Submitter : Dr. Orthopedic Surgeon

Organization : Dr. Orthopedic Surgeon

Category : Physician

Date: 08/03/2005

Issue Areas/Comments

GENERAL

GENERAL

Dear CMS, every cost in my practice has increased, yet CMS is cutting fees. This is in addition to mandated services such as HIPAA. It is time to quit. Please post instructions on how to opt out of Medicare as part of your news release.

Submitter : Dr. Mingxiong Huang

Organization : Univ of California San Deigo/San Diego VA Hospital

Category : Other Health Care Professional

Date: 08/03/2005

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1502-P-2-Attach-1.DOC

UCSD *Medical Center*
HILLCREST

August 3, 2005

Shirl Ackerman-Ross, DFO, CMS, DOC
Attention: CMS-1501-P
Mail Stop C4-05-17
Centers for Medicare and Medicaid Services
7500 Security Blvd.
Baltimore, MD 21244-1850

Ref: CMS MEG Reimbursement

Dear Ms. Ackerman-Ross:

I am very surprised to know from the government website for MEDICARE, indicating that the new APC values for all 3 MEG codes will be changed to $620 from about $5200 previously for an epilepsy MEG scan. As an MEG scientist for more than ten years, I strongly encourage CMS to re-evaluate this decision.

When making the decision about the CMS MEG reimbursement, the following crucial factors should be considered: 1) The cost of MEG system (MEG sensor unit plus the magnetic shielded room) is in the order $2M ~ $3M, and siting cost can easily be $0.5M ~$1M; 2) The cost for operating an MEG system includes the service contract costs of $60,000 ~ $120,000/year plus the liquid helium cost of ~$40,000/year; 3) The MEG scanning time for each epilepsy case is about 4 hours (in two sessions), much longer than the scanning times for other imaging methods such as MRI; 4) The cost of manpower -- In general, it takes a PhD level MEG scientist about 20 hours to identify and localize spikes in one patient. Considering all these costs, it is clear that the previous rate at about $5200/scan is more reasonable than the new rate at $620/scan.

As a large number of publications have demonstrated that MEG's high temporal resolution and high spatial resolution and localization accuracy is unique for non-invasively localizing epileptic foci, **the new APC codes at approximately $ 620 per scan may drive many MEG clinical programs out of business and lead to a major lost to our epileptic patients.**

I sincerely hope that CMS can re-evaluate new MEG Reimbursement rate. If you have any questions about this letter, please feel free to contact me. Thank you very much for your time and consideration.

Sincerely,

Mingxiong Huang

Mingxiong Huang, Ph.D.
Associate Adjunct Professor, Associate Director of MEG
Department of Radiology Service, University of California San Diego/
VA San Diego Healthcare System
3350 La Jolla Village Drive
San Diego, CA 92161
Tel: 858-552-8585 ext 2947
Fax: 858-552-7404 or 858-642-3836
Email: mxhuang@ucsd.edu

Submitter : Dr. Rodger Barnette **Date:** 08/04/2005

Organization : Temple University

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

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. Rodger Barnette** **Date: 08/04/2005**

Organization : **Temple University**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1502-P-4-Attach-1.DOC

Centers for Medicare and Medicaid Services
Department of Health and Human Services
P.O. Box 8017
Baltimore, MD 21244-8017

Re: CMS-1502-P and Teaching Anesthesiologists

Dear Sir or Madam:

I am an academic physician who is board-certified in Anesthesiology, Internal Medicine and Critical Care Medicine. As such I believe I am uniquely qualified to address the severe reimbursement problems faced by Teaching Anesthesiologists in regard to Medicare Reimbursement.

As an internist I may supervise residents in 4 overlapping outpatient settings and collect 100% of the fee for each, when certain requirements are met. A surgical colleague may supervise residents in 2 overlapping operations and collect 100% of the fee for each case from Medicare. However, a teaching anesthesiologist will collect only 50% of the Medicare fee if he or she supervises residents in 2 overlapping cases.

Additionally, the Medicare anesthesia conversion factor is less than 40% of prevailing commercial rates (this is dramatically less than other medical specialties' conversion factors). Reducing reimbursement by an additional 50% results in revenue that is inadequate to sustain the tripartite mission (service, teaching and research) of teaching anesthesiologists and their academic anesthesia training programs.

This is neither fair nor reasonable. I ask you to recognize these issues as they relate to the delivery of anesthesiology care and pay Medicare teaching anesthesiologists on par with their surgical and internist colleagues.

Because of this inequity in Medicare reimbursement Anesthesiology teaching programs are suffering severe economic losses that cannot be absorbed elsewhere. The CMS Anesthesiology teaching rule needs to be changed to allow academic departments to cover their costs.

Sincerely,

Rodger E. Barnette, MD
Chairman, Department of Anesthesiology
Professor, Anesthesiology & Internal Medicine
Temple University School of Medicine
Philadelphia, PA 19140

Submitter : **Dr. William Hurford** **Date: 08/05/2005**

Organization : **U Cincinnati Dept of Anesthesia**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

From: William E. Hurford, MD
Professor and Chair
Department of Anesthesia
University of Cincinnati Medical Center
PO Box 670531
231 Albert Sabin Way
Cincinnati, Ohio 45267-0532

Date: August 4, 2005

Re: Comment on CMS-1502-P TEACHING ANESTHESIOLOGISTS

I note with concern that CMS? proposed changes to the Medicare Fee Schedule for 2006, released on August 1, 2005, do not include a correction of the discriminatory policy of paying teaching anesthesiologists only 50% of the fee for each of two concurrent resident cases.

Clearly, the proposed rule remains unworkable for academic anesthesiologists who suffer serious shortfalls since CMS provides only 50% of the Medicare fee for each of two overlapping procedures involving resident physicians.

As a result, budget shortfalls either demand that residency training be curtailed, or that anesthesiologists must seek support from other public sources. At the University of Cincinnati, this teaching penalty amounts to a shortfall in excess of $300,000 each year. Our practice largely cares for the indigent population of our county. As a result of this shortfall, we have difficulty attracting qualified anesthetists to care for our patients, who find their surgery delayed for hours to days. Those hospitals without teaching programs in our county are unwilling or unable to take up the slack

Sixty percent of our patients are covered by Medicare, Medicaid, or have no coverage. There are inadequate alternative sources to cover the economic losses causes by the CMS anesthesiology teaching rule.

Accordingly, the CMS anesthesiology teaching rule must be changed to allow academic departments such at the University of Cincinnati, who serve a disproportionate share of Medicare patients in urban communities, to cover their costs.

A surgeon may supervise residents in two overlapping operations and collect 100% of the fee for each case from Medicare. An internist may supervise residents in four overlapping outpatient visits and collect 100% of the fee for each when certain requirements are met. A teaching anesthesiologist will only collect 50% of the Medicare fee if he or she supervises residents in two overlapping cases.

The reason for this disparity remains unclear. The Medicare anesthesia conversion factor already is less than 40% of prevailing commercial rates. Reducing that by 50% for teaching anesthesiologists results in revenue grossly inadequate to provide care to our patients. For example, in Cincinnati, the teaching penalty results in payment of roughly $8.50 per unit, or $34 per hour. There is no way for a practice to be able to cover costs at this rate, which is less than half the rate received by a plumber or garage mechanic.

I urge CMS to correct this serious disparity in the Medicare Fee Schedule for 2006.

CMS-1502-P-6

Submitter : **Dr. Sam Golden** **Date: 08/05/2005**

Organization : **University of Chicago**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

Teaching Anesthesiologists

8-5-05

To whom it may concern at CMS,

I am an academic pediatric anesthesiologist at the University of Chicago. I wish to impress upon you the dire situation we are in regarding adequate reimbursement and its implications for the future. All of us are overworked; I average about 60-70 hours a week at my job. I could make about 80% more in private practice but wish to teach and further medical knowledge in an academic setting. Because we are only reimbursed 50% per case for supervising 2 resident rooms, our department?s income is severely limited. Of course, combine this with the fact that Medicare reimburses about 40% of what private insurers pay, and Medicaid even less. Thus we are working these long hours just to be financially alive. Many institutions are loosing quality people to private practice and virtually every academic institution I know of is short-staffed. Because of the limitation in reimbursement, institutions are leery to hire more people for fear that it will require lowering salaries, in turn leading to a further exodus of faculty. Thus, our group of pediatric anesthesiologists are doing only clinical work and little to no research as we are all exhausted just keeping financially afloat. I would never have believed it unless I was living it. The situation is no different at Loyola University Medical Center in suburban Chicago, where I worked previously.

Therefore, our mission of advancing medical knowledge and educating future practitioners is being compromised, and people are leaving to go into private practice. Lastly, I know that the vast majority of anesthesiologists and all physicians for that matter, are honest, hard-working and caring people. I don?t understand how it can be that there is 100% reimbursement for a surgeon concurrently supervising 2 resident rooms (and an internist 4 rooms) while anesthesiologists are reimbursed at only 50% for 2 rooms. There may be many issues to this (although it seems grossly unfair to me) but the bottom line is this?people go where the work load and reimbursement are fair, reasonable and equitable compared to that for other specialties. At the rate we are going, academic anesthesia will decline in quality and numbers and we all will suffer in the long run. I ask that you reconsider the 50% reimbursement rule. Please don't hesitate to contact me for further discussion.

Sincerely,

Sam Golden, MD FAAP
Comer Children?s Hospital
Universithy of Chicago
708-702-5307
sgolden@dacc.uchicago.edu

CMS-1502-P-6-Attach-1.DOC

CMS-1502-P-6-Attach-2.DOC

Teaching Anesthesiologists

8-5-05

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I am an academic pediatric anesthesiologist at the University of Chicago. I wish to impress upon you the dire situation we are in regarding adequate reimbursement and its implications for the future. All of us are overworked; I average about 60-70 hours a week at my job. I could make about 80% more in private practice but wish to teach and further medical knowledge in an academic setting. Because we are only reimbursed 50% per case for supervising 2 resident rooms, our department's income is severely limited. Of course, combine this with the fact that Medicare reimburses about 40% of what private insurers pay, and Medicaid even less. Thus we are working these long hours just to be financially alive. Many institutions are loosing quality people to private practice and virtually every academic institution I know of is short-staffed. Because of the limitation in reimbursement, institutions are leery to hire more people for fear that it will require lowering salaries, in turn leading to a further exodus of faculty. Thus, our group of pediatric anesthesiologists are doing only clinical work and little to no research as we are all exhausted just keeping financially afloat. I would never have believed it unless I was living it. The situation is no different at Loyola University Medical Center in suburban Chicago, where I worked previously.

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Sincerely,

Sam Golden, MD FAAP
Comer Children's Hospital
Universithy of Chicago
708-702-5307
sgolden@dacc.uchicago.edu

Teaching Anesthesiologists

8-5-05

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Sincerely,

Sam Golden, MD FAAP
Comer Children's Hospital
Universithy of Chicago
708-702-5307
sgolden@dacc.uchicago.edu

Submitter : Mr. Norman Jensen **Date:** 08/05/2005

Organization : Meridian Health Resources, Inc.

Category : Other Health Care Provider

Issue Areas/Comments

GENERAL

GENERAL

Physicians cannot sustain a 4.3% negative payment impact. Other costs are continually rising, managed care companies are not responsive, and even if you are able to negotiate with them most contracts are based on the Medicare rates so preferred rates would also be reduced by 4.3%. We should be providing the most comprehensive, quality health care in the world in the United States and with this proposed reduction and already strained industry will be put closer to the breaking point. It is unfortunate but patient care will almost certainly be compromised.

Submitter : Dr. Mark Warner **Date:** 08/05/2005

Organization : Mayo Clinic College of Medicine

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1502-P-8-Attach-1.DOC

MAYO CLINIC

Mayo Clinic
200 First Street SW
Rochester, Minnesota 55905
507-284-2511

Mark A. Warner, M.D.
Professor and Chair
Department of Anesthesiology

August 8, 2005

CMMS, Department of HHS
PO Box 8017
Baltimore, MD 21244-8017

Re: Reference file code CMS-1502-P (Teaching Anesthesiologists)

Dear sir or ma'am;

I represent 107 anesthesiologists who are members of one of the country's largest anesthesiology training programs. Mayo Clinic's anesthesiology residency program has produced 72% of all practicing anesthesiologists in the state of Minnesota during the past decade. It has produced another 92 anesthesiologists during that same time period who work in 41 of the other states in this country.

We are deeply troubled by the reluctance of CMS to correct the discriminatory policy of paying teaching anesthesiologists only 50% of the fee for each of two concurrent resident cases. This course is not fair to anesthesiology academic teaching programs and will, over time, reduce the number of anesthesiologists who are trained, an exceedingly bad idea at a time that patients are becoming older, sicker, and more in need to surgical and diagnostic interventions under anesthesia.

Why do we believe your current policy is unfair? Teaching surgeons may supervise trainees in two overlapping operations and collect 100% of the fee for each case from Medicare. An internist may supervise trainees in four overlapping outpatients visits and collect 100% of the fee for each when certain requirements are met. A teaching anesthesiologist can collect only 50% of the Medicare fee if he or she supervises trainees in two overlapping cases. We don't understand the distinction between surgeons, internists, and anesthesiologists as they provide needed services to our elderly patients.

At this time the Medicare anesthesia conversion factor is less than 40% of prevailing commercial rates. Reducing that factor by 50% for teaching anesthesiologists results in so little revenue that it is increasingly difficult to sustain the academic mission in our teaching programs.

I urge you to correct this unjust policy and allow teaching anesthesiologists equity with our colleagues in surgery and medicine. There is no logical reason for this payment difference between teaching physicians. Continuation of the policy will further hinder our ability to produce anesthesiologists at a crucial time in the demographic changes that are occurring in our country.

Sincerely,

Mark A Warner

Mark A. Warner, M.D.

Submitter : **Dr. John Butterworth** **Date: 08/05/2005**

Organization : **Indiana University School of Medicine**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Department of Anesthesia
Indiana University School of Medicine
1120 South Drive, FH 204
Indianapolis, IN 46202

Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attn: CMS-1502-P
P.O. Box 8017
Baltimore, MD 21244-8017

In reference to: TEACHING ANESTHESIOLOGISTS?

To Whom It May Concern:

I write to you as the Chairman of the Anesthesia Department at Indiana University School of Medicine. Academic anesthesiology departments such as ours are responsible for teaching medical students and resident physicians to take care of tomorrow?s patients. We are the only anesthesiology training program in Indiana and our program has trained about 75% of anesthesiologists practicing in our state.

There is a critical problem facing every academic anesthesiology department in the United States. Medicare treats teaching anesthesiologists (those of us who work with resident physicians) in a very different way from teaching physicians in other fields (including surgery, emergency medicine, and internal medicine). Specifically, if a surgeon performs an operation with residents in one operating room (and is present for all the key parts of the procedure), then begins surgery on a second patient (while the residents finish the first procedure), the surgeon is paid his or her full surgical fee for both patients. Teaching anesthesiologists are treated differently. Medicare reduces the fee paid to teaching anesthesiologists if the teaching anesthesiologist is covering more than one resident, even though NO OTHER acute care physician is treated this way! This rule is unwise and unfair. This rule will ultimately lead to a continuing shortage of anesthesiologists, to the detriment of American patients.

Academic anesthesiology departments are generally in poor financial shape in the United States. Despite a continuing national shortage of anesthesiologists, several anesthesiology residency programs have closed in recent years (including the nearby program in Memphis, TN). The income of teaching anesthesiologists across the United States averages at 50-60% of that of anesthesiologists in private practice, despite comparable hours and the added responsibilities of teaching young physicians. There is no reason for Medicare to add to our financial troubles.

I urge you in the strongest possible way to correct this policy that discriminates against teaching anesthesiologists, relative to other teaching physicians.

Cordially,

John Butterworth, MD
Robert K. Stoelting Professor and Chairman

Submitter : **Dr. Steve Lipman** **Date: 08/05/2005**

Organization : **Stanford University Department of Anesthesia**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

To whom it may concern,

I am a Clinical Assistant Professor in the Department of Anesthesia in a major California medical center. My department cares for a significant number of Medicare patients. The Medicare anesthesia conversion factor is less than 40% of prevailing commercial rates. Reducing that by 50% for teaching anesthesiologists results in revenue grossly inadequate to sustain the service, teaching and research missions of academic anesthesia training programs.

Our patients are getting older and in general are higher acuity. When further financial constraints are superimposed on the already significant time pressure, decreasing resources, decreasing staffing, increased paperwork, ever present beepers and cell phones ringing, and other stressors such as the rise of HIV, Hepatitis C, homelessness, drug addiction, gang related activity - all of which have significant ramifications for the practice of anesthesia - what is produced is a situation where errors will occur more frequently and patient safety is compromised.

A surgeon may supervise residents in two overlapping operations and collect 100% of the fee for each case from Medicare. An internist may supervise residents in four overlapping outpatient visits and collect 100% of the fee for each when certain requirements are met.

A teaching anesthesiologist will only collect 50% of the Medicare fee if he or she supervises residents in two overlapping cases.

Medicare must recognize the challenges associated with and the skill sets required by the field of anesthesiology. Medicare must pay for Medicare teaching anesthesiologists must be on par with their surgical colleagues so as to generate the needed revenue for research, adequate staffing, and adequate physical resources & equipment so as to ultimately enhance patient safety.

Thank you,
Steve

Steve Lipman MD
Clinical Assistant Professor
Department of Anesthesia
Division of Obstetrical Anesthesia
Stanford University School of Medicine

Submitter : **Dr. oscar viefgas**

Date: **08/05/2005**

Organization : **indiana university**

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

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. Jeffrey Grass **Date:** 08/06/2005

Organization : The Western Pennsylvania Hospital

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1502-P-12-Attach-1.DOC

CMS-1502-P-12-Attach-2.DOC

MAYO CLINIC

Mayo Clinic
200 First Street SW
Rochester, Minnesota 55905
507-284-2511

Mark A. Warner, M.D.
Professor and Chair
Department of Anesthesiology

August 8, 2005

CMMS, Department of HHS
PO Box 8017
Baltimore, MD 21244-8017

Re: Reference file code CMS-1502-P (Teaching Anesthesiologists)

Dear sir or ma'am;

I represent 107 anesthesiologists who are members of one of the country's largest anesthesiology training programs. Mayo Clinic's anesthesiology residency program has produced 72% of all practicing anesthesiologists in the state of Minnesota during the past decade. It has produced another 92 anesthesiologists during that same time period who work in 41 of the other states in this country.

We are deeply troubled by the reluctance of CMS to correct the discriminatory policy of paying teaching anesthesiologists only 50% of the fee for each of two concurrent resident cases. This course is not fair to anesthesiology academic teaching programs and will, over time, reduce the number of anesthesiologists who are trained, an exceedingly bad idea at a time that patients are becoming older, sicker, and more in need to surgical and diagnostic interventions under anesthesia.

Why do we believe your current policy is unfair? Teaching surgeons may supervise trainees in two overlapping operations and collect 100% of the fee for each case from Medicare. An internist may supervise trainees in four overlapping outpatients visits and collect 100% of the fee for each when certain requirements are met. A teaching anesthesiologist can collect only 50% of the Medicare fee if he or she supervises trainees in two overlapping cases. We don't understand the distinction between surgeons, internists, and anesthesiologists as they provide needed services to our elderly patients.

At this time the Medicare anesthesia conversion factor is less than 40% of prevailing commercial rates. Reducing that factor by 50% for teaching anesthesiologists results in so little revenue that it is increasingly difficult to sustain the academic mission in our teaching programs.

I urge you to correct this unjust policy and allow teaching anesthesiologists equity with our colleagues in surgery and medicine. There is no logical reason for this payment difference between teaching physicians. Continuation of the policy will further hinder our ability to produce anesthesiologists at a crucial time in the demographic changes that are occurring in our country.

Sincerely,

Mark A Warner

Mark A. Warner, M.D.

August 6, 2005

Centers for Medicare and Medicaid Services
Department of Health and Human Services

RE: CMS-1502-P TEACHING ANESTHESIOLOGISTS

The current Medicare teaching anesthesiologist payment rule is unwise, unfair and unsustainable. Quality medical care, patient safety and an increasingly elderly Medicare population demand that the United States have a stable and growing pool of physicians trained in anesthesiology. Right now, slots in anesthesiology residency programs are going unfilled because of ill-conceived Medicare policy that shortchanges teaching programs, withholding 50% of their funds for concurrent cases.

We currently have 24 residents, 4 pain fellows and 8 faculty openings in the Western Pennsylvania Hospital/Temple University Anesthesiology Program. This creates great inefficiencies in scheduling, personnel allocation, and case assignments. It is very difficult for us to recruit and retain faculty due to budget shortfalls and non-competitive salaries that can be directly attributed to the current Medicare teaching anesthesiologist policy. Our two integrated teaching hospitals subsidize the anesthesia program with payment of $3.9 million annually, which is non-sustainable for our hospitals! Anesthesiology teaching programs, caught in the snare of this trap, are suffering severe economic losses that cannot be absorbed elsewhere.

The CMS anesthesiology teaching rule must be changed to allow academic departments to cover their costs. Academic research in anesthesiology is also drying up as department budgets are broken by this arbitrary Medicare payment reduction.

A surgeon may supervise residents in two overlapping operations and collect 100% of the fee for each case from Medicare. An internist may supervise residents in four overlapping outpatient visits and collect 100% of the fee for each when certain requirements are met. A teaching anesthesiologist will only collect 50% of the Medicare fee if he or she supervises residents in two overlapping cases. This is not fair, and it is not reasonable.

Medicare must recognize the unique delivery of anesthesiology care and pay Medicare teaching anesthesiologists on par with their surgical colleagues. The Medicare anesthesia conversion factor is less than 40% of prevailing commercial rates. Reducing an already grossly inadequate reimbursement fee by 50% for teaching anesthesiologists will make us unable to sustain the service, and teaching and research missions of academic anesthesia training programs.

Sincerely,

Jeffrey A. Grass, MD, MMM
Chairman and Program Director
The Western Pennsylvania Hospital/Temple University
Anesthesiology Residency Program

August 6, 2005

Centers for Medicare and Medicaid Services
Department of Health and Human Services

RE: CMS-1502-P TEACHING ANESTHESIOLOGISTS

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Sincerely,

Jeffrey A. Grass, MD, MMM
Chairman and Program Director
The Western Pennsylvania Hospital/Temple University
Anesthesiology Residency Program

CMS-1502-P-13

Submitter : Dr. Timothy Angelotti **Date:** 08/06/2005

Organization : Stanford University

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

Please see attached letter (PDF).

CMS-1502-P-13-Attach-1.PDF

August 8, 2005

Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attn: CMS-1502-P
P.O. Box 8017
Baltimore, MD 21244-8017

Re: CMS-1502-P "Teaching Anesthesiologists"

Dear CMS Administrators:

As an Assistant Professor in an academic anesthesiology department, I am writing to ask for your strong support for the revision of the Medicare Physician payment rule, as applied to academic anesthesiology programs. I chose a career in academic medicine and specifically academic anesthesiology, following extensive training. However the current payment schedule from Medicare is preventing me and others like me from pursuing our mission, namely service, resident training, and research. With the aging population, the proportion of Medicare patients for whom we provide anesthesia services will increase. With the current Medicare Physician payment rule for anesthesiologists, my department will continue to suffer financial hardships, preventing us from fulfilling our multiple missions.

A healthy academic anesthesia department is determined by economics, specifically reimbursements for clinical care. At present, the current Medicare teaching anesthesiologist payment rule is unwise, unfair and unsustainable. By withholding 50% of the funds for providing anesthesia services to concurrent surgical cases, my department suffers due to a loss of revenue. I find it interesting that my surgical colleagues can supervise two overlapping cases and my internist colleagues can supervise four concurrent outpatient visits and each receive 100% of the Medicare fee for each case. Such a discrepancy in payment schedules leaves the impression that Medicare does not recognize the challenges and skill sets associated with the specialty of anesthesiology, nor the unique challenges of taking care of the elderly.

In order to achieve my mission of furthering anesthesia research, I need to be part of a healthy academic anesthesia department. The Medicare anesthesia conversion factor of less than 40% of prevailing market rates has led to a loss of revenue that is inadequate to support the service, teaching and research missions of academic anesthesia training programs. The NIH has supported my training throughout medical and graduate school, for which I am sincerely grateful. I have received support from the NIGMS under the Pharmacological Sciences Training Program (PSTP), an NINDS training grant (NRSA),

and the NIGMS Medical Scientist Training Program (MSTP). I chose the specialty of anesthesiology because I felt that I could best use my research and teaching skills to train and develop the future of anesthesiology.

Too much training, money, and time has been put into preparing me to be an academic anesthesiologist. It would be a waste of taxpayers' money, if I was not able to give back to this country. I implore you to modify the Medicare payment rule and bring us on par with our surgical and medical colleagues, namely allowing for 100% payment for concurrent delivery of anesthesia services. Doing so, will ensure that academic anesthesiology departments can continue to thrive and achieve the goals to which we are committed.

Sincerely,

Timothy Angelotti

CMS-1502-P-14

Submitter : Dr. Phillip Brown **Date:** 08/07/2005

Organization : University of Oklahoma Health Sciences Center

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

RE: TEACHING ANESTHESIOLOGISTS (CMS-1502-P)

Please see attached letter.

CMS-1502-P-14-Attach-1.PDF

PHILLIP BENTON BROWN, M.D.

2916 NORTH ALEXANDER LANE • BETHANY, OK 73008-4514
TELEPHONE: 405.694.6255 • TELECOPIER: 405.621.1163
E-MAIL: PHILLIP-BROWN@OUHSC.EDU

August 8, 2005

Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attn: CMS-1502-P
P.O. Box 8017
Baltimore, MD 21244-8017

RE: TEACHING ANESTHESIOLOGISTS (CMS-1502-P)

Dear Sir or Madam:

The proposed payment updates and policy changes to the Medicare Physician Fee Schedule fail to offer a remedy to the anesthesiology teaching rule. Under this rule, teaching anesthesiologists may collect only 50% of the Medicare reimbursement when supervising concurrent cases; meanwhile, a surgeon may supervise residents in two overlapping cases and collect 100% of the fee for each case from Medicare. In some instances, an internist may supervise residents in four overlapping outpatient visits and expect complete reimbursement. Clearly, the current Medicare teaching anesthesiologist payment rule is unreasonable and unfair.

The consequences of this irrational rule are devastating. Anesthesiology teaching programs are sustaining significant economic losses that affect departmental ability to recruit quality residents, hire new faculty, and fund academic research. The CMS teaching rule must be changed to allow academic departments to cover their costs, and pay Medicare teaching anesthesiologists on par with their surgical and medical colleagues.

Sincerely,

Phillip B. Brown, M.D. /S/

Submitter : Dr. Jon Barrett
Organization : OUHSC
Category : Physician
Date: 08/07/2005

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1502-P-15-Attach-1.RTF

J. Val Barrett D.O.
18005 Chestnut Oak Drive
Edmond, OK 73003
(405) 285-4327
jon-barrett@ouhsc.edu

August 7, 2005

Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attn: CMS-1502-P
P.O. Box 8017 Baltimore, MD 21244-8017

RE: TEACHING ANESTHESIOLOGISTS (CMS-1502-P)

Dear Sir or Madam:

The proposed payment updates and policy changes to the Medicare Physician Fee Schedule fail to offer a remedy to the anesthesiology teaching rule. Under this rule, teaching anesthesiologists may collect only 50% of the Medicare reimbursement when supervising concurrent cases; meanwhile, a surgeon may supervise residents in two overlapping cases and collect 100% of the fee for each case from Medicare. In some instances, an internist may supervise residents in four overlapping outpatient visits and expect complete reimbursement. Clearly, the current Medicare teaching anesthesiologist payment rule is unreasonable and unfair. The consequences of this irrational rule are devastating. Anesthesiology teaching programs are sustaining significant economic losses that affect departmental ability to recruit quality residents, hire new faculty, and fund academic research. The CMS teaching rule must be changed to allow academic departments to cover their costs, and pay Medicare teaching anesthesiologists on par with their surgical and medical colleagues.

Sincerely,

J. Val Barrett D.O.

CMS-1502-P-16

Submitter : Dr. Jonathan Nunley **Date:** 08/08/2005

Organization : University of Oklahoma Department of Anesthesiolog

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1502-P-16-Attach-1.PDF

Jonathan S. Nunley M.D.
304 Cherryvale Rd.
Edmond, OK 73003

August 8, 2005

Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attn: CMS-1502-P
P.O. Box 8017
Baltimore, MD 21244-8017

RE: TEACHING ANESTHESIOLOGISTS (CMS-1502-P)

Dear Sir or Madam:

The proposed payment updates and policy changes to the Medicare Physician Fee Schedule fail to offer a remedy to the anesthesiology teaching rule. Under this rule, teaching anesthesiologists may collect only 50% of the Medicare reimbursement when supervising concurrent cases; meanwhile, a surgeon may supervise residents in two overlapping cases and collect 100% of the fee for each case from Medicare. In some instances, an internist may supervise residents in four overlapping outpatient visits and expect complete reimbursement. Clearly, the current Medicare teaching anesthesiologist payment rule is unreasonable and unfair.

The consequences of this irrational rule are devastating. Anesthesiology teaching programs are sustaining significant economic losses that affect departmental ability to recruit quality residents, hire new faculty, and fund academic research. The CMS teaching rule must be changed to allow academic departments to cover their costs, and pay Medicare teaching anesthesiologists on par with their surgical and medical colleagues.

Sincerely,

Jonathan S. Nunley M.D.

Submitter : **Bruce Rogers** **Date: 08/08/2005**

Organization : **Rogers Pharmacy**

Category : **Pharmacist**

Issue Areas/Comments

GENERAL

GENERAL

The proposed 2006 dispensing fees for inhalation drugs are not adequate. If these fees are established, our pharmacies will give notice to our customers that we can no longer dispense inhalation medicines to them under Medicare and that they will need to find another supplier.This will be hardship on these patients, as very few pharmacies in our area provide this service. I find astonishing that your decision to lower fees are based on comments from two retail pharmacies.

The low fees does not provide for an adequate margin to allow us to continue in business. It would be nice if the government would look at other industires profits such as Microsoft and Exxon.

Submitter : **Dr. Francis Kumar** **Date: 08/08/2005**

Organization : **Oklahoma university health sciences center**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

As a level-I trauma center anesthesiologist, we train excellent young residents. All of them are quite worthy of your support. It is not fair when the system doesn't pay 100% when a physician is supervising two residents. The same system pays 100% when a surgeon or an internist were to supervise under similar conditions. As anesthesiologists, we play a key and a vital role to help patients and so and equitable payment is in order as an example of fairness. We need your help. Thanks!!!

Submitter : **Date: 08/08/2005**

Organization :

Category : **Drug Industry**

Issue Areas/Comments

GENERAL

GENERAL

I represent a drug manufacturer of inhalation drugs and am quite familiar with homecare pharmacies. These pharmacies have not been shipping 90 day supplies because it is far less proftable ($80 vs $171). Our company is working to package products in a 90 day format to make it more economical to ship in a 90 day format. Most patients who are on neb drugs are unlikely to switch to MDI'as most studies show Dr.'s cannot even tell a patient how to use them properly.One result of reduced fees will be an exodus of smaller homecare pharmacies and increase in patient obtaining their meds from more tradtional pharmacies such as chain and independent retail. These entities will have to "gear up" for this additional business by stocking more product on the shelves or rerouting the patient to its mail service pharmacy

Submitter : **Dr. Robert Presson** **Date: 08/08/2005**

Organization : **Indiana University School of Medicine**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1502-P-20-Attach-1.DOC

August 8, 2005

Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attn: CMS-1502-P
P.O. Box 8017
Baltimore, MD 21244-8017

In reference to: TEACHING ANESTHESIOLOGISTS'

To Whom It May Concern:

I write to you as the Chairman of the Anesthesia Department at Indiana University School of Medicine. Academic anesthesiology departments such as ours are responsible for teaching medical students and resident physicians to take care of tomorrow's patients. We are the only anesthesiology training program in Indiana and our program has trained about 75% of anesthesiologists practicing in our state.

There is a critical problem facing every academic anesthesiology department in the United States. Medicare treats teaching anesthesiologists (those of us who work with resident physicians) in a very different way from teaching physicians in other fields (including surgery, emergency medicine, and internal medicine). Specifically, if a surgeon performs an operation with residents in one operating room (and is present for all the key parts of the procedure), then begins surgery on a second patient (while the residents finish the first procedure), the surgeon is paid his or her full surgical fee for both patients. Teaching anesthesiologists are treated differently. Medicare reduces the fee paid to teaching anesthesiologists if the teaching anesthesiologist is covering more than one resident, even though NO OTHER acute care physician is treated this way! This rule is unwise and unfair. This rule will ultimately lead to a continuing shortage of anesthesiologists, to the detriment of American patients.

Academic anesthesiology departments are generally in poor financial shape in the United States. Despite a continuing national shortage of anesthesiologists, several anesthesiology residency programs have closed in recent years (including the nearby program in Memphis, TN). The income of teaching anesthesiologists ac ross the United States averages at 50-60% of that of anesthesiologists in private practice, despite comparable hours and the added responsibilities of teaching young physicians. There is no reason for Medicare to add to our financial troubles.

I am appealing to you to correct this discriminatory and detrimental policy.

Sincerely,

Robert G. Presson, Jr., M.D.
Professor

Submitter : Dr. Robert Presson **Date:** 08/08/2005

Organization : Indiana University

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

See Attached

CMS-1502-P-21-Attach-1.PDF

INDIANA UNIVERSITY

SCHOOL OF MEDICINE

August 8, 2005

Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attn: CMS-1502-P
P.O. Box 8017
Baltimore, MD 21244-8017

In reference to: TEACHING ANESTHESIOLOGISTS'

To Whom It May Concern:

I have been a faculty member of the Department of Anesthesia of Indiana University School of Medicine for 18 years. During this time, I have cared for some of the most critically ill patients in the state and have helped to train the next generation of anesthesiologists. We are the only anesthesia residency program in the state, and roughly three quarters of the anesthesiologists practicing in Indiana were trained by our program.

Over the years, I have witnessed a steady decline in the health of academic anesthesia to the point that something must now be done. The financial health of these programs is poor due to the low levels of reimbursement. Teaching institutions shoulder the lion's share of Medicaid patients and are also penalized by concurrency rules for their care of Medicare patients. The income of teaching anesthesiologists across the United States averages at 50-60% of that of anesthesiologists in private practice despite comparable work hours and the added responsibilities of teaching young physicians. This has driven many anesthesiologists out of the academic setting into private practice. The result has been the closure of several residency programs in recent years. At the same time, there continues to be a national shortage of anesthesiologists coupled with a growing demand for their services fueled by our aging population.

This serious situation would be greatly helped by the elimination of the concurrency rules for teaching anesthesiologists which reduce payment when an anesthesiologist supervises more than one resident. No other acute care physician is penalized in such a way. For example, if a surgeon performs an operation with residents in one operating room (and is present for all the key parts of the procedure), then begins surgery on a second patient (while the residents finish the first procedure), the surgeon is paid his or her full surgical fee for both patients. In contrast, teaching anesthesiologists are reimbursed at a reduced rate even though they perform the pre-anesthetic examination and evaluation, prescribe the anesthetic plan, personally participate in the most demanding procedures of the anesthetic including induction and emergence, monitor the course of anesthesia administration at frequent intervals, remain physically present and available for immediate diagnosis and treatment of emergencies, and provide indicated post-anesthesia care

I am appealing to you to correct this discriminatory and detrimental policy.

Sincerely,

Robert G. Presson, Jr., M.D.
Professor

DEPARTMENT OF ANESTHESIA

SECTION OF PEDIATRIC ANESTHESIA AND CRITICAL CARE

Riley Hospital for Children
Room 2001
702 Barnhill Drive
Indianapolis, Indiana
46202-5200

317-274-9981
317-274-8222
Fax: 317-274-0282

Submitter : **Mr. Charles Levine** **Date: 08/09/2005**

Organization : **none**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

What a welcome move to propose the revision to the physician reimbursement for Medicare services in Santa Cruz County, Ca. Our cost-of living is among the highest in the Country and we have a terrible time trying to keep physicians here. My wife has lost two family doctors in the last year due to their moving to another county. I volunteer in the local hospital and continually hear the the physicians talk about the monetary advantages of moving out of this County. PLEASE, PLEASE, we are not a low priced rural area!

Thank you!

Charles Levine
124 Buena Vista Ave
Santa CRuz, CA
831-427-1428

Submitter : Dr. Jeffrey Lane **Date:** 08/09/2005

Organization : Indiana University School of Medicine

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

This comment is concerning TEACHING ANESTHESIOLOGISTS.

See Attachment

CMS-1502-P-23-Attach-1.DOC

Department of Anesthesia
Indiana University School of Medicine
1120 South Drive, FH 204
Indianapolis, IN 46202

Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attn: CMS-1502-P
P.O. Box 8017
Baltimore, MD 21244-8017

In reference to: TEACHING ANESTHESIOLOGISTS'

To Whom It May Concern:

I write to you as a Faculty Anesthesiologist from the Department of Anesthesia at Indiana University School of Medicine. Academic anesthesiology departments such as ours are responsible for teaching medical students and resident physicians to take care of tomorrow's patients. We are the only anesthesiology training program in Indiana and our program has trained about 75% of anesthesiologists practicing in our state.

There is a critical problem facing every academic anesthesiology department in the United States. Medicare treats teaching anesthesiologists (those of us who work with resident physicians) in a very different way from teaching physicians in other fields (including surgery, emergency medicine, and internal medicine). Specifically, if a surgeon performs an operation with residents in one operating room (and is present for all the key parts of the procedure), then begins surgery on a second patient (while the residents finish the first procedure), the surgeon is paid his or her full surgical fee for both patients. Teaching anesthesiologists are treated differently. Medicare reduces the fee paid to teaching anesthesiologists if the teaching anesthesiologist is covering more than one resident, even though NO OTHER acute care physician is treated this way! This rule is unwise and unfair. This rule will ultimately lead to a continuing shortage of anesthesiologists, to the detriment of American patients.

Teaching anesthesiologists across the United States are giving up their practices, and teaching, to take more lucrative positions in private practice. Anesthesia programs are closing across the country, in spite of a growing need for anesthesiologists.

Teaching hospitals get a disproportionate share of Medicare patients, relative to non-teaching hospitals. The acuity of cases done in teaching programs exceeds that in private practice, plus the teaching anesthesiologist shoulders both the burden of patient care and the additional burden of teaching. In spite of this, anesthesiologists in teaching institutions make far, far less than their colleagues in private practice, so many of the best and brightest leave academic medicine to practice in institutions with less of a burden of uninsured patients and patients with Medicare.

Academic anesthesiology departments are generally in poor financial shape in the United States. Despite a continuing national shortage of anesthesiologists, several anesthesiology residency programs have closed in recent years. The income of teaching anesthesiologists across the United States averages at 50-60% of that of anesthesiologists in private practice, despite comparable hours and the added responsibilities of teaching young physicians. There is no reason for Medicare to add to our financial troubles.

We need to work together to correct the errors that were introduced when the relative value system was established. Anesthesia services have been grossly undervalued from day one, and the gap was to a large degree covered by insurance. Now too large a proportion of the population are Medicare, so insurance companies can no longer shoulder the burden. The government has to move away from the unfunded mandate for anesthesia services. Come

around to my hospital and follow me around for a few days, then see if you are paying me an equitable amount, relative to my colleagues in private practice. There's a reason good physicians are shunning teaching jobs in anesthesia, and those of us left are leaving. If our program fails, as is quite possible, this entire state will suffer from an even greater shortage of qualified providers.

I urge you in the strongest possible way to correct this policy that discriminates against teaching anesthesiologists, relative to other teaching physicians.

Sincerely,

Jeffrey L. Lane, MD
Associate Professor of Clinical Anesthesiology

Submitter : Mrs. LouAnn Reid **Date:** 08/09/2005

Organization : Mrs. LouAnn Reid

Category : Drug Industry

Issue Areas/Comments

GENERAL

GENERAL

Nuclear Medicine Services

How will the physician self referral ruling effect physicians who have a financial relationship with a company that produces and supplies radiopharmaceuticals (FDG: C1775, A4641) to PET centers? Since FDG is on the list of CPT/HCPCS codes for Nuclear Medicine Designated Health Services, will that effect where a physician sends patients for PET/CT scans?

Submitter : Dr. Robert Geer

Organization : Holston Medical Group

Category : Physician

Date: 08/09/2005

Issue Areas/Comments

GENERAL

GENERAL

With these reductions, expect to see more limitation of acsess of Medicare patients to physicians.

Submitter : Dr. Russell Wall

Date: 08/09/2005

Organization : Georgetown University Hospital

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

see attachment

CMS-1502-P-26-Attach-1.DOC

August 9, 2005

To Whom It May Concern,

I am writing to contest the CMS medicare rule 1502-P which discriminates against teaching anesthesiologists. The current rule which reduces fees by 50% for concurrent resident supervision is unwise, unfair, and unsustainable. Quality medical care, patient safety and an increasingly elderly Medicare population demand that the United Stated have a stable and growing pool of physicians trained in anesthesiology. This policy shortchanges teaching programs resulting in severe economic losses that cannot be absorbed elsewhere. The rule must change to allow academic departments to cover their costs. We are experiencing daily inefficiencies in scheduling, personnel allocation , and case assignments directly attributable to the current Medicare teaching anesthesiologist policy. Our colleagues in surgery collect 100% of the fees for concurrent resident supervision. Our internal medicine colleagues may supervise residents in four overlapping outpatient visits and collect 100% of the fee for each case when certain requirements are met. For teaching anesthesiologists to collect only 50% of the Medicare fee when supervising residents in two overlapping cases is not fair and is not reasonable. Medicare must recognize the unique deliver of anesthesiology care and pay Medicare teaching anesthesiologists on par with their colleagues. The Medicare anesthesia conversion factor is less that 40% of prevailing commercial rates. Reducing that by 50% results in revenue grossly inadequate to sustain the clinical service, teaching and research missions of academic anesthesia programs. CMS 1502-P must be modified to secure anesthesia teaching programs now and in the future.

Sincerely,

Russell T. Wall. MD
Vice-Chairman and Program Director
Georgetown University Hospital
Department of Anesthesiology

Submitter :

Date: 08/09/2005

Organization :

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

'TEACHING ANESTHESIOLOGIST'

CMS-1502-P-27-Attach-1.DOC

August 9, 2005

To Whom It May Concern,

I am writing to contest the CMS medicare rule 1502-P which discriminates against teaching anesthesiologists. The current rule which reduces fees by 50% for concurrent resident supervision is unwise, unfair, and unsustainable. Quality medical care, patient safety and an increasingly elderly Medicare population demand that the United Stated have a stable and growing pool of physicians trained in anesthesiology. This policy shortchanges teaching programs resulting in severe economic losses that cannot be absorbed elsewhere. The rule must change to allow academic departments to cover their costs. We are experiencing daily inefficiencies in scheduling, personnel allocation , and case assignments directly attributable to the current Medicare teaching anesthesiologist policy. Our colleagues in surgery collect 100% of the fees for concurrent resident supervision. Our internal medicine colleagues may supervise residents in four overlapping outpatient visits and collect 100% of the fee for each case when certain requirements are met. For teaching anesthesiologists to collect only 50% of the Medicare fee when supervising residents in two overlapping cases is not fair and is not reasonable. Medicare must recognize the unique deliver of anesthesiology care and pay Medicare teaching anesthesiologists on par with their colleagues. The Medicare anesthesia conversion factor is less that 40% of prevailing commercial rates. Reducing that by 50% results in revenue grossly inadequate to sustain the clinical service, teaching and research missions of academic anesthesia programs. CMS 1502-P must be modified to secure anesthesia teaching programs now and in the future.

Sincerely,

Russell T. Wall. MD
Vice-Chairman and Program Director
Georgetown University Hospital
Department of Anesthesiology

Submitter :

Date: 08/09/2005

Organization :

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

"TEACHING ANESTHESIOLOGISTS"

CMS-1502-P-28-Attach-1.DOC

August 9, 2005

To Whom It May Concern,

I am writing to contest the CMS medicare rule 1502-P which discriminates against teaching anesthesiologists. The current rule which reduces fees by 50% for concurrent resident supervision is unwise, unfair, and unsustainable. Quality medical care, patient safety and an increasingly elderly Medicare population demand that the United Stated have a stable and growing pool of physicians trained in anesthesiology. This policy shortchanges teaching programs resulting in severe economic losses that cannot be absorbed elsewhere. The rule must change to allow academic departments to cover their costs. We are experiencing daily inefficiencies in scheduling, personnel allocation , and case assignments directly attributable to the current Medicare teaching anesthesiologist policy. Our colleagues in surgery collect 100% of the fees for concurrent resident supervision. Our internal medicine colleagues may supervise residents in four overlapping outpatient visits and collect 100% of the fee for each case when certain requirements are met. For teaching anesthesiologists to collect only 50% of the Medicare fee when supervising residents in two overlapping cases is not fair and is not reasonable. Medicare must recognize the unique deliver of anesthesiology care and pay Medicare teaching anesthesiologists on par with their colleagues. The Medicare anesthesia conversion factor is less that 40% of prevailing commercial rates. Reducing that by 50% results in revenue grossly inadequate to sustain the clinical service, teaching and research missions of academic anesthesia programs. CMS 1502-P must be modified to secure anesthesia teaching programs now and in the future.

Sincerely,

Russell T. Wall. MD
Vice-Chairman and Program Director
Georgetown University Hospital
Department of Anesthesiology

Submitter : Dr. Ronald Ramsdell

Date: 08/09/2005

Organization : Multidisciplinary Academy - M.A.A.M.A.

Category : Health Care Provider/Association

Issue Areas/Comments

GENERAL

GENERAL

'Therapy Cap'. We realize that Congressional action is needed on this however restriction to hospital outpatient therapy departments would seem to indicate that CMS considers those facilites superior to other therapy facilities when, in fact the supervision level for the performance is 'general' wherein the patient may not encounter with a licensed physical therapist during regular visits. Secondly, the provisions appears to be discriminatory in favor of only the hospitals to the exclusion of CORF, ORF and other certified rehab facilites that are fully capable of performing the services with equal or superior staffing and supervision. Should the provisions and caps reach implementation, the Multidisciplinary Academy of Affiliated Medical Arts goes to the record in favor of including all certified facilities and not just hospital outpatient departments. This would provide a more diversified base through which the patient could more easily access the needed care and help reduce the probable overload that could reasonably be expected at the hospital departments. We are generally concerned with the actual capabilities of hospital departments to handle significant increases in patient load without compromising quality and individual attention to the patient.

Submitter : Dr. Ronald Ramsdell

Date: 08/10/2005

Organization : Multidisciplinary Academy- M.A.A.M.A.

Category : Health Care Provider/Association

Issue Areas/Comments

GENERAL

GENERAL

'CHIROPRACTIC SERVICES' Our Academy would like to suggest that an additional consideration be employed in calculation of the buget neutrality of the demonstration project. We should consider that the therapy rendered by the Chiropractors and/or their therapists is medical necessary therapy that would have previously required evaluation, order and re-certification by a medical doctor and is therefore a 'trade off' of associated costs for both evaluation and therapy. Second, the management of neuromuscular conditions is more efficient when all contrubuting factors are identified and addressed simultaneously by the combined skills of each specialty. The patient would normally return to function more rapidly through concurrent multidisciplinary management than with any limited single approach. The possibility of re-occurance is also reduced since medical management, correction, strenghtening and modification of daily activities are all addressed in the overall goals of the active therapy process. To accurately assess the demonstration results one would need to apply factors that permit reasonable consideration for conversion of 'medical services not were not required, services directly replaced by another provider (ie: therapy vs therapy) and a compensating factor on reduced therapy requirements due to the simultaneous multidisciplinary approach that effectively removes the 'fail at one approach, start another' continuations that prolongs recovery and encourages chonicity.
We feel that the variables must be considered to produce mathematical validity.

Submitter : Dr. Scott Schneiderman, DO **Date:** 08/11/2005

Organization : Monterey County Medical Society

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

Argument against extracting Santa Cruz County and Sonoma County from California's Area 99 Medicare payment locality. See Attachment.

CMS-1502-P-31-Attach-1.DOC

Monterey County
Medical Society

August 11, 2005

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1502-P
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

To Whom It May Concern:

On August 3, CMS unveiled its physician payment rules for 2006 and is proposing to move two California counties (Santa Cruz and Sonoma) out of payment Locality 99, "Rest of California" at the cost of reducing reimbursement to the remaining Area 99 counties, including those already adversely impacted by averaging with lower cost counties. The proposed rule would result in a 0.4% cut in physician reimbursement for Monterey County physicians.

The Monterey County Medical Society, representing over 350 physicians practicing in Monterey County and over 90 retired physicians (Medicare beneficiaries) residing here, objects to the proposed rule because it fails to correct proven inadequacies in physician reimbursement to all the counties in Area 99 that exceed a 5% threshold (the "105% rule") over the national 1.000 average. Specifically, by extracting Santa Cruz and Sonoma counties from Area 99, CMS is exacerbating reimbursement deficiencies for the California counties of Monterey, San Diego, Sacramento, Santa Barbara, and El Dorado.

The Monterey County Medical Society (MCMS) supported and continues to support the proposal drafted by the California Medical Association for and at the recommendation of the Centers of Medicare and Medicaid Services. The proposal included a formula to determine which counties qualified for their own payment regions. Unfortunately, we vigorously oppose the half-hearted attempt by CMS is put a tiny and inadequate band-aid on a problem recognized by all physicians in California as a lethal wound.

In 1996, CMS began an attempt to decrease the number of payment localities for Medicare Part B providers. In determining which counties belonged where, CMS determined that a 5%-or-greater differential in practice costs from other California counties, would secure a county's qualifying for its own payment region. When CMS determined that Monterey County did not qualify as a greater-than-5% county, MCMS was shocked – national publications had identified Monterey County as one of the counties in America that had the highest health care costs. For the past several years, as practice costs in Monterey County have increased at the same rate

as those in San Francisco County, physicians have become more and more disillusioned with the Medicare system.

Hopes were high when the California Medical Association House of Delegates was able to secure consensus on a formula that would allow, with CMS' regular updates, for counties demonstrating 5%-or-greater differential from the "Rest of California" to be moved into their own payment locality with the financial burden being spread throughout the entire state, including those counties that were already in their own payment localities.

Who would have thought that California physicians could reach consensus on a Medicare GPCI formula proposal in which most counties would have had to accept less reimbursement? With all the angst, politicking, and frustration that went into obtaining a consensus among physicians, it was quite discouraging to find that the August 1, 2005 edition of the *Federal Register*, obliterated everything the CMA had tried so ardently to achieve. Again, California physicians find themselves butting heads with CMS! Why is it that CMS seems hell-bent on creating divisiveness among physicians in our state?!

No one disparages Santa Cruz and Sonoma County physicians – the squeaky wheels obviously got the oil – but the Monterey County Medical Society urges you to reconsider the well-thought-out and debated proposal of the California Medical Association. The CMA proposal established a formula for determining geographic disparities, recommended regularly scheduled Geographic Adjustment Factor updates, and recommended the implementation of regularly scheduled locality adjustments for qualifying counties in California.

The Monterey County Medical Society supports the California Medical Association's recommendation that Congressman Thomas and the Centers for Medicare and Medicaid Services work together to devise a nationwide fix to the GPCI problem. The proposed rule to extract Santa Cruz and Sonoma counties from California's Area 99 is *not*, in our collective opinion, a viable first step toward that goal.

Monterey County physicians cannot afford another cut in Medicare reimbursement.

Sincerely,

Scott H. Schneiderman, DO
President

cc: U.S. Congressman Sam Farr, 17th District of California

Monterey County Medical Society
19065 Portola Drive, Suite M ⋮ Salinas, CA 93908 ⋮ (831) 455-1008 ⋮ Fax: (831) 455-1060 ⋮ www.montereymedicine.org

Submitter : Dr. jeffrey kaufman **Date:** 08/12/2005

Organization : vascular services of western new england

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

practice expense issue:

we have seen some confusion from our carrier on the issue of whether casting/strapping is a separate service from active wound care. we have had some denials for unna boots placed at the same time as a wound debridement.

if one goes through the logic of casting strapping expense under page 45578, then it is obvious that there is a significant expense and labor needed to do these services. if one looks at the codes for active wound care, such as the family 1104x, there is no accounting for the expense of any casting/strapping service, such as an Unna boot.

it should be made clear that these services casting strapping, etc are distinct from wound care debridement, suturing, etc.

Submitter : Mr. Geoff MacKay **Date:** 08/12/2005

Organization : Organogenesis, Inc.

Category : Comprehensive Outpatient Rehabilitation Facility

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.

Date: 08/12/2005

Submitter : Dr. Jeffrey R. Kirsch

Organization : Oregon Health

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1502-P-34-Attach-1.DOC

OHSU
Oregon Health & Science University

SCHOOL OF MEDICINE
DEPARTMENT OF ANESTHESIOLOGY AND PERI-OPERATIVE MEDICINE

Mail Code UHS-2 • 3181 S.W. Sam Jackson Park Rd. • Portland, Oregon 97239-3098
Tel. 503-494-4908 • Fax. 503-494-4588 • kirschje@ohsu.edu

Jeffrey R. Kirsch, M.D.
Professor and Chairman

August 12, 2005

Centers for Medicare and Medicaid Services
Department of Health and Human Services
PO Box 8017
Baltimore, Maryland 21244-8017

Attention: Teaching Anesthesiologists CMS – 1502 – P

Thank you for the opportunity to respond to the proposed change in the anesthesia teaching rule regarding reduction of fees by 50% when an academic anesthesiologist supervises two resident trainees.

As CMS is well aware, this is an arbitrary ruling that penalizes the anesthesia specialty. It is not applied to Surgical or Medical specialties, although these academic practices also provide concurrent care under the Teaching Regulations. Under the Teaching Regulations, surgeons can medically direct two overlapping operations, internists can medically direct up to 4 overlapping patient visits, and anesthesiologists can medically direct two overlapping resident cases. Only anesthesia is required to report the concurrency, and only anesthesia is financially penalized with a 50% reduction in pay for medically directed concurrent cases. In addition to the basic unfairness, we also object for these reasons:

1. We do not think it is appropriate to consider a resident as a "qualified" provider of care under the definition for modifier "QK" which results in the 50% payment rule. In the care team model, this modifier is used for medically directing two or more "qualified providers", including CRNAs, AAs, or interns and residents. Only CRNAs and AAs are qualified providers who have completed their training and are fully licensed and credentialed as anesthesia providers. A resident is a trainee and is not a "qualified" provider of care yet. As a qualified provider, the CRNA portion of the case is billable to CMS under the modifier "QX", resulting in an additional 50% payment of the fee schedule. It does not make sense for a resident to be considered "qualified" under the "QK" definition but to not recognize their "qualified" contribution to the care team with a second billable modifier. This could be rectified by including residents as a "qualified provider" under "QX", or deleting them from the definition of "QK". Another option, if CMS wants to track the cases with resident involvement, would be to report all cases with a medically directed resident using modifier "GC", whether performed concurrently or under one to one medical direction.

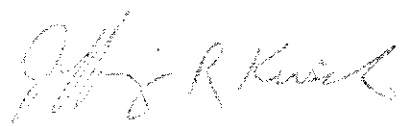
2. The Medicare anesthesia fee schedule is already significantly less, when compared to prevailing commercial rates, than other specialties. This means that anesthesia is already the poorest paid specialty under Medicare, receiving 40% of prevailing commercial rates compared to the 60% rate received by other specialties. When payment is reduced by 50% for cases done under concurrent care (2 residents under the supervision of one faculty anesthesiologist), it worsens the economic impact of Medicare revenue support for this undervalued field.

3. Anesthesia is in the midst of a critical manpower shortage. Recruitment and retention for academic anesthesia practices is especially difficult. This is because academic institutions can not compete with private practice compensation, due partially to the unfair payment treatment by Medicare. Academic institutions tend to be DSH facilities (Disproportionate Share Hospitals that serve more of the indigent population), so clinical revenue is less. Medicare adds to this problem by the practice of disallowing 50% payment for concurrent cases.

4. Academic institutions are training the providers of care for the future. Anesthesiology is a field that has contributed tremendously to patient care and safety over the past ten years, with impressive results that have been widely recognized in the business and insurance fields. In order to continue to make strides in this area through research and education programs, academic anesthesia practices need to have support from the government, not be treated unfairly.

Please act to correct this unfair Medicare guideline. We urge you to reconsider the definition of "qualified providers" under the modifier "QK" and clarify that this term relates only to CRNAs. All resident cases (whether medical direction is 1:1 or 1:2) should be billed under modifier "GC" and paid at 100%, as they are in all other specialties.

Sincerely,



Jeffrey R. Kirsch, M.D.
Professor and Chair
Department of Anesthesiology
and Peri-Operative Medicine
Oregon Health & Science University

Submitter : **Dr. Carmelita Pablo** **Date: 08/15/2005**

Organization : **UAMS**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

To Whom It May Concern:

I am the present Chair in the Department of Anesthesiology at the University of Arkansas for Medical Sciences. As such, I make every effort to be aware of all Medicare policies affecting our program. The CMS? proposed changes to the Medicare Fee Schedule for 2006 has one glaring omission, that of correcting the discriminatory policy of paying teaching anesthesiologists only 50% of the fee for each of two concurrent resident cases. This current Medicare teaching anesthesiologist payment rule is unwise, unfair and unsustainable.

Our increasingly elderly Medicare population demands that we have a stable and growing pool of anesthesiology trained physicians to provide quality medical care and patient safety. Right now, programs such as ours are having slots unfulfilled because of the rule of withholding 50% of funds for concurrent cases. We currently seek two CAII residents and two faculty in our Department of Anesthesiology. The CMS anesthesiology teaching rule must be changed to allow academic departments to cover their costs. Because of this arbitrary Medicare payment reduction, academic research is also being squandered as department budgets are being broken up. Our program is suffering economic losses that cannot be absorbed elsewhere.

Consider this. A surgeon can supervise residents in two overlapping operations and collect 100% of the fee for the case from Medicare. An internist may supervise residents in four overlapping outpatient visits and collect 100% of the fee when certain requirements are met. A teaching anesthesiologist will only collect 50% of the Medicare fee if he/she supervises residents in two overlapping cases. Not only is this not fair, but it is unreasonable. Medicare must recognize the unique delivery of anesthesiology care and pay Medicare teaching anesthesiologists on par with their surgical colleagues.

The Medicare anesthesia conversion factor is less than 40% of prevailing commercial rates. By reducing that conversion factor 50% for teaching anesthesiologists, this results in revenues grossly inadequate to sustaining the service, teaching, and research missions of academic anesthesia training programs.

I implore that this current Medicare rule be revised as soon as possible so that we can provide the quality of care that the patient deserves. We also deserve a fair and workable policy in par with our colleagues in surgery ? 100% of the Medicare fee for each of two overlapping procedures involving resident physicians.

Thank you for your consideration in this matter.

Sincerely,

Carmelita S. Pablo, M.D.
Associate Professor and Chair

Submitter : **Date: 08/15/2005**

Organization :

Category : **Health Plan or Association**

Issue Areas/Comments

GENERAL

GENERAL

Empire Medicare Services Part A has a couple questions regarding the Proposed Payment Update and Policy Changes.

1. Will the proposed payment and policy changes listed delay the MPFS fee rate files used by intermediaries effective January 1, 2006?

2. Would the implementation of January 2, 2006 be postponed to accomodate these potential file delays?

Thank you.

Submitter : Mr. Geoff MacKay **Date:** 08/15/2005

Organization : Organogenesis

Category : Device Industry

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

Revised comment letter with support documentation

CMS-1502-P-37-Attach-1.DOC

CMS-1502-P-37-Attach-2.DOC

Organogenesis Inc.

LIVING TECHNOLOGY

150 Dan Road, Canton,
Massachusetts 02021

August 12, 2005

The Honorable Mark McClellan
Administrator
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
Room 445-G, Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Washington, DC 20201

ATTN: FILE CODE CMS-1501-P

Re: Medicare Program; Changes to the Hospital Outpatient Prospective Payment System and Calendar Year 2006 Payment Rates -- Drugs, Biologicals, and Radiopharmaceuticals Non Pass-throughs

Dear Administrator McClellan:

Organogenesis, Inc. is writing to comment on an error in the proposed rule, CMS-1501-P, "Medicare Program; Changes to the Hospital Outpatient Prospective Payment System and Calendar Year 2006 Payment Rates" relating to the payment rate for our product Apligraf®. Organogenesis is a biotechnology company based in Canton, Massachusetts and we manufacture and market Apligraf (C1305), a unique human skin substitute for diabetics and the elderly who suffer from chronic ulcers. As set out below, Apligraf has been paid in the hospital outpatient prospective payment system as a specified covered outpatient drug and should be paid in 2006 similar to other such drugs. We are notifying the agency as soon as possible due to the significant decrease in reimbursement for Apligraf as a result of the error in Addendum A of the proposed rule and the negative impact on beneficiary access to wound care treatment. We respectfully request that CMS reimburse hospitals for Apligraf as a specified covered outpatient drug in the final rule based on the average sales price (ASP) data that has been reported to CMS on a quarterly basis under Apligraf's NDC number (NDC #09978-0001-99).

Apligraf® Is A Unique, Medically-Necessary And Cost-Saving Treatment

Apligraf is a unique, bioengineered, cell-based living human skin substitute for the treatment of chronic, hard-to-heal venous leg ulcers and diabetic foot ulcers. Like human skin, it is made from living cells and it is composed of two layers, a dermis and an epidermis comprised of healthy, functioning, responsive cells that stimulate the wound to heal. Apligraf® is the only active wound-healing product approved by the

U.S. Food and Drug Administration (FDA) to treat both venous leg ulcers and diabetic ulcers. The incidence of chronic wounds in the United States is approximately 5 to 7 million per year, and the annual costs for management of these wounds is greater than $20 billion. No other active wound-healing product is indicated for treatment of venous leg ulcers. Before the development of Apligraf, physicians had few options for treating hard-to-heal venous leg ulcers, which comprise approximately one-third of all treated venous ulcers. Apligraf has preserved and improved the quality of life of tens of thousands of diabetics and other elderly patients who suffer from chronic leg and foot ulcers. Many of them would have had to undergo limb amputations without the benefit of Apligraf. Apligraf and similar advanced bioactive products have been specified by leading clinicians in published algorithms as the standard of care for wounds that have not responded to conventional therapy. Apligraf is a proven cost-effective therapy for chronic foot ulcers, providing savings in wound care costs of $7,500 for these patients.

Apligraf is a Specified Covered Outpatient Drug

The Medicare history of Apligraf demonstrates that Apligraf has been recognized and paid as a biologic and under MMA recognized as a specified covered outpatient. The following background may help clarify for the agency the classification of Apligraf in the hospital outpatient setting.

- **In 2001 and 2002**: Apligraf was paid in the hospital outpatient setting as a biological under the pass through list. In February, 2001 CMS (then HCFA) issued a Program Memorandum (Transmittal B-01-07) that states *"Apligraf has met the statutory requirement as a biologic."* (See attachment 1).

- **In 2003:** Following the enactment of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 Apligraf has been paid in the hospital outpatient setting as a sole source biological at 88% of AWP in 2004 and 83% of AWP in 2005 under the specified covered outpatient drug provision.

- **As recent as 2005 in the GAO:** As a specified covered outpatient drug Apligraf was included in the General Accountability Office (GAO) survey of acquisition costs for hospital outpatient drugs. The GAO Report dated June 30, 2005 (GAO-05-581R) on specified covered outpatient drugs states *"[GAO] obtained from our survey data the average and median purchase prices for each of the 53 SCOD drug categories."* Apligraf is listed under number 38 in Table 1 of the report detailing the acquisition costs for specified covered outpatient drugs. (See attachment 2.)

Apligraf's History of HCPCS C1305 and J7340

On February 7, 2001, the Program Memorandum (Transmittal B-01-07) that CMS (then HCFA) issued also provided two HCPCS codes for Apligraf: C1305 for hospital outpatient and Q0185 for the physician office. (See attachment 1).

The transmittal states:

> ***For these services, physicians should not bill Apligraf using HCPCS code C1305 since this code has been approved solely for use under the hospital outpatient prospective payment system.***

Effective July 1, 2002, in Transmittal B-02-015, CMS assigned J7340 to Apligraf for billing in the physician setting and eliminated the use of the temporary Q0185. The new J code was provided the descriptor of "*Metabolic active Dermal/Epidermal tissue*". (See attachment 3). Consequently, since July 1, 2002 Apligraf® has been billed under J7340 in physician's office.

It has been CMS policy that the C1305 code is for sole use in the hospital outpatient setting. In Chapter 17 of the Medicare Claims Processing Manual covering payment for drugs and biologics CMS provided the following guidance for pass-through drugs:

> ***Only HCPCS code C1305 is reportable under the hospital OPPS. HCPCS J7340 should NOT be reported for Apligraf under the hospital OPPS.***

(See attachment 4.)

Apligraf's Payment Rate is Incorrectly Listed in Addendum A

In the proposed Hospital Outpatient Rule for calendar year 2006 the Centers for Medicare and Medicaid Services (CMS) proposed to pay specified covered outpatient drugs at average sales price (ASP) plus six percent for the acquisition cost of the drug. The rule proposes to pay a pharmacy overhead charge of an additional two percent which results in a total payment for specified covered outpatient drugs of ASP plus eight percent.

We understand based on communication with the agency that CMS paid Apligraf based on mean costs derived from historical hospital claims data because there had been no ASP payment rate specific to HCPCS C1305. We believe the confusion in the proposed rule is because the ASP rate for Apligraf is reported by CMS under HCPCS J7340.

Based on the April 1, 2005 ASP rate for Apligraf, payment at ASP plus 8% would be $1,203.69. However, Apligraf is listed in addendum A of the proposed rule at $766.84 which is clearly in error. (See attachment 5.)

It is important to note that the CMS reporting requirements for ASP submissions are by NDC not HCPCS code. Organogenesis has reported ASP data for Apligraf since the inception of the ASP system and regularly submits ASP quarterly updates to CMS under the NDC # 09978-0001-99. In the July 2005 quarterly update, CMS published an ASP rate for Apligraf of $1,182.72 ($26.88 sqcm). The ASP data submitted by Organogenesis includes all sales irrespective of the site of care for the respective quarter. Attached is the most recent ASP filing submitted by Organogenesis for Apligraf (See Attachment 6). **Therefore, Apligraf's ASP is comprised of sales billed by providers under C1305 in the hospital OPPS and under J7340 in the physician setting.**

Conclusion

The proposed payment rate is incorrect and will significantly underpay hospitals for Apligraf. We have already been contacted by a number of leading wound care providers in the country regarding their concern that the proposed payment rate will have a significant negative impact on beneficiary access to standard of care wound treatment. Thus, we believe it is very important that in the final hospital outpatient rule it is clarified that hospitals will be reimbursed for the acquisition of Apligraf at ASP plus six percent and an additional two percent for pharmacy overhead cost similar to other specified covered outpatient drugs. In this regard, we would like to meet with agency staff during the comment period. You may contact me directly at 1 (781) 401-1040.

Thank you for your attention to this issue

Sincerely,

Geoff MacKay
President & CEO

ATTACHMENT 1

Program Memorandum Carriers

Department of Health and Human Services (DHHS)
HEALTH CARE FINANCING ADMINISTRATION (HCFA)

Transmittal B-01-07 **Date: FEBRUARY 7, 2001**

CHANGE REQUEST 1521

SUBJECT: Apligraf (Graftskin)

On August 12, 2000, Apligraf (Graftskin) was approved for inclusion in the United States Pharmacopeia. The FDA labeling for Apligraf states that the indications for its use are the treatment of venous leg ulcers and diabetic foot ulcers. There is no national coverage decision regarding Apligraf. Carriers and intermediaries have discretion regarding coverage of Apligraf.

Under the hospital outpatient prospective payment system, Apligraf is reportable with HCFA Common Procedure Coding System (HCPCS) code C1305. Current Procedural Terminology (CPT) codes describing the services delivered are reported on the bill. The CPT codes to describe services associated with the use of Apligraf can include 15000 for the wound site preparation and 15342 and 15343 for application of the bilaminate skin substitute. Apligraf has been recognized as a biologic and will be paid at 95 percent of its average wholesale price (AWP) effective January 1, 2001.

Code Q0185 should be used for Apligraf for claims submitted to the carriers. CPT codes 15000, 15342, and 15343 can be used to describe the services delivered when Apligraf is used. For these services, physicians should not bill Apligraf using HCPCS code C1305 since this code has been approved solely for use under the hospital outpatient prospective payment system. The payment mechanism for Q0185 is 95 percent of its AWP since Apligraf has met the statutory requirement as a biologic.

The *effective date* for this Program Memorandum (PM) is February 7, 2001.

The *implementation date* for this PM is February 7, 2001.

These instructions should be implemented within your current operating budget.

This PM may be discarded after January 31, 2002.

If you have any questions, contact your local regional office.

ATTACHMENT 2

Table 1: Purchase Prices for Drugs Accounting for 80 Percent of Medicare Spending on SCODs

Rank in Medicare spending on drug SCODs	HCPCS code	Description	Medicare spending on SCOD, 2004[a] ($ in millions)	% of Medicare spending on SCODs, 2004	Number of hospitals in sample	Total number of hospitals[c]	CMS payment rate for 2005[d] ($)	ASP (average sales price)[e] ($)	Average purchase price[f] ($)	95% confidence interval of the average purchase price[g] ($)	Median purchase price[h] ($)	95% confidence interval of the median purchase price[i] ($)
1	Q0138	Injection, Epoetin Alpha (for non-ESRD use), per 1,000 units	199.6	10.1	973	2,758	11.09	9.25	9.74	9.55–9.94	10.12	10.11–10.13
2	J9310	Rituximab, 100 mg	158.4	8.0	871	1,118	437.83	414.93	412.31	407.43–417.20	412.50	412.13–412.62
3	J2505	Injection, Pegfilgrastim, 6 mg	144.8	7.3	759	1,177	2,448.50	2,017.55	'	'	'	'
4	Q9941	Injection, Immune Globulin, Intravenous, Lyophilized, 1 g	'	'	626	'	60.68	36.54	36.50	36.37–36.63	37.24	37.15–37.24
4	Q9943	Injection, Immune Globulin, Intravenous, Non-Lyophilized, 1 g	'	'	381	'	60.68	53.04	50.63	50.11–51.15	30.98	30.98–87.06
5	J1745	Injection, Infliximab, 10 mg	114.8	5.8	897	1,303	57.40	50.23	'	'	'	'
6	Q0137	Injection, Darbepoetin alfa, 1 mcg (non-ESRD use)	100.6	5.1	743	1,117	3.95	3.04	3.00	2.96–3.05	3.09	3.09–3.11
7	J9170	Docetaxel, 20 mg	75.7	3.7	829	1,257	312.89	278.95	295.05	294.10–295.96	294.51	294.46–294.89
8	J9045	Carboplatin, 50 mg	70.7	3.6	893	1,382	129.95	71.46	132.10	131.65–132.55	132.59	132.55–132.63
9	C9205	Injection, Casopitant, per 5 mg	67.0	3.4	708	1,173	82.53	77.88	75.91	74.90–76.91	77.69	77.65–77.76
10	J3487	Injection, Zoledronic Acid, 1 mg	66.9	3.4	852	1,316	197.97	187.47	185.27	183.71–186.83	190.67	190.29–191.01
11	J9201	Gemcitabine Hcl, 200 mg	65.0	2.8	855	1,317	106.73	100.79	105.89	105.13–106.24	106.34	106.44–106.65
12	J9206	Irinotecan, 20 mg	38.4	2.0	780	1,109	127.33	119.56	118.21	113.87–118.75	122.87	122.18–123.13
13	J2324	Injection, Nesiritide, 0.25 mg	37.8	1.9	852	1,319	69.23	69.64	'	'	'	'
14	J9265	Paclitaxel, 30 mg	32.0	1.6	792	1,388	79.04	17.70	14.45	14.44–14.46	14.45	14.45–21.34
15	J9355	Trastuzumab, 10 mg	31.4	1.6	679	1,089	50.79	49.99	46.72	45.92–47.53	47.97	47.93–48.04
16	J9217	Leuprolide Acetate (for depot suspension), 7.5 mg	30.8	1.6	804	1,319	649.72	210.83	234.06	223.21–244.90	199.88	195.83–215.41
17	J0256	Injection, Alpha 1 - Proteinase Inhibitor - Human, 10 mg	20.9	1.1	39	279	3.72	3.06	2.35	2.33–2.37	2.46	2.27–2.46

Rank in Medicare spending on drug SCODs	HCPCS code	Description	Medicare spending on SCOD, 2004[a] ($ in millions)	% of Medicare spending on SCODs, 2004[a]	Number of hospitals in sample	Total number of hospitals[b]	CMS payment rate for 2005[c] ($)	ASP (average sales price)[d] ($)	Average purchase price ($)	95% confidence interval of the average purchase price[e] ($)	Median purchase price[e] ($)	95% confidence interval of the median purchase price[e] ($)
18	J9035[*]	Injection, Bevacizumab, 10 mg	19.6	1.0	436	416	57.11	53.88	53.31	53.01–53.61	53.72	53.69–53.75
19	J1441	Injection, Filgrastim (G-CSF), 480 mcg	17.1	0.9	928	1,879	274.40	261.46	257.21	253.46–260.96	253.64	253.45–253.76
20	J1950	Injection, Leuprolide Acetate (for depot suspension), per 3.75 mg	16.8	0.9	541	504	451.96	409.18	454.10	453.04–455.17	454.68	454.03–456.72
21	J9001	Doxorubicin hydrochloride, all lipid formulations, 10 mg	16.3	0.8	614	455	343.78	338.66	338.33	332.22–340.44	338.70	338.78–338.97
22	J2353	Injection, Octreotide, depot form for intramuscular injection, 1 mg	15.7	0.8	545	452	69.44	80.95	71.13	69.63–72.62	74.04	73.54–74.87
23	J9055[*]	Injection, Cetuximab, 10 mg	15.1	0.8	288	506	49.65	46.85	.	.	.	.
24	J9041[*]	Injection, Bortezomib, 0.1 mg	14.1	0.7	452	431	28.38	28.37	.	.	.	.
25	J9350	Topotecan, 4 mg	13.9	0.7	586	468	697.76	689.75	674.91	656.60–690.21	709.19	706.34–710.59
26	J1440	Injection, Filgrastim (G-CSF), 300 mcg	13.0	0.7	950	1,914	182.41	165.23	151.61	156.81–156.42	159.18	158.04–159.31
27	J1785	Injection, Imiglucerase, per unit	12.9	0.7	41	59	3.91	3.89	3.62	3.60–3.64	3.62	3.61–3.66
28	J3396	Injection, Verteporfin, 0.1 mg	12.3	0.6	10	46	8.49	8.48	.	.	.	.
29	J9202	Goserelin Acetate Implant, per 3.6 mg	11.4	0.6	390	379	190.00	181.78	201.76	193.30–210.23	206.58	175.73–220.33
30	J1626	Injection, Granisetron Hydrochloride, 100 mcg	11.1	0.6	682	188	16.20	6.71	6.45	6.27–6.62	6.61	6.60–6.64
31	J0585	Botulinum Toxin Type A, per unit	10.8	0.6	480	1,082	4.32	4.44	.	.	.	.
32	J0207	Injection, Amifostine, 500 mg	10.5	0.5	477	705	395.75	400.84	.	.	.	.
33	J2430	Injection, Pamidronate Disodium, per 30 mg	10.2	0.5	945	1,987	128.74	54.10	58.49	51.51–65.47	72.59	71.50–72.72
34	J9390	Vinorelbine Tartrate, per 10 mg	9.8	0.5	564	433	57.78	58.30	48.15	48.13–48.16	48.14	48.13–52.05
35	J2993	Injection, Reteplase, 18.1 mg	8.9	0.4	505	1,073	1,192.00	832.49	846.53	844.18–848.87	846.30	844.46–848.37

HCPCS	DESCRIPTION	JURISDICTION
A4361 - A4421	Ostomy Supplies	If provided in the physician's office for a temporary condition, the item is incident to the physician's service & billed to the Local Carrier. If provided in the physician's office or other place of service for a permanent condition, the item is a prosthetic device & billed to the DME REGIONAL Carrier
A4454 - A4455	Tape;Adhesive Remover	Local Carrier if incident to a physician's service (not separately payable). If other DME REGIONAL Carrier
A4460	Elastic Bandage	Local Carrier if incident to a physician's service (not separately payable). If secondary surgical dressing, DME REGIONAL Carrier. (See MCM 2079)
A4462	Abdominal Dressing	Local Carrier if incident to a physician's service (not separately payable). If other DME REGIONAL Carrier
A4464	Joint Supportive Device/Garment	DME REGIONAL Carrier
A4465	Non-elastic Binder for Extremity	DME REGIONAL Carrier
A4470	Gravlee Jet Washer	Local Carrier
A4480	Vabra Aspirator	Local Carrier
A4481	Tracheostomy Supply	Local Carrier if incident to a physician's service (not separately payable). If other DME REGIONAL Carrier
A4483	Moisture Exchanger	DME REGIONAL Carrier
A4490 - A4510	Surgical Stockings	DME REGIONAL Carrier
A4550	Surgical Trays	Local Carrier
A4554	Disposable Underpads	DME REGIONAL Carrier
A4556 - A4558	Electrodes; Lead Wires; Conductive Paste	Local Carrier if incident to a physician's service (not separately payable). If other DME REGIONAL Carrier
A4561 - A4562	Pessary	Local Carrier
A4565	Sling	Local Carrier
A4570	Splint	Local Carrier
A4572	Rib Belt	DME REGIONAL Carrier
A4575	Topical Hyperbaric Oxygen Chamber, Disposable	Local Carrier
A4580 - A4590	Casting Supplies & Material	Local Carrier
A4595	TENS Supplies	Local Carrier if incident to a physician's service (not separately payable). If other DME REGIONAL Carrier
A4608	Transtracheal Oxygen Catheter	DME REGIONAL Carrier
A4611 - A4613	Oxygen Equipment Batteries and Supplies	DME REGIONAL Carrier

HCPCS	DESCRIPTION	JURISDICTION
A9900	Miscellaneous DME Supply or Accessory	Local Carrier if used with implanted DME, if other, DME REGIONAL Carrier
A9901	Delivery	DME REGIONAL Carrier
B4034 - B9999	Enteral and Parenteral Therapy	DME REGIONAL Carrier
D0120 - D9999	Dental Procedures	Local Carrier
E0100 - E0105	Canes	DME REGIONAL Carrier
E0110 - E0116	Crutches	DME REGIONAL Carrier
E0130 - E0159	Walkers	DME REGIONAL Carrier
E0160 - E0175	Commodes	DME REGIONAL Carrier
E0176 - E0199	Decubitus Care Equipment	DME REGIONAL Carrier
E0200 - E0239	Heat/Cold Applications	DME REGIONAL Carrier
E0241 - E0246	Bath and Toilet Aids	DME REGIONAL Carrier
E0249	Pad for Heating Unit	DME REGIONAL Carrier
E0250 - E0297	Hospital Beds	DME REGIONAL Carrier
E0305 - E0326	Hospital Bed Accessories	DME REGIONAL Carrier
E0350 - E0352	Electronic Bowel Irrigation System	DME REGIONAL Carrier
E0370	Heat Pad	DME REGIONAL Carrier
E0371 - E0373	Decubitus Care Equipment	DME REGIONAL Carrier
E0424 - E0480	Oxygen and Related Respiratory Equipment	DME REGIONAL Carrier
E0481	Intra-Pulmonary Percussive Ventilation System	DME REGIONAL Carrier
E0482	Cough Stimulating Device	DME REGIONAL Carrier
E0500	IPPB Machine	DME REGIONAL Carrier
E0550 - E0585	Compressors/Nebulizers	DME REGIONAL Carrier
E0590	Drug Dispensing Fee	DME REGIONAL Carrier
E0600	Suction Pump	DME REGIONAL Carrier
E0601	CPAP Device	DME REGIONAL Carrier
E0602 - E0604	Breast Pump	DME REGIONAL Carrier
E0605	Vaporizer	DME REGIONAL Carrier
E0606	Drainage Board	DME REGIONAL Carrier
E0607	Home Blood Glucose Monitor	DME REGIONAL Carrier
E0608	Apnea Monitor	DME REGIONAL Carrier
E0610 - E0615	Pacemaker Monitor	DME REGIONAL Carrier
E0616	Implantable Cardiac Event Recorder	Local Carrier
E0617	External Defibrillator	DME REGIONAL Carrier
E0620	Skin Piercing Device	DME REGIONAL Carrier
E0621 - E0635	Patient Lifts	DME REGIONAL Carrier
E0650 - E0673	Pneumatic Compressor and Appliances	DME REGIONAL Carrier
E0690	Ultraviolet Cabinet	DME REGIONAL Carrier
E0700	Safety Equipment	DME REGIONAL Carrier

ATTACHMENT 4

Medicare Claims Processing Manual

Chapter 17 - Drugs and Biologicals

Table of Contents

(Rev. 248, 97-23-04)

(Rev. 224, 97-23-04)

(Rev. 327, 10-22-04)

90.2.6 - Additional Billing and Reporting Information Related to Pass-Through Drugs Effective April 1, 2002

(Rev. 1, 10-01-03)

PM A-02-026 §IX.F

Below is additional information for the HCPCS codes listed in the November 30, 2001, and/or March 1, 2002 Final Rule.

HCPCS Code	APC	Short Descriptor	Additional Information
A9504	1602	Technetium tc 99m apcitide (per vial)	Payment rate for this radiopharmaceutical is based on "per vial."
C1064	1064	I-131 cap, each addl mCi	This code should be reported after the first initial 1-5 mCi. This dosage is to be used for 6 or more capsules and is used in conjunction with C1188. For example, for a patient that received 7 mCi of I-131 capsules, the following codes should be reported: C1188 initial 1-5 mCi Units of service: 1 C1064 each add'l mCi Units of service: 2
C1065	1065	I-131 sol, each add mCi	This code should be reported after the first initial 1-6 mCi. For example, for a patient that received 7 mCi of I-131 solution, the following codes should be reported: C1348 initial 1-6 mCi Units of service: 1 C1065 each add'l mCi Units of service: 2
C1066	1066	In 111 Satumomab pentetide	Under OPPS, A4642 will no longer be reportable effective 04/01/2002. This radiopharmaceutical has been replaced with C1066.
C1188	1188	I-131 cap, per 1-5 mCi	This code should be reported for only the initial 1-5 mCi dose of I-131 capsules.
C1305	1305	Apligraf	Only HCPCS code C1305 is reportable under the hospital OPPS. HCPCS 37340 should NOT be reported for Apligraf under the hospital OPPS.
C1348	1348	I-131 sol, per 1-6 mCi	This code should be reported for only the initial 1-6 mCi dose of I-131 solution.

HCPCS Code	APC	Short Descriptor	Additional Information
C9003	9003	Palivizumab, per 50 mg	The payment rate for this drug was based on a pediatric dose.
C9019	9019	Caspofungin acetate, 5 mg	Dosage Descriptor Alert: The dosage for this code has been changed from 50 mg to 5 mg
C9020	9020	Sirolimus solution, 1 mg	Dosage Descriptor Alert: The descriptor for this code has been changed from Sirolimus tablet, 1 mg to Sirolimus solution 1 mg.
J1565	906	RSV-ivig	The payment rate for this drug was based on a pediatric dose.
Q2008	7027	Fosaprepitant, 15 mg	Dosage Descriptor Alert: The dosage for this code has been changed from 1.5 mg to 15 mg.

90.2.7 - Typographical Errors from the March 1, 2002, OPPS Final Rule

(Rev. 1, 10-01-03)

PM A-02-026 §IX.G

The dosage descriptors and short descriptors for the following HCPCS codes were incorrectly listed in Addendum A and B of the March 1, 2002, Final Rule. The information below corrects the information published in the Final Rule.

Attachment 5

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2006—Continued

CPT/HCPCS	SI	CI	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
C1092	H		In 111 pentetate per 0.5 mCi	1092				
C1093	H		TC99M fanolesomab	1093				
C1122	H		Tc 99M ARCITUMOMAB PER VIAL	9151				
C1178	K		BUSULFAN IV, 6 Mg	1178	0.2881	$16.50		$3.30
C1200	N		TC 99M Sodium Glucoheptonat					
C1201	H		TC 99M SUCCIMER, PER Vial	1201				
C1300	S		HYPERBARIC Oxygen	0659	1.5403	$81.42		$16.28
C1305	K		Apligraf, 44cm2	1305	12.8206	$785.84		$157.17
C1713	N		Anchor/screw bn/bn,tis/bn					
C1714	N		Cath, trans atherectomy, dir					
C1715	N		Brachytherapy needle					
C1716	H		Brachytx source, Gold 198	1716				
C1717	H		Brachytx source, HDR Ir-192	1717				
C1718	H		Brachytx source, Iodine 125	1718				
C1719	H		Brachytx sour, Non-HDR Ir-192	1719				
C1720	H		Brachytx sour, Palladium 103	1720				
C1721	N		AICD, dual chamber					
C1722	N		AICD, single chamber					
C1724	N		Cath, trans atherec,rotation					
C1725	N		Cath, translumin non-laser					
C1726	N		Cath, bal dil, non-vascular					
C1727	N		Cath, bal tis dis, non-vas					
C1728	N		Cath, brachytx seed adm					
C1729	N		Cath, drainage					
C1730	N		Cath, EP, 19 or few elect					
C1731	N		Cath, EP, 20 or more elec					
C1732	N		Cath, EP, diag/abl, 3D/vect					
C1733	N		Cath, EP, othr than cool-tip					
C1750	N		Cath, hemodialysis,long-term					
C1751	N		Cath, inf, per/cent/midline					
C1752	N		Cath,hemodialysis,short-term					
C1753	N		Cath, intravas ultrasound					
C1754	N		Catheter, intradiscal					
C1755	N		Catheter, intraspinal					
C1756	N		Cath, pacing, transesoph					
C1757	N		Cath, thrombectomy/embolect					
C1758	N		Catheter, ureteral					
C1759	N		Cath, intra echocardiography					
C1760	N		Closure dev, vasc					
C1762	N		Conn tiss, human(inc fascia)					
C1763	N		Conn tiss, non-human					
C1764	N		Event recorder, cardiac					
C1765	N		Adhesion barrier					
C1766	N		Intro/sheath,strble,non-peel					
C1767	N		Generator, neurostim, imp					
C1768	N		Graft, vascular					
C1769	N		Guide wire					
C1770	N		Imaging coil, MR, insertable					
C1771	N		Rep dev, urinary, w/sling					
C1772	N		Infusion pump, programmable					
C1773	N		Ret dev, insertable					
C1775	H		FDG, per dose (4-40 mCi/ml)	1775				
C1776	N		Joint device (implantable)					
C1777	N		Lead, AICD, endo single coil					
C1778	N		Lead, neurostimulator					
C1779	N		Lead, pmkr, transvenous VDD					
C1780	N		Lens, intraocular (new tech)					
C1781	N		Mesh (implantable)					
C1782	N		Morcellator					
C1783	N		Ocular imp, aqueous drain de					
C1784	N		Ocular dev, intraop, det ret					
C1785	N		Pmkr, dual, rate-resp					
C1786	N		Pmkr, single, rate-resp					
C1787	N		Patient progr, neurostim					
C1788	N		Port, indwelling, imp					
C1789	N		Prosthesis, breast, imp					

*Code is subject to contiguous body area imaging discount policy discussed in Section XX of this proposed rule.

Attachment 6

Addendum B

The Centers for Medicare & Medicaid Services
Average Sales Price Data

Organogenesis (as "manufacturer" is defined in section 1927(k)(7) of the Social Security Act):

Legal Address: 150 Dan Road, Canton, MA 02021

Manufacturer Contact(s):

Name: Geoff MacKay Email: GMacKay@Organo.com

Title: President & CEO Fax: 1(781) 575-1570

Address: 150 Dan Road, Canton, MA 02021

Telephone No.: 1(781) 401-1115

Name: Gary Gillheeney Email: GGillheeney@Organo.com

Title: Executive Vice President, Chief Operating Officer and Chief Financial Officer

Fax: 1(781) 575-1570

Address: 150 Dan Road, Canton, MA 02021

Telephone No.: 1(781) 401-1115

Technical Contact Name: Antonio S. Montealvo

Email: AMontealvo@Organo.com

Title: Director of Customer Support Services

Fax: 1(781) 575-1570

Address: 150 Dan Road, Canton, MA 02021

Telephone No.: 1(781) 401-1055

I certify that the reported Average Sales Prices were calculated accurately and that all information and statements made in this submission are true, complete, and current to the best of my knowledge and belief are made in good faith. I understand that information contained in this submission may be used for Medicare reimbursement purposes.

ASP was calculated on NDC# 09970-0001-99 for sales April 01, 2005 to June 30, 2005. Organogenesis provides for a prompt pay discount of 2%. This discount was applied to all goods. Nominal sales of less than 10 percent of the Average Manufacturer's Price as calculated under the Medicaid Rebate Program agreements were excluded.

Organogenesis received 184 return units in the seocond quarter. These returned units were not included in this ASP calculation. Organogenesis has received a request for credit by one customer for 119 units of our product Apligraf. Organogenesis is presently reviewing this request. These units were included in the ASP calculation for the first quarter of 2005.

Geoff MacKay:
President & CEO

Signature

July 27, 2005
Date

[redacted]	[redacted]	$5,617.15	8.44%

Submitter : Dr. Philip Junglas

Date: 08/16/2005

Organization : Cleveland Physicians Incorporated

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

Good Day. Thank you for the opportunity to comment. The following is to enlighten on the topic of reductions and primary care givers.

I, as president of their group, represent 16 Internists in Greater Cleveland, Ohio. We have cut staff to the bare minimum, offered no raises for over three years, bought used computers and other office equipment to reduce overhead. Our rent has increased, our malpractice has seen hyperinflation, our direct expenses for anything medical have increased. We can no longer offer very competitive wages, so our choices for hire are disappointing frequently. This last point affects patient safety. Medical care starts when the phone rings. Next, quality measures soon to be implemented will require us to look at unaffordable software to manage the data manipulation, which itself will cost money. So, if you reduce the reimbursement, I hope you can see what will happen to the front line primary care physicians and other care givers.

On a separate note.
I am sour that the cost of covering prescription drugs has been inflated by the pharmaceutical industry. Around four years ago, when the Government was first bringing the issue to the table, my patients notes a spike in their prescriptions of over 100% in some cases. There was no shortage or lack of primary ingredients to explain it. The demands did not suddenly rise. No, there was a sent of "free lunch" in the air. Now look at the mess. My elderly patients cannot afford their pills and the "discount" simply brings the prices down to their previous levels. This is not economically sound. This has forced the AARP to not support the physicians in this round of discussion. It is a pity the multibillioon dollar industry duped Washington. It reminds me of $900 toilet seets from 20 years ago paid for by the military.

Your comments are welcome.

Submitter : Dr. Howard Nearman
Organization : University Hospitals of Cleveland
Category : Physician

Date: 08/16/2005

Issue Areas/Comments

GENERAL

GENERAL

See attachment

CMS-1502-P-39-Attach-1.DOC

I am writing to express my concern regarding the Medicare anesthesia teaching payment policy. As you are aware, the current rule allows teaching anesthesiologists to receive only 50% of the fee for medically supervising two residents in overlapping cases. This is in contrast to reimbursement plans in place for surgeons and internists supervising residents in similar clinical circumstances within their specialties. Academic anesthesia programs are suffering financially now, and maintaining a sufficient number of staff to maintain quality and safety of patient care will grow increasingly difficult if this situation is not corrected. We at Case had a more difficult time recruiting good residents this past year, and our faculty has taken cuts in salary over the last three consecutive years. The financial status has certainly impacted on my ability to maintain a full complement of physicians, and has, at times, forced closing of operating rooms. I am concerned about the ability of our specialty to continue to recruit the best and the brightest. The Medicare anesthesia conversion factor is less than 40% of prevailing commercial rates – a number that in and of itself is not fair reimbursement for the level of expertise that anesthesiologists bring to our patients (not to mention trying to cover increasing costs such as malpractice). Please do not allow this to be further diluted for teaching anesthesia faculty. Thank you for your consideration.

Sincerely yours,

Howard Nearman, MD, MBA
Professor and Chair
Department of Anesthesiology
University Hospitals of Cleveland
Case School of Medicine

Submitter : Ms. Linda Smith

Organization : Ms. Linda Smith

Category : Individual

Date: 08/16/2005

Issue Areas/Comments

GENERAL

GENERAL

I am very much in favor of my county, Santa Cruz County, to be taken our of RURAL rating. This is a great discrepancy!!!!! We are not RURAL

thanks

Submitter : Dr. Thomas Pajewski

Organization : Dr. Thomas Pajewski

Category : Physician

Date: 08/16/2005

Issue Areas/Comments

GENERAL

GENERAL

Please see attachment

CMS-1502-P-41-Attach-1.DOC

UNIVERSITY of VIRGINIA HEALTH SYSTEM

Department of Anesthesiology

August 16, 2005

Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attn: CMS-1502-P
P.O. Box 8017
Baltimore, MD 21244-8017

RE: File code CMS-1502-P

Dear Centers for Medicare and Medicaid Services,

I am writing to add my support that the Centers for Medicare and Medicaid Services (CMS) needs to be corrected the current anesthesia teaching payment policy in the proposed rule changes for the 2006 Medicare Fee Schedule.

The current policy that penalizes academic anesthesiologists, when compared to academic surgeons, is not only unreasonable and unfair, but results in a significant economic hardship that handicaps academic anesthesiology departments in their recruitment of faculty, conduct of anesthesia-related research, and education of anesthesiology residents who, after all, continue to be in great demand to care for our increasing population of Medicare-eligible patients. Under the present system, a teaching surgeon may supervise residents in two overlapping operations and collect 100% of the fee for each case from Medicare, whereas, a teaching anesthesiologist will only collect 50% of the Medicare fee if he or she supervises residents in two overlapping cases. The Medicare anesthesia conversion factor is less than 40% of prevailing commercial rates. Reducing that by 50% for teaching anesthesiologists results in revenue grossly inadequate to sustain the service, teaching and research missions of academic anesthesia training programs.

My department, at the University of Virginia, is struggling with faculty recruitment and retention, in part, due to the fact that we serve a large population of Medicare patients and hence have difficulty competing financially with other teaching programs and with hospital anesthesiology departments that do not provide services in teaching hospitals. I believe that it is important that Medicare recognize the unique delivery of anesthesiology care and pay Medicare teaching anesthesiologists on par with their surgical colleagues. Correcting the current policy and creating a policy that has been enjoyed by my surgical colleagues, where 100% of the Medicare fee for each of two overlapping procedures involving resident physicians is allowed, will enhance the economic viability of academic anesthesiology programs.

Thank you for your consideration in this matter.

Sincerely,

Thomas N. Pajewski, Ph.D., M.D.
Associate Professor of Anesthesiology and Neurosurgery
Director, Division of Neuroanesthesiology

P.O. Box 800710 • Charlottesville, VA 22908-0710
Tel: 434-982-0609 • Fax: 434-982-1893

Submitter : Dr. David McNutt

Organization : Retiree

Category : Other Health Care Professional

Date: 08/16/2005

Issue Areas/Comments

GENERAL

GENERAL

Dear CMS:

Santa Cruz County along with several other counties in California is considered "rural" and is included in Locality 99 for Medicare reimbursement. I retired this year as Health Officer of Santa Cruz County, and in that position, faced innumerable challenges in obtaining medical care services for our Medicare and Medicaid beneficiaries. Now as a retiree and new Medicare beneficiary, I too am having difficulties accessing physicians for my medical care needs. Recruitment and retention of physicians in our community that has the second highest housing costs in the nation are also severely hampered by the unconscionably low reimbursement rates under Medicare. This illogical and unfair situation multiplies itself many fold because so many other insurers peg their rates to those of Medicare.

Please move ahead with the proposed administrative solution to the problem in our community and elsewhere, and rectify this patently inequitable situation.

Thank you.

David R. McNutt, MD, MPH
Former Health Officer
County of Santa Cruz, CA

Submitter : Dr. Danny Wilkerson

Organization : Dr. Danny Wilkerson

Category : Physician

Date: 08/16/2005

Issue Areas/Comments

GENERAL

GENERAL

August 16, 2005

Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attn: CMS-1502-P
P.O. Box 8017
Baltimore, MD 21244-8017

Re: CMS-1502-P Medicare Teaching Anesthesiologists Payment Rule

To Whom It May Concern:

I am writing in reference to the CMS Medicare Fee Schedule for 2006 which contains the current policy of paying teaching anesthesiologists only 50% of the fee for each of two concurrent resident cases. As an Anesthesiologist with the University of Arkansas for Medical Sciences, I find that this Medicare teaching anesthesiologist payment rule is unfair to both physicians and patients and needs to be changed. Our elderly Medicare population is growing and these patients demand quality medical care and patient safety. Because of the policy in place, our department is having slots unfulfilled as well as decreasing funding for academic research. The severe economic loss under these current rules cannot be absorbed elsewhere. The rule must be changed so that we have the ability to cover our costs.

Currently, a teaching anesthesiologist will only collect 50% of the Medicare fee if he/she supervises residents in two overlapping cases. A surgeon can supervise residents in two overlapping operations and collect 100% of the fee for the case from Medicare. An internist may supervise residents in four overlapping outpatient visits and collect 100% of the fee when certain requirements are met. Not only is this not fair, but it is unreasonable that these specialties are handled differently. Medicare must recognize the unique delivery of anesthesiology care and pay Medicare teaching anesthesiologists on par with their surgical colleagues.

The Medicare anesthesia conversion factor is less than 40% of prevailing commercial rates. By reducing that conversion factor 50% for teaching anesthesiologists, this results in revenues grossly inadequate to sustaining the service, teaching, and research missions of academic anesthesia training programs.

I am requesting that the current Medicare rule be revised as soon as possible so that we can provide quality care to the patient while covering our costs. Anesthesiologists deserve a fair and workable policy equal to that of our colleagues in surgery ? 100% of the Medicare fee for each of two overlapping procedures involving resident physicians.

Thank you for your consideration in this matter.

Sincerely,

Danny Wilkerson, M.D.
Assistant Professor

DW/cp

Submitter : Mr. Rocco Barbieri

Organization : Retired

Category : Individual

Date: 08/16/2005

Issue Areas/Comments

GENERAL

GENERAL

Santa cruz county is currently classified as " Rural " for Medicare reimbursement fees. The profile of the county has changed over the past 15 years and has exceeded past and outdated growth projections. Only one corner of the county is truly " Rural " , and , the over-all county has become more " metropolitan " in size and function. The " Rural " designation no longer fits Santa Cruz County.

The "Rural " designation results in lower fees to physicians. This helps to negate a continuing flow of physicians into the county and has caused others to leave to practice in nearby cities. This is particularly true for "specialists " who can command higher fees elsewhere. Twice my wife and I were rejected " specialist " services and had to travel to another city for gastroenterologist services. I urge you to carefully reconsider removing the " Rural " designation from Santa Cruz County. It would remove inequities currently imposed on senior citizens and more truly reflect the changed demographics and business activities within the county.

Thank you.

Submitter : Mr. Frank Plant

Organization : Mr. Frank Plant

Category : Individual

Date: 08/16/2005

Issue Areas/Comments

GENERAL

GENERAL

I have lived in Santa Cruz County for thirty years. It is not a rural community even if a large part of its gross revenue derives from agriculture. Physicians are finding it difficult to make ends meet in this high cost area. One of our eye doctors recently moved to lower cost area in another county. Median residence prices are over $650,000. Competition from nearby urban areas makes recruiting replacement candidates difficult. Medicare's recompense based on the illusion that this is a rural community are leading to a shortage of medical personnel. Please change the current designation of Santa Cruz County, CA to Urban. Frank Plant

Submitter : Dr. Jeffrey Pearson **Date:** 08/17/2005

Organization : Dr. Jeffrey Pearson

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

Regretably, this legislation does absolutely nothing to remedy the situation facing physicians in San Diego county. We pay overhead expenses commensurate with an affluent urban region (rent, staff salaries, etc) and yet we're reimbursed at a much lower rural rate.

This has repercussions beyond Medicare, of course, b/c private insurers often tie their physician reimbursements to a percentage of Medicare rate, so we end up getting the short end of the stick from everybody.

I've already had to limit my Medicare patients b/c I simply cannot afford to care for a large number of patients for less than the cost of doing business. Obviously, as a small business owner, if I can't turn a profit (or at least cover my expenses), I will have to cut out the revenue losing portions of my practice completely. I would feel very badly about this b/c I truly enjoy caring for seniors (Several times a month, I invite some of my senior patients out for lunch. They've led interesting lives and share their stories with me. And, no, I do NOT bill insurance for these as visits!).

Please reconsider this legislation and do the right thing to fix the problems that we face here in San Diego.

Thank you for your time and consideration.

Sincerely,

Jeffrey Pearson, D.O.
Family Medicine
120 Craven Rd, Ste. 101
San Marcos, CA 92078

760-591-0955
joedoc@medicine-in-motion.com

Submitter : **linda lillehaugen**

Date: **08/17/2005**

Organization : **linda lillehaugen**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

I live in Santa Cruz Calif 95062. My sister came from the bay area with terminal cancer and we couldn't find a primary care physician that would take her. Except for a dr. that had been practicing for 2 months. She ended up having the oncologist being the primary care physician too. It was very sad. We took her to doc in the boxes a few times as the emergency room was the only other source if the oncologist wasn't available. Drs here say they're paid less and so don't except any new medicare patients. What's the use of having Medicare if no drs except it. What happened to my sister shouldn't have happened. She had AARP as her supplemental. It made no difference. Most of the big organizations do not except new medicare patients. Some organizations say it's up to the dr. but then none of them take new patients. Santa Cruz is not a rural area. The drs should be paid the same as the ones in San Jose. Just come and take a drive through our county---we're conjested---not some mountain community.

Submitter : Mr. Wayne Stanfield

Date: 08/17/2005

Organization : Home Care Pharmacy

Category : Home Health Facility

Issue Areas/Comments

GENERAL

GENERAL

As a unit dose inhalation drug provider, I am currently loosing money with the dispensing fee at $57. I need to have a dispensing fee of $68 to show even a small profit. The suggested CMS reduction in the $57 fee on 1/1/06 will force me to close my pharmacy and eliminate this much needed service to more than 1000 patients. The change to ASP+6% was not based on reality. My cost continue to rise each year. Everything from health insurance to delivery and shipping cost continue to rise. CMS is basing ASP on the manufacturers average sale price, but most pharmacies do not buy direct from the manufacturers. I buy from a wholesaler and my cost is higher than the ASP+6%. It is simply unrealistic to expect us to provide services at a loss. CMS has made it clear that they are not concerned about whether I make a profit, but I am and so is my family. As independent businesses we deserve the right to be a part of the health care system and to follow our chosen career, not be forced out of business by our own government.

Submitter : Dr. Mary Glass **Date:** 08/18/2005

Organization : Dr. Mary Glass

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

I strongly oppose suggested Medicare cuts proposed by the CMS. As overhead expenses continue to increase it becomes increasingly difficult to stay in business, let alone provide quality care. Cutting Medicare reimbursement to physicians will only decrease access to health care for elderly Americans. Please reconsider the position on medicare cuts to reimbursement.

Submitter : **Linda Proudfoot** **Date: 08/18/2005**

Organization : **Linda Proudfoot**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1502-P
P.O. Box 8017
Baltimore, MD 21244-8017

Re: GPCI

To Whom It May Concern:

We strongly support the proposed revision to the physician payment localities in California that you published in the reference rule.

You are to be commended for addressing an important issue for physicians and Medicare beneficiaries in the San Francisco Bay Area. You have addressed the two most problematic counties in the state, and you have made an important change that will go a long way to ensuring access to care for health care services in our county

We understand this also to be a fundamental issue of fairness. Neighboring counties to Santa Cruz and Sonoma Counties have some of the highest payment levels for physician services in the nation. The adjustment that you propose appropriately addresses the current inequitable payment problem

CMS acknowledges that they have the responsibility to manage physician payment localities. We understand that there have been not been revisions to the localities since 1996. You have selected the most important area in our state to begin to correct this problem.

Sincerely,

Linda Proudfoot

Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1502-P
P.O. Box 8017
Baltimore, MD 21244-8017

Re: GPCI

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CMS acknowledges that they have the responsibility to manage physician payment localities. We understand that there have been not been revisions to the localities since 1996. You have selected the most important area in our state to begin to correct this problem.

Sincerely,

Submitter : **William Proudfoot** **Date: 08/18/2005**

Organization : **William Proudfoot**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1502-P
P.O. Box 8017
Baltimore, MD 21244-8017

Re: GPCI

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CMS acknowledges that they have the responsibility to manage physician payment localities. We understand that there have been not been revisions to the localities since 1996. You have selected the most important area in our state to begin to correct this problem.

Sincerely,

William Proudfoot

Submitter : Dr. Lorne Kapner **Date: 08/18/2005**

Organization : North County Eye Center

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

Not including San Diego County in the cost of living increase is an unfair oversight. The continuous decreases in Medicare reimbursement will continue to fuel an atmosphere in which physicians will be forced to opt out of Medicare which will likely cause a national crisis. Medicine and consumer electronics are the only two industries I know of that continue to get lower reimbursement despite the fact that the cost of doing business continues to increase. Medicare needs to do a national cost of living study and completely overhaul it's reimbursement. How can Medicare justify paying the Area 99 physician one of the lowest reimbursements in the country when that same area is one of the most expensive regions in the country from a cost of living standpoint?

Submitter : Dr. Colleen O'Leary **Date:** 08/19/2005

Organization : SUNY Upstate Medical University

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

See attachment

CMS-1502-P-54-Attach-1.TXT

August 19, 2005

Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attn: CMS-1502-P "TEACHING ANESTHESIOLOGISTS"
PO Box 8017
Baltimore, MD 21244-8017

Dear Sir or Madam:

I am writing to you as the Interim Chair of the Department of Anesthesiology at SUNY Upstate Medical University in Syracuse NY to express my dismay over the Proposed Rule for the 2006 Physician Fee Schedule. I'm very concerned that it does not include a correction of the discriminatory policy of paying teaching anesthesiologists only 50% of the fee for each of two concurrent resident cases.

Upstate Medical University is a teaching institution providing primary, secondary and tertiary care to a 17 county region in central New York State. Approximately 40% of our patients use Medicare as their primary insurance carrier. Data from the US Census Bureau reveal that in the year 2000, the number of people in the US greater than 65 years of age was 35 million, representing a 12% increase over 1990. It is projected that by 2025, the portion of the US population over age 65 will increase by a staggering 80%!! Our elderly population requires an increasing amount of health care to maintain quality of life. An ever growing number of patients over 65 years of age present for surgery, many of them to teaching hospitals such as ours.

Although we anticipate seeing an increase in the number of elderly patients in our operating rooms, there is a currently a short fall nationally in the number of practicing anesthesiologists. Additionally, anesthesiology training programs are not able to train adequate numbers of physicians to meet the projected future need. Economic factors force salaries for teaching anesthesiologists to be less than those for anesthesiologists in the private sector, so attracting faculty to train the next

generation is problematic. I currently have four open faculty positions. The Medicare anesthesia conversion factor is less than 40% of the prevailing commercial rates. Reducing that meager amount by a further 50% for providing medical direction concurrently to two residents results in revenue stream which is grossly inadequate to cover faculty salaries. In 2004, my Department provided excellent anesthesia care to over 2700 Medicare patients.
Page 2

Residents were involved in the care of all patients. The residents gain the experience they need to practice state of the art anesthesia upon completion of their residency and our elders receive cutting edge care. In 68% of the cases, a faculty anesthesiologist provided concurrent care to a second case for a portion of time. My Department lost in excess of $293,000 in revenue as a result of the discriminatory concurrency policy. This is clearly not a sustainable situation for us.

My surgical colleagues are able to supervise residents performing two overlapping surgical procedures and collect 100% of their fee for each case from Medicare. My colleagues in internal medicine can supervise residents in four overlapping outpatient visits and collect 100% of the fee for each case. Reducing a teaching anesthesiologist's fee by 50% is neither fair nor reasonable. Failure to promptly correct this discriminatory policy will continue to adversely affect my ability to train residents in anesthesiology thereby reducing the availability of well trained anesthesiologists to care for tomorrows' senior citizens.

Sincerely,

Colleen E. O'Leary, MD
Associate Professor & Interim Chair
Department of Anesthesiology
SUNY Upstate Medical University
Syracuse, New York

Cc: Congressman James Walsh
Senator Charles Schumer
Senator Hillary Rodham Clinton
American Society of Anesthesiologists, Washington Office

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Submitter : **Dr. James White** **Date: 08/19/2005**

Organization : **University of Virginia Health Sciences Center**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attn: CMS-1502-P
P.O. Box 8017
Baltimore, MD 21244-8017

Re: CMS-1502-P ?TEACHING ANESTHESIOLOGISTS?

* The current Medicare teaching anesthesiologist payment rule is unwise, unfair and unsustainable.

* Quality medical care, patient safety and an increasingly elderly Medicare population demand that the United States have a stable and growing pool of physicians trained in anesthesiology.

* Right now, slots in anesthesiology residency programs are going unfilled because of ill-conceived Medicare policy that shortchanges teaching programs, withholding 50% of their funds for concurrent cases. My program at the University of Virginia, considered to be one of the more desirable academic programs in the country for both resident training and faculty, is unable to fill at least four faculty positions because of the reduced reimbursement rates for academic programs, which in turn do not allow us to offer competitive salaries. Therefore:

* Anesthesiology teaching programs, caught in the snare of this trap, are suffering severe economic losses that cannot be absorbed elsewhere.

* The CMS anesthesiology teaching rule must be changed to allow academic departments to cover their costs.

* Academic research in anesthesiology is also drying up as department budgets are broken by this arbitrary Medicare payment reduction.

* A surgeon may supervise residents in two overlapping operations and collect 100% of the fee for each case from Medicare. An internist may supervise residents in four overlapping outpatient visits and collect 100% of the fee for each when certain requirements are met. A teaching anesthesiologist will only collect 50% of the Medicare fee if he or she supervises residents in two overlapping cases.

* This is not fair, and it is not reasonable.

* Medicare must recognize the unique delivery of anesthesiology care and pay Medicare teaching anesthesiologists on par with their surgical colleagues.

* The Medicare anesthesia conversion factor is less than 40% of prevailing commercial rates. Reducing that by 50% for teaching anesthesiologists results in revenue grossly inadequate to sustain the service, teaching and research missions of academic anesthesia training programs.

Sincerely,

J. Lee White, M.D.
Associate Professor of Anesthesiology
University of Virginia Health Sciences Center

CMS-1502-P-55-Attach-1.DOC

Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attn: CMS-1502-P
P.O. Box 8017
Baltimore, MD 21244-8017

Re: CMS-1502-P "TEACHING ANESTHESIOLOGISTS"

- The current Medicare teaching anesthesiologist payment rule is unwise, unfair and unsustainable.

- Quality medical care, patient safety and an increasingly elderly Medicare population demand that the United States have a stable and growing pool of physicians trained in anesthesiology.

- Right now, slots in anesthesiology residency programs are going unfilled because of ill-conceived Medicare policy that shortchanges teaching programs, withholding 50% of their funds for concurrent cases. My program at the University of Virginia, considered to be one of the more desirable academic programs in the country for both resident training and faculty, is unable to fill at least four faculty positions because of the reduced reimbursement rates for academic programs, which in turn do not allow us to offer competitive salaries. Therefore:

- Anesthesiology teaching programs, caught in the snare of this trap, are suffering severe economic losses that cannot be absorbed elsewhere.

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- This is not fair, and it is not reasonable.

- Medicare must recognize the unique delivery of anesthesiology care and pay Medicare teaching anesthesiologists on par with their surgical colleagues.

- The Medicare anesthesia conversion factor is less than 40% of prevailing commercial rates. Reducing that by 50% for teaching anesthesiologists results in revenue grossly inadequate to sustain the service, teaching and research missions of academic anesthesia training programs.

Sincerely,

J. Lee White, M.D.
Associate Professor of Anesthesiology
University of Virginia Health Sciences Center

Submitter : **Ms. Linda Bergthold** **Date: 08/19/2005**

Organization : **none - consumer**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

Please support the change in reimbursement for Santa Cruz County to "urban". We are separated from the Bay Area by mountains and difficult roads but our housing and living costs are comparable. We need to keep our doctors in the County, and many are leaving for financial reasons. The median house in SC is now $800,000! Could you all live and work here??? This is an equity and access issue.

Submitter : Mr. Philip Trautman **Date:** 08/19/2005

Organization : Self

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

Santa Cruz County is now designated Rural. Nothing costwise supports this designation. Housing, Services, food probably exceed that of 99% of the rest of the Country. The rural designation jeopardizes my health coverage (Secure Horizons). Nothing requires them to operate in this county.

Ther are crops grown here but not what was grown here 25 years ago. Apples are gone and replaced by higher yield berry crops. Too expensive for apples.

I was dumped by my first Medicare supplement carrier because I am a Zip Code away from where it was originally established. Don't compound the felony by continuing thie "RURAL" designation.

Continuity is obviously desirable for Senior coverage. Don't jeopardize same.

We don't and didn't put less into SS because of our county's designation.

Philip H. Trautman

Submitter : **Mrs. Nancy Rader** **Date: 08/19/2005**

Organization : **Mrs. Nancy Rader**

Category : **Congressional**

Issue Areas/Comments

GENERAL

GENERAL

Santa Cruz County is living in the Dark Ages with Medicare reimbursement. Our Medium home price is over $800,000. and our cost of living is one of the highest in the Nation. Doctors are leaving this county and doctors that stay are not taking any new Medicare patients.
WE NEED SANTA CRUZ COUNTY STATUS CHANGED TO URBAN! We are not, by any means, a rural county! That's a big joke, and we, in the county, haven't been laughing for many years.
I can never figure out why our government is so inefficient and why it takes so long to correct a problem.
Hopefully your agency is finally going to fix this long standing problem.
Thank you for finally doing something to correct this injustice. And No, I am not in the medical field, nor are any of my relatives.

Sincerely,
Nancy G. Rader

Submitter : Mr. Robert Bosso **Date:** 08/19/2005

Organization : BossoWilliams Law Firm

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

This is in support of the change of Santa Cruz County from rural to urban. We are facing a shortage of doctors (especially those who will accept medicare) because we are not competitive with adjacent counties (Santa Clara, San Mateo etc.) who are classified as urban. In addition, insurance companies use the medicare reimbursement schedule as a starting point for their reimbursement which further hinders doctor income and makes this community less attractive to skilled physicians. In the last two years we have gone from one neurosurgeon to one (who may be close to retirement!) as others have moved to more profitable areas. Housing here is among the highest cost in the nation, but our reimbursement level is one of the lowest in California. Please, change the designation to urban.

Submitter : Scott Rowe **Date:** 08/19/2005

Organization : Scott Rowe

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

Re: file code CMS-1502-P
As a resident of Santa Cruz county, I urge this organization to redesignate Santa Cruz from rural to urban in consideration of Medicare reimbursements to physicians. Our county is a bedroom community to the San Francisco Bay area. I, myself, commute to and from work in San Jose. Housing prices and living expenses here are as high or higher than any metropolitan area in California. One look at the landscape would tell you that Santa Cruz county is an urban area. We have been fortunate to attract very talented physicians, but as the cost of living continues to rise here disproportionately to the rise in other, even already designated urban areas, we are in danger of losing our physicians to areas where the cost of living is lower and the reimbursement schedule is more favorable. Please help correct this problem by designating Santa Cruz county as an urban area in consideration for Medicare reimbursement rates. Thank you.
-Scott Rowe
906 Daniel Ct.
Santa Cruz, CA 95062
srowe3@pacbell.net

Submitter : Ms. Linda Smith **Date:** 08/19/2005

Organization : Ms. Linda Smith

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

Please change our county's rate from rural to urban. Rural rating is unfair to our county. Doing business here is very expensive and we are losing doctors at an alarming rate. thanks

Submitter : **Ms. Deborah Lawrence** **Date: 08/19/2005**

Organization : **Self on Medicare**

Category : **Health Care Professional or Association**

Issue Areas/Comments

GENERAL

GENERAL

I am in support of changing Santa Cruz Co. out of rural rate status.

Submitter : Ms. Kathy Welch **Date:** 08/19/2005

Organization : Ms. Kathy Welch

Category : Nurse

Issue Areas/Comments

GENERAL

GENERAL

I strongly encourage the change from rural to urban for Santa Cruz County. I work in a private practice setting as a chemotherapy nurse and clinical research coordinator. We offer state of the art treatment in our community, in many cases avoiding the need for patients to commute to Stanford or UCSF for their care. The cost of living in Santa Cruz County is extremely high, rivaling San Francisco or Santa Clara. We have need of two new physicians to join our pracice to adequately care for our large patient population, and recruitment is difficult due to the cost of living. Physicians in Santa Cruz are not able to offer competetive wages to their nursing staff, thus endangering access to care for the residents of this community. Considering Santa Cruz County as rural is extremely outdated, and must be changed. Physicians should be reimbursed adequately for the quality-care they deliver, and not penalized for being willing to remain in a very high cost of living area giving care to the residents of that community.

Submitter : Dr. **Date:** 08/19/2005

Organization : Dr.

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

Date: August 16, 2005
To: Centers for Medicare and Medicaid Services
From: Alexander Volfson, M.D.
Re: TEACHING ANESTHESIOLOGISTS RULE

I am writing to urge a change in payment policy for teaching anesthesiologists. The current Medicare teaching anesthesiologist payment rule is unwise, unfair and unsustainable. Quality medical care, patient safety, and an increasingly elderly Medicare population, demand that the United States have a stable and growing pool of physicians trained in anesthesiology.

Anesthesiology teaching programs are suffering severe economic losses that cannot be absorbed elsewhere. Academic research in anesthesiology is increasingly difficult to sustain, as department budgets are broken by this arbitrary Medicare payment reduction. The current Medicare payment policy is unfair.

The CMS anesthesiology teaching rule must be changed to allow academic departments to cover their costs. It is not fair, and it is not reasonable. Please recognize the unique delivery of anesthesiology care and pay Medicare teaching anesthesiologists on par with their surgical colleagues.

Sincerely,

Alexander Volfson, M.D.
Resident in Anesthesiology
Weill Cornell Medical College
New York Presbyterian Hospital

Submitter : **Alicia Bautista** **Date: 08/19/2005**

Organization : **Alicia Bautista**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

Please help STOP the Doctor drain in Santa Cruz County! Already there are some areas of practice where there are no specialists in our county (gynecologist/oncologists for one) and one must travel to San Jose (or they travel here). Increasing the Medicare reimbursement rate (file code CMS-1502-P) is a good start. Our household income is over $100,000 yet we are unable to purchase a home. Luckily we have a good health insurance. Adding a 45 minute commute to doctor's appointments is very expensive especially given the cost of gasoline. Help!!!

Submitter : Mr. Herbert Lee

Date: 08/19/2005

Organization : Mr. Herbert Lee

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

I am writing to support the change in designation of Santa Cruz county, California, to that of an 'urban' county. Santa Cruz is now part of the greater Bay Area, and prices clearly reflect this. According to the American Community Survey done by the Census Bureau (http://www.census.gov/acs/www/Products/Ranking/2003/R08T050.htm),
Santa Cruz county has the fourth highest median housing prices of all counties in the country. How this county could be considered a 'low cost rural county' is beyong belief. Please change the designation to an 'urban' county, to reflect the outrageously expensive costs that operating in Santa Cruz county now entails. If this change is not made, our current shortage of medical personnel will continue to get worse.

Thank you for your attention to this matter.

Herbert Lee,
Santa Cruz, CA

Submitter : Mrs. Christie Maurer

Organization : Mrs. Christie Maurer

Category : Individual

Date: 08/19/2005

Issue Areas/Comments

GENERAL

GENERAL

I am 68 and retired. I strongly support recommendations to designate Santa Cruz County, CA, as Urban for Medicare physician reimbursement.

Santa Cruz County has grown enormously since it was designated at Rural. It has the 2nd highest housing costs in the country. As is happening everywhere, the population is aging.

Doctors refuse to move here because of high housing costs on top of low Medicare reimbursements. Why should they when they can get far more 20 miles away. No local doctor will take new Medicare patients. My husband has Parkinson's and he'd rather do without care than see a Neurologist he dislikes. A friend's doctor dropped her as soon as she turned 65 and got on Medicare. I personally know two doctors who live in Santa Cruz but can't afford to practice here because of low Medicare reimbursements. Doctors work long hours, 7 days a week, because they can't recruit new doctors to join their practices. Many are badly burned out. If they retire or leave and there's no one to take their place.

I strongly urge you to designate Santa Cruz County as Urban. The level of medical care here is suffering badly.

Submitter : Mrs.

Organization : Mrs.

Category : Individual

Date: 08/19/2005

Issue Areas/Comments

GENERAL

GENERAL

I feel it is critical that you reconsider and revise the rural designation of Santa Cruz County for Medicare payment. We have ceased to be predominantly rural for many years. The 50 percent reimbursement rate hardly covers our local doctors' needs, and we have been experiencing a serious drain of doctors in recent years who have decided that they cannot afford to live here with such inequities. Doctors are refusing new Medicare patients and they certainly cannot be faulted as many of them already have practices of 40 per cent Medicare. Recruiting doctors is harder now for the same reasons. I believe our county's health care infrastructure is in danger of collapsing. Reclassifying us as "Urban" with at least a 10 per cent increase in reimbursement rate is an effective way to reverse this direction.

Submitter : Patricia Blanchette

Date: 08/19/2005

Organization : none

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

Please redesignate Santa Cruz County to URBAN for Medicare reimbursement for physicians. It is ridiculous to consider a designation from 1967 to apply to 2005 in our area. Just get on a plane and come out and take a look-see for yourselves. It's just common sense and good judgement. Thank you.

Submitter : **Dr. Jonathan Beathe** **Date: 08/19/2005**

Organization : **New York Presbyterian Hospital - Cornell Campus**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Date: August 16, 2005
To: Centers for Medicare and Medicaid Services
From: Jonathan Beathe, MD
Re: TEACHING ANESTHESIOLOGISTS RULE

I am writing to urge a change in payment policy for teaching anesthesiologists. The current Medicare teaching anesthesiologist payment rule is unwise, unfair and unsustainable. Quality medical care, patient safety, and an increasingly elderly Medicare population, demand that the United States have a stable and growing pool of physicians trained in anesthesiology.

Anesthesiology teaching programs are suffering severe economic losses that cannot be absorbed elsewhere. Academic research in anesthesiology is increasingly difficult to sustain, as department budgets are broken by this arbitrary Medicare payment reduction. The current Medicare payment policy is unfair.

The CMS anesthesiology teaching rule must be changed to allow academic departments to cover their costs. It is not fair, and it is not reasonable. Please recognize the unique delivery of anesthesiology care and pay Medicare teaching anesthesiologists on par with their surgical colleagues.

Sincerely,

Jonathan Beathe, MD
Resident in Anesthesiology
Weill Cornell Medical College
New York Presbyterian Hospital

Submitter : **linda howe** **Date: 08/20/2005**

Organization : **linda howe**

Category : **Social Worker**

Issue Areas/Comments

GENERAL

GENERAL

Santa Cruz County is not rural and our physicians need increased medi-care reimbursement. Physicians are refusing to take medi-care patients, forcing many of the patients into emergency rooms for what should be routine care. Our seniors and disabled are suffering enough with the high cost-of-living here; they should at least be able to see a doctor. Thank you.
Linda Howe, Sr. Social Worker, Santa Cruz County

Submitter : Mr. Phillip Ayers

Organization : Mr. Phillip Ayers

Category : Individual

Date: 08/20/2005

Issue Areas/Comments

GENERAL

GENERAL

I urge you to raise reimbursments for Santa Cruz County from rural to urban. Many Doctors are leaving our area becuse of the low rates and high cost of living here. Many are also refusing new Medicare patients, the fastest growing segment of our population. Santa Clara County with a lower cost of living already is higher than Santa Cruz County. Santa Cruz County has not been rerated since 1967 and it has changed alot since then. We are already losing Doctors because of the low rates and it needs to be changed. Look at the housing cost surveys in the area and you will see the very high cost here. Santa Cruz County is no longer a rural area.

Submitter : Mrs. Penelope Carless

Date: 08/20/2005

Organization : Mrs. Penelope Carless

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

I am a Senior Citizen resident in Santa Cruz County, California. I would urge that Santa Cruz County designation be changed from rural to urban. Doctors here are leaving because they can't make a living in Santa Cruz County seeing mostly Medicare patients. From the patient's point of view it is of great concern that many doctors here are refusing to see any more Medicare patients because of the lack of adequate reimbursement. Please, change this unfair designation.

Submitter : Dorothea Gibson

Organization : Dorothea Gibson

Category : Individual

Date: 08/20/2005

Issue Areas/Comments

GENERAL

GENERAL

Having retired within the past three years from working in a hospital environment for 24 years. I am well aware of the impact that Medicare reimbursement to physicians at the rural level has had on the rapid turnover of physicians in the Santa Cruz County area. Medicare needs to reimburse physicians in this area nearer or at the level designated for urban areas. Santa Cruz County has changed dramatically since the inception of the Medicare program. I have lived here since 1965 and have witnessed these changes. The cost of living and of buying a home in this area means that Medicare reimbursement for physicians, hospitals, and all health care providers should be increased to encourage the location and retention of adequate medical personnel and facilities to provide for quality care for all Medicare recipients and other citizens residing here.

Submitter : Heidi Donald, PHN

Date: 08/20/2005

Organization : Heidi Donald, PHN

Category : Nurse

Issue Areas/Comments

GENERAL

GENERAL

Re: CMS-1502-P
I urge an increase in Medicare reimbursement by designating Santa Cruz County an urban area. I recently enrolled in Medicare and almost immediately needed hospitalization. As a retired public health nurse, I was stunned at the low reimbursement rates to the physicians and hospital. Santa Cruz is no longer a rural area, and reimbursement should reflect at least some realization of the high costs of living and working here.

Submitter : Dr. Donald Rowell

Date: 08/20/2005

Organization : Dr. Donald Rowell

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

I support the proposal as a practicing physician in Sonoma County. Costs have risen, especially in Sonoma County, and the current reimbursement does not reflect this. The coverage for the specialty of ENT/Head and Neck is especially weakened in Sonoma county as a result.

Submitter : Dr. David Schmidt **Date:** 08/20/2005

Organization : Sonoma County Medical Association

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

Re: GPCIs

As a physician practicing medicine in Sonoma County, California, I strongly support your proposal to create a new payment locality for Sonoma County. The new locality would lessen the disparity between practice expenses and Medicare reimbursements.

This disparity has adversely affected our local health care system for several years. Medicare reimbursements have not kept pace with our increased costs for providing such care, and a significant number of my colleagues have stopped taking Medicare patients, retired early, or have left the county. The disparity has also hampered efforts to recruit new physicians to Sonoma County. Several years ago, half a dozen physicians in my group left the area for ecomonic reasons.

By creating a new payment locality for Sonoma County, you will help ensure the viability of physician practices in this county. It should also improve access to care for local Medicare beneficiaries. Currently, less than 50% of our primary care physicians accept new Medicare patients. Your proposal will correct existing payment inequities and will help you achieve your goal of reimbursing physicians based on the cost of practice in their locality.

Thank you for the opportunity to comment on this important issue.

Respectfully,

David H. Schmidt, M.D.
President Redwood Regional Medical Group
185 Sotoyome St.
Santa Rosa, CA 95405

Submitter : **linda lilleghaugen** **Date: 08/20/2005**

Organization : **subject cms-1502-P**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Because Santa Cruz, Calif is classed as rual, few primary-care doctors accept new Medicare patients--if any. My sister had terminal cancer and moved from the Bay Area to be near her children. We found an oncologist that accepted Medicare, but finding a primary-care physician that would accept a new Medicare patient was another story.

Having AARP as her supplemental insurance made no differnece. Because we could not find a primary-care physician, the oncologist had to try and be the primary-care physician too. It was a heartrending time and not having a primary-care physician added to the pain.

I can't understand why your center thinks of Santa Cruz as rural. I can't understand why this hasn't been rectified. I can't understand why there's even debate about this issue. It's a discrepancy---fix it. If no one in your department has not heard of Santa Cruz, let me tell you---it's not rural. Santa Cruz is congested, with house prices the third highest in the nation. During commute times, the cars are bumper to bumper on the freeway. A little beach city it is not. Santa Cruz is an extension of the Bay Area/Silicon Valley.

Being able to find a primary-care physician wouldn't have changed my sister's impending death, but being able to find a primary-care physician at the beginning of her illness would have caused less stress for everyone.

Please, please, take that rural rating off of Santa Cruz, California. It's a blemish to our senior citizens that need to find qualified doctors when they are ill. What good does it do to have Medicare if no doctors accept it?

Submitter : Dr. Ronald Harter **Date:** 08/20/2005

Organization : Dr. Ronald Harter

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

I wish to comment regarding the teahing rule for anesthesiolgy residency programs. I am disappointed that my specialty's quest for parity with teaching surgeons did not yet occur. I certainly agree with the proposed rule where it acknowledges that the existing policy is not workable for anesthesiologists and that revisions are necessary. As before, the goal of our specialty remains achieving 100% of the Medicare fee for each of two overlapping procedures involving resident physicians. The future of our academic training centers depends on acheiving parity with teaching surgeons under CMS. I am but one of many anesthesiologists who has recently left the faculty of a teaching program to enter private practice. In part, that move was necessitated by the growing disparity in income that can be obtained in private practice, relative to teaching centers.

Submitter : **Dr. milamari cunningham** **Date: 08/21/2005**

Organization : **Cunningham Anesthesia**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

The current Medicare teaching anesthesiologist payment rule is unwise, unfair and unsustainable.

Quality medical care, patient safety and an increasingly elderly Medicare population demand that the United States have a stable and growing pool of physicians trained in anesthesiology.

Anesthesiology teaching programs, caught in the snare of this trap, are suffering severe economic losses that cannot be absorbed elsewhere.

The CMS anesthesiology teaching rule must be changed to allow academic departments to cover their costs.

A surgeon may supervise residents in two overlapping operations and collect 100% of the fee for each case from Medicare. An internist may supervise residents in four overlapping outpatient visits and collect 100% of the fee for each when certain requirements are met. A teaching anesthesiologist will only collect 50% of the Medicare fee if he or she supervises residents in two overlapping cases.

This is not fair, and it is not reasonable.

Medicare must recognize the unique delivery of anesthesiology care and pay Medicare teaching anesthesiologists on par with their surgical colleagues.

The Medicare anesthesia conversion factor is less than 40% of prevailing commercial rates. Reducing that by 50% for teaching anesthesiologists results in revenue grossly inadequate to sustain the service, teaching and research missions of academic anesthesia training programs.

With Boone Hospital Center anesthesia department in Columbia MO which has a high Medicare load of patients in a private setting has to be subsidized to continue to function, what do you think the cash flow for the University of Missouri teaching anesthesia department is with 50% of Medicare fee for 2 resident cases?

Anestheisa is only asking for parity with other physicians. The anesthesia teaching rule is not equivalent to surgeon teaching rule.

Submitter : Dr. Donald Martin **Date:** 08/21/2005

Organization : American Society of Anesthesiologists

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

I am writing to strongly urge CMS to apply the teaching physician payment policy equitably to all medical specialists, including anesthesiologists. Under the teaching physician payment policy for complex surgery, the full fee schedule payment for a service is to be made to a teaching physician as long as the teaching physician is present with the resident for the key or critical portions of the service. This rule was meant to apply to all physicians. However, for more than 10 years, anesthesiologists, for reasons that have never been clear, have been singled out and limited to payment of only 50% of the full fee schedule payment.

It is long past time that this inequity should be corrected. It places an unfair burden on teaching anesthesiology programs in Pennsylvania, including ours at Penn State University, reducing our ability to recruit faculty members, train future anesthesiologists, and provide adequate access to quality care for Medicare beneficiaries in our state.

Senator Rick Santorum was very clear in his May 6, 2005 letter to Dr. Mark McClellen, requesting that this situation be completely corrected, and hopefully this year, for the benefit of all Medicare patients in Pennsylvania.

CMS-1502-P-83-Attach-1.PDF

RICK SANTORUM
PENNSYLVANIA

REPUBLICAN CONFERENCE
CHAIRMAN

WASHINGTON, DC
SH. DIRKSEN SENATE OFFICE BUILDING
WASHINGTON, DC 20510
(202) 224-6324

United States Senate

https://santorum.senate.gov

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May 6, 2005

Dr. Mark B. McClellan
Administrator
Centers for Medicare and Medicaid Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Room 314-G
Washington, D.C. 20201

Dear Administrator McClellan:

I am writing to ask that the reimbursement rules for teaching anesthesiologists be revised so that payment for teaching anesthesiologists is equitable compared to other complex and high-risk specialties under the Medicare teaching program. I am hopeful that this inequity could be addressed in this year's 2006 physician fee schedule rule.

As you are likely aware, under current Medicare regulations, other teaching physicians in complex or high-risk medical specialties receive full Medicare reimbursement when working with residents on overlapping cases, so long as the teaching physician is present for critical or key portions of the procedure. The teaching physicians in other specialties bill Medicare for full reimbursement for each of the procedures in which he or she was involved.

Teaching anesthesiologists, also high-risk specialists, are permitted to work with residents on overlapping cases so long as they are present for critical or key portions of the procedure and immediately available during the other portions of the procedure. However, it is my understanding that unlike the other complex and high-risk specialties, the teaching anesthesiologists who work with residents on overlapping cases face a discriminatory payment penalty under Medicare where the payment for each case is reduced 50 percent.

The 50 percent payment penalty has had a significant adverse impact on the programs in the Commonwealth of Pennsylvania. For example, at the University of Pittsburgh Medical Center alone, the anesthesia penalty reduces annual Medicare revenues by more than $4 million. Not only do these important academic programs have difficulty retaining skilled faculty to train new anesthesiologists but, in some cases, the revenue shortfalls which result from this inequitable policy threaten the economic viability of the programs.

Therefore, I ask that the anesthesia teaching inequity be addressed in this year's 2006 physician fee schedule rule in a manner consistent with Medicare's teaching payment rules for other complex or high-risk specialties. Your support for this change will go a long way toward assuring that important academic programs are supported in their mission to train

ALLENTOWN
ALTOONA
ERIE
HARRISBURG
PHILADELPHIA
SCRANTON

future generations of physicians in Pennsylvania and across our nation. Further, I would appreciate your advising me of your actions on this matter at your earliest convenience. Again, thank you in advance for your attention to this important issue.

Sincerely,

Rick Santorum
United States Senate

Submitter : Dr. Gifford Eckhout

Date: 08/21/2005

Organization : Cleveland Clinic Foundation

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

TEACHING ANESTHESIOLOGISTS:

I am writing to support changing the CMS payment methodology for teaching anesthesiologists. The current reduction of 50% payment for working with two residents concurrently is unfair to anesthesiologist training programs and is not consistent with CMS payment policies to other teaching physicians, such as surgeons. This reduction is unwise, unfair, and unsustainable. I would make the following points:
1. Academic anesthesiology programs are struggling financially, due in large part to their generally high volume of Medicare patients
2. The CMS reimbursement for anesthesia is about 35% of commercial payment in Ohio. A 50% reduction in this already insufficient amount is not economically viable for any institution.
3. A surgeon may supervise two residents concurrently for invasive surgery and receive full CMS payment. It is obviously unfair and discriminatory to pay teaching anesthesiologists differently than other teaching physicians.
4. Medicare recipients of the future will rely heavily on the expertise, experience and scientific research into anesthesiology that academic programs provide. The crippling effect of the adverse reimbursement policy has a direct impact on these programs and their future.

I strongly encourage CMS to revisit this payment methodology and pay teaching anesthesiologists the full CMS fee schedule for overlapping cases. We have the additional support of Senator DeWine, who recognizes the critical impact this rule has on Ohio?s teaching programs in anesthesiology.

Thank you for considering this important issue,
Gifford Eckhout, MD, MBA
Department of General Anesthesiology
Cleveland Clinic Foundation
Cleveland, OH 44105
216-444-6954
eckhoug@ccf.org

Submitter : Dr. Michael Reinhard

Organization : Kaiser Permanente

Category : Physician

Date: 08/21/2005

Issue Areas/Comments

GENERAL

GENERAL

As a physician practicing medicine in Sonoma County, California, I strongly support your proposal to create a new payment locality for Sonoma County. The new locality would lessen the disparity between practice expenses and Medicare reimbursements.

The existing disparity has adversely affected our local health care system for several years. In many cases, Medicare reimbursements don?t cover expenses, and a significant number of local physicians have stopped taking Medicare patients or have simply left the county. This disparity has also hampered efforts to recruit new physicians to Sonoma County.

By creating a new payment locality for Sonoma County, you will help ensure the viability of physician practices in the county and will improve access to care for local Medicare beneficiaries. Your proposal will correct existing payment inequities and will help you achieve your goal of reimbursing physicians based on the cost of practice in their locality.

Thank you for the opportunity to comment on this important issue.

Submitter : Dr. Tricia Pockey

Organization : Cornell University Anesthesiology

Category : Physician

Date: 08/21/2005

Issue Areas/Comments

GENERAL

GENERAL

I am writing to urge a change in payment policy for teaching anesthesiologists. The current Medicare teaching anesthesiologist payment rule is unwise, unfair and unsustainable. Quality medical care, patient safety, and an increasingly elderly Medicare population, demand that the United States have a stable and growing pool of physicians trained in anesthesiology.

Anesthesiology teaching programs are suffering severe economic losses that cannot be absorbed elsewhere. Academic research in anesthesiology is increasingly difficult to sustain, as department budgets are broken by this arbitrary Medicare payment reduction.

The CMS anesthesiology teaching rule must be changed to allow academic departments to cover their costs. Please recognize the unique delivery of anesthesiology care and pay Medicare teaching anesthesiologists on par with their surgical colleagues.

Sincerely,

Tricia Pockey
Resident in Anesthesiology
Weill Cornell Medical College
New York Presbyterian Hospital

Submitter : Pat Wells

Organization : Pat Wells

Category : Individual

Date: 08/21/2005

Issue Areas/Comments

GENERAL

GENERAL

GPCIs.....currently some doctors are moving out of santa cruz california and others are refusing care to medicare patients because in spite of the high cost of living here we are designated as rural by medicare..i hope that soon that designation is changed to urban, as it is in 8 other san francisco bay area counties, so patients here in santa cruz can get adequate medical care and so there can be adequate reimbursement for physician ..thank you for your attention...pat wells

Submitter : Mr. Eric Olsen

Organization : Mr. Eric Olsen

Category : Individual

Date: 08/21/2005

Issue Areas/Comments

GENERAL

GENERAL

GPCIs I urge you to desginate Santa Cruz and Sonoma counties as urban counties for Medicare payments.

Submitter : Dr. Bahar Aghighi

Organization : Santa Cruz Medical Foundation

Category : Physician

Date: 08/21/2005

Issue Areas/Comments

GENERAL

GENERAL

GPCIs

As a young physician living and practicing in Santa Cruz, CA, I see an urgent need to change Santa Cruz locality. Santa Cruz is not a rural area. The cost of living has become so high that many young physicians can not afford living in Santa Cruz and many of our Medicare patients cannot find primary care physicians as less and less PCPs are accepting Medicare patients. We are dealing with a health crisis here if GPCI is not going to be changed for next year.

Sincerely,

Bahar Aghighi,MD

Submitter : Mrs. Teresa Ruff

Organization : Mrs. Teresa Ruff

Category : Individual

Date: 08/21/2005

Issue Areas/Comments

GENERAL

GENERAL

GPCIs

We would like to express our support in the decision to remove Santa Cruz County from CA Locality 99. Santa Cruz County is no longer a rural area. I grew up here in San Lorenzo Valley (part of Santa Cruz County), as has my father, and it has expanded beyond the definition of a rural area. We would like to see more support for all of the medical facilities in this County.

Please show your support for our community by making this change. We may have the beach, a lot of trees, and the mountains here in the County, but we have far too many people to take care of to be considered "rural" any longer. Thank you for your time and consideration.

Submitter : **Mr. Steven Ruff** **Date: 08/21/2005**

Organization : **Central Coast Sleep Disorders Center**

Category : **Other Technician**

Issue Areas/Comments

GENERAL

GENERAL

I would like to express my support in the decision to remove Santa Cruz County from CA Locality 99. Santa Cruz County is no longer a rural area. I would like to see more support for all of the medical facilities in this County. We need physicians to stay in Santa Cruz County (especially in my field of Sleep Medicine) rather than having to go to another county because they can rightfully earn more than here. If the physicians leave, then the patients will have to travel a greater distance to seek care. It is also known that some physicians in this area can't accept Medicare because it's too much of a burden.

Please show your support for our community by making this change. Santa Cruz County is no longer a "rural" area. Thank you for your time and consideration.

Submitter : Mrs. Mary Phillips **Date:** 08/21/2005

Organization : private citizen/retired

Category : Other

Issue Areas/Comments

GENERAL

GENERAL

GPCIs Santa Cruz County has some of the most highly trained physicians in the nation, many of them associated with Stanford University Hospital and Cancer Center. However, for the past 10 years, Medicare designates SCC as rural and its physicians are paid 25 percent less than neighboring counties. Many can no longer afford to live here and move away, or refuse Medicare patients. I support the urban designation to increase Medicare payments to county doctors.

Submitter : Mr. Robert Mapes **Date:** 08/21/2005

Organization : Mr. Robert Mapes

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

GPCIs. Please designate Santa Cruz County California as urban instead of rural. We have a very high cost of living here, and our doctors are leaving.

Submitter : Mrs. Gail Mapes **Date:** 08/21/2005

Organization : Mrs. Gail Mapes

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

GPCIs. Please designate Santa Cruz County California as urban instead of rural. We have a very high cost of living here, and our doctors are leaving.

Submitter : Ms. Joy Bertrand **Date:** 08/21/2005

Organization : N/A

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

"GPCIs"
I urge you to change Santa Cruz County's rural designation and increase physician payments 10%

Submitter : Carolyn Chiesa

Organization : Carolyn Chiesa

Category : Health Care Industry

Date: 08/21/2005

Issue Areas/Comments

GENERAL

GENERAL

Santa Cruz County in California MUST be changed to the urban designation. It is crucial for the recruitment and retention of doctors. There has been an dramatic exodus of physicians and many more are planning to leave if the designation is not changed. Medicare patients wait weeks to get an appointment! All costs are higher here than in "rural" areas : rent, salaries, support staff. This is the central coast of California. A very ordinary home here costs upwards of $900,000. Doctors making $100,000 to $180,000 have a hard time qualifying! Even as small as the proposed increase is, it will make a big difference. The situation here is dire. WE NEED HELP NOW. We qualify for the urban designation. We DESERVE recognition of our huge contribution to Medicare.

Submitter : **Ms. Madeline Spencer** **Date: 08/22/2005**

Organization : **Ms. Madeline Spencer**

Category : **Health Plan or Association**

Issue Areas/Comments

GENERAL

GENERAL

GPCIs

We support the increase in Medicare reimbursement rates to doctors in Santa Cruz County by changing our designation from rural to urban. Santa Cruz is one of the most expensive areas in the country and we are part of the extended Bay Area, yet we are considered rural. This designation has not been changed in 40 years. It is not fair to our doctors, our seniors and our disabled to retain this archaic designation. We are losing many of our good doctors who are underpaid and can not afford housing here.

Please make this change.

Madeline Spencer

Submitter : Ms. Mayrebelle Lukins

Organization : Ms. Mayrebelle Lukins

Category : Health Plan or Association

Date: 08/22/2005

Issue Areas/Comments

GENERAL

GENERAL

GPCIs

We support the increase in Medicare reimbursement rates to doctors in Santa Cruz County by changing our designation from rural to urban. Santa Cruz is one of the most expensive areas in the country and we are part of the extended Bay Area, yet we are considered rural. This designation has not been changed in 40 years. It is not fair to our doctors, our seniors and our disabled to retain this archaic designation. We are losing many of our good doctors who are underpaid and can not afford housing here.

Please make this change.

Mayrebelle Lukins

Submitter : Susan Howells

Date: 08/22/2005

Organization : Susan Howells

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

I support the change of designation for Santa Cruz County, California from Rural to Urban. This is an extremely expensive area in which to live & work. We simply cannot retain medical professionals if they are reimbursed at rates out of sync with the cost of living in this area.

My 82 year old father in law recently moved to this area to be close to his only son. We have had no luck -- in 3 years -- finding an acceptable physician that will take a new Medicare patient (with an active case of emphesema. He does not have a primary care doctor at this time.

In order to care for our aging population and to attract and retain physicians our Medicare reimbursement designation must change to be competitive with our neighboring counties.

Thank you for your consideration.

Suz Howells

Submitter : Dr. Renwick Curry

Organization : Dr. Renwick Curry

Category : Individual

Date: 08/22/2005

Issue Areas/Comments

GENERAL

GENERAL

RE: GPCIs

Because Santa Cruz County, California, is now designated as a "rural" county, Medicare payments fall far below actual costs. We are very close to the San Francisco Bay area, so many physicians have left to practice there. Most of the other physicians remaining in Santa Cruz have stopped accepting new Medicare patients.

Please change the designation for Santa Cruz County from a rural designation to an urban designation.