Submitter : **Mr. Thomas Mullen** **Date: 08/22/2005**

Organization : **none**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

I would like to encourage you to change the status of Santa Cruz County to an urban designation for Medicare reimbursement. The situation in this county is very serious as the high cost of living makes it difficult to attract young physicians to the area . We are one of the least affordable home buying areas in the nation. As a medicare recipient it is increasingly difficult to find doctors who will take Medicare because of low payment rates.Changing the designation would be very helpful.

Tom Mullen

Submitter : **Dr. Jerome Adams** **Date: 08/22/2005**

Organization : **American Society of Anesthesiologists- Resident**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

My name is Jerome Adams and I am a resident physician at Indiana University. I am writing you to ask that you make a change in the payment policy for teaching anesthesiologists.

The current policy of providing anesthesiologists who supervise residents only 50% reimbursement for two concurrent medicare cases while allowing surgeons to collect 100% in the same circumstances is unfair, and is causing great harm to many academic programs around the country.

Because of this rule, anesthesiology teaching programs, are suffering severe economic losses that cannot be absorbed elsewhere. This is causing many of our staff to leave the academic arena, and is discouraging residents from going into academic anesthesia.

Furthermore, the staff that remain are overworked just trying to keep the departments going, and not able to spend as much time teaching as they have in the past.

Quality medical care, patient safety and an increasingly elderly and complex patient population demand that the United States have a stable and growing pool of physicians trained in anesthesiology. Given the (relatively) small expenditure it would take to remedy the currently unfair payment situation versus the rapidly increasing number of medicare patients that will come into our operating rooms in the future, leaving the teaching rule as is seems to be penny-wise and pound foolish.

I ask that for the sake of my training, and so that in the future I will be able to provide the same level of anesthesia care to your medicare beneficiaries that has so far resulted in unpredented levels of safety in the operating room, you change the anesthesia teaching rule.

Thank you for your consideration,
Jerome Adams

Submitter : Dr. Brenda Lewis **Date:** 08/22/2005

Organization : American Society of Anesthesiologists

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

Commenting on the Anesthesia teaching rule. CMS has invited comment on payment for an anesthesiologist to supervise 2 residents. Currently CMS pays an anesthesiologist 50% for supervising 2 residents. Resident teaching rules require a 2:1 supervision ratio. Surgeons are not penalized for supervising 2 residents in the operating room. This is fundamentally unfair. CMS used to pay 100% for anesthesiologists supervising 2 residents but singled out anesthesiologist for reduced payments in 1996. In 2004 this cost Ohio teaching programs over 2 million dollars and my own institution 1 million. Teaching programs find it difficult to recruit and maintain staff because they cannot compete in the market.
CMS has a "teaching rule" for CRNA's that is not workable for anesthesiologists. In order to use this rule we would have to document every minute spent in each operating rule. The focus of a physician should be on patient care not document their minute by minute presence. In addition this is a compliance nightmare to administrate. My current department does about 200 cases per day. To make sure there is not a minute overlap on any two cases would cost us more that we would receive by billing full base units. My insitution is close to an all electronic anesthesia record. To re-program the system to check for compliance on a minute by minute basis is very costly and perhaps not possible at this point. The CRNA "teaching rule" is totally ineffective.
I urge CMS to re-consider this rule. We have been penalized for 9 years. We should be allowed to supervise two physicians and receive 100% reimbursement for each case as our surgical colleagues do.

Submitter : Miss. jeanne allen **Date:** 08/22/2005

Organization : health management systems

Category : Health Care Professional or Association

Issue Areas/Comments

GENERAL

GENERAL

when submitting claims to medicaid in NJ where medicare payment is greater than the medicaid rate with a coinsurance due amount identificd on medicare remit will the state medicaid program have a responsibility to pay for the coinsurance/and or deductible amount to provider?

Submitter : Dr. john dombrowski **Date:** 08/22/2005

Organization : asa

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

I am writing you as a constituent to ask that you contact the Centers for Medicare and Medicaid Services (CMS) and urge a change in payment policy for teaching anesthesiologists.

Please support academic medicine in our state.

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.

The current policy is causing great harm to my program.

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.

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.

Please let me know as soon as possible your position on this critically important issue for our program.

Submitter : Dr. Lydia mertens **Date:** 08/22/2005

Organization : Kaiser

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

I am a family practice doc in sonoma county. I was in private practice for 11 years but joined kaiser when it was too hard to make it financially. I t has been a steady shift every year of family docs to Kaiser. all our small hospitals are closing. It is hard to recruit prmary care docs to sonoma county since the cost of living is so high but reimbursement so low. Medicare"s reimbursement in sonoma county is the main cause of this crunnch

Submitter : Ms. Cathy Wray **Date:** 08/22/2005

Organization : Santa Cruz Medical Foundation

Category : Health Care Industry

Issue Areas/Comments

GENERAL

GENERAL

I wish to state that I do NOT agree with the rural designation for Santa Cruz County. If any of you have vacationed here you can clearly see it is not rural.

Submitter : Jesse Duncan

Date: 08/22/2005

Organization : Jesse Duncan

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

Medicare desparately needs to increase the reimbursements for Santa Cruz County here in California. Our housing prices and cost-of-living are equal, and in some cases even greater, than many areas of the San Francisco Bay Area. As Medicare patients we are finding doctors leaving and many doctors remaining are limiting their services to Medicare patients. As senior citizens who have paid our dues, we rightfully deserve equal access to medical care.

Submitter : Dr. Sarah Merritt **Date:** 08/22/2005

Organization : ASA

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

Medicaid's 1994 "Teaching Rule" reimbursement policy has had a large negative financial impact on the department of anesthesiology at UNC.

The Centers for Medicare and Medicaid Services 2006 fee schedule revisions do NOT change the academic anesthesiologist "teaching rule." I am writing to comment that it is vital to the health of UNC and acedemic medical centers everywhere to change this rule and allow full fair reimbursement to academic medical centers based on cases being performed and not based on whether teaching residents is involved.

As you know, this has placed immense financial burden on all academic programs including UNC. CMS discriminates against academic anesthesiologists by paying them only 50% of the reimbursement, should s/he oversee 2 rooms both containing residents and Medicaid patients. Keep in mind that a surgeon may run 2 resident/Medicaid rooms and receive full reimbursement for both cases.

The impact of this CMS change on the financial viability of anesthesiology teaching programs has been significant ? representing an estimated one-eighth the amount by which institutions must subsidize academic anesthesiology departments in order to keep them afloat and to permit faculty positions to remain competitive with practice opportunities in the private marketplace. With these departments already struggling to meet demand (there are 300 fewer available residency positions per year than the estimated 1,600 positions annually required to meet growth in demand in the next several years), the CMS teaching rule penalty has become a significant factor in departmental health.

thanks for your attention

Submitter : Mr. JAMES THOMPSON **Date:** 08/22/2005

Organization : INDIVIDUAL

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

I AM A SENIOR LIVING IN SANTA CRUZ COUNTY CALIFORNIA AND IT IS IMPERATIVE THAT THE REGULATIONS BE CHANGED IN ORDER TO REFLECT THE ACTUAL COST OF LIVING IN SANTA CRUZ COUNTY (one of the highest on the list of LEAST affordable places to live) AND ALLOW IT TO ATTRACT AND RETAIN COMPETENT PHYSICIANS. IT IS ESSENTIAL THAT MEDICARE REIMBURSEMENT BE BASED UPON URBAN STANDARDS..

THANKS
JAMES THOMPSON

Submitter : **Ms. Elizabeth Bennett** **Date: 08/22/2005**

Organization : **Elizabeth Bennett, MS, MFT**

Category : **Other Practitioner**

Issue Areas/Comments

GENERAL

GENERAL

Physicians in Santa Cruz County are paid 25% less than comparable physicians in nearby counties because Santa Cruz County has been designated as a "rural" area. The San Francisco area, Orange County and Santa Cruz County are reportedly the most expensive housing areas in the state. We are losing physicians because they cannot afford to live and practice here. Please consider a redesignation of the Physician Fee Schedule for Santa Cruz County.

Submitter : Mr. Paul Bottone **Date:** 08/22/2005

Organization : Mr. Paul Bottone

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

Please change the status of Santa Cruz County from rural to Urban. We are losing all the Doctors because they are not being reimbursed enough for their services.

Submitter : **Dr. Douglas Abbott** **Date: 08/22/2005**

Organization : **Dr. Douglas Abbott**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

August 22, 2005

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

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. 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. The 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.

Sincerely

Douglas Abbott, M.D.

CMS-1502-P-113-Attach-1.DOC

Submitter : **Ms. Nancy Knudegard** **Date: 08/22/2005**

Organization : **Ms. Nancy Knudegard**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

GPCIs

I strongly urge you to accept the propossl to change Santa Cruz County and Sonoma County from a rural designation to an urban designation. It has been more than 10 years since the status of these counties has been reviewed and they are clearly no longer "rural" areas.

Physicians in these counties do not receive competitive payments from Medicare compared to counties with urban designations. This has two disasterous effects for seniors living in these counties.

1. Physicians are leaving for "urban" Medicare counties, causing a continual decline in the availability of Medicare coverage to seniors.

2. Because of the very high cost of living, especially in Santa Cruz county, the physicians that do choose to stay are frequently refusing to accept Medicare patients.

This penalizes not only the patients seeking Medicare services, but the physicians who are still willing to accept Medicare assignment. It forces doctors to leave our area, and depletes basic medical care that should be readily available to those most in need.

Please help stop this downward spiral of health care service in Santa Cruz and Sonoma Counties. Our health care system in the United States has enough problems already. This is one that can be fixed.....SO JUST DO IT! CHANGE THE STATUS OF SANTA CRUZ AND SONOMA COUNTY FROM RURAL TO URBAN! It is long overdue.

Nancy C. Knudegard

Submitter : Mr. Earle Hale **Date:** 08/22/2005

Organization : Mr. Earle Hale

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

The present designation of Santa Cruz, California as a rural county is clearly in need of revision. A county which has an average home price of almost $800,000 is hardly one that should be designated rural. It badly needs a redesignation to urban if the county is to retain physicians willing to accept medicare patients. Too many physicians have already left the county or have refused to accept medicare patients.

Submitter : **Dr. Bob Dozor** **Date: 08/22/2005**

Organization : **Integrative Medical Clinic of Santa Rosa**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

GPCIs

Each year I come closer to not taking any new MediCare patients, and I actually did stop taking any for about a month until I heard about Sonoma County getting some relief from our unfair reimbursement rates. If this goes through; I'm on board!

Bob Dozor MD
bob@imcsr.com

Submitter : Mr. Richard Carson **Date:** 08/22/2005

Organization : Alabama State Society of Anesthesiologists

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

Please fix this problem and value our services similar to the method other physician specialists are treated under similar circumstances.

Submitter : Dr. Glenn Jonas **Date:** 08/22/2005

Organization : Dr. Glenn Jonas

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

Q-CODES AND CASTING the new bundling of casting codes will significantaly decrease our ability to best treat our patients. It is time consuming and expensive to make and change casts. Unfortunately by limiting reimbursement, we cannot afford to change casts and will force us to limit care. May result in more surgery, more ER visits, and poorer results. Pay for good medicine! don't limit access to appropriate treatment by discouraging good medicine!!!!

Submitter : Dr. Alexander Hannenberg **Date:** 08/23/2005

Organization : Commonwealth Anesthesia Associates

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

RE- ANESTHESIOLOGY TEACHING PAYMENTS

Anesthesia training programs are unfairly and dramatically disadvantaged by the application of CRNA medical direction payment rules to the teaching anesthesiologist. Considering that commercial anesthesia conversion factors average $50 per anesthesia unit nationally, a teaching anesthesiologist with overlapping cases receives 50% of the $18 Medicare anesthesia conversion factor, or $9 per unit. The penalty for caring for Medicare beneficiaries in the teaching setting is dramatic and handicaps the training of specialists in an area with serious shortages.

The NPRM references to payment policies for training of student nurse anesthetists should have no bearing on physician graduate medical education payment. Are payment policies for nurse midwives tied to obstetrical resident payment policies? For nurse practitioners to primary care residency training? If not, why should anesthesiology residency payment policies depend on nurse education? This unique connection cannot be justified and must not be a barrier to instituting a payment policy for anesthesiologists that is comparable to the longstanding policy for surgical and other high risk procedural specialties.

Many thanks,

Alexander A. Hannenberg, M.D.
Newton-Wellesley Hospital
Newton MA

Submitter : **Dr. John Roberts** **Date: 08/23/2005**

Organization : **Crawfordsville Family Care**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

See attachment

CMS-1502-P-120-Attach-1.DOC

John R. Roberts, M.D.
89 N Sugar Cliff Drive
Crawfordsville, IN 47933

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

To Whom It May Concern:

I am writing to express my concern that CMS and Congress are not moving forward to revamp the sustainable growth rate formula. As a family physician, I have no doubt that reducing physician payments in 2006 and subsequent years will have a chilling effect on access to health care for Medicare beneficiaries. I'm sure you are aware of the sobering statistics regarding physicians not accepting new Medicare patients into their practices. We simply cannot afford to provide our services for free or to lose money when caring for a Medicare patient. I hope CMS can get the ball rolling to prevent lack of access for our seniors.

Sincerely,

Submitter : Dr. Jennifer Dollar **Date:** 08/23/2005

Organization : American Society of Anesthesiologists

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

I am writing in support of a change in the current Medicare teaching anesthesiologist payment rule. The current payment rule seriously devalues the services provided by the teaching anesthesiologist. The future of the field of anesthesia lies in its training programs. However, these programs will face an uncertain future if teaching anesthesiologists do not achieve 100% of the Medicare fee for each of two overlapping procedures involving resident physicians. We are asking to be placed on par with our teaching surgical colleagues who receive 100% of the Medicare fee for each of two overlapping procedures. As a recent graduate of a residency training program, I cannot stress the importance of a solid educational program. I was fortunate to receive excellent training. I currently supervise resident physicians in my post-residency position. I am committed to continuing the strong tradition of vigilance, which is the basis of the American Society of Anesthesiologists. This organization has set the bar for the the medical community with regards to improving patient safety. As a larger portion of the American population lives longer, we will have a larger number of Medicare patients requiring anesthesia services. I want tomorrow's senior population to receive the same level of excellent medical care that today's senior population receives when they require anesthesia services. Please reconsider the current Medicare teaching anesthesiologist payment rule and make a committment to excellent care for the future.

Submitter : Mrs. Judith Foreman **Date:** 08/23/2005

Organization : Mrs. Judith Foreman

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

Please change the Medicare designation for Santa Cruz, CA from rural to urban. I became a Medicare recipient two months ago and had an extremely difficult time finding a local physiciian who would take new Medicare patients because doctors in this region do not receive adequate compensation for Medicare patients. Santa Cruz is a cosmopolitan city of over 55,000 people. The average price of a home here is over $800,000 (one of the three most expensive real estate markets in the US). It is ridiculous to classify our area as rural.

Submitter : donna **Date:** 08/23/2005

Organization : donna

Category : Physical Therapist

Issue Areas/Comments

GENERAL

GENERAL

GPCIs

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

To Whom It May Concern:

Santa Cruz County is a wonderful place to live and work, but for our older residents it has become a somewhat frustrating place for receiving the necessary medical care.

Working as a physical therapist assistant in Santa Cruz over the last 24 years, I personally have seen the attitude of medical providers become more negative toward treating Medicare patients, as it has come to light that payments to the facilities are inadequate to cover the costs.

Recently, the Santa Cruz Sentinel carried an article, which stated that; purchasing a median priced home in Santa Cruz requires a yearly income of $198,000. I do not own a house, and my wages are not in parity with what I could make 'over the hill' in Santa Clara County.

With the removal of Santa Cruz County from the Area 99 designation, maybe we could make our doctors content and we, in physical therapy, could give those deserving patients the treatments that can enhance their quality of life.

Thank you for your plans to reassign Santa Cruz County from Locality 99.

Submitter :

Date: 08/23/2005

Organization :

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

cast and medical supplies should not be bundled into surgical global fees because these materials are very expensive. The internal cost has nothing to do with fracture management evaluation and decision or reduction treatment. If bundling is to be considered, the surgical fee schedule needs to be increased to accommodate this added expense in fracture management. After all, your car mechanic rightfully charges for supplies over and above the labor fee.

Submitter : Dr. Carol E. Rose **Date:** 08/23/2005

Organization : Dr. Carol E. Rose

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

Please reconsider the decrease in reimbursement for the Physician Fee Schedule for 2006. If these fee reductions take place and continue as expected, physicians like myself may have to retire earlier than expected. It just won't pay to continue to care for Medicare patients. We need to continue to be available for the best care of the patients. However, loosing money to care for the patients, just doesn't make sense financially.

Submitter : Dr. Eric Kahle **Date:** 08/23/2005

Organization : Eye Associates of Sebastopol

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

This comment is regarding issue identifier "GPCI's." I work and reside in Sonoma County California, where we are reimbursed for medical services based upon a "rural" designation. While it is true a good portion of our county industry is agricultural, it is also "wine country." It is a haven for tourism and has one of the most expensive costs for housing in the country. The median home price is now over $600,000! It is certainly one of the most costly places to live in the country. We struggle covering our expenses in this locality under the rural designation with its decreased reimbursement. Please make the decision to raise our reimbursements coincident with the high costs of living and working in this beautiful but very expensive county.
Thank you for your consideration,
Eric J. Kahle, MD

Submitter : Dr. michael womack **Date:** 08/23/2005

Organization : resurgens orthopaedics

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

i would like to voice my appeal not to accept the proposed changes in payment for casting supplies. casting remains one of the most cost effective non surgical forms of treatment for a multitude of sprain strains fractures and overuse injuries. the time commitment required to apply a well fitted custom cast removes the physician from other forms of revenue generating care. casting is not appropriately reimbursed at this time and to cut the reimbursement of the actual supplies further will only push providers away from this cost effective form of care to other more expensive less cost effective options.

Submitter : Ms. Becky Peters **Date:** 08/23/2005

Organization : lifespan

Category : Nurse

Issue Areas/Comments

GENERAL

GENERAL

To whom It May Concern: Please redesignate Santa Cruz County as a urban county for Medicare Reimbursement. It is becoming more and more difficult for the elders here to locate a physician that accepts Medicare. Santa Cruz county is a very expensive place to live with extremely high housing costs, and physicians cannot afford to live here with low Medicare rates. Please help the elderly in our county and recharacterize our county appropriately. Thank you.

Submitter : Dr. Leighan Bye **Date:** 08/23/2005

Organization : IU School of Medicine

Category : Critical Access Hospital

Issue Areas/Comments

GENERAL

GENERAL

To whom it may concern,
I am a teaching anesthesiologist at IU school of Medicine. I love my job as I love contributing to the lives and education of young physicians. However, as the percentage of medicare/medicaid cases rises our revenues fall. Contributing to this problem is the concurrency rule, which, as you know, cuts our reimbursement by half if we supervise another room while supervising a MC/MK room. If both rooms are MC/MK the compensation, as you can imagine, is abysmal. Teaching institutions all over the country are facing the financial reality that it is just not reasonable to try to continue this way. Some have even closed their doors. When you consider your actions in this ruling I would ask you to remember that anesthesia is not just a nap. Anesthesia is acute critical care. It is the suspension of all the patient's protective reflexes to facilitate a surgical procedure. The patient cannot gag or cough to protect his lungs from aspiration. He cannot cry out or move if he is having pain. He cannot even blink to protect his eyes. Anesthesia delivered by inadequately trained personel can be tramatic, dangerous or even deadly. As the population ages and brings more comorbid conditions to the OR such as obesity, heart disease, vascular disease, emphasema (to name a few) we need more well trained physician anesthesiologists. I would like to think that for my next anesthetic I would be in the hands of a well trained physician, wouldn't you? Are you really very healthy? Can your heart/lungs tolerate the stress of a sloppy or dangerous anesthetic. Teaching institutions are closing or cutting their residency programs. There will be fewer and fewer well trained physician anesthesiologists as there will be nobody willing to train them for unfair compensation.
Please fix this problem. Don't make those of us in the teaching institutions decide between and decent living and our calling to teach. The concurrency rule is unjust. 1 minute of overlap between 2 cases causes our fees for the MC/MK cases to go down by half even if hours of anesthetic have been safely administered with no overlap. How is that fair?
Look into your hearts and do what is right.
Thank you for your thoughtful consideration.

Submitter : Bruce K. Donald, DDS **Date:** 08/23/2005

Organization : Bruce K. Donald, DDS

Category : Other Health Care Professional

Issue Areas/Comments

GENERAL

GENERAL

Re: CMS-1502-P Living and working expenses in Santa Cruz County have risen over the years to match, and in some cases surpass, those in other counties nearby. We are no longer a rural community, and Medicare reimbursement for physicians and medical facilities should be equivalent to areas like San Francisco and Santa Clara. Please support changing our designation to "urban."

Submitter : Meg Harlor **Date:** 08/23/2005

Organization : Meg Harlor

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

Please change the status of Santa Cruz county from rural to urban. We are losing doctors at an alarming rate and losing doctors who will take new medicare patients. The reimbursement rates under the rural designation are too low for doctors to survive here. I wish this change would make the rates on par with our neighbors but it is better than nothing and is a step closer. I'm just a few years away from medicare age and would hope to have good medical service here then.

Submitter : Sandi Palumbo **Date:** 08/23/2005

Organization : CMA District VI Delegation/Kern County Medical Soc

Category : Health Care Professional or Association

Issue Areas/Comments

GENERAL

GENERAL

"See Attachment"

CMS-1502-P-132-Attach-1.DOC

District VI

District Chair: Ronald L. Morton, MD ❖ Email RMorton222@aol.com
Staff Liaison: Sandi Palumbo ❖ Email spalumbo@kms.org
Mailing address : c/o KCMS, 2229 Q Street, Bakersfield, CA 93301-2900

Representing
Fresno-Madera Medical Society
Kern County Medical Society
Kings County Medical Society
Merced-Mariposa Medical Society
San Joaquin Medical Society
Stanislaus County Medical Society
Tulare County Medical Society
Tuolumne County Medical Society

August 23, 2005

Mark B. McClellan, MD, PhD
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244-1850

Sent electronically to: http://www.cms.hhs.gov/regulations/ecomments

Subject: August 8, 2005 - Proposed Rule: CMS-1502-P

Dear Doctor McClellan:

CMS recently unveiled its physician payment rules for 2006 and its proposal 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. The proposed rule would result in a 0.4% cut in physician reimbursement for the physicians of CMA's District VI (Alpine, Amador, Calaveras, Fresno, Kern, Kings, Madera, Mariposa, Merced, San Joaquin, Stanislaus, Tulare and Tuolumne Counties) in 2006. This reduction would be in addition to and on top of the projected 2006 4.3% sustainable growth rate formula decrease effective January 1.

CMA District VI comprises the counties of the geographic California San Joaquin Valley in addition to some adjacent mountain counties. The eight (8) District VI component medical societies, located in Fresno, Kern, Kings, Merced, San Joaquin, Stanislaus, Tulare and Tuolumne Counties, represent over 2,250 practicing physicians and many retired physicians residing in these thirteen (13) "Locality 99" counties. Economic and healthcare statistics and policy reports for the San Joaquin Valley note the challenges currently facing this predominantly rural agricultural region.

Known for its low provider reimbursements, this region has had and continues to experience difficulty in recruiting and retaining adequate numbers of healthcare providers for its increasing number of residents. As reported in *Health in the Heartland: The Crisis Continues*, a Fresno State University Report on Health Status and Access to Care in the San Joaquin Valley, **"Changes in Medicare benefits or in reimbursement to providers could have a major effect on the San Joaquin Valley."** The Report further noted, **" Considering many private health plans base their reimbursement rates on Medicare rates, *increasing* Medicare reimbursements is a critical step for revenue enhancement." "*Any* decrease in funds will directly affect the availability of services in the Valley."**

District VI Delegation opposes the CMS proposed rule in favor of supporting the following August 8, 2005 recommendation of the CMA Executive Committee, and subsequently approved unanimously by the CMA GPCI Task Force, based on the use of additional funding:

> ***"That CMA pursue federal Medicare legislation that requires the Centers for Medicare and Medicaid Services (CMS) to move any county in the country whose Medicare geographic adjustment factor (GAF) exceeds its Medicare geographic payment locality GAF by 5% to a new locality. Such legislation should provide additional funding to pay for the change."***

The Valley continues to have high rates of disease, poor community health, and lacks an adequate provider network. The Valley continues to lead the state in infant mortality, teen births, and late access to prenatal care. Some Valley residents have a harder time than do other Californians in finding care due to lack of health insurance, a scarcity of providers, and language and cultural barriers.

Despite advances in medical care across the state, many Valley residents still lack the most basic of services. The rising costs of treatment for chronic disease and continued reliance on state and federal funding in a climate of budgetary deficits will lead to further erosion in the health care delivery system and further economic decline. If current trends continue, the Valley will be less and less able to adequately care for its needy residents.

CMA District VI component medical societies support the California Medical Association's current recommendation that Congressman Bill Thomas and the Centers for Medicare and Medicaid Services work together to devise a nationwide fix to the GPCI problem utilizing new funding. However, of greater concern to our physicians at this time is the looming SGR cuts.

The proposed rule to extract Santa Cruz and Sonoma counties from California's Locality 99 at this time, is *not*, in our collective opinion, a viable solution to this problem. Rather any attempt to revise GPCIs would best be served based upon timely and appropriate data (reference March 2005 GAO Report Viability of GPCIs), a nationwide fix and utilize new funding.

The physicians of California's San Joaquin Valley and adjacent counties cannot afford *any* decrease in reimbursement.

Sincerely,

Ronald L. Morton, MD, Chair
CMA District VI Delegation
Representing the Counties of Alpine, Amador, Calaveras, Fresno, Kern, Kings, Madera, Mariposa, Merced, San Joaquin, Stanislaus, Tulare and Tuolumne.

Cc: Michael O. Leavitt, Secretary, U.S. Department of Health and Human Services
Jeff A. Flick, Regional Administrator, CMS Region IX
U.S. Congressman William Thomas, Chair, Committee on Ways & Means
U.S. Congressman Dennis Cardoza
U.S. Congressman Jim Costa
U.S. Congressman Devin Nunes
U.S. Congressman Richard Pombo
U.S. Congressman George Radanovich
U.S. Senator Diane Feinstein
U.S. Senator Barbara Boxer
District VI Component Societies
CMA Executive Committee
John Lewin, MD, EVP/CEO, California Medical Association
Elizabeth McNeil, Director Federal Issues, CMA

Submitter : Dr. Frank Joseph **Date:** 08/23/2005

Organization : Dr. Frank Joseph

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

I am strongly opposed to changes which will eliminate reimbursement for casting/splinting and dressing supplies. These are expensive items we use on a daily basis and we clearly must be reimbursed in order to adequately take care of our elderly medicare population.
Thank you for your attention to this matter
Frank R. Joseph MD

Submitter : Dr. Ellen Barnett **Date:** 08/23/2005

Organization : Dr. Ellen Barnett

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

This comment is to strongly support Sonoma and Santa Cruz having a separate designation for Medicare Payments.
For years we have been underpaid with our Rural Designation. As many as 1/3 of primary care doctors have left town and/or joined Kaiser as they cannot pay their bills in private practice.
TO offer care to elders, it takes time and explanation. Otherwise, under pressure of time, we order drugs and tests and interventions that the patient may not even want .
In the long run, this will save money.
Thank you

Submitter : Diane Reymer **Date:** 08/23/2005

Organization : Diane Reymer

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

Re: CMS-1502-P, GPCI's. Santa Cruz County seniors are being penalized by the continuing designation as a 'rural' community in that the senior population is increasing and the disparity in Medicare payments is causing a decrease in the number of physicians who will accept new Medicare patients and the number of physician who are leaving the area due to the lower compensation. Pls change our designation to 'urban' so that we may receive the care we need to survive.

Submitter : Ms. Virginia Law

Date: 08/24/2005

Organization : Concerned Citizen

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

GPCIs

I live in Santa Cruz County, CA. This county is clearly inappropriately labeled rural. We are a very expensive bedroom community for Silicon Valley as well as a University and resort town. Our doctors must be paid on an urban cost basis. Young doctors cannot afford houses here and the older ones are retiring. Please raise their medicare payments.

Submitter : Dr. j dombrowski **Date:** 08/24/2005

Organization : Dr. j dombrowski

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

I am writing you as a constituent to ask that you contact the Centers for Medicare and Medicaid Services (CMS) and urge a change in payment policy for teaching anesthesiologists.

Please support academic medicine in our state.

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.

The current policy is causing great harm to my program.

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.

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.

Please let me know as soon as possible your position on this critically important issue for our program.

Submitter : Dr. Dennis Glick

Organization : Dr. Dennis Glick

Category : Physician

Date: 08/24/2005

Issue Areas/Comments

GENERAL

GENERAL

ISSUE IDENTIFIER: GPCI's

SEE ATTACHMENT

CMS-1502-P-138-Attach-1.DOC

August 23, 2005

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

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. 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. The 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.

Sincerely,

Dennis Glick, MD

Submitter : Dr. Tim Gieseke **Date:** 08/24/2005

Organization : Northern California Medical Associates

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

I am writing regarding GPCIs. I have practiced general internal medicine in Sonoma County since 1979. During the last 10 years, the cost of living has increased exponentially. This has meant we are no longer able to keep good employees, because we can not afford to pay them what it costs to live here. This past year, we lost 3 long standing employees, because they found out, they were barely making more than untrained new hires. We now have only 2 of 9 employees who have been with us for more than 10 monthes. Needless to say, our patients are being poorly served, and we are getting very discouraged. Because of this frustration and because of the high overhead costs that were causing me to work about 16 hrs/day 5 days a week, I left my office practice of 26 years August 1st. I told my 5 associates last November that I couldn't continue working this hard and therefore needed to be replaced. Though we hired a employment company and advertised in prestigious journals like the NEJM, we did not receive one acceptable canidate. Eventually my associates said I could leave without a replacement and they would absorb the patients they could. Unfortunately, there were a number of my more difficult patients, who became undoctored. This is very traumatic to them and our community. I respectfully request that you consider the proposed Calif. fee adjustment that would increass the rates for Medicare reimbursement by 8% in Sonoma and Santa Cruz counties. With this added fee, we could address some of the economic difficultics noted above, more effectively.

Sincerely,
Tim Gieseke MD, CMD

Submitter : Dr. Kay Kirkpatrick **Date:** 08/24/2005

Organization : Dr. Kay Kirkpatrick

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

The proposed changes to reimbursement for casting supplies are just ridiculous and will cost my practice a huge amount of money. We pay our suppliers for the materials required for cast application, which has nothing to do with the time and expertise required to apply the cast or splint, and indeed nothing to do with the potential liablility associated with cast/splint application. I am strongly opposed to bundling the supply costs into the code for cast application.

Submitter : Dr. Kevin Cuccaro **Date:** 08/24/2005

Organization : Dr. Kevin Cuccaro

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

Please review and reconsider the Medicare and Medicaid Fee schedule for 2006. Unfortunately, CMS has once again denied parity for anesthesiology teaching institutions by providing only 50% of the possible reimbursable amount (compared to surgeons).

As you well know without an anesthesiologist or anesthesia provider, surgery cannot be performed. Why is it then that CMS does not reimburse anesthesia departments on the same scale as surgeons?

In this day and age of much more medically complex, older and "sicker" patients undergoing surgeries that, in the past, would never have been considered it is of paramount importance that anesthesia departments teaching the next wave of anesthesiologists be reimbursed at an equal level as other physicians. Many teaching institutions already have funding problems as they provide care to the sickest of the sick, many of who do not have any sort of insurance coverage. Without adequate funding for residents some institutions may, out of financial necessity, stop teaching residents. With a projected shortfall of anesthesiologists over the coming years it does not make sense to further hamper the ability of teaching institutions to provide new graduates to meet the need of the population at large.

Please, please, please help support academic anesthesiology. Someday, we will all likely be under a surgeons scalpel and I, for one, would like to make sure that both the surgeon and the anesthesiolgists keeping me alive during the procedure are the best trained in the world.

Thank you for your time.

Submitter : **Dr. Raafat Hannallah** **Date: 08/24/2005**

Organization : **Children's Hospital**

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.

The current policy is causing great harm to my program.

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.

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.

Submitter : Dr. Jon Minter **Date:** 08/24/2005

Organization : Resurgens Orthopaedics

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

I oppose the changes in regards to the casting materials and lumping them into the global fee. The costs of practice overhead are growing and now with this proposal we see futher price increases being thrown directly at us.

Submitter : **Mr. franklin harris** **Date: 08/24/2005**

Organization : **medicare**

Category : **Congressional**

Issue Areas/Comments

GENERAL

GENERAL

GPCIs We need your help to raise thr reimbursement to the medical field in Santa Cruz Co. California. Thank you for you help.

Submitter : Janice Cockren **Date:** 08/24/2005

Organization : Janice Cockren

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

I write to support changing the 'rural' designation for Santa Cruz County as it relates to paying physicians for treating Medicaire patients. One only has to understand the very, very high cost of living in this county where housing prices far outweighs what one may hope to earn. Santa Cruz county must be equal to Santa Clara and other bay area counties in the realm of Medicaire payment.

Submitter : **Donald Schmitz** **Date: 08/24/2005**

Organization : **Donald Schmitz**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

GPCIs

As a medicare subscriber in Santa Cruz County I urge revision of our reimbursement classification to 'urban county'. The large majority of county residents are not involved in 'rural' or agricultural operations or are retired and primarily dependent on Medicare for health support. Also, the cost of living and housing in the county is well above the median for the state of California and the U.S., which absolutely requires that reimbursement for our doctors be improved to ensure maintenance of adequate health care for county residents. We can not afford to lose our doctors to 'Silicon Valley' or to be dropped by supplemental HMO's because of inadequate Medicare coverage.

Respectfully,
Donald Schmitz
42 Loma Ave.
La Selva Beach, CA 95076
831-684-1266

Submitter : Mrs. Carol Harris **Date:** 08/24/2005

Organization : MediCare

Category : Nurse

Issue Areas/Comments

GENERAL

GENERAL

GPCIs

Santa Cruz County is losing good doctors by the numbers due to the high cost of living here and the low reimbursement rate on MediCare patients. Please redesignate Santa Cruz County as an urban county instead of rural, so that we who are 65 and over will be able to receive good medical care. Thank you.

Submitter : Dr. Tim VadeBoncouer **Date:** 08/24/2005

Organization : Univ of Illinois @ Chicago Dept of Anesthesiology

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

Date: August 24, 2005
Subject: TEACHING ANESTHESIOLOGISTS file code CMS-1502-P
Dear CMS,

The current Medicare teaching anesthesiologist payment rule (concurrency) 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. Presently, slots in anesthesiology residency programs are going unfilled because of an ill-conceived Medicare policy that shortchanges teaching programs, withholding 50% of their funds for concurrent cases. 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.

It is totally unfair that Medicare cuts our fee in half for concurrency when they do not cut the fee for any other medical specialty. 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 currently 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,

Tim VadeBoncouer, M.D.
Associate Professor of Clinical Anesthesiology
University of Illinois at Chicago College of Medicine
Chicago, IL

Submitter : Mr. Cornelius Hospers **Date:** 08/24/2005

Organization : Mr. Cornelius Hospers

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

I am a medicare subscriber residing in Santa Cruz County California. Medical costs have soared here in recent years but medicare reimbursements have not kept up with those increases. My wife and I have 'lost' excellent medical care providers who could no longer afford to live in this area. Living here is not a self-indulgence for us; I am a cardiac patient and our children and grandchildren reside here. We are dependent also on our jobs here in order to make ends meet. PLease raise the payment rates for Santa Cruz County.

Submitter : Richard Woodbury **Date:** 08/24/2005

Organization : Richard Woodbury

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

I am a citizen, and a taxpayer, and I live in the California County of Santa Cruz.It is my understanding the this county is presently classified as rural, and therefore considered to be less expensive for residents.

I can attest to the fact that this county has experienced a meteoric rise in the cost of housing leading to a recent suggestion in the local newspaper that to service a loan on a typical home today, one need to earn nearly $200,000 annually. New doctors may be appearing here, but they are not advertising available spaces in their day for Medicare patients.

What good is Medicare to its intended recipients if there are no doctors accepting patients? That is the status that is rapidly occuring in Santa Cruz County.

While classifying Santa Cruz County as urban may not immediately fix the problem, it would be a helpful step to correcting the current Medicare doctor drought.

Thank you, Richard Woodbury

Submitter : **Dr. Kevin Roberts** **Date: 08/24/2005**

Organization : **Albany Medical College**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

August 17, 2005

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

To Whom It May Concern:

I am the chairman of an academic Anesthesiology Department that has an anesthesiology residency program and cares for many Medicare and Medicaid recipients. Our residency program currently trains 20 residents in anesthesiology and the medicare policy with- holding 50% of the funds for concurrent cases short changes our teaching program and ultimately medicare recipients. It causes inefficiency in scheduling, personnel allocation, case assignments and budget short falls. In the current environment where there is a shortage of both anesthesiologists and nurse anesthetists these monetary short falls lead to artificially low salaries which results in my own department having three anesthesiology positions that we are unable to fill.

Ultimately, academic anesthesia departments are responsible not only for the education of medical students and residents in anesthesiology, but also research and one of the first missions that suffers is academic research in anesthesiology since scarce resources are first directed to patient care services. It is unfair and unreasonable that a surgeon may supervise residents in two over lapping operations and collect 100% of the fee in each case from Medicare, and that an internist may supervise a resident in four overlapping out-patient visits and collect 100% of the fee for each when certain requirements are met, while an anesthesiologist will only collect 50% of the Medicare fee if she or he supervises in two overlapping cases.

While the medicare conversion factor reimburses surgeons and internists at approximately 80% of the currently prevailing commercial rates, the Medicare anesthesia conversion factor is only 40% of those commercial rates and reducing that by a further 50% for teaching anesthesiologist concurrence results in revenue grossly inadequate to sustain the service, teaching and research missions of academic anesthesia training programs.

In my own department the cost of delivering a unit of anesthesia is approximately $36.00 and the medicare conversion factor in the state of New York is approximately $17.00 while the Medicaid conversion factor is $10.00 per unit. Thus our budget short falls are compounded every time we care for a recipient of Medicare or Medicaid and extremely exacerbated when we care for a Medicare or Medicaid patient in concurrent cases.
As the elderly population grows the number of patients who are Medicare recipients also grows. Our anesthesia residents need training to care for this population. Patients with cerebral vascular disease, renal disease, coronary artery disease, and peripheral vascular disease are overwhelmingly Medicare recipients. The complex nature of these cases which involves specific expertise, complex and lengthy care compounds the financial loss incurred in caring for these patients. Many of the advancements in the care of the elderly surgical patients and the increased safety of the perioperative period has been the result of advances in anesthesiology care. Medicare must recognize that the future of the anesthesiology care of the elderly requires paying the teaching anesthesiologist on a par with their surgical colleagues.

Sincerely,

Kevin W. Roberts, MD
Professor & Chairman

Submitter : **Mrs. Bridget Smith** **Date: 08/24/2005**

Organization : **Mrs. Bridget Smith**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

GPCIs

Please change the Medicare designation for Santa Cruz. We are no longer a rural area. In fact the cost of buying a house is more expensive than almost anywhere else in the state. Doctors are leaving our area because it is too expensive to practice here. It's a beautiful place to live, and even a small change would give Dr's incentive to continue their practices here. Older adults in Santa Cruz need access to health care!

Thank you,

Bridget Smith
Mother of three, Daughter of two older parents who need affordable health care
Santa Cruz, Ca

Submitter : Lee/Emily Duffus **Date:** 08/24/2005

Organization : Lee/Emily Duffus

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

We SUPPORT the proposed change in Medicare reimbursement for physicians practicing in Santa Cruz County (CA). A change in categorization of the county from rural to urban is long overdue. The cost of living in this area mirrors that of the greater San Francisco/San Jose/Silicon Valley Area. Dozens of medical practitioners have left our area because they cannot afford to maintain practices here. A change in the classification will help mitigate this problem. Thank you.

Submitter : **Ms. Sharon Dirnberger** **Date: 08/24/2005**

Organization : **Ms. Sharon Dirnberger**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

Please update the status of Santa Cruz County to an urban designation. It is one of the most expensive places to live in the US; housing costs are exhorbitant. In the past 15 years I have had nine different primary care physicians; many moved away because they could not afford the cost of living here. Many local physicians are not accepting Medicare patients because of the low rate of reimbursement, leaving our elderly with fewer options for care. Santa Cruz County is not a rural community.

Submitter : Mrs. Sylvia Raffetto **Date:** 08/24/2005

Organization : Mrs. Sylvia Raffetto

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

I am a senior and read in the paper this morning that doctors in Santa Cruz area are paid 50% of the their costs per patient by Medicare, where Santa Clara Valley doctors are paid 55%. It is important to realize that the cost of living here in Santa Cruz is the same and more (housing costs are higher) that Santa Clara Valley. I care about this since we lose young doctors from our system because they cannot afford to live in this area. As our older established doctors move on to retirement, we need good quality young doctors as replacements. Our older citizens (and there are many) need to have the same care available to them as those in other areas.

Submitter : Ms. Beth Balen **Date:** 08/24/2005

Organization : Anchorage Fracture and Orthopaedic Clinic

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

I would like to protest the proposed Medicare fee schedule reductions for casting supplies and for the technical component of multiple radiology procedures.

Casting supplies have become more and more expensive. For an orthopedic practice this cost is significant. Reimbursement for Medicare patients is already insufficient to cover overhead costs. If fracture care treatment must now also include the cost of the cast supplies, treatment of Medicare patient fractures in the non-facility environment will become prohibitively expensive. The ruling would encourage physicians to avoid handling Medicare patient fracture care in the office. This will result in increasing emergency room use, adding expense rather than savings to the Medicare program. The ruling may also encourage physicians, out of sheer survival demands, to use lower quality casting material, such as substituting plaster for fiberglass.

There is also a proposed rule that would reduce payments for the technical component of a second radiology procedure performed on the same patient by 50%. Apparently Medicare believes that most of the costs for the technical component of the charge are incurred in the first image, and that most labor activities and supplies are not furnished twice. I would point out that multiple images require multiple pieces of film and processing chemicals, which have the same cost as the initial piece. Film costs are significant. In addition, multiple views take additional staff time, and reduce the life of machines through the additional usage. It is unrealistic to say that there is little cost incurred for additional images.

I would like to encourage you not to take either of these steps. In Alaska it is becoming difficult to find physicians who will accept Medicare patients. These rules will only exacerbate that problem.

Beth A. Balen, FACMPE
Administrator, Anchorage Fracture & Orthopaedic Clinic
907-261-7135

Submitter : Dalton Cantey **Date:** 08/24/2005

Organization : Dalton Cantey

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

GPCIs. I support the change in rules that would increase payments to Doctors and other medical practitioners in Santa Cruz County, California so that they are on a level with payments made in neighboring Santa Clara County and other California Bay Area jurisdictions. I just found a good young physician in Santa Cruz County that takes medicare patients. I have already lost him because he is relocating to another county because medicare payments are better there. Santa Cruz County is clearly no longer a "rural" county and the cost of living here is as high or higher than that in adjacent counties.

Submitter : Mrs. LILY KEPHART **Date:** 08/24/2005

Organization : Mrs. LILY KEPHART

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

Santa Cruz County is a very expensive place to live and our doctors should be reimbursed at the highest level. It has been difficult for our county to retain or attract doctors due to the high cost of living.

Submitter : Dr. Mark Lema **Date:** 08/24/2005

Organization : University at Buffalo, Dept of Anesthesiology

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

Re: CMS-1502-P Teaching Anesthesiologists

Dear Sir/Madam:

I was profoundly disappointed that CMS officials did not appreciate the deleterious impact that CMS-1502-P has caused academic medical centers with respect to this disparity in payment among physicians in surgical specialties. The current Medicare teaching anesthesiologist payment rule has been shown to be 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. At the University at Buffalo, we train 36 residents who fall victim to the inefficiencies in scheduling, personnel allocation, case assignments, and budget shortfalls that are directly attributed to the current Medicare teaching anesthesiologist policy. 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 and meet their mission goals. 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 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. Moreover, the Medicare anesthesia conversion factor is less that 40% of prevailing commercial rates. Reducing that lower payment by an additional 50% for teaching anesthesiologists results in revenue grossly inadequate to sustain the service, teaching and research missions of academic anesthesia training programs.

Anesthesiologists have made the delivery of anesthesia one of the safest medical practices in the nation. We have been cited by the Institute of Medicine as leading the way for patient safety reform. Ironically, if this rule is not changed, those programs that serve the sickest, poorest and oldest patients in our society will be forced to cut back or close their training sites reversing the century of progress made to reduce medical errors and deaths in the operating room.

Sincerely,
Mark J. Lema MD PhD
Professor and Chair of Anesthesiology
University at Buffalo
The State University of New York
Roswell Park Cancer Institute
Buffalo, NY 14263

Submitter : Jill Sakamoto **Date:** 08/24/2005

Organization : Jill Sakamoto

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

GPCIs
It is vital that Santa Cruz county no longer be designated as rural. The demographics and cost of living have drastically changed in the last few decades and our medical community has a difficult time surviving, which of course affects all residents. My very first question to my new doctor was "Do you plan on staying in Santa Cruz for awhile?"

Submitter : **Parmalee Taff** **Date: 08/24/2005**

Organization : **Individual**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

GPCIs

Please increase physician reimbursements for Santa Cruz county CA. Santa Cruz is decidely not "rural".

Submitter : Doug Urbanus **Date:** 08/24/2005

Organization : Doug Urbanus

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

It's quite apparent to a layman that the disparity caused by GPCI between reimbursements to physicians in Santa Cruz and Santa Clara counties have absolutely no basis in reality. Cost factors are similar. The housing affordability scale indeed makes Santa Cruz county more expensive than Santa Clara. And the turnover in young physicians who merely sojourn through Santa Cruz county speak directly to the inequity of the GPCI formula. Santa Cruz county has features that resemble a rural county, but they are largely geographic, historical and archaic. Please make the fee schedule fair and equitable, before patients are universally turned away.

Submitter : Dr. Robert Brown **Date:** 08/24/2005

Organization : Dr. Robert Brown

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

Dear Dr. McClellan:
I am writing to urge the Centers for Medicare and Medicaid Services (CMS) to change the Medicare anesthesiology teaching payment policy.

Medicare?s discriminatory payment arrangement, which applies only to anesthesiology teaching programs, has had a serious detrimental impact on the ability of programs to retain skilled faculty and to train the new anesthesiologists necessary to help alleviate the widely-acknowledged shortage of anesthesia providers -- a shortage that will be exacerbated in coming years by the aging of the baby boom generation and their need for surgical services.

Under current Medicare regulations, teaching surgeons and even internists are permitted to work with residents on overlapping cases and receive full payment so long as the teacher is present for critical or key portions of the procedure. Teaching surgeons may bill Medicare for full reimbursement for each of the two procedures in which he or she is involved. An internist my supervise residents in four overlapping office visits and collect 100% of the fee when certain requirements are met.

Teaching anesthesiologists are also permitted to work with residents on overlapping cases so long as they are present for critical or key portions of the procedure. However, unlike teaching surgeons and internists, since 1995 the teaching anesthesiologists who work with residents on overlapping cases face a discriminatory payment penalty for each case. The Medicare payment for each case is reduced 50%. This penalty is not fair, and it is not reasonable.

Correcting this inequity will go a long way toward assuring the application of Medicare?s teaching payment rules consistently across medical specialties and toward assuring that anesthesiology teaching is reimbursed on par with other teaching physicians.

Please end the anesthesiology teaching payment penalty.

Submitter : **Dr. Roxann Barnes** **Date: 08/24/2005**

Organization : **Mayo Clinic**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Mark McClellan, M.D., Ph.D.
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attn: CMS-1502-P/TEACHING ANESTHESIOLOGISTS
P.O. Box 8017
Baltimore, MD 21244-8017
Dear Dr. McClellan:
I am writing to urge the Centers for Medicare and Medicaid Services (CMS) to change the Medicare anesthesiology teaching payment policy.
Medicare?s discriminatory payment arrangement, which applies only to anesthesiology teaching programs, has had a serious detrimental impact on the ability of programs to retain skilled faculty and to train the new anesthesiologists necessary to help alleviate the widely-acknowledged shortage of anesthesia providers -- a shortage that will be exacerbated in coming years by the aging of the baby boom generation and their need for surgical services.
Under current Medicare regulations, teaching surgeons and even internists are permitted to work with residents on overlapping cases and receive full payment so long as the teacher is present for critical or key portions of the procedure. Teaching surgeons may bill Medicare for full reimbursement for each of the two procedures in which he or she is involved. An internist my supervise residents in four overlapping office visits and collect 100% of the fee when certain requirements are met.
Teaching anesthesiologists are also permitted to work with residents on overlapping cases so long as they are present for critical or key portions of the procedure. However, unlike teaching surgeons and internists, since 1995 the teaching anesthesiologists who work with residents on overlapping cases face a discriminatory payment penalty for each case. The Medicare payment for each case is reduced 50%. This penalty is not fair, and it is not reasonable.
Correcting this inequity will go a long way toward assuring the application of Medicare?s teaching payment rules consistently across medical specialties and toward assuring that anesthesiology teaching is reimbursed on par with other teaching physicians.
Please end the anesthesiology teaching payment penalty.
Name__Roxann D. Barnes, M.D.___Address _1322 19th Ave. SW Rochester, MN 55902

Submitter : **Dr. matthew doane** **Date: 08/24/2005**

Organization : **columbia presbyterian hospital**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Mark McClellan, M.D., Ph.D.
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attn: CMS-1502-P/TEACHING ANESTHESIOLOGISTS
P.O. Box 8017
Baltimore, MD 21244-8017
Dear Dr. McClellan:
I am writing to urge the Centers for Medicare and Medicaid Services (CMS) to change the Medicare anesthesiology teaching payment policy.
Medicare?s discriminatory payment arrangement, which applies only to anesthesiology teaching programs, has had a serious detrimental impact on the ability of programs to retain skilled faculty and to train the new anesthesiologists necessary to help alleviate the widely-acknowledged shortage of anesthesia providers -- a shortage that will be exacerbated in coming years by the aging of the baby boom generation and their need for surgical services.
Under current Medicare regulations, teaching surgeons and even internists are permitted to work with residents on overlapping cases and receive full payment so long as the teacher is present for critical or key portions of the procedure. Teaching surgeons may bill Medicare for full reimbursement for each of the two procedures in which he or she is involved. An internist my supervise residents in four overlapping office visits and collect 100% of the fee when certain requirements are met.
Teaching anesthesiologists are also permitted to work with residents on overlapping cases so long as they are present for critical or key portions of the procedure. However, unlike teaching surgeons and internists, since 1995 the teaching anesthesiologists who work with residents on overlapping cases face a discriminatory payment penalty for each case. The Medicare payment for each case is reduced 50%. This penalty is not fair, and it is not reasonable.
Correcting this inequity will go a long way toward assuring the application of Medicare?s teaching payment rules consistently across medical specialties and toward assuring that anesthesiology teaching is reimbursed on par with other teaching physicians.
Please end the anesthesiology teaching payment penalty.
Name___M.A Doane M.D._____
Address __30 W63rd st NY, NY 10023_____

Submitter : Harry N Lalor **Date:** 08/24/2005

Organization : Harry N Lalor

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

GPCI

As a recent resident of Santa Cruz County I have experienced the difficulty in obtaining a local physician. For two years I had to travel 50 miles back to Santa Clara County because every local doctor I contacted said they were not taking any new medicare patients.
Designating Santa Cruz County an Urban area would go a long way in improving Medical access to Seniors in the County and I urge your favorable consideration of this revision.

Submitter : **Dr. Tracie Saunders** **Date: 08/24/2005**

Organization : **SUNY @ Stony Brook**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Mark McClellan, M.D., Ph.D.
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attn: CMS-1502-P/TEACHING ANESTHESIOLOGISTS
P.O. Box 8017
Baltimore, MD 21244-8017
Dear Dr. McClellan:
I am writing to urge the Centers for Medicare and Medicaid Services (CMS) to change the Medicare anesthesiology teaching payment policy.
Medicare?s discriminatory payment arrangement, which applies only to anesthesiology teaching programs, has had a serious detrimental impact on the ability of programs to retain skilled faculty and to train the new anesthesiologists necessary to help alleviate the widely-acknowledged shortage of anesthesia providers -- a shortage that will be exacerbated in coming years by the aging of the baby boom generation and their need for surgical services.
Under current Medicare regulations, teaching surgeons and even internists are permitted to work with residents on overlapping cases and receive full payment so long as the teacher is present for critical or key portions of the procedure. Teaching surgeons may bill Medicare for full reimbursement for each of the two procedures in which he or she is involved. An internist my supervise residents in four overlapping office visits and collect 100% of the fee when certain requirements are met.
Teaching anesthesiologists are also permitted to work with residents on overlapping cases so long as they are present for critical or key portions of the procedure. However, unlike teaching surgeons and internists, since 1995 the teaching anesthesiologists who work with residents on overlapping cases face a discriminatory payment penalty for each case. The Medicare payment for each case is reduced 50%. This penalty is not fair, and it is not reasonable.
Correcting this inequity will go a long way toward assuring the application of Medicare?s teaching payment rules consistently across medical specialties and toward assuring that anesthesiology teaching is reimbursed on par with other teaching physicians.
Please do the right thing end the anesthesiology teaching payment penalty.
Thank you very much for your time and attention to this matter.
Name: Tracie A. Saunders, MD
Address: 8 Timber Ridge Court, Coram, NY 11727

Submitter : Dr. Max Kelz **Date:** 08/24/2005

Organization : University of Pennsylvania

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

Mark McClellan, M.D., Ph.D.
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attn: CMS-1502-P/TEACHING ANESTHESIOLOGISTS
P.O. Box 8017
Baltimore, MD 21244-8017

Dear Dr. McClellan:

I am writing to urge the Centers for Medicare and Medicaid Services (CMS) to change the Medicare anesthesiology teaching payment policy. Medicare?s discriminatory payment arrangement, which applies only to anesthesiology teaching programs, has had a serious detrimental impact on the ability of programs to retain skilled faculty and to train the new anesthesiologists necessary to help alleviate the widely-acknowledged shortage of anesthesia providers -- a shortage that will be exacerbated in coming years by the aging of the baby boom generation and their need for surgical services.

Under current Medicare regulations, teaching surgeons and even internists are permitted to work with residents on overlapping cases and receive full payment so long as the teacher is present for critical or key portions of the procedure. Teaching surgeons may bill Medicare for full reimbursement for each of the two procedures in which he or she is involved. An internist my supervise residents in four overlapping office visits and collect 100% of the fee when certain requirements are met.

Teaching anesthesiologists are also permitted to work with residents on overlapping cases so long as they are present for critical or key portions of the procedure. However, unlike teaching surgeons and internists, since 1995 the teaching anesthesiologists who work with residents on overlapping cases face a discriminatory payment penalty for each case. The Medicare payment for each case is reduced 50%. This penalty is not fair, and it is not reasonable.

Correcting this inequity will go a long way toward assuring the application of Medicare?s teaching payment rules consistently across medical specialties and toward assuring that anesthesiology teaching is reimbursed on par with other teaching physicians. Please end the anesthesiology teaching payment penalty.

Sincerely,

Max B. Kelz, MD PhD
Assistant Professor
Department of Anesthesiology and Critical Care
University of Pennsylvania, School of Medicine
3620 Hamilton Walk, 334 John Morgan building
Philadelphia, PA 19104

Submitter : Dr. Matthew McEvoy **Date:** 08/24/2005

Organization : Medical Univerity of South Carolina

Category : Health Care Professional or Association

Issue Areas/Comments

GENERAL

GENERAL

see attachment

CMS-1502-P-169-Attach-1.DOC

August 24, 2005

To Whom It May Concern:

I am writing to you concerning the issue of inadequate repayment for anesthesia services to academic anesthesiologists. The current rule is that I can only bill for 50% of the services rendered in two concurrent cases while supervising residents. However, my surgical colleagues are able to bill for 100% of surgical services in two concurrent cases when supervising residents. Thus, there is a grave discrepancy in this system that is unfair to anesthesiologists.

Furthermore, I see this issue as having far-reaching effects that will greatly affect patients and providers. Medicare currently comprises a large part of any academic anesthesiologist's practice. The current repayment rate by Medicare is roughly 40% of that of commercial insurance. Thus, the current payment and billing schedule by Medicare makes competing with the private sector difficult. This has resulted, and will continue to result, in difficulties in recruiting excellent faculty to care for these patients. Furthermore, it makes the support of non-clinical activities, namely teaching and research, very difficult, as the salary support to provide this time is very slim.

I am a junior clinician-researcher and the current repayment schedule makes it very difficult to allow me to have the time needed to support research endeavors that will improve patient safety and outcomes in anesthesia. I know that this is true for scores of my colleagues as well. Thus, this is not a ploy to rob the system, but rather a plea that you would vote to right the inequity in the Medicare repayment system and a plea that you would vote for the future of patient safety and medical research.

Thank you for your time and consideration.

Sincerely,

Matthew D. McEvoy, MD
mcevoymd@musc.edu

Submitter : Dr. JANET CHEN **Date:** 08/24/2005

Organization : UCSF DEPT OF ANESTHESIA/PERIOPERATIVE CARE

Category : Health Care Professional or Association

Issue Areas/Comments

GENERAL

GENERAL

see attachment

CMS-1502-P-170-Attach-1.DOC

Mark McClellan, M.D., Ph.D.
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attn: CMS-1502-P/TEACHING ANESTHESIOLOGISTS
P.O. Box 8017
Baltimore, MD 21244-8017

Dear Dr. McClellan:

I am a 3rd year anesthesia resident at UCSF. I am writing to urge the Centers for Medicare and Medicaid Services (CMS) to change the Medicare anesthesiology teaching payment policy.

As a resident, I know the level of care and attention that each patient receives, regardless of whether there are overlapping cases or not. Patients in our teaching program all receive the highest quality care we can give. Our attendings work doubly hard to ensure that resident are monitoring and treating the patient equally or BETTER than if an attending alone were caring for the patient.

Anesthesia departments at academic centers already have a very difficult time retaining new attendings. The reimbursement contrast between academics and private practice is already outstanding. In the last year alone at our department, we have had at least 8 attendings leave, most of whom mentioned financial aspects as an important factor.

Medicare's discriminatory payment arrangement, which applies only to anesthesiology teaching programs, has had a serious detrimental impact on the ability of programs to retain skilled faculty and to train the new anesthesiologists necessary to help alleviate the widely-acknowledged shortage of anesthesia providers -- a shortage that will be exacerbated in coming years by the aging of the baby boom generation and their need for surgical services.

Under current Medicare regulations, teaching surgeons and even internists are permitted to work with residents on overlapping cases and receive full payment so long as the teacher is present for critical or key portions of the procedure. Teaching surgeons may bill Medicare for full reimbursement for each of the two procedures in which he or she is involved. An internist my supervise residents in four overlapping office visits and collect 100% of the fee when certain requirements are met.

Teaching anesthesiologists are also permitted to work with residents on overlapping cases so long as they are present for critical or key portions of the procedure. However, unlike teaching surgeons and internists, since 1995 the teaching anesthesiologists who work with residents on overlapping cases face a

discriminatory payment penalty for each case. The Medicare payment for each case is reduced 50%. This penalty is not fair, and it is not reasonable.

Correcting this inequity will go a long way toward assuring the application of Medicare's teaching payment rules consistently across medical specialties and toward assuring that anesthesiology teaching is reimbursed on par with other teaching physicians.

Please end the anesthesiology teaching payment penalty.

Name__Janet K. Chen M.D._____

Address _1251 10th Ave #3 San Francisco, CA 94122_____

Submitter : Dr. David Eckmann **Date:** 08/24/2005

Organization : University of Pennsylvania

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

see attachment

CMS-1502-P-171-Attach-1.DOC

UNIVERSITY OF
PENNSYLVANIA
MEDICAL CENTER

David M. Eckmann, Ph.D., M.D.
Associate Professor of Anesthesiology and Critical Care,
Mechanical Engineering and Bioengineering
Member, Institute for Medicine and Engineering

September 1, 2005

Mark McClellan, M.D., Ph.D.
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attn: CMS-1502-P/TEACHING ANESTHESIOLOGISTS
P.O. Box 8017
Baltimore, MD 21244-8017

Dear Dr. McClellan:

I am writing to urge the Centers for Medicare and Medicaid Services (CMS) to change the Medicare anesthesiology teaching payment policy.

Medicare's discriminatory payment arrangement, which applies only to anesthesiology teaching programs, has had a serious detrimental impact on the ability of programs to retain skilled faculty and to train the new anesthesiologists necessary to help alleviate the widely-acknowledged shortage of anesthesia providers -- a shortage that will be exacerbated in coming years by the aging of the baby boom generation and their need for surgical services.

Under current Medicare regulations, teaching surgeons and even internists are permitted to work with residents on overlapping cases and receive *full payment* so long as the teacher is present for critical or key portions of the procedure. Teaching surgeons may bill Medicare for full reimbursement for each of the two procedures in which he or she is involved. An internist my supervise residents in four overlapping office visits and collect *100% of the fee* when certain requirements are met.

Teaching anesthesiologists are also permitted to work with residents on overlapping cases so long as they are present for critical or key portions of the procedure. However, unlike teaching surgeons and internists, since 1995 the teaching anesthesiologists who work with residents on overlapping cases face a discriminatory payment penalty for each case. The Medicare payment for each case is reduced 50%. This penalty is not fair, and it is not reasonable.

Correcting this inequity will go a long way toward assuring the application of Medicare's teaching payment rules consistently across medical specialties and toward assuring that anesthesiology teaching is reimbursed on par with other teaching physicians.

Please end the anesthesiology teaching payment penalty.

Sincerely,

David M. Eckmann, Ph.D., M.D.

3400 Spruce Street • Anesthesia – HUP • Philadelphia, PA 19104-4283 • 215-349-5348 • FAX 215-349-5078 • eckmanndm@uphs.upenn.edu

Submitter : Dr. DANNY WILKERSON **Date:** 08/24/2005

Organization : UNIVERSITY OF ARKANSAS FOR MEDICAL SCIENCES

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

Mark McClellan, M.D., Ph.D.
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attn: CMS-1502-P/TEACHING ANESTHESIOLOGISTS
P.O. Box 8017
Baltimore, MD 21244-8017
Dear Dr. McClellan:
I am writing to urge the Centers for Medicare and Medicaid Services (CMS) to change the Medicare anesthesiology teaching payment policy.
Medicare?s discriminatory payment arrangement, which applies only to anesthesiology teaching programs, has had a serious detrimental impact on the ability of programs to retain skilled faculty and to train the new anesthesiologists necessary to help alleviate the widely-acknowledged shortage of anesthesia providers -- a shortage that will be exacerbated in coming years by the aging of the baby boom generation and their need for surgical services.
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Correcting this inequity will go a long way toward assuring the application of Medicare?s teaching payment rules consistently across medical specialties and toward assuring that anesthesiology teaching is reimbursed on par with other teaching physicians.
Please end the anesthesiology teaching payment penalty.
Name_____Danny Wilkerson, M.D._____
Address ___UAMS
4301 W. Markham St. Slot 515
Little Rock, AR. 72205_____

Submitter : Dr. Bernard Pygon **Date:** 08/24/2005

Organization : American Society of Anesthesiologists

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

Mark McClellan, M.D., Ph.D.
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attn: CMS-1502-P/TEACHING ANESTHESIOLOGISTS
P.O. Box 8017
Baltimore, MD 21244-8017
Dear Dr. McClellan:
I am writing to urge the Centers for Medicare and Medicaid Services (CMS) to change the Medicare anesthesiology teaching payment policy.
Medicare?s discriminatory payment arrangement, which applies only to anesthesiology teaching programs, has had a serious detrimental impact on the ability of programs to retain skilled faculty and to train the new anesthesiologists necessary to help alleviate the widely-acknowledged shortage of anesthesia providers -- a shortage that will be exacerbated in coming years by the aging of the baby boom generation and their need for surgical services.
Under current Medicare regulations, teaching surgeons and even internists are permitted to work with residents on overlapping cases and receive full payment so long as the teacher is present for critical or key portions of the procedure. Teaching surgeons may bill Medicare for full reimbursement for each of the two procedures in which he or she is involved. An internist my supervise residents in four overlapping office visits and collect 100% of the fee when certain requirements are met.
Teaching anesthesiologists are also permitted to work with residents on overlapping cases so long as they are present for critical or key portions of the procedure. However, unlike teaching surgeons and internists, since 1995 the teaching anesthesiologists who work with residents on overlapping cases face a discriminatory payment penalty for each case. The Medicare payment for each case is reduced 50%. This penalty is not fair, and it is not reasonable.
I work at a large urban university medical center. Medicare is one of our three largest payers. This inequitable and discriminatory rule coupled with further proposed cuts in the already low Medicare reimbursement for anesthesiology services threaten the viability of our department. 10% our department has resigned this year already and taken other jobs. Recruitment of new academic anesthesiologists continues to be a challenge that threatens the access to future health care for everyone. Please correct this obvious wrong.
Correcting this inequity will go a long way toward assuring the application of Medicare?s teaching payment rules consistently across medical specialties and toward assuring that anesthesiology teaching is reimbursed on par with other teaching physicians.
Please end the anesthesiology teaching payment penalty.
Bernard Pygon, M.D.
969 S. Hillside Ave, Elmhurst, Illinois, 60126

Submitter : Dr. Matthew Weinger **Date:** 08/24/2005

Organization : Vanderbilt University Medical Center

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

Dear Dr. McClellan:

I am writing to urge the Centers for Medicare and Medicaid Services (CMS) to change the Medicare anesthesiology teaching payment policy.

Medicare?s discriminatory payment arrangement, which applies only to anesthesiology teaching programs, has had a serious detrimental impact on the ability of programs to retain skilled faculty and to train the new anesthesiologists necessary to help alleviate the widely-acknowledged shortage of anesthesia providers -- a shortage that will be exacerbated in coming years by the aging of the baby boom generation and their need for surgical services.

Since this rule went into effect, I have personally observed a steady stream of outstanding clinician educators leave academic anesthesiology because our Department could not earn enough clinical income to pay the faculty who supervise residents a salary competitive with private practice. Moreover, we have been unable to recruit and retain most of the best and brightest graduating residents to teach future generations.

Under current Medicare regulations, teaching surgeons and even internists are permitted to work with residents on overlapping cases and receive full payment so long as the teacher is present for critical or key portions of the procedure. Teaching surgeons may bill Medicare for full reimbursement for each of the two procedures in which he or she is involved. An internist may supervise residents in four overlapping office visits and collect 100% of the fee when certain requirements are met.

Teaching anesthesiologists are also permitted to work with residents on overlapping cases so long as they are present for critical or key portions of the procedure. However, unlike teaching surgeons and internists, since 1995 the teaching anesthesiologists who work with residents on overlapping cases face a discriminatory payment penalty for each case. The Medicare payment for each case is reduced 50%.

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

Correcting this inequity will go a long way toward assuring the application of Medicare?s teaching payment rules consistently across medical specialties and toward assuring that anesthesiology teaching is reimbursed on par with other teaching physicians.

Thank you for giving this important issue your full and careful consideration.

Sincerely,
Matthew B. Weinger, MD
Professor of Anesthesiology and Medical Education
Vanderbilt University

Submitter : Dr. Lori Conklin **Date:** 08/24/2005

Organization : Baylor College of Medicine

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1502-P-175-Attach-1.DOC

Mark McClellan, M.D., Ph.D.
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attn: CMS-1502-P/TEACHING ANESTHESIOLOGISTS
P.O. Box 8017
Baltimore, MD 21244-8017

Dear Dr. McClellan:

I am writing to urge the Centers for Medicare and Medicaid Services (CMS) to change the Medicare anesthesiology teaching payment policy.

Medicare's discriminatory payment arrangement, which applies only to anesthesiology teaching programs, has had a serious detrimental impact on the ability of programs to retain skilled faculty and to train the new anesthesiologists necessary to help alleviate the widely-acknowledged shortage of anesthesia providers -- a shortage that will be exacerbated in coming years by the aging of the baby boom generation and their need for surgical services.

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Teaching anesthesiologists are also permitted to work with residents on overlapping cases so long as they are present for critical or key portions of the procedure. However, unlike teaching surgeons and internists, since 1995 the teaching anesthesiologists who work with residents on overlapping cases face a discriminatory payment penalty for each case. The Medicare payment for each case is reduced 50%. This penalty is not fair, and it is not reasonable.

Correcting this inequity will go a long way toward assuring the application of Medicare's teaching payment rules consistently across medical specialties and toward assuring that anesthesiology teaching is reimbursed on par with other teaching physicians.

Please end the anesthesiology teaching payment penalty.

Name: Lori D. Conklin, M.D.

Address: 1122 St. John Drive, Pearland, TX 77584

Submitter : Dr. Tod Sloan **Date:** 08/24/2005

Organization : Colorado Anesthesiology Teaching Faculty

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

8-23-2005

Mark McClellan, M.D., Ph.D.
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attn: CMS-1502-P/TEACHING ANESTHESIOLOGISTS
P.O. Box 8017
Baltimore, MD 21244-8017

RE: Attn: CMS-1502-P/TEACHING ANESTHESIOLOGISTS
Dear Dr. McClellan:
I am writing to urge the Centers for Medicare and Medicaid Services (CMS) to change the Medicare anesthesiology teaching payment policy.
I have been in academic anesthesiology for over 25 years and have observed a steady decline in reimbursement such that the viability of many training programs is threatened. The reduced reimbursement makes it difficult or impossible to recruit and retain qualified anesthesiology teachers such that our ability to teach medical trainees (MDs) and nurses (CRNA?s) will continue to decline. As such, the current shortage of anesthesiology caregivers will worsen and threaten our country?s ability to provide care.
Medicare?s discriminatory payment arrangement, which applies only to anesthesiology teaching programs, has had a serious detrimental impact on the ability of programs to retain skilled faculty and to train the new anesthesiologists necessary to help alleviate the widely-acknowledged shortage of anesthesia providers -- a shortage that will be exacerbated in coming years by the aging of the baby boom generation and their need for surgical services.
Under current Medicare regulations, teaching surgeons and even internists are permitted to work with residents on overlapping cases and receive full payment so long as the teacher is present for critical or key portions of the procedure. Teaching surgeons may bill Medicare for full reimbursement for each of the two procedures in which he or she is involved. An internist my supervise residents in four overlapping office visits and collect 100% of the fee when certain requirements are met. There is no clear reason why this should be different for Anesthesiology.
Teaching anesthesiologists are also permitted to work with residents on overlapping cases so long as they are present for critical or key portions of the procedure. However, unlike teaching surgeons and internists, since 1995 the teaching anesthesiologists who work with residents on overlapping cases face a discriminatory payment penalty for each case. The Medicare payment for each case is reduced 50%. This penalty is not fair, is not reasonable and it threatens the viability of our ability to train Anesthesiology physicians and CRNA?s for future patient care.
Correcting this inequity will go a long way toward assuring the application of Medicare?s teaching payment rules consistently across medical specialties and toward assuring that anesthesiology teaching is reimbursed on par with other teaching physicians.
Please end the anesthesiology teaching payment penalty.
Tod Sloan MD
12123 Briar Leaf Ct., Parker, CO 80138

Submitter : Dr. William Merritt **Date:** 08/24/2005

Organization : Johns Hopkins

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

Mark McClellan, M.D., Ph.D.
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attn: CMS-1502-P/TEACHING ANESTHESIOLOGISTS
P.O. Box 8017
Baltimore, MD 21244-8017
Dear Dr. McClellan:

As an academic anesthesiologist, I am writing to urge the Centers for Medicare and Medicaid Services (CMS) to change the Medicare anesthesiology resident teaching payment policy.
Medicare?s discriminatory payment arrangement, which applies only to anesthesiology teaching programs, has had a serious detrimental impact on the ability of programs to retain skilled faculty and to train the new anesthesiologists necessary to help alleviate the widely-acknowledged shortage of anesthesia providers -- a shortage that will be exacerbated in coming years by the aging of the baby boom generation and their need for additional and potentially more sophisticated surgical services.
Under current Medicare regulations, teaching surgeons and even internists are permitted to work with residents on overlapping cases and receive full payment so long as the teacher is present for critical or key portions of the procedure. Teaching surgeons may bill Medicare for full reimbursement for each of the two procedures in which he or she is involved. An internist my supervise residents in four overlapping office visits and collect 100% of the fee when certain requirements are met. Teaching anesthesiologists are also permitted to work with residents on overlapping cases so long as they are present for critical or key portions of the procedure. However, unlike teaching surgeons and internists, since 1995 the teaching anesthesiologists who work with residents on overlapping cases face a discriminatory payment penalty for each case. The Medicare payment for each case is reduced 50%. This penalty is not fair, and it is not reasonable.
Correcting this inequity will go a long way toward assuring the application of Medicare?s teaching payment rules consistently across medical specialties and toward assuring that anesthesiology teaching is reimbursed on par with other teaching physicians.
Please end the anesthesiology teaching payment penalty.
William T. Merritt, MD, MBA
Department of Anesthesiology
Johns Hopkins Hospital
Baltimore, MD.

Submitter : Dr. Ram Ravindran **Date:** 08/24/2005

Organization : Wishard Anesthesia Group

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

See attachment

CMS-1502-P-178-Attach-1.DOC

Mark McClellan, M.D., Ph.D.
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attn: CMS-1502-P/TEACHING ANESTHESIOLOGISTS
P.O. Box 8017
Baltimore, MD 21244-8017

Dear Dr. McClellan:

I am writing to urge the Centers for Medicare and Medicaid Services (CMS) to change the Medicare anesthesiology teaching payment policy.

Medicare's discriminatory payment arrangement, which applies only to anesthesiology teaching programs, has had a serious detrimental impact on the ability of programs to retain skilled faculty and to train the new anesthesiologists necessary to help alleviate the widely-acknowledged shortage of anesthesia providers -- a shortage that will be exacerbated in coming years by the aging of the baby boom generation and their need for surgical services.

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Teaching anesthesiologists are also permitted to work with residents on overlapping cases so long as they are present for critical or key portions of the procedure. However, unlike teaching surgeons and internists, since 1995 the teaching anesthesiologists who work with residents on overlapping cases face a discriminatory payment penalty for each case. The Medicare payment for each case is reduced 50%. This penalty is not fair, and it is not reasonable.

Correcting this inequity will go a long way toward assuring the application of Medicare's teaching payment rules consistently across medical specialties and toward assuring that anesthesiology teaching is reimbursed on par with other teaching physicians.

Please end the anesthesiology teaching payment penalty.

Name____Ram S. Ravindran, M.D._

7731 Traders Cove Ln, Indianapolis, In 46254

Submitter : Dr. Jared Scott **Date:** 08/24/2005

Organization : KUMC -Wichita Dept. of Anesthesiology

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

Mark McClellan, M.D., Ph.D.
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attn: CMS-1502-P/TEACHING ANESTHESIOLOGISTS
P.O. Box 8017
Baltimore, MD 21244-8017

Dear Dr. McClellan:

I am writing to urge the Centers for Medicare and Medicaid Services (CMS) to change the Medicare anesthesiology teaching payment policy.

Medicare?s discriminatory payment arrangement, which applies only to anesthesiology teaching programs, has had a serious detrimental impact on the ability of programs to retain skilled faculty and to train the new anesthesiologists necessary to help alleviate the widely-acknowledged shortage of anesthesia providers -- a shortage that will be exacerbated in coming years by the aging of the baby boom generation and their need for surgical services.
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Teaching anesthesiologists are also permitted to work with residents on overlapping cases so long as they are present for critical or key portions of the procedure. However, unlike teaching surgeons and internists, since 1995 the teaching anesthesiologists who work with residents on overlapping cases face a discriminatory payment penalty for each case. The Medicare payment for each case is reduced 50%. This penalty is not fair, and it is not reasonable.
Correcting this inequity will go a long way toward assuring the application of Medicare?s teaching payment rules consistently across medical specialties and toward assuring that anesthesiology teaching is reimbursed on par with other teaching physicians.

This teaching payment inequity is a problem that is being seen more and more as new residents come into the picture and need the experience and expertise of an established Anesthesiologist. They are not receiving the training that they need because teaching faculty are not reimbursed for their time as other physician?s are. Would you spend time teaching and helping resident?s if the money was coming out of your pocket day after day. All we are asking that you do is make it fair. Teaching personnel should get the same reimbursement as other specialties. This will turn into a future problem as new, younger anesthesiologists are coming out into practice and have not received the training that they need because faculty are penalized for doing this.

Please end the anesthesiology teaching payment penalty.

Name Jared Scott M.D.
Address 2724 Beacon Hill Ct.
Wichita, KS 67220

Submitter : Dr. Howard Trachtenberg **Date:** 08/24/2005

Organization : Dr. Howard Trachtenberg

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

I am writing you as a retired Chairman of a large anesthesia teaching program, to ask that you contact the Centers for Medicare and Medicaid Services (CMS) and urge a change in payment policy for teaching anesthesiologists. This is a critical issue for all teaching departments which are essential to maintain the high level of care for all citizens and expecially for the elderly, of which I am one.

The current Medicare ?Teaching Anesthesiologist? payment rule is unwise, unfair and unsustainable. Right now, slots in anesthesiology residency programs are going unfilled because of ill-conceived Medicare policy that shortchanges. Anesthesiology teaching programsare suffering severe economic losses that cannot be absorbed elsewhere. Academic research in anesthesiology is also impaired, 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.

Submitter :

Date: 08/24/2005

Organization :

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1502-P

Re: GPCIs

I understand that Medicare is proposing to create a new payment locality in Sonoma County, which is an increasingly expensive place to live and work. In the new locality, the Medicare reimbursement rate would be more closely matched to actual practice expenses than it is now.

The new locality would help Sonoma County physicians improve the quantity and quality of care they deliver to Medicare beneficiaries and other patients. The locality change would also benefit efforts to recruit and retain physicians in the county, which has a large Medicare population.

I fully support your proposal to change Sonoma County's payment locality, and I appreciate the opportunity to comment on this important issue.

Sincerely,

Michael Arendt
804 Fourth Street
Santa Rosa, CA 95404

Submitter : Dr. Jonathan Moss **Date:** 08/24/2005

Organization : University of Chicago

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

I have been a teaching physician for 30 years. I am disheartened by the failure to recognize my role in providing care and teaching by allowing 100% of the Medicare fee for each of two overlapping procedures involving resident physicians. I believe your failure to allow this will lead to a significant deterioration in care over time. I urge you to consider the long term consequences of failing to provide fair treatment to teaching anesthesiologists.

Submitter : **Dr. Adam Wendling** **Date: 08/24/2005**

Organization : **University of Florida**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

To Whom It May Concern:

I am writing to urge the Centers for Medicare and Medicaid Services (CMS) to change the Medicare anesthesiology teaching payment policy. Medicare's discriminatory payment arrangement, which applies only to anesthesiology teaching programs, has had a serious detrimental impact on the ability of programs to retain skilled faculty and to train the new anesthesiologists necessary to help alleviate the widely-acknowledged shortage of anesthesia providers -- a shortage that will be exacerbated in coming years by the aging of the baby boom generation and their need for surgical services.

Under current Medicare regulations, teaching surgeons and even internists are permitted to work with residents on overlapping cases and receive full payment so long as the teacher is present for critical or key portions of the procedure. Teaching surgeons may bill Medicare for full reimbursement for each of the two procedures in which he or she is involved. An internist my supervise residents in four overlapping office visits and collect 100% of the fee when certain requirements are met.

Teaching anesthesiologists are also permitted to work with residents on overlapping cases so long as they are present for critical or key portions of the procedure. However, unlike teaching surgeons and internists, since 1995 the teaching anesthesiologists who work with residents on overlapping cases face a discriminatory payment penalty for each case. The Medicare payment for each case is reduced 50%. This penalty is not fair, and it is not reasonable.
Correcting this inequity will go a long way toward assuring the application of Medicare?s teaching payment rules consistently across medical specialties and toward assuring that anesthesiology teaching is reimbursed on par with other teaching physicians.

Please end the anesthesiology teaching payment penalty.

Adam Wendling, MD
Department of Anesthesiology, University of Florida
PO Box 100254
Gainesville, Florida 32610

Submitter : Dr. Ruth Winter **Date:** 08/24/2005

Organization : Dr. Ruth Winter

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

Mark McClellan, M.D., Ph.D.
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attn: CMS-1502-P/TEACHING ANESTHESIOLOGISTS
P.O. Box 8017
Baltimore, MD 21244-8017
Dear Dr. McClellan:
I am writing to urge the Centers for Medicare and Medicaid Services (CMS) to change the Medicare anesthesiology teaching payment policy.
Medicare?s discriminatory payment arrangement, which applies only to anesthesiology teaching programs, has had a serious detrimental impact on the ability of programs to retain skilled faculty and to train the new anesthesiologists necessary to help alleviate the widely-acknowledged shortage of anesthesia providers -- a shortage that will be exacerbated in coming years by the aging of the baby boom generation and their need for surgical services.
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Correcting this inequity will go a long way toward assuring the application of Medicare?s teaching payment rules consistently across medical specialties and toward assuring that anesthesiology teaching is reimbursed on par with other teaching physicians.
Please end the anesthesiology teaching payment penalty.
Name: Ruth R. Winter, M.D.
Address _University of Michigan Medical Center
Department of Anesthesiology Box 0049
1500 E. Medical Center Drive
Ann Arbor, MI 48109

Submitter : Dr. Jeffrey Galinkin **Date:** 08/24/2005

Organization : The Children's Hospital, Devner

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

Mark McClellan, M.D., Ph.D.
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attn: CMS-1502-P/TEACHING ANESTHESIOLOGISTS
P.O. Box 8017
Baltimore, MD 21244-8017
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Correcting this inequity will go a long way toward assuring the application of Medicare?s teaching payment rules consistently across medical specialties and toward assuring that anesthesiology teaching is reimbursed on par with other teaching physicians.
Please end the anesthesiology teaching payment penalty.

Sincerely,
Jeffrey L. Galinkin MD,FAAP
Associate Professor of Anesthesiology
Director of Research, Department of Anesthesia
The Children's Hospital
1056 E. 19th Ave,B090
Denver, Colorado 80218

Submitter : Dr. Scott Schartel **Date:** 08/24/2005

Organization : Dr. Scott Schartel

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

Mark McClellan, M.D., Ph.D.
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attn: CMS-1502-P/TEACHING ANESTHESIOLOGISTS
P.O. Box 8017
Baltimore, MD 21244-8017

Dear Dr. McClellan:

As the program director of an urban anesthesiology residency, I am writing to urge the Centers for Medicare and Medicaid Services (CMS) to change the Medicare anesthesiology teaching payment policy.
Medicare?s discriminatory payment arrangement, which applies only to anesthesiology teaching programs, has had a serious detrimental impact on the ability of programs to retain skilled faculty and to train the new anesthesiologists necessary to help alleviate the widely-acknowledged shortage of anesthesia providers -- a shortage that will be exacerbated in coming years by the aging of the baby boom generation and their need for surgical services.
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Correcting this inequity will go a long way toward assuring the application of Medicare?s teaching payment rules consistently across medical specialties and toward assuring that anesthesiology teaching is reimbursed on par with other teaching physicians.

Please end the anesthesiology teaching payment penalty.

Very truly yours,

Scott A. Schartel, DO
Professor & Associate Chair for Education
Department of Anesthesiology
Temple University
3401 N. Broad St.
Philadlephia, PA 19140
e-mail: schartel@temple.edu

Submitter : Mrs. Sybille Miller **Date:** 08/24/2005

Organization : Century 21 Award Real estate

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

GPCI

It is very important that the amount of reimbursement received by Physicians in Santa Cruz be increased. The cost of living in Santa Cruz has increased tremendously and to attract young doctors to stay in our community they need to get more money. We need to be level with neighboring counties at least. I would also like to encourage Medicare to work on a different way to fund the reimbursement...our aging population demands it.

Sincerely,

Sybille Miller

Submitter : Dr. Andranik Ovassapian **Date:** 08/24/2005

Organization : American Society of Anesthesiologists

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

See attachment

CMS-1502-P-188-Attach-1.DOC

CMS-1502-P-188-Attach-2.DOC

CMS-1502-P-188-Attach-3.DOC

CMS-1502-P-188-Attach-4.DOC

Mark McClellan, M.D., Ph.D.
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attn: CMS-1502-P/TEACHING ANESTHESIOLOGISTS
P.O. Box 8017
Baltimore, MD 21244-8017

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Correcting this inequity will go a long way toward assuring the application of Medicare's teaching payment rules consistently across medical specialties and toward assuring that anesthesiology teaching is reimbursed on par with other teaching physicians.

It is hard to understand why surgeons and internists can bill for all simultaneous services that they provide but not the anesthesiologists. I don't see the logic for this rule. Please, do your best to correct this discriminatory rule.

Andranik Ovassapian, M.D.

Professor of Anesthesia

The University of Chicago

5841 South Maryland Avenue, MC 4028

Chicago, IL 60637

Mark McClellan, M.D., Ph.D.
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attn: CMS-1502-P/TEACHING ANESTHESIOLOGISTS
P.O. Box 8017
Baltimore, MD 21244-8017

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The University of Chicago

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Chicago, IL 60637

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

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Andranik Ovassapian, M.D.

Professor of Anesthesia

The University of Chicago

5841 South Maryland Avenue, MC 4028

Chicago, IL 60637

Submitter : Dr. thomas vasileff **Date:** 08/24/2005

Organization : Dr. thomas vasileff

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

I would like to protest the proposed Medicare fee schedule reductions for casting supplies and for the technical component of multiple radiology procedures.

Casting supplies have become more and more expensive. For an orthopedic practice this cost is significant. Reimbursement for Medicare patients is already insufficient to cover overhead costs. If fracture care treatment must now also include the cost of the cast supplies, treatment of Medicare patient fractures in the non-facility environment will become prohibitively expensive. The ruling would encourage physicians to avoid handling Medicare patient fracture care in the office. This will result in increasing emergency room use, adding expense rather than savings to the Medicare program. The ruling may also encourage physicians, out of sheer survival demands, to use lower quality casting material, such as substituting plaster for fiberglass.

There is also a proposed rule that would reduce payments for the technical component of a second radiology procedure performed on the same patient by 50%. Apparently Medicare believes that most of the costs for the technical component of the charge are incurred in the first image, and that most labor activities and supplies are not furnished twice. I would point out that multiple images require multiple pieces of film and processing chemicals, which have the same cost as the initial piece. Film costs are significant. In addition, multiple views take additional staff time, and reduce the life of machines through the additional usage. It is unrealistic to say that there is little cost incurred for additional images.

I would like to encourage you not to take either of these steps. In Alaska it is becoming difficult to find physicians who will accept Medicare patients. These rules will only exacerbate that problem.

Submitter : Dr. Courtney McKay **Date:** 08/24/2005

Organization : Wake Forest Baptist Medical Center

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

Mark McClellan, M.D., Ph.D.
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attn: CMS-1502-P/TEACHING ANESTHESIOLOGISTS
P.O. Box 8017
Baltimore, MD 21244-8017
Dear Dr. McClellan:
I am writing to urge the Centers for Medicare and Medicaid Services (CMS) to change the Medicare anesthesiology teaching payment policy.
Medicare?s discriminatory payment arrangement, which applies only to anesthesiology teaching programs, has had a serious detrimental impact on the ability of programs to retain skilled faculty and to train the new anesthesiologists necessary to help alleviate the widely-acknowledged shortage of anesthesia providers -- a shortage that will be exacerbated in coming years by the aging of the baby boom generation and their need for surgical services.
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Correcting this inequity will go a long way toward assuring the application of Medicare?s teaching payment rules consistently across medical specialties and toward assuring that anesthesiology teaching is reimbursed on par with other teaching physicians.
Please end the anesthesiology teaching payment penalty.
Name____Courtney A. McKay, MD
Address 833 Lockland Avenue, Winston-Salem, NC 27103

Submitter : Dr. James Berry **Date:** 08/24/2005

Organization : Dr. James Berry

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

Dear Dr. McClellan:

I am writing to urge the Centers for Medicare and Medicaid Services (CMS) to change the Medicare anesthesiology teaching payment policy.
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Correcting this inequity will go a long way toward assuring the application of Medicare's teaching payment rules consistently across medical specialties and toward assuring that anesthesiology teaching is reimbursed on par with other teaching physicians.
This impacts our ability to recruit outstanding teachers, as the pay differential for private practice is can approach 50% in many situations.
Please end the anesthesiology teaching payment penalty.

Thank you

James M. Berry, M.D.
Nashville TN

Submitter : Dr. Daren Filsinger **Date:** 08/24/2005

Organization : Univerity of California, San Francisco

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

Mark McClellan, M.D., Ph.D.
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attn: CMS-1502-P/TEACHING ANESTHESIOLOGISTS
P.O. Box 8017
Baltimore, MD 21244-8017
Dear Dr. McClellan:
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Please end the anesthesiology teaching payment penalty.
Name_Daren Filsinger, MD_____
Address _UCSF, San Francisco, CA 94143_____

Submitter : Dr. J. Kent Garman **Date:** 08/24/2005

Organization : Stanford University School of Medicine

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

Mark McClellan, M.D., Ph.D.
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attn: CMS-1502-P/TEACHING ANESTHESIOLOGISTS
P.O. Box 8017
Baltimore, MD 21244-8017

File Code: CMS-1502-P
Issue Identifier: ?TEACHING ANESTHESIOLOGISTS?

Dear Dr. McClellan:

I am writing to urge the Centers for Medicare and Medicaid Services (CMS) to change the Medicare anesthesiology teaching payment policy.

I am a Professor of Anesthesia at Stanford University. Our department is financially disadvantaged as a result of this discriminatory policy.

Medicare?s discriminatory payment arrangement, which applies only to anesthesiology teaching programs, has had a serious detrimental impact on the ability of programs to retain skilled faculty and to train the new anesthesiologists necessary to help alleviate the widely-acknowledged shortage of anesthesia providers -- a shortage that will be exacerbated in coming years by the aging of the baby boom generation and their need for surgical services.

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Correcting this inequity will go a long way toward assuring the application of Medicare?s teaching payment rules consistently across medical specialties and toward assuring that anesthesiology teaching is reimbursed on par with other teaching physicians.

I also understand that the Nurse Anesthesia community is opposing any changes to this rule. Their arguments are not valid since nurse trainees and anesthesia residents will continue to be supervised by teaching anesthesiologists with no changes favoring resident training.

Please end the anesthesiology teaching payment penalty.

Sincerely,

J. Kent Garman, MD, MS (Management)
Associate Professor
Department of Anesthesia
Stanford University School of Medicine
Stanford, CA 94305-5640

Submitter : Dr. Alan Artru **Date:** 08/24/2005

Organization : University of Washington School of Medicine

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

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.

Submitter : Dr. Evan Pivalizza **Date:** 08/24/2005

Organization : University of Texas Health Science Center - Housto

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

TEACHING ANESTHESIOLOGISTS
Mark McClellan, M.D., Ph.D.
Administrator, Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attn: CMS-1502-P/TEACHING ANESTHESIOLOGISTS
P.O. Box 8017, Baltimore, MD 21244-8017
Dear Dr. McClellan:
As one of the rapidly- dwindling faculty members at the University of Texas – Houston, I am writing to urge the Centers for Medicare and Medicaid Services (CMS) to change the Medicare anesthesiology teaching payment policy without delay.
Medicare’s discriminatory payment arrangement, which applies only to anesthesiology teaching programs, has had a serious detrimental impact on the ability of programs to retain skilled faculty and to train the new anesthesiologists necessary to help alleviate the widely-acknowledged shortage of anesthesia providers -- a shortage that will be exacerbated in coming years by the aging of the baby boom generation and their need for surgical services.
Under current Medicare regulations, teaching surgeons and even internists are permitted to work with residents on overlapping cases and receive full payment so long as the teacher is present for critical or key portions of the procedure. Teaching surgeons may bill Medicare for full reimbursement for each of the two procedures in which he or she is involved. An internist my supervise residents in four overlapping office visits and collect 100% of the fee when certain requirements are met.
Teaching anesthesiologists are also permitted to work with residents on overlapping cases so long as they are present for critical or key portions of the procedure. However, unlike teaching surgeons and internists, since 1995 the teaching anesthesiologists who work with residents on overlapping cases face a discriminatory payment penalty for each case. The Medicare payment for each case is reduced 50%. This penalty is not fair, and it is not reasonable.
Correcting this inequity will go a long way toward assuring the application of Medicare’s teaching payment rules consistently across medical specialties and toward assuring that anesthesiology teaching is reimbursed on par with other teaching physicians.
Please end the anesthesiology teaching payment penalty. The future of medical student and resident education in anesthesiology is at stake!
Name_____Evan G. Pivalizza, Professor of Anesthesiology_____
Address __Dept. Anesthesiology, University of Texas – Houston, MSB 5.020, 6431 Fannin Street, Houston, TX, 77030_____

Submitter : Dr. jose melendez **Date:** 08/24/2005

Organization : Dr. jose melendez

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

Anesthesiologist are already re-imbursed at half the rate of other physicians. To add to the injury, the Congress of the United States discourages the education of anesthesiologist by grossly undervaluing their services. Medicare patients can be some of the illess group. Academic anesthesiologist are reimbursed at the rate of $32/hr for anesthetic care.

Submitter : Dr. Daniel Brown **Date:** 08/24/2005

Organization : Dr. Daniel Brown

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

Mark McClellan, M.D., Ph.D.
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attn: CMS-1502-P/TEACHING ANESTHESIOLOGISTS
P.O. Box 8017
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Teaching anesthesiologists are also permitted to work with residents on overlapping cases so long as they are present for critical or key portions of the procedure. However, unlike teaching surgeons and internists, since 1995 the teaching anesthesiologists who work with residents on overlapping cases face a discriminatory payment penalty for each case. The Medicare payment for each case is reduced 50%. This penalty is not fair, and it is not reasonable.
Correcting this inequity will go a long way toward assuring the application of Medicare?s teaching payment rules consistently across medical specialties and toward assuring that anesthesiology teaching is reimbursed on par with other teaching physicians.
Please end the anesthesiology teaching payment penalty.
Daniel R. Brown, PhD, MD
6803 County Road 7, SE
Chatfield, Minnesota 55923

Submitter : Dr. Julian Waggoner III **Date:** 08/24/2005

Organization : Mayo Foundation

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

Mark McClellan, M.D., Ph.D.
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attn: CMS-1502-P/TEACHING ANESTHESIOLOGISTS
P.O. Box 8017
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Please end the anesthesiology teaching payment penalty.

Julian Richard Waggoner III, MD
21301 Indian Hills Rd
Albert Lea, MN 56007

Submitter : Ms. Roberta Haver **Date:** 08/24/2005

Organization : Ms. Roberta Haver

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

GPCIs

I support the increase in the Medicare reimbursement rate for Santa Cruz County physicians.

Submitter : Mr. Paul Ahern **Date:** 08/24/2005

Organization : none

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

Please upgrade the reimbursement level of medical providers in the County of Santa Cruz, CA, above the level of rural so that they are level with those in Santa Clara County (our next door neighbor)and the surrounding S.F. Bay area counties. Santa Cruz County is one of the most expensive places to live in the U.S.A. and the citizens need all the help we can get to attract and retain qualified medical attention. Thank you. GPCI