Submitter : Dr. Matthew Vo **Date:** 09/17/2005

Organization : Dr. Matthew Vo

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 as an anesthesiologist at Harbor-UCLA Medical Center 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.
b
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.

Please end the anesthesiology teaching payment penalty.

Sincerely,

Matthew Vo, M.D.

Submitter : Dr. Matthew Vo **Date:** 09/17/2005

Organization : Dr. Matthew Vo

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 as an anesthesiologist at Harbor-UCLA Medical Center 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 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.
Please end the anesthesiology teaching payment penalty.
Sincerely,

Matthew Vo, M.D.

Submitter : Dr. Leonard Gerstein **Date:** 09/17/2005

Organization : Dominican Hospital Foundation

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

As a semiretired physician and board member of Dominican Hospital Foundation and I strongly support the proposed revision to physician payment localities to correct the abomination of paying physicians in Santa Cruz 25% less than surrounding counties. After 35 years of practice I hope to have a physician to take care of me, if needed. Leonard Gerstein, M.D.

Submitter : Mr. Kenneth Riner **Date:** 09/17/2005

Organization : Mr. Kenneth Riner

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

Re: GPCIs

I am a Medicare beneficiary who receives medical care from a physician in Sonoma County, California. Some local doctors are refusing to accept new Medicare patients, and some are leaving Sonoma County.I understand that Medicare is proposing to create a new payment locality for 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 me and other Medicare beneficiaries. 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.

Kenneth Riner

Submitter : **Dr. marc sedwitz** **Date: 09/17/2005**

Organization : **Pacific Vascular Inc.**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Any continued cuts in reimbursement for physicians and hospitals is inappropiate and non-negotiable. Further drops and I will drop off the call panels at three hospitals for vascular and general surgical services and I will encourage my colleagues to do the same. Are you taking the same administrative cuts in your salaries

Submitter : **Dr. Michelle Lawrence** **Date: 09/17/2005**

Organization : **University of Chicago**

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 as an anesthesiology resident at University of Chicago 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 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.

This has the potential to have dire effects on the future of Academic Anesthesiologist as it has also become known that the National office of CRNAs oppose this revision as they contend that they do not need supervision. This is one of the most irrational comments I have heard made by a professional society. I am a masters trained Registered Nurse who practiced nursing for 10 years before making the decision to go back to medical school to satify my desire to learn as much as I could in the field of health care. I can surely attest that the difference between nursing knowledge (even with advanced training)and medical knowledge is vast. It just seems that this actual difference can not even be imagined unless you actually experience both. So, it seems to me, that their stance is one based in ignorance and not fact.

Please end the anesthesiology teaching payment penalty. As our future and the future of safe patient care depends on it.

Name_____Michelle Lawrence_____
Address __6730 S. South Shore DR #801 Chicago, IL 60649__

Submitter : **Dr. Lynn Knox** **Date: 09/17/2005**

Organization : **University of Texas Medical Branch**

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 as a faculty anesthesiologist at University of Texas Medical Center, Galveston, Texas to urge the Centers for Medicare and Medicaid Services (CMS) to change the Medicare anesthesiology teaching payment policy. 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.

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 may supervise residents in four overlapping office visits and collect 100% of the fee when certain requirements are met.

As a teaching anesthesiologist, I am also permitted to work with residents on overlapping cases so long as I am present for critical or key portions of the procedure. However, unlike teaching surgeons and internists, since 1995 the teaching anesthesiologists like me 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. Department budgets are broken by this arbitrary Medicare payment reduction. The CMS anesthesiology teaching rule must be changed to allow academic teaching departments to cover their costs.

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,

S. Lynn Knox, MD, Program Director, Anesthesiology Residency
UTMB, 301 University Blvd.,Galveston, TX, 77555-0591

Submitter : **Dr. Stephen Kimatian** **Date: 09/17/2005**

Organization : **Penn State Milton S. Hershey 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 as the Program Director for Anesthesiology Residency Training at the Penn State Milton S Hershey Medical Center 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 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.
Please end the anesthesiology teaching payment penalty.
Stephen J. Kimatian, MD
32 Elm Ave
Hershey PA 17033

Submitter : Mr. Jon Frieseke **Date:** 09/18/2005

Organization : Mr. Jon Frieseke

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

I want to express my support for the proposed change to the Sonoma County payment locality. It is important to recognize that the costs to live and work in Sonoma County have increased at a greater rate than in many other places in California. In order to retain quality physicians who will provide quality Medicare supported medical services to Sonoma County residents it is important to provide an appropriate payment rate. Failure of this proposal will result in physicians rejecting their Medicare patients and/or leaving this area.

Submitter : Mrs. Vera Frieseke **Date:** 09/18/2005

Organization : Mrs. Vera Frieseke

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

Here in Sonoma County it is becoming difficult to find a physician who will accept Medicare patients. I am told that this is because of the Medicare payment level. For this reason, I am writing to support the "New Payment Locality" for Sonoma County. Sonoma County is growing rapidly and housing and other leving costs are increasing rapidly. I believe that this proposed change to the payment rate will encourage physicians to stay in Sonoma County and to be willing to accept Medicare patients.

Submitter : **Dr. steven goldfien** **Date: 09/18/2005**

Organization : **Dr. steven goldfien**

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 an anesthesiologist in private practice in San Francisco and am writing you to urge the Centers for Medicare and Medicaid Services (CMS) to change the Medicare anesthesiology teaching payment policy.
Medicare?s current payment arrangement, which applies only to anesthesiology teaching programs, has had a serious detrimental impact on the ability of programs to retain skilled faculty. This in turn is adversely affecting the ability of these programs to do the research that advances the science of anesthesiology and provides the basis for safer patient care. Please do not be swayed by arguments proffered by the American Association of Nurse Anesthetists (AANA) claiming that increased support for the training of anesthesiologists will decrease the incentive to train nurse anesthetists. These are two separate problems and you would do a disservice to the American public by linking them together. Despite their claims to the contrary, the nurse anesthetist do not now and never have played a significant role in the scientific research necessary for the improvment of the clinical care and safety of patients undergoing anesthesia.
Payment for teaching anesthesiologists that is fair and based on the same principles used to pay other physician specialists is urgently necessary. I urge you to enact these changes as soon as possible.
Respectfully, Steven Goldfien, M. D.

Submitter : **Dr. Asokumar Buvanendran** **Date: 09/18/2005**

Organization : **Rush University Medical Center**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Sept 17th 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:
Re: CMS-1502-P ?Teaching Anesthesiologist?
I am writing as an anesthesiologist at Rush University Medical Center, in Chicago, IL to urge the Centers for Medicare and Medicaid Services (CMS) to change the Medicare anesthesiology teaching payment policy. I am the Director of orthopedic anesthesia and administer anesthetics to a large number of medicare patients undergoing joint replacements. In addition, we at Rush University (rated # 4 in the country for orthopedics) are carrying out extensive clinical research to improve patient?s outcome and reduce the health care costs for all patients across the nation. Time taken by Physicians such as myself, to carry out quality research in University hospitals, is not reimbursed, but rather deprived of potential income loss. In addition, we at the University hospitals are being compromised of the reimbursement due to the below mentioned reason.
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 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. Not correcting this problem now, will lead quality, ambitious young anesthesiologist such as myself to leave the University hospital to a private practice setting, which will deprive new and innovative research which will improve outcome in elderly patients with reduced health care cost.
Please end the anesthesiology teaching payment penalty.

A. Buvanendran, MD
Associate Professor
Director of Orthopedic Anesthesia
Department of Anesthesiology
Rush University Medical Center
Chicago, IL 60612

Submitter : **Dr. Vik Virupannavar** **Date: 09/18/2005**

Organization : **University of Chicago**

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 as an anesthesiologist at The University of Chicago 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.

Vik Virupannavar, MD

Submitter : Dr. Steven Needell **Date:** 09/19/2005

Organization : Boca Radiology Group

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

Submitter : **Camille Andre** **Date: 09/19/2005**

Organization : **Camille Andre**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

I understand that Medicare is proposing to create a new payment locality for Sonoma County, which is an increasingly expensive place to live and work. In the new locality, the Medicate reimbursement rete 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 me and other Medicre beneficiaries. 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 oportunity to comment on this important issue.

Sincerely,
Camille Andre
123 Calistoga Rd. #307
Santa Rosa, CA 95409

Submitter : Dr. Daniel Seftel **Date:** 09/19/2005

Organization : Dr. Daniel Seftel

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

I am writing to strongly support the proposed revision to physician paymnet localities in California. Physicians in Santa Cruz receive reimbursement levels at25% less than in two of our neighboring counties.

Submitter : **Mrs. berna bruzzone** **Date: 09/19/2005**

Organization : **Dominican Hospital Guild**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

I am writing in support of changing the designation of Santa Cruz County from "rural" to "urban". This change is warranted by the county's proximity to the Silicon Valley and San Francisco Bay area and the county"s extremely high cost of living. Respectfully, Berna Bruzzone

Submitter : Dr. Kirk Smith **Date:** 09/19/2005

Organization : University of Chicago Hospitals

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1502-P-1118-Attach-1.DOC

Submitter : **Dr. Yasser sakawi** **Date: 09/19/2005**

Organization : **University of Alabama at Birmingham**

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 as an anesthesiologist at University of Alabama at Birmingham 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 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.
Please end the anesthesiology teaching payment penalty.

Yasser Sakawi, M.D.
Associate Professor
University of Alabama at Birmingham, Anesthesiology
619 South 19 th Street, Jefferson Tower suite 941
Birmingham, AL 35249-6810
Phone 205-934-4696
Fax 205-975-5963
yasakawi@uab.edu

CMS-1502-P-1119-Attach-1.DOC

Submitter : **Dr. Anthony Ivankovich** **Date: 09/19/2005**

Organization : **Rush University Medical Center**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

September 16, 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 as the Chairman of the Department of Anesthesiology and the anesthesiology residency program director at Rush University Medical Center 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 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 is an important step 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.

Anesthesiology teaching programs are currently struggling financially and operating on negative revenue margins that severely hamper the ability to retain and recruit faculty, who increasingly migrate to non-teaching centers where the teaching payment penalty does not apply. The consequences of this are an inevitable reduction of our ability to train the next generation of anesthesiologists - physicians who play a critical role in our nation?s health care delivery to elderly Medicare patients.

I urge you to reform Medicare?s unfair payment policy for teaching anesthesiologists.

Sincerely,

Anthony D. Ivankovich, M.D.
Department of Anesthesiology
Rush University Medical Center
1653 W. Congress Parkway
Chicago, Illinois 60612

Submitter : **Dr. Marvin Cohen** **Date: 09/19/2005**

Organization : **Dr. Marvin Cohen**

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 as an anesthesiologist at Universtiy of Texas Medical Branch at Galveston, Texas 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.

Marvin S Cohen MD
Associate Professor
Vice Chairman for Clinical Affairs
Director of Pediatric Anesthesiology
Dept. of Anesthesiology
UTMB

Submitter : **Gerald Cabak** **Date: 09/19/2005**

Organization : **Gerald Cabak**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

Re: GPCI

My parents are Medicare beneficiaries who are receiving great care from the Santa Cruz Medical Foundation organization of physicians and services. I think that these physicians and other health professionals in our area should receive comparable and adequate payments from Medicare which is on par with other counties in the San Francisco Bay area.

I would, therefore, appreicate your close attention and scrutiny to this important issue.

Sincerely and Respectfully,

Gerald Cabak
129 Carbonera
Santa Cruz, CA
95060

On behalf of parents
Edward and Kate Cabak
2030 Pajaro Lane, #1321
Freedom, California
95019

Submitter : Dr. Gary Mishkin **Date:** 09/19/2005

Organization : self

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

see attachment

CMS-1502-P-1123-Attach-1.DOC

Submitter : **Dr. Pat petrozza** **Date: 09/19/2005**

Organization : **Wake forest University Baptist Medical Center**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam,

I am an academic anesthesiologist and I have made my career training Anesthesiology residents for the past 22 years. Our Medicare reimbursement is severely limited by the fact that we can only bill for a 50% fee when covering two resident cases. We have a high percentage of Medicare cases because we are a tertiary/quaternary care center and overall our ability to recruit faculty is severely constrained due to our limited reimbursement. I take overnight call in the Hospital to assure proper resident and CRNA supervision, and it is unfair that I should accept a discounted fee when other specialty physicians who also supervise two residents and two procedures at times are not forced to accept a discount. Please recommend equity for the academic physicians in Anesthesiology and fairness relative to other teaching physicians.

Submitter : **Dr. stephen levinson** **Date: 09/19/2005**

Organization : **Dr. stephen levinson**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Re: GPCIs

I understand that Medicare is proposing to create a new payment locality for Sonoma County, California, which is an increasingly expensive place to live, work and practice medicine. 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 quality and quantity of care they deliver to Medicare beneficiaries and other patients as well. The locality change would also benefit efforts to recruit and retain physicians in the county, which has a large Medicare population. This has been a big problem for Sonoma County for many years. Many superb physicians have turned down offers to live and work in Sonoma County due, in part to the high costs of living, the high costs to practice medicine and the inappropriately low Medicare reimbursement. This has caused critical gaps in the coverage for patients and has created difficulties in access to care for Medicare patients and all patients alike. Many primary care doctors are restricting the amount of Medicare patients in their practices for these reasons. As a physician who has practiced in Sonoma County for many years I have personally witnessed this decline in care and I feel that your proposal to create a new Medicare locality for Sonoma County is the first step to correct this problem.

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

Sincerely,

Stephen R. Levinson, M.D.

Submitter : **Mr. Patrick Mauldin** **Date: 09/19/2005**

Organization : **Mr. Patrick Mauldin**

Category : **Ambulatory Surgical Center**

Issue Areas/Comments

GENERAL

GENERAL

September 19, 2005

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

Re: File Code CMS1502-P

Issue Identifier GPCI?s / Payment Localities

Dear CMS Staff:

I am writing to strongly support the proposed revision to physician payment localities in California that you published earlier this month. I hope that you adopt this rule as final in November. As Dominican Hospital Foundation Board member, I am very concerned that as our physician?s age and retire, we as a community are able to attract new physicians to take their place. I have followed the issues surrounding the inclusion of Santa Cruz County within Locality 99 for California and welcome the opportunity to support your proposed solution to the current inequitable payment policy. I believe adoption of your proposed rule will go a long way to ensuring ongoing access to high quality care for community residents.

As you know, physicians in Santa Cruz receive reimbursements at levels 25% less than physicians in two of our neighboring counties. Current payments are about 10% less than they should be, given the county?s current GAF. They do not reflect the high cost of practice in our community.

You are to be commended for proposing a rule that would address this problem for physicians in Santa Cruz and Sonoma Counties, the two most problematic counties in California. I believe this to be fair and appropriate. Thank you for considering my comments.

Sincerely,

Patrick Mauldin
2121 41st Avenue, Suite 301
Capitola, California 95010

Submitter : **Mrs. Elizabeth Karrer** **Date: 09/19/2005**

Organization : **Mrs. Elizabeth Karrer**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

The subject is GPCIs. I support creating a new payment locality for Sonoma County, California. Our local doctors are finding it difficult to financially survive in Sonoma County due to the high cost of living. Increasing the amount of money they receive for treating Medicare patients would help them continue to take care of these patients close to home. In five years, I will be a Medicare patient and I am concerned about the ability of Sonoma County to keep its doctors. Thank you, Elizabeth Karrer

Submitter : **Dr. Arpad Zolyomi** **Date: 09/19/2005**

Organization : **University of New Mexico**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

September 19, 2005

Re: Teaching Anesthesiologists
To Whom It May Concern:

I am an assistant professor at the University of New Mexico. I enjoy my work and my efforts at teaching are appreciated by the residents, however I am considering moving to private practice because across the street at Lovelace Health Care I could make 50% more with less hours spent at work. Looking back at the history of this department it is striking that many quality people have left because of being overworked and underpaid. One of my brightest colleagues had to give up research because funding was redirected towards salary payments. Our pediatric anesthesia colleagues are taking home call every third night because we are unable to hire another pediatric anesthesiologist due to lack of money.

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.

If CMS would change this payment strategy our practice would not change much. We currently supervise 2 residents at a time or 2 anesthesia assistants except for the first 4-6 weeks of training when we are one on one with residents. It is very rare that we end up supervising 3 residents, as it happens during call when the third case is an emergency. Receiving full payment for 2 cases performed by residents at a time would help us to retain more faculty who are experienced in teaching residents by offering more competitive wages, hire more faculty and decrease the workload, thus spend more time with the residents, and overall improve resident education and quality of care.

Sincerely,

Zolyomi, Arpad
Assistant professor
Director Obstetric Anesthesia
University of New Mexico
Tel: 505-272-2611

Submitter : **Ms. Judith Barlas** **Date: 09/19/2005**

Organization : **Ms. Judith Barlas**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

Please raise the medicare reimbursements for physicians here in Sonoma County. They are being paid rural rates for a metropolitan area. The quality of our health care in compromised as a result. No doctors are moving here as they cannot afford to live here given the rural reimbursement rate, and rapidly rising cost of living. The median priced home here is near $700,000. This is no longer a rural area. Please act accordingly! Thank you, J Barlas

Submitter : **Dr. Deborah Donlon** **Date: 09/19/2005**

Organization : **N/A (self-employed)**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

9/19/05

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

Re: GPCIs

I understand that Medicare is proposing to create a new payment locality for Sonoma County, California. I would like to address some specific concerns from the perspective of a group of three self-employed family physicians in Healdsburg, CA.

Sonoma County now ranks with retirement destinations such as Clearwater, St. Petersburg, and Miami, Florida.

Among cities with a population of 100,000 or more, Santa Rosa is sixth in the United States for the highest percentage of people 85 and older. The demographic of Healdsburg, where we practice, is similar.

According to State of California Department of Finance, seniors 60 and older represent 16.6% of the total population in Sonoma County, with a projected rate of change of 196% by 2020.

Amid the astounding growth in our elder population, Sonoma County is facing strains on the health care delivery network that are unacceptable to Medicare recipients:

The number of practicing physicians in Sonoma County has not kept pace with local population growth. From 1995 to 2002, the population increased 13%, but the number of practicing physicians increased by only 4%.

As of July 2005, 60% of Sonoma County primary care physicians were NOT accepting new Medicare patients.

Many physicians are leaving our county to practice where reimbursement is more favorable. As a result, many specialties are under-supplied. For example, we have only two gerontologists in the county for more than 76,000 seniors.

The new locality would increase the Medicare reimbursement rate to more closely match actual practice expenses, helping Sonoma County physicians improve the quantity and quality of care they deliver to Medicare beneficiaries and other patients. The locality change would also aid 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,

Deborah T. Donlon, M.D.
717 Center Street
Healdsburg, CA 95448

Submitter : **Mrs. Martha Waller** **Date: 09/20/2005**

Organization : **Mrs. Martha Waller**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

I am writing in support of your proposal to create a new payment locality for Sonoma County, California. Many local physicians have either moved from the area or discontinued care to Medicare patients. I am a seventy-eight year old widow on a small fixed income, and if I lost my Medicare benefits my income would not last long. I have friends who are not getting the care they need because their resources are even less than mine. Sonoma County has one of the highest cost-of-living indexes in California, and our seniors need all the help they can get. I urge you go forward with your proposal to correct this inequity in physician reimbursement in Sonoma County.

Submitter : Mr. Rodney Thomas **Date:** 09/20/2005

Organization : Mr. Rodney Thomas

Category : State Government

Issue Areas/Comments

GENERAL

GENERAL

Please remove Santa Cruz County from Locality 99 so that the Medicare payments are higher for doctors effective 1/1/2006. Santa Cruz County has a large senior population and there is a need for physians who will accept Medicare patients.

Thank you for your help in this matter.

With regards,
Rodney Thomas
121 Paul Way
Santa Cruz, CA 95060

Submitter : Dr. K Daniel Rose **Date:** 09/20/2005

Organization : K Daniel Rose, MD

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

I have been a Family Practice physician in Sonoma County since 1974. I saw DRG's arrive and witnessed the dramatic changes in patient care over the following decades. Our county has faced skyrocketing costs of labor, malpractice insurance, and supplies without a corresponding increase in reimbursement from the government or private carriers. Several primary care physicians have actually gone out of business and left to work at Kaiser, or left the area altogether. Many of my colleagues are my age and will be retiring soon. It is impossible to recruit doctors to replace the ones who have left the area. Patients are being denied access to care. It will be impossible to replace the retiring practitioners, and this will exacerbate the problem of access. It is essential that the reimbursement rate for physicians be raised to make practices here financially feasible. Our expenses are very similar to those of our urban colleagues, yet our reimbursement lags drastically. Please correct this inequity and restore access to care in Sonoma County. Thank you.

CMS-1502-P-1133-Attach-1.DOC

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

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

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

Submitter : Dr. Gary Kanter **Date:** 09/20/2005

Organization : Dept. of Anesthesiology-Baystate Medical Cente

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

see attachment

CMS-1502-P-1134-Attach-1.DOC

September 15, 2005

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

Re: TEACHING ANESTHESIOLOGISTS

Throughout the State of Massachusetts, there are continuing concerns about the adequacy of federal support for teaching institutions. The current Medicare teaching anesthesiologist payment rule is unwise, unfair and unsustainable. Quality medical care, patient safety and an increasingly elder 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 Medicare policy that shortchanges teaching programs by withholding 50% of funds for concurrent cases. Anesthesiology teaching programs 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 at a loss as there are limited funds available because of this arbitrary Medicare payment reduction.

Why is it that surgeons may supervise residents in two overlapping operations and collect 100% of the fee for each case from Medicare and an anesthesiologist on the same case can only collect 50% of the Medicare fee if he or she is supervising two residents on overlapping cases? In addition, internists are allowed to supervise four residents for outpatient visits and are reimbursed at 100% of the fee if certain requirements are met. 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 rate is less than 40% of prevailing commercial rates. Reducing the fees by another 50% for teaching anesthesiologists results in revenue grossly inadequate to sustain our programs. The service, teaching and research missions of academic anesthesia training programs in our country will surely suffer from this course of action.

I appreciate your attention to this important issue and hope that you are able to address these concerns. Academic anesthesiology departments are depending on changes to this rule in order to improve the quality of care for patients at all teaching institutions.

Sincerely,

Gary Kanter, M.D.
Assistant Professor of Anesthesiology-Department of Anesthesiology
Associate Director of Health Care Quality-Department of Heath Care Quality
Baystate Medical Center
Springfield MA

Submitter : **Dr. Robert Johnstone** **Date: 09/20/2005**

Organization : **West Virginia University**

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 as a faculty anesthesiologist at West Virginia University to urge the Centers for Medicare and Medicaid Services (CMS) to change the Medicare anesthesiology teaching payment policy.
The Medicare 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.
We are having great trouble funding our teaching program at West Virginia University. 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.
Please end the anesthesiology teaching payment penalty.
Robert E. Johnstone, MD
369 Lakeview Drive, Morgantown, WV 2650

Submitter : **Dr. Stewart Lauterbach** **Date: 09/20/2005**

Organization : **Dr. Stewart Lauterbach**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

20 September 2005

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

Re: Support for change in the Sonoma County GPCIs.

I understand that Medicare is proposing to create a new payment locality for Sonoma County, California, which is an increasingly expensive place to live, work and practice medicine. 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 quality and quantity of care they deliver to Medicare beneficiaries and other patients as well. The locality change would also benefit efforts to recruit and retain physicians in the county, which has a large Medicare population. This has been a big problem for Sonoma County for many years. Many superb physicians have turned down offers to live and work in Sonoma County due, in part to the high costs of living, the high costs to practice medicine and the inappropriately low Medicare reimbursement. This has caused critical gaps in the coverage for patients and has created difficulties in access to care for Medicare patients and all patients alike. Many primary care doctors are restricting the amount of Medicare patients in their practices for these reasons. As a physician who has practiced in Sonoma County for many years I have personally witnessed this decline in care and I feel that your proposal to create a new Medicare locality for Sonoma County is the first step to correct this problem. We are now short of ENT, Plastics, Primary Care, Ophthalmology, Radiology, Endocrinology, Rheumatology, and other specialties willing to take Emegency call and see Medicare patients.

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

Sincerely,

Stew Lauterbach, M.D.
6225 Heights Rd.
Santa Rosa, CA 95404

707-578-0537

Submitter : Dr. Bruce Cullen **Date:** 09/20/2005

Organization : University of Washington

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

See attachment

CMS-1502-P-1137-Attach-1.DOC

UNIVERSITY OF WASHINGTON SCHOOL OF MEDICINE

Department of Anesthesiology

Bruce F Cullen, MD
Professor and Chief of Service

Harborview Medical Center
Box 359724
325 Ninth Avenue
Seattle WA 98104-2499
Telephone: (206) 731-3059
FAX: (206) 731-8009
E-mail: cullen@u.washington.edu

22 September, 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 as an anesthesiologist at University of Washington to urge the Centers for Medicare and Medicaid Services (CMS) to change the Medicare anesthesiology teaching payment policy. All of the research and advances in anesthesia have been accomplished by anesthesiologists - many of them from our department. Under CMS current policy we are losing large amounts of money, we cannot attract new teachers, the quality of our training program is deteriorating, and young physicians are no longer motivated to enter the specialty.

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 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.

Please end the anesthesiology teaching payment penalty.

Cordially,

(signed electronically)

Bruce F Cullen, MD
Professor, University of Washington
Chief of Service, Harborview Medical Center

Submitter : **Ms. Sandy Silagy** **Date: 09/20/2005**

Organization : **Orthopaedic Assoc of Reading**

Category : **Health Care Professional or Association**

Issue Areas/Comments

GENERAL

GENERAL

As an insurance coordinator for an orthopedic surgeons group employing 6 physicians, I am against your suggested changes to delete the Q codes for casting and splinting. As I am sure you are not planning on increasing the surgical code allowances, our practice would no doubt lose revenue due to this proposal. IN every instance, when CMS makes changes to coding or establishes temporary codes, out of necessity, the staff that bills, must learn the new rules. We have not had any problem billing for the casting supplies as a separate code when it is appropriate. If a patient is non-compliant and requires numerous casting or splint changes due to recklessness, this new ruling would merely penalize the physician for doing what is medically necessary when replacing casts in disrepair.

Submitter : **Dr. Edward Bentley** **Date: 09/20/2005**

Organization : **Santa Barbara County Medical Society**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

See attachment

CMS-1502-P-1139-Attach-1.DOC

SANTA BARBARA COUNTY MEDICAL SOCIETY

5350 Hollister Avenue, Suite A-4
Santa Barbara, California 93111
(805) 683-5333 FAX (805) 967-2871
sbcms@sbmed.org www.sbmed.org

September 20, 2005

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1502-P
P.O. Box 8013
Baltimore, MD 21244-8013

Re: "GPCIs"

Dear Sirs,

I am writing on behalf of the Santa Barbara County Medical Society in response to solicitation of comments on proposed rules regarding Medicare physician payment localities (70FR45783) and GPCI's. Since 1997, our county has been adversely affected by CMS locality decisions, including the most recent proposal. We have extensively studied the problem developing an understanding that few outside of CMS have. It is appropriate, therefore, that we comment on the most recent proposal.

The intent of current Medicare law is to reimburse providers according to the cost of providing services, make adjustments for geographic differences in those costs, and distribute payments accordingly. Since payments within localities are uniform, costs within localities should also be uniform. In 1997, HCFA applied a 5 percent threshold to existing localities to consolidate them into comparable cost areas creating our current national physician fee schedule structure (61FR59494). In the ruling, there was no provision for future locality revision. In response to comments regarding managing future cost changes, it was stated "while we do not plan to routinely revise payment areas as we implement new GPCIs, we will review the areas in multiple locality States if the newer GPCI data indicates dramatic relative cost changes among areas." (61FR59497).

Since 1997, dramatic relative cost changes within current localities have occurred (CMS county data). Eighty counties in twelve multi-locality states currently have cost indices (GAF's) that exceed their payments (locality GAF) by the 5% threshold. California has the greatest disparity, amounting to a nearly $50 million annual payment error (money redistributed from high cost counties to low cost counties within a locality). This year, ten California Counties in two localities have cost indices that exceed their locality's GAF by the 5% rule. These dramatic relative cost changes warrant locality revision to correct inconsistencies in payment for geographic adjustment. The proposed two county solution falls far short of addressing the problem in our state. It also ignores seventy counties outside of California.

Unfortunately, as noted in the CMS proposal, the redistributive effect of restructuring all localities in 2006 as was done in 1997 would result in significant payment reductions to remaining localities. For all, this is the main barrier to revision. Having experienced a 3.4% reduction in 1997, our county cannot advocate subjecting other areas to such hardship. Furthermore, our modeling concludes that other methods (70FR45784) result in greater negative impacts. We prefer the 5% iterative rule as applied in 1997 using the county as the basic unit to create new localities, since it leaves most payment areas intact and minimizes negative impact.

We also cannot support continued inaction in California where cost indices over the years have increased at a greater rate in high cost counties. When these higher GPCI's are averaged across the locality, the redistribution worsens the disparities. Relative overpayments occur in thirty-nine lower cost California counties (76%) and are greater than five percent in twenty of those counties. In addition, the current redistributive effect of locality revision has become seemingly insurmountable. Redistributing GPCI increases rather than making locality changes only compounds the problem.

We have identified two solutions to the problem that avoid payment reductions, each applying the 5% rule. The first requires legislation setting a floor in localities revised and appropriating additional revenues to maintain that floor (since the opportunity to take advantage of significant GPCI increases as proposed by CMA in 2004 has been lost). The second requires CMS to perform locality revision over several years in increments, not to exceed the offsetting amounts of GPCI and annual adjustment increases.

The California Medical Association prefers the first solution because it is expedient, all-inclusive, does not withhold increases to revised payment areas, is relatively inexpensive and has widespread support. The two-county Locality proposal (CMS-1502-P) is the only option available to CMS that applies the second solution (California is the only state affected with GPCI increases sufficient to offset redistributive reductions). Although the proposal excludes our county and others, we support it as an initial step because it fulfills our principles of locality revision without payment reduction and is preferable to no action. The proposal appropriately addresses the most adversely affected counties in California rather than applying GPCI increases to a locality with relative overpayment to a majority of counties, some of which are also receiving additional revenues as underserved areas. Furthermore, it facilitates future locality revision (including the CMA preference) by reducing the number of adversely affected counties.

We believe that our county and California are better served by making this small locality change now and making locality revision a priority rather than perpetuating the current inequities by applying GPCI increases. We fully understand the difficulties that Santa Cruz and Sonoma Counties are experiencing as a result of their higher practice costs. In no way would a 0.4% GPCI increase at their expense diminish the difficulties that our county is experiencing due to high practice costs. We recognize that only locality revision will diminish that difficulty. With that recognition, the proposal will benefit Santa Cruz and Sonoma to a far greater degree than the 0.4% payment increase would benefit our county. For this reason, we support a proposal that moves us closer to complete locality revision.

We make this statement, however, with the full understanding that California's current locality problem includes ten counties, not two counties, and that the CMS proposal is considered the first step towards a final solution that includes all counties adversely affected and any additional counties similarly affected with future GPCI revisions applying our principles nationwide. With that understanding, reducing the current locality inequities facilitates a final solution. If CMS considers the proposal a final solution, we oppose it as being incomplete.

Because annual adjustments have not kept pace with the Medical economic index resulting in system wide under funding, CMS can expect opposition to the proposal from California counties that will have the 0.4% GPCI increases negated. We encourage CMS to view this opposition in the proper context of equitable geographic distribution of payment for practice costs. In considering opposing viewpoints, compelling arguments should be made as to why it would be preferable to apply the 0.4% GPCI increase and maintain the status quo than

begin to address the worsening payment inequities. Although not an ideal or final solution, we agree with the decision to address the two most adversely affected high cost counties and avoid increasing relative overpayment to thirty-nine low cost counties than reduce the overpayment in seven high cost counties, including ours, by a negligible 0.4% and ignore the problem. We have commented on the historical trend of widening cost disparities in California and predict the problem will worsen with continued inaction.

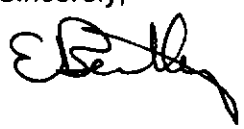
We applaud CMS for taking this unprecedented action in addressing California's locality problem without forcing payment reductions. Opposing this proposal ignores that precedence, ignores the difficulties of the two counties, and places the value of a 0.4% GPCI increase over the value of locality revision. We strongly recommend support of the proposal and continued cooperation for a complete resolution.

Although we agree that state medical associations should be an impetus behind locality changes, we disagree with your proposal that state medical associations should be the impetus behind locality changes. Congress delegated CMS to administer payment localities because of their expertise and objectivity, not state medical associations. State Medical Societies are not impartial and, with few exceptions, do not have expertise on this very complex issue. Furthermore, as ironically pointed out in response to the proposed demonstration project last year (70FR45783), the body is not representative of all providers.

In summary, we support the two-county locality proposal as the first step in an incremental final solution to the problem that avoids payment reductions. The current locality structure in many multi-locality states does not fulfill the 1996 objective of minimizing input price difference and county boundary difference and warrants revision. Implementing the proposed GPCI's and further delaying locality revision in our state will worsen the negative impact of that revision. Future locality revision should occur with introduction of new GPCIs to minimize input price differences within localities. Furthermore, without additional appropriation from Congress, locality revision should be incremental and take advantage of annual adjustments to avoid payment reductions. Methodology such as the iterative 5% rule should be applied to automatically accommodate locality revision with new GPCIs or define limits of existing localities that would prompt revision rather than requiring a proposal from state medical associations. A process for locality review and appeal should be developed that does not require divisive resolutions from state medical associations.

The intent of the GPCI is to reimburse physicians appropriately for geographical differences in the cost of providing medical care. The intent of establishing localities was to simplify but not undermine GPCI reimbursement. In multiple locality states such as California, maintaining localities with large differences among the basic locality units (defined by the rulemaking process as greater than 5 percent) violates criteria established in 1996, undermines the intent of GPCI, and, therefore, warrants revision of those localities.

Sincerely,



Edward S. Bentley, M.D.
Immediate Past President
Santa Barbara County Medical Society

Submitter : Mrs. Anne Gough **Date:** 09/20/2005

Organization : The Orthopaedic Center of Central Va.

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

The decision to remove payment for Q codes for splint and cast supplies will significantly reduce the ability to provide quality care to patients. The cost of these items to our practice continues to climb and reimbursement through the fracture repair codes is not increased enough to cover these costs.

This concept has failed miserably in the past and I am unable to see any reason this would be acceptable at this time, especially when you are proposing a 5% reduction for Total Knee and Hip replacements, some hip fracture care and E/M codes.

Submitter : **Dr. Andy Chang** **Date: 09/20/2005**

Organization : **Palo Alto Medical Clinic**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

To Whom It May Concern,

I'm just writing to voice my support for the proposed change to physician payment localities that removes Santa Cruz and Sonoma Counties from California's Locality 99. It is my understanding that CMS has not changed localities for almost a decade, while the population as well as the expenses have grown significantly.

I would also like to offer my help for any medically relevant topics if you ever have questions on them. Please feel free to contact me at 510-498-2937. Thank you,

Sincerely,

Andy T Chang MD

Submitter : **Dr. Elliott Bennett-Guerrero** **Date: 09/20/2005**

Organization : **Duke University 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 as an anesthesiologist at Duke University Medical Center 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 abi!ity 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 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.
Please end the anesthesiology teaching payment penalty.
Thank you.
Sincerely,
Elliott Bennett-Guerrero, MD
Associate Professor of Anesthesiology

Submitter : **Dr. David Hardman** **Date: 09/20/2005**

Organization : **Duke University 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
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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.

David Hardman, MD, MBA
Assistant Professor of Anesthesiology
Director of Billing and Reimbursements
Duke University Medical Center
PO Box 3094
Durham, NC 27710

Submitter : Dr. D MacLeod **Date:** 09/20/2005

Organization : Duke University Medical Center

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

See attachment

CMS-1502-P-1144-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 as an anesthesiologist at Duke University Medical Center 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 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.

Please end the anesthesiology teaching payment penalty.

Dr David MacLeod

Assistant Clinical Professor

Department of Anesthesiology

Duke University Medical Center

Erwin Road

Durham, NC 27710

Submitter : **Dr. Dianne Scott** **Date: 09/20/2005**

Organization : **Duke 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
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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.

Dianne L Scott, M. D.
Associate Professor Anesthesiology
Duke Medical Center, Box 3094
Durham, N. C. 27710

Submitter : Dr. Thomas Brummett **Date:** 09/20/2005

Organization : Piasa Pain Medicine

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

My practice incurs significant expense to keep our nurses trained on the stimulator programmer. There is also significant time spent with each patient. This costs the practice money and should be reimbursed.

Submitter : **Dr. Ian Welsby** **Date: 09/20/2005**

Organization : **Duke University**

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.
Yours sincerely,
Dr Ian J Welsby, Assistant Professor, Department of Anesthesiology, Duke University Medical Center, Erwin Road, Durham, NC 27710

Submitter : **Dr. Linda Shore-Lesserson** **Date: 09/20/2005**

Organization : **Mount Sinai School of Medicine**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

September 19, 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 as an anesthesiologist at the Mount Sinai Medical Center in New York City 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. Increasingly, academic anesthesiology programs are losing skilled physicians to the private practice sector, and the percentage of residents who enter academic anesthesiology after they graduate anesthesiology residency programs is dramatically decreasing. There is already a shortage of anesthesia providers in the United States and that shortage is going to become more apparent as the baby boom generation ages. It would be wrong to allow teaching anesthesiology programs to suffer critical shortages in staff and decreasing quality of staff, especially the staff that cares for our elder population.
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 improve the reputation and stature of the academic anesthesiologist and will ensure that skilled physicians continue to enter this specialty. It will also assure the application of Medicare?s teaching payment rules consistently across medical specialties and toward assuring that anesthesiology teaching is reimbursed fairly, and similarly to the teaching in other medical specialties.
Please end the anesthesiology teaching payment penalty.

Sincerely,
Linda Shore-Lesserson MD

Linda Shore-Lesserson M.D.
Associate Professor of Anesthesiology
Director, Cardiothoracic Anesthesiology
Mount Sinai Medical Center
One Gustave L. Levy Place, box 1010
New York, NY 10029

CMS-1502-P-1148-Attach-1.DOC

CMS-1502-P-1148-Attach-2.DOC

Mount Sinai

The Mount Sinai Medical Center

The Mount Sinai Hospital
Mount Sinai School of Medicine

One Gustave L. Levy Place
New York, NY 10029-6574

Linda Shore-Lesserson, M.D.
Associate Professor
Director,
Cardiothoracic Anesthesiology
Box 1010

Tel (212) 241-7467
Fax (212) 987-6675
E-mail: linda.shore@msnyuhealth.org

September 19, 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:

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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. Increasingly, academic anesthesiology programs are losing skilled physicians to the private practice sector, and the percentage of residents who enter academic anesthesiology after they graduate anesthesiology residency programs is dramatically decreasing. There is already a shortage of anesthesia providers in the United States and that shortage is going to become more apparent as the baby boom generation ages. It would be wrong to allow teaching anesthesiology programs to suffer critical shortages in staff and decreasing quality of staff, especially the staff that cares for our elder population.

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Please end the anesthesiology teaching payment penalty.

Sincerely,

Linda Shore-Lesserson MD

Linda Shore-Lesserson M.D.
Associate Professor of Anesthesiology
Director, Cardiothoracic Anesthesiology
Mount Sinai Medical Center
One Gustave L. Levy Place, box 1010
New York, NY 10029

Submitter : **Linda Shore** **Date: 09/20/2005**

Organization : **Linda Shore**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

see attached word document

CMS-1502-P-1149-Attach-1.DOC

Mount Sinai

The Mount Sinai Medical Center

The Mount Sinai Hospital
Mount Sinai School of Medicine

One Gustave L. Levy Place
New York, NY 10029-6574

Linda Shore-Lesserson, M.D.
Associate Professor
Director,
Cardiothoracic Anesthesiology
Box 1010

Tel (212) 241-7467
Fax (212) 987-6675
E-mail: linda.shore@msnyuhealth.org

September 19, 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

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Please end the anesthesiology teaching payment penalty.

Sincerely,

Linda Shore-Lesserson MD

Linda Shore-Lesserson M.D.
Associate Professor of Anesthesiology
Director, Cardiothoracic Anesthesiology
Mount Sinai Medical Center
One Gustave L. Levy Place, box 1010
New York, NY 10029

Submitter : Mr. mark perry **Date:** 09/20/2005

Organization : citizen

Category : Federal Government

Issue Areas/Comments

GENERAL

GENERAL

It continues to be difficult to find medical providers in Sonoma County, CA, who accept medicare. They understandably are refusing to accept the ridiculous reimbursement payments for the work they do. Sonoma county is no way a "rural" county as presently determined by your agency. Please approve an 8% increase in the county's reimbursement rate as soon as possible. We the senios in the county will thank you and the doctors will get a just reimbursement rate

Submitter : Mr. Rob West **Date:** 09/20/2005

Organization : none

Category : Nurse

Issue Areas/Comments

GENERAL

GENERAL

I would like to express my support for the revision to physician payments in the County of Santa Cruz. As an employee of a local hospital I am aware how hard it is to recruit physicians to settle in the area. Housing costs are high and Santa Cruz can no longer be considered a rural county. Thank you for your time.

Submitter : Dr. James Fletcher **Date:** 09/20/2005

Organization : University of North Carolina at Chapel Hill

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

Dear Dr. McClellan:
I am an anesthesiologist at the University of North Carolina and urge the CMS to change the Medicare anesthesiology teaching payment policy. Because of restrictions in the number of rooms that a teaching anesthesiologist can cover when teaching residents (two rooms only), the 50% reimbursement per room places an undue hardship on the ability to practice anesthesia in a teaching hospital. This situation is out-of-line with other specialties, who can cover multiple rooms/sites and still be fully paid for their professional services. Teaching anesthesiologists should be brought into line with other specialties in order to further the ability of teaching programs to train the next generation of anesthesia providers.

Yours sincerely

James Fletcher

Submitter : **Mrs. Cammy Goldmann** **Date: 09/20/2005**

Organization : **Mrs. Cammy Goldmann**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

I am writing to strongly support the proposed revision to physician payment localities in California that you published earlier this month. I hope that you adopt this rule as final in November! As a concerned citizen I am very concerned that as our doctors age and retire our community is able to attract new physicians to take there place. I have followed the issues surrounding the inclusion of Santa Cruz County within Locality 99 for California and welcome the opportunity to support your proposed solution to the current inequitable payment policy. I believe adoption of your proposed rule will go a long way to ensure ongoing access to high quality care for all of the residents in our community. Physicians in Santa Cruz receive 25% less reimbursement than doctors in two other communities close by. Thank you for proposing a rule that would address this problem for our physicians in Santa Cruz County. I believe this is the fair thing to do. Thanks for considering my comments.
Sincerly,
Cammy Goldmann
Employee of Santa Cruz County

Submitter : Dr. Ryan Brandt **Date:** 09/20/2005

Organization : Dr. Ryan Brandt

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

I live and work in Santa Cruz County. I STRONGLY support CMS in having Santa Cruz receive a specific locality code. We are no longer a rural county and have not been one for a number of years. Each year our patients and physicians are not receiving the reimbursement/care they deserve due to a flaw in the system. I applaud the CMS for their ongoing efforts and hope this is signed into effect Jan 2006. Thank you.

Submitter : **Karla Perez-Hunter** **Date: 09/20/2005**

Organization : **Dominican Hospital**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

9/20/05

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

Re: File Code CMS1502-P

Issue Identifier: GPCI?s / Payment Localities

Dear CMS Staff:

I strongly support the proposed revision to physician payment localities in California that you published earlier this month. I hope that you take on this rule as final in November. As an employee of Dominican Hospital, I am very concerned that as our physicians age and retire, we as a community are able to attract new physicians to take their place. I welcome the opportunity to support your proposed solution to the current inequitable payment policy. I believe adoption of your proposed rule will go a long way to ensuring ongoing access to high quality care for community and county residents.

As you know, physicians in Santa Cruz receive reimbursement at levels 25% less than physicians in two of our neighboring counties. Current payments are about 10% less than they should be, given the county?s current GAF. They do not reflect the high cost of practice in our community.

You are to be commended for proposing a rule that would address this problem for physicians in Santa Cruz and Sonoma Counties, the two most problematic counties in California. I believe this to be fair and appropriate. Thank you for considering my comments.

Sincerely,

Name: Karla Perez-Hunter
Address: Human Resources
1555 Soquel Drive
Dominican Hospital

Submitter : **Ms. Rayette Andrews** **Date: 09/20/2005**

Organization : **Ms. Rayette Andrews**

Category : **Health Care Professional or Association**

Issue Areas/Comments

GENERAL

GENERAL

Sept. 20, 2005

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

Re: File Code CMS1502-P

Issue Identifier: GPCI?s / Payment Localities

Dear CMS Staff:

I am writing to strongly support the proposed revision to physician payment localities in California that you published earlier this month. I hope that you adopt this rule as final in November. As an employee of Dominican Hospital, I am very concerned that as our physicians age and retire, we as a community are able to attract new physicians to take their place. I have followed the issues surrounding the inclusion of Santa Cruz County within Locality 99 for California and welcome the opportunity to support your proposed solution to the current inequitable payment policy. I believe adoption of your proposed rule will go a long way to ensuring ongoing access to high quality care for community residents.

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You are to be commended for proposing a rule that would address this problem for physicians in Santa Cruz and Sonoma Counties, the two most problematic counties in California. I believe this to be fair and appropriate. Thank you for considering my comments.

Sincerely,
Rayette Andrews, RN, MSN
157 Casa Linda Lane
Aptos, CA 95003
r.andrew@charter.net

Submitter : Dr. Peter Hendricks **Date:** 09/20/2005

Organization : AGE

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

I am a physician who in thirty years of practice spent 9 years as director of resident training in two major teaching instutiion. Residents are the life blood of our speciality but because of the inequality of Medicare payments to teaching anesthesiologists in academic institutions have helped to put these teaching instutions in crisis. The medicare teaching rules were changed arbitarily in 1996 where anesthesiologists were suddenly treated differently than their surgical and medical counterparts who recieve full payment for teaching two residents concurrently . The anesthesiologist recieves only one half for each.. This is not fair and is recognized as such by CMS itself in the Federal register. Please change the Medicare Teaching Rule for anesthesiologists so that the academic programs will survive and you will have anesthesiologists to provide care and safety to the Medicare patients

Submitter : **Ms. NZ Carol** **Date: 09/20/2005**

Organization : **Dominican Hospital Foundation**

Category : **Other Health Care Professional**

Issue Areas/Comments

GENERAL

GENERAL

Date: 9-19-05

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

Re: File Code CMS1502-P

Issue Identifier: GPCI?s / Payment Localities

Dear CMS Staff:

I strongly support the proposed revision to physician payment localities in California that you published earlier this month. I hope that you adopt this rule as final in November. As an employee of Dominican Hospital, I am very concerned that as our physicians age and retire, we as a community are able to attract new physicians to take their place. I have followed the issues surrounding the inclusion of Santa Cruz County within Locality 99 for California and welcome the opportunity to support your proposed solution to the current inequitable payment policy. I believe adoption of your proposed rule will go a long way to ensuring ongoing access to high quality care for community residents, particularly our vulnerable seniors.

Physicians in Santa Cruz receive reimbursement at levels 25% less than physicians in our neighboring counties. Current payments do not reflect the high cost of practice in our community.

You are to be commended for proposing a rule that would address this problem for physicians in Santa Cruz and Sonoma Counties, the two most problematic counties in California. I believe this to be fair and appropriate. Thank you for considering my comments. It is time for this inequity to cease. Much appreciation.

Sincerely,

NZ Carol, CFRE
755 14th Ave #510
Santa Cruz, CA 95062

Submitter : **Ms. Gloria Hersch** **Date: 09/20/2005**

Organization : **Ms. Gloria Hersch**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

Date:

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

Re: GPCIs

I am a Medicare beneficiary who receives medical care from a physician in Sonoma County, California. I understand that Medicare is proposing to create a new payment locality for 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 me and other Medicare beneficiaries. 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,

Name:
Address:
City, State, ZIP

Date: 9/21/05

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

Re: GPCIs

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The new locality would help Sonoma County physicians improve the quantity and quality of care they deliver to me and other Medicare beneficiaries. 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,

Gloria Hersch

Name: Gloria Hersch
Address:711 Alta Vista Drive
City, State, ZIP Healdsburg, CA 95448

Submitter : Mr. W Mark Gwin **Date:** 09/20/2005

Organization : Mr. W Mark Gwin

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

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The new locality would help Sonoma County physicians improve the quantity and quality of care they deliver to me and other Medicare beneficiaries. 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.

Submitter : **Ms. Annette Masters** **Date: 09/21/2005**

Organization : **Ms. Annette Masters**

Category : **Occupational Therapist**

Issue Areas/Comments

GENERAL

GENERAL

I am writing to strongly support the proposed revision to physician payment localities in California that you published earlier this month. I hope that you adopt this rule as final in November. As an employee of Dominican Hospital, I am very concerned that as our physicians age and retire, we as a community are able to attract new physicians to take their place. I have followed the issues surrounding the inclusion of Santa Cruz County within Locality 99 for California and welcome the opportunity to support your proposed solution to the current inequitable payment policy. I believe adoption of your proposed rule will go a long way to ensuring ongoing access to high quality care for community residents.

As you know, physicians in Santa Cruz receive reimbursement at levels 25% less than physicians in two of our neighboring counties. Current payments are about 10% less than they should be, given the county?s current GAF. They do not reflect the high cost of practice in our community.

You are to be commended for proposing a rule that would address this problem for physicians in Santa Cruz and Sonoma Counties, the two most problematic counties in California. I believe this to be fair and appropriate. Thank you for considering my comments.

Sincerely,

Name: Annette Masters, MA,OTR,CHT

Address:1550 Soquel Dr.
Santa Cruz, CA 95062

Submitter : **Dr. Geoffrey Bernstein** **Date: 09/21/2005**

Organization : **Santa Cruz Medical Foundation**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Dear Representatives
An elderly lady(someone like your mother)notes pain and yellow skin and dark urine. She dials her doctor but gets a recorded message "Dr Smith has unfortunately left the area, please go to the ER". She with difficulty drives herself to the ER where luckily on of the old time ER physicians is there to help. He tells her:"Well you have a gallstone stuck in your bile duct but there is no skilled gastroenterologist here to take it out, they all left".

"What shall I do?" she asks.

"Think of driving yourself up to San Francisco, or if you wish we can get an ambulance that you may have to pay for".

"I sure wish that Locality 99 issue had been resolved favorably for our doctors".

"Yes, it's too bad. This my last shift here, I'm moving to Texas next week, good luck"

Submitter : **Ms. Carol George** **Date: 09/21/2005**

Organization : **Dominican Hospital / Santa Cruz CA**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

I am writing to strongly support the proposed revision to physician payment localities in California that you published earlier this month. I hope that you adopt this rule as final in November. As an member of the community served by Dominican Hospital, I am very concerned that as our physicians age and retire, we as a community are able to attract new physicians to take their place. I have followed the issues surrounding the inclusion of Santa Cruz County within Locality 99 for California and welcome the opportunity to support your proposed solution to the current inequitable payment policy. I believe adoption of your proposed rule will go a long way to ensuring ongoing access to high quality care for community residents.

As you know, physicians in Santa Cruz receive reimbursement at levels 25% less than physicians in two of our neighboring counties. Current payments are about 10% less than they should be, given the county?s current GAF. They do not reflect the high cost of practice in our community.

You are to be commended for proposing a rule that would address this problem for physicians in Santa Cruz and Sonoma Counties, the two most problematic counties in California. I believe this to be fair and appropriate. Thank you for considering my comments.

Sincerely,
Carol George
1461 30th Ave
Santa Cruz, CA 95062

831 477 9162

Submitter : Mr. Scott Anderson **Date:** 09/21/2005

Organization : Mr. Scott Anderson

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

Please increase the Medicare reimbursement rate in Sonoma County, California. We have been in the reimbursement rate that other rural areas are categorized in, while we are a very high cost area. The low reimbursement rate is causing health care professionals to leave our area.

Thank you!

Submitter : **Dr. David Campell** **Date: 09/21/2005**

Organization : **Santa Rosa Memorial Hospital**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

September 20, 2005

I understand that Medicare is proposing to create a new payment locality for Sonoma County, California, which is an increasingly expensive place to live, work and practice medicine. 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 quality and quantity of care they deliver to Medicare beneficiaries and other patients as well. The locality change would also benefit efforts to recruit and retain physicians in the county, which has a large Medicare population. This has been a big problem for Sonoma County for many years. Many superb physicians have turned down offers to live and work in Sonoma County due, in part to the high costs of living, the high costs to practice medicine and the inappropriately low Medicare reimbursement. This has caused critical gaps in the coverage for patients and has created difficulties in access to care for Medicare patients and all patients alike. Many primary care doctors are restricting the amount of Medicare patients in their practices for these reasons. As a physician who has practiced in Sonoma County for many years I have personally witnessed this decline in care and I feel that your proposal to create a new Medicare locality for Sonoma County is the first step to correct this problem.

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

Sincerely,

David Campell, MD

Submitter : Dr. J. Michael Gospe **Date:** 09/21/2005

Organization : Dr. J. Michael Gospe

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

I am a retired gastroenterologist who had practiced medicine in Sonoma County for 29 years. I have seen many physicians leave the area, or refuse to move to the county, in large part because of the very low medicare payment schedule. Housing prices, cost of living, and office assistance prices in Sonoma County are comparable to those in Marin and San Francisco Counties. The suggested raise is clearly not substantial enough, but is a start. I strongly recommend passage of CMS-1502-P. Sincerely, J. Michael Gospe, M.D.

Submitter : **Ms. Saralee McCormick** **Date: 09/21/2005**

Organization : **Dominican Hospital**

Category : **Other Health Care Professional**

Issue Areas/Comments

GENERAL

GENERAL

I support the proposed revision to physiscian payment localities that you published earlier this month, specifically including Santa Cruz County within Locality 99. Adopting this rule as final in November will enable Dominican Hospital, of which I am an employee, to recruit new physicians to our area. Our housing prices and cost of living in our area, as well as our lifestyle, classifies us as urban community and our physicians should be reimbursed as such. Thank you.

Submitter : **Charlene Staples** **Date: 09/21/2005**

Organization : **Charlene Staples**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

Medicare reimbursement should reflect the actual cost of practicing medicine in Sonoma county which is no more a rural county than is Los Angeles or San Francisco. This is a very expensive place to live with housing prices out of sight.

Sonoma County needs a realistic reimbursement rate not only for medicare, but also because insurance companies base their reimbursement on the medicare fee schedule. I am embarassed when I see how little my physicians are paid for the excellent care I receive. Physicians are NOT PROVIDERS, they are highly educated and trained PHYSICIANS. Their level of responsibility is truly that of life and death decisions. Shouldn't that be reflected in their reimbursement especially in such an expensive place to live.

Value the physicians of Sonoma County. Pay them commensurate with their locale and with their level of responsibility for the health and well being of the citizens of this county.

Thank you for your consideration and I trust that you will do the right thing for health care in Sonoma county

Sincerely,

Charlene Staples

Submitter : **Date: 09/21/2005**

Organization :

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

This message is in support of removing Sonoma and Santa Cruz from CA Locality 99 and assigning them to their own localiites effective January 1, 2006

Submitter : **Dr. michael lazar** **Date: 09/21/2005**

Organization : **Dr. michael lazar**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Re: GPCIs

I write to strongly support creating a new payment locality for Sonoma County, California. As a physician, I find the cost of living and of doing business is outstripping compensation for services rendered to Medicare patients. We have been unable to recruit new physicians due to the doubling of housing costs over the last 5 years and the inadequate compensation for medical care of our large Medicare population. Please reconsider our 'rural' designation and provide Sonoma County physicians fair compensation for medical care.

Michael J. Lazar MD

Submitter : Dr. Eileen Tyler **Date:** 09/21/2005

Organization : University of North Carolina School of Medicine

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

I am a teaching Anesthesiologist at a University Medical Center, and I am urging CMS to change the discriminatory payment arrangement. The 50% reduction in Medicare payment for supervising residents during two concurrent surgical cases is unfair and unreasonable. Medicare's teaching payment rules should be consistently applied across all medical subspecialties--current payment rules allow 100% fee collection for our teaching colleagues in Surgery and Medicine. Our department at UNC has become financially crippled by these inconsistent reimbursement policies. We have become unable to retain an adequate number of faculty to meet the surgical demands in our academic institution. Our ability to train residents in our specialty has become severely compromised.
I have NEVER understood the blatant discrimination against teaching Anesthesiologists exhibited by CMS reimbursement policies. It is well past time to put us on par with our academic colleagues in other specialties!

Submitter : **Dr. David Mayer** **Date: 09/21/2005**

Organization : **UNC Hospitals**

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 as an anesthesiologist at UNC Hospital , Chapel Hill, NC 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 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.
Please end the anesthesiology teaching payment penalty.
David C. Mayer, MD
UNC Department of Anesthesiology
Chapel Hill, NC 27517

Submitter : **Dr. Richard Juda** **Date: 09/21/2005**

Organization : **Baystate Hospital**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

September 15, 2005

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

Re: TEACHING ANESTHESIOLOGISTS

Throughout the State of Massachusetts, there are continuing concerns about the adequacy of federal support for teaching institutions. As a physician at a teaching institution, I see the growing concerns within our facility and throughout the state. The impact of inadequate funding on access to necessary medical services by those in need is being felt on every level of patient care.

More specifically, and on a more immediate level, academic anesthesiology departments face severe difficulties with regards to funding. Anesthesiologists are not allowed to receive a full fee for supervision of two cases running simultaneously. The same rule does not apply to surgeons at teaching facilities. Surgeons are allowed to bill Medicare full fees for two overlapping surgeries involving residents, as long as they are present during the critical portions of each procedure involving a resident. Why is there no such flexibility for anesthesiologists? The teaching anesthesiologist is only reimbursed a full fee if he was involved with a single resident on a one-to one basis.

You can certainly see that providing the same rule for teaching anesthesiologists would enhance the opportunities and allow us to divide our time between two concurrent resident cases allowing full fee reimbursement for each. This simple adjustment would improve the payment structure for our own institution and others like it throughout the State and across the country.

I appreciate your attention to this important issue and hope that you are able to address these concerns. Academic anesthesiology departments would surely benefit from this adjustment and improve the quality of care for patients at all teaching institutions.

Sincerely,

Richard J Juda, MD
Department of Anesthesiology
Baystate Medical Center

Submitter : **Ms. Carmen Martinez** **Date: 09/21/2005**

Organization : **Dominican Hospital**

Category : **Other Technician**

Issue Areas/Comments

GENERAL

GENERAL

September 21, 2005

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

Re: File Code CMS1502-P

Issue Identifier: GPCI?s / Payment Localities

Dear CMS Staff:

I am writing to strongly support the proposed revision to physician payment localities in California that you published earlier this month. I hope that you adopt this rule as final in November. As an employee of Dominican Hospital, I am very concerned that as our physicians age and retire, we as a community are able to attract new physicians to take their place. I have followed the issues surrounding the inclusion of Santa Cruz County within Locality 99 for California and welcome the opportunity to support your proposed solution to the current inequitable payment policy. I believe adoption of your proposed rule will go a long way to ensuring ongoing access to high quality care for community residents.

As you know, physicians in Santa Cruz receive reimbursement at levels 25% less than physicians in two of our neighboring counties. Current payments are about 10% less than they should be, given the county?s current GAF. They do not reflect the high cost of practice in our community.

You are to be commended for proposing a rule that would address this problem for physicians in Santa Cruz and Sonoma Counties, the two most problematic counties in California. I believe this to be fair and appropriate. Thank you for considering my comments.

Sincerely,

Carmen L. Martinez
100 N. Rodeo Gulch Rd.
Soquel, Ca. 950736

Submitter : Ms. Pamela Tennant **Date:** 09/21/2005

Organization : Ms. Pamela Tennant

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

I've lived in Sonoma County, California, for 2 years and am a native of central California. Sonoma County is an hours drive from San Francisco, is considered within the commute radius of that city, and has one of the highest housing costs in all of California. Yet I've read that the physicians here are reimbursed at the same level as the more remote, rural areas. It is imperative that they receive compensation for their services proportional to their costs, or we will lose many physicians to areas where they can do so. Soon I will be enrolling in Medicare, and I fervently hope I will be able to continue seeing my same doctor and that we will have a full compliment of well-qualified physicians to treat our aging population in Sonoma County.

Submitter : **Ms. Wayne Hawkins** **Date: 09/21/2005**

Organization : **Dominican Hospital**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

See attachment

CMS-1502-P-1177-Attach-1.DOC

September 21, 2005

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

Re: File Code CMS1502-P

Issue Identifier: GPCI's / Payment Localities

Dear CMS Staff:

As a long time resident of Santa Cruz County I have seen a great deal of growth in the area and with that a tremendous increase in the cost of living and doing business. It is every bit as expensive to live and work here as it is in our neighboring county of Santa Clara. As an employee of Dominican Hospital, I am very concerned that as our physicians age and retire, we as a community are able to attract new physicians to take their place. I have followed the issues surrounding the inclusion of Santa Cruz County within Locality 99 for California and welcome the opportunity to support your proposed solution to the current inequitable payment policy. I believe adoption of your proposed rule will go a long way to ensuring ongoing access to high quality care for community residents.
I strongly support the proposed revision to physician payment and hope that you adopt this rule as final in November.

Sincerely,

Wayne Hawkins
195 Coon Heights Dr.
Ben Lomond, CA 95005

Submitter : Dr. Irving Berkowitz **Date:** 09/21/2005

Organization : Irving M Berkowitz DOPA

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

If these Medicare cuts go through I will not be able to treat any patients in my office. This will cause a delay in the patients treatment. As you know that can be life threatening at times. If that happens, I am positive I will no longer be able substain my practice. I have a patient base of about 700 patients, who will care for them? Is Medicare going to come in and take over? The other oncologist in the USA are in the same position I am in, so who will treat these patients? You are causing a hardship for the physician, the patient and the hospitals.

Submitter : Ms. MARY CLAY **Date:** 09/21/2005

Organization : cancer care centers of south texas

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

see attachment

Submitter : Dr. John Eckardt **Date:** 09/21/2005

Organization : The Center for Cancer Care and Research

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir/Madam:

I am deeply concerned that community cancer care will face major losses in 2006. On January 1st, the 3% drug administration transition adjustment will fall to zero, the special funding CMS invested in 2005 in quality cancer care will end, and the physician fee schedule will be hit with a 4.3% cut. These changes will move our most vulnerable patients out of the community setting to higher cost and difficult access hospital setting.

These changes are projected to result in a net operating loss for community cancer care of $437,225,175 in 2006 (bad debt additional). In other words, Medicare payments for services provided to beneficiaries in 2006 will be more than half a billion dollars below the estimated cost of those services. This loss could imperil the community cancer care delivery system on which more than 4 out of 5 patients now depend.

To prevent this crisis, I urge CMS to consider the following proposals:

Provide compensation for the pharmaceutical management and related handling costs incurred by community cancer caregivers. CMS has proposed to compensate HOPDs for such costs by providing an additional 2% of ASP. To help prevent the access crisis discussed above and achieve equity among treatment settings, this payment should also be made available to community cancer care. This payment would increase funding for community cancer care by nearly $85 million next year and would offset nearly one-fifth of the $437,225,175 Medicare operating loss projected for 2006 (bad debt additional).

Continue the Agency?s investment in quality cancer care. This critical source of funding needs to be maintained for 2006, a step recently endorsed by the House Energy and Commerce Committee when it passed H.Res. 261. Doing so would offset nearly two-thirds of the $437,225,175 Medicare operating loss projected for 2006 (bad debt additional), while preventing patient access disruption in 2006 and supporting quality improvement efforts for cancer care.

Change the time inwhich the CMS adjusts payment for drugs from every three months to yearly. This would allow purchasers to pressure pharma companies to lower prices, overall driving down the cost of drugs. There will be no incentive for pharma to lower prices if it changes every 3 months.

Work with Congress to replace the SGR formula with annual fee updates. If the 4.3% cut in the Physician Fee Schedule can be corrected before it goes into effect on January 1st, the fix will offset over 8% of the $437,225,175 operating loss projected for 2006 (bad debt additional). In addition, correction of the SGR cut would also provide relief for the reductions that will also impact radiation oncology and physician evaluation and management services.

Refine the proposed revisions to the practice expense methodology. While I commend CMS for the changes it is proposing to make to Medicare practice expense payment policy, I am troubled by the decision to exclude drug administration services from these revisions. Instead, the Agency should include drug administration services in the phase-in of the bottom-up methodology in 2006 and ensure they are exempt from budget neutrality.

Refine the interpretation of ?Prompt Pay Discount.? CMS?s current view of MMA as requiring that all prompt pay discounts be netted out of ASP is reducing Medicare drug reimbursement from 106% of ASP to 104% of ASP. Congressional intent and Supreme Court case law direct that only prompt pay discounts received by the end user-purchasers of drugs should be netted out. Correcting this would restore nearly $85 million in Medicare reimbursement, offsetting one-fifth of the $437,225,175 Medicare operating loss projected for 2006 (bad debt additional).

Submitter : Dr. Kavita Kalra **Date:** 09/21/2005

Organization : Dr. Kavita Kalra

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

I am deeply concerned that, without much-needed administrative action, community cancer care could face major losses in 2006. On January 1st, the 3% drug administration transition adjustment will fall to zero, the special funding CMS invested in 2005 in quality cancer care will end, and the physician fee schedule will be hit with a 4.3% cut.

These changes are projected to result in a net operating loss for community cancer care of $437,225,175 in 2006 (bad debt additional). In other words, Medicare payments for services provided to beneficiaries in 2006 will be more than half a billion dollars below the estimated cost of those services. This loss could imperil the community cancer care delivery system on which more than 4 out of 5 patients now depend.

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Review the proposed reimbursement policy for imaging of contiguous body parts. The cost efficiencies that can be achieved through multiple scans in a single setting may total far less than the 50 percent factor proposed by CMS. As a result, the Agency should review this policy to assess whether a smaller reimbursement change would more closely track those overlapping costs that may occur.

Provide reimbursement for Image Guided Radiation Therapy. Image Guided Radiation Therapy (IGRT) has enabled significant progress in the quality of radiation oncology services by enabling treatment to be targeted on cancerous tissu

Submitter : M Kalra **Date:** 09/21/2005

Organization : M Kalra

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

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Submitter : **Mrs. Jennifer Espinoza** **Date: 09/21/2005**

Organization : **Mrs. Jennifer Espinoza**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

In the last eight years I have had my O.B. doctor move from our county where she was unable to make a decent living and I've had prospective doctors not accept our insurance. Sonoma County is a very expensive place to live and to work. My husband, an R.N. in the operating room, is well paid. However, it is disheartening and frustrating when our family is unable to receive high quality medical care due to doctors inability to take certain insurances and doctors who leave the area due to financial strain.

I understand that Medicare is proposing to create a new payment locality for Sonoma County. In the new locality, the Medicare reimbursement rate would be more closely matched to actual practice expenses than it is now.

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

Sincerely,

Jennifer Espinoza
1171 Halyard Drive
Santa Rosa, CA 95401

JGESPI@aol.com

Submitter : **nicolina chapman** **Date: 09/21/2005**

Organization : **nicolina chapman**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

I am deeply concerned that, without much-needed administrative action, community cancer care could face major losses in 2006. On January 1st, the 3% drug administration transition adjustment will fall to zero, the special funding CMS invested in 2005 in quality cancer care will end, and the physician fee schedule will be hit with a 4.3% cut.

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Submitter : Dr. Joseph Panaro **Date:** 09/21/2005

Organization : individual

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

I am writing in support of the locality 99 issue and the proposal to change Santa Cruz County's status from rural to urban. We are a high cost area in every way and physicians and other health care workers have a hard time with the high cost of living while earning pay based on the scale for a rural area. As a result they are leaving us in droves. We desperately need to have our status changed to URBAN. My wife and I have had trouble getting doctors in this area because there is a shortage due to this 'rural policy'.

Submitter : **Dr. James Kamplain** **Date: 09/21/2005**

Organization : **Birmingham Radiological Therapy Division**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

I am writting this in regard to the Physician Fee Schedule. I feel that the fee schedule greatly undervalues the physician payments.

Submitter : **Mr. James Anderson** **Date: 09/21/2005**

Organization : **Central Business Office**

Category : **Health Care Professional or Association**

Issue Areas/Comments

GENERAL

GENERAL

I support the COMMENTS that have been submitted by US Oncology to you.

Submitter : Mr. Jeff Miller **Date:** 09/21/2005

Organization : Augusta Oncology Associates

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

I'm commenting on this issue because if CMS follows through on its proposed changes for 2006, delivering quality cancer care to Medicare patient's will become nearly impossible in the outpatient setting. I don't think anyone wants to see the delivery of chemo migrate back to the inpatient setting. Such great strides have been made in the outpatient practices, therefore; it would be of grave injustice to the cancer community to 'pull the rug out from under their feet'. I don't believe that is the intention of CMS, but perception and reality are two different animals all together.

If ASP is correctly defined, then some of the reimbursement to drugs would not be so devastating. I work for a private practice and I can tell you (even show you if you would prefer) that by the time the drug is in our office we are not realizing 'cost plus 6 percent'. If fact, depending on the drug 'cost' is all over the place. Most of the drugs we administer to Medicare patients are 'cost' minus various percents. CMS has unfortunately created formularies in some practices due to cost. Some practices are forced to use drugs they would rather not, but don't have a choice because the ASP does not support their cost to deliver a particular drug. Hence quality of care is being compromised due to practices trying to figure out a way to stay in business.
This is an environment that has many oncologists and patients very troubled.

The changes in 2006 are only going to create more problems and strengthen 'not so good' formularies. Early pay discounts should not be counted in the definition of ASP. By doing this, 2% comes right of the top, and then the middleman takes their 3% and if we are lucky we might be whole on a few drugs. Add in bad debt, pharmacy costs, inventory management, treatment planning costs, social worker services, and etc., which are not reimbursable, then a Medicare patient is going to cost every private practice money. Name one business that can operate in the red (without government assistance).

The figures are out and public knowledge in reagrds to the cuts being made to Oncology. Its obvious that input from the cancer community was not sought out with CMS's model for reimbursement. It is not too late to take corrective measures to insure that the huge advances made in outpatient oncology are not jeopardized by law-makers that are not informed and unaware of how a private practice operates.

I invite anyone to visit our practice to not only discuss these issues in greater detail, but share some of our financials, in hopes to shed some more light on this extremely important issue.

Submitter : **Mr. Travis Pederson** **Date: 09/21/2005**

Organization : **us oncology**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

Medicare needs to step up to the plate and cover the expences of people that are covered under this insurance and not leave it to the tax payors to burden the remainder of the cost. It is an injustice that they take away the monies provided for drugs and make them the responsibility of the patients who cannot afford this.

I would like to see the goverment take an active role in repairing the healthcare system by improving there reimbursement and not setting standards that are unrealistic.

Sincerely,

Jay Travis Pederson

Submitter : **Christine Zito** **Date: 09/21/2005**

Organization : **Assoc Oncology/Hematology**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

I am deeply concerned that, without much-needed administrative action, community cancer care could face major losses in 2006. On January 1st, the 3% drug administration transition adjustment will fall to zero, the special funding CMS invested in 2005 in quality cancer care will end, and the physician fee schedule will be hit with a 4.3% cut.

These changes are projected to result in a net operating loss for community cancer care of $437,225,175 in 2006 (bad debt additional). In other words, Medicare payments for services provided to beneficiaries in 2006 will be more than half a billion dollars below the estimated cost of those services. This loss could imperil the community cancer care delivery system on which more than 4 out of 5 patients now depend.

To prevent this crisis, I urge CMS to consider the following proposals:

Provide compensation for the pharmaceutical management and related handling costs incurred by community cancer caregivers. CMS has proposed to compensate HOPDs for such costs by providing an additional 2% of ASP. To help prevent the access crisis discussed above and achieve equity among treatment settings, this payment should also be made available to community cancer care. This payment would increase funding for community cancer care by nearly $85 million next year and would offset nearly one-fifth of the $437,225,175 Medicare operating loss projected for 2006 (bad debt additional).

Continue the Agency?s investment in quality cancer care. This critical source of funding needs to be maintained for 2006, a step recently endorsed by the House Energy and Commerce Committee when it passed H.Res. 261. Doing so would offset nearly two-thirds of the $437,225,175 Medicare operating loss projected for 2006 (bad debt additional), while preventing patient access disruption in 2006 and supporting quality improvement efforts for cancer care.

Work with Congress to replace the SGR formula with annual fee updates. If the 4.3% cut in the Physician Fee Schedule can be corrected before it goes into effect on January 1st, the fix will offset over 8% of the $437,225,175 operating loss projected for 2006 (bad debt additional). In addition, correction of the SGR cut would also provide relief for the reductions that will also impact radiation oncology and physician evaluation and management services.

Refine the proposed revisions to the practice expense methodology. While I commend CMS for the changes it is proposing to make to Medicare practice expense payment policy, I am troubled by the decision to exclude drug administration services from these revisions. Instead, the Agency should include drug administration services in the phase-in of the bottom-up methodology in 2006 and ensure they are exempt from budget neutrality.

Refine the interpretation of ?Prompt Pay Discount.? CMS?s current view of MMA as requiring that all prompt pay discounts be netted out of ASP is reducing Medicare drug reimbursement from 106% of ASP to 104% of ASP. Congressional intent and Supreme Court case law direct that only prompt pay discounts received by the end user-purchasers of drugs should be netted out. Correcting this would restore nearly $85 million in Medicare reimbursement, offsetting one-fifth of the $437,225,175 Medicare operating loss projected for 2006 (bad debt additional).

Review the proposed reimbursement policy for imaging of contiguous body parts. The cost efficiencies that can be achieved through multiple scans in a single setting may total far less than the 50 percent factor proposed by CMS. As a result, the Agency should review this policy to assess whether a smaller reimbursement change would more closely track those overlapping costs that may occur.

Provide reimbursement for Image Guided Radiation Therapy. Image Guided Radiation Therapy (IGRT) has enabled significant progress in the quality of radiation oncology services by enabling treatment to be targeted on cancerous tissu

Submitter : **Jim Clarke** **Date: 09/21/2005**

Organization : **Jim Clarke**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

If your are trying to bring small practice Oncology, I work for 3 oncologists, to it knees your doing a good job. The demonstration project brought $100,000 to our department in '05. Gone in '06. Part of the reason for this project reconizied the hard year '05 was going to be. How about '06? ASP + 6% is making drug reimbursement a wash with drug cost. We are not internist, there is a $4000000 drug use, at any one time we have $250000 in inventory. We are not always reimbursed. 65% of our patients are Medicare, 15% Medicaid, 10% without insurance and many don't and cannot afford to pay copays. One of our physician is just starting and he remains in debt for start up cost and drugs inventory a year later. He ask the question, should I stay with Oncology. We need help. ASP + 10% is closer to a real number. THe converion factors need to be left along or increased. Another demonstration project. I'm angry and unfortuately it show.

Submitter : **Mrs. Margie Fields** **Date: 09/21/2005**

Organization : **Individual**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

I have heard that Medicare intends to reduce the fees paid to primary care doctors and I beg you to reconsider this decision and DO NOT MAKE FURTHER CUTS IN PRIMARY CARE DOCTORS REIMBURSEMENT. I am on Medicare and had trouble finding a primary care doctor who will even accept Medicare here in Pearland, TX and where I previously lived in Bartlesville, OK. Since Medicare patients usually have multiple health problems, doctors have to spend a lot of time with each patient and are not paid nearly enough now for their time involved. Again, I ask you, "PLEASE DO NOT REDUCE THE REIMBURSEMENT FEES paid to primary care doctors" or all primary care doctors will refuse to see patients 65 and over. We will not be able to even get a doctor.

Submitter : Dr. Muhammad Ghotbi **Date:** 09/21/2005

Organization : Kaiser Permanente Medical Center

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

I am writing as a cardiovascular anesthesiologist at Kaiser Permanente Medical Center in San Francisco 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 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.

Please end the anesthesiology teaching payment penalty.

Submitter : Dr. Nancy Wilkes **Date:** 09/21/2005

Organization : ASA

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

see attachment

CMS-1502-P-1195-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 as an anesthesiologist at the University of North Carolina Hospitals in Chapel Hill, NC, 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 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.

This inequity has directly contributed to reduced income for our department and subsequent faculty attrition secondary to substandard salaries. This is jeopardizing our ability to recruit new faculty and entice quality resident candidates for what has been an outstanding training program. At our institute and at other great institutes the very future of anesthesiology is being threatened because this unfair reimbursement model.

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 Nancy Wilkes, MD

Address Scenic View Dr.

Chapel Hill, NC 27516

Submitter : **Dr. salvador mendez** **Date: 09/21/2005**

Organization : **McAllen Bone**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

You continue to reduce payments to us all the while the costs of employees, supplies (ie casting materials, etc.) continue to rise!!!! If the bundling of casts materials is included with the surgery you leave us no alternative but to withdraw from seeing Medicare patients in the future. Because what Medicare does ever other insurance company does. Medicare sets the standard. You need to be fair! If casting supplies cost us separetly then we should be paid for them separetly!!!!

Submitter : **Dr. Douglas Hoffmann** **Date: 09/21/2005**

Organization : **Piedmont Hospital**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

CMS should maintain the current CPT coding and reimbursement for flow cytometry.
Why?
1. Flow cytometry is overutilized, ordered when it is unnecessary in the majority of cases, and more markers are billed for than are necessary by many laboratories
2. In approximately 70% of cases at my institution, flow cytometry is ordered and performed when not indicated.

This needs to stop.

Submitter : Dr. Andrew F. Stasic **Date:** 09/21/2005

Organization : American Society of Anesthesiologists

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

"See Attachment"

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

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

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

Submitter : Dr. Andrew F. Stasic **Date:** 09/21/2005

Organization : American Society of Anesthesiologists

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

September 21, 2005

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

RE: CMS-1502-P/TEACHING ANESTHESIOLOGISTS

Dear Dr. McClellan:

I am an anesthesiologist and have served as a fulltime faculty member at Indiana University School of Medicine, Indianapolis, Indiana for the past 13 years. I am writing this letter to urge the Centers for Medicare and Medicaid Services (CMS) to revise the Medicare anesthesiology teaching payment policy.

The current Medicare anesthesiology teaching payment policy (which was instituted in 1995) has been very detrimental to the economic survival of anesthesiology departments in teaching institutions. With decreasing levels of income of anesthesiology faculty, it has become increasingly difficult to retain skilled faculty. The number of unfilled anesthesia faculty positions at teaching institutions across the country has continually increased during the past decade. This has had a serious detrimental impact on the ability of programs to train the future 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 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.

Academic anesthesiologists similar to surgeons and internists are permitted to work with residents on overlapping cases as long as they are present for critical

or key portions of the procedure. However, unlike teaching surgeons and internists, the reimbursement of teaching anesthesiologists who work with residents on overlapping cases is reduced by 50%. Compared to other specialties in medicine Medicare payment for anesthesia services is much lower (approximately 40% of usual and customary). The impact of lower payment is accentuated by 50% reduction for overlapping cases when the anesthesiologist is working with residents. The low reimbursement for anesthesia services and 50% reduction in reimbursement is unfair and unreasonable.

To ensure the training of much needed future anesthesiologists, I am requesting that CMS review and revise Medicare payment rules for anesthesia services.

Sincerely,

Andrew F. Stasic, M.D.
Associate Professor of Anesthesia
Indiana School of Medicine
Riley Hospital for Children
Indianapolis, IN 46202

Submitter : Mrs. Cecilia Bowden **Date:** 09/21/2005

Organization : Orthopaedic Associates of Augusta, PA

Category : Health Care Provider/Association

Issue Areas/Comments

GENERAL

GENERAL

I am writing in opposition to the 4.3% across-the-board reduction in reimbursement for orthopaedic surgeons in 2006 and in opposition to the proposal to eliminate reimbursement for cast/splint codes Q4001-Q4051 and roll those codes into the global fee for fracture care. Both of these proposals would result in a great loss to our orthopaedic practice and would affect not only our Medicare payments, which are already too low, but also all other payers who base their reimbursement on a percentage of Medicare. I urge you to reconsider both of these proposals.