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AnMed Health
Medicus Surgery Center, LLC

10/31/2006

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:

I am the Director of Business Services at AnMed Health Medicus Surgery, Center, LLC located in Anderson, SC. The AnMed Health Medicus Surgery Center, LLC is a multi-specialty Ambulatory Surgery Center. We service patients in the states of South Carolina, North Carolina, and Georgia.

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

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

Physicians continue to provide the impetus for the development of new ASCs. By operating in ASCs instead of hospitals, physicians gain the opportunity to have more direct control over their surgical practices. In the ASC setting, physicians are able to schedule procedures more conveniently, are able to assemble teams of specially-trained and highly skilled staff, are able to ensure the equipment and supplies being used are best suited to their technique, and are able to design facilities tailored to their specialty.

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Simply stated, physicians are striving for, and have found in ASCs, the professional autonomy over their work environment and over the quality of care that has not been available to them in hospitals. These benefits explain why physicians who do not have ownership interest in ASCs (and therefore do not benefit financially from performing procedures in an ASC) choose to work in ASCs in such high numbers.

Overview

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

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

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

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

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

Alignment of ASC and HOPD Payment Policies

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

system site of service incentives that will cost the taxpayer and the beneficiary more than necessary.

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

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

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

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

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

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

- **Secondary rescaling of APC relative weights:** CMS applies a budget neutrality adjustment to the OPPS relative weight values after they are recalibrated with new cost data each year. The agency proposes a secondary recalibration of the relative weights before they are used by ASCs. This secondary recalibration will result in

annual and potentially cumulative variation between ASC and HOPD payments without any evidence that the cost of providing services has further diverged between settings.

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

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

Ensuring Beneficiaries' Access to Services

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

The implementation of the revised payment system proposed by Medicare will result in significant redistribution of payments for many specialties. Because ASCs are typically focused on a narrow spectrum of services that require similar equipment and physician expertise, they have a limited ability to respond to changes in the payment system other than to adjust their volume of Medicare patients. On the one hand, for procedures such as ophthalmology, there is a limited market for these services in the non-Medicare population. If the facility fee is insufficient to cover the cost of performing the procedure in an ASC, responding to the change may mean relocating their practice to the HOPD. Such a decision would increase expenditures for the government and the beneficiary. On the other hand, the demand for services such as diagnostic colonoscopies is extremely high in the non-Medicare population. If ASCs determine that the payment rates for such services are too low, they may be able to decrease the proportion of Medicare patients they see without reducing their total patient volume. In that case, beneficiaries may

experience significant delays accessing important preventive services or treatment. Neither outcome is optimal for the beneficiary of the Medicare program.

Establishing Reasonable Reimbursement Rates

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

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

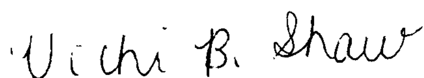
- Budget Neutrality: Adopt an expansive, realistic interpretation of budget neutrality. The new payment system and the expansion of the ASC list will result in migration of services from one site of service setting to another. CMS has the legal authority and the fiduciary responsibility to examine the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

- By setting the proposed rates at 62% of HOPD, CMS would force doctors to move cases to the more expensive hospital setting, increasing the amount of money paid by Medicare beneficiaries and the government. Rather than paying ASCs a set percentage of HOPD rates, the proposed rule establishes a complicated formula to link ASC payment to HOPD payment but does not link payment in a uniform manner. This will impede Medicare beneficiaries' ability to understand their real costs in alternative settings. In the words of President Bush, Medicare beneficiaries need to be able to make "apples to apples" comparisons in order to increase transparency in the health care sector.

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

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

Sincerely,



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Attention: CMS-1506-P
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

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

Dear Ms. Norwalk:

On behalf of The GI Endoscopy Center, we appreciate the opportunity to submit comments to the Centers for Medicare and Medicaid Services ("CMS") proposed refinements to the ambulatory surgical center ("ASC") payment system for calendar year 2008. At **The GI Endoscopy Center,** approximately 40% of our patients are Medicare beneficiaries. The revised ASC payment system will significantly impact our business operations and the 1700 patients we treat annually.

General Comments

We are concerned that the revised ASC payment system, if finalized as proposed, would have a detrimental effect on Medicare beneficiary access to outpatient surgery, particularly for gastroenterology and pain management procedures. We also believe that the proposed rule does not take into account a priority of Congress and Bush Administration-the promotion of setting-neutral payment policies.

ASCs provide high quality, low-cost outpatient surgical care to millions of Medicare beneficiaries each year. Medicare beneficiaries choose to receive care in ASCs due to their convenience, high quality and low cost. We believe CMS should make modifications to the proposed rule in order to ensure continued beneficiary access to low-cost, high quality ASC services.

Specific Comments

The rule, as it is announced, disproportionately impacts two specialties negatively. These two specialties are gastroenterology and pain management. CMS proposes to reimburse ASC procedures at 62% of the HOPD rate for the same procedure. This percentage will lower ASC payments for gastroenterology and pain management procedures overall by approximately 30%. This severe cut to these two specialties will

force some single-specialty ASCs to close, eliminating access to life-saving detection and early treatment of colon cancer for Medicare beneficiaries.

Medicare has frozen payment updates to ASCs for six straight years. At the same time, payments for HOPD procedures have increased each year. We have seen the same escalation in our costs that hospitals have during this period of time. We pay the same salaries and benefits for nursing personnel, and our equipment costs have continued to rise. With escalating costs and frozen payments, we are losing ground financially. To compound that situation with a further 30% cut in payment will put many ASCs in an untenable position.

The 62% rate is also problematic when applied to services that are not currently performed in ASCs, but may be added to the list of Medicare-covered ASC procedures. Congress intended to create a level playing field between outpatient surgical settings in order to foster competition, and expansion of the Medicare-approved ASC list is a positive step in that direction. However, 62% of the HOPD rate may not be enough to justify the ASC investments (equipment, supplies, etc.) required to support delivery of these new services. And as a result, patients will continue to have only one outpatient option for these procedures: the HOPD. If CMS truly intends for the ASC list expansion to result in greater access and choice for patients, it should set the rate closer to 100% of HOPD than one-half of the HOPD. Setting the rate too low will only undermine Congress' broader goals of increasing access and fostering competition.

Congress directed CMS to revise the ASC payment system in a budget-neutral manner so that Medicare spending for outpatient surgical services would not increase. Beneficiaries prefer ASCs due to their high quality, lower cost and overall positive experience. The budget-neutral implementation of the revised ASC payment system should take into account the anticipated migration of procedures from HOPD to ASC. Since the exact migration statistics cannot be predicted, CMS should adopt a realistic interpretation of budget neutrality that examines the impact of the new ASC payment system on all Medicare spending on outpatient surgery, as Congress intended.

In the proposed rule, CMS proposes to add 750 procedures to the list of ASC-covered procedures. While this expansion of the list is welcome, it does not go far enough. CMS should adopt HHS Secretary Leavitt's suggestion and MedPAC's recommendation to create an exclusionary list for Medicare-covered ASC procedures. Many outpatient surgical procedures are not currently reimbursed by the Medicare Program despite being performed in ASCs safely and effectively for years. Only through the adoption of an exclusionary list will Medicare beneficiaries have access to multiple settings for outpatient surgery.

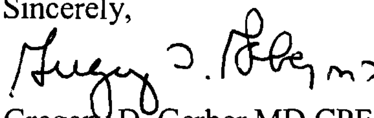
CMS proposes to annually update the payment rates for ASC services by the increase in the consumer price index, while HOPD rates would continue to be updated by

the hospital market basket. If CMS is going to tie ASC reimbursement to the HOPD payment rate, the annual updates should be identical. The consumer price index is not an accurate reflection of the annual increase in health care costs. If CMS finalizes the proposed annual update to ASC procedures, in a few short years, ASC payments rates would be significantly underpaid compared with the HOPD rate. Again, the intention of Congress in creating a level competitive playing field for outpatient surgery would be ignored, and Medicare spending would needlessly increase as a result.

The proposed rule represents a complete overhaul in the payment system to which ASCs have been subject for a quarter-century; yet CMS has proposed to phase in this complex system over two years. We believe that the new payment system should be phased in over at least four years and that special payment rules should be adopted to protect facilities that would otherwise be encumbered by significant and precipitous payment decreases that compromise their ability to treat Medicare patients.

We appreciate CMS' consideration of our comments and hope that CMS will recognize the value ASCs provide to Medicare beneficiaries. If you have any questions regarding these comments, please contact me at 513-422-5915.

Sincerely,



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November 3, 2006

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

Re: Medicare Program: Ambulatory Surgery Centers PPS Proposed Rule (CMS1506-P)

Dear Dr. McClellan,

I am submitting comments on the CMS proposed changes for Ambulatory Surgery Center (ASC) reimbursement.

I am a member of a thirteen physician group of gastroenterologists in Knoxville, Tennessee. We are the largest GI group in Knoxville, and serve a large East Tennessee community that includes numerous outlying rural counties. We have three ambulatory surgery centers located geographically in our community to provide convenient quality services for our patients. Our ASC's are state licensed and Medicare certified. Between our ASC's and our practice, we employ 100 persons in addition to our physicians.

ASC's have provided quality services to Medicare patients since inception. Cost savings have been significant compared to the hospital environment and patient satisfaction studies have shown a higher satisfaction in ASC's compared to hospitals. ASC's have proven their value and quality of service while maintaining high patient satisfaction. However we are now extremely concerned about the negative impact that may be created by the recent CMS-proposed reduction in ASC payments.

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The proposed 62% reimbursement reduction is targeted primarily toward gastroenterology. As such, it is an unprecedented action taken that greatly impacts a single specialty. Obviously, such a proposal would be unfair to our specialty.

We understand that part of this proposal is related to the CMS definition of budget neutrality. In our opinion, this definition should be re-evaluated. It certainly should not be used to devastate a single targeted specialty. Unfortunately, this will happen to gastroenterology services in ASC's.

Specifically for our ASC network and Medicare community, the negative impact is likely to be profound. It will assuredly impair our ability to remain current in providing new technologies and quality services to Medicare and other beneficiaries. It will also strain our ability to see the increasing numbers of Medicare patients who opt for colon cancer screening. Currently Medicare patients comprise roughly 35% of all patients who undergo procedures in our ASCs. As such, reimbursement for greater than one-third of patients seen in our facilities is expected to decrease substantially. As a single-specialty ASC network, our flexibility to offset the effects of a decrease to 62%, or even perhaps 75% of HOPD reimbursement is highly limited as well. While this may not force our facilities to close, the most practical compromise may well be a migration of Medicare patients back to the hospital HOPD.

Passage of the 1998 Medicare Screening Benefit put in place the high priority Congress and CMS have placed on colorectal cancer screening. However, if the proposed rules are enacted and we are forced to do fewer colon cancer screening procedures on Medicare patients in our ASC but try to do them in the HOPD, our area hospital labs will be overwhelmed and will simply not be able to handle the volume. In addition, Medicare patients will be severely inconvenienced if they have to "go back" to the hospital setting for colonoscopy screening. The proposed policy will limit access for Medicare patients to this benefit in more convenient, high quality ASCs, is contrary to the intent of Congress and should therefore be changed to provide adequate reimbursement for GI procedures in ASCs.

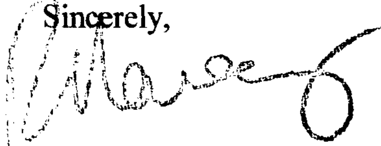
Migration to the HOPD will also be problematic in the following way. Our physician group employs a GI hospitalist (board certified gastroenterologist) who provides high quality inpatient care for Medicare and non-Medicare patients. Migration of Medicare patients from our ASC's to the hospital HOPD risks will overwhelm our hospitalist with additional outpatient procedures, hindering his ability to provide high quality care. Furthermore it is important to point out that the overall cost to CMS from such a migration would likely increase.

A major issue our practice/ASC has with the proposed rules is concern about maintaining our highly trained nursing personnel. Personnel costs of course continuously increase. Currently our centers have margins that allow us to hire top level quality staff. If our margins decrease, we will not be able to employee nurses and others with the expertise we think is required for providing high quality of care to Medicare patients. If layoffs are

required, a very negative business environment is created that would greatly impact our ability to provide the standard of care that we feel is due Medicare patients.

Our recommendations include that CMS re-evaluate the definition of budget neutrality, factor in the impact of inflation and our current frozen ASC reimbursement structure, and give priority consideration to the Lewin Group study and recommendations.

Sincerely,



Raj I. Narayani, M.D.

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November 2, 2006

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

Dear Administrator Norwalk:

Thank you for the opportunity to respond to the newly proposed ruling on the Medicare ASC Payment System and ASC List Reform. I write to you with deep concern for the healthcare industry and the effects this newly proposed rule will have on the future of our healthcare landscape. Harmony Ambulatory Surgery Center, LLC, is honored to provide quality, cost effective healthcare to our community in Fort Collins, Colorado and to the surrounding areas. Our goal is to ensure everyone including Medicare beneficiaries continue to have the open access and the choice to obtain healthcare at our high quality ambulatory surgery center. Our facility is accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) to show our customers our commitment to quality healthcare and our patient satisfaction rate has remained at 98% or above for the past 6 years which is one of the hallmarks of the surgery center industry and just one of the valuable contributions surgery centers offer to its patients and communities. In addition, we are a joint venture between our local health system and local physicians. This outstanding partnership has lead to collaboration for the best outcomes and cost effective healthcare in our community. I urge you to reconsider some of the points discussed in the proposed ruling as they would harm our ability to see Medicare beneficiaries which is currently 26% of our patient population. My concerns with the proposed Medicare ASC Payment System are as follows:

1) To assure Medicare beneficiaries' access to ASCs, CMS should broadly interpret the budget neutrality provision enacted by Congress. 62% is simply not adequate.

   Currently, for a colonoscopy for Colorectal Screening, CPT Code G0105, CMS reimburses our ASC $446, under the newly proposed payment system our reimbursement for the same procedure would be $298.17 which would make it hard if not impossible for us to continue this procedure at our surgery center. We are very efficient and cost effective but if you decrease the reimbursement to the proposed rate under the newly proposed system CMS would be driving those procedures back to the hospital outpatient department in turn paying a much higher rate. Driving procedures back to the hospital outpatient department would not accomplish budget neutrality it would further stress the Medicare financial dollars which CMS has statec is not a sustainable system.

2) ASC list reform proposed by CMS is too limited. CMS should expand the ASC list of procedures to include any and all procedures that can be performed in an HOPD. CMS should exclude only those procedures that are on the inpatient only list.

   President Bush has advocated surgery centers on numerous occasions recently, stating that ASCs are a more cost-effective environment than the hospital to receive key medical services. Private insurance carriers have realized the quality, cost effective care ASCs provide to their customers and have actually encouraged their patients to utilize ASCs instead of hospital outpatient department. An excellent example is the laparoscopic cholecystectomies (removal of the gallbladder with the assistance of a laparoscope), CPT code 47562-47570. The ASC industry has been safely performing this procedure on many patients for years in the ambulatory surgery center setting, yet CMS still has not added this procedure to the "Medicare ASC Approved List" which amounts to limited choice for Medicare beneficiaries and increased financial burden to the Medicare financial system due to the higher reimbursement CMS is paying to have this procedure performed in a hospital outpatient department. This procedure does not require an overnight; therefore by CMS standards should be a surgical procedure allowed to be performed in an ASC. Nearly all of our laparoscopic cholecystectomies are discharged after only 2-3 hours of recovery care following their procedure. We would be happy to provide CMS with any data needed showing our quality outcomes and outstanding patient care. This is only one example of many of why the ASC procedure list should be aligned with the HOPD procedure list. I ask that you strongly consider aligning the ASC allowed procedures to the HOPD procedures.

3) ASCs should be updated based upon the hospital market basket because this more appropriately reflects inflation in providing surgical services than does the consumer price index. Also, the same relative weights should be used in ASCs and hospital outpatient departments.

4) 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.

Please help us to continue to be able to provide care to Medicare beneficiaries by addressing our concerns and changing the newly proposed ruling in favor of choice and quality, cost effective care provided by ASCs.

Thank you very much for your time and consideration of our comments. I look forward to working with CMS to revise the ASC Payment System so as to ensure that Medicare beneficiaries will have full access to the many benefits ASCs offer. Please feel free to contact me at (970) 297-6350 if you need any additional information. Thank you.

Sincerely,

Rebecca R. Craig, RN, BA, CNOR, CASC
Administrator, Harmony Ambulatory Surgery Center, LLC

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October 30, 2006

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

RE: PROPOSED ASC PAYMENT REFORM AND PROCEDURES LIST RULEMAKING

To Whom It May Concern:

I am an owner of an ophthalmic/optometric group practice, who performs surgeries at the Kingston Surgery Center (KSC), located at 601 Wyoming Avenue, Kingston, PA 18704. Over 3,000 cataract surgeries are performed at the KSC every year, of which 40% are Medicare patients.

The eleven (11) ophthalmologists at Eye Care Specialists are committed to high quality and lower cost cataract and other ophthalmic surgical care, and value the convenience and expediency of an ASC.

The following are my comments concerning the proposed ASC Payment Reform and Procedures List Rulemaking:

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

Proposed ASC Payment of 62% of the Hospital Outpatient Department (HOPD) Rate - CMS, citing budget neutrality restrictions imposed by Congress is proposing to pay ASC's only 62% of the procedural rates paid to HOPD's. This percentage rate is wholly inadequate and doesn't reflect a realistic differential of the costs incurred by hospitals and ASC's in providing the same services. The agency should interpret the budget neutrality provision to permit ASC's to be paid at a rate of 75% of the HOPD rate, as recommended by the ASC industry.

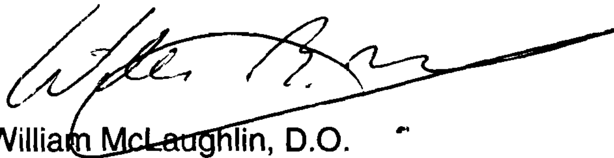
Uniform Percentage for All Services - Whatever percentage is eventually adopted by CMS in the final regulation, should be applied uniformly to all ASC services, regardless of the type of procedure or the specialty of the facility.

Payment Rates for Office-Type Procedures - Although CMS has added many ophthalmic services to the ASC list, the agency would pay for many office-type services, like laser procedures, at the Medicare Professional Fee Schedule practice expense amount; i.e., your current reimbursement rate, rather than at the 62% rate. As noted above, whatever percentage is ultimately adopted by CMS, it should be applied uniformly to all services, regardless of type.

Annual Updates of Payment Rates - Under current law, ASC's are provided no annual cost-of-living updates from 2004-2009, notwithstanding significant increases in the costs of delivering care. Commencing in 2010, CMS is proposing to pay ASC's an update equal to the Consumer Price Index (CPI), while HOPD's would be paid an update based on the hospital market basket (HMB), which is typically higher. The new payment system should provide hospital market basket updates to both ASC's and HOPD's since both provide the same services and incur the same costs in delivering high quality surgical care.

I sincerely appreciate your consideration of my comments concerning this matter.

Sincerely,



William McLaughlin, D.O.

206-0
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October 31, 2006

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

Re: Medicare Program: Ambulatory Surgery Centers PPS
Proposed Rule

Dear Dr. McClellan:

I am an R.N. that is employed at an Ambulatory Surgery Center that treats a significant amount of Medicare beneficiaries. I am writing to express my significant concern with CMS's recent proposal to change the way Medicare pays ambulatory surgery centers for their services, via facility fee payments.

Treatment for a substantial percentage of Medicare patients that we manage includes performing screening colonoscopies for those who are at average risk for colorectal cancer, as well as colonoscopies for those who have already been detected as having either polyps, or who have had cancerous lesions excised previously. Additionally we see a very significant number of patients with other conditions such as GI bleeding, inflammatory bowel disease, gastroesophageal reflux disease (GERD), and/ or Barrett's esophagus for whom ready access to an appropriate, safe, cost-efficient site for GI endoscopy is critical to either restoring them to good health, or sustaining them in good health.

Medicare seems to be ignoring both the stated priorities of the current Administration as well as the lessons of cost management in the private sector. President Bush and his staff are on record, on multiple occasions, stating that ASCs are a more cost-effective environment than the hospital to receive key medical services. When private sector insurers have sought to reduce total health care costs, they have actively sought to encourage patients to receive their services in an ambulatory surgery center, instead of the hospital outpatient department. In a recent example, Blue Cross of California has announced that it will pay a 5% premium to physicians for every GI endoscopy that is performed in the ASC, rather than in the HOPD. This CMS proposal, which would always pay more to HOPDs and always pay less to ASCs, is contradictory to the direction adopted by the private sector insurers.

The reality is that for every single case that moves from the HOPD to the ASC under this expansion of the ASC approved list, the Medicare program will save money. This is so because at the current rates, ASC payments are always lower than, or at least never greater thatn the facility fee that CMS pays to HOPDs. Again, if the pool of dollars for

the ASC payments were fixed despite a large increase in the number of cases done in the ASC (because of expansions to the ASC list), then the pool of dollars paid out to HOPDs Will decline, because fewer cases are likely to be done there. So, the only accurate approach to budget neutrality is to consider the impact on the total pool of **Both** ASC payments and HOPD facility payments. In summary, the agency currently has budget neutrality completely wrong- (1) you cannot expect the same pool of funds to cover all costs when the expansion of the ASC approved list will likel y result in millions of additional cases moving to the ASC; and (2) CMS must take into account, a nd not ignore, the savings that are generated in HOPD payments because many cases will likely move for HOPD to the ASC setting.

It is clear what will happen if the CMS proposal is adopted in an ything close to its current form: Underutilization of the Medicare colorectal cancer screening benefit, cancers will go undetected, because GI ASCs will be forced to close, waiting times for screening will increase, and the overall rate of CRC screening will plummet further. Medicare facility fee payments for GI services will increase, rather than decrease, because the access of Medicare beneficiaries to GI ASCs will be markedly reduced. CRC screening colonoscopies will be reduced, but the volume of diagnostic colonoscopies and endoscopies will not decline. With fewer ASCs, a larger portion of all GI procedures will need to be performed in the HOPD, where the facility fees that CMS pays will be greater.

It is hard to believe that these are the results the CMS is seeking, but the on ly way to avoid this outcome is to modify this proposal so as to increase, not decrease, the facility fees to GI ASCs. This will avoid closure of G I ASCs, preventing an increase in the number of GI procedures performed in the more costly HOPD setting.

Having worked in both the HOPD and ASC, I can certainly speak for the efficiencies that are recognized in the ASC. Patient satisfaction is enhanced at the ASC and therefore patient compliance naturally increases. This fact should not be overlooked when there is concern of underutilization of the Medicare colorectal screening benefit.

Respectfully submitted,

Amy Stout, R.N.
Digestive Health and Endoscopy Center

207-O
(54)

Dr. Robert Martin, M.D.
275 Taylor Station Rd.
Columbus, Ohio 43213
November 1, 2006

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

Dear Administrator Norwalk,
I am writing to ask you to support Ambulatory Surgical Centers (ASC) in the United States. The Centers for Medicare and Medicaid Services has developed a proposed rule that will significantly affect the ASC in which I work. These provisions mark the wholesale reform of the ASC payment system by eliminating the historic grouper payments and adopting the APC relative weights used in the hospital outpatient prospective payment system.

I am concerned by the proposed ruling for many different reasons. The proposed ruling may not assure Medicare beneficiaries' access to ASC's. CMS should broadly interpret the budget neutrality provision enacted by Congress. **62% is simply NOT adequate**.

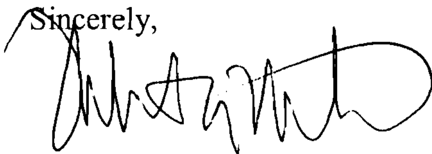
The ASC list reform proposed by CMS is too limited. CMS should expand the ASC list of procedures to include any and all procedures that can be performed in a hospital outpatient department. CMS should exclude only those procedures that are on the inpatient only list.

The ASC's 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 ASC's and hospital outpatient departments.

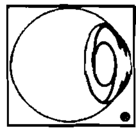
Aligning the payment systems for ASC's and hospital outpatient departments will improve the transparency of cost and quality data used to evaluate outpatient surgical services for Medicare beneficiaries. I believe that the benefits to the taxpayer and the Medicare consumer will be maximized by aligning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

Thank you for your support.

Sincerely,



Dr. Robert Martin, M.D.



COMMONWEALTH EYE SURGERY™

208-0 (C6)

Lance S. Ferguson, M.D. Consultative Ophthalmology
Howell M. Findley, O.D. Consultative Optometry
R. Marty Smith, O.D. Consultative Optometry

November 1, 2006

Centers for Medicare and Medicaid Services
Department for Health and Human Services
Attention: CMS-1506-P
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

Dear Miss Norwalk, Esq:

I am writing this letter to provide you input on CMS' intent to establish a new ASC payment system and update the ASC procedures list. I am the Practice Manager for Commonwealth Eye Surgery and Commonwealth Eye SurgiCenter located in Lexington, Kentucky. We are a dedicated ophthalmic ASC that specializes primarily in Cataract, Oculoplastic, and Vitreoretinal surgery. We perform close to 5000 surgeries on an annual basis, with the greatest majority being Medicare and Medicaid covered individuals. Our surgery center's volume and financial demographics represent the top 1% of the nation's ASCs. We are also the largest, by provider volume, specialized surgery center in Central Kentucky, if not the entire state.

First, I would like to tell you that the CMS proposed reform of the ASC procedures list remains far too restrictive. The decision as to site of surgery should be made by the surgeon in consultation with his patient and not by an outside party. ASC's should be permitted to furnish and receive facility reimbursement for any and all procedures that are performed in Hospital Outpatient Departments (HOPD).

Second, it is my understanding that the proposed ASC payment is going to be only 62% of the Hospital Outpatient Department rates. This is, quite frankly, unfair and unfounded. This percentage rate is wholly inadequate and doesn't reflect a realistic differential of the costs incurred by hospitals and ASCs in providing the exact same services. The agency should interpret the budget neutrality provision to permit ASCs to be paid at a rate of 75% or greater of the HOPD rate, as recommended by the ASC industry.

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

Fourth, although CMS has added many ophthalmic services to the ASC list, the agency would pay for many office-type services, like laser procedures, at the Medicare

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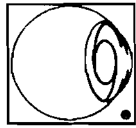

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Lance S. Ferguson, M.D.
Consultative Ophthalmology

Howell M. Findley, O.D.
Consultative Optometry

R. Marty Smith, O.D.
Consultative Optometry

Professional Fee Schedule practice expense amount rather than the proposed 62% rate. As noted above, whatever percentage is ultimately adopted by CMS, it should be applied uniformly to all services, regardless of type.

Finally, under current law, ASCs are provided no annual cost-of-living updates from 2004-2009, notwithstanding significant increases in the costs of delivering care, which at our estimate is greater than 10% annually. Commencing in 2010, CMS is proposing to pay ASC's an update equal to the consumer price index (CPI), circa 1-3%, while HOPDs would be paid an update based on the hospital market base (HMB), which is typically higher. The new payment system should provide hospital market base updates to both ASCs and HOPDs since both provide the exact same services and incur the same costs in delivering high quality surgical care.

I sincerely appreciate your time and look forward to your support on these issues. If you would like to speak with me personally about further details outlined in this letter, I may be reached from the information below.

Regards,

Jennifer Lackey
Practice Manager
Commonwealth Eye Surgery

2353 Alexandria Dr. • Suite 350 • Lexington, Kentucky 40504-3208
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HEALTHSOUTH
Surgery Center of Gwinnett

209-0
(19)

24 October 2006

Centers for Medicare and Medicaid Services
Department of Health and Human Resources
Attention: CMS-4125-P
Post Office Box 8011
Baltimore, Maryland 21244-1850

VIA FIRST CLASS MAIL

RE: Proposed Rule on New ASC Payment System

To Whom It May Concern:

As an administrator of an ASC I am fully aware of the convenience and benefits we provide to the patients we treat. It concerns me that CMS continues to consider perpetuating the double standard of reimbursing HOPD and ASC at different rates for the same surgery.

Granted, there are some procedures and patients that are inappropriate for ASC's and in that instance the HOPD should be paid whatever CMS feels is appropriate. But if both facilities do the same case on a patient with similar risk factors then the reimbursement should be equal.

ASC's are more efficient and our infection rates are lower than hospitals because of the healthier population we serve; a healthier individual who enters a hospital for a procedure is at greater risk of contracting a nosocomial infection thereby increasing CMS costs for post operative complications. A more efficient system for delivering health care also benefits CMS from a cost factor; because ASC's do not perform emergency surgeries our cases are on time, surgeons are not rushed and the delivery of healthcare is better. Not to mention the satisfaction of our patients reflected in the patient satisfaction responses.

I urge you to reconsider the proposed rule and:

- Make reimbursement equal – HOPD and ASC's should be paid the same for the same procedure.
- Review and expand the current list of procedures appropriate for ASC's; with each year new technology makes performing procedures safer in an ASC.
- Realize the cost for providing care in and ASC and HOPD are similar salaries, equipment and supply costs do not vary because one facility is an ASC or HOPD.
- Reconsider reimbursement of implants and DME when reimbursing ASC's for procedures, once again ASC's and HOPD's should be paid equally.

Thank you, in advance, for listening to my concerns.

Sincerely,

Linda F. Coker, RN
Administrator

2131 Fountain Drive • Snellville, GA 30078 • 770 979-8200 • Fax 770 979-0728

210-0
(2)

October 27, 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:

We were originally excited to see that after freezing the reimbursement schedule for several years CMS was reviewing and going to propose a reimbursement system similar to hospital HOPD rates. After careful review of the latest Medicare proposal we would like to make you aware of our grave concerns not only on the impact for our surgery center but surgery centers across America as well.

Budget Neutrality: ASCs are currently reimbursed less than a hospital outpatient facility for the same procedures. Based on the current list of approved procedures we could perform procedure code 29888 in our surgery center; however, we are not able to do so based on the current grouper methodology primarily due to most implants not being covered in an ASC. The facility cost for the implants alone on this type of procedure is $3365.00; with the current grouper reimbursement of $510 we are not able to perform this procedure because the cost is prohibitive to the ASC. With the migration to HOPD rates, it is still not feasible at $2630.83 much less at the proposed 62% of HOPD.

The cost to perform these procedures is the same if not higher than hospital based surgery centers (due to their volume and multiple sites they are normally able to negotiate more cost efficient vendor contracts). Unfortunately, we are not able to perform the same procedures for a lesser cost than an HOPD nor are we able to employ nurses or surgical technicians for a lesser salary. We are recommending that CMS re-evaluate the 62% reimbursement proposal and instead propose something that is fair to both ASCs and HOPD without such a significant difference between the two.

Surgery Centers are normally much more cost efficient than a hospital or hospital outpatient surgical department; however, most of our cost are equal to and/or greater than those incurred by the hospital outpatient facility.

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813-972-4905 • Fax 813-615-8850

ASC Procedure List: Currently, the approved ASC list is very limited and we would recommend that CMS expand the list to include all those procedures that can be performed in an HOPD. We feel that the indicator CMS is using is too limiting and that the final decision in regards to the safety of the patient and whether or not the procedure can safely be performed in a surgery center should be left in the hands of the patient's treating physician, surgeon and anesthesia personnel.

Inflation factors: CMS is proposing two separate inflation factors one for surgery centers and one for HOPDs. The Consumer Price Index produces monthly data on changes in prices paid by urban consumers while the Hospital market basket is based on a fixed-weight index tied into a base period structure. We are recommending that CMS use the Hospital market basket which more appropriately reflects inflation for surgical services versus the Consumer Price Index as well as using the same relative weights.

We would also like to point out that ASCs are held to the same high standards as hospitals and HOPDs; however, your proposal suggests that while we are required to give the same level of care that there will not be equality in reimbursement for the same procedure performed in an ASC.

In summary, we are recommending that CMS align the paymeňts systems, expand the ASC list to include all procedures that can be performed in an HOPD and use the same inflation factors. By doing so, we feel that the new proposed payment system will be more fair, realistic and cost efficient for the taxpayers, Medicare beneficiaries, HOPD and free standing outpatient facilities.

If you have any questions or would like to discuss this further, please do not hesitate to contact me.

Sincerely,

Debbie Baker, MBA
Administrator

13060 Telecom Parkway • Temple Terrace, FL 33637
813-972-4905 • Fax 813-615-8850

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

211-0
(3)

As members of the healthcare community we have been involved in serving the Medicare population for many years. We feel that if you continue to negatively impact the Ambulatory Surgery Center Community we will not survive and that the outpatient hospital service will be the only alternative left. This would be a shame. We deliver safe, quality, affordable care to those who struggle to make ends meet. By forcing patients into the hospital based system you will greatly increase the cost to our Medicare patients. This will negatively impact the patients ability to access and receive the care they need. Unless this is your goal, please consider the following information:

- The ASC reimbursement system should be modeled on the methodology applicable to surgical services furnished in hospital outpatient departments ("HOPDs"), with ASCs paid on the basis of a *reasonable percentage of the rates paid to HOPD* for the same services. This will create the proper incentives for beneficiaries and physicians to use a less costly setting when medically appropriate. This should include the same pass-through payments for medical devices or other new technologies in both settings.

- ASC payment rates should be updated annually in coordination with HOPD rates.

- Changes to the ASC reimbursement system should be *phased in over a multi- year period*. Special rules should be established to prevent disruptive or excessive one-time price changes for some procedures and to ensure a smooth transition to a new payment system.

- The Medicare *beneficiary's copayment should remain at 20%* of the service (as provided under current law), which will ensure that patients will pay less for surgical services provided in ASCs.

- Any new system should allow ASCs to perform and receive payment for any surgical service covered in an HOPD unless (1) the service requires an *overnight stay*; or (2) the Secretary of the Department of Health and Human Services has determined that performance in an ASC would pose a significant *risk to safety*.

- We ask your support for these key principles as ASC reimbursement reform moves forward in order to ensure that patients are given access to the best choices available.

If you agree with the point above please show your support by signing below.

David W C[illegible] M.D