endoscopic procedure reimbursement under the new proposal. The current CMS proposal does not take in consideration the rising costs of caring for patients or the fact that Medicare will save enormous amounts of money when many of the services now provided in HOPDs move to ASCs. This savings to Medicare allows for the reimbursement of endoscopic procedures in ASCs to remain at its current rate. True budget neutrality would weigh the ASC and HOPD costs and allow for higher reimbursement levels at ASCs than currently proposed. Medicare would still come out ahead and provide the medical services our senior citizens deserve.

Thank you for your consideration.
Respectfully,

SMDaly MD

Suzanne M. Daly

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www.womensdigestivehealth.com

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Salt Lake City, UT 84124-1362
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VILLAGE SURGICAL ASSOCIATES, PA.

"A Tradition of Service and Quality Care to the Cape Fear Region"

162

Michael S. Bryant, M.D., FACS
American Board of Surgery
Certified, Critical Care

T. Tommy Chang, M.D.
American Board of Surgery

James A. Classen, M.D., FACS
American Board of Surgery

Leo W. Davidson, M.D., FACS
American Board of Surgery

Joel Horowitz, M.D., FACS
American Board of Surgery
Fellowship, Surgical Oncology

Paul J. Nordness, M.D.

James M. Thomas, M.D., FACS
American Board of Surgery

Teresa McLean
Practice Administrator

Crystal Orrvick, PA-C

October 31 2006
Centers for Medicare and Medicaid Services
Department of Heath and Human Resources
Attention: CMS-4125-P
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

Dear Sirs,

Since the early 1980's, freestanding outpatient ambulatory surgery center (ASCs) have help reduce the overall crowding of hospital surgical services, provide cost effective efficient care, and provided patients with an alternative to hospital ambulatory surgical services. This is evident in the fact that in the early 1980's –1990's many hospitals built their own free standing ambulatory surgical facilities in order to facilitate greater patient surgical flow at the same time creating a more patient-friendly service.

Since 2000 ACSs have been burdened by a reimbursement freeze and in addition the cuts in the Deficit Reduction Act have resulted in much lower payments to ACSs relative to payments made when services are provided in Hospital Outpatient Departments (HOPDs). Since that time HOPDs have appropriately received significant payment updates and relative adjustments to offset the rising fixed costs (qualified staff, supplies, and services just to mention a few). Because of these adjustments HOPDs have remained financially healthy. Unfortunately ACSs have not had that same financial luxury and at the same time handcuffed by static reimbursements.

As a general surgeon my prospective regarding ACSs and HOPDs may be different from the administrative prospective of CMS. From the physicians prospective ACSs provide more efficient effective personalized patient care. Ambulatory surgical care is a specialized subset of all surgical care. ASCs have an opportunity to "fine tune" ambulatory services that may get lost in the quagmire of in patient surgical care. Efficiency in all systems result in cost savings. ASCs in general offer efficiency from both patient and physician perspective

Surgical Care with
Emphasis on:
Bariatric Surgery
Breast Diseases
Stereotactic Biopsy
Breast Conserving Surgery
Critical Care
General Surgery
Laparoscopic Surgery
Anti-Reflux, Nissen
Appendectomy
Cholecystectomy
Diagnostic
Hernia
Pediatric Surgery
Surgical Oncology
Thyroid Surgery
Trauma Surgery
Vascular Surgery
Arterial
Dialysis Access

VILLAGE SURGICAL ASSOCIATES, PA.

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James M. Thomas, M.D., FACS
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Teresa McLean
Practice Administrator

Crystal Ortvick, PA-C

while resulting in an overall cost savings and a preferred choice for both the patient and the physician.

The crux of the matter (in all healthcare arenas) is efficient, safe, cost effective care. This is the overall goal of all healthcare delivery models whether it is private or governmental. Under current law, it is estimated that the Medicare program pay an average of $320 more per case to HOPDs than to the ACSs for the identical surgical procedure, thereby creating a billion dollars worth of additional expense for Medicare. If there is failure to achieve some equalization of payment for ASCs(in comparison to HOPDs) the billion-dollar expense could escalate and the ASCs could be financially forced out of business thus reducing or eliminating the benefits of ASCs from the healthcare delivery model. ACSs fixed costs have increased significantly greater than the consumer price index (CPI) in the last six years. As I'm sure you are aware the medical price index (MPI) is at least 1.5 times the CPI. Thus a mere CPI adjustment to ACSs reimbursements is incongruous to the adjustments afforded to HOPDs.

ACSs provide a parallel service to HOPDs but are disadvantaged by unparalleled imbursements and access to cases. Why CMS has proposed a differential in reimbursements is perplexing. Prosthetics and DME are bundled in payments that allow full pass-through costs for HOPDs. ACSs on the other hand are not are not reimbursed (or allowed pass-through costs) for prosthetics and DME thereby eliminating some services that have long been and routinely can be safely and efficiently provided in an ASC setting. In some instances the DME costs (not reimbursed) greatly exceed the facility reimbursement costs. Therefore many procedures that could be safely performed in an ASC more efficient and convenient for patients and physicians and with less costs to Medicare, are not available.

As my grandfather always said, "complaints without logical solutions are useless". Thus, in conclusion, my recommendations are:

1. Equalization reimbursement schedule for both ACSs and HOPDs
2. Allow pass through cost for prosthetics and DME to ASCs under the same guidelines that HOPDs currently use
3. Create true exclusionary list of ASC service (such as that proposed by Secretary Leavitt in his letter to senator Crapo or in accordance to the proposed suggestions by MedPac)
4. Provide annual updates and relative adjustments to both ASCs and HOPDs to the same magnitude across the board

Surgical Care with Emphasis on:
Bacriatric Surgery
Breast Diseases
Stereotactic Biopsy
Breast Conserving Surgery
Critical Care
General Surgery
Laparoscopic Surgery
Anti-Reflux, Nissen
Appendectomy
Cholecystectomy
Diagnostic
Hernia
Pediatric Surgery
Surgical Oncology
Thyroid Surgery
Trauma Surgery
Vascular Surgery
Arterial
Dialysis Access

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Mailing Address: P.O. Box 64367 • Fayetteville, NC 28306

VILLAGE SURGICAL ASSOCIATES, P.A.

"A Tradition of Service and Quality Care to the Cape Fear Region"

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American Board of Surgery
Certified: Critical Care

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Fellowship: Surgical Oncology

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American Board of Surgery

Teresa McLean
Practice Administrator

Crystal Orrvick, PA-C

With implementation of these solutions in a gradual phase-in approach, Medicare beneficiaries (and other governmental programs) would have enhanced access in a highly qualified and convenient facility in addition to a less expensive option. These cost strategies could potentially equate to billions of dollars of savings in an already 'dollar-strapped' Medicare system.

Thank you for your attention to this matter. If I can clarify any points or provide any additional information please feel free to contact me at your convenience.

Sincerely,

Michael S. Bryant M.D. FACS
Village Surgical Associates
Fayetteville, NC 28304
(910) 829-6565

Surgical Care with
Emphasis on:
Bariatric Surgery
Breast Diseases
Stereotactic Biopsy
Breast Conserving Surgery
Critical Care
General Surgery
Laparoscopic Surgery
Anti-Reflux, Nissen
Appendectomy
Cholecystectomy
Diagnostic
Hernia
Pediatric Surgery
Surgical Oncology
Thyroid Surgery
Trauma Surgery
Vascular Surgery
Arterial
Dialysis Access

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Mailing Address: P.O. Box 64367 • Fayetteville, NC 28306

Richard G. Mitchell, M.D.
Robert E. Mitchell III, M.D.
Gastroenterology

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October 24, 2006

Mark McClellan, MD
Center for Medicare and Medicaid
Attn: CMS-1506-P
PO Box 8014
Baltimore, MD 21244-8014

Dear Dr. McClellan:

Through my professional societies I was informed about the impending cuts regarding payment to ambulatory care centers. These centers provide high quality and efficient care to seniors and require strict accreditation to ensure safety. They are as strict as hospital out-patient endoscopy centers.

Although I do not currently perform endoscopic procedures on Medicare patients at ambulatory centers and do most of them in the hospital setting, I can assure you that these cuts will drive physicians to perform these much needed procedures in the more expensive hospital endoscopy lab or to restrict their care of Medicare patients all together. From an economic and patient care respective, this proposal makes no sense. I hope that you will please reconsider.

Sincerely,

Robert E. Mitchell III, M.D.

REM/tt
F:102906MIII

7605 Forest Avenue, Ste 211 Richmond, VA 23229
Phone (804)282-3114 Fax (804)285-9723

Drexel University College of Medicine
In the tradition of Woman's Medical College of Pennsylvania and Hahnemann Medical College

Division of Gastroenterology and Hepatology

James C. Reynolds, M.D.
Asyia S. Ahmad, M.D.
Harris R. Clearfield, M.D.
Mervyn Danilewitz, M.D.
Barbara B. Frank, M.D.
Julian Katz, M.D.
Joyann A. Kroser, M.D.
Ricardo Morgenstern, M.D.
Sreekant Murthy, Ph.D.

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October 27, 2006

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

RE: MEDICARE PROGRAM:
AMBULATORY SURGERY CENTERS
PPS PROPOSED RULE

Dear Dr. McClellan:

I am a member of an Academic Gastroenterology Unit in Center City, Philadelphia. We see a great number of indigent patients. We do operate an EndoscopicAmbulatory Surgical Center. I am quite concerned about the proposed decrease in reimbursement for the facility fees of GI Ambulatory Surgical Centers because it may well reduce the viability of these units. Should we not have the ability to refer our patients to our ambulatory unit, the delay in scheduling such patients to our hospital endoscopy unit would be severe. We all realize that the frequency of patients canceling procedures increases with the time and delay in obtaining the examination. It will probably be a schedule delay of several months should we have to close our ASC as result of the draconian proposed decrease in facility fees. It should also be clear that the costs for operating and reimbursing our hospital endoscopic unit are significantly greater than our ambulatory unit.

With great concern for our patients and for the ability to schedule patients within a reasonable time and the likely reduction in colon cancer screening that will occur as result of decreased access to hospital units, I would sincerely ask that the proposed cuts not be implemented. The unanticipated effects of decisions like this will adversely change the face of our practice of medicine

With kind regards,

Very truly yours,

Harris R. Clearfield, M.D.

Harris R. Clearfield, M.D.
Professor of Medicine and Section Chief
Division of Gastroenterology
Hahnemann University Hospital

cc: American College of Gastroenterology
6400 Goldsboro Road, Suite 450
Bethesda, MD 20817

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Gastroenterology Associates of Fredericksburg, P.C.
John C. Spivey, M.D.
Frank J. DeTrane, M.D.
Peter W.K. Wong, M.D.

Gastroenterology
and
Internal Medicine

Diplomate
American Boards of
Gastroenterology and
Internal Medicine

October 23, 2006

Mark McClellan, II, M.D.
Centers for Medicare and Medicaid Services
Department of Health and Human Services
ATT: CMS – 1506 – P
PO Box 8014
Baltimore, MD 21244-8014

RE: MEDICARE PROGRAM: AMBULATORY SURGERY CENTERS PPS PROPOSED RULE

Dear Dr. McClellan:

I am a private practice gastroenterologist who presently treats Medicare beneficiaries in my practice. I am writing to express my concern with CMS proposal to lower payments to Gastroenterology Ambulatory Surgery Centers.

In my practice we see a large number of Medicare patients. We provide screening colonoscopies for those who are at average risk for colon cancer screening as well as high risk individuals and surveillance colonoscopies for those who already had polyps. We also treat a large number of patients with gastrointestinal bleeding and gastroesophageal reflux disease. These patients need an appropriate, safe and cost effective study for gastrointestinal endoscopy.

In our town of Fredericksburg, Virginia, we have one Ambulatory Surgical Center which provides the service. In fact, our office is planning to build an endoscopy center to provide such service to eligible beneficiaries to include potentially Medicare patients.

As you know, CMS has proposed a significant reduction of payment to Gastrointestinal Ambulatory Surgery Centers by 30% (89% of the facility fee to 62% of the HOPD payment). (HOPD stands for hospital outpatient department). If this occurs, this may lead to closure of ASC to Medicare beneficiaries.

Medicare seems to be ignoring both the stated priorities of the current administration well as lessons of cost management in private sector. President Bush and his staff have stated that ASC are a cost effective environment than the hospital to receive key medical services. .

When private sector insurers have started to reduce total health care costs, they have actively sought to encourage patient to receive services in an ambulatory surgical center instead of in the hospital out patient department. For example, Blue Cross of California has announced it will pay a 5% premium to physicians for gastrointestinal endoscopy performed in the ASC rather than the HOPD

The agency's concept of budget neutrality in this proposal is incorrect, unfair and short-sighted. By reducing the cost to ASC, there would be a higher cost to the government and possibly private sector insurers. The reality is that under this proposal the Medicare program will spend more money than saving. This is so because at the current rates, ASC payments are always lower than, or at least never greater than the facility fee that CMS pays to the HOPD.

I propose that the ASC in groups like gastroenterology to be at a higher tier of payment that is at or higher than the current 89% we now receive. Then a second, lower tier, the facility fee for ASC in other specialties which are not involved with lifesaving preventive services such as colorectal cancer screening tests.

I want to thank you for your time in reviewing this critical information regarding the negative impact of the proposed cut in payment to gastrointestinal ASCs. This negative impact will affect both gastroenterologists as well as patients, both Medicare and eventually non-Medicare patients.

Sincerely,

Frank J. DeTrane, M.D.

PWKW/rch
J: 1023-196

Center for Digestive Endoscopy
1817 North Mills Avenue
Orlando, Florida 32803-1853

Center for Digestive Health

Henry Levine M.D.
F.A.C.P.

Philip N. Styne M.D.
A.G.A.F.

Steven D. Feiner D.O.
A.G.A.F.

William B. Ruderman M.D.
F.A.C.P., F.A.C.G.

William Mayoral M.D.

Marlon B. Ilagan M.D.

October 19, 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

Dear Dr. McClellan,

This communication is in response to the proposed rules on ASC and Hospital Outpatient Prospective Payments and the 2007 Physician Fee Schedule.

The proposed reduction in reimbursement for Gastroenterology ASC technical service fees will do nothing but impair the delivery of high quality outpatient care to our patients.

At the present time, these ASC sites can provide the following advantages:

1. **Less costly procedures-** ASC cost are traditionally far below that of outpatient hospital facilities. By keeping these procedural costs down, the ASC environment provides lower cost means to provide endoscopic services to your Medicare patient population.
2. **More timely delivery of care-** physicians are readily able to schedule procedures in their own facilities far easier than battling with hospital schedules involving many more procedures and physicians. This produces better patient outcomes as patients experience fewer delays to diagnosis.
3. **Patient ease of access** in an ASC is far superior to the cumbersome, time consuming process of hospital outpatient medicine, making the patient experience more desirable in an ASC.
4. **Endoscopic equipment is often of higher quality** than that of hospital endoscopy suites. The ASC environment is more closely physician supervised allowing optimal selection and installation of endoscopic equipment. Newer endoscopic technologies are more often available in the ASC, providing "state of the art" quality care delivery.
5. **Improved turnover rates for GI procedures** in the ASC allow accommodation to a larger volume of patients, thereby facilitating in a much more efficient way the need to meet the volume of patients requiring "screening colonoscopy". Hospital endoscopy suites cane rarely provide turnover time comparable to the ASC, and their volumes are traditionally far less.
6. **Most ASC endoscopy units have immediate electronic record systems.** This allows instantaneous post delivery of data to patients, referring physicians and the medical record. It also allows the ASC to more readily transition to the ultimate goal of total EMR. No hospital in our area has such capability and most hospital systems have not converted to such system.
7. Some ASC facilities have offered flexible scheduling including weekend elective cases-another mechanism by which this type of facility can meet

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Center for Digestive Health

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Marlon B. Ilagan M.D.

the demand of elective screening colonoscopy. Hospitals generally do not provide this option.

Our Orlando facility provides care to more than 10,000 patients/calendar year. No hospital in our city provides that volume. Our patient satisfaction surveys document the overwhelmingly positive experience our patients have come to know and their desire to return to our facility instead of local hospitals. There is no question that endoscopic services provided at our unit are at a level above that provided in any hospital environment in Central Florida. Medicare patients presently enjoy their benefits.

Development and implementation of an ASC requires a significant capital investment. Funds necessary for this development are loaned on the basis of a long-term business model. A capricious drop in facility fees will destabilize the ASC business environment resulting in closure of many ASC facilities and curtail the development of new facilities. No hospital organization could survive the capricious and abrupt reduction of fees by 25% or more over a 15-month period. In our unit all carriers link their fees to Medicare rates.

In order to continue to provide quality endoscopic services at a low cost per case, we request the re-examination of the reduction in Medicare ASC fees. We request that the benefits provided by ASC centers be recognized and fairly reimbursed. Abrupt changes do not give credit to the significant investment in quality represented by ASC centers.

In summary, the GI ASC provides a community resource that is justifiable to maintain and in fact provides facilities that exceed the benefits of the hospital experience on many levels. Instead of diminishing their reimbursement and jeopardizing their existence, we argue the administration would best be advised to allow them to flourish- for the benefit of patient care delivery.

Sincerely,

Henry Levine M.D.

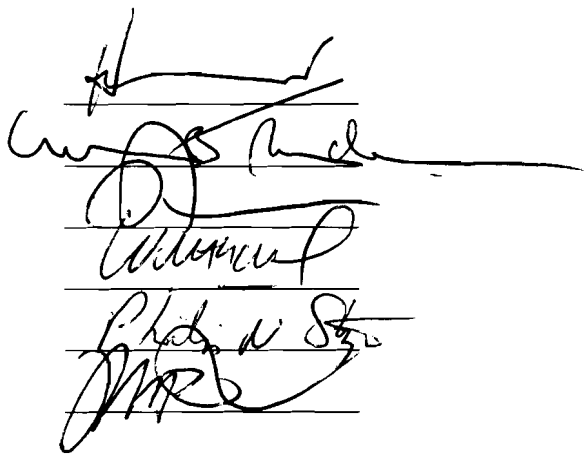
William Ruderman M.D.

Steven Feiner D. O.

William Mayoral M.D.

Philip Styne M.D.

Marlon Ilagan M.D.



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Northbank Surgical Center

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November 1, 2006

Centers for Medicare and Medicaid Services
Department of Health and Human Resources
Attention: CMS-4125-P
Mail Stop C4-26-05
7500 Security Blvd.
Baltimore, MD 21244-1850

As an ambulatory surgery center (ASC), Northbank Surgical Center was one of the first multi-specialty ASC's in the Salem area. Northbank Surgical Center employs over 50 health professionals and has served over 50,000 patients since opening in 1986.

Over the past 20 years, Northbank Surgical Center has provided an important role in the Salem area and outlying Marion/Polk health care community. We combine a safe, convenient and friendly environment with the latest medical technologies and highly-skilled physicians and clinicians. All of our procedures have been performed in a surgical environment focused on patient safety, patient outcome, patient satisfaction and cost effectiveness.

We are writing to comment on the proposed CMS changes to the ASC payment system. Medicare covers just over 2,500 surgical procedures performed in ASCs. Over the past ten years, there has been a major movement of surgical procedures from the inpatient to the outpatient setting. In fact, due to medical and technological advances, it is estimated that very shortly 80+% of all surgery will be performed in the outpatient setting.

At this point we applaud CMS for taking on the daunting task of updating the current system as it applies to Medicare patients in the outpatient setting. In reviewing the proposed changes we have several concerns that we would like to bring to your attention.

ASC list of procedures:
The current proposal allows for the addition of 750 procedures to the current ASC list. Medicine is a dynamic environment, evolving on a daily basis. With the current style of an "approved procedure list", it does not lend itself to keep up with the rapidly changing times. By the time the proposed rules have been implemented, a new technology or surgical process will provide for another procedure to be safely performed in an outpatient setting.

The current approved procedure list creates an inequality for Medicare recipients, prejudicing against them. Medicare recipients are not allowed the flexibility of site choice that other patients have for their procedures. This has happened time and time again over our 20 years of providing care to patients. For instance, we have provided care to lumbar diskectomy and anterior cervical fusion patients for 10 years. The literature reflects the appropriateness of the procedure in an outpatient setting. Despite multiple medical reports, those two procedures will not be available to Medicare patients in the outpatient setting. If CMS would adopt an exclusionary list, Medicare recipients would enjoy the same choices as any other consumer.

No other insurance company maintains a list of "appropriate procedures" limiting patients to a purely hospital setting. The companies have realized that thousands of dollars can be saved when procedures are performed in an outpatient setting when compared to the inpatient environment. If CMS were to adopt an exclusionary list in place of the "approved procedure list", the situation would be more manageable, and millions of dollars would be saved as procedures move safely to the outpatient setting.

700 Bellevue Street S.E., Suite 300 • Salem, OR 97301 • 503 364-3704 • Fax 503 399-9722

Definition of Outpatient:

In reviewing the process of defining procedures that are appropriate for the outpatient setting we believe there are serious flaws. The document admits the difficulty in coming to a consensus of a definition that would stand the test of time as medicine evolves. If CMS would follow the lead of other insurances and adopt an exclusionary list would allow for change and do away with definitions that do not adequately represent those patients appropriate for the outpatient setting.

Another definition of concern is the definition of overnight. In the past CMS has stated that it was not considered an overnight stay if the non-Medicare patient was in the facility less than 24 hours. In the proposed rule change, CMS reverses this position and defines overnight as any stay past midnight. Why has CMS proposed such an antiquated definition? The document states that hospitals define inpatient as those in beds past midnight. This is half true, acute facilities also code patients that stay less than 24 hours as outpatients. CMS should maintain the definition of overnight as less than 24 hours. We would recommend also that Medicare patients should also be afforded the same rights and options as any other consumer and be allowed to stay in the facility up to 23 hours 59 minutes. Medicare patients deserve the same opportunities and choices as all other patients.

Proposed ASC list

In an attempt to develop an appropriate list of approved procedures CMS has utilized HOPD data and the definitions listed in the CMS Rule proposal. The data includes those procedures where the stay was not past midnight. This data set is not representative of true "safe" procedures. Hospitals are famous for not knowing how to discharge their patients home in a timely manner.

Hospitals have not adopted the outpatient mentality or the philosophy of an ambulatory setting. Patients frequently spend the night in a hospital when in an ASC setting they would have all been safely discharged. The ASC data set should be used to show those CPTs routinely performed in an ASC. (e.g. we have been performing cervical fusions on non-Medicare patients for 10 years with an average PACU stay of 3 hours and excellent outcomes). The HOPD set should be used to find those procedures routinely performed safely as outpatient, but that have not found their way in to the ASC setting. This would help clear up the issue of establishing appropriate ASC procedures and not allow hospital's inability to efficiently care for outpatient procedures to cloud the picture. Of course if an exclusionary list was used all of this would not be necessary.

Budget Neutrality

As CMS has been charged to create a system that would be budget neutral, we believe that greater consideration needs to be given to the savings resulting from movement to the outpatient ASC setting and not just the savings from the difference in site reimbursement.

CMS is proposing 62% of HOPD rates. After multiple studies, major ASC agencies (FASA, AAASC...) have recommended 75% as a rate that would benefit both CMS and the ASCs. The 62% represents, for many of the ASCs, a reduction to the point of not covering the expenses necessary to keep the ASC doors open. ASCs are instrumental in the success of cost effective, safe healthcare for the Medicare insured. If reimbursements to ASCs remain at 62%, centers would be forced to evaluate if providing care to Medicare patients would be possible.

In an attempt to maintain budget neutrality the current proposal initially freezes reimbursement to ASCs. This only creates a greater difference in the reimbursement of ASCs when compared to HOPDs. In order to maintain the safe quality of care that we currently provide for our patients, we have to maintain cutting edge technology, pay our staff competitive wages with the local hospital and purchase the same supplies as an HOPD. Freezing the reimbursement can only weaken the ability of the ASC to provide services for the community. We believe that if the calculation on neutrality takes more into account the savings from Medicare patients moving to an ASC setting, there should be no reason to freeze ASC rates.

Implants and DME
At this point many implants and DME are not reimbursed by CMS in the care of Medicare patients. At this time HOPD is paid at a rate that allows for full pass through of implant and DME costs. The current proposal would penalize the ASC by only paying a percent of HOPD reimbursement. This would not allow the same ability for full reimbursement of the implant or DME. We believe that the percent difference of payment to ASC's should not apply to the portion of the payment related to the cost of the DME or implant. Again this sets up an inequity between the HOPD and ASCs that should not be created. It places the ASCs in a position of being unable to cover hard costs and creates a situation where those services would not be available to Medicare patients.

Again, we appreciate the efforts that CMS has taken to address this issue. We understand the enormous undertaking. We believe the above comments/concerns/recommendations are necessary in updating an antiquated system for Medicare patients. We hope to see an updated system that provides choices or options for Medicare patients that have not been available in the past, options that have been available to all other insured consumers. ASCs pride themselves in providing safe, cost effective care to patients. There is no reason why Medicare patients shouldn't be able to enjoy a safe, efficient ASC experience.

Thank you for allowing us the opportunity to provide input in this process.

Peggy Seidler, R.N.
Administrator

John Johnson, MD
Medical Director

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THE SURGERY CENTER
AT CRANBERRY

November 3, 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:

As an administrator of an ASC in Pennsylvania, I would like to comment on the CMS proposed rule concerning the Medicare ASC payment system and ASC list reform.

While I feel that ASC reimbursement rates should be aligned with those of HOPDs, 62% is simply not enough. I have worked in hospital inpatient and outpatient surgery settings, as well as an ASC, and know that the cost of providing surgical services in an ASC is not 38% lower than in a hospital. Setting ASC payment rates this low could have a possible negative effect on Medicare beneficiaries' access to services in an ASC. If the low ASC reimbursement rate does not adequately cover the costs of performing certain procedures in an ambulatory surgery center, physicians would be forced to move cases to the more expensive hospital setting, increasing the amount of money paid by Medicare beneficiaries and the government.

In keeping ASC reimbursements in alignment with those of HOPDs, annual updates for inflation for ASCs should be calculated based on the hospital market basket (as in HOPDs) not on the consumer price index for urban consumers as proposed. The hospital market basket more appropriately reflects inflation in providing surgical services than does the consumer price index. Also, the same updated relative weights should be used in ASCs and hospital outpatient departments, not just initially but in the future as well. Inflationary costs, such as nursing and medical supply and device costs, affect ASCs in the same way as hospitals. Without equitable updates, ASCs have a difficult time competing in a fiercely competitive labor market.

Because ASCs are proportionately small businesses in comparison to hospitals, the transition to a new reimbursement system should be phased in over several years as changes in payment rates for specific procedures and specialties may disproportionately impact certain types ASCs. The reimbursement rate for one procedure that constitutes 26% of the cases performed annually in our facility is slated to be cut by 29.25% in 2007 and by another 17.75% in 2008 under the proposed rule. This is a rather large deficit for a small business to absorb in a short amount of time.

105 Brandt Drive Cranberry Township, PA 16066 724.772.1766

The ASC list reform proposed by CMS should be expanded to include any and all procedures that can be performed in an HOPD, excluding only those procedures that are on the inpatient only list. The current criteria used to judge the appropriateness of performing a certain procedure in an ASC are obsolete. With advances in medical technology, anesthesia, pharmaceuticals, etc., ASCs meet clinical safety standards and are an appropriate setting for most surgical procedures. The expansion of the ASC list will offer Medicare consumers more options, enhance their access to care and reduce Medicare program costs. The environment in an ASC is healthier than in a hospital setting from an infection control standpoint with less risk of exposure to infected patients, thus reducing the risk of surgical site infection and the associated cost to treat it.

The proposed rule establishes a complicated formula to link ASC reimbursement to that of HOPDs, but that reimbursement is not linked in a uniform way. This hinders Medicare beneficiaries' ability to understand their real costs in alternative surgical settings and make a clear comparison. Aligning the payment systems for ambulatory surgical centers and hospital outpatient departments in a more equitable manner will enhance the transparency of cost and quality information used to evaluate outpatient surgical services so that Medicare consumers are able to make informed health care choices. These educated decisions will benefit both the Medicare beneficiary and the taxpayer.

ALL staff members functioning as a team with the goal of providing quality, safe, efficient and cost-effective care in a patient-friendly, patient-focused atmosphere is the essence of the surgery center mentality and environment.

The staff of The Surgery Center at Cranberry is proud of our efforts and accomplishments and our involvement in the ambulatory surgery industry and welcomes the opportunity to educate others about this valuable patient care alternative.

If I can ever be of service to you or provide further information, please don't hesitate to contact me.

Sincerely,

Mary Doutt, RN

Mary Doutt, RN, Facility Administrator
On behalf of The Surgery Center at Cranberry

Oct 27 06 03:03p Golden Triangle Surgicent 9516984675 p.2

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Golden Triangle SurgiCenter
A HEALTHSOUTH SURGERY CENTER

October 27, 2006

VIA FACSIMILE

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

To Whom It May Concern:

For more than 20 years, ambulatory surgery centers (ASCs) have provided patients with high-quality, convenient, and affordable options for their outpatient surgery. Medicare and their beneficiaries save money when the procedures are performed in the ASC, as opposed to a hospital setting. ASCs are highly efficient and effective in our delivery of care. We not only strive to continue, but increase, the services we provide to Medicare beneficiaries. In order to do that we must receive reimbursement that is fair and enables us to be viable entities.

Equally important is the fact that our patients who have had similar procedures in both the hospital and outpatient settings, overwhelmingly prefer the intimate, personal attention and care they receive in our ASC, as opposed to the laborious and impersonal hospital environment.

The Medicare Modernization Act requires that ASCs be transitioned from their current Medicare payment systems to a new payment system by 2008. This provides an opportu to provide more transparency across sites of service and permit ASCs to be a vital and competitive alternative to more expensive outpatient hospital departments.

While MedPAC and the ASC community support moving to the hospital outpatie prospective payment systems (HOPPS), the proposed rule would tie ASC payme HOPPS in some but not all respects.

The six year payment freeze to ASCs and the cuts in the Deficit Reduction in much lower payments to ASCs relative to payments made when servic HOPD. Conversely, during this time, HOPDs have received significan In the proposed rule, CMS estimates that ASCs should be paid only 62 providing identical outpatient surgical services. The lower payment significant cuts to a number of important, commonly performed se GI and ophthalmology. These are procedures performed mainly will have a direct impact on our ability to provide these services

CMS help Medicare and beneficiaries save money? native to outpatient hospitals by fixing the

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Murrieta, CA 92

Golden Triangle SurgiCenter
A HEALTHSOUTH SURGERY CENTER

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October 27, 2006

VIA FACSIMILE

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

To Whom It May Concern:

For more than 20 years, ambulatory surgery centers (ASCs) have provided patients with high-quality, convenient, and affordable options for their outpatient surgery. Medicare and their beneficiaries save money when the procedures are performed in the ASC, as opposed to a hospital setting. ASCs are highly efficient and effective in our delivery of care. We not only strive to continue, but increase, the services we provide to Medicare beneficiaries. In order to do that we must receive reimbursement that is fair and enables us to be viable entities.

Equally important is the fact that our patients who have had similar procedures in both the hospital and outpatient settings, overwhelmingly prefer the intimate, personal attention and care they receive in our ASC, as opposed to the laborious and impersonal hospital environment.

The Medicare Modernization Act requires that ASCs be transitioned from their current Medicare payment systems to a new payment system by 2008. This provides an opportunity to provide more transparency across sites of service and permit ASCs to be a vital and competitive alternative to more expensive outpatient hospital departments.

While MedPAC and the ASC community support moving to the hospital outpatient prospective payment systems (HOPPS), the proposed rule would tie ASC payments to the HOPPS in some but not all respects.

The six year payment freeze to ASCs and the cuts in the Deficit Reduction Act have resulted in much lower payments to ASCs relative to payments made when services are provided in HOPD. Conversely, during this time, HOPDs have received significant payment updates. In the proposed rule, CMS estimates that ASCs should be paid only 62% of HOPD for providing identical outpatient surgical services. The lower payment rate will result in significant cuts to a number of important, commonly performed services in ASCs including GI and ophthalmology. These are procedures performed mainly on Medicare recipients and will have a direct impact on our ability to provide these services to them.

How can CMS help Medicare and beneficiaries save money? By making ASCs a viable, competitive alternative to outpatient hospitals by fixing the following problems in the proposed rule:

- ***Adopt an expansive, realistic interpretation of budget neutrality that examines total Medicare spending on outpatient surgery.*** The ASC industry is working with respected actuarial and Medicare payment experts to present quantitative analysis on the ASC percentage of HOPD that should be provided if CMS adopts a realistic interpretation of budget neutrality that examines the impact of the new ASC payment system on all Medicare spending on outpatient surgery. That number should be substantially higher than the 62% CMS announced in its "alternative methodology."
- ***As suggested by MedPAC, create an exclusionary list for ASC services.*** Only ASCs are bound to a list of permitted procedures as determined by CMS. While the proposed rule would add procedures to the ASC list, it fails to include many higher complexity services that have for years been safely and effectively performed in ASCs throughout the country. The exclusionary list would afford CMS the opportunity to increase patient choice and rely on the clinical judgment of the surgeon.
- ***Stop the widening gap between HOPD and ASC payments.*** ASCs confront the identical inflationary pressures as hospitals – staffing with qualified personnel, supply and equipment expenses. CMS has proposed updating ASC payments by the CPI, rather than by hospital market basket update. This results in a full percentage differential each year. The disparity in payments will create deeper divisions between prices paid in the HOPD and the ASC without any evidence that different payment rates are warranted.
- ***Create a parallel system to HOPD.*** The CMS proposed rule continues to treat HOPD and ASCs differently in key respects. These difference should be eliminated and ASCs and HOPD payments made on the same basis
- ***CMS can save Medicare beneficiaries money WITHOUT sacrificing high quality care.*** CMS and ASCs have a common goal. We both strive to provide quality care to Medicare beneficiaries at affordable prices. By enabling ASCs to expand their services via a more equitable payment system, Medicare beneficiaries will benefit by having the choice to be cared for in an environment which is conducive to their needs; providing compassion and personal attention to each patient and his/her family.

Our goals are the same, to save Medicare and its beneficiaries money. ASCs are highly capable providers of outpatient surgical services and were created and known for their efficiencies. It only makes sense to enable us to care for a greater number of patients by creating an equitable reimbursement system and expanding the list of procedures we can perform.

Sincerely,

Judy Grimaldi, M.B.A.
Administrator

DIPLOMATE, AMERICAN BOARD OF OPHTHALMOLOGY

J. MICHAEL GEIGER, JR. M.D.
OPHTHALMOLOGY
810 ELM STREET
FAYETTEVILLE, NC 28303

Phone: (910) 321-0356
Fax: (910) 321-0359

FELLOW, AMERICAN ACADEMY OF OPHTHALMOLOGY

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3 November 2006

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

Re: Proposed Rule for Setting ASC Rates at 62% of HOPD Rates.
The Ambulatory Surgical Center Medicare Payment Modernization Act,
S.1884 and H.R. 4042

Dear Sirs:

It is my strong recommendation that CMS adopt a uniform ASC payment schedule that will tie ASC payments directly to the HOPD schedule at a rate of 75% of the HOPD schedule, instead of the 62% rate proposed by CMS. Approving the 75% rate will significantly decrease Medicare surgery costs to the government, decrease out-of-pocket expenses to Medicare beneficiaries, and provide a choice of facilities to beneficiaries.

ASCs over the past two decades have proven to be safe, convenient, and cost-effective in the delivery of community surgical services. The number of procedures performed at ASCs has grown 15-18% per year for the past decade as patients and physicians have come to realize the advantages of ASCs versus hospital OPDs.

Unfortunately, in my specialty of ophthalmology, there are a number of procedures that are not routinely performed at ASCs simply because the ASC payments are too low to cover the actual costs of the surgery. These procedures include, but are certainly not limited to, corneal transplants and retinal membrane peelings with vitrectomies. ASC payments for these two procedures are at 44% and 33% of HOPD rates respectively. These two procedures, and many more, could safely be performed in an ASC, but instead are routinely performed as outpatient surgery in hospitals. Medicare beneficiaries needing these procedures have little or no choice in facilities, because ASCs cannot afford to offer these procedures at the current Medicare rates. Subsequently, these beneficiaries are subject to higher hospital copays and CMS pays more than necessary for these procedures. By increasing the ASC rate to 75% of HOPD rates and including pass through payments for implants and tissue acquisition as provided to hospitals, CMS will allow the transition of these and other procedures from the more expensive HOPDs to the more efficient ASCs.

Cataract surgery provides a good example of the savings that can occur when ASC payments are high enough to allow ASCs to offer the procedure. The ASC rate for cataracts is currently at 70% of HOPD. According to Rand Health in a 2004 MedPac study, over 550,000 Medicare paid cataract surgeries (52% of all Medicare cataracts) were performed in ASCs. The HOPD rate for cataracts is $414.71 more per case than the ASC rate. Had those cataracts been performed in an HOPD, CMS would have paid an additional $229 million

for cataracts in 2004. If CMS lowers the ASC rate for cataracts from the current 70% to a 62% rate, it will discourage the growth of ASCs and may actually reverse the current trend of shifting surgeries from HOPDs to ASCs.

Even at the current volume of ASC cataract surgery, there is still room for savings if more patients are encouraged to have cataract surgery at ASCs. The attached Table 1 demonstrates a potential additional savings of up to $50 million annually if ASC rates are set at 75% and more patients are encouraged to use ASCs. These annual savings could even be more over the next few years as the population ages and cataract volume rises.

Table 2 shows the increase in ASC volume necessary for cataract payments to remain budget neutral if the ASC rate is increased to 75% of HOPD.

In summary, CMS historically has realized savings when usage of ASCs over HOPDs is encouraged. Procedures cannot be shifted to ASCs if reimbursement is not adequate to cover ASC costs. I strongly recommend that CMS permanently link ASC rates to 75% of HOPD rates, and to include ASC pass through payments for drugs, biologicals, and implants equal to HOPD.

Thank you for your consideration in this matter.

Sincerely,

J.Michael Geiger, Jr. MD

Attachment
JMG:nbw

J.MICHAEL GEIGER, MD

910-321-0359

MEDICARE COST SAVINGS
ASC at 75% HOPD

Table 1

PROCEDURE		ASC			HOPD			ASC+HOPD	Potential Annu
CATARACT & IOL		VOLUME	PAYMENT	ASC COST	VOLUME	PAYMENT	HOPD COST	TOTAL COST	SAVINGS
66984	Current	553,223	$973.00	$538,285,979	510,667	$1,387.71	$708,657,703	$1,246,943,682	
	Proposed 75 %	808,557	$1,040.78	$841,529,954	255,333	$1,387.71	$354,328,157	$1,195,858,112	$51,085,570
66982	Current	12,273	$973.00	$11,941,629	11,329	$1,387.71	$15,721,367	$27,662,996	
	Proposed 75 %	17,937	$1,040.78	$18,668,516	5,665	$1,387.71	$7,861,377	$26,529,893	$1,133,103

Medicare Annual Savings $52,218,672

Table 2

CATARACT & IOL									
66984	Current	553,223	$973.00	$538,285,979	510,667	$1,387.71	$708,657,703	$1,246,943,682	
	Proposed 75 %	661,307	$1,040.78	$688,275,099	402,583	$1,387.71	$558,668,455	$1,246,943,554	$127
66982	Current	12,273	$973.00	$11,941,629	11,329	$1,387.71	$15,721,367	$27,662,996	
	Proposed 75 %	14,671	$1,040.78	$15,269,320	8,931	$1,387.71	$12,393,638	$27,662,958	$38

Medicare Budget Neutral $165

Table 1, showing potential savings, is based on two assumptions:

- ◊ that CMS adopts an ASC payment schedule based on 75% HOPD payments, and
- ◊ that ASCs' share of Medicare cataract volume rises to 75% from current 52%.

Table 2 shows a budget neutral condition if ASCs' share of Medicare cataract volume rises to 62%.

The data in these tables were obtained from a MedPac 2004 report.

JM Geiger MD 3 Nov 2006

PHYSICIANS' SURGICAL CARE CENTER

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Leslie Norwalk, Esq., Acting Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Resources
Attention: CMS-4125-P
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

Dear Ms Norwalk:

I am writing to you concerning the Notice of Proposed Rulemaking published on June 12, 2006, regarding updates to rate-setting methodology, payment rates, payment policies, and the list of covered surgical procedures for ambulatory surgical centers. I am the administrator of Physicians' Surgical Care Center in Winter Park, Florida. We have approximately 35 physicians which perform about 7000 orthopedic, pain and ear, nose and throat cases a year.

The goal for all of us; providers, physicians, and payors; is to create a health care system that delivers excellent clinical outcomes in a cost efficient environment. Ambulatory surgical centers offer a safe, convenient and often less costly alternative to hospital-based surgical services.

The broad statutory authority granted to the Secretary to design a new ASC payment system in the Medicare Modernization Act of 2003 presents the Medicare program with a unique opportunity to better align payments to providers of outpatient surgical services. Given the antiquated cost data and crude payment categories underlying the current ASC system, we welcome the opportunity to link the ASC and hospital outpatient department (HOPD) payment systems.

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. 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. We are concerned that the linkage is not complete and that inconsistencies between payments for ASC and hospitals will create volatility between the ASC and HOPD payment rates and along with the new payment system site of service incentives will cost the taxpayer and the beneficiary more than necessary. We see a need to expand the list of services for which Medicare coverage and payment is available in ASCs and provide payment for procedures which are not yet listed by the CPT book. CMS failed to include on the procedure list many higher complexity services that have for years been safely and effectively performed in ASCs throughout the country. Private payors long ago discovered that we could safely perform outpatient procedures at a much lower cost than the hospital based outpatient departments. CMS is losing an opportunity to increase patient choice and rely on the clinical judgment of the surgeon.

2056 Alamo Avenue • Winter Park, FL 32792 • Phone (407) 647-5100 • Fax (407) 647-1966

Ambulatory surgery centers are an important component of beneficiaries' access to surgical services. As innovations in science and technology have progressed, ASCs have demonstrated that we have the capacity to meet the growing need for outpatient surgical services. We can adjust our services to meet the needs of our patients and physicians as needed. Sudden changes in the payments for services can have a significant effect on Medicare beneficiary's access to services. If the facility fee is insufficient to cover the cost of performing the procedure, we may be forced to relocate those surgeries to the hospital which would increase expenditures for the government and the beneficiary. To remedy this situation and offset future financial losses we strongly recommend that CMS create a final rule that does not make drastic rate cuts and that makes the computation of rates and rate changes the same for both the HOPD and the ASC reimbursement. In addition, CMS should expand the list of approved procedures to include any and all procedures that can be performed in an HOPD.

In summary, while there are elements of the proposed rule that I and my surgeons, support, our concern is that the proposed major overhaul of ASC payment policies contains serious flaws that must be addressed in order to keep the program viable for our ambulatory surgery center.

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

Sincerely,

Beth Davis

Beth Davis
Administrator

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Woodward Park SurgiCenter

October 31, 2006

Dear Sir,

I am an Ambulatory Surgery Center (ASC) Administrator in Fresno, CA. The surgery center has four operating rooms. Our case load is primarily orthopedic, pain management and podiatry. At this point our Medicare patient population is 24% of our monthly census. I am writing to express my concerns about the Proposed Rule for Ambulatory Surgery Centers.

To enable Medicare beneficiaries' access to ASCs, CMS should adopt an expansive, realistic interpretation of budget neutrality. The proposed payment system at 62% of HOPD would force doctors to move cases to the more expensive hospital setting, thus increasing the amount of money paid by Medicare beneficiaries and the government. I appreciate the many ways in which the agency proposes to align the payment system, I am concerned that the linkage is incomplete and may lead to further distortion s between the payment systems. Many policies applied to payments for hospital outpatient services were not extended to the ASC setting, and these inconsistencies undermine the appropriateness of the APC relative weights, create disparities in the relationship between the ASC and HOPD payment rates, and embed in the new payment system site of service incentives that will cost the taxpayer and the beneficiary more that necessary.

The ASC list of approved procedures reform proposed by CMS is too limited. The approved procedures list should be expanded 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. CMS failed to include on the procedure list many higher complexity services that have for years been safely and effectively performed in ASCs throughout the country. By no creating a truly exclusionary list, CMS is losing an opportunity to increase patient choice and rely on the clinical judgment of the surgeon.

The ASC payment system 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.

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. 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.

7055 N. Fresno Street, Suite 100 • Fresno, CA 93720 • 559 449-9977 • Fax 559 449-9350 • healthsouth.com

ASCs pride themselves on the ability to provide first and foremost safe care to our patients. We provide this care cost effectively, efficiently and efficiently. Our elderly patients appreciate the ease of navigating about our facilities. We are smaller than hospitals
so we are able to give more personal attention to our patient's needs. The number of staff the patients interacts with limited, so they see familiar faces with each visit. It is not an overwhelming experience going to an ASC. Our elderly patients facing surgery or other procedures have enough to endure without having to feel like a "number or just one of the masses".

Please feel free to contact me at 559-449-9977 with any questions or for clarifications.

Thank you for your consideration,

Sandra Buck, RN

Sandra Buck, RN
Administrator