Urology Center
Of Spartanburg, P.C.

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October 19, 2006

ATTN: CMS-4125-P
Centers for Medicare and Medicaid Services
Department of Health and Human Services
P.O. Box 8011
Baltimore, Maryland 21244-8013

To Whom It May Concern:

I am writing in regards to your proposed rule regarding the new system for ASC payment. It is my understanding that this system will use ambulatory payment classifications (APCs) as a mechanism of grouping procedures and determining their relative payment weight. CMS proposed rule plans to pay ASCs approximately 62% of the hospital outpatient department APC payment rate. It is my understanding there is an assumption that the cost of providing care in the ASC for many procedures did not involve the high cost of providing this care in the hospital outpatient department. If this rule is passed as presently proposed, this would have a marked adverse affect on urologic procedures. For example, we would not be able to place any type of prosthesis or incontinence procedure using the sling. The cost for the penile prostheses as well as the incontinent sling material is the same for the hospital or the ASC. The purposed payment is inadequate at this time to cover the cost of the implant and the procedure could not be performed in the ASC. Another example that would prevent the ambulatory surgery centers from performing certain procedures include lithotripsy and laser treatment of the prostate. Most of this technology is expensive, and the hospitals and the ASCs usually lease this equipment. Once again in these circumstances, the hospital outpatient department and the ASC incur the same lease expense. The reimbursement should be the same for these type of procedures since the costs are equal.

CMS is proposing to cap the level of reimbursement for office-based procedures that are performed in the ASC. This level of payment would effectively mean that they would not be performed in the ASCs. CMS recognizes that the proposed rule will have procedures that are exempt and it is critical that all procedures that are presently on the ASC list be exempt from the present proposed cap. The cap completely disregards the additional complexity and cost of performing these procedures in the ASC environment. If CMS feels that these procedures can appropriately be performed in the ASC, then they should be reimbursed at a reasonable level so that the financial obligation of the ASC performing these procedures can be achieved. Once again, I strongly encourage CMS to consider all procedures that are on the 2007 ASC list to be exempt from the office-based classification.

I encourage CMS to strongly reevaluate their present proposed rule changes regarding ASC reimbursement to further allow our Medicare patients access to this cost-effective, convenient healthcare setting.

Respectively submitted,

Clifton L. Williams, Jr. MD F.A.C.S.

CC: Society of Ambulatory; Urologic Surgeons, 3201 Southwest 34th St. Ocala, Florida 34474

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HEALTHSOUTH
Centennial Lakes Surgery Center

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October 27, 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

To Whom It May Concern:

My name is Dylan Carroll and I am the Administrator of the HealthSouth Centennial Lakes Ambulatory Surgery Center in Edina, Minnesota. Approximately 65 physicians perform surgical procedures in our facility, and we employ 35 people in various capacities including nurses, surgical technicians, and business office staff. Each year our facility performs approximately 3,300 surgical procedures. This letter is in response to recently released CMS proposal for changes to the payment methodology for ambulatory surgery centers (ASCs).

Ambulatory surgical centers provide patients with a high-quality, convenient and less expensive option for their outpatient surgery. When Medicare beneficiaries choose ASCs for their outpatient surgery, they and Medicare saves money. Private payers have recognized the high-quality care and value provided by ASCs and along with their employer-customers have expanded the scope of safe surgical services available for payment in ASC.

MedPAC and the ASC community support moving to the hospital outpatient prospective payment system (HOPPS). The proposed rule would tie ASCs 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 a much lower payments to ASCs relative to payments made when services are provided in the HOPD. During this time, HOPD has received significant payment updates. In the proposed rule, CMS estimates that ASCs should be paid only 62% of HOPD for providing the identical outpatient surgical services. That low payment rate will result in significant cuts to a number of important, commonly performed services in ASCs including GI and ophthalmology. At the same time, payments for other specialties such as orthopedics will rise but it is not clear whether they will increase enough to become viable and be provided ubiquitously at ASCs.

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CMS can 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.

1. **Adopt an expansive, realistic interpretation of budget neutrality that examines total Medicare spending on outpatient surgery**. It is clear that 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. 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. We expect that number to be substantially higher than the 62% CMS announced in its "alternative methodology."

2. **Create a truly exclusionary list for ASC services, as suggested by MedPAC and Secretary Leavitt**. Of the many payment systems administered through CMS, only the ASCs are bound to a list of permitted procedures determined by CMS. In December 2005, Secretary Leavitt wrote a letter to Senator Crapo that HHS intends to "maximize choices" for beneficiaries by significantly expanding the list of procedures that could be performed in an ASC. While the proposed rule would add 750 procedures to the ASC list, most are low complexity procedures and are capped at the physician fee schedule rate, not paid using a percentage of HOPD rates. CMS failed to include on the list many higher complexity services that have for years been safely and effectively performed in ASCs through 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.

3. **Do not widen the gap between HOPD and ASC payments over time**. ASCs confront the identical inflationary pressures as hospitals – hiring and retaining qualified OR nurses, purchasing medical supplies and the like. Yet CMS has proposed updating ASC payments by the consumer price index, a general measure of inflation of the economy rather than the hospital market basket update. 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 HOPD and the ASC without any evidence that different payment rates are warranted.

4. **Create a truly parallel system to HOPD in all aspects**. 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 on the same basis. For example, prosthetic devices and implantable DME are bundled in HOPD payments at rates that allow a full pass though of the DME costs. Payment levels for ASCs should be set at similar levels to allow full reimbursement for

DME costs (*i.e.*, whatever discount factor is used to determine ASC payments relative to HOPD should not apply to the portion of the payment related to DME 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.

I appreciate the opportunity to comment on these proposed rules. Please do not hesitate to contact me with any questions or comments about the material included in this letter.

Sincerely,

Dylan Carroll

Dylan Carroll, Administrator

HEALTHSOUTH
Salt Lake Surgical Center

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October 25, 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

To Whom It May Concern:

I am writing in the capacity of the Administrator of the Salt Lake Surgical Center. The Salt Lake Surgical Center was Utah's first licensed free-standing ambulatory surgical center. We recently celebrated our 30th Anniversary, having provided quality services to over 120,000 patients. Patient satisfaction is monitored closely at our ASC. Medicare patients are among our most satisfied patients. Our high nurse to patient ratio, attention to detail and convenient access appeal to the Medicare population. These patients are extremely appreciative of the attention given to the details of their care when treated in the ambulatory surgical centers.

We certainly appreciate the consideration that CMS has provided by agreeing to add 750 procedures to the ASC list, but feel that an exclusionary list for ASC services, as suggested by MedPAC and Secretary Leavitt is more appropriate. The 750 procedures that have been proposed are procedures that are mostly low complexity and are capped at the physician fee schedule rate rather than using a percentage of HOPD rates. More complex services that have been performed safely and effectively at ASCs around the country have not been added. This discrepancy decreases patient choice and eliminates surgeon clinical judgment.

In regard to budget neutrality, we would propose that CMS look at a more realistic interpretation, examing the impact of the new ASC payment system on all Medicare spending for outpatient surgery. We would expect that number to be significantly higher than the 62% CMS has proposed in its "alternative methodology".

We would also like you to consider that you are widening the gap between HOPD and ASC payments over time by proposing to update ASC payments by the consumer price index, 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 larger gaps between the prices paid in the HOPD and the ASC.

We believe ASCs and HOPDs should be treated equally in certain key aspects. Payments should be made on the same basis. For example, implantable prosthetic devices and DME are bundled into the HOPD payments at rates that allow a full pass through for the DME costs. Payment levels for ASCs should be set at similar levels to allow full reimbursement for the prosthetic or DME. Whatever discount factor is used to determine ASC payments relative to HOPD should not apply to the portion of the payment related to the prosthetic devices or DME 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 payment will remain below cost. This issue is a problem within the current CMS reimbursement system and will remain a problem unless the current proposal is changed. This could be such a tremendous savings for the Medicare program. It is hard to understand why it has not been considered in the past.

As a healthcare provider and consumer, I ask that you carefully review these issues again. We want all Medicare patients to have access to the same quality, cost effective services that we provide to all other ambulatory surgical patients.

Sincerely,

Robyn Archer, R.N.
Administrator