SCOPES
South County Outpatient Endoscopy Services

5139 Mattis Rd., Suite 100
St. Louis, MO 63128
Tel: 314-729-9780

213-0
(24)

November 3, 2006

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

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

Dear Ms. Norwalk:

I am a private practice physician who treats Medicare patients in my practice. I am writing to express my concern with CMS's recent proposal to change the way the agency pays ambulatory surgery centers (ASC's) for their services.

In my practice, we see a large number of Medicare patients. Treatment for many of these patients includes performing diagnostic colonoscopies for high risk patients and screening colonoscopies for patients with average risk to develop colon cancer. Additionally, we see a number of patients with other conditions like GI bleeding, inflammatory bowel disease, reflux (GERD), Barrett's esophagus, etc. These patients all deserve ready access to a safe, cost-efficient site for their GI endoscopy procedures.

Current Situation --- Both the GAO and CMS have stated that the Medicare colorectal cancer screening benefit is underutilized. MEDPAC has repeatedly endorsed the concept that medical procedures and services should be site-neutral. CMS's current proposal institutionalizes the concept of paying significantly more to the hospital than to the ASC. The reimbursement proposed by CMS would reduce our payments by about $95 per procedure: a 22% reduction. This 22% reduction means that the freestanding endoscopy center where I work can't cover its expenses. We will be forced to consider closing our doors not only to Medicare beneficiaries, but also to commercial and self pay patients since our contracts with commercial payers are tied to Medicare payment levels.

Private Sector --- Medicare is apparently ignoring the stated priorities of the current Administration as well as the lessons of cost management in the private sector. I'm sure you are aware of the billions of dollars that freestanding ASC's have saved the Medicare program when procedures and surgeries that otherwise would have been performed in the hospital were moved to the ASC. Similarly, in the private sector insurers are actively encouraging patients to receive their services in ASC's. Most recently, Blue Cross of California proposed incenting physicians with a 5% premium to move their cases from the hospital to the ASC. Conversely, CMS's proposal would pay more to HOPD's and less to ASC's.

Budget Neutrality

CMS's concept of budget neutrality in this proposal is in error and unfair for many reasons. The agency is correct in proposing to increase markedly the number of procedures, from a variety of different specialties that are performed in the ASC (By raising the reimbursement for vascular, orthopedic and urologic services, many more of these patients can be cared for in an ASC). But in computing budget neutrality, every new service/procedure that is added to the ASC list forces CMS to reduce the ASC facility fee reimbursement for a GI endoscopy. This public policy does not make good sense.

The reality is that for 99% of cases that move from the HOPD to the ASC under this expansion of the ASC approved list, the Medicare program will save money. And the more cases that move from the hospital to the ASC, the more money that Medicare will save.

In summary, CMS's perspective on budget neutrality is completely wrong. CMS cannot expect the same pool of funds to cover all costs when the expansion of the ASC approved list will likely result in millions of additional cases moving to the ASC. The only accurate approach to budget neutrality is to consider the impact on the total pool of BOTH ASC facility fee payments AND HOPD facility fee payments.

Summary --- If CMS adopts its proposal close to its current form, then both patients and Medicare will be adversely impacted: **Patients** – Colorectal screening utilization will drop precipitously as freestanding endoscopy centers close and HOPD departments struggle to keep up with diagnostic colonoscopies and thereby shut out screening procedures. While reductions in screening will save Medicare money, the negative impact on preventative public health policy will be significant. **Medicare** – Fewer ASC's will choose to provide a "loss-leader" like colonoscopy services. Screening colonoscopies will decrease but diagnostic colonoscopies and other endoscopies will remain at current levels. With fewer ASC's, a larger proportion of all GI procedures will be performed in the HOPD, where the facility fees CMS pays will be higher.

Although I don't believe that these are the results that CMS is seeking, the inevitable result of CMS's proposed action will be:

1. Higher total GI facility expenditures because GI procedures will migrate from ASC's back to the HOPD.

2. Reduced access to GI endoscopies by Medicare beneficiaries who need to wait longer to go to the HOPD.

3. Increased morbidity and mortality of Medicare beneficiaries who are more likely to die from colorectal cancer as screening rates decline.

Questions

There really are just three questions that CMS must ask itself:

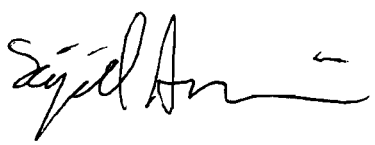
1. Where does Medicare get more bang for its buck? Is the less expensive provider the HOPD or ASC?

2. If CMS underpays for GI Endoscopy, then will ASC's discontinue providing these unprofitable services?

3. If Medicare really does save money in ASC's, then how can CMS encourage more surgeries and procedures (including GI procedures) to be done in ASC's?

Solution --- The best way to avoid an unintended outcome is to modify this proposal in order to increase, not decrease, the facility fees to GI ASC's. If CMS insists on pegging ASC payments to a percentage of HOPD payments, then it should adopt either much higher payment levels or institute a bi-level approach relative to ASC procedures like GI and Pain Management so that these specialties can cover their costs. This will avoid the closure of GI ASC's and thereby prevent an increase in the number of GI procedures performed in the more costly HOPD setting.

Sincerely,



Sajidul Ansari, MD

214-0
(2)

November 1, 2006

2006 NOV -3 AM 9:57

Jyoti Patel, M.D.
Physicians Pain Center
Suite 310
HealthPark South
St. Augustine, Florida 32086

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 a practicing pain Physician in St. Augustine Florida and work through a surgery center. Although the surgery center is multispecialty, it is primarily GI, Pain Management, and Ophthalmology. CMS-1506-P will have a significant negative impact on the operations of this center. The physicians who work in this center do so because they believe in the concept of patients receiving the highest level of care for less money than would be spent if the service was provided in a hospital setting. They are involved in the decisions that affect the care of their patients, and they appreciate the efficiency demonstrated by the surgery center staff. Spending is carefully monitored, both for staffing and supplies, so no money is wasted.

In the past, reimbursement methodologies have not been equitable for the same services provided in Hospital Outpatient Departments (HOPDs) and Ambulatory Surgery Centers (ASCs). We charge using global fees, and we are paid according to Medicare groupers.. We cannot charge for the use of fluoroscopy in pain management, and the equipment alone costs over $100,000 to purchase. Hospitals are reimbursed for fluoroscopy procedures.

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

- Reimbursement for any procedures that are not included on the inpatient-only list. HOPDs are currently eligible for payments for these cases.
- Payment for CPT codes that are not specific and hence "unlisted". HOPDs are currently reimbursed for these; ASCs are not.
- Payment for services provided in addition to the procedure, i.e. fluoroscopy, labs. HOPDs are reimbursed for these services; ASCs are not.
- Eliminating the proposed ASC payment based on office-based physician payments. This limitation does not apply to HOPDs.
- Updating the annual increases using the hospital market basket, not the CPI for all urban consumers, as proposed for ASCs. The increases should be based on the same factors.

- Eliminating the proposal for a secondary recalibration for revised cost data each year. The current proposal calls for a secondary recalibration for ASCs, which will result in a cumulative variation between HOPDs and ASCs.
- ASCs should receive all eligible new technology pass-through payments, as currently reimbursed to HOPDs.
- Allow the use of the same forms for filing claims in both the ASC and HOPD settings. Commercial payers require claims to be filed using the UB-92, and I believe Medicare should do the same.

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

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

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

Please consider my concerns. This is so important to the patients, the physicians, and to the ASCs. If you need more information, or if you have any questions, please contact me at 904-823-1447. I would be pleased to speak with you about this important issue.

Respectfully,

Jyoti Patel, M.D.
Physicians Pain Center
Suite 310
HealthPark South
St. Augustine, Florida 32086

HEALTHSOUTH
SurgeCenter of Louisville

215-O
(63)
(38 signatures)

November 2, 2006

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

Dear Sir/Madam,

We are writing on behalf of SurgeCenter of Louisville of which we are all employees. The purpose of this letter is to briefly explain the reasons we feel that CMS should develop a new ASC payment system as well as expansion of the allowed procedure listing for ambulatory surgical facilities.

First, many of us have been employed at this center for a number of years. During this we have experienced explosive growth in medical technology. This new technology allows us to offer our patients many procedures that could not have been safely performed in the out-patient surgical setting 20 years ago. Examples include new laser technology which reduces trauma to surrounding tissue and allows smaller incisions. New laparoscopic technology allowing procedures which, in the past required major incisions, extend hospital stays and painful recoveries to be performed safely in the out-patient setting.

Next, as a free standing out-patient surgical facility our patients are not exposed to viruses and airborne organisms simply by walking in the door. Due to the age and/or the fragile condition of many of the Medicare patients we feel that this is a clinical benefit to our patients.

Additionally, the physical layout of our facility is in itself much easier for the fragile patients to access. Parking is just outside the front door, once inside there are not different departments to navigate through the halls to reach.

Finally, and of equal importance, we provide high quality healthcare at a cheaper rate than hospital outpatient departments. This saves our patients (many of whom live on fixed incomes) money as well as saving the government money. Because we focus on one type of care we are able to find the best products at the best prices based on volumes.

HEALTHSOUTH
SurgeCenter of Louisville

Unfortunately we are currently limited from caring for some patients who would benefit from our out-patient surgical care. Due to current restrictions within the Medicare system, many procedures we perform are not available the Medicare patient. These same procedures are performed at hospitals increasing your cost, the patient cost, unnecessary exposures and inconvenience.

Each of us takes our responsibility to provide the best patient service very seriously. We treat patients as if they were our family. We are proud of the service that we provide to our patients and community. We respectfully request your consideration in extending the allowable services to mirror the services provided in a hospital outpatient department.

Thank you for your time and consideration.

Sincerely,

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

LAWRENCE SURGERY CENTER

216-0
(5)

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

November 1, 2006

Dear Administrator Norwalk:

My name is Thomas Nique MD a Board Certified Anesthesiologist and I currently serve as the Medical Director of Lawrence Surgery Center in Lawrence Kansas. Our ambulatory surgery center (ASC) offers multi-specialty services and has been providing high-quality, patient-centered, and cost-effective interventional procedures and surgery since 1999. Our 33 employees and over 25 surgeons care for approximately 3500 patients a year (this includes over 1000 Medicare beneficiaries) at our surgery center. I am taking this opportunity to offer my concerns regarding a proposed regulation issued several months ago by the Centers for Medicare and Medicaid Services (CMS) to establish a new payment system for ASC's.

The Medicare drug benefit legislation enacted in 2003 requires CMS to implement a new ambulatory surgical center (ASC) payment system by 2008. HR 4042, introduced by Representative Herger, and 1884, introduced by Senator Crapo, would provide guidance to CMS as it develops the new system. The legislation adopts the recommendation of the Medicare Payment Advisory Commission that ASCs should be allowed to perform and receive Medicare facility payments for any outpatient surgical service, except for those that the HHS Secretary designates as posing a risk to beneficiary safety when furnished in an ASC. Further, the bill would pay ASCs at 75 percent of the fee schedule amount provided to hospitals for the same covered services, as well as the same annual payment updates and other adjustments afforded hospitals.

On August 24, 2006, CMS issued its proposal to overhaul the ASC payment system. To say the least, the regulation is unacceptable to the ASC industry in virtually every material respect.

- CMS failed to include, on the ASC procedures list, a multitude of services which have, for years, been safely and effectively performed on non-Medicare patients

in ASCs throughout the country, depriving Medicare of significant cost savings and beneficiaries of access to high quality care at lower co-payment amounts.

- In 2008, CMS essentially proposes to pay ASCs 38 percent less than what they pay a hospital for the exact same surgical procedure. This untenable price differential is unrelated to the costs that ASCs incur in delivering services. It is driven entirely by the agency's narrow interpretation of budget neutrality requirements and will jeopardize the ability of many ASCs to continue to provide high-quality surgical care to Medicare beneficiaries. (The ASC industry recommends that ASCs be paid at 75 percent of hospital rates.)

- CMS proposes to use the Consumer Price Index for urban consumers to annually update ASC payment rates, while rates paid to hospital outpatient departments are updated by the Hospital Market Basket, which is typically about a full point higher. This will create greater disparity in the prices paid in the hospital and ASC without any evidence that hospital costs increase at rates in excess of those of surgery centers.

- The agency has proposed to phase in the new payment system over only two years. In order to ensure stability in the industry as the new system is implemented, the ASC legislation would phase in the new payment program over four years and incorporate special payment rulers to avoid disruptive cuts in payments.

As a physician I believe that patient should have choice in where they can seek their healthcare. Lawrence Surgery Center has created an additional access point that patients have come to appreciate not only from the compassionate care they receive but also from the fair price they are charged.

CMS' proposed rule is unacceptable to the ASC industry. It jeopardizes beneficiaries' access to ASC services and squanders the government's opportunity to save Medicare Trust Fund dollars through the migration of outpatient services to the less costly ASC. I would ask that you reconsider many of the terms and conditions of this important new payment system of our industry.

Sincerely,

Thomas Nique, MD
Medical Director
Lawrence Surgery Center
1112 West 6th Street
Lawrence, Kansas 66109

Grand River Gastroenterology, P.C.

217-0
(6)

310 Lafayette St., S.E., Ste 400
Grand Rapids, MI 49503
Telephone (616) 752-6525
Fax (616) 752-6556

WM. GENE HEERINGA, M.D.
PAUL O. FARR, M.D.
STEVEN A. CRANE, M.D.
MARTIN P. GREYDANUS, M.D.
PATRICIA K. RAU, APRN

SRINIVAS K. JANARDAN, M.D.
KENNETH S. LOWN, M.D.
J. BRADLEY MORROW, M.D.
STEPHEN T. WEBSTER, M.D.

November 2, 2006

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

Dear Administrator Norwalk:

I am a Gastroenterologist in Grand Rapids, Michigan. The purpose of this letter is to share my concerns regarding the proposed changes in the Ambulatory Surgery Center (ASC) payment system.

As our population ages and health care expenditures increase, we must all partner in providing high quality, cost effective care to the elderly population. Ambulatory surgery centers are proven to be a safe, cost effective alternative setting to traditional hospitals. While the proposed changes address some of the issues – the proposals fall short of accomplishing meaningful change that can be translated into real life practice.

Please consider the following:

- ASC's are much more efficient than hospitals allowing the physician to perform more procedures – thereby increasing access and timely service to patients.
- The proposed payment of 62% of HOPD rates is simply not adequate. ASC's often do not have the same discount pricing as large hospital systems. Hospitals pass along those charges to third party payors and ultimately patients – ASC's cannot.
- Relative value weights for hospitals and ASC's should be the same. This is an example of not rewarding efficiency. Remember, all of our costs are relatively similar – labor, supplies, energy. We are in the *same* community. Costs shifting high cost procedures to lower cost procedures have led us to the cry for "transparency" in health care. We cannot know the true cost of one procedure when it is shifted to another. This affects each person in the health care system, as a provider, an employer and as an individual. The inequity rewards cost shifting – hence we never capture true costs.

- The ASC list reform should exclude only those procedures that are on the hospital inpatient list. Physicians are in the best position to decide the most appropriate place of service for their patients.

As a practicing physician and an investor in ambulatory surgery center, I urge you to re-examine this proposal and align the ASC and HOPD payment systems to increase access for the senior citizen population, decrease out of pocket expenses and to help contribute to the transparency that will ultimately help us address skyrocketing health care costs.

Sincerely,

J. Bradley Morrow, M.D.
Gastroenterologist

218-0
(2)

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:

I am a physician practicing ophthalmology in Thomasville, Georgia. I participate in the Thomasville Surgery Center which is a dedicated ophthalmic outpatient surgical facility. We provide outpatient surgical services to approximately 2,000 Medicare patients annually. We are Joint commission accredited.

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

CMS, citing budget neutrality restrictions imposed by Congress, is proposing to pay ASCs only 62% of the procedural rates paid to HOPDs. This percentage rate is wholly inadequate and doesn't reflect a realistic differential of the costs incurred by hospitals and ASCs in providing the same services. 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.

Whatever percentage is eventually adopted by CMS in the final regulation, it should be applied uniformly to all ASC services, regardless of the type of procedure or the specialty of the facility. (Note: some specialty groups are recommending that their facilities receive a higher percentage-of-HOPD, which would result in a decline in payment for all other services.)

WILLIAM Z. BRIDGES, M.D. | ROBERT D. WEBB, M.D. | 2282 E. PINETREE BLVD. THOMASVILLE, GA 31792
MICHAEL L. HANEY, M.D. | W. DERRICK THORNTON, O.D. | PH: 229-226-6000 1-800-421-2020 FAX: 229-226-5859

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

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

I appreciate your consideration of our concerns.

Best regards,

Robert D. Webb, M.D.

RDW/dh