Submitter : Dr. Timothy Bittenbinder **Date:** 09/23/2005

Organization : Texas A

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. Allen Lavee **Date:** 09/23/2005

Organization : Dr. Allen Lavee

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 who trained at UC 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.
The Medicare anesthesia conversion factor is less than 40% of prevailing commercial rates. Reducing that to 20% for teaching anesthesiologists results in revenue grossly inadequate to sustain the service, teaching and research missions of academic anesthesia training programs. This penalty is not fair, and it is not reasonable.
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%.
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,
Allen Lavee, MD
San Rafael, CA

Submitter : **Date: 09/23/2005**

Organization :

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 Barnes-Jewish Hospital 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.

Han Paik, M.D.
Washington University School of Medicine
Department of Anesthesiology
660 S. Euclid Ave., Box 8054
St. Louis, MO 63110

Submitter : **Dr. Catherine Bachman** **Date: 09/23/2005**

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:

Re: Teaching anesthesiologists

I am writing as an anesthesiologist at the University of Chicago Hospitals 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.
The academic anesthesiology payment issue impacts all academic anesthesiologists and academic anesthesia institutions. Advances in anesthesia and the quality and supply of our future colleagues are inextricably linked to the well-being of our nation?s academic anesthesiology programs. And right now the well-being of these programs is threatened by an unworkable and discriminatory Medicare payment policy.

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,

Catherine Bachman M.D.
Section Chief, Pediatric Anesthesia
Clinical Clerkship Director
University of Chicago Hospitals

Submitter : **Dr. Maura C. Berkelhamer** **Date: 09/23/2005**

Organization : **University Anesthesiologists**

Category : **Individual**

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 Hospitals of Cleveland and Rain bow Babies and Childrens 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.
Name___Maura C. Berkelhamer, MD, FAAP_____
Address _University Hospitals of Cleveland 11100 Euclid Avenue Cleveland, OH 44106_____

Submitter : Dr. Todd Stine **Date:** 09/23/2005

Organization : JLR Medical Group / Florida Hospital

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

To whom it may concern,

This revision is the key to continuing to produce outstanding anesthesiologists and physicians for our country. The current reimbursment is unfair and is greatly harming the training programs of one of our greatest subspecialties of our country. No other subspecialty training programs has these penalties in reimbursement compared to the private sector. To correct this current inequity would greatly benefit the training programs of anesthesia and in turn assure the continued production of outstanding anesthesiologists to treat the citizens of the USA! Please correct the reimbursement of academic anesthesia programs. It is these programs that have spearheaded the saftey of the general public by researching medical errors and how to prevent them before any other specialty was thinking about these errors and their impact on the public. Please reward these far reaching academicians with improved reimbursement!

Sincerely,

Todd Stine

Submitter : Dr. Gwendolyn Boyd **Date:** 09/23/2005

Organization : Callahan Eye Foundation Hospital

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

Dear Dr. McClellan,
I am writing this time in my capacity as chief of anesthesia at Callahan Eye Foundation Hospital, the largest hospital in the USA for eye diseases. Please rescind the penalty for teaching anesthesiologists. Each day many of our best and busiest ophthalmologists perform surgery in two operating rooms assisted by their residents and fellows. They bill and collect for both simultaneous surgical procedures provided that they are present and perform the most difficult aspects of the surgery.
It is extraordinarily discriminitory not to allow teaching anesthesiologists to be able to do the same. It is through the research as well as educational efforts of teaching anesthesiologists that the remarkable increases in patient safety during anesthesia have occurred. In order to preserve quality anesthesia care for our seniors and most ill Americans, we need to preserve the quality of anesthesiologists who teach and provide care for them.
Please let me know if I may be of any further assistance to you in this matter.
Gwendolyn L. Boyd, MD
Professor
Chief of Anesthesiology
Callahan Eye Foundation Hospital
Birmingham Alabama 35233

Submitter : Dr. Kenneth Elmassian **Date:** 09/23/2005

Organization : Ingham Regional Medical Center

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1502-P-1309-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 Ingham Regional Medical Center to urge the Centers for Medicare and Medicaid Services (CMS) to change the Medicare anesthesiology teaching payment policy.

Our institution has identified the training of anesthesiologists as a priority specialty for the future of the hospital's existence to deliver quality health care to our community. The training for our ten residents is the responsibility of an anesthesia department with fourteen members. This has put a tremendous economic burden on our personnel.

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.

Kenneth Elmassian, D.O.
Director, Cardiac Anesthesia Services
Ingham Regional Medical Center
Lansing, MI 48910

Submitter : Dr. Robert Pearce **Date:** 09/23/2005

Organization : University of Wisconsin, Madison

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

I am an academic anesthesiologist at the University of Wisconsin, Madison. I am engaged in patient care, teaching and research, and I serve as the Vice Chair for Research. I have a life-long commitment to our specialty, and to the patients who look to me for their care. I am writing to urge a change in the policy governing Medicare payment for teaching anesthesiologists. In doing so, this will provide crucial support for academic anesthesiologists who contribute to importantly to the care of this important patient population, not only now through their direct patient care, but through the training of the next generation of clinical practitioners and teachers.

This request comes at a critical juncture in our specialty. We have recently experienced severe constraints on our ability to attract new physicians into our specialty, particularly into academic practices, in large part because of the existing payment structure whereby teaching anesthesiologists are reimbursed at only 50% of the usual rate. This short-sighted approach has undoubtedly saved a few dollars, but the cost has been high. Teaching anesthesiogists have left academic practices; resident recruitment has suffered; increased workloads for the remaining faculty members has prevented them from pursuing academic activities necessary for a vigorous and healthy medical specialty; and research, which is the seed from which springs life-saving advances, has undergone a startling decline. As an Associate Editor of our specialty?s premier journal, Anesthesiology, I watched the numbers of submissions from the United States fall precipitously over the past several years. We are at risk of failing, despite the best efforts of many hard-working and dedicated individuals.

As I am sure you know, under current Medicare regulations, other teaching physicians who work with residents on overlapping cases receive full payment so long as they are present for critical or key portions of the procedure. Teaching surgeons may bill Medicare for full reimbursement for each of two procedures, and an internist may supervise residents in four overlapping office visits and collect 100% of the fee when certain requirements are met. However, when teaching anesthesiologists work with residents on overlapping cases, even when we are present for critical or key portions of the procedure, we receive a reduced Medicare payment for each case. This penalty is a large factor in the recent decline of our specialty, and correcting the inequity by allowing full reimbursement for concurrent cases will contribute to the future of a strong and stable crucial medical specialty.

Thank you for your attention,

Robert A. Pearce, M.D., Ph.D.
Betty J Bamforth Professor of Anesthesiology
University of Wisconsin, Madison

Submitter : **Dr. Thiruppathy Sabapathy** **Date: 09/23/2005**

Organization : **University of Chicago 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 University of Chicago Hospitals 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,
Thiruppathy R. Sabapathy, DO
University of Chicago Hospitals
Department of Anesthesia & Critical Care
5841 S. Maryland Ave., MC 4028
Chicago, IL 60637

Submitter : Dr. Jonathan Krohn **Date:** 09/23/2005

Organization : Park Ridge Anesthesiology Associates

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 Lutheran General Hospital, Park Ridge, IL, 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. We are already suffiring a dimuntition of the quality and quantitiy of new anesthesiologists in our country. This change will onoy make it worse.

Submitter : Ms. Diana Miller, MD **Date:** 09/23/2005

Organization : Yale Center for Sleep Medicine

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

Please see my letter to Dr. Mark McClellan in Attachment

CMS-1502-P-1313-Attach-1.DOC

09-22-2005

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

Diana Miller, MD
119 Jacob Road
Southbury, CT 06488
E-mail: Diana.miller@yale.edu

Re: CMS-1502-P/TEACHING ANESTHESIOLOGISTS

Dear Dr. McClellan:

I am an anesthesiologist in training, currently between residency programs. Based on my professional experience from the preliminary (PGY/1 internship) year at the Scott & White Memorial Hospital in Temple, TX and especially at my CA-1 and CA-2 specialty training in your city, at an outstanding and hard working Department of Anesthesiology of the UMD Medical Center, I can attest to an ongoing, day-by day efforts, never-ending-stress which manifest itself though the fact that our attending anesthesiologists and other members of the team have to do with the fact that when the operations end and the day ends they are left – unlike other specialists – with amount of financial resources insufficient to maintain what everyone expects them to provide to the patients and to the public at large.

And it is especially residency programs and teaching hospitals such as the one at UMD in Baltimore, which have to maintain academic excellence, keep up the tradition of top-notch medicine of their respective institutions, provide the very best care for their patients and do it quickly – as anyone from Shock Trauma Center with emergencies coming in on frequent basis will attest to - while a substantial segments of our patient population can rely only on Medicare or – like in Baltimore or here, in New Haven – on Medicaid.

I believe and I know that any proposed further reduction in reimbursement of teaching anesthesiologists cost will substantially and in many ways make situation worse as all the priorities, i.e. an adequate teaching of resident physicians, quality care for our patients, maintenance of facilities, logistical and technological base supporting health care delivery will be very negatively affected with any subsequent damages and overall deterioration in all keys objectives of teaching institutions healthcare delivery hard to improve and bring back.

I am not describing the inequities in reimbursements of teaching anesthesiologists in comparison to other specialties as you might already be well apprised of them and as this is information widely available. But an immediate and especially longer-term impact of such inequities is very real, negative, and, ultimately, unsafe indeed.

Diana O. Miller, MD

Submitter : **Dr. Todd Hermann** **Date: 09/23/2005**

Organization : **Dr. Todd Hermann**

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 Summit Surgical 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,
Todd Hermann M.D.
21 Rolling Glen
Mt. Laurel,N.J. 08054

Submitter : Mr. Michael Paget

Date: 09/23/2005

Organization : California Dialysis Council

Category : End-Stage Renal Disease Facility

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1502-P-1315-Attach-1.DOC

Medicare Program; Conditions for Coverage for End Stage Renal Disease Facilities.
Comments on Proposed Rule
CMS-3818-P

Submitted by: California Dialysis Council
1904 Naomi Place • Prescott, AZ 86303
Tel: (928) 717-1156 email: mail@caldialysis.org

In re:

Federal Register/Volume 70, No. 151/Monday, August 8, 2005/Proposed Rules
Department of Health and Human Services
42 CFR, Parts 504, 410, 411, 413, 414, and 426

Referencing: ESRD Composite Payment Rate Wage Index

The CDC congratulates CMS on the changes to dialysis reimbursement outlined in the proposed rule. In particular the changes in the geographical wage index are welcomed and go far to correct an obvious deficiency in the composite rate payment for California, where the cost of providing dialysis care is among the highest in the US. They are especially timely in view of the recent hospital nurse/patient ratios mandated by the state of California, which have aggravated the chronic nursing shortage in the state, and so further driven up labor costs in dialysis facilities. We note, however, a fallacy of geographic areas used to develop wage indexes is the assumption that people can only work where they live. In many areas with large, densely populated metropolitan areas overlapping more suburban areas, which is common in California, wage factor differences mitigate against working where you live.

We agree with increasing the labor component of the composite rate to 53.7%, and further agree with the suggestion in the proposed rule that the proportion of labor/non-labor costs will be monitored and adjusted on an annual basis. We also support CMS' decision to rely on the core-based statistical areas developed by the OMB.

Market Basket: Although the commentary states that data from 1996 through 1999 showed "little difference" in cost weights, there have been some significant changes since then. In our view, using CY 1997 as the base year for the market basket is not especially meaningful. HIPAA had not been implemented, wages and the cost of employee benefits, especially health benefits and worker's compensation, had not shot up as significantly.
Recommendation: Our preference is that the most current Hospital Market Basket formula be used for the ESRD program. We compete with hospitals for labor pool and negotiate with the same vendors for supplies, making the Hospital Market Basket a more appropriate measure. Alternatively, an annually updated dialysis-specific formula should be devised.

Timing and Phase in of Changes: With regard to the timing and phase in of the changes, we agree that they should be introduced immediately in those centers which have been underpaid under the current system, while there should be a longer phase-in in those centers which will have a reduced payment under the new system. CMS may consider a longer phase-in period in the latter case.

Wage Index Cap: We agree that there the wage index cap should be eliminated. We are concerned that isolated facilities, which are essential but treat relatively small numbers of patients will be adversely affected under the proposed wage index scheme.

Recommendation: We urge that an exception continue to be allowed for these facilities as under § 413.186.

Cost of Living Adjustment: Recommendation: All other Medicare provider types (hospitals, physicians, SNFs, etc.) receive an automatic annual inflationary adjustment. Dialysis facilities are the only Medicare providers who do not. This is not equitable, and periodic legislative adjustments do not keep pace with inflation, as the past 15 years have illustrated. ESRD needs a built in Cost of Living adjustment.

Use of Floor/Ceiling Values: A 2 year transition where facilities would be paid the higher of the wage-adjusted composite rate OR a 50-50 blend would be less painful all the way around and for most of us in California, would work pretty well.

Recommendation: The concept of "commuting ties" needs to be expanded.

Part 413 Subpart H Maintaining Exception Rates: We strongly support the change recommended. In the old method, a center which wished to keep its grandfathered exception rate because the exception rate was higher than the new composite rate had 30 days to notify CMS. The new method is that a center which wishes to keep its grandfathered exception rate needs to do NOTHING. A center which wishes to switch because the new composite rate is higher needs to notify CMS in writing within 30 days. This is much less problematic for a facility and a facility is less likely to accidentally lose an exception they want to keep.

We also strongly support the ability of a facility to immediately file a second exception request addressing and documenting issues cited in a previous denial.

We are concerned, however, that the composite rate as modified by MMA will be maintained for patients under age 18. Patients under age 18 require additional resources. Many units that provide services to pediatric patients have not and will not qualify for a pediatric exception because the pediatric population is below 50% of all patients dialyzed. Recommendation: A unit should qualify for a Pediatric Exception if 25% of its patients are ≤ 21.

Referencing: ESRD-Drugs and Biologicals

Overall, CDC agrees that the correction to 11% is more appropriate and better reflects actual data. We further agree with the proposal to update the payments on a quarterly basis.

Submitter : Lora Newton

Organization : Lora Newton

Category : Individual

Date: 09/23/2005

Issue Areas/Comments

GENERAL

GENERAL

RE: GPCIs
I am writing to voice my support for the proposal to creat a new "payment locality" for Sonoma County, CA to increase reimbursements for medical services in that county. As you are aware, Sonoma County experiences higher medical expenses than other counties that are designated as "rural" counties and therefore medical providers in that county who accept Medicare are struggling financially in order to do so. I am disabled and my doctor practices in Sonoma County. Although I do not currently live in that county I have continued to travel there to see my doctor since he is experienced in treating patients with my conditions. Recently, he has informed his patients that he is unable to continue taking Medicare, which I am sure is largely in part to the low reimbursement rates. Please help ensure that others in Sonoma County do not lose access to medical care by instating the proposed new rule to increase the county's reimbursement rate by 8%. Thank you very much.

Submitter : Dr. Sylvia Wilson **Date:** 09/23/2005

Organization : Dr. Sylvia Wilson

Category : Health Care Provider/Association

Issue Areas/Comments

GENERAL

GENERAL

I am writing as a resident anesthesiologist at UNC Medical Center in Chapel Hill, NC to urge the Centers for Medicare and Medicaid Services 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.

Thank you for your time,

Sylvia H. Wilson, MD

CMS-1502-P-1318

Submitter : Dr. CHRISTINA MORA MANGANO
Organization : STANFORD UNIVERSITY
Category : Physician
Date: 09/23/2005

Issue Areas/Comments

GENERAL

GENERAL
SEE ATTACHMENT

CMS-1502-P-1318-Attach-1.DOC

September 23, 2005

To whom it may concern:

It has been my privilege to be associated with academic anesthesiology over the last 20 years of my career. Over this time, I have seen a robust commitment to resident education and outstanding, humanistic delivery of anesthesia care. However, the last decade has included a loss of people willing to have reduced compensation for the privilege of caring for patients with two residents rather than two nurses. This is the current regulation as delineated in CMS Code

Please consider revising the code to be fair rather than discriminatory. Please reimburse for the supervised anesthesia care for 2 patients when an attending anesthesiologist works with two other physician-residents, rather than nurse anesthetists.

Thank you for your consideration

Christina T. Mora Mangano, M. D.
Professor, Department of Anesthesiology
Stanford University
Chief, Division of Cardiovascular Anesthesiology

CMS-1502-P-1319

Submitter : Mr. Jack Lund
Organization : Case Western Reserve University
Category : Individual
Date: 09/23/2005

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1502-P-1319-Attach-1.PDF

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 assistant student at Case Western Reserve University 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.

Jack Truman Lund

Submitter : Dr. James Kaufmnan

Date: 09/23/2005

Organization : First Colonies Anesthesia Associates

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

see attachment

CMS-1502-P-1320-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 [name of institution] 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.

James A. Kaufman 7514 Arrrowood Road Bethesda, Maryland 20817

Submitter : Dr. Nina Wong **Date:** 09/23/2005

Organization : Brigham and Women's Hospital

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

Mark McClellan, M.D., Ph.D.
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attn: CMS-1502-P/TEACHING ANESTHESIOLOGISTS
P.O. Box 8017
Baltimore, MD 21244-8017
Dear Dr. McClellan:
I am writing as an anesthesiologist at Brigham and Women's Hospital 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,
Dr. Nina Wong

Submitter : Dr. Steve Lee
Organization : Dr. Steve Lee
Category : Physician

Date: 09/23/2005

Issue Areas/Comments

GENERAL

GENERAL

see attachment

CMS-1502-P-1322-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:

Anesthesiology is certainly a full-fledged specialty of medicine as surgery or internal medicine that deserves to be funded as such. The training of new anesthesiologists depends on a fair reimbursement from CMS. I am writing to protest the marked underpayment by CMS and hope that you will consider reimbursing academic anesthesia practices at the same level as our surgical colleagues. Medicare's discriminatory payment arrangement applies only to anesthesiology teaching programs and has had a serious detrimental impact on the ability of programs to retain skilled faculty to train new anesthesiologists. The current shortage of anesthesiologists will only worsen just as the need for them increases with the aging of the baby boom generation.

Since 1995 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%. However, 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, two for surgery and up to four cases simultaneously for internists! This fee schedule is unreasonable and short sighted.

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 help keep anesthesiology as a viable specialty of medicine.

Steven E. Lee MD

167 El Pinar

La Selva Beach, Ca 95076

Submitter : Dr. David Swanson **Date:** 09/23/2005

Organization : University of Iowa Hospitals and Clinics

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 Iowa Hospitals and Clinics 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.
At the University of Iowa we have been understaffed for the past several years. There is no indication that this trend will change with the present disparity.
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 E. Swanson, M.D.
200 Hawkins Drive, 6JCP
Iowa City, IA 52242

Submitter : Dr. ROSCOE KATENDE **Date:** 09/23/2005

Organization : METRO ANESTHESIOLOGISTS, LLC

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 Our Lady of Mercy 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.

Name: ROSCOE KATENDE, MD
Address 142 Euclid Avenue, Ardsley, NY 10502

Submitter : Dr. Patricia Gramling-Babb

Organization : University of Chicago

Category : Physician

Date: 09/23/2005

Issue Areas/Comments

GENERAL

GENERAL

The very future of medicine in all its diversity depends on the education and training of physicians. These programs are dependent upon generated income to provide salaries and educational materials for those who spend their careers teaching others the art and science of anesthesiology. At the present time we are penalized for teaching residents in two rooms simultaneously. The same ruling does not apply to surgeons who operate in two different rooms at the same time nor internal medicine attendings who oversee 3-4 residents simultaneously in a clinic situation. Thus, we are asking for fair and equal reimbursement such as our surgical colleagues. To provide quality education we must be able to retain impressive faculty. At the same time, we must maintain a Departmental income that can provide the tools and staff to train these residents. The future of quality anesthesia care depends on the revisions to the payment policies under the physicians fee schedule docket CMS-1502-P.

Thank you
Patricia Gramling-Babb MD

Submitter : Dr. Gyorgy Frendl **Date:** 09/23/2005

Organization : Brigham and Women's Hospital/ Harvard Medical Scho

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 Brigham and Women?s Hospital / Harvard Medical School (Boston, MA) 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.

Name_____Gyorgy Frendl, MD, PhD_____
Address
75 Francis St, CWN-L1
Department of Anesthesiology, Perioperative and Pain Medicine
Brigham and Women?s Hospital / HMS
Boston, MA 02115

Submitter : Dr. Mitchell Berman
Organization : Columbia University
Category : Physician
Date: 09/23/2005

Issue Areas/Comments

GENERAL

GENERAL

see attached letter

CMS-1502-P-1327-Attach-1.DOC

College of Physicians & Surgeons of Columbia University | *New York, N.Y. 10032*

DEPARTMENT OF ANESTHESIOLOGY

630 West 168th Street

(212) 305-2070
(212) 305-6221 (fax)
mfb1@columbia.edu

September 28, 2005

Mark McClellan, M.D., Ph.D.
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Baltimore, MD 21244-8017

Dear Dr. McClellan:

I am sure you are aware that the Medicare policy on anesthesiology reimbursement in teaching institutions needs to be fixed.

As an anesthesiologist at Columbia University in New York City, I can tell you that the current policy is wreaking havoc on our department and will in the end have a negative impact on the care provided to Medicare recipients.

As you know, other specialties within medicine can have staff overlapping cases and still bill normally. Only anesthesia is penalized, and the 50% reduction in fees on top of Medicare's already low (40% of commercial fees) conversion rate is making it impossible to staff hospitals that treat patient populations with significant numbers Medicare patients.

At Columbia we care for a large number of inner city residents and Medicare recipients, and we cannot retain staff anesthesiologists because of the low reimbursement rates resulting, in part, from this unreasonable policy. Medicare recipients already have difficulty finding physicians willing to accept them as new patients. Eventually, hospitals will staff these operative procedures in ways that reflect the low reimbursement associated with the intraoperative period, and this will adversely affect the care provided Medicare recipients.

I trust you will find an equitable solution to this problem.

Sincerely,

Mitchell F. Berman, MD

Mitchell F. Berman, M.D., M.P.H.
Associate Professor of Clinical Anesthesiology

Submitter : Dr. John Lucio

Date: 09/23/2005

Organization : Center for Pain Management

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

I am against the reduction in reimbursement for codes 62367 and 62368. Any "savings " realized by the removal of practice expense for the hand held programmer will be quickly consumed by the increasing overhead at physician's offices. This will ultimately result in decreased access to care since many practitioners will cease to offer these services. It is unfair to assume that because practices were not charged for the programmers that physicians realized a windfall in profits from using this technology. On the contrary the introduction of this technology to physician practices is at best a breakeven proposition.

Submitter : Ms. Cassandra Thomas **Date:** 09/23/2005

Organization : US Oncology

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 : Mrs. Lori LeBlanc
Organization : AKDHC
Category : Physician
Date: 09/23/2005

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. Jason Sankar** **Date: 09/23/2005**

Organization : **Dr. Jason Sankar**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Jason D. Sankar MD
September 23, 2005

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

Dear Dr. McClellan:
I am writing as an anesthesiologist at The George Washington University 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 Yours,

Jason D. Sankar MD
Department of Anesthesiology
The George Washington University
900 23Rd St. NW
Washington DC 20037

Submitter : Dr. Alvin Manalaysay **Date:** 09/23/2005

Organization : Dr. Alvin Manalaysay

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

Subj: Teaching anesthesiologist. I am in private practice but I used to be director of the Triservice Military Anesthesiology residency program in Washington, D.C. The rule governing billing practices when a teaching anesthesiologist is supervising two anesthesiology residents is discriminatory to anesthesiologists, is not fair when compared to rules governing other medical specialties, and does not have a logical rationale for its existence. I am requesting that the said rule be brought in line with the rules governing billing by other medical specialists (e.g. surgeons) when the teaching practitioner is supervising up to two residents.

Thank you.
Alvin R. Manalaysay Ph.D., M.D.

Submitter : Dr. Douglas Merrill **Date:** 09/23/2005

Organization : Virginia Mason 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 the Virginia Mason Clinic to urge CMS to change the Medicare anesthesiology teaching payment policy.
This policy has led directly to the loss of two of our most skilled teachers in the past year. It is keeping our program and all programs from retaining or recruiting new faculty. Going forward, this means that we are in danger of having to decrease the number of residency spots, because we are unable to provide adequate teaching time. This will pay off negatively for the next three decades, as we are already in an anesthesiologist and CRNA shortage, and this will make it significantly harder for our elderly and poor to obtain surgical care.
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.
Douglas Merrill

Submitter : Joseph Vulgamore **Date:** 09/23/2005

Organization : Joseph Vulgamore

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

I note with alarm another unjustified decrease in Medicare payments to teaching anesthesiologists. We are entering the time of greatest retirements, a shortfall of anesthesia residents, and a burgeoning of Medicare recipients as the "baby boomers" enter that age. Yet the amount of money that Medicare reimbursed for my father's emergent wrist surgery at a local teaching hospital was less than his cab fare to that same hospital.

Right now, slots in anesthesiology residency programs are going unfilled because of ill-conceived Medicare policy that shortchanges teaching programs, withholding 50% of their funds for concurrent cases. Anesthesiology teaching programs, caught in the snare of this trap, are suffering severe economic losses that cannot be absorbed elsewhere.

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

This is not fair, and it is not reasonable.

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

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

Who will be left to provide anesthesia for your parents--or you--if this unreasonable and discriminatory cut is made?

Submitter : **Dr. Glen Rosenfeld** **Date: 09/23/2005**

Organization : **Milford Anesthesiologists**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

Dear Dr. McClellan:

I am writing as an anesthesiologist at Bristol Hospital 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.

Glen Rosenfeld, MD
Department of Anesthesiology
Bristol Hospital

Submitter : Dr. Cameron Burrup **Date:** 09/23/2005

Organization : Univeristy of New Mexico Health Sciences 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 the University of New Mexico Health Sciences 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. I would hope that you would the support cessation of the anesthesiology teaching payment penalty.
Sincerely,
Cameron Bururp, MD
4th year resident, UNMHSC

Submitter : Dr. Xiuli Zhang **Date:** 09/23/2005

Organization : SUNY Upstate Medical 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 anesthesiologist on the faculty of SUNY Upstate Medical University, Syracuse. I write to urge the Centers for Medicare and Medicaid Services (CMS) to change the Medicare anesthesiology teaching payment policy.

Medicare?s payment policy, under which reimbursement is reduced by 50% when two residents are supervised concomitantly, has had and continues to have a detrimental impact on the ability of programs to retain the skilled faculty. Without adequate mentors, the widely acknowledged shortage of anesthesia providers will grow worse.

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.

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, since 1995, teaching anesthesiologists are not paid in a manner consistent with other specialties; Medicare payment for each case is reduced 50%. This discriminatory policy is detrimental and unsustainable for those who work with residents.

In time, most of us will need Medicare services and may need quality and competent anesthesia care. Whether this is one or several years down the line, fair reimbursement of teaching anesthesiologists will go a long way towards ensuring that the care is there when it is needed.

Please end the anesthesiology teaching payment penalty.

Sincerely yours,

Xiuli Zhang, MD
Clinical Instructor, Anesthesiology
SUNY Upstate Medical University
Email: zhangx@upstate.edu

CMS-1502-P-1337-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 anesthesiologist on the faculty of SUNY Upstate Medical University, Syracuse. I write to urge the Centers for Medicare and Medicaid Services (CMS) to change the Medicare anesthesiology teaching payment policy.

Medicare's payment policy, under which reimbursement is reduced by 50% when two residents are supervised concomitantly, has had and continues to have a detrimental impact on the ability of programs to retain the skilled faculty. Without adequate mentors, the widely acknowledged shortage of anesthesia providers will grow worse.

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.

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, since 1995, teaching anesthesiologists are not paid in a manner consistent with other specialties; Medicare payment for each case is reduced 50%. This discriminatory policy is detrimental and unsustainable for those who work with residents.

In time, most of us will need Medicare services and may need quality and competent anesthesia care. Whether this is one or several years down the line, fair reimbursement of teaching anesthesiologists will go a long way towards ensuring that the care is there when it is needed.

Please end the anesthesiology teaching payment penalty.

Sincerely yours,

Xiuli Zhang, MD
Clinical Instructor, Anesthesiology
SUNY Upstate Medical University
Email: zhangx@upstate.edu

Submitter : Dr. Mark Flanery **Date:** 09/23/2005

Organization : Self

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1502-P-1338-Attach-1.DOC

September 23rd, 2005

Mark McClellan, M.D., Ph.D.
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 who is in private practice with a small group 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 unfair, and it is not evenhanded.

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 terminate the anesthesiology teaching payment penalty.

Sincerely,

Mark F. Flanery, MD

32721 111th Place SE
Auburn, WA 98092
Phone: 253.939.6534 // Fax: 253.931.8228

Submitter : Dr. Erik Eckman **Date:** 09/23/2005

Organization : UNC Hospitals

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

To whom it may concern regarding CMS-1502-P -TEACHING ANESTHESIOLOGISTS:

I am currently a resident physician, training in anesthesiology at the University of North Carolina. During my first two years of training a significant number of our teaching anesthesiologists have left our academic department for jobs in private practice. This exodus from academic anesthesiology practices is due to the economic disparities between academic and private practices, as well as the inability to accomplish the mission of any academic department: patient care, education, and research. The majority of our recent residency graduates are also taking jobs in private practice. The current medicare rule regarding reimbursement of teaching anesthesiologists is unreasonable and unfair when compared to rules regarding reimbursement of other teaching physicians, and it has contributed significantly to the instability in academic anesthesiology departments. Without fair and equitable compensation, an academic anesthesiology department simply cannot afford to train young physicians. The ability to train the next generation of physicians for this country is imperative in order to deliver quality medical care. Please take the time to remedy CMS-1502-P. It is an investment in the future of medical care in this country.

Best regards,

Erik Eckman, MD
Resident Physician
Department of Anesthesiology
University of North Carolina Hospitals
Chapel Hill, NC

Submitter : Dr. Marcos Vidal Melo **Date:** 09/23/2005

Organization : Massachusetts General Hospital

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

September 23, 2005

The CMS proposed changes to the Medicare Fee Schedule for 2006 were released on August 1, 2005, and do not include a correction of the discriminatory policy of paying teaching anesthesiologists only 50% of the fee for each of two concurrent resident cases. Instead, CMS has invited comments suggesting improvements to the current payment policy that would allow it to be more flexible for teaching anesthesia programs. The proposed rule acknowledges that the existing policy is not workable for anesthesiologists and that revisions are necessary -- a positive step forward from the final Medicare physician payment rule published last year. Still, there is no assurance that CMS will change its policy and help teaching anesthesiologists realize 100% of the Medicare fee for each of two overlapping procedures involving resident physicians.

Several points are essential to be noticed in the current setting:

* The current Medicare teaching anesthesiologist payment rule is unwise, unfair and unsustainable. As a consequence of this, a number of highly qualified anesthesiologists leave academic medicine for private practice. In our program, which attracts a significant amount of highly qualified medical graduates, the minority of residents stay as staff. Those who stay, do so only for a few months until they have a private practice contract. This corrodes the quality teaching and research in our specialty. And, ultimately, the quality of medical care to our patients.
* Associated with this, 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.
* Quality medical care, patient safety and an increasingly elderly Medicare population demand that the United States have a stable and growing pool of physicians trained in anesthesiology.
* Right now, slots in anesthesiology residency programs are going unfilled because of ill-conceived Medicare policy that shortchanges teaching programs, withholding 50% of their funds for concurrent cases.
* Anesthesiology teaching programs, caught in the snare of this trap, are suffering severe economic losses that cannot be absorbed elsewhere.
* The CMS anesthesiology teaching rule must be changed to allow academic departments to cover their costs.
* Academic research in anesthesiology is also drying up as department budgets are broken by this arbitrary Medicare payment reduction.
* A surgeon may supervise residents in two overlapping operations and collect 100% of the fee for each case from Medicare. An internist may supervise residents in four overlapping outpatient visits and collect 100% of the fee for each when certain requirements are met. A teaching anesthesiologist will only collect 50% of the Medicare fee if he or she supervises residents in two overlapping cases. This is absolutely not fair (and far from reasonable).
* Medicare must recognize the unique delivery of anesthesiology care and pay Medicare teaching anesthesiologists on par with their surgical colleagues.

These are very relevant points to our specialty and to our patients. I urge you to dedicate the necessary time and thought in order to reach correct decisions.

Sincerely,

Marcos F. Vidal Melo, MD, PhD

Submitter : Dr. Kashif Abdul-Rahman **Date:** 09/24/2005

Organization : Southern Indiana Anesthesia and Pain Management

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

see attachment

CMS-1502-P-1343-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 Southern Indiana Anesthesia 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.

Thank you, Kashif Abdul-Rahman, MD

Submitter : Dr. Joseph Annis **Date:** 09/24/2005

Organization : American Society of Anesthesiologists

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

Mark McClellan, M.D., Ph.D.
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attn: CMS-1502-P/TEACHING ANESTHESIOLOGISTS
P.O. Box 8017
Baltimore, MD 21244-8017
Dear Dr. McClellan:
I am writing, as an anesthesiologist at St. David?s Medical Center in Austin, Texas and a part-time faculty in the anesthesia department at Dartmouth-Hitchcock Medical Center in Lebanon, New Hampshire, 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 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 by the aging of the baby boom generation.
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. Anesthesiology teaching should be reimbursed on par with other teaching physicians.
Sincerely,
Joseph P. Annis, MD
3 Sundown Parkway, Austin, Texas 78746

CMS-1502-P-1345

Submitter : Dr. vincent phillips **Date:** 09/24/2005

Organization : asa

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

This letter is in opposition of CMC-1502-P Teaching Anesthesiologist. This rule change could have devastating long term consequences to the field of anesthesia by both reducing the number of residents entering and the number of faculty (both entering and retaining). The academic faculty have driven the push for patient safety that makes having an operation in this country extremely safe. Academic centers are vital to the health of the medical field. I support reembursements at 100% for two (2) residents per teaching anesthesiologist.

Submitter : Lawrence Tsen **Date:** 09/24/2005

Organization : Harvard Medical School

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 Harvard Medical School and the Brigham and Women?s Hospital 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.
Name___Lawrence C. Tsen, MD_____
Address ___10 Turtle Lane, Dover, MA 02030_____

Submitter : Dr. Wendy Zerngast
Organization : University of Washington Medical Center
Category : Physician
Date: 09/24/2005

Issue Areas/Comments

GENERAL

GENERAL

See attached

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

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

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

Submitter : Dr. Wendy Zerngast **Date:** 09/24/2005

Organization : University of Washington 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 University of Washington 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. At our institution, teaching anesthesiologists supervise 2 or even 3 residents at a time in order to keep the operating rooms going, usually around the clock. We care for most of the indigent, the uninsured, and underinsured of Washington state. In this situation it is extremely important that Medicare payment be fair and 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. Indirectly, it will increase the quality of training nationwide as the ?brain drain? of experienced academic anesthesiologists leaving teaching hospitals for private practice diminishes.
Please end the anesthesiology teaching payment penalty.

Sincerely,
Wendy Zerngast, M.D.
University of Washington Medical Centers
Harborview Medical Center
Department of Anesthesiology
325 9th Avenue
Seattle, WA 98104

CMS-1502-P-1349

Submitter : Dr. James Modir **Date:** 09/24/2005

Organization : UCSD Dept. of Anesthesia

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 UCSD to urge the Centers for Medicare and Medicaid Services (CMS) to change the Medicare anesthesiology teaching payment policy as it is paralyzing growth and success of academic anesthesia departments, including UCSD.
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.
Addressing this inequity will begin to assure 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. Furthermore, the future of academic anesthesia as well as the benefits resulting from critical research and development are in peril. These results will impact the way we care for our patients by making anesthesia safer for sick patients undergoing large invasive surgeries.

Please end the anesthesiology teaching payment penalty.
Thank you for your time,
James Modir, M.D.
4328 Valle Vista
San Diego, CA 92103

Submitter : Mrs. Mary Fay **Date:** 09/24/2005

Organization : Olean General Hospital

Category : Dietitian/Nutritionist

Issue Areas/Comments

GENERAL

GENERAL

I,as the RD, CDE and Diabetes Program Coordinator, and the Olean General Hospital Diabetes Advisory Committee- in our rural acute care facility with an ADA Recognized Diabetes program - fully support the proposal of payment for tele-health services for both Medical Nutrition Therapy and Diabetes Self-Management Education to enhance the care, education and follow-up to Medicare recipients. Tele-health services are an especially critical service for continuity of care and follow-up to individualized and group education. We have instituted 48 Hour Call Backs to patients following individual education and we are able to clarify and expeditiously follow-up on immediate concerns and encourage adherence to the lifestyle management plan resulting in better outcomes.

Submitter : Dr. Suhail Aftab **Date:** 09/24/2005

Organization : Dr. Suhail Aftab

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 [name of institution] 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.
Name Suhail Aftab, M.D.
Address 2600 Navarre Ave, 6th Floor, Oregon, OH 43616

Submitter : Dr. Gary Okum **Date:** 09/24/2005

Organization : Hahnemann University Hospital

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

Dear Dr. McClellan:

I am writing as an anesthesiologist at Hahnemann University Hospital, Philadelphia, PA 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,

Gary S. Okum, M.D.

241 South 6th Street Apt 1112

Philadelphia, PA 19106

Submitter : Dr. Stephen Lowry
Organization : Dr. Stephen Lowry
Category : Other Health Care Professional
Date: 09/24/2005

Issue Areas/Comments

GENERAL

GENERAL

see attachment

CMS-1502-P-1354-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 a concerned anesthesiologist 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 has affected my community and 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 Lowry, M.D.

8618 Ranch Road

Abilene, Texas 79602

CMS-1502-P-1355

Submitter : Dr. Ata Siddiqui **Date:** 09/24/2005

Organization : Mid-Missouri Anesthesia Consultants, PC

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

"See attachment"

CMS-1502-P-1355-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 St. Joseph Hospital Kirkwood, Kirkwood, MO 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.

Name Ata Siddiqui, MD

Submitter : Dr. Ajay Lalvani

Date: 09/24/2005

Organization : Dr. Ajay Lalvani

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 Hoag Hospital 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.
Ajay M. Lalvani MD
Laguna Beach, California

Submitter : Dr. Wai Leung
Organization : Fremont-Rideout Medical Group
Category : Physician
Date: 09/24/2005

Issue Areas/Comments

GENERAL

GENERAL

Please see attachment

CMS-1502-P-1357-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 Fremont-Rideout Medical Group 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.

Wai Kwong Leung, Ph. D., M.D.

Submitter : Dr. D. Scott Colclasure
Date: 09/24/2005
Organization : Anesthesiology Assoc. Clark County
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 Clark Memorial Hospital in Jeffersonville, IN who trained at Indiana University 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.
I received great training at Indiana University by the anesthesia teaching staff and want that level of training to continue on into the future at not only my training program but all the training programs in the country. Patients deserve well trained anesthesiologists taking care of them during surgery and if current Medicare and Medicaid practices do not change I fear that the level of training will be compromised. Please end the anesthesiology teaching payment penalty.

Thank you for your time,
D. Scott Colclasure, M.D.
400 E Main St., #310
Louisville, KY 40202

Submitter : Dr. RAMACHANDRAN RAMANI **Date:** 09/24/2005

Organization : YALE UNIVERSITY SCHOOL OF MEDICINE

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

Mark McClellan, M.D., Ph.D.
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attn: CMS-1502-P/TEACHING ANESTHESIOLOGISTS
P.O. Box 8017
Baltimore, MD 21244-8017
Dear Dr. McClellan:
I am writing as an anesthesiologist at Yale University School of Medicine 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. It greatly affects the academic commitment and responsibility of Universities by not being able to allocate resources for research.
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.
RAMACHANDRAN RAMANI, MD
9/24/2005.
Address _____

Submitter : Dr. John Elinger **Date:** 09/24/2005

Organization : Dr. John Elinger

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. Denham Ward **Date:** 09/24/2005

Organization : University of Rochester

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1502-P-1361-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 a professor of Anesthesiology and the former Chair of the Department of Anesthesiology at the University of Rochester 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 and help us save academic anesthesiology.

Denham S. Ward, M.D., Ph.D.
Department of Anesthesiology
University of Rochester School of Medicine
601 Elmwood Ave, Box 604
Rochester, NY, 14642

Submitter : **Joseph Jaros** **Date: 09/24/2005**

Organization : **Anesthesia Specialists of Albuquerque**

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 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,
Joseph A Jaros, MD
Anesthesia Specialists of Albuquerque
Albuquerque, NM 87102

Submitter : **Dr. michelle Schultz** **Date: 09/24/2005**

Organization : **Dr. michelle Schultz**

Category : **Health Care Professional or Association**

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 Agencya??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 a??Prompt Pay Discount.a?? CMSa??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.

Submitter : Dr. Joseph Bordelon **Date:** 09/24/2005

Organization : NYSSA

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

Dear Dr. McClellan:
I am writing to you as a brand-new anesthesiologist 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 provide quality training experiences for new anesthesiologists and to retain skilled faculty. Let me explain to you how this rule has impacted my training experience and now, my practice:
On July 11th, 2005, my first day at work as an attending anesthesiologist, I provided care to a 93 year old lady who was having her fractured hip surgically repaired. Can you recall all the pressures you felt on your the first day? My employing group was watching me, the surgeons are watching me, the OR nurses and recovery room nurses are all watching me, making first impressions and judgements. Most importantly the patient and her family are depending on me.
Leaning on my prior 4 years of studying and training, I did the case. I had very limited experience with the advanced-in-age patient as a direct consequence of the Medicare policy. Since the department where I trained wanted to be able to continue to pay the bills, these types of cases were frequently allocated to CRNA's instead of residents. I will tell you that I had to heavily rely on book knowledge since I had such limited clinical experience with this type of patient. This patient suffered no lasting consequences, but her perioperative experience was...shall we say... less than smooth. I'd be happy to give you the details later if you'd like.
This was not an issue of competence, as I was a very solid resident, in fact I was awarded to serve as chief resident and I've scored consistently well above average on all national in-training exams. I feel totally confident and competent in nearly every other type of anesthesia cases except for two- the elderly and renal failure/dialysis patients. Why? Because of the pressures that this unfair Medicare policy has placed on my training opportunities in residency. Three months later, my blood pressure still rises and I feel tense when I encounter these types of cases.
Under current Medicare regulations, teaching surgeons and even internists are permitted to work with residents on overlapping cases and receive full payment as long as the teacher is present for critical or key portions of the procedure. Teaching surgeons are allowed to collect full reimbursement from Medicare 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. Because of this, these residents are free to care for whatever type of patient case that presents itself. In other words, there is no outside pressure to bias the patient population from which those residents learn.
Teaching anesthesiologists are also permitted to work with residents on overlapping cases as long as they are present for critical or key portions of the procedure. But the Medicare payment for each case is reduced 50%. This forces training programs to decide to suffer with much fewer resources for retaining quality teaching personnel or to distort the residents' training experience. With either decision, the residents lose and this can have potential consequences to our aging parents and grandparents when they most need the care of a well-trained anesthesiologist.
Why not correct this inequity and assure the application of Medicare's teaching payment rules consistently across medical specialties? Why not reimburse anesthesiology teaching on par with other teaching physicians?
Please end the anesthesiology teaching payment penalty.
Sincerely,
J Spencer Bordelon, MD
10 Kimberly Lane
Queensbury, NY 12804

Submitter : **Dr. Daniel H Eudaily** **Date: 09/24/2005**

Organization : **self**

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 contract anesthesiologist to urge the Centers for Medicare and Medicaid Services (CMS) to keep the Medicare anesthesiology teaching payment policy.

The apparently discriminatory payment arrangement applied to anesthesiology teaching programs is needed, though late in coming.

Whether or not a shortage exists of anesthesia providers -- a shortage that will be exacerbated in coming years by the aging of the baby boom generation---is irrelevant. Equally irrelevant is how you choose to pay surgeons and others.

I think with a notable portion of anesthesiologists have "lost their way" while "pigging out" at the Federal subsidy "slop bucket", this payment cut may serve to focus attention on the professions duties to self and to their patients. If not, then the pressure may lead to professional improvement by means not yet visible.

Your ham-handed attacks in the past on "fraud and abuse" have harmed the teaching side of the anesthesiology profession.

More specific investigation into lapses of patient assessment, care plan development and documentation of the care would be the most helpful audit actions for furthering public policy adjustments. This requires activities in the field, away from easily audited electronic data bases.

If the aging, at risk public is to be ably served, CMS MUST attack the multiple cancers of

1. itself promoting money dispersion,which feeds the greed;
2. "tame" physician referrals for preoperative evaluations in lieu of using patient regular physicians: pre-operative workups become MORE unbelievable and dangerous.
3. faked anesthesia documentation.
4. reliance on certification papers (which were aimed at early (1900-1950)20th century problems of training and education) behind which the ASA lobbyists can hide while they shout "this is quality".
5. lack of READABLE patient documentation:a national standard need exists so handwriting cannot be used on patient records.

Please DO NOT end the anesthesiology teaching payment penalty.

Sincerely yours,
Daniel H Eudaily, MD
270 Vista Drive
Dillon, Montana 59725-3111
406 683 6456

CMS-1502-P-1366

Submitter : Dr. John Ahlering **Date:** 09/24/2005

Organization : Stanford University Medical Center

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

I am writing you as an anesthesiologist at Stanford University Medical Center to ask that you contact the Centers for Medicare and Medicaid Services (CMS) and urge a change in payment policy for teaching anesthesiologists.

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

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

Right now, slots in anesthesiology residency programs are going unfilled because of ill-conceived Medicare policy that shortchanges teaching programs, withholding 50% of their funds for concurrent cases.

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

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

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

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

This is not fair, and it is not reasonable.

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

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

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

Submitter : **Dr. Loan Vu** **Date: 09/24/2005**

Organization : **American Society of Anesthesiologists**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

Dear Dr. McClellan:
I am writing as an anesthesiologist at University of Wisconsin Hospital and Clinics 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.

I can assure you, as a resident anesthesiologist, that my staff is always available during the most significant portions of the case and that they are present whenever a problem arises. Therefore, they should be reimbursed far greater than 50% since their work entails solving 100% of the problems.

Loan Vu, M.D._____

Submitter : Dr. Mark Perlman **Date:** 09/24/2005

Organization : Dr. Mark Perlman

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

Please help us correct San Diego's Medicare discount. San Diego is an incredibly expensive city in which to live; not only for Doctors but for our staff who need higher pay. There is no reason that San Diego should be grouped with low cost-of-living rural cities.

If reimbursement continues to decline, we will not be able to provide care for the growing number of elderly. Medicare patients will simply be unable to obtain quality care.

Thank you

Submitter : Dr. Mukesh Nigam **Date:** 09/24/2005

Organization : Danville Anesthesiologists Inc.

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 Danville Regional Medical Center, Danville, VA 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 and save Teaching anesthesiologists hard work to train coming generation and keep specialty intact for the best interest and care of patients who are mostly under Medicare. Who will take care of us when we will be older if atmosphere is discouraging?
Name : Mukesh Nigam MD
Address: 1114 Main St, Danville VA 24541

Submitter : **Dr. Mark Vogelhut** **Date: 09/24/2005**

Organization : **Dr. Mark Vogelhut**

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 private practice anesthesiologist in Charlotte, 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. The NC residency programs have already lost many highly skilled and talented teaching anesthesiologists.
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%inspite of the fact that prevailing medicare rates are 40% or less than comercial rates. 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,

Mark M. Vogelhut, M.D.

Submitter : **Dr. Thomas Lemmer** **Date: 09/24/2005**

Organization : **Dr. Thomas Lemmer**

Category : **Other Health Care Professional**

Issue Areas/Comments

GENERAL

GENERAL

Re: GPCI Support removal of two counties from Locality 99

We strongly support removing Santa Cruz and Sonoma Counties from Locality 99, the Federal Registry 8/25/05 proposal to change physician payment localities in California.

Living and working in Santa Cruz County we have experienced the inequity here for many years. This particular county is repeatedly categorized as one of the top 4 most expensive places in the State. I personally vouch for the fact that the cost of doing business here is as high as the cost of living here. Santa Cruz County has had the worst physician cost/payment mismatch in the state for nine years.

The adjustment proposed addresses the gross inequity of grouping Santa Cruz and Sonoma into Locality 99 so that reimbursements are some of the lowest in the State.

Thank you for taking responsibility for addressing this inequity in physician payment localities, and removing Santa Cruz and Sonoma Counties from Locality 99. You will have helped the people of California by making these populous areas a place where citizens with Medicare can obtain proper medical care.

Thomas A. Lemmer, DPM
4765 Soquel Drive
Soquel CA 95073

Date: 09/24/2005

Submitter : Dr. Geoff Taylor

Organization : Dr. Geoff Taylor

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

Mark McClellan, M.D., Ph.D.
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 Deaconess Hospital in Oklahoma City to urge the Centers for Medicare and Medicaid Services (CMS) to change the Medicare anesthesiology teaching payment policy. I recently completed my training as an anesthesiologist and strongly support an equitable reimbursement system in contrast to the discriminatory policy currently in effect.
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.
Geoff L. Taylor, M.D.
1620 N.W. 182nd Street
Oklahoma City, OK 73003

Date: 09/24/2005

Submitter : **Dr. Douglas Hetzler**

Organization : **Dr. Douglas Hetzler**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

September 24, 2005

Dear Sirs:

I am writing in support of your proposed change regarding physician payment localities in California.

As per the Revisions to Payment Policies Under the Physician Fee Schedule for Calendar Year 2006, page 92, you are proposing to place Santa Cruz County and Sonoma County in unique localities and no longer combine them into Locality 99 in the state of California.

This action is appropriate and necessary since the locality system is designed to account for the cost of providing medical services and the present arrangement short-changes these two counties.

Your data has shown that the cost of medical practice in these two counties is significantly higher than the value assigned to Locality 99, and so it is appropriate to make a correction at this time. It is also necessary to make this correction to help preserve medical services for those patients who benefit from your programs. I have had patients move out of our area upon their retirement, and subsequently move back to our area because they could not find physicians in their new locale willing to take care of them under the Medicare system. Many physicians in our area are contemplating no longer providing services to Medicare patients, due to the disparity between the cost of providing services and the re-imbursements tied to the Locality 99 designation.

I strongly support your correction of the locality designation for Santa Cruz and Sonoma Counties, and the subsequent correction of the payment schedules.

Thank you for your efforts and I look forward to seeing this matter come to a satisfactory resolution.
Sincerely,

Douglas G. Hetzler, MD, FACS
Soquel, CA 95073

Submitter : Dr. W. Keith Thorpe **Date:** 09/24/2005

Organization : Central Anesthesia Service Exchange, Sacramento

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 9-24-05

Dear Dr. McClellan:

I am writing as an anesthesiologist at Sutter Roseville Medical Center to urge the Centers for Medicare and Medicaid Services (CMS) to change the Medicare anesthesiology teaching payment policy.

As a practicing anesthesiologist I have seen the difficulty our group, Central Anesthesia Service Exchange, has had in obtaining qualified anesthesiologists to join our professional corporation. We have had to delay new anesthesia services at Sutter Roseville Medical Center for lack of new members in our group. A shortage definitely exists in our field made worse by the reimbursement rate paid to teaching anesthesia programs.

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.

Keith Thorpe, MD,
Sutter Roseville Medical Center, One Medical Plaza, Roseville, CA 95661

Submitter : Dr. vernon h. ross **Date:** 09/24/2005

Organization : wake forest university baptist medical center

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

I am writing to ask support for a change in the teaching rule which causes academic anesthesiologist to have their medicare fees reduced 50% while covering 2 residents simultaneously. It is unfair to academic anesthesiologist. Our surgical collegues receive full compensation while directing 2 resident cases simultaneously while an anesthesiologist fees are reduced 50%. This makes it more difficult to recruit academic facultly for our programs while there is already a nation wide shortage of academic anesthesiologist. This rule if not changed puts an unfair burden on academic practices and threatens the future of anesthesia and patient care.

Submitter : Dr. James Loftus **Date:** 09/24/2005

Organization : Dr. James Loftus

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

Please support the proper funding of academic anesthesia. Some in the medical field maintain that the two most important medical advancements in the last century have been antibiotics and anesthesia. the advancements in anesthesia have been made at the great university systems in the US. Academic medicine is in trouble and anesthesia in particular. Please fund these programs properly or else the quality of anesthesia services will suffer.

CMS-1502-P-1379-Attach-1.WPD

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 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.

Name__James B. Loftus,III

Address __8 West 78th Street

Harvey Cedars, NJ 08008

Submitter : Dr. Matt Herren **Date:** 09/24/2005

Organization : Panhandle Anesthesia

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 Sacred Heart Hospital Pensacola, Florida 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.
Matt Herren D.O.
Board Certified Anesthesiologist
4091 Grande Drive
Pensacola, Florida
32504

CMS-1502-P-1382

Submitter : Mrs. Katherine Lopez **Date:** 09/24/2005

Organization : Santa Cruz Medical Foundation

Category : Other Technician

Issue Areas/Comments

GENERAL

GENERAL

I support the reassignment of Santa Cruz County from Locality 99 to its own locality. Santa Cruz is not a rural community and the cost of living and doing business here is very expensive. Our physicians and other health care providers need to be adequately compensated so that they may continue to provide quality care to our Medicare patients.

CMS-1502-P-1383

Submitter : Dr. Jay Horrow **Date:** 09/24/2005

Organization : Drexel University College of Medicine

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

Please see attachment

CMS-1502-P-1383-Attach-1.DOC

25 September 2005

Mark McClellan, M.D., Ph.D.
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 Drexel University College of Medicine in Philadelphia to urge the Centers for Medicare and Medicaid Services (CMS) to change the Medicare anesthesiology teaching payment policy.

Medicare's payment arrangement, which applies only to anesthesiology teaching programs, has had a serious detrimental impact on the ability of our program and on most anesthesiology training programs to recruit and 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 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. It drives anesthesiologists out of academia to private practice.

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.

Sincerely,

Jay C. Horrow, MD, MS
Professor and Chairman (designated), Department of Anesthesiology
Drexel University College of Medicine
Broad and Vine Streets, Mail Stop 310
Philadelphia, PA 19102

CMS-1502-P-1384

Submitter : Dr. Robert Shupak **Date:** 09/24/2005

Organization : Dr. Robert Shupak

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

Please support academic anesthesiologists by not allowing CMS to cut payments from Medicare to teaching physicians. Although I am presently not involved in academic medicine, one should not underestimate the importance of such programs. They further medicine by training new healthcare providers and fostering research. The future of anesthesiology is threatened by negative regulations and reimbursements.

CMS-1502-P-1385

Submitter : Dr. Alex Dumanovsky **Date:** 09/25/2005

Organization : University of Iowa Hospitals and Clinics

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 Iowa Hospitals and Clinics to urge the Centers for Medicare and Medicaid Services (CMS) to change the Medicare anesthesiology teaching payment policy.
Over the recent couple of years out hospital and program have witnessed (and suffered from) an alarming trend that is, unfortunately, representative of academic anesthesiology nationwide - continuous loss of high quality faculty members to private practice. Talented teachers, excellent clinicians, and talented researchers leave academic positions to pursue private practice opportunities. This has resulted in loss of role models and mentors for residents, greatly decreased and decreasing morale in the whole department, and increased workload on the remaining (undercompensated) staff - only increasing the pressure on them to go elsewhere and making it more difficult to hire replacement. The overall quality of my residency program has consequently decreased significantly.
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,
Alex Dumanovsky, M.D.

Submitter : Dr. William Strohmeyer D.O. **Date:** 09/25/2005

Organization : Scott

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 Scott and White hospital 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.
William Strohmeyer D.O.
2401 South 31st Street, Temple, Texas, 76508

Submitter : Ms. Suzanne Drake **Date:** 09/25/2005

Organization : self

Category : Physical Therapist

Issue Areas/Comments

GENERAL

GENERAL

Re: GPCIs 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. The new locality would make the Medicare reimbursement more closely match the actual practice expenses.
The new locality would help Sonoma County physicians improve the quantity and quality of care they deliver to Medicare beneficiaries and other patients. The locality change would also benefit efforts to recruit and retain physicians in the county, which has a large Medicare population. We have lost many highly qualified and caring physicians because they could not support their families nor give the type of care to their patients that they so desired to continue to give.
I fully support your proposal to change Sonoma County's payment locality and I appreciate the opportunity to comment on this importantissue.

Sincerely,

Suzanne C. Drake, RPT, CWS

Submitter : Dr. Leonid Liptsen **Date:** 09/25/2005

Organization : Denver Health Medical Center

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

Dear Dr. McClellan,
I am one of the part time Attending Physicians helping the Anesthesiology program at Denver Health to SURVIVE. This Hospital is a Level One Trauma Center and we are taking severely injured patients from all over Colorado and even Kansas and Wyoming.
This is the last resort for indigent homeless and elderly residing in Denver area.
This is also a very nice place to work because of all highly trained
professionals still practicing there. I am afraid not for much longer.
Unfair and shortsited discriminatory decision to pay 50% for supervision of 2 residents is aiming right into the heart of teaching anesthesiology group.
People who were nurturing the future of American Anesthesiology leaving this facility, because the pay for this selfless work and teaching is highly inadequate.
I and several other anesthesiologists working at DH almost pro bono, just to help the group to continue with the programs for MDs and CRNAs, so my comment does not carry any personal financial interest.
It seems so unjust to ruin perfectly fine organization instead of helping one, that I have to send this letter.
Pleas for sake of the future of whole Anesthesia specialty, change your policy!
Respectfully
L.Liptsen
Attending Anesthesiologist
Denver, CO

Submitter : Dr. Steven Mandel **Date:** 09/25/2005

Organization : Dr. Steven Mandel

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 Olympia 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.
Steven L Mandel MD
269 S Beverly Drive, #120, Beverly Hills CA 90212

Submitter : Dr. Irwin Mansdorf
Organization : Dr. Irwin Mansdorf
Category : Other Health Care Professional
Date: 09/25/2005

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1502-P-1390-Attach-1.DOC

TELEHEALTH COMMENTS

I would like to take this opportunity to offer my comments on adding services to the list of Medicare Telehealth Services, as noted in Section D of the proposed rules dated August 8, 2005.

This comment is specific to section D (2)(c) "Definition of a Telehealth Originating Site" and the proposal to include skilled nursing facilities (SNF's) as an originating site.

While the need for medical services for geriatric residents of SNF's is well documented, one area is particularly critical, namely mental health services. Research studies continue to show that the needs of SNF residents are underserved when it comes to mental health services. Estimates have found that upwards of 27% of residents of SNF's are in need of mental health care at any given time (http://www.cdc.gov/nchs/fastats/mental.htm).

Behavioral care in SNF's is largely regulated by OBRA (1987) regulations that mandate that both psychotropic medication and behavior management intervention be implemented. However, the lack of mental health providers in rural SNF's prevents these regulations from being fully implemented. Without professional psychiatric care and clinical psychology intervention, the management of medications and the implementation of behavior management therapy for SNF residents remains lacking.

In many non-MSA areas, psychiatrists are either in short supply or non-existent. Rathbone-McCuan notes that 85% of the rural geriatric population with mental health problems goes untreated (Rathbone-McCuan E (1993), Rural geriatric mental health care: a continuing service dilemma. In: Aging in Rural America, Bull CN, ed. Newbury Park, Calif.: Sage Publications, pp146-169). Considering the high rate of psychiatric problems in SNF's, this figure is certainly even more significant in the SNF environment.

Many rural SNF's simply do not provide professional psychiatric or mental health care, with medication needs handled by non-psychiatric physicians. Psychological counseling either is provided by paraprofessional staff or not provided at all. Overall, studies have found that rural nursing home residents have less access to professional mental health care than urban nursing home residents. (http://muskie.usm.maine.edu/Publications/rural/wp11.pdf)

One mechanism to overcome this critical need is telehealth technology. The American Psychiatric Association has long held that telepsychiatry is "...a potentially appropriate technology for the delivery of clinical psychiatric services" (http://www.psych.org/psych_pract/tp_paper.cfm). As documented in several studies (e.g., Tucker, et.al. Psychiatric medicine for rural New York State, Journal of Psychiatric Practice, July 2001) technology for providing psychiatric consultation as well as mental health treatment exists and has been successfully implemented in a number of settings. Rabinowitz has already demonstrated how telepsychiatry consultations

for nursing home residents can be successfully implemented (http://www.fahc.org/Telemedicine/telepsych_abstract.html).

The absence of skilled nursing facilities as approved originating sites in telehealth results in an inability to provide critical psychiatric and behavioral care to untold numbers of residents in non-MSA areas. The lack of available care results in higher rates of psychiatric hospitalizations and the inability to effectively manage medications many residents are taking and behavior residents are exhibiting. This undoubtedly causes significant clinical complications and economic losses as well as personal and family distress of SNF residents and staff. Approving SNF's as originating sites for telehealth services would be an equitable and cost-effective mechanism to deal with the critical needs related to behavioral care of SNF residents in rural areas throughout the United States.

Respectfully,

Irwin J. Mansdorf, PhD
Member, - Council for the National Register of Health Service Providers in Psychology
Diplomate, American College of Forensic Examiners
Clinical Fellow, Behavior Therapy and Research Society
September 23, 2005

Submitter : Dr. Ajay Gopalka
Organization : University of Chicago
Category : Physician
Date: 09/25/2005

Issue Areas/Comments

GENERAL

GENERAL

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

Attn: CMS-1502-P/TEACHING ANESTHESIOLOGISTS

Dear Dr. McClellan:
I am writing as an anesthesiologist 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.
Please end the anesthesiology teaching payment penalty.

Ajay Gopalka, MD
5841 S. Maryland; MC 4028
Chicago, Ilinois 60637

CMS-1502-P-1391-Attach-1.DOC

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

Attn: CMS-1502-P/TEACHING ANESTHESIOLOGISTS

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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.

Ajay Gopalka, MD

5841 S. Maryland; MC 4028
Chicago, Ilinois 60637

CMS-1502-P-1392

Submitter : Dr. Cedric Dupont

Organization : Faculty Anesthesiologist

Category : Physician

Date: 09/25/2005

Issue Areas/Comments

GENERAL

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As a Faculty Anesthesiologist at Univeristy of Texas Health Science Center in Houston, your proposed measure would effectively halt our teaching of this important field of medicine for the future. We are colstantly short staffed under the current state of affairs and are forced to cancel cases on a daily basis. Few anesthesiologists desire to practice in academic medicine because of the pay difference.

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

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

Right now, slots in anesthesiology residency programs are going unfilled because of ill-conceived Medicare policy that shortchanges teaching programs, withholding 50% of their funds for concurrent cases.

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

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

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

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

This is not fair, and it is not reasonable.

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

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

Thank you for you consideration in revoking this bill.

Submitter :

Organization :

Date: 09/25/2005

Category : Physician

Issue Areas/Comments

GENERAL

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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 practicing in St. Albans, Vermont 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.
As a physician, I strive to provide the best care for my patients. All physicians rely on teaching institutions for the training that enabled us to practice our specialty and the research that keeps anesthesiology on the cutting edge. Anesthesiology has been a leader in paving the way for patient safety initiatives and progress in medicine and technology. It is illogical to punish a sector of the specialty that we should instead support, not only for past and future accomplishments but also the dedication to place teaching as an integral part of their careers.
Please end the anesthesiology teaching payment penalty.
Name___Janice E. Gellis, MD
Address 133 Fairfield St.
St. Albans, VT 05478

CMS-1502-P-1394

Submitter : Dr. Joel Johnson

Date: 09/25/2005

Organization : University of Missouri-Columbia

Category : Physician Assistant

Issue Areas/Comments

GENERAL

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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 Chair and Program Director at the University of Missouri-Columbia 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.

The fact is, anesthesiologists on the faculty at the University of Missouri do not produce enough revenue to pay a salary commensurate to salaries that can be earned in the private sector, partially due to this teaching rule. The Institution supplements the salary of the anesthesiologists in order to effectively compete for qualified, excellent practitioners willing to serve as teachers. The long term impact of this unfair practice may lead to a decline in the quality of anesthetic care in the United States.

If you want to impact the delivery of health care to the people of this country in a positive manner, you need to eliminate the discrepancy in payment to teaching anesthesiologists.

Sincerely,

Joel O. Johnson, MD PhD
Russell D. Shelden Professor & Chair
Department of Anesthesiology and Perioperative Medicine
3W27 Health Sciences Center
One Hospital Drive
Columbia, MO 65212

Submitter : Dr. Lloyd Halpern

Organization : Dr. Lloyd Halpern

Category : Physician

Date: 09/25/2005

Issue Areas/Comments

GENERAL

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I am an anesthesiologist in private practice. The research that is done in academic institutions is paramount to continuing improvement in patient care. It is vital that these institutions continue to attract top notch physicians and researchers, and that they have an opportunity to devote time and money to research. Please make sure that these research physicians are reimbursed 100% for supervising residents.
They are vital to making sure residents are trained well, that safe care is provided, and that continued improvements in our field are realized.
Thank you for your support,
Lloyd Halpern, M.D.

Submitter : Dr. Mark Rainosek

Organization : Dr. Mark Rainosek

Category : Physician

Date: 09/25/2005

Issue Areas/Comments

GENERAL

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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 who works with residents at the University Of New Mexico Hospital as well as Arkansas Children?s Hospital. I would like to urge the Centers for Medicare and Medicaid Services (CMS) to change the Medicare anesthesiology teaching payment policy.
The policy, 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.
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. 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.
Sincerely,
Mark Rainosek, MD
2400 Central Ave. SE
Albuquerque, NM 87106

CMS-1502-P-1397

Submitter : Dr. James King

Organization : University of Chicago Hospitals

Category : Physician

Date: 09/25/2005

Issue Areas/Comments

GENERAL

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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 the University of Chicago Department of Anesthesia and Critical Care to encourage the Centers for Medicare and Medicaid Services (CMS) to change the Medicare anesthesiology teaching payment policy.
Medicare?s 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 resident 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.
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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. Thank you for your time and attention to this matter.

Sincerely yours,
Name: James C. King M.D.
Address: University of Chicago, Department of Anesthesia & Critical Care, 5841 S. Maryland, MC 4028, Chicago, IL 60637

Submitter : Ms. HOPE HOOPER

Organization : Ms. HOPE HOOPER

Category : Individual

Date: 09/25/2005

Issue Areas/Comments

GENERAL

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"GPCIs"
I support the proposal on the Federal Register to change Santa Cruz County's RURAL designation to URBAN; increase Medicare payments for doctors in Santa Cruz and Sonoma counties to EQUAL Santa Clara County, NOT JUST %10!

Submitter : Dr. Michael Jakubowski
Organization : Dr. Michael Jakubowski
Category : Physician
Date: 09/25/2005

Issue Areas/Comments

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Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attn: CMS-1502-P/TEACHING ANESTHESIOLOGISTS
P.O. Box 8017
Baltimore, MD 21244-8017
Dear Dr. McClellan:
I am writing as an anesthesiologist at [name of institution] to urge the Centers for Medicare and Medicaid Services (CMS) to change the Medicare anesthesiology teaching payment policy.
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Please end the anesthesiology teaching payment penalty.
Michael S. Jakubowski
1350 Hawthorn Rd.
Schenectady, NY 12309

Submitter : Dr. Joseph Carpenter

Organization : Dr. Joseph Carpenter

Category : Physician

Date: 09/25/2005

Issue Areas/Comments

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