Submitter : Mrs. Cynthia Hastings **Date:** 10/31/2006

Organization : Nueterra

Category : Health Care Professional or Association

Issue Areas/Comments

GENERAL

GENERAL

see attached

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

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

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

CMS-1506-P2-594

Submitter : Lucie Owens **Date:** 10/31/2006

Organization : Nueterra Healthcare

Category : Health Care Professional or Association

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1506-P2-594-Attach-1.DOC

#591

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

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

Dear Ms. Norwalk:

I am writing regarding the proposed payment changes for Ambulatory Surgery Centers. I work for Nueterra Healthcare, a management company for ASCs. Through our affiliated centers, we serve thousands of Medicare recipients each year. We are very concerned that the changes, as currently proposed by CMS will have a detrimental affect on ASCs and the Medicare program.

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

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

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

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Sincerely,

Lucie A. Owens
Sr. VP Project Management
Nueterra Healthcare

Submitter : **Mr. Dean Ott** **Date: 10/31/2006**

Organization : **Grand Island Surgery Center**

Category : **Ambulatory Surgical Center**

Issue Areas/Comments

CY 2008 ASC Impact

CY 2008 ASC Impact

Dear Administrator Norwalk:
Please read the proposal, do the math and make the right decision. If you make the correct decision, you will be personally responsible for saving CMS and taxpayers millions of dollars annually. The ASC industry has proven in many ways that we are a more affordable and efficient option for outpatient procedures. Don't discriminate against our elder population. A wrong decision will cause the demise for many Centers. 62% is not acceptable.

Submitter : **Dr. Kaveh Kian** **Date: 10/31/2006**

Organization : **Denver Nephrology**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Vascular access is one of the greatest sources of complications and cost for dialysis patients. Why, because America uses more surgical grafts and catheters for vascular access than the rest of the developed world, even though there is substantial evidence that they impose higher initial and maintenance costs, lead to greater clinical complications, and result in higher mortality than arterio-venous (AV) fistulae.

The inclusion of CPT codes 35475, 35476, 36205 and 37206 to the list of Medicare approved ambulatory surgical center (ASC) procedures would provide Medicare the opportunity to reduce the cost of, and promote quality outcomes for, end-stage renal disease (ESRD) patients through more thoughtful reimbursement and regulation of vascular access procedures.

Submitter : **Mr. Jason Thomas** **Date: 10/31/2006**

Organization : **DaVita**

Category : **End-Stage Renal Disease Facility**

Issue Areas/Comments

ASC Payable Procedures

ASC Payable Procedures

I support CMS practice of re-examining its policies as technology improves and practice patterns change, especially when supported by recommendations made by the Medicare Payment Advisory Commission (MedPAC) in their March 2004 report to Congress. The report concludes that clinical safety standards and the need for an overnight stay be the only criteria for excluding a procedure from the approved list.

Please support patient choice! There is clear scientific evidence that vascular access procedures are safe and can be performed in Ambulatory Surgical Center setting, and more importantly, patients are extremely satisfied with having the option to secure vascular access repair and maintenance care in an outpatient setting. Further, the inclusion of angioplasty codes in the ASC setting would support CMS Fistula First initiative by permitting a full range of vascular access procedures to be performed in an ASC setting, a less expensive and more accessible option than the current prevalent hospital setting.

Please treat End Stage Renal Disease patients fairly by ensuring all angioplasty codes, including CPT 35476 are allowed in the ASC setting.

Submitter : **Ms. Linda Neville** **Date: 10/31/2006**

Organization : **Nueterra Healthcare**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

see attached

CMS-1506-P2-599-Attach-1.DOC

#579

Leslie V. Norwalk, Esq., Acting Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
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Sincerely,

Linda Neville

CMS-1506-P2-600

Submitter : Mr. Phil Carpenter

Date: 10/31/2006

Organization : Nueterra Healthcare

Category : Other Health Care Professional

Issue Areas/Comments

GENERAL

GENERAL

See Attached

CMS-1506-P2-600-Attach-1.DOC

#600

Leslie V. Norwalk, Esq., Acting Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
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Sincerely,

Phil Carpenter
Nueterra Healthcare

Submitter : Ms. Sandra Martyn **Date:** 10/31/2006

Organization : Ms. Sandra Martyn

Category : Nurse

Issue Areas/Comments

ASC Payable Procedures

ASC Payable Procedures

As a Nephrology Nurse with 30 years experience, I believe that fistula/graft surgery can be safely and economically performed in a ASC atmosphere.

GENERAL

GENERAL

As a nephrology nurse with over 30 years experience, I would like to see vascular access surgery allowed in ASC sites as a way to increase access to early intervention and fistula first initiatives. I see many patients waiting too long for accesss surgeries due to overbooked Operating rooms. It would also be a cost effective alternative to hospitalizations.

CMS-1506-P2-559

Submitter : Dr. Jon-Marc Weston **Date:** 10/30/2006

Organization : Vision Surgery

Category : Ambulatory Surgical Center

Issue Areas/Comments

CY 2008 ASC Impact

CY 2008 ASC Impact

The ASC payable proceedure list shoould include all HOPD procedures unless there is clear indication that would be unsafe. The proposed criteria are cumbersome and would result in additional cost to the system since under all scenarios the HOPD payment would be more expensive.

The budget neutrality scenario will result in an unfair pay schedule for ASCs as currently configured. It should be obvious that if a certain number of proceedures are done, increasing the percentage of those performed in the ASC will result in savings. The global budget should include anticipated payments for all of these proceedures regardless of location. Including the HOPD and ASC funding in the same pool is the only fair way to allocate funding.

The annual update in rates should not be lower for ASCs than Hospitals. Over the past decade ASC reimbursement has not kept pace with inflation, So those updates should begin immdiately. Increased costs for a given proceedure will not be lower in the ASC, so the index used should be the same.

Submitter : Mrs. Veronica McDonnell

Organization : DaVita St. Louis West PD Dept.

Date: 10/31/2006

Category : Dietitian/Nutritionist

Issue Areas/Comments

GENERAL

GENERAL

I do feel that there are certain procedures such as inserting a permacatheter that can be done in an outpatient setting w/o high risk of potential harm and should be reimbursed. However, I do feel that fistulas, vascular accesses and peritoneal dialysis catheters should be placed in the hospital setting so that other services are available in the case of emergencies stemming from these procedures.

Submitter : **Mr. Jason Thomas** **Date: 10/31/2006**

Organization : **DaVita**

Category : **End-Stage Renal Disease Facility**

Issue Areas/Comments

GENERAL

GENERAL

Vascular access is one of the greatest sources of complications and cost for dialysis patients. Why, because America uses more surgical grafts and catheters for vascular access than the rest of the developed world, even though there is substantial evidence that they impose higher initial and maintenance costs, lead to greater clinical complications, and result in higher mortality than arterio-venous (AV) fistulae.

The inclusion of CPT codes 35475, 35476, 36205 and 37206 to the list of Medicare approved ambulatory surgical center (ASC) procedures would provide Medicare the opportunity to reduce the cost of, and promote quality outcomes for, end-stage renal disease (ESRD) patients through more thoughtful reimbursement and regulation of vascular access procedures.

CMS-1506-P2-604

Submitter : Mr. Jose Zambrano **Date:** 10/31/2006

Organization : DaVita, Inc

Category : Other Technician

Issue Areas/Comments

ASC Payable Procedures

ASC Payable Procedures

I support CMS practice of re-examining its policies as technology improves and practice patterns change, especially when supported by recommendations made by the Medicare Payment Advisory Commission (MedPAC) in their March 2004 report to Congress. The report concludes that clinical safety standards and the need for an overnight stay be the only criteria for excluding a procedure from the approved list.

Please support patient choice! There is clear scientific evidence that vascular access procedures are safe and can be performed in Ambulatory Surgical Center setting, and more importantly, patients are extremely satisfied with having the option to secure vascular access repair and maintenance care in an outpatient setting. Further, the inclusion of angioplasty codes in the ASC setting would support CMS Fistula First initiative by permitting a full range of vascular access procedures to be performed in an ASC setting, a less expensive and more accessible option than the current prevalent hospital setting.

Please treat End Stage Renal Disease patients fairly by ensuring all angioplasty codes, including CPT 35476 are allowed in the ASC setting.

GENERAL

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Vascular access is one of the greatest sources of complications and cost for dialysis patients. Why, because America uses more surgical grafts and catheters for vascular access than the rest of the developed world, even though there is substantial evidence that they impose higher initial and maintenance costs, lead to greater clinical complications, and result in higher mortality than arterio-venous (AV) fistulae.

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CMS-1506-P2-605

Submitter : Ms. Judith Doell

Date: 10/31/2006

Organization : Dayton Eye Surgery Center

Category : Ambulatory Surgical Center

Issue Areas/Comments

GENERAL

GENERAL

see attachment

CMS-1506-P2-605-Attach-1.DOC

#605

Comments to CMS on proposed rule ASC rule:

My name is ( ) and I am Administrator for Dayton Eye Surgery Center in Dayton, Ohio. Our ambulatory surgery center offers a variety of ophthalmic services and has been providing high quality, patient centered, and cost effective interventional procedures and surgery since 1999. Our 45 employees and over 25 surgeons care for approximately 5000 patients a year (this includes over 3000 Medicare beneficiaries) at our surgery center. It is for these reasons that I ask you to consider how the new rules may affect us.

To assure Medicare beneficiaries' access to ASCs, CMS should broadly interpret the budget neutrality provision enacted by Congress. The current proposal of 62% would be disastrous for ophthalmic surgery centers, as this would result in major decreases in revenue for a service that is already struggling to maintain standards of care in a constantly changing arena of new technology and increasing costs of sales.

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

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.

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

This legislation will enable centers like ours to continue to offer to Medicare beneficiaries the highest quality surgical care at lower cost in a patient-friendly environment.

Sincerely,

Medical Staff - Dayton Eye Surgery Center
Dayton, Ohio

CMS-1506-P2-606

Submitter : **Rachel Ware** **Date:** **10/31/2006**

Organization : **Nueterra Healthcare**

Category : **Ambulatory Surgical Center**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1506-P2-606-Attach-1.DOC

#606

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

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

Dear Ms. Norwalk:

I am writing regarding the proposed payment changes for Ambulatory Surgery Centers. I work for Nueterra Healthcare, a management company for ASCs. Through our affiliated centers, we serve thousands of Medicare recipients each year. We are very concerned that the changes, as currently proposed by CMS will have a detrimental affect on ASCs and the Medicare program.

Given the outdated cost data and crude payment categories underlying the current ASC system, we welcome the opportunity to link the ASC and hospital outpatient department (HOPD) payment systems. Although the HOPD payment system is imperfect, it represents the best proxy for the relative cost of procedures performed in the ASC.

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

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

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

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

Alignment of ASC and HOPD Payment Policies

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

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

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

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

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

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

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

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

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

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

ASCs to submit claims using the UB-92, and the Medicare program should likewise align the payment system at the claim level.

Ensuring Beneficiaries' Access to Services

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

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

Establishing Reasonable Reimbursement Rates

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

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

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

consequences of the new ASC payment system on all sites of care – the physician office, ASCs, and HOPD.

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

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

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

In conclusion, I am asking for a reconsideration of many of the elements of the proposed changes as outlined above. Truly aligning the ASC payment system with that of the HOPDs is the most logical, fair and best policy approach to benefit the Medicare program those served by the program. Should you have any questions regarding any of the issues in this letter, do not hesitate to contact me. My e-mail is rware@nueterra.com, my phone number is (913) 387-0553 and my mailing address is Nueterra Healthcare 11221 Roe Ave, Suite 320 Leawood, KS 66211.

Sincerely,
Rachel L. Ware

Submitter : **Mr. Stan Murray** **Date: 10/31/2006**

Organization : **Arnold Surgery Center, LLC**

Category : **Ambulatory Surgical Center**

Issue Areas/Comments

GENERAL

GENERAL

October 30, 2006

Leslie V. Norwalk, Esq., Acting Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1506-P

Dear Administrator Norwalk;

Arnold Vision and Arnold Surgery Center provides high-quality medical and surgical care to its patients. The majority of these patients are Medicare subscribers who choose our facility and physicians over others in our area, even hospitals, because of this high quality as well as the personal care given by our physicians and staff. As administrator of this facility I have concerns about the proposed changes to the ASC payment system.

Although I am not opposed to the linking of reimbursement between ASCs and HOPDs, the methodology should be more direct and consistent. I agree with the more historical and realistic percentage of 75% rather than the proposed 62%. The cost of operating an efficient ASC continues to increase dramatically. Once set, it seems simpler, more equitable and sensible to maintain the percentage rather than adjusting the HOPD and ASC rates using different calculations. It seems that over time the gap will widen between HOPD and ASC reimbursements and again, the costs of operating and ASC continue to increase as dramatically as those of the HOPD.

Keeping with the theme of fairness and simplicity, I believe the percentage payment rate should be applied uniformly across all procedures and all specialties. No specialty should appear to be favored over another. This also applies to the ASC approved procedure list, which should be expanded to include the same procedures as are allowed in HOPDs. The decision of where and how a procedure is performed should be left to the patient and physician. I understand why the list had to be developed slowly for a few years, but the time has come to allow ASCs to operate with all of the tools of their trade and not just a portion of them.

Thank you for your time and attention in this matter.

Stan Murray
Administrator
Arnold Vision, LLC. 1011 E. Montclair Springfield, MO 65807
(417) 890-8877

Submitter : Ms. Kim Fisher

Date: 10/31/2006

Organization : Nueterra Healthcare Inc

Category : Other Health Care Professional

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

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

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

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

Submitter : **Dr. Matthew Parsons** **Date: 10/31/2006**

Organization : **Central Utah Surgical Center**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

See attachment

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

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

Submitter : **Ms. Joanne McLaughlin** **Date: 10/31/2006**

Organization : **Ambulatory Surgery Center of Greater New York, Inc**

Category : **Ambulatory Surgical Center**

Issue Areas/Comments

CY 2008 ASC Impact

CY 2008 ASC Impact

My letter is attached.

CMS-1506-P2-610-Attach-1.DOC

610

Ambulatory Surgery Center

of Greater New York, Inc.

October 31, 2006

Leslie V. Norwalk, Esq., Acting Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue, NW
Washington, D.C. 20201

Attention: CMS-1506-P, Room 445-G

Dear Administrator Norwalk:

The Ambulatory Surgery Center of Greater New York is a New York State Article 28 freestanding surgery center. We have been providing high quality, patient centered and cost-effective ophthalmic laser and surgical services since 1987 and we care for more than 8200 patients a year, over 85% of who are Medicare beneficiaries.

This letter is in regard to the Notice of Proposed Rulemaking published on June 12, 2006 regarding updates to the rate-setting methodology, payment rates, payment policies and the list of covered surgical procedures for ambulatory surgery centers. I am submitting the following comments in the interest of creating a healthcare system that delivers excellent clinical outcomes in a cost-efficient environment:

- The Centers for Medicare and Medicaid Services' proposed reform of the ambulatory surgery center procedures list remains far too restrictive. The expansion of the list to include any and all procedures that can be performed in a hospital outpatient department will result in migration of services from one site of service setting to another.

- The decision as to the site of surgery should be made by the surgeon in consultation with his patient. The Centers for Medicare and Medicaid Services' proposal to limit the physician's ability to determine the appropriate site of service for a procedure excludes many surgical procedures appropriate for the ambulatory surgery setting.

1101 Pelham Parkway N., Bronx, New York 10469 (718) 515-3500 FAX (718) 515-3503
Accredited by Accreditation Association for Ambulatory Health Care, Inc.

- Ambulatory surgery centers should be permitted to furnish and receive facility reimbursement for any and all procedures that are performed in hospital outpatient departments. When hospital outpatient departments perform services or procedures for which specific codes are not provided, they use an unlisted procedure code, identify the service and receive payment. I believe ambulatory surgery centers should also be eligible to utilize this process.

- Proposing to pay ambulatory surgery centers only 62% of the procedural rates paid to hospital outpatient departments does not reflect a realistic differential of the costs incurred by ambulatory surgery centers and hospitals in providing the same services. The budget neutrality provision should be interpreted to permit ambulatory surgery centers to be paid at a rate of 75% of the hospital outpatient department rate as recommended by the ambulatory surgery center industry. Such interpretations should include all hospital outpatient department payments in addition to just ambulatory surgery center payments. Broadly interpreting the budget neutrality requirement imposed by Congress would provide Medicare beneficiaries with access to ambulatory surgery centers, thereby reducing Medicare costs.

- The percentage that is eventually adopted by the Centers for Medicare and Medicaid Services in the final regulation should be applied uniformly to all ambulatory surgery center services, regardless of the type of procedure or the specialty of the facility.

- Although the Centers for Medicare and Medicaid Services has added many ophthalmic services to the ambulatory surgery list, it 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 it should be applied uniformly to all services, regardless of type. Most such services will also be transferred from the hospital outpatient department to the ambulatory surgery center setting thereby reducing Medicare costs and offsetting possible increased costs on the shifting of such services from office to ambulatory surgery center.

- Ambulatory surgery centers should be updated based upon the hospital market basket because it more appropriately reflects inflation in providing surgical services than does the consumer price index. The same relative weights should be used for ambulatory surgery centers and hospital outpatient departments since both provide the same services and incur the same costs in delivering surgical care.

- Aligning the payment systems for ambulatory surgery centers 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.

- The cap on office-based payments is inappropriate for the ambulatory surgery center and should be omitted from the final regulation.

- Devices used for surgical procedures should be included in the global fee.

- Ambulatory surgery centers should be eligible to receive new technology pass-through payments.

- The computation of rates and rate changes should be the same for both the hospital outpatient department and ambulatory surgery center reimbursement.

In summary, my firm belief is that the proposed changes to the ambulatory surgery center payment policies contain serious flaws that must be addressed in order to keep the Medicare program viable for ambulatory surgery centers. I urge that your serious attention be given to the items discussed above and I thank you for your time reviewing this correspondence.

Sincerely,

Joanne McLaughlin, R.N., M.H.A.
Administrator

CMS-1506-P2-611

Submitter : Dr. Jerome Levy

Date: 10/31/2006

Organization : Ambulatory Surgery Center of Greater New York, Inc

Category : Ambulatory Surgical Center

Issue Areas/Comments

CY 2008 ASC Impact

CY 2008 ASC Impact

My letter is attached.

CMS-1506-P2-611-Attach-1.DOC

#611

Ambulatory Surgery Center
of Greater New York, Inc.

October 31, 2006

Leslie V. Norwalk, Esq., Acting Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue, NW
Washington, D.C. 20201

Attention: CMS-1506-P, Room 445-G

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1101 Pelham Parkway N., Bronx, New York 10469 (718) 515-3500 FAX (718) 515-3503
Accredited by Accreditation Association for Ambulatory Health Care, Inc.

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Sincerely,

Jerome H. Levy, M.D.
Surgeon Director

Submitter : **Ms. Erin P. Duffy, R.N.** **Date: 10/31/2006**

Organization : **Ambulatory Surgery Center of Greater New York, Inc**

Category : **Ambulatory Surgical Center**

Issue Areas/Comments

CY 2008 ASC Impact

CY 2008 ASC Impact

My letter is attached.

CMS-1506-P2-612-Attach-1.DOC

#612

Ambulatory Surgery Center
of Greater New York, Inc.

October 31, 2006

Leslie V. Norwalk, Esq., Acting Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue, NW
Washington, D.C. 20201

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- The percentage that is eventually adopted by the Centers for Medicare and Medicaid Services in the final regulation should be applied uniformly to all ambulatory surgery center services, regardless of the type of procedure or the specialty of the facility.

- Although the Centers for Medicare and Medicaid Services has added many ophthalmic services to the ambulatory surgery list, it 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 it should be applied uniformly to all services, regardless of type. Most such services will also be transferred from the hospital outpatient department to the ambulatory surgery center setting thereby reducing Medicare costs and offsetting possible increased costs on the shifting of such services from office to ambulatory surgery center.

- Ambulatory surgery centers should be updated based upon the hospital market basket because it more appropriately reflects inflation in providing surgical services than does the consumer price index. The same relative weights should be used for ambulatory surgery centers and hospital outpatient departments since both provide the same services and incur the same costs in delivering surgical care.

- Aligning the payment systems for ambulatory surgery centers 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.

- The cap on office-based payments is inappropriate for the ambulatory surgery center and should be omitted from the final regulation.

- Devices used for surgical procedures should be included in the global fee.

- Ambulatory surgery centers should be eligible to receive new technology pass-through payments.

- The computation of rates and rate changes should be the same for both the hospital outpatient department and ambulatory surgery center reimbursement.

In summary, my firm belief is that the proposed changes to the ambulatory surgery center payment policies contain serious flaws that must be addressed in order to keep the Medicare program viable for ambulatory surgery centers. I urge that your serious attention be given to the items discussed above and I thank you for your time reviewing this correspondence.

Sincerely,

Erin P. Duffy, R.N.
Director of Operating Room Services

CMS-1506-P2-613

Submitter : Dr. Priscilla Arnold **Date:** 10/31/2006

Organization : Arnold Vision

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

I am writing to comment on the ASC payment system and update of procedure list. I have been an ASC owner for the past eight years (in two separate centers) and have performed surgery in the ambulatory center setting for over 10 years. I also participated on the Rand panel of 3 years ago which found that safety of Ophthalmic procedures in the ASC setting was equal to that in a hospital setting, while providing greater efficiency of care.

The proposal to link ASC reimbursement at 62% of HOPD rates does not seem to be reasonable or fair. Supply and labor costs are identical. In fact, many hospitals have buying consortiums which make their expenses considerably less. No logical explanation can be given for making this ratio almost half that of hospital reimbursement. Similarly, the annual update should be linked to the hospital market basket, not the CPI. There should be annual update based on the market basket calculation, as there is for HOPDs.

On a second point, all procedures allowed on the hospital outpatient surgery list should be included on the ASC list of approved procedures, unless and overnight stay is necessary. Surely, the years of experience with ASCs should indicate the safety, efficiency, and greater patient satisfaction in these settings. There is every logical reason to expand this list.

Thank you for this opportunity to make these comments
Sincerely,
Priscilla P. Arnold, MD FACS
Past President, Amer. Society of Cataract & Refractive Surgery

CMS-1506-P2-614

Submitter : Mr. bob swovelan **Date:** 10/31/2006

Organization : Mr. bob swovelan

Category : Nurse Practitioner

Issue Areas/Comments

ASC Payable Procedures

ASC Payable Procedures

patients should have the oppertunilty to chose the setting and time that they have their healthcare procedures performed. this should include in and out patient settings. neither the patient or provider should be penalized for their choice in either cost nor quality.

CMS-1506-P2-615

Submitter : Mrs. Virginia Pecora **Date:** 10/31/2006

Organization : Oregon Eye Surgery Center

Category : Ambulatory Surgical Center

Issue Areas/Comments

GENERAL

GENERAL

See attachment. My comment is listed in the "ASC Payable Procedures" field above.

CMS-1506-P2-615-Attach-1.DOC

CMS-1506-P2-615-Attach-2.DOC

#615

October 31, 2006

Centers for Medicare & Medicaid Services
CMS-1506-P
Department of Health and Human Services
Attention: CMS-1506-P

I am providing input during your comment period to proposed rules to further reduce payments to ASCs. As the Administrator of the Oregon Eye Surgery Center, an ASC specializing in Ophthalmology since 1988, I am very concerned over the proposal to set ASC payments at 62% of the Hospital Outpatient Department rate. This is wholly inadequate and doesn't reflect a realistic differential in the costs incurred by hospitals and ASCs in providing services. The agency should interpret the budget neutrality provision to permit ASC's to be paid at 75% of the HOPD rate.

Our ASC treats over 2,000 cases per year and 75% are Medicare Patients. I have been the Administrator since 1993 and can attest to our commitment to high quality and lower cost cataract and ophthalmologic surgical care. The proposed reform of the ASC procedure list remains far too restrictive. As a Registered Nurse, I am concerned over the quality of care for our patients. The surgeon in consultation with his patient should make the decision as to the site of surgery. ASCs should be permitted to furnish and received facility reimbursement for any and all procures that are performed in HOPDs.

Finally, I want to point out that under current law, ASCs are provided no annual cost-of-living updates from 2004-2009, notwithstanding significant increase in the costs of delivering care. Commencing in 2010, CMS is proposing to pay ASCs an update equal to the CPI while HOPDs would be paid an update based on the HMB, which is typically higher. The new payment system should provide hospital market basket updates to both ASCs and HOPDs since both provide the same services and incur the same costs in delivering high quality surgical care.

Thank you for considering these comments.

Virginia Pecora, RN
Administrator
Oregon Eye Surgery Center
1550 Oak St.
Eugene, OR 97401
1-888-503-8771

https://aimscms.fda.gov:8443/cmsView/docdispatchserv?error_page=/ErrorPage.jsp&r_object_id=090f3ddd800cbd3a

Submitter : **Date: 10/31/2006**

Organization :

Category : **Individual**

Issue Areas/Comments

ASC Payable Procedures

ASC Payable Procedures

{INSERT DATE HERE}

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1506-P2
P.O. Box 8011
Baltimore, MD 21244-1850

Dear Sirs:

Please consider the following comments for CMS 1506-P2; The Hospital Outpatient Prospective Payment Systems and CY 2007 payment Rates; FY 2008 ASC Payment.

General Comments
Vascular access is one of the greatest sources of complications and cost for dialysis patients. Why, because America uses more surgical grafts and catheters for vascular access than the rest of the developed world, even though there is substantial evidence that they impose higher initial and maintenance costs, lead to greater clinical complications, and result in higher mortality than arterio-venous (AV) fistulae

The inclusion of CPT codes 35475, 35476, 36205 and 37206 to the list of Medicare approved ambulatory surgical center (ASC) procedures would provide Medicare the opportunity to reduce the cost of, and promote quality outcomes for, end-stage renal disease (ESRD) patients through more thoughtful reimbursement and regulation of vascular access procedures.

ASC Payable Procedures (Exclusion Criteria)
We support CMS practice of re-examining its policies as technology improves and practice patterns change, especially when supported by recommendations made by the Medicare Payment Advisory Commission (MedPAC) in their March 2004 report to Congress. The report concludes that clinical safety standards and the need for an overnight stay be the only criteria for excluding a procedure from the approved list

Please support patient choice! There is clear scientific evidence that vascular access procedures are safe and can be performed in Ambulatory Surgical Center setting, and more importantly, patients are extremely satisfied with having the option to secure vascular access repair and maintenance care in an outpatient setting. Further, the inclusion of angioplasty codes in the ASC setting would support CMS Fistula First initiative by permitting a full range of vascular access procedures to be performed in an ASC setting, a less expensive and more accessible option than the current prevalent hospital setting.

Please treat End Stage Renal Disease patients fairly by ensuring all angioplasty codes, including CPT 35476 are allowed in the ASC setting.

Thank you.
Sincerely,
Daniela Luciu

Submitter : Mrs. Teresa McElhattan **Date:** 10/31/2006

Organization : DaVita

Category : Nurse

Issue Areas/Comments

GENERAL

GENERAL

It is imperative to the health of patients with chronic kidney disease that more fistulae are placed than grafts or catheters. To do this, we must allow alternative means of patients accessing this option. Fistulae placement and the procedures needed to maintain their function need to be able to be performed in ambulatory care surgical centers. Please allow these patients this life saving opportunity.

CMS-1506-P2-618

Submitter : Dr. Richard Schulze, Jr.

Date: 10/31/2006

Organization : Schulze Surgery Center

Category : Physician

Issue Areas/Comments

ASC Conversion Factor

ASC Conversion Factor

see attached MS Word document

Submitter : **Dr. Ken Staggs** **Date: 10/31/2006**

Organization : **Total Pain Care**

Category : **Physician**

Issue Areas/Comments

ASC Conversion Factor

ASC Conversion Factor

The proposed 62% rate for ASC's of the HOPD rate is outrageous and not fair or reasonable. We simply cannot provide care at that rate. Having worked 10 yrs in a pain HOPD and now in an ASC environment, I absolutely assure you that patients prefer, and ASC's provide better value, convienence, and saftey than HOPD centers. To arbitrarily propose cuts of this magnitude is a diservice to the patients and a death blow to those of us providing this "better care for less" in an ASC setting. Instead of playing politics for the hospital's benefit, think about closing down the HOPD pain centers and drive these services to outpatients ASC's for better access, cost, quality, and value. That was your orginal intent years ago; save the hospitals some other way.

Submitter : **Mrs. Crystal Boler** **Date: 10/31/2006**

Organization : **East Mississippi Endoscopic Center, LLC**

Category : **Ambulatory Surgical Center**

Issue Areas/Comments

ASC Payable Procedures

ASC Payable Procedures

The ASC list reform proposed by CMS is too limited. The list should be expanded to all procedures that are payable in the HOPD. Exclusion should only be those procedures that are on the in patient list only. ASC's are required to provide a high standard of care. Any procedure that is performed in any out patient facility whether it be hospital or freestanding is safe to be performed in an accredited ASC. If it's safe and if it's cost effective, the consumer should have the choice.

GENERAL

GENERAL

Medicare beneficiaries should be allowed access to ASC's. The enactment by Congress for budget neutrality greatly jeapordizes this. The 62% of HOPD rate proposed is not in any way adequate. The same procedure for 62% of the rate? ASC's have repeatedly proven their efficiencies. This rate would force some ASC's to close there doors. Where's the budget considerations in this?

Also, ASC's should be updated based on the hospital market value which more appropriately reflect inflation in surgical servies than does the CPI. The same relative weight should be used in the ASC as in the HOPD thereby improving transparency of cost and quality data that is used to evaluate surgical services.

Aligning the two payment policies to the greatest extent provided by law can only serve to benefit the taxpayer and the Medicare consumer

Submitter : **Date: 10/31/2006**

Organization :

Category : **Ambulatory Surgical Center**

Issue Areas/Comments

ASC Payable Procedures

ASC Payable Procedures

I support CMS practice of re-examining its policies as technology improves and practice patterns change, especially when supported by recommendations made by the Medicare Payment Advisory Commission (MedPAC) in their March 2004 report to Congress. The report concludes that clinical safety standards and the need for an overnight stay be the only criteria for excluding a procedure from the approved list.

Please support patient choice! There is clear scientific evidence that vascular access procedures are safe and can be performed in Ambulatory Surgical Center setting, and more importantly, patients are extremely satisfied with having the option to secure vascular access repair and maintenance care in an outpatient setting. Further, the inclusion of angioplasty codes in the ASC setting would support CMS Fistula First initiative by permitting a full range of vascular access procedures to be performed in an ASC setting, a less expensive and more accessible option than the current prevalent hospital setting.

Please treat End Stage Renal Disease patients fairly by ensuring all angioplasty codes, including CPT 35476 are allowed in the ASC setting.

GENERAL

GENERAL

Vascular access is one of the greatest sources of complications and cost for dialysis patients. Why, because America uses more surgical grafts and catheters for vascular access than the rest of the developed world, even though there is substantial evidence that they impose higher initial and maintenance costs, lead to greater clinical complications, and result in higher mortality than arterio-venous (AV) fistulae.

The inclusion of CPT codes 35475, 35476, 36205 and 37206 to the list of Medicare approved ambulatory surgical center (ASC) procedures would provide Medicare the opportunity to reduce the cost of, and promote quality outcomes for, end-stage renal disease (ESRD) patients through more thoughtful reimbursement and regulation of vascular access procedures.

Submitter : **Mr. Vidyasagar Pampati** **Date: 10/31/2006**

Organization : **Pain Management Center of Paducah**

Category : **Individual**

Issue Areas/Comments

CY 2008 ASC Impact

CY 2008 ASC Impact

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 concerned citizen, I am writing to express my alarm at CMS s proposed rule for ambulatory surgery centers payment system. This rule will create significant inequities between hospitals, ASCs, and ultimately will harm beneficiary access. While this may be good for some specialties, it is clear that interventional pain management will suffer substantially - approximately 20% in 2008 and approximately 30% in 2009 and thereafter. At these reduced reimbursement rates, physicians will not be adequately reimbursed for the services they provide to their Medicare patients and consequently, because all payers follow Medicare, this reduction in ASC reimbursements will affect not only patient access for Medicare patients but all interventional pain management patients.

Thank you for your consideration.

Given the impact this proposed rule would have on interventional pain physicians practicing in ASCs and their ability to provide services to Medicare patients, I ask that CMS reverse the proposal and that a means be established where surgery centers are reimbursed at least at the present rate and will not go below that rate. If no realistic proposal can be achieved at this time, Congress should repeal the previous mandate and leave the system alone as it is now, with inflation adjustments immediately reinstated.

On behalf of all the patients in the United States and especially the elderly, I thank you for your consideration.

Sincerely,
Vidyasagar Pampati

Submitter : **Dave Bono** **Date: 10/31/2006**

Organization : **Nueterra Healthcare**

Category : **Health Care Professional or Association**

Issue Areas/Comments

GENERAL

GENERAL

See Attached

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

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

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

Submitter : **Mrs. Laurie Eberly** **Date: 10/31/2006**

Organization : **Newark Surgery Center**

Category : **Ambulatory Surgical Center**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1506-P2-624-Attach-1.DOC

#6211

October 31, 2006

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

Dear Administrator Norwalk:

This letter is in reference to CMS' proposed changes to the ASC Payment System for calendar year 2008.

I serve as the administrator of the only multi-specialty surgery center in Licking County. We will perform approximately 7,000 procedures this year. Our center was formed over ten years ago by a core group of five physicians. The primary goal of our physicians is to provide high quality, compassionate care in a cost-effective environment.

Prior to the development of Newark Surgery Center, our physicians were increasingly frustrated with hospital scheduling delays, limited operating room availability, slow operating room turnover times, and the lack of updated equipment and supplies. Once our Center became operational, these physicians gained the opportunity to have increased control over patient care. This includes decreasing or eliminating long waits to schedule a patient for surgery, ensuring that the equipment and supplies available for use are the best and most appropriate for each individual procedure and patient, and the ability to increase operating room efficiencies. Many of the physicians who utilize our center do not have ownership interest. They utilize the center simply because it affords the best patient care. We know that we can provide excellent care in a cost-effective environment. We accept Medicare, Medicaid, and uninsured patients.

I understand that one of the goals of the new ASC payment system is to better align payments to providers of outpatient surgical services. I support and welcome the opportunity to link the ASC and hospital outpatient department payment systems as it will improve transparency of cost data for Medicare beneficiaries. However, it appears as though many policies applied to payments for hospital outpatient services are 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. Some examples are:

- **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 and excludes many surgical procedures appropriate for the ASC setting. 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.

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

- **Different Measures of Inflation:** CMS updates the OPPS conversion factor for annual changes in inflation using the hospital market basket; however CMS proposes to update the 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 evidenc that the cost of providing services has further diverged between settings.

- **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.

- **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:** The current ASC proposed payment methodology is only 62% of the HOPD rate. This percentage is inadequate and does not reflect a realistic differential of the costs incurred by hospitals and ASCs in providing the same services. 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 rates this low, CMS would force doctors to move cases to the more expensive hospital setting, increasing the amount of money paid by Medicare beneficiaries and the government. Rather than paying ASCs a set percentage of HOPD rates, the proposed rule establishes a complicated formula to link ASC payment to HOPD payment but does not link payment in a uniform manner. This will impede Medicare beneficiaries' ability to understand their real costs in alternative settings. In the words of President Bush, Medicare beneficiaries need to be able to make "apples to apples" comparisons in order to increase transparency in the health care sector. The agency should interpret the budget neutrality provision to permit ASCs to be paid at a rate of 75% of the HOPD rate, as recommended by the ASC industry.

Thank you for consideration of my comments.

Sincerely,

Laurie J. Eberly
Chief Operating Officer
Newark Surgery Center
2000 Tamarack Road
Newark, Ohio 43055
(740) 788-6010

Submitter : Dr. R Richard Rasmussen

Date: 10/31/2006

Organization : Utah County Surgical Associates

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

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

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

Submitter : Mrs. Rochelle Deardorff **Date:** 10/31/2006

Organization : Nueterra

Category : Health Care Provider/Association

Issue Areas/Comments

GENERAL

GENERAL

See Attached

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

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

Submitter : **Mr. Thomas Mallon** **Date: 10/31/2006**

Organization : **Regent Surgical Health**

Category : **Ambulatory Surgical Center**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1506-P2-627-Attach-1.DOC

#627

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

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

Dear Ms. Norwalk:

I am writing you as CEO of Regent Surgical Health, a company based in Chicago with 17 sites across the United States. We are corporate partners with approximately 300 physicians performing in excess of 30,000 surgical procedures per year in ASCs and small physician owned hospitals.

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

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

Physicians continue to provide the impetus for the development of new ASCs. By operating in ASCs instead of hospitals, physicians gain the opportunity to have more direct control over their surgical practices. In the ASC setting, physicians are able to schedule procedures more conveniently, are able to assemble teams of specially-trained and highly skilled staff, are able to ensure the equipment and supplies being used are best suited to their technique, and are able to design facilities tailored to their specialty. Simply stated, physicians are striving for, and have found in ASCs, the professional autonomy over their work environment and over the quality of care that has not been available to them in hospitals. These benefits explain why physicians who do not have ownership interest in ASCs (and therefore do not benefit financially from performing procedures in an ASC) choose to work in ASCs in such high numbers.

36 Regent Drive • Oak Brook, Illinois 60523 • 708.686.1522 • Fax: 630.654.1258
tmallon@regentsurgicalhealth.com
www.regentsurgicalhealth.com

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.

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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

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tmallon@regentsurgicalhealth.com
www.regentsurgicalhealth.com

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.

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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.

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

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

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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.

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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

36 Regent Drive • Oak Brook, Illinois 60523 • 708.686.1522 • Fax: 630.654.1258
tmallon@regentsurgicalhealth.com
www.regentsurgicalhealth.com

insufficient to cover the cost of performing the procedure in an ASC, responding to the change may mean relocating their practice to the HOPD. Such a decision would increase expenditures for the government and the beneficiary. On the other hand, the demand for services such as diagnostic colonoscopies is extremely high in the non-Medicare population. If ASCs determine that the payment rates for such services are too low, they may be able to decrease the proportion of Medicare patients they see without reducing their total patient volume. In that case, beneficiaries may experience significant delays accessing important preventive services or treatment. Neither outcome is optimal for the beneficiary of the Medicare program.

Establishing Reasonable Reimbursement Rates

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

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

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

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

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

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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.

We trust that you will assess the potential impact of these proposed rules and make adjustments that will enable the patients the choice they have grown to appreciate and allow this innovative sector of healthcare to continue to grow. We provide outstanding care and see the results daily in our patient satisfaction surveys.

Sincerely,

Thomas Mallon
CEO
Regent Surgical Health

36 Regent Drive • Oak Brook, Illinois 60523 • 708.686.1522 • Fax: 630.654.1258
tmallon@regentsurgicalhealth.com
www.regentsurgicalhealth.com

CMS-1506-P2-628

Submitter : Dr. Joseph Jasper **Date:** 10/31/2006

Organization : West Tacoma Surgery Center

Category : Ambulatory Surgical Center

Issue Areas/Comments

GENERAL

GENERAL

see attachment

CMS-1506-P2-628-Attach-1.DOC

CMS-1506-P2-628-Attach-2.DOC

#628

West Tacoma Surgery Center, LLC

1628 South Mildred St #110
Tacoma, WA 98465-1613

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

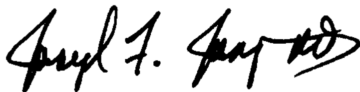
Dear Ms. Norwalk:

I am disappointed and shocked at CMS's proposed rule for ASC payments. This rule will create significant inequities between hospitals and ASCs. Worse, beneficiaries in pain will find access to relief will be reduced, more expensive and inconvenient. While this may be a boon for some specialties, **interventional pain services will suffer substantially** (approximately **-20% in 2008 and approximately -30% in 2009 and after**). The various solutions proposed in the rule with regards to mixing and improving the case mix, etc., are not really feasible for single specialty centers. Our surgery center is a center of excellence for interventional pain procedures; these are the only procedures we perform and are predominantly Group 1. We would certainly fail in business with the proposed cuts. CMS should also realize that in general healthcare uses, the topdown methodology or bottom-up methodology used by Medicare is the primary indicator for other payers - everyone following with subsequent cuts. Using this methodology, Medicare will remove any incentive for other insurers to pay appropriately.

Based on this rationale, I suggest that the proposal be reversed and a means be established where surgery centers are reimbursed at least at the present rate and will not go below that rate, particularly for Groups 1-3. We understand there are multiple proposals to achieve this. If none of these proposals are feasible, Congress should repeal the previous mandate and leave the system alone as it is now. However, inflation adjustments must be immediately reinstated.

I hope this letter will assist in coming with appropriate conclusions and helping the elderly in the United States.

Sincerely,



Joseph F Jasper, MD

CMS-1506-P2-629

Submitter : Dr. Brian Smith

Date: 10/31/2006

Organization : Eye Surgery Center of Hinsdale

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1506-P2-629-Attach-1.RTF

CMS-1506-P2-629-Attach-2.RTF

#629

Thursday, November 02, 2006

To: CMS

From: Brian D. Smith, MD

Re: Proposed ASC payment systems

Dear Sirs:

I am commenting on the proposed rule changes that would affect payments to Ambulatory Surgical Centers "ASCs". I believe that the proposed changes would be detrimental to the health of both ASCs in general and the patients that they serve. The proposed payment of 62% of the hospital outpatient prospective payment system is inadequate. This will most likely cause the shifting of patients from ASCs, who are able to perform the services for lower cost, to hospitals and their inherent higher costs. The end result of this will be higher costs to our nation for the same services.

ASCs form an important link in our healthcare system. They provide high quality care at a cost to the government that is substantially less then what patients receive at a comparable hospital outpatient department. I am the owner of a single specialty ASC devoted to ophthalmic surgery. We are able to deliver care that exceeds the expectations of our patients using the latest and most up to date equipment at a fraction of the cost that hospitals charge. My understanding is that hospitals in my area charge more then 7 times our fee and receive at least double if not triple the amount of money from CMS for the same procedure. Clearly shifting more cases to the hospital would waste taxpayer dollars currently being more effectively spent in an ASC setting. Changes to the payment system that negatively affect ASCs would be a detriment to our healthcare system in general.

As medicine progresses certain procedures become safer and less traumatic to patients. Cataract surgery is an excellent example of this. When I started practice most physicians performed their cataract surgeries in a hospital setting. Inpatient stays were not uncommon. Labs were run, blood tests ordered, IVs started and in addition to the facility charge and the physician charge patients would get a charge from their anesthesiologist. In my facility we do not use intravenous anesthesia, just oral sedatives and have success with this method in over 4000 cases. That means no lab charges, no anesthesia bills and a vastly improved experience for the patient. The government is able to save money because of these changes as well. I calculate that on average each patient's charges are

$400-500 dollars less because we have effectively cut out anesthesia charges and lab charges prior to cataract surgery. Multiply that by 4000-5000 cases and we have saved somewhere around 2 to 2.5 Million dollars to the Medicare system. Changing the payment system where we will receive less will just add costs to our healthcare system and shift patients back to the higher cost hospital setting.

I don't know of any cataract surgeon anywhere who desires to return to the hospital setting after doing surgery in an ASC. It is not only an excellent experience to the physicians but an improved experience to our patients. I do not get bumped off the surgical schedule because of an emergency. I do not get delayed because I am following a complicated inpatient case. My patients get into the OR at the specified time consistently because we pay attention to the length of time each case takes and account accordingly. Running on schedule makes for good outcomes and happy patients and Medicare beneficiaries.

What is fair is if all parties were playing on a level playing field. Trying to float a hospital's inefficiencies on the back of the more efficient ASC model is a bad idea. Pay them the same or at least don't diminish the ASC payment below their current level. Find a way to let more patients into ASCs by making them financially viable. That in the long run will decrease costs and increase quality and outcomes to our patients.

Sincerely,

Brian D. Smith, MD

Submitter : **Dr. Marshall Bedder** **Date: 10/31/2006**

Organization : **Coastal Pain management and rehabilitation**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

To CMS:

From: Marshall Bedder MD, FRCP

Date: October 31, 2006

I am writing this Halloween evening truly afraid of the effect that CMS has proposed in regards to changes to ASC regulations for calendar year 2008 and 2009. I have been a Pain Physician since 1985 and have watched as the treatment of Pain has gained the priority it deserves, especially for our senior population. The proposed changes, with a 62% of HOPD payment rate is woefully insufficient to allow us to be able to perform pain procedures at an ASC. We are already saving CMS significant costs by moving away from the hospital and inpatient environment into outpatient based services in the ACS environment. As it stands, Interventional Pain Procedures are the major loser and Medicare beneficiaries will be the real big losers with access to care harmed irreparably by this action.

CMS needs to establish a fair and reasonable conversion factor that appropriately reflects the cost effectiveness associated with an ASC procedure for Interventional Pain techniques. There has been insufficient time to adequately study and evaluate this methodological change. It will only force physicians into a Hospital outpatient setting and drive up costs for CMS.

Your proposed changes in reimbursement will ultimately reduce appropriate care for pain to the Medicare population. This is very sad for a most needy population that suffers the burden of degenerative disease and aging effect.

Yours Truly

Marshall Bedder

Submitter : Ms. Linda Nash **Date:** 10/31/2006

Organization : Manatee Surgical Center

Category : Ambulatory Surgical Center

Issue Areas/Comments

CY 2008 ASC Impact

CY 2008 ASC Impact

See Attached

CMS-1506-P2-631-Attach-1.DOC

#631

Manatee Surgical Center

601 Manatee Avenue West
Bradenton, FL 34205
941-745-2727

October 31, 2006

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

Dear Sir or Madam:

I am writing to comment on the proposed 2007 and 2008 changes to the ambulatory surgical center payment system. I would like to make sure that all Medicare beneficiaries have access to ambulatory surgical centers (ASCs). I am hoping that CMS will broadly interpret the budget neutrality provision enacted by Congress. I feel that offering to reimburse ASCs 62% of the hospital outpatient department (HOPD) fee schedule is simply not adequate for us to provide quality, safe care.

I also feel the ASC list reform proposed by CMS is too limited. I hope that CMS will expand the ASC list of procedures to include any and all procedures that can be performed in a HOPD. CMS should exclude only those procedures that are on the inpatient only list.

ASC reimbursements 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. I feel 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.

For these reasons, I respectfully request CMS revise the proposed 2007 and 2008 ambulatory surgical center payment system and increase the reimbursement percentage to at least 75%.

Sincerely,

Linda M. Nash, MBA, CASC, LHRM
Administrator/Risk Manager
Manatee Surgical Center, Inc.
601 Manatee Avenue West
Bradenton, Florida 34205

Submitter : **Mr. Paul Skowron** **Date: 10/31/2006**

Organization : **Palos Surgicenter LLC**

Category : **Ambulatory Surgical Center**

Issue Areas/Comments

ASC Ratesetting

ASC Ratesetting

Since ASC rates have been frozen for four years now, starting the new methodology at 62% of HOPD is simply inadequate. It ignores inflation.ASC's should be updated in the future using the same hospital market basket because we pay for supplies at a higher rate than hospitals who have more purchasing power. Also, because our wages and supplies are comparable, the same relative weights should be used in ASC's and hospital outpatient departments.

Submitter : **Dr. mohamed kourtu** **Date: 10/31/2006**

Organization : **warren pain clinic and acupuncure center**

Category : **Physician**

Issue Areas/Comments

CY 2008 ASC Impact

CY 2008 ASC Impact

this will be devastating to patient care will force to close services and employees cant,s sustaine level of quality care

Submitter : **Ms. Nicky Oldfield** **Date: 10/31/2006**

Organization : **Kootenai Outpatient Surgery**

Category : **Ambulatory Surgical Center**

Issue Areas/Comments

CY 2008 ASC Impact

CY 2008 ASC Impact

Below please find my comments on the Medicare ASC Payment System Proposal:

The proposed payment of 62% of the HOPD rates is not adequate payment to assure Medicare Beneficiaries access to ASCs.

CMS needs to expand the ASC list of procedures to include all procedures that can be performed in an HOPD. CMS should exclude only those procedures that are on the inpatient only list.

The same relative weighs should be used in ASCs as hospital outpatient departments. In addition, ASCs should be not be updated using the consumer price index. Instead they should be updated based on the hospital market basket because this more appropriately reflects inflation in providing surgical services.

The payment systems for ASCs and HOPDs should be aligned as much as possible. This will improve the transparency of cost and quality data used to evaluate outpatient surgical services for Medicare beneficiaries.

Submitter : **Ms. Patricia Dougherty** **Date: 10/31/2006**

Organization : **Davita Healthcare**

Category : **End-Stage Renal Disease Facility**

Issue Areas/Comments

ASC Payable Procedures

ASC Payable Procedures

Vascular access is one of the greatest sources of complications and cost for dialysis patients. Why, because America uses more surgical grafts and catheters for vascular access than the rest of the developed world, even though there is substantial evidence that they impose higher initial and maintenance costs, lead to greater clinical complications, and result in higher mortality than arterio-venous (AV) fistulae.

The inclusion of CPT codes 35475, 35476, 36205 and 37206 to the list of Medicare approved ambulatory surgical center (ASC) procedures would provide Medicare the opportunity to reduce the cost of, and promote quality outcomes for, end-stage renal disease (ESRD) patients through more thoughtful reimbursement and regulation of vascular access procedures.

Submitter : Pamela Wolfrum **Date:** 10/31/2006

Organization : Pamela Wolfrum

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

As a home hemodialysis patient for the past 20 years, I urge the inclusion of CPY codes 35475, 35476,36205 and 37206 to the list of Medicare approved ambulatory surgical center procedures.

Submitter : **Ms. Laura Gilmer** **Date: 10/31/2006**

Organization : **Davita Crystal River Dialysis Center**

Category : **End-Stage Renal Disease Facility**

Issue Areas/Comments

GENERAL

GENERAL

Hi!
I am a technician at a Dialysis Center. I am responding to comment form.
The patients access is their life line. They need these to be functioning in order to live. Our patients go to a vascular surgeon who takes care of their access and any problems that may arrise. We want as many patients as possible to have fistulas. This is the most natural access for their bodies. Their access is placed by having out-patient surgery. This is the most convient for them. They do not have to be admitted and stay overnight at the hospital. Our patients want to live the most easiest way possible. They already have to come and dialyze 3x per week. They just want to live their life to the fullest possible.
Thankyou,
Laura Gilmer

Submitter : **Ms. Marilyn Mellenthin** **Date: 10/31/2006**

Organization : **Oregon Eye Associates, LLP**

Category : **Other Health Care Professional**

Issue Areas/Comments

CY 2008 ASC Impact

CY 2008 ASC Impact

I am writing to comment on the CMS proposed rules to further reduce payments to ASCs, scheduled to begin in 2008. As the Administrator of Oregon Eye Associates, LLP, I work closely with the Oregon Eye Surgery Center (OESC), and see first hand the efficient, cost effective surgical care delivered to our Medicare patients as they present for ophthalmic surgery. CMS's proposal to reimburse ASCs at 62% of the Hospital Outpatient Department (HOPD) rate, jeopardizes the OESC's ability to contine to deliver top quality care. The ASC associations considering the CMS proposal believe strongly that in order to keep ASCs open and serving patients, they should be paid no less than 75% of the HOPD rate.

An additional problem is CMS's plan to provide no annual cost-of-living updates for ASCs from 2004-2009, regardless of the fact that costs continue to rise each and every year. This proposal essentially takes the most cost effective means of delivering high quality care, the ASC, and degrades it by not providing adequate reimbursement. The new CMS payment system should provide updates to both ASCs and HOPDs to assure that both are available to deliver necessary medical services to the Medicare population.

The third issue that is faulty in the CMS proposal is the one that restricts certain procedures from being done in an ASC by withholding facility reimbursement. Reimbursement for a procedure done in an HOPD should likewise be available for the same procedure done in an ASC. There should be no arbitrary procedure differentiation between the two facilities.

Please consider my comments in your deliberations surrounding the proposed CMS rules for ASC payment. Thank you.

Kay Mellenthin, Administrator
Oregon Eye Associates, LLP
1550 Oak St.
Eugene, Oregon 97401
1-800-426-3937

Submitter : **Stewart Van Horn** **Date: 10/31/2006**

Organization : **Laurel Eye Clinic**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Thank you in advance for your attention to this comment. Our practice is located in rural, central Pennsylvania. In 2005, physicians in our ASC performed eye surgery (mostly cataracts) on over 2000 medicare patients. Our clinic is visited by thousands more.

As you know, ASCs provide similar services that HOPDs do. They do so at a lower cost than do HOPDs. In fact, a recent study shows that they may provide these services in a manner that is safer for the patient. This seems to indicate that the presence of ASCs should be encouraged.

I would ask that you lessen the restrictions on which procedures can be performed in an ASC. We have run into difficulties with local community hospitals refusing to purchase necessary equipment to allow various procedures to be performed. By allowing ASCs to perform more services, we will be able to allow these patients to be treated locally, rather than forcing them to travel over 2 hours to the closest large city.

Also, I would urge you to allow ASCs to be reimbursed at 75% of the HOPD rate. The 62% rate does not realistically reflect the true cost differential between ASCs and HOPDs. It also tends to reward the inefficiency with which the HOPDs in our area are run.

I would also encourage CMS to adopt a uniform percentage for reimbursement (regardless of what percentage is finally adopted). This uniform percentage would also include ASC office-based procedures.

Finally, I would urge CMS to allow annual cost-of-living increases to ASCs. These cost-of-living increases should be based on the Hospital Market Basket (as are the HOPD increases). ASCs and HOPDs provide the same services and incur the same costs. Therefore, they should receive the same cost-of-living increases.

ASCs provide the same services that HOPDs do. In our area, our ASC performs these services with greater efficiency and, I believe, greater patient safety and convenience than the local HOPDs. I ask that you continue to support the existence of these lower cost alternatives to HOPDs.

Thank you again for your consideration of these comments.

Stewart Van Horn, MD
814-849-8344

Submitter : **Dr. Edward Bentley** **Date: 10/31/2006**

Organization : **Santa Barbara Endoscopy Center**

Category : **Physician**

Issue Areas/Comments

ASC Ratesetting

ASC Ratesetting

see attached letter

CMS-1506-P2-640-Attach-1.PDF

#640

Santa Barbara Endoscopy Center

25 West Micheltorena Street • Santa Barbara, CA 93101 • Phone 805-966-1600 • Fax 805-966-6700

October 17, 2006

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1506-P
P.O. Box 8013
Baltimore, MD 21244-8013

Re. "ASC Ratesetting"

Dear Sirs,

Santa Barbara Endoscopy Center is a one room ambulatory endoscopy center that we use in Santa Barbara, California performing approximately 2400 procedures per year, about one third on Medicare beneficiaries that will be significantly affected by your proposed payment changes for endoscopy and colonoscopy. We are writing to oppose the proposed ratesetting method outlined in CMS-1506-P.

Current law requires CMS to take into account recommendations in a report to Congress prepared by the GAO based on its study of the comparative relative costs of procedures furnished in ASC's and procedures furnished in hospital outpatient departments paid under the OPPS, and the extent to which the APC's reflect costs of procedures performed in ASC's (71FR49646). In addition Section 1833 of Title XVIII of the Social Security Act requires the amount of payment to be made for facility services furnished in connection with a surgical procedure "takes into account the costs incurred by such centers, or classes of centers, generally in providing services furnished in connection with the performance of such procedure as determined in accordance with a survey (based upon a representative sample of procedures and facilities) of the actual audited costs incurred by such centers in providing such services". CMS-1506-P is made without consideration of any such study.

Several assumptions have been made in the proposed ratesetting method that may not be valid. By proposing that the relative weights for procedures performed in the ASC be the same as the relative weights for OPPS, it is assumed that the relative costs of procedures performed in all ASC's are uniformly identical to the relative costs of similarly coded procedures performed in hospital outpatient departments. In addition, by utilizing the same fraction of the conversion factor, the proposal assumes that the difference in costs between similarly coded procedures performed in all ASC's and hospital outpatient departments is uniform for all procedures. Packaging all ASC services into a percentage of OPPS payments may be appropriate if all ASC's performed the same services as hospital outpatient departments but may be inappropriate for ASC's that perform a subset of services. Without comparison cost studies, it is not possible to determine whether these assumptions are valid

Our ASC performs only endoscopic procedures. The cost of providing those procedures for Medicare beneficiaries in our center significantly exceeds your proposal of 62% OPPS for all procedures performed. If your proposal is implemented, our staff of physicians will be forced to perform these procedures in hospital outpatient departments. Such shifting of procedures will increase costs to the Medicare Part B Fund and our Medicare beneficiaries. Increasing costs to beneficiaries may limit access of important screening procedures performed at centers such as colonoscopy. Since our

25 West Micheltorena Street • Santa Barbara, CA 93101 • Phone 805 966-1600 • Fax 805 966-6700

center is managed by a company that also manages fourteen centers (EMSO, Palo Alto, Ca.), we have no reason to believe that it is less efficient than others.

In critically evaluating your proposal without an appropriate cost survey, it is difficult to determine where it is flawed. The intent of the proposal, aligning ASC payment to OPPS methodology thereby simplifying administration, is plausible. However, the proposal applies the hospital outpatient department payment methodology inconsistently. The relative payment weights proposed for ASC's are the same as the hospital OPPS, however, include drugs, biologicals, contrast agents, and imaging. Since these items are not used in the same relative way for all procedures, packaging them, changes the relative weights for ASC's. If the same relative weights are to be used, the same packaging of costs should also be used. If not, the hospital outpatient costs no longer serve as a valid proxy because the additional expenses of the items not included in the OPPS are included in the ASC relative weights. Furthermore, the relative mix of procedures for each relative payment weight (or packaging of procedures) may vary considerably from ASC to Hospital Outpatient Department.

If a cost study shows that the relative payment weights for each procedure package performed in the Hospital Outpatient Department correlates with each corresponding package performed in the ASC (i.e. the relative payment weights are a valid proxy), the relative payment weights should not be altered by applying different budget neutrality scaling adjustments between the hospital and ASC. Rather, the budget neutrality adjustments should be applied to the conversion factor, maintaining the common relative payment weights. The geographic adjustment is also applied inconsistently. A 60% Hospital wage index adjustment compared with a 34.45% ASC wage index adjustment favors hospital payments in high cost areas and ASC payments in low cost areas. Once again, the same percentage wage index should be applied to both, using the conversion factor to adjust for the differences in wage overhead costs between the two settings. The annual inflation adjustment is also applied inconsistently. If hospital costs correlate with ASC costs, inflation of those costs should also correlate. Methodology for the annual inflation adjustment, like geographic adjustment, should be the same for ASC's as the hospital outpatient departments.

The greatest flaw of the proposal is the calculation of the conversion factor. If ASC costs can be perfectly aligned to the same percentage of hospital outpatient department costs for each group of procedures, then that percentage (of the OPPS conversion factor) should be calculated as a fraction of each cost. (ASC cost in numerator; hospital outpatient department cost in denominator). The proposed conversion factor (.62 of OPPS) is calculated not as a cost adjustment factor between the hospital outpatient department and ASC but a budget neutrality adjustment factor. It redistributes historical payments without regard to the accuracy of those payments. CMS should seek the authority through Congress to base the conversion factor on ASC costs relative to the hospital outpatient department, not historical payments. Furthermore, since costs are incurred in both settings, budget neutrality calculations should be made inclusive of both settings, not separately.

Santa Barbara Endoscopy Center

25 West Micheltorena Street • Santa Barbara, CA 93101 • Phone 805-966-1600 • Fax 805-966-6700

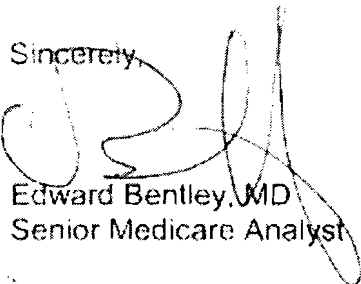
In summary, the current proposal does not appropriately reimburse Santa Barbara Endoscopy Center for the cost of providing endoscopic services to Medicare beneficiaries. We believe this is true of most other endoscopy centers. If implemented, these procedures will be performed in the more costly hospital outpatient department. It is possible, however, that if the conversion factor is calculated based on ASC costs relative to the hospital outpatient department and all other aspects of payment for hospital outpatient department procedures are consistently aligned (wage index, inflation, budget neutrality adjustments), that a simple conversion of all OPPS procedures can be used for ASC payment. This may be the intent, but not the effect of your proposal.

The proposed .62 OPPS conversion factor is not accurate for our costs. We oppose the method in which it was calculated. We request that if such proposal be made, CMS seek authority from Congress to calculate the conversion factor based on ASC costs relative to OPPS.

The current proposal should not be implemented.

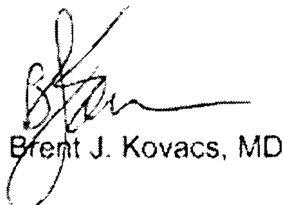
In addition, because of the consequences, no proposal should be made until a valid cost analysis is available and CMS has the authority to calculate an accurate conversion factor.

Sincerely,

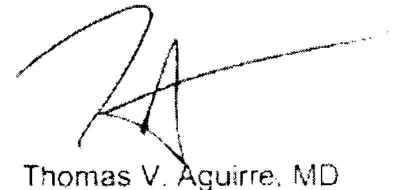


Edward Bentley, MD
Senior Medicare Analyst

Stephen K. Lemon, MD



Brent J. Kovacs, MD



Thomas V. Aguirre, MD

Submitter : **David Mair** **Date: 10/31/2006**

Organization : **David Mair**

Category : **Ambulatory Surgical Center**

Issue Areas/Comments

CY 2008 ASC Impact

CY 2008 ASC Impact

Dear Sir:

I want to urge you to not drastically cut the 2008 ASC fee schedule to 62% of what the hospitals get paid.

As a patient at a surgery center before, I can attest to the high quality of care and the efficiency of the care. I want the option to have my surgical procedures done at the surgery center. There is no economic basis to force the ASC to accept only 62% of the fee that a hospital gets.

Please keep a good thing going.

Sincerely,

David Mair

Submitter : Dr. Craig Nairn **Date:** 10/31/2006

Organization : Pain Solutions

Category : Physician

Issue Areas/Comments

ASC Payable Procedures

ASC Payable Procedures

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:

I am an interventional pain physician practicing in Albuquerque, NM. I am writing to express my serious concern over CMS s proposed rule for ASC payments and the resultant huge reduction in payments for Interventional Pain Procedures in both an ASC and the office setting. This new rule would favor performing many procedures in the hospital outpatient setting which is much more expensive for everyone involved and will ultimately increase costs to the Medicare system. Interventional pain management will see substantial decreases in reimbursement (approximately 20% in 2008 and approximately 30% in 2009 and after). Furthermore, almost all payors in my region base their reimbursement on Medicare rates so we will see a reduction across the board. This will most likely lead to fewer physicians able to practice in the specialty because of financial restraints which will further decrease access for patients desperate for adequate pain management. I don t think the ramifications of this proposed new rule have been studied adequately and your Medicare beneficiaries are going to suffer!!!

Based on this rationale, I suggest that the proposal be reversed and a means be established where surgery centers are reimbursed at least at the present rate and will not go below that rate. We understand there are multiple proposals to achieve this. If none of these proposals are feasible, Congress should repeal the previous mandate and leave the system alone as it is now. However, inflation adjustments must be immediately reinstated.

I hope this letter will assist in coming with appropriate conclusions and helping the elderly in the United States.

Sincerely,

Craig S. Nairn MD
Pain Solutions LLC
715 Dr. Martin Luther King NE #201
Albuquerque, NM 87102
(505)247-9700

CMS-1506-P2-643

Submitter : Dr. Jon Aoki

Date: 11/01/2006

Organization : Intermountain Ear Nose Throat LLC

Category : Health Care Provider/Association

Issue Areas/Comments

GENERAL

GENERAL

see attachment

CMS-1506-P2-643-Attach-1.DOC

#643

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

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

Dear Ms. Norwalk:

I am writing regarding the proposed payment changes for Ambulatory Surgery Centers. Utah Surgical Center is located in West Valley City, Utah and serves hundreds of Medicare recipients each year. We are very concerned that the changes, as currently proposed by CMS, will have a detrimental affect on the ability for ambulatory surgical centers (ASC) to service patients who are insured through and the Medicare program.

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 ASC's 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:** HOPD's 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. HOPD's receive payment for such unlisted codes under OPPS; ASC's 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 HOPD's perform services outside the surgical range that are not packaged, they receive additional payments for which ASC's 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 ASC's, 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 ASC's. 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 ASC's 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

ASC's 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, ASC's have demonstrated tremendous capacity to meet the growing need for outpatient surgical services. In some areas and specialties, ASC's 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 ASC's.

The implementation of the revised payment system proposed by Medicare will result in significant redistribution of payments for many specialties. Because ASC's 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 ASC's 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, ASC's 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.

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

- By setting rates this low, CMS would force doctors to move cases to the more expensive hospital setting, increasing the amount of money paid by Medicare beneficiaries and the government. Rather than paying ASC's 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 ASC's 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.

In conclusion, I am asking for a reconsideration of many of the elements of the proposed changes as outlined above. Truly aligning the ASC payment system with that of the HOPDs is the most logical, fair and best policy approach to benefit the Medicare program those served by the program. Should you have any questions regarding any of the issues in this letter, do not hesitate to contact me. My e-mail is aoki54@comcast.net. My phone number is (801) 966-8534 and my mailing address is 4052 Pioneer Pkwy Ste 210, West Valley City, UT 84120.

Sincerely,

Jon Richard Aoki, MD

CMS-1506-P2-644

Submitter : Dr. Michele Freeman **Date:** 11/01/2006

Organization : Dr. Michele Freeman

Category : Physician

Issue Areas/Comments

ASC Payable Procedures

ASC Payable Procedures

I support CMS practice of re-examining its policies as technology improves and practice patterns change, especially when supported by recommendations made by the Medicare Payment Advisory Commission (MedPAC) in their March 2004 report to Congress. The report concludes that clinical safety standards and the need for an overnight stay be the only criteria for excluding a procedure from the approved list.

Please support patient choice! There is clear scientific evidence that vascular access procedures are safe and can be performed in Ambulatory Surgical Center setting, and more importantly, patients are extremely satisfied with having the option to secure vascular access repair and maintenance care in an outpatient setting. Further, the inclusion of angioplasty codes in the ASC setting would support CMS Fistula First initiative by permitting a full range of vascular access procedures to be performed in an ASC setting, a less expensive and more accessible option than the current prevalent hospital setting.

Please treat End Stage Renal Disease patients fairly by ensuring all angioplasty codes, including CPT 35476 are allowed in the ASC setting.