Submitter : Dr. Matthew Thorson **Date:** 08/26/2005

Organization : University of Florida/Shands

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

To Whom it May Concern:

I am a senior Anesthesiology Resident at the University of Florida. I am writing with major concerns over the reimbursment schedule planned for academic anesthesiologists. A payment plan of 50% of the norm for a case where a resident is being supervised by staff is totally unacceptable. It will cripple academic anethesiology programs and could short the nation of a vital part of our health care system in the long run. Anesthesiology is a profession with a long history that touches virtually every aspect of medicine. We in our profession have done much to improve patient safety and a reimbursment plan by medicare/medicaid to hurt that cause is just not acceptable.

Submitter : Dr. Jennifer Hogan **Date:** 08/26/2005

Organization : UT Houston Department of Anesthesiology

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

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

Submitter : Dr. Nikolaos Skubas` **Date:** 08/26/2005

Organization : NewYork-Presbyterian Weill Cornell Medical Center

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

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

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

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

Sincerely,

Submitter : Dr. Thomas Spackman **Date:** 08/26/2005

Organization : American Society of Anesthesiologists

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

Please See Attachment.

CMS-1502-P-304-Attach-1.DOC

Thomas N. Spackman, MD
2001 14 St. NE
Rochester, MN 55906

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

Dear Dr. McClellan:

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

Teaching anesthesiologists are 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%.

While it may seem that this is fair payment for the anesthesiologist involved in the cases, in reality the anesthesiologist is paid by the institution at market rates and the teaching institution is penalized for teaching residents rather than the alternative of employing nurse anesthetists.

This discriminatory payment arrangement, which applies only to anesthesiology teaching programs, has a serious negative 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 and other procedures.

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

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 the mission of training excellent anesthesiologists will continue for future generations.

Please end the anesthesiology teaching payment penalty.

Sincerely,

Thomas N. Spackman, MD

Submitter : Ms. Gayle Ortiz

Date: 08/26/2005

Organization : Ms. Gayle Ortiz

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

I am in favor of changing the designation "rural" for Santa Cruz County. With the housing prices and our population, there is no way Santa Cruz County should be considered rural. We must have this changed to attract qualified doctors. Thank you.

Submitter : **Dr. Tyler Yeates** **Date: 08/26/2005**

Organization : **Mayo Clinic**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

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

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

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

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. More importantly, in the long term it will help provide quality anesthesia and providers for a population with increasing needs.

Please end the anesthesiology teaching payment penalty.

Sincerely,

Tyler Yeates, M.D.
Mayo Clinic Anesthesia Resident
1225 Cascade St. NW
Rochester, MN 55901

Submitter : Dr. Philip Balestrieri

Date: 08/26/2005

Organization : University of Virginia Health System

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

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

Dear Dr. McClellan:

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

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

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

Please end the anesthesiology teaching payment penalty.

Name_Philip J. Balestrieri, MA, MD_____

Address _1070 West Leigh Drive, Charlottesville, VA 22901_____

Submitter : **Dr. John Eisenach** **Date: 08/26/2005**

Organization : **Mayo Clinic**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

Dear Dr. McClellan:

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

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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. At Mayo Clinic we care for extremely ill patients from all over the world, and I can't understand why we are penalized for this.

John H. Eisenach, M.D.
Assistant Professor
Mayo Clinic College of Medicine
eisenach.john@mayo.edu

Submitter : **Dr. Michael Berrigan**

Date: **08/26/2005**

Organization : **Dr. Michael Berrigan**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1502-P-309-Attach-1.DOC

August 26, 2005

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

RE: CMS-1502-P "TEACHING ANESTHESIOLOGISTS"

I am responding to the invitation to provide comments on improving CMS' current payment policy on teaching anesthesia programs. This is done with the hope that CMS may correct the current policy of paying teaching anesthesiologists only 50% of the fee for two concurrent resident cases.

These are difficult times for academic anesthesia programs. Many, if not most, academic anesthesiology groups exist only because of substantial subsidies from their hospitals. These subsidies are clearly not sustainable in many cases. With a well-documented shortage of anesthesiologists, it seems doubly unwise to economically discriminate against academic anesthesia training programs. We need to promote growth in the pool of physicians trained in anesthesiology, not make it more difficult. Paying academic clinicians less than others is unwise and will severely impact the financial viability of these programs faced with crucial task of training anesthesiologists to care for our increasingly elderly population.

The Medicare anesthesia conversion factor is already shockingly less than common commercial conversion rates. Reducing this further is not fair to academic programs and will have far reaching negative repercussions. I urge the CMS to correct its discriminatory policy. I thank you for the opportunity to provide comments on this important issue.

Sincerely,

Michael J. Berrigan, MD, PhD
Chairman and Program Director
Department of Anesthesiology
The George Washington University Medical Center
Washington, DC

Submitter : **Dr. Janet Brierley** **Date: 08/26/2005**

Organization : **University of New Mexico**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

Janet Brierley MD
Professor of Anesthesiology and Critical Care Medicine
University of New Mexico
Albuquerque NM 87131

Submitter : **Harry Barlow** **Date: 08/26/2005**

Organization : **Harry Barlow**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

GPCIs
Dear Sirs,

Re CMS-1502-P, I beleive the Medicare reimbursement rate for MDs in Santa Cruz County, California, should be increased so we can attract good doctors, keep those we already have, and so doctors won't drop Medicare patients. The cost of living here is, unfortunately for many, near the highest in the nation.

Thank you for your consideration.

Yours truly,

Harry Barlow

Submitter :

Date: 08/26/2005

Organization :

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

RE: CMS-1502-P (Teaching Anesthesiologists)

To Whom It May Concern:

I have served as program director of the anesthesiology residency at Mayo School of Graduate Medical Education in Rochester, Minnesota for the past eleven years. During this time, I have been responsible for training more than 150 physicians who now practice in the state of Minnesota and around the country. In fact, the Mayo residency program has produced 72% of the practicing anesthesiologists in the state of Minnesota during the past decade.

The purpose of this letter is to strongly encourage CMS to promptly correct the unfair policy of paying teaching anesthesiologists only 50% of the fee for each of two concurrent cases. This unfair policy damages academic teaching programs and undermines our ability to train anesthesiologists for the complex critical needs of our aging population.

We believe the policy is unfair as surgeons? may supervise trainees in two overlapping operations and collect 100% of the fee for each case from Medicare. Internists may supervise four trainees in overlapping outpatient visits and collect 100% of the fee for each when certain requirements are met. These distinctions among specialists are discriminatory and, ultimately, negatively impact our ability to provide a quality training environment.

With the Medicare anesthesia conversion less than 40% of commercial rates, reducing that factor by 50% for teaching anesthesiologists compromises our academic mission.

We urge you to correct this unjust policy and treat anesthesiologists in a manner similar to that in surgery and medicine.

Thank you for your consideration.

Steven H. Rose, M.D.
Program Director
Anesthesiology Residency
Mayo School of Graduate Medical Education
Rochester, MN 55905

Submitter : Mr. Henry Traylor

Date: 08/26/2005

Organization : CA Coastal Commission

Category : State Government

Issue Areas/Comments

GENERAL

GENERAL

Please change the Physician designation from rural to urban and increase the Medicare/Medical payment reimbursement for physicians practicing in Santa Cruz County.

Submitter : Mr. Tab McBride

Organization : Mr. Tab McBride

Category : Individual

Date: 08/26/2005

Issue Areas/Comments

GENERAL

GENERAL

I support the rule to add a new payment locality for Somona County, CA

Submitter : Dr. Richard McEvoy

Date: 08/26/2005

Organization : Anchorage Fracture

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

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

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

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

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

Submitter : **Dr. Michael Sandison** **Date: 08/26/2005**

Organization : **Albany Medical Center, Anesthesiology Department**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Mark McClellan, M.D., Ph.D.
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attn: CMS-1502-P/TEACHING ANESTHESIOLOGISTS
P.O. Box 8017
Baltimore, MD 21244-8017
Dear Dr. McClellan:
I am writing to urge the Centers for Medicare and Medicaid Services (CMS) to change the Medicare anesthesiology teaching payment policy.
Medicare?s discriminatory payment arrangement, which applies only to anesthesiology teaching programs, has had a serious detrimental impact on the ability of programs to retain skilled faculty and to train the new anesthesiologists necessary to help alleviate the widely-acknowledged shortage of anesthesia providers -- a shortage that will be exacerbated in coming years by the aging of the baby boom generation and their need for surgical services.
Under current Medicare regulations, teaching surgeons and even internists are permitted to work with residents on overlapping cases and receive full payment so long as the teacher is present for critical or key portions of the procedure. Teaching surgeons may bill Medicare for full reimbursement for each of the two procedures in which he or she is involved. An internist my supervise residents in four overlapping office visits and collect 100% of the fee when certain requirements are met.
Teaching anesthesiologists are also permitted to work with residents on overlapping cases so long as they are present for critical or key portions of the procedure. However, unlike teaching surgeons and internists, since 1995 the teaching anesthesiologists who work with residents on overlapping cases face a discriminatory payment penalty for each case. The Medicare payment for each case is reduced 50%. This penalty is not fair, and it is not reasonable.
Correcting this inequity will go a long way toward assuring the application of Medicare?s teaching payment rules consistently across medical specialties and toward assuring that anesthesiology teaching is reimbursed on par with other teaching physicians.
Please end the anesthesiology teaching payment penalty.
Name: Michael Sandison, M.D.
Address Administrative Director, Anesthesiology Residency Program, MC 131
Albany Medical Center
Albany NY 12208

Submitter : Dr. Nancy Greilich **Date:** 08/26/2005

Organization : UT Southwestern Medical School

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

Regarding Anesthesiology reinbursement for resident supervision cases. It is imperative that the government reimburse these cases with a 2:1 ratio of providers to teaching faculty. It would be impossible to run the operating room with a 1:1 ratio because of staffing limitations or be able to financially continue medical teaching without this reimbursement . Please see that it is changed accordingly for the betterment of medical education and the running of the public hospital systems

Submitter : **Mrs. Rebecca Salmon** **Date: 08/26/2005**

Organization : **New York Pain Center**

Category : **Health Care Professional or Association**

Issue Areas/Comments

GENERAL

GENERAL

This is in regards to the proposal to chop the RVU's for CPT code 62367 and 62368: The practice is not charged for the actual programmer, but we are charged for batteies and the paper that is needed to print off the telemetry(which isn't cheap). Programming is not easy to learn nor can someone just take the programmer and program a pump! Since when did the RVU be based on equipment cost? The medications are high risk to the patient and if the pump is not programmed correctly the danger to the patient could be under infusion causing withdrawl, or overdosing causing death. Part of this CPT code is a nursing assessment, vital signs are taken and assessment as to the benefits of treatment. Programming is not like pressing buttons and the machine does it all, NO, the operator must be educated and programm the programmer correctly, it can become complex.

Submitter : **Dr. Robert Cross** **Date: 08/26/2005**

Organization : **OHSU Department of Anesthesiology**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

Dear Dr. McClellan:

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

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

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

Please end the anesthesiology teaching payment penalty.

Robert L. Cross, Jr., DMD,MD
Assistant Professor
OHSU Department of Anesthesiology & Peri-Operative Medicine
Portland, Oregon 97239

Submitter :

Date: 08/26/2005

Organization :

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

I hope that Santa Cruz County is changed from a "rural" designation to an "urban" designation. The fact that doctors are limiting or refusing to take Medicare patients due to the current Medicare reimbursement is an outrage to senior citizens. Santa Cruz County is a small county and it is already difficult to find good doctors. Older people may not have the resources to travel farther away in search of medical care. It should be noted that this problem not only affects Medicare aged patients, but it affects younger patients as well when physicians pull up stakes and leave the county because they cannot afford to practice here. For example, I am only 50 years old, but I am directly impacted by the fact that both of the ophthalmologists at Santa Cruz Medical Clinic left the county. One of the ophthalmologists left in May and the other in June. They both left the area because of the high cost of living here. As of today, August 26th, the Santa Cruz Medical Clinic still has not been able to replace both doctors. I suffer from glaucoma and I need regular check-ups. In addition, our family doctor resigned and the replacement physician lamented to us how she could not afford to buy a home in this area. We are considering moving out of this area because we realize that we will need medical care as we age and we do not see Santa Cruz County as offering the necessary services to its citizens.

Submitter : **Dr. Carmen L Dominguez** **Date: 08/26/2005**

Organization : **UMDNJ**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

Submitter : Dr. Philip Boysen

Date: 08/26/2005

Organization : University of North Carolina

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

See attachment.

CMS-1502-P-323-Attach-1.DOC

CMS-1502-P-323-Attach-2.DOC

August 25, 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:

When you recently visited the University of North Carolina, we had a chance to talk briefly about the CMS policy for payment to the academic or teaching anesthesiologist. I write to urge that CMS change the payment policy for teaching anesthesiologists when working with resident physicians.

Every conversation I have had leads to agreement that the current payment policy is discriminatory and unfair. Physicians skilled not only in clinical medicine but also dedicated to teaching are difficult to recruit and difficult to retain. At a time when our specialty is facing a critical manpower shortage, the numbers of qualified faculty are important to maintaining our programs for resident physicians. In my own state, there are 15 counties (out of 100) that do not have a physician trained in anesthesiology in their hospital. A recent study from the UNC School of Public Health and the Sheps Center indicates that physicians are increasingly moving into smaller and mid-size towns, but we are not graduating adequate numbers to meet the need.

We only ask to be treated equitably, and in line with our colleagues in other specialties. Our surgeons, internists, emergency physicians, and family practitioners are permitted to work with multiple residents and on overlapping or concurrent cases, and receive full payment for each patient, as long as they are present for critical portions of the procedure or transaction. While these colleagues receive full payment, our payments are reduced by 50%. This is not fair, not equitable, and there is no logic to support it.

Correcting this inequity will make a difference. It will help the physicians who are teaching anesthesiologists achieve the educational goals necessary to provide our communities with the expertise they seek. Please end this teaching payment penalty.

Sincerely,

Philip G. Boysen MD, FACP, FCCP, FCCM
Professor of Anesthesiology and Medicine
Chair, Department of Anesthesiology

Submitter : **Dr. Bernard DeLeo** **Date: 08/26/2005**

Organization : **Dr. Bernard DeLeo**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

The current CMS proposed changes to the Medicare Fee Schedule for 2006 discriminates againsts Anesthesiologists by paying them only 50% of the Medicare fee if they are supervising 2 residents while paying 100% to surgeons supervising 2 surgical residents and an internist may supervise four overlapping outpatient visit and collect 100% of the fee when certain conditions are met.

The Medicare anesthesia conversion rate is less than 40% of prevailing commercial rates.

As an academic anesthesiologist for 26 years before I retired 9 years ago I know how difficult it is to recurit and retain good faculty and also quality residents. I hope that you realize how important anesthesiology is to surgery and medicine. We must all work to continue to make American medical care the best in the world.

Please change this policy to provide 100% payment to Academic Anesthesiologists when supervising two anesthetic residents.

Bernard C. DeLeo, M.D.

Submitter : **Mr. Yoshiharu Kuroiwa** **Date: 08/26/2005**

Organization : **Parent of Disabled Person**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

As a parent of a disabled child in Santa Cruz County I ask that you please increase the Medicare funding for doctors and other medical practitioners. As it is commonly known, our county is now in the top 3 most expensive places to live in the entire country. Doctors are leaving because they cannot afford to live here due to the high cost of homes, expenses, taxes, etc.. Our children are the ones to suffer the most and they are the least capable of expressing their desires. More and more doctors are not accepting Medicare or Medicaid patients due to the low reimbursement rates. Please help our families by allowing these children to live with some form of affordable medical protection. They suffer silently and long in waiting rooms for proper medical services to ease their pain. I hope you will have compassion and consideration for those that need your help now. Please allow the increased rates to be approved. Thank you very, very much. Y. Kuroiwa (Santa Cruz, California)

Submitter : **Dr. Francis Marzoni** **Date: 08/26/2005**

Organization : **Palo Alto Division, Palo Alto Medical Foundation**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

GPCIs
I am in full support of removing Santa Cruz and Sonoma Counties from the "Area 99" designation. In Santa Cruz County the mismatch between physician costs and MediCare payment has hampered recruitment and retention of physicians--both in primary care and specialty care--to an extent that health care delivery is being compromised. Giving Santa Cruz County another designation will be a big help.

Submitter : Dr. L REED WALKER JR **Date:** 08/26/2005

Organization : Dr. L REED WALKER JR

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

Date: August 26, 2005

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

Re: GPCIs

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

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

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

Sincerely,

L. Reed Walker, Jr., MD
990 Sonoma Avenue-Suite 5
Santa Rosa CA 95404

Submitter : **Dr. DENISA HARET** **Date: 08/27/2005**

Organization : **UAMS**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

Submitter : **Dr. Donald Loarie** **Date: 08/27/2005**

Organization : **Dr. Donald Loarie**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

It is absolutely essential to create a new payment locality in Sonoma County.
At present there is a huge disparity between practice expenses and Medicare reimbursements. Because of this disparity, many of the best physicians have been leaving Sonoma County for practice elsewhere. Furthermore, it is next to impossible to attract new young physicians to the area, who have no possibility of making adequate income to cover the high living expenses in Sonoma County.

I urge you to ensure the future viability of medical care in Sonoma County by creating a new payment locality for this area. This would go a long way towards correcting existing inequalities.

Sincerely,

Donald J. Loarie, MD

Submitter : Dr. **Date:** 08/27/2005

Organization : Dr.

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

The reimbursement policy for teaching Anesthesiologists is unfair and discourages research, teaching, and entry into the specialty at a time when more and more older/sicker Medicare patients are requiring complex anesthesia and surgery done safely.

It is unfair that a surgeon may supervise residents in 2 overlapping operations and collect 100% of the fee for each case from Medicare and an internist may supervise residents in 4 overlapping clinic visits and collect 100% of the fee for each while a teaching anesthesiologist only collects 50% of the Medicare fee when supervising residents in 2 overlapping cases. Anesthesiologists should be reimbursed similarly to thse other specialists simply for fairness, as well as to ensure adequate funding for research and teaching. Also, entry of new practitioners into the field is required to replace those leaving the field to prevent a predicted shortage of Anesthesiologists as the population of aging Medicare beneficiaries and need for surgical procedures increases. Disparity with other specialists combined with an already low conversion factor (relative to private insurers) will discourage entry into the specialty of Anesthesiology in favor of better-paying specialties and promote this shortage of skilled Anesthesia practitioners.

Submitter : **Dr. John Coleman** **Date: 08/27/2005**

Organization : **Stony Brook University Hospital**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1502-P-331-Attach-1.DOC

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

Dear Dr. McClellan:

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

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

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

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

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

Please end the anesthesiology teaching payment penalty.

Name: John F. Coleman MD

Address: Department of Anesthesiology
Stony Brook Univ. Hospital__
Stony Brook, New York 11794-8480

Submitter : Dr. Warner Lucas **Date:** 08/27/2005

Organization : UNC School of Medicine, Dept. of Anesthesiology

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1502-P-332-Attach-1.DOC

Regarding CMS Medicare Fee Schedule for Teaching Anesthesiologists
CMS-1502-P

With all due respect...WHAT are you THINKING?

My anesthesiology residency training program, of which I have been a devoted participant for over 20 years is going out of business. And an unfair, inadequate, and unwise reimbursement guideline for clinical services is the the cause of the demise of my program.

The demand for the best possible medical care and the shortage of affordable medical insurance coverage have collided at academic medical centers. Teaching centers such as mine find themselves with a higher than ever penetration of Medicare and Medicaid sponsored patients. Subsequently our incomes are more than ever at the mercy of government reimbursement plans.

Anesthesiologist in teaching centers have been singled out by unfair Medicare guidelines to take a 50% cut in reimbursement for any concurrency of care delivered while teaching residents. Surgeons get full freight while supervising residents at 2 locations, internist may supervise up to 4 locations and collect full Medicare rates. What makes it ok to penalize anesthesiologist?

The catastrophic effect of this unfair, unwise reimbursement practice is now upon us. Academic anesthesiology programs all over America are unable to meet internal budget requirements. Faculty are leaving to explore opportunities in private practice or other medical specialties. In my program we have a shortfall of faculty by over 25%. Remaining faculty are overworked. The teaching environment is stifled by the need to promote "efficient throughput"...and still we lose money. Residents are unhappy, and medical students (erstwhile anesthesiology wannabees) are painfully aware and staying away in droves. WHY? BECAUSE WE ARE NOT PAID FOR THE CARE WE DELIVER. If we close the doors to training programs, where will tomorrow's patients get the quality of anesthesiology care they demand and deserve?

What are you thinking?

Please think about fairness, and our country's medical future. Support changes in reimbursement to teaching anesthesiologist which will allow us to survive and to teach the next generation of caregivers.

Thanks for your attention to this important matter, and for your service to our nation's medical needs.

Warner J. Lucas DDS, MD
Professor of Anesthesiology
Director of Cardiac and Thoracic Anesthesiology
Director of Resident Selection
University of North Carolina School of Medicine
Chapel Hill, NC

Submitter : Dr. Karen Staggs **Date:** 08/27/2005

Organization : Teaching Anesthesiologists

Category : Academic

Issue Areas/Comments

GENERAL

GENERAL

Mark McClellan, M.D., Ph.D.
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attn: CMS-1502-P/TEACHING ANESTHESIOLOGISTS
P.O. Box 8017
Baltimore, MD 21244-8017
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Under current Medicare regulations, teaching surgeons and even internists are permitted to work with residents on overlapping cases and receive full payment so long as the teacher is present for critical or key portions of the procedure. Teaching surgeons may bill Medicare for full reimbursement for each of the two procedures in which he or she is involved. An internist my supervise residents in four overlapping office visits and collect 100% of the fee when certain requirements are met.
Teaching anesthesiologists are also permitted to work with residents on overlapping cases so long as they are present for critical or key portions of the procedure. However, unlike teaching surgeons and internists, since 1995 the teaching anesthesiologists who work with residents on overlapping cases face a discriminatory payment penalty for each case. The Medicare payment for each case is reduced 50%. This penalty is not fair, and it is not reasonable.

Correcting this inequity will go a long way toward assuring the application of Medicare?s teaching payment rules consistently across medical specialties and toward assuring that anesthesiology teaching is reimbursed on par with other teaching physicians.
At my residency, for example, we have lost 5 attendings recently because of the disparity. This has been in the last 2 months, from July-August, 2005.
Please end the anesthesiology teaching payment penalty.
Karen M Staggs M.D.
5554 N. Paulina, Apt G
Chicago, Illinois, 60640-1140

Submitter : Mrs. Judy Kessler **Date:** 08/27/2005

Organization : Concerned Citizen

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

GPCI's
I am writing to support higher Medicare reimbursements for doctors in Santa Cruz County. Our county is one of the most expensive places to live in the country and the doctors here deserve to be reimbursed at the highest level possible. The cost of living here makes it hard to attract good young doctors. Also,we have about 200,000 people living in the county, so it seems unfair to call us a rural area. Please redesignate Santa Cruz county as an urban area. Our older citizens need to have good medical care as they have given so much to our area and are still able to give if they are healthy.
Thank you, Judy Kessler

Submitter : Dr. Zhiyi Zuo **Date:** 08/27/2005

Organization : University of Virginia

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

August 27, 2005
Mark McClellan, M.D., Ph.D.
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attn: CMS-1502-P/TEACHING ANESTHESIOLOGISTS
P.O. Box 8017
Baltimore, MD 21244-8017
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Under current Medicare regulations, teaching surgeons and even internists are permitted to work with residents on overlapping cases and receive full payment so long as the teacher is present for critical or key portions of the procedure. Teaching surgeons may bill Medicare for full reimbursement for each of the two procedures in which he or she is involved. An internist my supervise residents in four overlapping office visits and collect 100% of the fee when certain requirements are met.
Teaching anesthesiologists are also permitted to work with residents on overlapping cases so long as they are present for critical or key portions of the procedure. However, unlike teaching surgeons and internists, since 1995 the teaching anesthesiologists who work with residents on overlapping cases face a discriminatory payment penalty for each case. The Medicare payment for each case is reduced 50%. This penalty is not fair, and it is not reasonable.
Correcting this inequity will go a long way toward assuring the application of Medicare?s teaching payment rules consistently across medical specialties and toward assuring that anesthesiology teaching is reimbursed on par with other teaching physicians.
Please end the anesthesiology teaching payment penalty.
Sincerely,
Zhiyi Zuo, MD, Ph.D.
2070 Brownstone Lane, Charlottesville, Virginia 22901

Submitter : Ms. Ailene Stokes **Date:** 08/27/2005

Organization : Ms. Ailene Stokes

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

Re: GPCIs

Dear Sirs:

I am a Medicare beneficiary who received medical care from a physician in Sonoma County, California. I understand that Medicare is proposing to create a new payment schedule for Sonoma County that will more closley reflect actual expenses.

Sonoma County has a large Medicare population, but I have already been turned down by one doctor due to the low rate of payment by Medicare.

I fully support this proposal to and appreciate the opportunity to comment on this issue.

Submitter : Dr. kody El-Mohtar **Date:** 08/27/2005

Organization : Albany Medical Center

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

Mark McClellan, M.D., Ph.D.
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attn: CMS-1502-P/TEACHING ANESTHESIOLOGISTS
P.O. Box 8017
Baltimore, MD 21244-8017
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Under current Medicare regulations, teaching surgeons and even internists are permitted to work with residents on overlapping cases and receive full payment so long as the teacher is present for critical or key portions of the procedure. Teaching surgeons may bill Medicare for full reimbursement for each of the two procedures in which he or she is involved. An internist my supervise residents in four overlapping office visits and collect 100% of the fee when certain requirements are met.
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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.

Thankfully,
Kody El-Mohtar M.D
6 Eastmount Dr. #233
Slingerlands, NY 12159

Submitter : Dr. Barbara Murray **Date:** 08/28/2005

Organization : Psychologist

Category : Other Health Care Professional

Issue Areas/Comments

GENERAL

GENERAL

I **STRONGLY SUPPORT** proposed rule changes regarding physician payment locality revisions regarding Santa Cruz County. Doctors' expenses here are more than 5% over the national average, yet they are not compensated appropriately. The inequities of reimbursement have a delcterious impact on seniors and the disabled.

Many doctors have stopped accepting Medicare patients or have moved out of the area. Limited physicians in some specialties in Santa Cruz now result in excessive waits for appointments. E.g. A friend with a severe swallow problem following cancer surgery (able to consume only 1 oz of solid food a day, otherwise only liquids) must wait over 1 month to see a gastroenterologist. She had to travel to San Francisco to find a doctor who would place a nose feed tube, as no local doctor was willing or able to do so. I personally have had to change doctors on occasion because they have stopped accepting Medicare and I could not afford it. I have had to receive treatment in a different county because there was no local practitioner qualified to provide the specific treatment needed. (Neighboring Santa Clara physicians are paid 25.1% more for the same service as a doctor in Santa Cruz.) My primary care physician is not a Medicare provider and I must therefore pay extra for treatment.

It is difficult to recruit and retain competent physicians in this area. I pay taxes and would like doctors in this area to be compensated more adequately so they will stay here, continue to be Medicare providers, and so I can receive treatment in my own county. Please make this desperately needed change to bring reimbursement more in line with expenses to maintain a practice. Thank you for taking on the challenging task of rectifying this situation.

Submitter : Dr. Neal Swanson **Date:** 08/28/2005

Organization : Dr. Neal Swanson

Category : Radiologist

Issue Areas/Comments

GENERAL

GENERAL

GPCIs

As a retiring radiologist and former Chief of Staff of Dominican Santa Cruz Hospital who has practiced in this county for 30 years I am concerned about the future of medicine in Santa Cruz. The rapid increase in housing costs coupled with declines in Medicare funding have resulted in a severe difficulty in recruiting and retaining new physicians. With median home prices above $800,000 and rents at all-time highs the cost of living in Santa Cruz is similar to that of San Francisco, for example. Santa Cruz, as a "bedroom" community for San Jose, Santa Clara, and the Silicon Valley no longer belongs in the rural reimbursement category. Neal Swanson MD

Submitter : Anne Hudgins **Date:** 08/28/2005

Organization : Anne Hudgins

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

It is time that you reclassify Sonoma County from "rural" to "urban" and adjust payment schedules appropriately. We are losing access to our physicians because they cannot afford to treat Medicare patients! I am 69years old and living on fixed income, barely able to meet my monthly expenses. You need to recognize the economic hardships facing us as jobs are lost to overseas and housing costs become out of reach to hardworking families! We need Medicare!

Submitter : Angela Pennell **Date:** 08/28/2005

Organization : UNC Hospitals, Chapel Hill

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

I am an anesthesiology resident physician at The University of North Carolina Hospitals. I am one of 51 anesthesiology residents at UNC Hospitals with a staff of 31 teaching anesthesiologists. I recognize that there is an urgent need to change payment policy for teaching anesthesiologists.

In the department of anesthesiology at UNC Hospitals, approximately 15% of the attending physicians responsible for teaching the resident physicians have resigned in the past 12 months. Their decision to leave UNC Hospitals was as a direct result of the curent Medicare teaching anesthesiologist payment rule. In addition, slots in our anesthesiology residency program are going unfilled because of ill-conceived Medicare policy that shortchanges teaching programs, withholding 50% of their funds for concurrent cases.
This 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. However, since January of 2005, the department of anesthesiology at UNC Hospitals has been severly financially compromised due to the current Medicare reimbursement protocol. 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. The CMS anesthesiology teaching rule must be changed to allow academic departments to cover their costs.

A surgeon may supervise residents in two overlapping operations and collect 100% of the fee for each case from Medicare. An internist may supervise residents in four overlapping outpatient visits and collect 100% of the fee for each when certain requirements are met. Therefore, it is obvious how unreasonable and unfair it is for a teaching anesthesiologist to only collect 50% of the Medicare fee if he or she supervises residents in two overlapping cases.

Submitter : Lydia Locatelli **Date:** 08/28/2005

Organization : Lydia Locatelli

Category : Health Plan or Association

Issue Areas/Comments

GENERAL

GENERAL

GPCIs SantaCruz Co., where I live, is a very expensive place to live. It is very difficult for doctors to afford to live here. As a result, the best ones leave for a better paying area or do not come here at all. I believe that if Medicare payments were risen for our area, Doctors would be encouraged to stay. Please work towards this end. Thank You, Lydia Locatelli

Submitter : Ms. Ann Tompkins **Date:** 08/28/2005

Organization : Ms. Ann Tompkins

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

I urge, plead, even demand, that there be an increase in payments to doctors and for medical services in Sonoma County, California, and also in all areas where the current Medicare payments do not meet local cost of service. I am already on Medicare and MediCal(Medicaid), and I know what has already happened to dental care in our area...it is virtually unavailable for people like me because there are very few dentists who can afford to accept us as patients. Now we are faced with the same process happening to other medical care, because doctors cannot afford to accept us as patients.

Please, please, act to increase the payments as quickly and thoroughly as you can!

Submitter : Judy Dudley **Date:** 08/28/2005

Organization : Judy Dudley

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

GPCIs

I am commenting about the unfairly low payments to doctors in Santa Cruz County for Medicare patients. Santa Cruz County is the 3rd most expensive county in the entire country to buy a house and other costs are also quite high. And yet Santa Cruz County is still designated as a rural county and doctors are paid far less. Doctors in neighboring Santa Clara County, where the cost of living is similar & may actually be less, and all other San Francisco Bay area counties, receive more compensation because those counties are designated as urban. Many doctors have left Santa Cruz County or stopped taking Medicare patients because the cost of living is very high and the reimbursement is unfairly low. Please designate Santa Cruz County as Urban and end this inequity before all the doctors here have left or none are taking Medicare patients anymore.

Submitter : Dr. Robert L Anderson **Date:** 08/28/2005

Organization : Dr. Robert L Anderson

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

Issue ident;GPCIs.
I'm an Ophthalmologist practicing in Sonoma County, Ca. I strongly support your proposal to create a new and more appropriate payment locality for Sonoma County. The existing disparity between practice expenses and reimbursments, combined with the high cost of housing, has made it all but impossible for practices like mine to recruit new physicians. This is while many physicians have left the area, or stopped seeing Medicare patients.
Your proposal will help improve access to care for Medicare beneficiaries. Thank you for an opportunity to comment.

Robert L Anderson
1017 Second St.
Santa Rosa Ca 95404

Submitter : Dr. Patrick Caskey **Date:** 08/28/2005

Organization : North Bay Vitreoretinal Consultants

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

Regarding GPCIs:

As a physician practicing in Sonoma County, I would like to add my comments about the proposal for creating a new payment locality for our county. This topic has taken on more urgency for our practice recently as we have attempted to add another young physician to our group; we have found that the 'word is out' that the cost of living in Sonoma County makes setting up a practice for a recently trained physician risky at best and untenable at worst. We are still hoping to attract someone of high skills and training but continue to struggle because of the financial burden created by our present Medicare status.

Because of the disparity between our traditional 'rural' designation and our increasingly 'urban' cost of living, we as physicians are having increasing difficulty retaining and attracting well-trained physicians to our area. A number of doctors have left the area because the reimbursement from Medicare has not been able to offset the cost of housing (the average cost of a house in Sonoma County has just reached $640,000, one of the highest in the country). Additionally, many doctors here are opting out of Medicare for the same reason despite the fact that our Medicare-eligible population is increasing at a fast pace.

The proposed reimbursement increase will go a long way to help alleviate this disparity and should help allow our medical community to remain intact and viable for the future.

Thank you for allowing me to comment on this issue. I would be happy to further discuss this by phone or email.

Patrick J Caskey MD

Submitter : **Dr. J. Elizabeth Schoemaker** **Date: 08/28/2005**

Organization : **Associated Anesthesiologist**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

For me personally, this meant a very hard choice when I finished residency. I was a leader and a teacher during residency and was offered a positon at my program as an attending. However, the increasing cost of medical education had resulted in an enormous debt load for me personally. I simply couldn't afford to work in a teaching institution at reduced pay. Teaching postions should be fully compensated. Those faculty physicians take on more malpractice risk, work twice as hard as teachers and deserve what every other teaching faculty gets in any other specialty.

Sincerely, J. Elizabeth Schoemaker, MD
Anesthesiologist
Lincoln, NE

Submitter : Dr. Timothy Curry **Date:** 08/28/2005

Organization : American Society of Anesthesiologists

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

CMS-1502-P-348-Attach-1.DOC

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

Dear Dr. McClellan:

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

Medicare's discriminatory payment arrangement, which applies only to anesthesiology teaching programs, such as that at the Mayo Clinic, where I practice, 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. This shortage will only be exacerbated in coming years by the aging of the baby boom generation and their need for surgical services.

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

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

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

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

Please end the anesthesiology teaching payment penalty.

Sincerely,

Timothy B. Curry, MD, PhD
Assistant Professor
Mayo Clinic College of Medicine

Submitter : Dr. Peter Castro **Date:** 08/28/2005

Organization : American Society of Anesthesiologists

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

Dear Dr. McClellan:

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

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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.

Peter L. Castro, M.D., M.B.A
5406 Oakmont Circle
Nashville, TN 37209

CMS-1502-P-349-Attach-1.DOC

Dear Dr. McClellan:

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

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

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

Please end the anesthesiology teaching payment penalty.

Peter L. Castro, M.D., M.B.A

5406 Oakmont Circle

Nashville, TN 37209

Submitter : Dr. Scott Springman **Date:** 08/28/2005

Organization : University of Wisconsin Medical School

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

TEACHING ANESTHESIOLOGISTS comment in attached file.

CMS-1502-P-350-Attach-1.DOC

8-28-05

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

Dear Dr. McClellan:

I am writing to urge the Centers for Medicare and Medicaid Services (CMS) to change the Medicare anesthesiology teaching payment policy. I am a Professor of Anesthesiology who has worked in both private practice and in academics. I have seen first hand how academic anesthesiologists are being discriminated against with a policy that singles out anesthesiology with reduced payment. At the University of Wisconsin Hospital, we have over 30 faculty anesthesiologists and over 36 anesthesiology residents. Every time I work with two residents, I am penalized by Medicare's policy. Our reimbursement rate has threatened our department's survival and only by receiving temporary "hand-outs" from our hospital and physician group are we able to maintain quality faculty.

Medicare's policy has had a serious adverse 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 for other specialties, 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 my supervise residents in four overlapping office visits and collect 100% of the fee when certain requirements are met.

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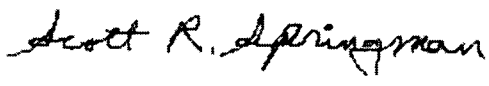
grossly inadequate to sustain the service, teaching and research missions of academic anesthesia training programs.

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.

Regards,



Scott R. Springman, MD

5721 Summerhill Ct

Fitchburg, WI 53711

Submitter : Dr. Brennan Watkins **Date:** 08/29/2005

Organization : University of Texas Southwestern

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

Please see attachment.

CMS-1502-P-351-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:

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

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

Best regards,

Brennan M. Watkins, MD
6203 Love Dr. Apt. 3138
Irving, TX 75039

Submitter : **Dr. Douglas Pile** **Date: 08/29/2005**

Organization : **Healdsburg Primary Care**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Issue identifier

GPCIs

August 29, 2005

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

Re: GPCI?s

I am a family physician who has practiced in Sonoma County for the past 31 years. In that time I have seen in our economy change dramatically. We are no longer a rural county, but instead are as urban as any of the other counties in the greater Bay Area.

I am in strong support of your proposal to create a new payment locality for Sonoma County. This locality would lessen the disparity existing between practice expenses and Medicare reimbursements that currently exists.

This disparity is causing increasing difficulties with recruitment of new physicians to our area, as well as with early retirement of our existing physician base, both brought about in part because reimbursement is not covering expenses of staying in practice. Not only do we have fewer medical providers in our community, but also we have fewer of them who were willing to take on Medicare patients. The demographics of Sonoma County indicate that the retirement age population is one of our fastest-growing segments, and soon will overburden our existing healthcare system.

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

I am eager to do what ever I can to help with this much-needed change in designation. It is long overdue.

Thank you for your consideration.

Respectfully yours,

Douglas D. Pile, M.D.
Healdsburg Primary Care ? 1312 Prentice Drive ? Healdsburg, California ? 95448 -- 707-433-3383
DDP/Voice recog
CC: Two copies attached
Sonoma County Medical Association ?
3033 Cleveland Ave, Suite 104, Santa Rosa, CA 95403

Submitter : Dr. F.C Kumar **Date:** 08/29/2005

Organization : Oklahoma university health sciences center

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

I appeal that the payments to anesthesiologists should be the same as for surgeons which is 100% and not 50% when covering two rooms.

We are also good health care providers like surgeons. I am happy that the surgeons get paid 100%

I want fairness in payments. Thank you all for your time.

Submitter : Dr. Deborah Rusy **Date:** 08/29/2005

Organization : Dept. of Anesthesiology, University of Wisconsin M

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

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

Please support academic medicine in Wisconsin.

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

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

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

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

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

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

This is not fair, and it is not reasonable.

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

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

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

Submitter : Dr. Bradley Hindman **Date:** 08/29/2005

Organization : University of Iowa

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1502-P-355-Attach-1.RTF

CMS-1502-P-355-Attach-2.RTF

UNIVERSITY of IOWA HEALTH CARE

Roy J. and Lucille A. Carver
College of Medicine
University of Iowa

Bradley J. Hindman, MD
Professor and Vice-Chair
Department of Anesthesia
200 Hawkins Drive, 6539 JCP
Iowa City, Iowa 52242-1079
319-356-2109 ***Tel***
319-356-2940 ***Fax***
brad-hindman@uiowa.edu

August 28, 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 Doctor McClellan:

I am writing to urge the Centers for Medicare and Medicaid Services (CMS) to change the Medicare anesthesiology teaching payment policy. As Vice-Chair of the Anesthesia Department, I can tell you "flat out" that it is just plain killing Anesthesiology as a medical specialty at the University of Iowa, and I imagine at other academic medical centers as well. We cannot retain faculty—everyone is leaving for private practice which pays far better. We cannot recruit new faculty—virtually no graduating residents are staying in academics to teach the next generation. We are not creating new knowledge—we just don't have enough people for some faculty to out of the operating room to do research. We are just barely holding on, and the only way we are surviving is by the College of Medicine and University Hospital pumping in millions of dollars a year. What we are paid to do our work is so very much less than it actually costs us to do it! Unless the teaching rule is reversed, in 5-10 years (when the remaining generation of academic anesthesiologists retire), there will be a total collapse in academic healthcare because there will just not be anybody left to provide anesthesia at academic hospitals (hence, no surgery!) nor anyone to teach the next generation of anesthesiologists. I am begging you, please correct Medicare's discriminatory payment arrangement, which applies only to anesthesiology teaching programs, terrible error before the consequences are irreversible.

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

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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.

Sir, please end the anesthesiology teaching payment penalty.

Bradley J. Hindman, M.D.

UNIVERSITY of IOWA HEALTH CARE

Roy J. and Lucille A. Carver College of Medicine University of Iowa

Bradley J. Hindman, MD
Professor and Vice-Chair
Department of Anesthesia
200 Hawkins Drive, 6539 JCP
Iowa City, Iowa 52242-1079
319-356-2109 ***Tel***
319-356-2940 ***Fax***
brad-hindman@uiowa.edu

August 28, 2005

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

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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.

Sir, please end the anesthesiology teaching payment penalty.

Bradley J. Hindman, M.D.

Submitter : Dr. Clinton La Grange **Date:** 08/29/2005

Organization : Dr. Clinton La Grange

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

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

Clinton La Grange, M.D.
AMGSB
425 W. Junipero St., Suite 3
Santa Barbara, CA 93105

Submitter : Dr. Anne Lunney **Date:** 08/29/2005

Organization : University of North Carolina

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 a resident physician at University of North Carolina (UNC). I am writing to stongly encourage the Centers for Medicaid and Medicare Services to change the Medicare anesthesiology teaching payment schedule instituted in 1995. This payment schedule unfairly penalizes anesthesiology teaching faculty for supervising greater than one resident physician. CMS-1502-P is a discriminatory payment schedule. Teaching faculty in disciplines other than anesthesiology are compensated at 100% provided that the faculty physician is present for key portions of care. This is not the case in anesthesiology, where the teaching faculty is penalized if they supervise the care provided by more than one resident physician. For example, an internist is compensated for the simultaneous care provided by four resident physicians at 100%, while in comparison, an anesthesiologist's reimbursement is decreased to 50% if they supervise the care provided by two resident physicians.
The impact of CMS-1502-P at UNC has been profound. As a state institution, UNC cares for underpriviledged and elderly patients. They can not continue to do so if they are not fairly compensated for the care provided. As of January 2005, the cost of providing anesthesia care at UNC has surpassed the reimbursement for care.
Specifically, inadequate reimbursement and subsequent compensation of teaching faculty contributed to the loss of five UNC teaching faculty in 2005. Training of current resident physicians, as well as the ability to recruit qualified resident and faculty physicians in the future, has been negatively impacted.
It is imperative that Medicare compensation be consistent across medical specialties. The current reimbursement policy is having, and will continue to have, a negative impact on teaching anesthesiology departments. Qualified teaching faculty will continue to choose to practice in the private sector, affecting both the care of patients at teaching institutions, as well as the training of future anesthesiologists.
I trust that the CMS is committed to the continued excellence of training anesthesiology physicians, and greatly appreciate your support in ending the descriminatory penalization of anesthesiology teaching physicians.

Yours Sincerely,

Anne T Lunney, M.D.
1366 Old Lystra Road
Chapel Hill, NC 27517
919-942-3367
alunney@aims.unc.edu

Submitter : Kathleen Swanson **Date:** 08/29/2005

Organization : Kathleen Swanson

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

To whom it may concern,
I am writing to encourage you to increase the Medicare reimbursements to doctors in Santa Cruz county. There was a recent study comparing housing prices in this county with salaries made. In this study Santa Cruz county was ranked the 3rd most expensive county in the US in which to live. Also my husband is part of an eleven doctor radiology group and for the past five years the group has had increasing difficulty recruiting replacements for the doctors retiring. Physicians coming directly from medical school certainly can't afford to live here.

Thank you for your thoughtful consideration, Kathleen Swanson

Submitter : Dr. Mark Schroeder **Date:** 08/29/2005

Organization : University of Wisconsin Medical School

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

8-29-05

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

Re: file code CMS-1502-P, ?Teaching Anesthesiologists?

Dear Dr. McClellan:

I am writing to urge the Centers for Medicare and Medicaid Services (CMS) to change the Medicare anesthesiology teaching payment policy. I am an Associate Professor of Anesthesiology at the University of Wisconsin. I have seen first hand how academic anesthesiologists are being discriminated against with a policy that singles out anesthesiology with reduced payment. Every time I work with two residents, I am penalized by Medicare?s policy. Our reimbursement rate has threatened our department?s survival and only by receiving temporary ?hand-outs? from our hospital and physician group are we able to maintain quality faculty.

Medicare?s policy has had a serious adverse impact on the ability of all anesthesia training 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 for other specialties, 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 my 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.

Regards,

Mark E. Schroeder, MD

Submitter : Dr. Kevin Tremper **Date:** 08/29/2005

Organization : University of Michigan

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

August 24, 2005

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

The purpose of this letter is to express my strong recommendation that you reverse the unfair payment practice for teaching anesthesiologists. Anesthesiologists are the only teaching physicians who have their reimbursement cut in half when teaching residents. All other specialties receive 100% reimbursement. This unfair practice has led to progressive financial difficulties in nearly every teaching program in the U.S. Over the last five years I have surveyed the financial status of teaching programs and the faculty vacancies in those anesthesia residency training programs. What we have found is that there has been a progressive need for the teaching institutions to provide more and more funds to their departments? of anesthesiology to enable them to remain solvent. In 2000 each department received approximately $30,000/faculty and in 2004 that had risen to $95,000/faculty in the average teaching anesthesia department. In spite of this there are still a significant number of faculty positions open in these departments (10% vacancy rate of anesthesia faculty). (1,2,3,4)

These surveys were initiated when I was the president of our chairs? organization (SAAC/AAPD). We have continued these surveys and noted the progressive deterioration of the financial status of these programs. In the financial analysis it was noted that the reimbursement rate, especially from Medicare, was extremely low. The average reimbursed unit value for anesthesia was in the range of $10/unit where the average charge is $75/unit. This charge to reimbursement ratio is substantially lower for anesthesiologists than any other medical specialty reimbursed by CMS. Anesthesiologists in private practice have the opportunity to supervise up to 4-on-1 CRNAs, thereby receiving a reasonable reimbursement, although still low in comparison to other specialties in medicine. Teaching anesthesiologists can only supervise a maximum of two residents simultaneously, thereby placing teaching anesthesiologists and their departments at significant financial disadvantage relative to the private practice community. This has resulted in a continuous drain of faculty talent from University programs into the community, making it more difficult to sustain the production of well qualified anesthesiologists for our country. Since the late 1990s a shortage of anesthesiologists has progressively grown to the point where we feel there is an approximate shortage of 3,000 to 4,000 anesthesiologists, while we train only 1300/year. One of the issues in training an adequate number of anesthesiologists relates to the ability to attract and retain academic faculty in teaching programs.

In conclusion, I strongly recommend that CMS reconsider changing the reimbursement methodology for teaching anesthesiologists so that they may receive 100% payment while supervising a maximum of two residents providing patient care. This has been a long-standing inequity which is aggravating the current financial problems in teaching departments and the nationwide issue of an anesthesiologist shortage. Thank you very much for you consideration.

Sincerely,

Kevin K. Tremper, PhD, MD
Robert B. Sweet Professor and Chair
Department of Anesthesiology

KKT:jjm

Cc: Governor Jennifer Granholm
Senator Carl Levin
Senator Debbie Stabenow
MI Congress Representatives

Attachments

CMS-1502-P-360-Attach-1.DOC

CMS-1502-P-360-Attach-2.PDF

CMS-1502-P-360-Attach-3.PDF

CMS-1502-P-360-Attach-4.PDF

Surviving the Perfect Storm:
Anesthesia
October 2000

Kevin K. Tremper, PhD, MD
University of Michigan
Committee Chair

Joseph G. Reves, MD
Duke University

Steven J. Barker, PhD, MD
University of Arizona

Albert J. Saubermann, MD
Albert Einstein College of Medicine

Simon Gelman, MD
Brigham & Women's Hospital

INTRODUCTION

The past decade has seen dramatic changes in the management of health care, which have placed academic medical centers in financial jeopardy. In the early 1900's managed care plans grew, reducing fee for service income and progressing toward a capitated environment in some markets.[1] The financial risk was shifting from insurers to the providers. Hospital patient length of stay dramatically reduced resulting in decreased occupancy with predictions that hospitalizations and surgical procedures may progressively reduce along with reimbursement. Health care planners envisioned a future with primary care gatekeepers which would decrease the need for specialists. In 1997 HCFA capped the number of residents for GME reimbursement and even proposed financial incentives to institutions who would voluntarily reduce their number of house officers voluntarily. Academic medical centers strived to produce a greater number of primary care trainees to meet the anticipated demand for these new gatekeepers of capitated care. Many academic medical centers expanded their primary care base by buying practices thereby ensuring their referrals to maintain academic and financial viability.

At the height of this push for primary care, the field of anesthesiology appeared to be targeted as one with an over supply that would be especially impacted by decreased surgical procedures resulting from full capitated care.[2] 1995 saw a unprecedented reduction in medical school applicants selecting anesthesiology programs. The graduating CA-3 class in 1994 was 1,843 while the entering CA-1 class for 1996 was only 745.[3] Although this class was ultimately supplemented to 885, this is still approximately 1,000 less than the graduating classes during the peak years of the early 1990's.[3] Nearly all training programs suffered a substantial drop in their number of residents and the field noted a dramatic increase in the percentage of international medical graduates (IMG) (10% in 1990 to 57% in 1999).[3] Managing an academic program while providing the necessary clinical service was a challenge with the residencies cut in half. This staffing problem has placed a significant stress upon the faculty of these training programs as well as the financial resources of the departments and the institutions in which they are inexplicably bound. To make a difficult financial environment even worse, Congress passed the Balanced Budget Amendment in 1997 in which HCFA would progressively

reduce GME reimbursement to teaching hospitals.[4,5] The result has been a progressive decrease in training hospital's profitability where many academic medical centers are either in the red, some to a dramatic degree, or are predicting progressive financial difficulties as the Balanced Budget Amendment is implemented.[5,6] Ironically this has occurred during a decade in which the US economy has been remarkably strong, producing a positive federal budget.

Academic department's of anesthesiology enter the new millennium facing the confluence of three adverse financial pressures: decreased professional fee reimbursement, working within academic medical centers that are struggling to remain financially viable and trying to retain academic faculty in the best job market for anesthesiologists in twenty years. The reduction in resident class size in the late 1990's has obviously resulted in the decreased availability of trained anesthesiologists today. As the overall job market has improved, the academic "life" has progressively deteriorated. When the number of residents decrease, academic faculty are required to spend a greater and greater portion of their time providing service thereby limiting time for academic development. It may be difficult for some faculty to determine the difference between an academic position and a private position other than a lower salary.[7,8] With hospitals trying to meet their budgets, there are greater pressures to shift costs to the academic departments by not providing the necessary support. The demands for more clinical productivity with less support have placed the academic department under unprecedented financial stress.[6]

In the fall of 1999, the SAAC/AAPD Council felt that it was important to analyze the current financial status of its training departments. Simon Gelman, MD, SAAC president, charged a task force to produce a white paper on the current financial environment threatening the health of our training programs. The following report is composed of five sections. The first section titled **Manpower in Anesthesiology** provides a brief history of manpower in our field with the predictions for the near future. Since academic faculty are the heart of the training program, it is essential that we recruit the next generation of teachers. The second section titled **Medicare Reimbursement: Past, Present and Future** reviews the development of the current Medicare reimbursement system and how it disadvantages our specialty. This section also reviews both Direct (DME) and Indirect (IME) Medical Education reimbursement to hospitals, how these funds are derived, their designated uses

and how they will be affected by the Balanced Budget Amendment. It is clear that if academic medical centers are in financial difficulty, those difficulties will be shared by the training programs within those institutions. The third section titled **Published Data: AAMC, MGMA and SAAC** reviews the data, which are published yearly by each of these organizations. This information covers a wide range of useful statistics with respect to physician salaries, both academic and private practice, costs of practice and productivity measures in all specialties. This information can be useful when determining the appropriate costs departments of anesthesiology should pay in managing their practices. It also is important for department chairs in anesthesiology to be aware of the data, which are reviewed by medical school deans and hospital administrators when they are determining necessary departmental support. The final section titled **Strategies for Improving Financial Well Being** provides a list of strategies that may be useful in negotiating the support required to maintain an academic department.

Finally it is hoped that the information provided in this report will not only be helpful to individual department chairs but also to the leadership of our specialty when they work with our medical societies and government agencies to address our current difficulties.

Section I - Manpower in Anesthesiology

According to a survey of SAAC/AAPD departments as of August 2000, there are approximately 490 open faculty positions or an average of 3.8 open positions per department (Section IV, page 35). The reasons for this faculty shortage appear to be a reduced number of graduating residents and a very healthy demand for anesthesiologists. The result is that many academic anesthesiology chairs, feeling under pressure from deans, senior hospital administrators, as well as from surgeons to provide anesthesia for growing clinical practices find themselves severely short of manpower. In addition thinned out ranks of faculty are putting pressure on anesthesiology chairs to replenish the manpower so that the work is more evenly distributed to allow some time to pursue academic activities. These faculty, now finding that they are mainly providing clinical care, wonder why they are remaining in an academic practice. Facing lower salaries than private practice and doing similar work, faculty members are being recruited away from academic departments.[7,8]

This problem is both a financial issue and a manpower issue. In a fully free market system, the laws of supply and demand largely determine manpower cost and availability. If the available manpower is not sufficient to meet demands there will be increased competition for that manpower leading to its increased production. Our medical professional educational systems are not a fully free market system. A number of market-affecting factors have contributed to significant challenges for academic anesthesiology trying to provide enough qualified academic faculty to fulfill clinical care, educational and academic missions. To understand the origin of the current faculty shortage, it is necessary to examine overall manpower in anesthesiology.

HOW MANY ANESTHESIOLOGISTS ARE ENOUGH?

One of the first questions is how many people are actually needed to do the work. This question has two major variables namely how much work will there be and who will do it. Unfortunately, the question of what will be the right amount of manpower for the future is not easily determined. Efforts to answer this question were undertaken by ABT Associates Inc. in a 1994 report written for the ASA.[9] The ABT report looked at four different models of care (physician intensive, two types of physician/CRNA teams, and CRNA intensive) to

try to answer the question of who will deliver the care. ABT also made certain key assumptions about the number of anesthetics likely to be given to try to answer the question of how much work there will be. From these assumptions an estimate of future manpower needs could be made based upon the care model chosen. Difficulties with such a projection have been the unpredictability of demand for anesthesia (since managed care's impact on the number and type of procedures requiring anesthesia is uncertain) and an uncertain but growing demand for specialized subspecialty expertise. Further, the assumptions about which practice model will prevail is not at all clear at this point although the demographics suggest the number of physician providers will continue to grow at a faster rate than CRNA providers. If the future needs could be predicted, then theoretically it should be possible to train the right number of new anesthesiologists, although efforts to manipulate the supply/demand equation has not worked well in other areas.

HISTORY

The growth of our specialty has followed the growth of academic anesthesiology departments. The advancement of our knowledge brought our specialty into the mainstream of academic medical schools and promoted the demand for consultant specialists in the community. As the demand for high quality anesthesia administered by specialist physicians grew there was an increase in the number of academic anesthesiology departments and the size of our training programs (Figs. 1 & 2).[6] The work force, including CRNA's grew steadily from 1969 to 1994 when it appeared to level off (Fig. 1).

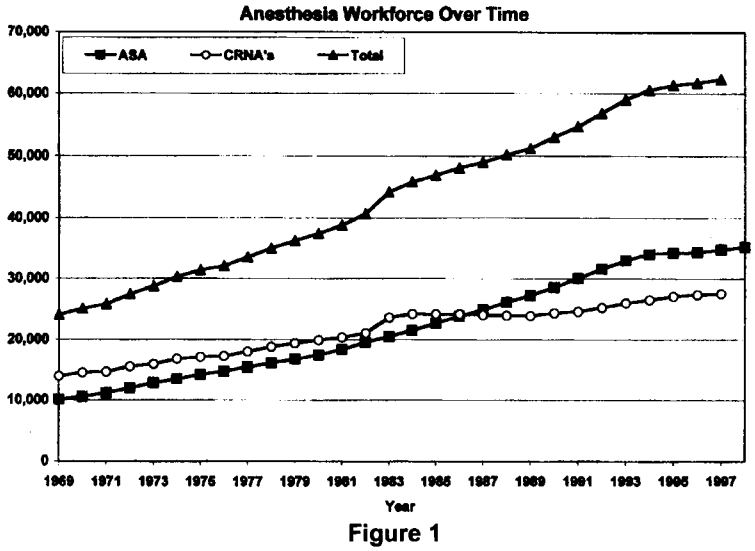
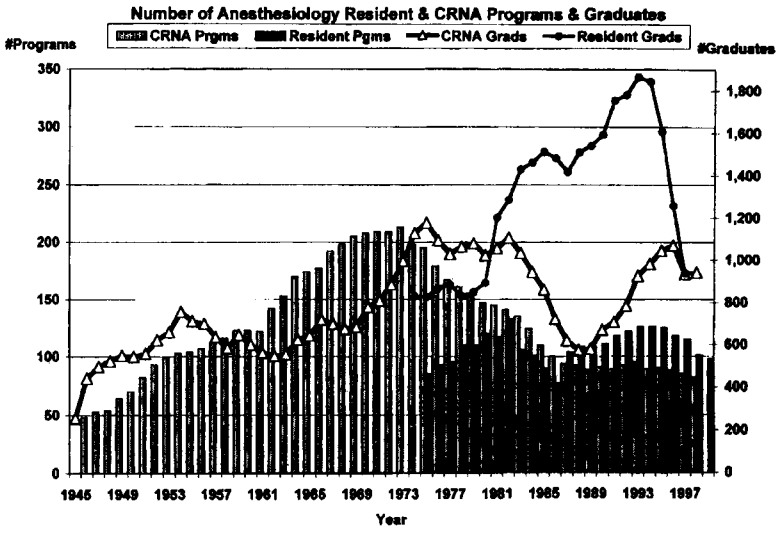


Figure 1

It is of interest to note that the number of CRNA's has actually remained relatively constant since 1983 with only a small increase in number over the past six years. In contrast the number of anesthesiologist continued to grow steadily until 1994 when that growth

Figure 2



appeared to level off. If the work force has leveled off and if there is a "shortage" of anesthesiologists, then the demand must have increased over the past several years. This may in fact be the case. Where could this added demand be coming from? There are several possibilities including 1) more surgery (in spite of promised reductions f rom m anaged care); 2) greater geographical dispersal of surgery (ie. office based anesthesia); 3) greater numbers of non-surgical procedures requiring anesthesia (ie. radiological procedures); and 4) other venues of practice (ie. pain management).

SUPPLY vs DEMAND

Over the years the number of anesthesiologists completing American training programs has varied (Figs. 2 & 3).[6] At one point in the early 1990's there was concern raised that too many new anesthesiologists were being produced and that they would have difficulty finding work.[2] These largely political concerns translated ultimately into a decrease in the size and the composition of the resident applicant pool. Since the size of the work force depended upon how many anesthesiologists were leaving the practice and how many were starting practice, a shift in the total manpower pool could be affected by one or both of these factors. The ages of members of the ASA show that anesthesiologists have an average age of 45.[6] The age distribution further shows that the curve is skewed to the left (Fig 4). Assuming that the

Figure 3

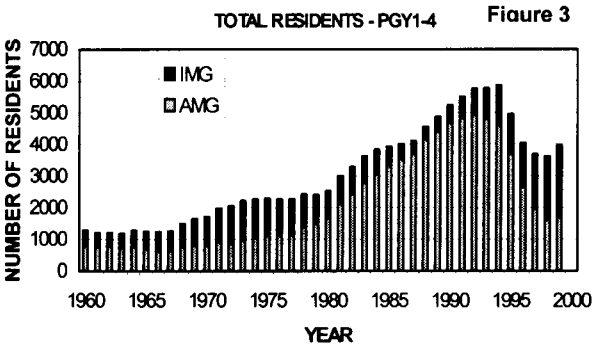
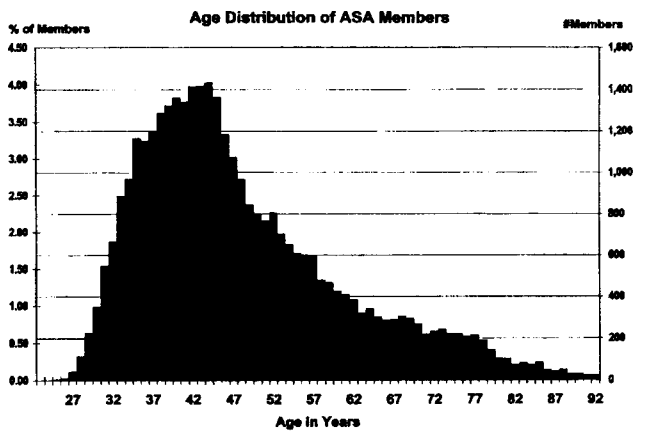


Figure 4



retirement rate is age related then we should expect to see a continued increase in the rate of retirement in the future. This appears to be occurring and is reflected in ASA membership according to Dr. Thomas Cromwell ASA Secretary.[10] Dr. Cromwell notes that the retired category of ASA membership has increased at the expense of the active and resident members. Further the growth rate of the ASA has declined in the latter half of the 1990's from 600-800 per year (1990-1995) to 164 new members in 1999.[10] If the rate at which anesthesiologists are leaving practice continues to increase, the question is what is the replenishment rate going to be?

In 1994, there was a dramatic decrease in the number of individuals in the residency application pool.[3] As a result many residency match positions (both CAY1 and PGY1) were not filled (Fig 5 unfilled CAY1 match positions) although the majority of positions are filled each year out of match (Fig. 6). Still, the total number of residents in training also declined (Fig. 3). At the same time we began to see an increase in resident attrition rate over the CAY1-3 training period (Fig 7). Some training programs were closed and most decreased the number of positions that they offered.

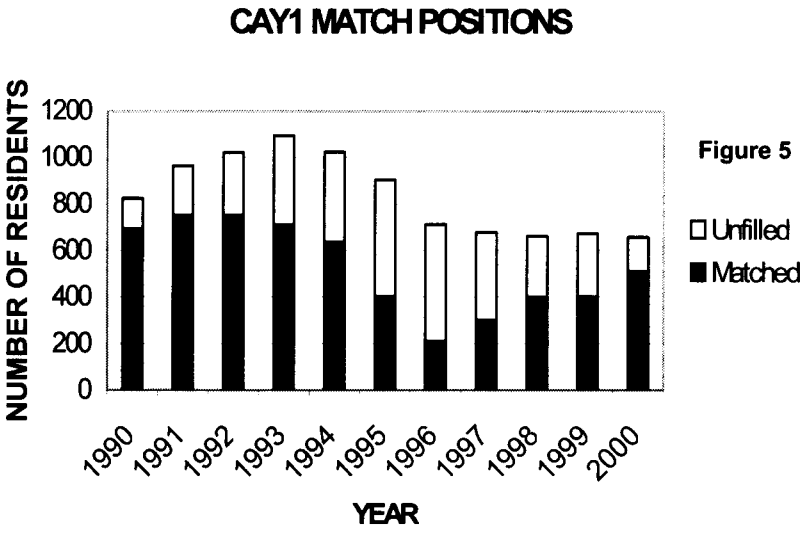


Figure 5

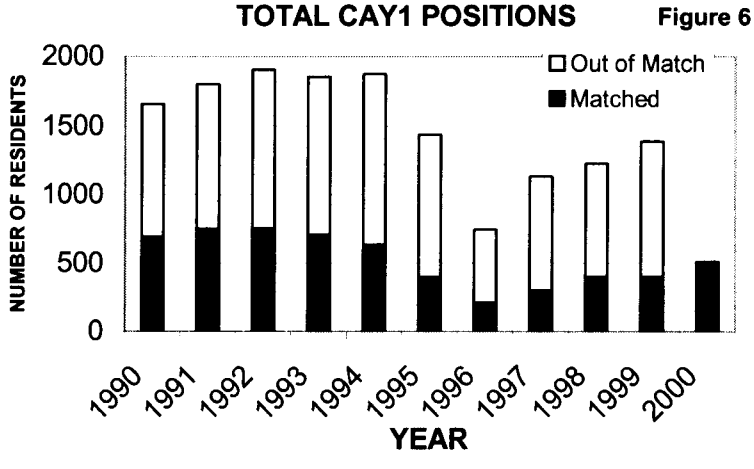


Figure 6

Many programs sought to meet manpower needs by having attendings provide care directly, or by hiring CRNA's. The overall effect was to decrease the total number of residents being trained to level similar to those seen in 1987 (Fig. 3). The passage of the Balanced Budge Act of 1997, has the effect of capping the number of government funded residency positions. The long term effect on anesthesiology training programs is to cap

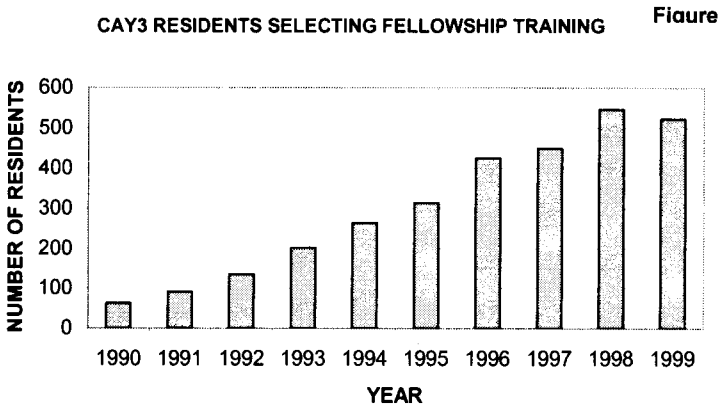
the capacity of our programs to a decreased number of graduates.[4] The BBA also puts stress on academic anesthesiology programs that relied on residents as part of their provider manpower.

Because a number of training programs depended upon residents to provide much of the anesthesia services, when the applicant pool dropped precipitously resident slots were largely filled with international medical graduates (IMG) some of who have J1 visas (Table 1).[3] Note that from 1995 to 1999 the total number of graduates not only reduced from 1,863 to 892, but the number of American medical graduates reduced from 1,547 to 544.

Table 1: Past Graduating Classes

Graduating Year	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999
AMG	1,179	1,324	1,372	1,388	1,512	1,455	1,547	1,358	1,101	792	544
IMG	102	100	152	171	206	217	316	339	347	308	348
TOTAL	1,281	1,424	1,524	1,559	1,718	1,672	1,863	1,697	1,448	1,100	892

Figure 8



In the latter half of the 1990's the number of international medical graduates was in the range of 300 to 350 thereby causing the percentage of IMG graduates to climb. No doubt many of these graduates encounter difficulties in remaining in this country due to restrictions on the J-1 visa and can not be seen as a means to replenish the work force. Additionally, the number of graduating residents opting for fellowship training has also seen an increase each year further slowing the replenishment rate (Fig. 8). It is not clear how many of these residents entering fellowship training are residents with visa problems. Pain management has become the most popular fellowship. How much time these practitioners will spend in OR anesthesiology practice is also not known. Since there are currently 227 anesthesiologists in pain fellow training, this may have a significant impact on manpower.[11]

As the manpower pool fails to provide enough anesthesiologists nation wide, the law of supply and demand may begin to bid up compensation putting an additional burden on academic departments.[8] Academic departments have traditionally paid lower salaries

while providing more time to pursue academic activities.[7] Because of the demand for clinical productivity, time for non-clinical pursuits becomes harder to maintain. Faculty finding their academic life looking more and more like that of someone entirely in a private practice wonder why they shouldn't move away from the academic practice altogether.

THE FUTURE

There appears to be more interest today in anesthesiology by medical students, and the number of residents graduating each year is increasing. Although the number of graduates is still well below that of the early 90s and the number of AMG graduates will be no more than 811 in the graduating class of 2003. Table 2 presents the graduating class of 2000 and the current CA-3, CA-2 and CA-1 classes as of the summer of 2000. Note that the number of AMG graduates was only 392 in the summer of 2000 and progressively increases to 811 by 2003 which is only 54% of AMG graduates of 1993. The overall class size grows from 919 to 1,453 during the next three years. Although some may predict that 1,453 graduates is sufficient to meet the nations needs, again it is unclear how many of the six to seven hundred IMG graduates will be able to stay in this country. The number of AMG, IMG and total graduates are presented graphically in figure 9.[12]

Table 2: Projected Graduating Classes

Current Year of Training	Recent Grads	CA-3	CA-2	CA-1
Graduating Yr	2000	2001	2002	2003
AMG	392	471	632	811
IMG	527	634	707	642
TOTAL	919	1105	1339	1453

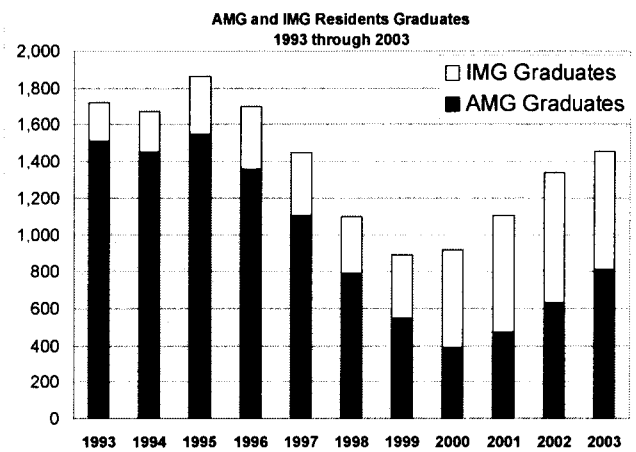


Figure 9

At the same time two major factors are likely to increase demands for anesthesiologists currently in practice: increased demand for services and increased attrition rate of anesthesiologists. The demand for anesthesia services will most likely parallel the number of surgical procedures performed each year in this country. Although some may argue this is a conservative estimate due to the number of requests for "off site" anesthesia for diagnostic procedures and the number of practitioners going into pain management. It is difficult to determine how many surgical procedures are performed in this country each year. The US Department of Health and Human Services provides estimates of inpatient

and outpatient cases from National Health Surveys. Between 1994 and 1996 the number of surgical procedures increased approximately 5.1% per year, totalling 71.9 million procedures per year in 1996. Again this does not include off site anesthetics for non-surgical procedures and office based anesthesia.[13,14]

The attrition rate of anesthesiologists is likely to increase over the next decade due to the age distribution of our current practitioner as discussed earlier and illustrated in Figure 4. It is therefore likely the demand will continue to grow for anesthesiologists for the foreseeable future. The challenge for academic programs is to be able to compete successfully for faculty who must provide cost effective anesthesia care, train future anesthesiologists and advance our knowledge.

CURRENT MANPOWER NEEDS IN ACADEMIC DEPARTMENTS

During the second two weeks in August 2000, a survey was distributed to all SAAC/AAPD members via e-mail asking two, two-part questions regarding their current staffing needs for faculty and CRNA's.[12] They were asked:

1. Are you looking for additional faculty? YES NO
   If yes, how many would you like to hire? _____
2. Are you looking for additional CRNA's? YES NO
   If yes, how many would you like to hire? _____

-

The initial e-mail survey was followed up with two additional requests a week apart. Each of the follow-up requests included the data from the responses to date at the time of each of the requests. The results are presented in Table 3.[12] The overall response rate was 66.2%. From the 85 departments that are seeking more faculty there were 326 open faculty positions or 3.8 faculty per department (10% shortage). If this rate of faculty recruitment were assumed for the non-responding departments, there would be as many as 494 openings as of August 2000. This suggests a significant shortage of faculty currently in our departments, but since there are no previous

Table 3: Current Manpower Needs in Academic Departments
August 2000

Response Rate: 66.2% (94/142)	Yes	No
Additional Faculty Needed?	91.5%	8.5%
# of Faculty Needed	326	
Average # Per Department	3.8	
Additional CRNAs Needed?	66.5%	33.5%
# of CRNAs Needed	246	
Average # Per Department	4.0	

data regarding faculty needs it is not definitive proof. Historically most academic departments recruit faculty during the winter and spring and have them arrive in during July and August. Consequently, most departments have their highest staffing levels at the end of the summer and generally lose faculty throughout the academic year. It is therefore very concerning that as of August there are such a large number of openings for faculty. The same can be said of CRNAs , Table 3.

Section II - Medicare Reimbursement: Past, Present and Future

In 1965 Medicare was instituted as a social program to provide medical care for the elderly, primarily patients over 65 years of age. Physician reimbursement for services is part of Medicare and is considered Part B. (Part A reimburses the hospitals for services provided Medicare recipients.) Determination of physician payments has evolved over time. Anesthesiology services are computed differently than all other physicians. Anesthesiologists are reimbursed with a time-based methodology whereas other physician services are based on a resource based system.

The "resource-based" system was developed by Hsiao and other health policy academicians during the late 1970s and early 1980s. In 1992, the Health Care Financing Administration (HCFA) moved to the new resource-based fee schedule and moved away from the historical physician charges. The new system was labeled the Medicare Fee Schedule (MFS). In an effort to standardize fee payment HCFA developed a "Resource Based Relative Value System" (RBRVS) which is based on "Current Procedural Terminology" (CPT) codes which are a listing of physician services (surgery and anesthesia CPT codes are different, even for services on the same patient.) There are 8,000 CPT codes in the MFS and 250 Anesthesia CPT codes.

There are three elements which make up the unit value of this resource-based methodology: 1) physician work, 2) practice expense and 3) professional liability costs. The purpose in creating this system was to establish proportional weights for all physician services that could then be converted into reimbursement levels. Each CPT code is reimbursed the same regardless of the medical specialty. The RBRVS-reimbursed procedures are paid at a predetermined fee calculated from the RVU. Reimbursement is initially determined under the fee schedule by multiplying the total relative value units for a procedure by a "conversion factor." The conversion factor (CF) is adjusted each year to account for inflation and other factors. There is also a geographic adjustment (GPCI) that is designed to take into account the regional differences in cost of living around the country.

(RVU X GPCI X CF) **Equation 1**

where: RVU= relative value unit

GPCI= geographic practice

CF= conversion factor

The 1999 (CF) dollar amount for all services except anesthesia codes was $34.73

HCFA is advised on the appropriate relative value setting of the RBRVS by the American Medical Association's Relative Value Update Committee (RUC), and this committee is made up of 28 members, each representing major specialty societies including the American Society of Anesthesiologists (ASA). The majority (about 90%) of recommendations regarding RBRVS made by RUC are accepted by HCFA.[15,16]

Anesthesiology does not participate in the RBRVS reimbursement methodology and is the only major medical specialty that does not. The reason for this is that the American Society of Anesthesiologists (ASA) has lobbied successfully to have anesthesiologists be reimbursed based on time and complexity of the case using the ASA Relative Value Guide (RVG) of 1988. In 2000, the anesthesia conversion factor used in calculating the reimbursement for Medicare cases was $17.77. The portions of this anesthesia conversion factor are now represented by physician work (74%), practice expense (19%) and malpractice liability cost (7%).[16,17] To calculate anesthesia reimbursement, the basic anesthesia RVUs are multiplied by time units and the conversion factor to compute anesthesiologists reimbursement. If an anesthesiologist is supervising a CRNA or a resident, then the anesthesiologist's fee may be reduced. The formulas used in computing the anesthesiologist's professional reimbursement by Medicare are listed below:

((Time Units + RVU) X CF) **Equation 2**

where: Time units (at 15 minute increments)

RVU = ASA relative value genda represents base units

CF = conversion factor ($17.77)

Medicare has successfully reduced anesthesia reimbursement over time through several mechanisms incorporating the ASA's (RVG) methodology. It put a cap on ASA base unit reimbursement for cataract surgery in the 1980s. In the mid 1990s, it introduced a four-year phase in of reimbursement for concurrent CRNA supervision so that at the end of the

process the anesthesiologist would get 50% of the Medicare fee when supervising a CRNA. (See below)

Attdg to Resident Case Ratio	Medicare Modifier	Attending Anesthesiologist Reimbursement
1 to 1	AA	Full Medicare Allowable per case
1 to 2	QK*	Half Medicare Allowable per case*

Effective January 2000 modifier AE has been discontinued; QK is to be used unless otherwise instructed by Medicare carrier.

Attdg to CRNA Case Ratio**	Medicare Modifier	Attending Anesthesiologist Reimbursement
1 to 1	QY	Half Medicare Allowable per case

Attdg to Res or CRNA Case Ratio**	Medicare Modifier	Attending Anesthesiologist Reimbursement
1 to 2	QK	Half Medicare Allowable per case
1 to 3	QK	Half Medicare Allowable per case
1 to 4	QK	Half Medicare Allowable per case
Greater than 1 to 4	AD	Three base units per case; add 1 unit if attending presence is documented at induction

**When a resident and CRNAs are supervised, modifier QK is to be used for multiple concurrent procedures - not to exceed four. Reimbursement follows QK pattern.

It has been recently estimated by the ASA that Medicare anesthesiology fees compared to other specialists are undervalued by as much as 40% using evaluation and management (E&M) codes for comparison.[18] Using a different analysis at Duke Medical Center, ie. Medicare versus HMO reimbursement for common anesthesia CPT services compared to other specialists common services was 56% undervalued.[19] Under-valuation of anesthesiology services causes another, related problem - "Medicare multiples." Integrated professional group practices are now using a methodology to disburse or to set contract fees according to Medicare multiples. Because Medicare undervalues anesthesia services, when a Medicare multiple is used for all specialties, then anesthesiology will have much lower compensation than other specialists. To correct for this error, a factor of 1.8 should be used in the Medicare multiple in calculations of anesthesia contract reimbursement. For example, if a group contract is negotiated at 1.2 of Medicare then anesthesiology should receive 2.2 of Medicare (1.8X1.2).

Marshall and J ablonski h ave dev eloped a m ethod o f c onverting anes thesia R VUs t o RBRVUs for business applications within their own practice plan.[15] They have found that this is feasible and most accurate using time units derived from one's own institution. Their methodology is attractive since most of the variables in the formula come from HCFA, and one ends with RVUs that can be compared among specialists. The formula is:

Equation 3

Imputed work RVUs = [((base + time)X anesthesia CF)/surgical CF] X specialty weight

where: base = base units per anesthesia CPT code

time = time units based on 15-minute increments

(best to use institutional data on times)

anesthesia CF = 1994 national anesthesia conversion factor (CF) of $15.32

surgical CF = 1994 national surgical conversion factor of $39.45

specialty share weight = anesthesia specialty share weight for work in 1994 or 0.695

MEDICARE REIMBURSEMENT OF HOSPITAL SERVICES

When Medicare was established in 1965 it was decided that a portion of the hospital compensation should defray the extra costs that resident physicians added to hospital costs and as well as the additional overhead costs that the presence of residents added to hospitals. It has long been known that hospitals with teaching and research programs are more expensive in the delivery of health care than hospitals without these additional missions. It likewise has been recognized that teaching hospitals often have a disproportionate share of non-reimbursed patient care loads for which they should receive some compensation if they are to remain viable providers of care for Medicare patients.

MEDICARE DIRECT GRADUATE MEDICAL EDUCATION (DGME) PAYMENTS

Medicare makes explicit payments to teaching hospitals for a portion of the added costs incurred with health professions graduate education programs. These added costs are for the stipends and fringe benefits of residents, salaries and fringe benefits of faculty who supervise the residents, and other direct costs. From 1965 until the mid 1980s, Medicare paid its share of DGME based on "Medicare-allowable" costs, which was an open-ended

reimbursement that allowed (encouraged) h ospitals to increase the size of residency programs.

In April 1986, Congress passed the Consolidated Omnibus Budget Reconciliation Act (COBRA) which uncoupled the relationship between direct costs and DGME payments. It did this by paying each hospital a portion of its per resident amount based on the DGME costs incurred by the hospital during a base year period and divided by the number of residents counted in the base year (not the current year.) Also Medicare limited the number of years that it would pay 100% of resident costs. The number of years is specialty specific: it is set at the number of years that it takes to become board-eligible or a maximal number of 5 years, whichever is lowest in each specialty. Medicare will only pay 50% of resident costs for residents that do not meet these time requirements. Also, beginning in 1993 hospitals have been paid slightly more for primary care residents and slightly less for specialty residents including, of course, anesthesiology. At present (because of the Balanced Budget Act of 1997 – see below) each hospital is effectively limited to the number of residents per hospital that they had in December 1996. There were a total of 3458 (CA-1 to CA-3) residents in anesthesiology in 1996, 32% of whom were international medical school graduates.[3]

DGME is paid based on a fixed rate per resident at each hospital under the following formula:

DGME = Per-resident rate X number of FTE residents X Medicare share **Equation 4**

where: "Medicare share" of resident costs is calculated as the number of Medicare patient days divided by the total number of in-patient days that a hospital has per year.

per-resident rate is hospital-specific based on 1985 hospital-specific GME costs that are adjusted for annual inflation and 1985 FTE residents.

FTE count is determined from eligible resident rotation schedules. Some residents and rotations are excluded in calculation of the count.

This formula does not make it clear how hospitals are to reimburse individual Departments or pay directly the physicians for whom the hospitals receive some payment in the form of DGME. It is likely that some hospitals do not directly pay clinical departments. It is also not clear by what formulation disbursements are made in those hospitals that do reimburse departments for the clinical teaching of the faculty. For anesthesiology it is tricky, although anesthesiologists spend a great deal of their clinical time working with residents and presumably much of this time is spent in teaching, HCFA forbids payment for education and simultaneous clinical care, so called "double-dipping." Nevertheless, hospitals should be paying departments some portion of their DGME for physician teaching of the residents.

MEDICARE INDIRECT MEDICAL EDUCATION (IME) PAYMENTS

In 1983 with the implementation of the prospective payment system (PPS), a "medical education" label was implicitly put in congressional language that added an adjustment for indirect medical education costs in teaching hospitals. This concept and payment was called the "indirect medical education adjustment" for hospitals receiving Medicare payment. The original IME PPS payment was 11.59% for each 10 percent increase in the intern and resident-to-bed ration (IRB) in 1983. The IME has been steadily recalculated and reduced over time. It fell to 8.1% in 1986, and with the Omnibus Budge Reconciliation Act of 1987 fell to 7.0% where it remained until 1997 with passage of the Balanced Budget Act (BBA - see below). The BBA has scheduled sequential decreases in the IME of 28.75% over a four-year period. The IME, therefore, was reduced from 7.0 percent to 6.5% in 1999 and is to be lowered to 6.0% in FY2000 and 5.5% in FY 2001. The recently passed Balanced B udget Refinement Act (BBRA) deferred t he l ast two years of t he planned IME reduction until 2002.

Equation 5

The IME formula adjustment to DRG payments is calculated:

IME = $(((1+\text{resident-to-bed ratio})^{.405})-1)$ X payment factor X Medicare DRG payments

where: The resident-to-bed ratio is the ratio of FTE residents to available beds.

The payment factor is a factor that is set by Congress and is currently 1.60.

This money is not specifically set for the payment of clinical faculty, but recognizes the added costs that interns and residents bring to a hospital. Because so many interns and residents are concentrated in the large teaching hospitals, primarily in the Northeastern

part of the country, about one-fifth of all teaching hospitals train two-thirds of all residents and received two-thirds of all IME funds. It is obvious that these hospitals are losing the greatest amounts of money as the IME is being scaled back. The Medicare Payment Advisory Commission (MedPAC) estimated that IME payments were $4.6 billion FY 1997. One may conclude then that the BBA as it scaled back the IME Medicare payments to teaching hospitals has indeed helped the country amass the enormous budget surplus reported in FY 2000.

MEDICARE DISPROPORTIONATE SHARE (DSH) PAYMENTS

In 1986, using the Tax Equity and Fiscal Responsibility Act (TEFRA) as a vehicle and after passing COBRA, Congress recognized the fact that the teaching hospitals cared f or uninsured patients and that this was putting financial stresses on the teaching hospitals. A Medicare Disproportionate Share (DSH) payment adjustment was added to compensate hospitals for caring for the low-income patients. It is also believed that DSH preserves access to care for Medicare and other low-income patients. The congressionally mandated program is an explicit adjustment for hospitals that serve a large share of low-income patients and was incorporated into the PPS in May 1986. In 1990 legislation about $1 billion was added over a five-year period through changes in the DSH formulae. In 1997 about 40 percent of all PPS hospitals were eligible for DSH payments amounting to $4.5 billion. More than 95% payments go to urban hospitals, and teaching hospitals received $3 billion DSH payments in 1997 or about two-thirds of all DSH payments.[20] The BBA reduces DSH payments by 5%, with the reduction to be implemented in 1% increments between fiscal years 1998 and 2002.

The DSH Payment Methodology is calculated as a percentage add-on to the basic prospective DRG payment. The amount of the DSH payment that a hospital receives is determined by a complex formula in which each hospital's DSH percentage is calculated. The BBA requires a new uniform formula be derived. This now requires a single minimum threshold for low-income market share. The 1999 BBRA stopped the decrease and will restore DSH prior cuts in 2003. To be eligible hospitals are required to provide new data about the amount of uncompensated charity care they provide by October 2001.

THE BALANCE BUDGET ACT (BBA) AND THE BALANCED BUDGET RELIEF ACT (BBRA)

Since the inception of the Medicare program in 1965, no congressional action has had more devastatingly negative financial impact on teaching hospitals than the passage in 1997 of the Balanced Budget Act (BBA). Medicare and Medicaid planned reduced spending of $116 billion (Medicare) and $15 billion (Medicaid) from 1998 to 2002. Teaching hospitals bear the brunt of these changes, although all hospitals are affected. (Figure 10) The more residents a hospital has, then the more severe the cut - thus, the larger teaching hospitals are hit the hardest with the decreases in IME, DSH and DGME provided in the BBA. The effect of teaching hospital size is illustrated by these AAMC data: On average, all hospitals will lose 0.5% in operating payments per case. Teaching hospitals with 100 or more residents will lose 1.5%, other teaching hospitals will lose 0.6%, and non-teaching hospitals will gain 0.2%.[21] Because of the obvious but unintended financial disastrous consequences of the B BA, the Balanced Budget Refinement Act (BBRA) was passed in November 1999 which slows the implementation

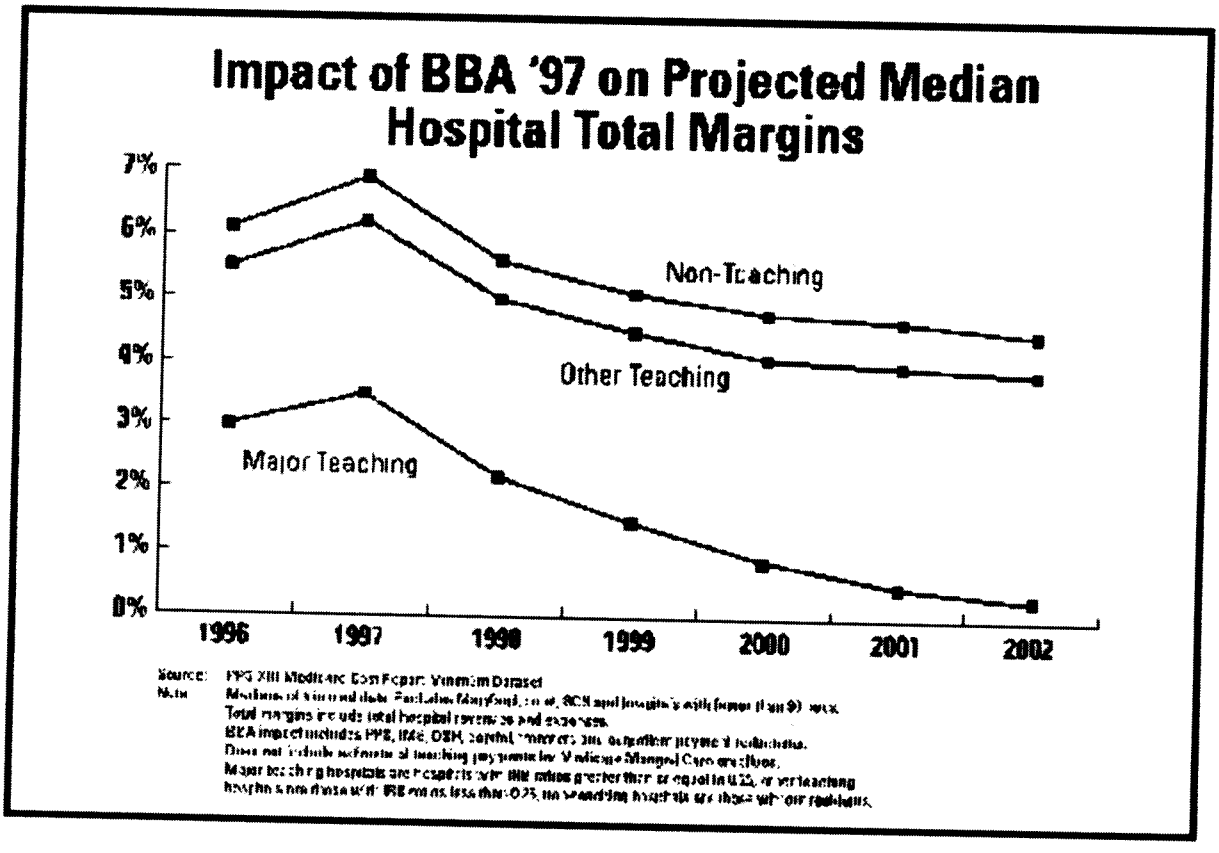


Figure 10. Numbers on the Y-axis are the financial margins (profit) and the X-axis shows the year and the affect that the Federal Balanced Budget Act will have on academic teaching hospitals. Hospitals with the most residents are by definition the largest teaching hospitals and

will suffer the greatest loss of indirect medical education monies from the withdrawal of medicare subsidies. This is denoted by the greater downward slope of this category of hospital. Hospitals with negligible teaching are less adversely impacted. Major Teaching Hospitals have an intern and resident to bed ratio of 0.25 or above. Other Teaching Hospitals have an intern and resident ratio to bed ratio of less than 0.25. Non-Teaching hospitals do not have interns and residents. (Data from Association of American Medical Colleges, Fact Sheet [23])

of the BBA and restores some of the losses already experienced by academic hospitals. In this congressional bill, $17 billion was restored. Since the BBRA provides only partial relief (amounting to about 10% restoration of the net loss in the BBA) the Association of American Medical Colleges (AAMC) and the American Hospital Association (AHA) have both independently estimated that teaching hospitals are on the brink of collapse. At the end of 2004, nearly 60% of the nation's hospitals will not be able to cover their costs when treating Medicare patients.[22] The AAMC has estimated that the typical member teaching hospital will lose over $40 million between 1998 and 2002, even with the enactment of the BBRA. Total hospital margins will continue to decline by over half from 4 percent in 1998 to 1.6 percent in 20 02.[23,24] T his has obvious impact on a hospital-based academic department like anesthesiology.

Aside from the important financial consequences of the BBA, there are some specific changes that the legislation makes in the calculation of DGME and IME payments to hospitals. Beginning FY 2001 each teaching hospital will receive DGME reimbursement based on its position within the range of teaching hospitals throughout the country. Hospitals with per resident weighted costs, adjusted for its specific geographic locality, of between 70% and 140% of the national reimbursement will receive inflation-adjusted, increased payments per resident each year. Hospitals whose costs are below the 70% floor will be increased to the 70% rate, but those above 140% will be capped at their current reimbursement level for FY 2001 and 2002 , and they will be ratcheted down for each of the next three years at a 2% rate. Individual hospitals, thus will be more or less affected by the BBA based in part on their historical reimbursement compared to the entire national experience. According to the AAMC predictions, increased DGME payments will occur for approximately 265 hospitals and a payment freeze for approximately 119 hospitals. Hospital-specific estimates can be found at www.aamc.org/coth/dgme.

In addition to the DGME hospital specific changes mentioned above, the BBRA is predicted to provide $600 million to teaching hospitals in IME, $100 million in DSH payments, and $40 million in GME to independent Children's hospitals.

The BBA also placed limits on the number of full-time equivalent (FTE) residents that hospitals can count for DGME payments and directed that the number of resident FTEs in 1996 was the maximal number that would be fully compensated. A three-year rolling average not to exceed the 1996 must be submitted by each hospital for DGME payment recalculations each year.

Clearly the effect of the BBA has been to significantly reduce hospital revenues. Its effect on resident numbers has also decreased the availability of residents as clinical providers. Recent adjustments to the BBA have not reduced its effect, but just delayed the onset of more severe reductions. One can not only hope that a continued strong economy will lead to greater pressures to possibly curtail the implementation of subsequent reductions or possibly even reverse previous reductions to teaching hospitals revenues.

Section III - Published Data: AAMC, MGMA & SAAC

Every year, the Medical Group Management Association (MGMA) publishes a report titled: "Physician Compensation and Production Survey," which provides national averages on salaries, costs, productivity, and working hours for physicians of all specialties. These data include practitioners of all types, but are heavily weighted towards private practice because of the number of respondents. In 2000 they have also published a "Faculty Compensation and Production Survey," showing data from academic departments. In addition, both SAAC and the AAMC publish average compensation data for academic physicians in all specialties. SAAC provides salary data by US region (West, Northeast, South, Midwest), while AAMC provides only national medians. Here we shall extract some highlights of the most recent reports of all three organizations, in order to facilitate comparisons of productivity, costs and salaries between different anesthesiology departments and different specialties.

COMPENSATION, CHARGES, OVERHEAD

Table 4 shows median values of both compensation and charges for anesthesiologists and "all specialists" from 1994 through 1998. The first four rows are from the MGMA 1999 report, reflecting mostly private practice data.[8] The fifth row comes from the 2000 MGMA report on faculty practice, and represents overall averages of academic anesthesiology salaries.[7] The right-hand column is the average percentage change for each year of the interval covered.

Table 4. Median compensation and charges; anesthesiology vs. all specialties

	1994	1996	1998	1999	change/yr
Private-Comp	$244,600	$237,749	$250,200		0.57%
Charges	$475,303	$515,160	$633,591		8.32%
Comp.- all	$212,183	$221,544	$231,993		2.34%
Charges - all	$560,000	$654,021	$724,275		7.33%
Faculty-Comp		$167,839	$171,774	$177,161	1.85%

The interesting trend for this four-year period is that anesthesiologists' compensation was nearly flat, while our charges grew by 8.3% per year. The growth in charges for "all specialties" was similar (7.3%), but the compensation increase was much greater (2.34% per year). Does this mean that anesthesiology charges increased only because we raised our rates, or are we actually producing more work and being paid less for it? We do not

see in these data the sharp upturn in faculty salaries that we are expecting to see in year 2000 data. It is also worth mention that in the MGMA faculty report only 30 of 111 departments responded to the survey.[7]

The MGMA 2000 report also found that "base compensation" represents a median of 82% of the total compensation for academic anesthesiologists. This implies that 18% of our compensation is "at risk" in the form of incentives or bonuses, which are not guaranteed income. This fraction of at-risk compensation is among the highest in the specialties. There are few earlier data with which to establish trends of this incentive fraction.

For entry-level anesthesiology faculty, the MGMA 2000 Report quotes a mean of $139,299, and the SAAC 1999 Survey gives a national median of $141,643.

We are all well aware of the large regional variations in academic salaries, shown in the 1999 SAAC Salary Survey report.[25] MGMA provides similar comparisons for median private practice anesthesiologist salaries, showing somewhat different trends:

Eastern: $236,000 Midwest: $311,165 Southern: $305,800 Western: $229,524

Compare these numbers with the SAAC 1999 Survey "stipend only" median for an Associate Professor of Anesthesiology:

Eastern: $210,045 Midwest: $222,341 Southern: $196,031 Western: $180,314

Two features of this comparison are striking. (1) The regional highest versus lowest variation in private practice is 35%, while in academics it is only 23%. (2) There is not a large difference between an Associate Professor and a private practitioner in the Eastern region, especially if we add the value of the fringe benefits. (SAAC Eastern Assoc. Prof., with fringe = $253,720.) It is possible that the MGMA numbers, based upon 1998 data, underestimate today's private practice salaries. Another way to look at regional variation is by the ratio of academic (Associate Professor) to private practice salaries:

Eastern: 0.89 Midwest: 0.71 Southern: 0.64 Western: 0.78

This ratio is highest in the East and lowest in the South.

Table 4 also shows that the compensation-to-charges ratio (1998) for all anesthesiologists is 0.39 (c.f. 0.32 for "all specialists"), but the MGMA 2000 Report shows that this ratio for academic anesthesiologists is 0.25. That is, private anesthesiologists have lower overhead expenses than other specialists, but academic anesthesiologists do not. Table 5, also derived from 1998 MGMA data, shows average overhead rates for various specialties.

Table 5: % of practice income used for MD expense vs overhead

Physician Specialty	Distribution of practice income	
	% MD Compensation	% Overhead
Anesthesiology	**90%**	**10%**
Family Medicine	45%	55%
Internal Medicine	50%	50%
Cardiology	58%	42%
Dermatology	50%	50%
Endocrinology	50%	50%
GI	50%	50%
General Med	50%	50%
Hem/Onc	50%	50%
Inf Disease	50%	50%
Nephrology	50%	50%
Pulmonary	50%	50%
Rheumatology	50%	50%
Neurology	55%	45%
OB/GYN	50%	50%
Ophthalmology	44%	56%
Orthopedics	57%	43%
Pathology	72%	28%
Pediatrics	48%	52%
Allergy/Immun	47%	53%
Pulmonary	47%	53%
Neonatology	47%	53%
Hem/Onc	39%	61%
Cardiology	58%	42%
General Peds	47%	53%
Critical Care	47%	53%
Psychiatry	60%	40%
Radiology	72%	28%
Radiation Oncology	72%	28%
Surgery	64%	36%
Vascular Gen	75%	25%
ER Med	64%	36%
ENT	64%	36%
Neurosurgery	65%	35%
Plastics	64%	36%
Urology	49%	51%
Cardiothoracic	69%	31%
Gen Sur/Trauma	64%	36%

Source: MGMA Cost Survey, 1997

Table 5 shows that anesthesiology has by far the lowest average overhead rate of all specialties, at about 10%. Of course this is a rate that reflects mostly private practice, and academic overhead rates are in the range of 10 to 30% depending on the type of system model, Section 4. Nevertheless, the data clearly illustrate that overhead rates are different among the various specialties. Even in academic medicine, anesthesiology should not have the same overhead burden as, for example, family medicine. Solid data for academic overhead rates are hard to obtain and there is wide variability depending on the structure of the academic practice, assessment rates, etc. However data from Section 4 demonstrates that in general, training departments of anesthesiology have higher rates than their community practice counterparts.

HOURS WORKED, PRODUCTIVITY

Interestingly, the MGMA report does not provide data for average hours worked by anesthesiologists, but it does for all other specialties. Since we have a good idea of our own work hours, here are some values of total weekly professional hours for other specialties.

Table 6a: Weekly total professional hours by specialty

Specialty	**25%-ile**	**Median**	**75%-ile**
Family Practice	40	45	50
Internal Medicine	40	50	55
Pediatrics	40	45	52
Emergency Med.	35	37	40
Radiology	40	47	53
OB-Gyn	40	52	60

Another way of comparing time worked is also presented by the MGMA data. Table 5b presents the percent of faculty who fall within the various thirds of percent billable time. Although this is not broken down by specialty, note that 52% of academic faculty spend between 0 and 66% of their time in billable activities, Table 6b

Table 6b. MGMA % Time Billable (All Specialties)

% Time Billable	% Faculty in this Range
0 to 33	21
34 to 66	31
67 to 100	48

Section IV - Strategies for Improving Financial Well Being

A. BE PROACTIVE IN MANAGING THE EFFECTS OF THE MEDICARE REIMBURSEMENT AND THE BBA

1. Medicare Reimbursement: Professional Services

Because anesthesiology does not have a PPS direct RBRVS comparable to all other specialties, we remain "outside looking in" on the Medicare PPS program. This makes it very difficult to defend our financial position in group practice contracting. Because anesthesiology "Medicare multiples" must be adjusted upward to achieve similar discount from fee-for-service rates to other specialties, anesthesiology appears to be unfairly and highly compensated. Only an aggressive and unremitting educational program will dispel the belief by other specialists that anesthesiologists are too demanding in their negotiations.

Should academic anesthesiology move to RBRVU based Medicare reimbursement system such as proposed by Jablonski and Marshall.[15] If not, then a set amount for each anesthesiology unit should be used in all group practices internal calculations of fees. Medicare multiples should not be used as they discriminate against anesthesiology. A third possibility is to try to get the practice plan leadership to set all contracts in terms of a percent of the usual and customary or as a fixed discount from standard charge. Ideally physician group practices would use a standard method that has all specialties give a similar discount off of fee-for-service in contract negotiations and capitated contract pay-outs.

2. Calculation Anesthesiology Department Share of DGME

Anesthesiology departments are hospital-based and many receive support from the hospital in a variety of ways. There appear to be few hospitals who actually pay directly to Anesthesiology Departments a payment for teaching residents (which is part of the hospital's DGME payment). The reduced payments that hospitals are experiencing from the BBA do not seem to be directly passed on to Departments of Anesthesiology. The financial crisis that

all teaching hospitals face is likely to force better accounting and Departments of Anesthesiology would be well served in developing high quality accounting of the costs to them of resident teaching borne by the faculty. Tools could be developed by SAAC/APPD to facilitate this accounting. Hospitals then should pay anesthesiology departments for an appropriate percentage of DGME payments. This should be done for all specialties.

3. Hospital Payments of Clinical Providers

Hospitals across the country pay differently for clinical services and with the financial crisis developing it is likely that a more consistent approach should and will be developed as to who pays for residents and CRNAs. Hospitals are reimbursed for hospital and CRNA costs by Medicare. Faculty who are uncompensated for their clinical duties such as those involved in charity care should be compensated some portion of DSH payment. Since the hospitals are compensated by Medicare for residents and CRNAs and paid supplements for services provided to low-income and non-paying patients (DSH), it would be useful for a consistent nation-wide, rationale approach to be adopted. Anesthesiology Departments can make a strong case for hospital funding of all residents (at 1996 level), CRNAs and some "donated" faculty service (coming from uncompensated care, such as staffing a Level 1 trauma center, etc.) It is not permissible for the hospital to pay for resident and faculty research time nor for faculty clinical time already compensated by Medicare as Part B.

4. Determination of House Staff Size

Departments of Anesthesiology must be involved in the decisions regarding house staff size. The hospitals are under a BBA forced mandate to have the same number of residents as of December 1996. There have been enormous fluctuations in the number of anesthesiology residents during the mid and late 1990s.[6] Discussion with the hospital about the number of total residents and the number of anesthesiology residents needs to occur.

5. Projected Effect of Reduced Hospital Reimbursement by Medicare

Because of the enormous loss in hospital revenues due to the changes in Medicare and Medicaid reimbursement, hospital-based Departments of Anesthesiology can expect less capital equipment, tighter controls on pharmaceutical expenditures, and increased scrutiny on the efficiency of operating rooms. This is an opportunity for anesthesiology to improve these areas by developing more cost-effective practices and by helping the hospital administration and surgery departments design operating room scheduling using productivity measures so that waste is eliminated.

B. KNOWING YOUR DATA

1. Calculate an Anesthesiology Unit Value to Compare Productivity and Compensation.

Productivity for anesthesiologists providing perioperative care is best measured by work-AUs (Anesthesia Units). In most specialties, AUs generated from a patient care encounter have a professional "work" component and a facility or "technical" component, which represents facility and supplies expense. In hospital-based anesthesiology, the technical component is billed separately by the hospital. Therefore, the AUs that we generate from coding our anesthesia records are entirely "work-AUs." Every operating room anesthetic generates a specific number of AUs dictated by a formula involving base-units, time-units, and modifiers. Unfortunately, some or our patient services are not measured in AUs, namely pain management and critical care. For these services, an AU-equivalent can be calculated as follows: divide the total annual professional fee charges for the service by the department AU conversion factor (dollars charged per AU). For example, the University of Arizona Pain Clinic generated $1.2 million in charges last year, and the anesthesia unit value is $55/AU. Therefore the AU-equivalent is

$$AU = \$1{,}200{,}000/\$55 = 21{,}818\ AU$$

Table 7 shows various percentiles for anesthesiology AU production per provider per year, along with compensation per AU, both for *all* anesthesiologists[8] and for *academic* anesthesiologists.[7]

Table 7: Anesthesiology AUs/provider/year and MD compensation/AU

	Mean	25%-ile	Median	75%-ile
AU/year*(all)*	7,611	4,661	8,748	10,025
Comp/AU*(all)*	$42.49	$25.80	$30.08	$46.56
AU/year*(acad.)*	5,706	2,556	3,593	9,676
Comp/AU*(acad)*	$47.37	$17.83	$42.37	$60.33

These numbers can be very helpful in comparing your department's clinical productivity with that of other departments at your institution and with other anesthesia departments, as we shall see below.

The second row in Table 18 provides an interesting perspective on the average private practice reimbursement per AU. If this truly represents physician compensation per AU, and the average overhead rate is 10%, then the median and mean values of a private practice AU must be:

Median AU = $30.08/0.9 = $33.42
Mean AU = $42.49/0.9 = $47.21

These numbers appear high from a Western perspective, but the results of the second row were calculated from only 97 providers. The fact that academic compensation per AU is higher than private practice simply reflects the fact that other (non-clinical) sources of revenue contribute to academic salaries.

How can we use these data to assess our department productivity, compare ourselves with other clinical departments, and determine our appropriate physician salary budget? The following method has been used in negotiating with the Practice Group and the College of Medicine at the University of Arizona.[26] Here is how the number of faculty and the salary budget of a department can be calculated.

√ *Determine equivalent number of private practice MD's:*

The department at the University of Arizona produced 320,000 AU of anesthesia care in FY 99/00. The median productivity of a full-time private practice anesthesiologist is 8,748 AU/year (Table 4). The ratio of these two numbers is then the number of full-time equivalent (FTE) anesthesiologists required to perform our clinical workload in private practice:

Ideal FTE	=	(Annual AU)/(MGMA median AU)
=		320,000/8,748
=		36.6 FTE

√ *Determine the ideal salary budget for this number of FTE in private practice:*

The 19 98 M GMA median s alary f or an a nesthesiologist w as $250 ,200 (Table 1). Multiplying this by the required number of FTE:

Ideal salary budget	=	#FTE X (MGMA median salary)
	=	36.6 X $250,200
	=	$9,157,320.

√ *Determine the ratio of academic to MGMA private practice salaries in your community; multiply "ideal salary budget" by this ratio.*

This is the most difficult part of the calculation. However, once you have determined this ratio it should be valid for ALL specialists in your academic practice. The Practice Group at the University of Arizona gathered data from salary surveys, deducted our central practice overhead (which is about $25%), and came up with a "local adjustment factor" of 0.56. A better way to calculate this ratio for your practice is to add up all the "ideal salary budgets" for all the clinical departments, and divide that number into the total clinical income that is available to pay salaries. For our example in Arizona:

Actual salary budget	=	(Ideal salary budget) X (adjustment factor)
	=	$9,157,320 X 0.56
	=	$5,128,099

This may not be the actual salary budget, but this is what it *should* be, based on a purely objective measure of clinical productivity and market values of salaries. The "adjustment factor" is obviously crucial to the calculation, as it reflects the "cost" of being in academics versus private practice, as well as the local reimbursement market in your community.

The above is an example of how published data from national organizations can help us achieve parity with our fellow departments in terms of salaries, overhead burden, and workload.

2. Knowing Your Minimum Unit Value

Your minimum anesthesia unit reimbursement (MAU) is the actual cost to your department of delivering a unit of anesthesia care. Obviously, you would prefer not to enter contracts that pay you less than this value. If your practice includes Medicare and Medicaid patients, or capitated managed care programs, you probably will have some contracts that are guaranteed to lose money. There is not a department in the country that can show a profit at the current Medicare reimbursement of $17.83 per unit.

To calculate your MAU, you must first determine the total amount of your department expense budget that supports clinical care. This would include all physician salaries less those supported by research grants, all practice expenses (malpractice insurance, etc.), and all overhead expense not covered by other sources (grants or state support). If some of your research expense must be covered by the clinical service rather than grants, be sure to include this.

Once you have determined your "total clinical expense" budget, simply divide this by the total number of units produced by your department over the same time period. The result is your MAU in dollars per unit. For example, in one year in a typical Western department, the clinical expense budget was $6.6 million, and 320,000 units were produced. The MAU for this year was $6,900,000/320,000 = $21.56 per unit.

Since the MAU is your average cost per unit, it includes contracts that are money losers as well as those that are profitable. Since the money losers are usually contracts regarding which you have no choice or control (Medicare and M edicaid) w e s hould al so c alculate a " modified" M AU (MMAU) af ter subtracting these contracts from the payer mix. In order to do this, you must know how much you were paid in these obligatory contracts (whether capitated or not) and how many units you provided on each. Subtract the income from your total clinical expense budget, and subtract the units from your total unit count. Then recalculate the ratio of dollars to units based on what is left. In the example department above, $1.43 million was collected from Medicare and Medicaid, and 95,667 unit were delivered. The average reimbursement from these two contracts was thus $14.94 per unit! Now we subtract the $1.43 million from the original $6.6 million clinical expense, subtract the 95,667 unit from the original 320,000, and compute the ratio of the remainders to get our MMAU:

MMAU = ($6.6 million - $1.43 million)/(320,000 – 95,667) = $23.05 per unit.

This means that even though the overall MAU for this department is $21.56 per unit (see above), we must negotiate for at least $23.05 per unit in the contracts we can control in order to break even.

C. INCREASE REVENUE

1. Revenue can be increased by increasing fee for service contract compensation and aggressive negotiation with each payor. The Chair should know the dates of when each contract comes due so that he/she is prepared to negotiate that contract at a unit value that is greater than the minimum required for their viability. Work with the institution to ensure that if the department is forced to accept a contract at a lesser unit, that other support will be provided.

2. Improve hospital support by providing information that services are being provided that are not being reimbursed: clinical services and administrative services. This support may be justified through HCFA reimbursement for IME as outlined in Section 3 of this report and by referring to data from this report, Section 5.

3. Determine capitated minimum per member per month necessary to achieve a break-even value based on a unit recovery analysis. This can be done if there are historical utilization data for a capitated contract. If so, the number of anesthetics provided and anesthesia units of service provided should be calculated and compared to MMAU to provide at least a break even contract. These data can then be used to estimate the per member per month capitation payment to generate that MMAU revenue.

D. RETAIN FACULTY

This may be accomplished by providing incentives other than financial for faculty to consider as they assess their career opportunities; time, research opportunities and support for research, educational opportunities, flexible working environment, supportive working environment. This is the most difficult and at the same time the most important factor in maintaining a viable academic department. If a Chair attempts to maximize faculty salaries by reducing academic time and support, he/she will ultimately end up with a non-academically productive department and most likely will still be unable to compete dollar for dollar with private practice salaries.

CONCLUSION

This report has attempted to clarify the current "business" environment of our academic training programs. It is clear there is a significant manpower shortage in anesthesiology which will most likely be felt more severely in academic departments. It is also clear that Medicare's method of reimbursing for anesthesiology places us at financial risk relative to other specialties. Published data suggest that anesthesiologists work longer hours and a greater percentage of those hours in clinical effort than other specialties on average. The departments in academic medical centers pay a greater percentage of their earnings in overhead expenses relative to their community private practice counterparts.

As of August 2000 there are approximately 490 open faculty positions (approximately 10% FTE shortage). Given the current increase in class size, there will be an increasing number of graduates over the next three years. In addition the percentage of those graduates who are American medical graduates is also increasing thereby insuring that more of each years graduating class will be available for the US workforce. Nevertheless, the size of this AMG graduating contingent will not surpass 800 until the year 2003 and this is only 54% of the AMG graduates of a decade earlier. For that reason it would appear that there will be a significant faculty shortage for the foreseeable future. It is also of interest to note that although not all departments employ CRNA's, the shortage of CRNA's in academic departments is nearly as great as the shortage of faculty and on a percentage basis is even greater (15% shortage of CRNA's in those departments that employ CRNA's). It is not clear at this point how the clinical void will be filled. All of these pressures will clearly place increasing stress on the individuals responsible for running training programs. It is hoped that this report will provide background material that may be of use to those individuals as they work with their institutions to maintain their academic programs while fulfilling their clinical commitments.

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SAAC/AAPD SURVEY
HOSPITAL / INSTITUTION SUPPORT

Please return completed survey to Elizabeth Daniels (edaniels@umich.edu), or fax to the Department of Anesthesiology, University of Michigan Health System at (734)-936-9091.

INSTRUCTIONS: *All questions here refer to Fiscal Year 1999 or your medical school's most recently completed twelve-month fiscal period for the hospital in which you do the majority of your resident teaching and you have primary fiscal responsibility.*

DEMOGRAPHIC DATA:

Name of Program (Optional): _____

Region (Circle One): Midwestern Northeastern Southern Western

Hospital Type:
University _____
Private _____
Public/County _____
VA _____

Number of Beds. . . . . _____
Number of ORs. . . . . _____
Number of Other Anesthetizing Locations. . . . . _____
Number of Cases *with Anesthesia* Per Year (not including OB). . . . . _____
Number of OB Deliveries in which Anesthesia is involved Per Year. . . . . _____
Number of ICU Beds Managed. . . . . _____
Pain Clinic Visits Per Year. . . . . _____
Pre-Op Clinic Visits Per Year (Staffed by an Anesthesiologist). . . . . _____
Acute Pain Service - Number of Epidurals per year. . . . . _____
PCA's managed by Anesthesia per year. . . . . _____
Number of Clinical Faculty FTE's . . . . . _____
Number of Full Time Research Faculty (PhD or not clinically active MD, ie, does no clinical work) . . . . . _____

VA Hospital: Are you responsible for staffing a VA? Yes_____ No_____
If yes, do you run at a financial deficit? Yes_____ No_____
If yes, how much? $_____

PERSONNEL

House Staff		Dept Pays		Hospital Pays		Med School Pays		Other Pays
Interns #_____	=	#_____	+	#_____	+	#_____	+	#_____
CA 1-3 #_____	=	#_____	+	#_____	+	#_____	+	#_____
Fellows ACGME #____ (Peds, Pain, CCM)	=#	_____	+	#_____	+	#_____	+	#_____

House Staff (Salary) Expense Deficit to Department. . . . . $_____

		Dept Pays		Hospital Pays		Med School Pays		Other Pays
Non-ACGME Fellows #_____	=	#_____	+	#_____	+	#_____	+	#_____
Research Fellows #_____	=	#_____	+	#_____	+	#_____	+	#_____
CRNAs or AAs #_____	=	#_____	+	#_____	+	#_____	+	#_____

MD FACULTY ACTIVITY: Average over the Department (The Department is defined as those faculty working at the primary teaching hospital)

% of time spent clinically. . . . . _____

% of time spent teaching. . . . . _____

% of time spent in research and/or grant management. . . . . _____

% of time spent in administration. . . . . _____

100%

BUDGET

Are You Funded by an Annual Budgeting Process by a County or a Group Practice in Such a Way that the Following Financial Data are Difficult to Determine? **YES_____ NO_____**
If yes, fill out only what you can.

Do You Receive Hospital/Medical School Support for:

OR Management	Yes____	No_____	Amount Received	$_____
OB	Yes____	No_____	Amount Received	$_____
ICU	Yes____	No_____	Amount Received	$_____
Pre Op	Yes____	No_____	Amount Received	$_____
General Administrative (Include GME funds)	Yes____	No_____	Amount Received	$_____
Other	Yes____	No_____	Amount Received	$_____
	TOTAL HOSPITAL SUPPORT RECEIVED.			$_____

REIMBURSEMENT

Payor Mix	**% of Payor Mix**	**Collection Rate as % of Full Charges**
Medicare	_____	Medicare _____
Medicaid	_____	Medicaid _____
HMO/Managed Care	_____	HMO/Managed Care _____
Indemnity Insurance	_____	Indemnity Insurance _____
Self Pay	_____	Self Pay _____
Other	_____	Other _____
TOTAL =	**100%**	**Overall Collection Rate** _____%

Full Amount of Charge $_____ per unit

REVENUE

REVENUE:	$ (Dollars)		% (Percent)
Clinical Care			
Research			
Teaching			
Administration			
Endowment/investment			
Other			
TOTAL	$	=	100%

REVENUE BY SOURCE	$ (Dollars)	% (Percent)
Practice of Anesthesia (Clinical Care)		
• Physician Fees		
• CRNA		
• VA Contract		
• Other		
Research		
• Federal Funding		
• Industrial Research		
• Other Research		
Other Support (Teaching & Administrative)		
• Medical School Support		
• State Support		
• Hospital		
• Other		
• Non-operating Income (Endowments, Investments, Gifts)		
TOTAL	$ =	100%

EXPENSES

EXPENSES	$ (Dollars)	% (Percent of Revenue)
TAXES		
• Dean		
• President		
• Other		
OVERHEAD (rent, etc)		
• Hospital		
• Med School		
• Malpractice		
PROFESSIONAL GROUP PRACTICE		
• Clinic overhead		
• Other Practice Overhead		
• Billing & collections including compliance		
COMPENSATION		
• Faculty (including bonuses)		
• House Staff		
• Fellows		
• CRNA		
• Other Personnel		
Research ($ from operating fund)		
Other (travel, supplies, etc)		
TOTAL OPERATING EXPENSES		

A Demographic, Service, and Financial Survey of Anesthesia Training Programs in the United States

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In February 2000, a demographic, service, and finance survey was sent to the directors of anesthesiology training programs in the United States under the auspices of the Society of Academic Anesthesia Chairs/Association of Academic Program Directors. In August of 2000, 2001, and 2002, shorter follow-up surveys were sent to the same program directors requesting the numbers of vacancies in faculty positions and certified registered nurse anesthetists (CRNA) positions. The August 2001 survey also inquired if departments had positive or negative financial margins for the fiscal year ending June 2001. The August 2002 survey included the questions of the 2001 survey and additionally asked if the departments had had an increase or decrease in institutional support and the amount of that current support. The survey results revealed that the average program had 36 anesthetizing locations and 36 faculty. Those faculty spent 69% of their time providing clinical service. Approximately one-half of the departments paid for some of their residents, whereas the other 50% paid for none. Eighty-five percent of the departments employed CRNAs who were funded by the hospital in one third of the departments. In 2000, departments received $34,319/yr in support per faculty full-time equivalent (FTE) from their institutions and had a mean revenue of $407,000/yr/faculty FTE. In 2002, the department's institutional support per FTE increased to $59,680 (a 74% increase since 2000). The departments in academic medical centers paid 20% in overhead expenses, whereas departments in nonacademic medical centers paid 10%. In 2000, 2001, and 2002, the percentage of departments with positive margins was 53%, 53%, and 65%, respectively, whereas the departments with a negative margin decreased from 44% in the year 2000 to 38% in 2001 and 33% in 2002. For the departments with a positive margin, the amount of margin per FTE over this 3-yr period was approximately $50,000, $15,000, and $30,000, respectively. Although the percentage of departments with a negative margin has been decreasing, the negative margin per FTE seems to be increasing from approximately $24,000 to $43,000. The number of departments with open faculty positions has decreased from 91.5% in the year 2000 to 83.5% in 2001 and 78.4% in 2002; in these departments, the number of open faculty positions has also decreased from 3.8 in 2000 to 3.9 in 2001 to 3.4 in 2002. The number of open CRNA positions seems to have been relatively constant with approximately two thirds of the departments requiring an average of approximately four CRNAs each. Overall, academic anesthesiology departments fiscal security seems to have eroded with an increased dependence on institutional support. Departments pay larger overhead rates relative to private practice, and there seems to be a continued, but possibly decreasing, shortage of faculty.

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Over the past decade, a variety of stressors have been placed on American academic medical centers and academic anesthesiology programs in particular. Professional fee reimbursement has progressively declined specifically for those specialties involved with procedures (1). Academic medical centers' income has not only been reduced because of the emergence of health maintenance organizations, but in the later part of the 1990s, the Balanced Budget Act significantly reduced direct and indirect graduate medical education payments (2). The mid-1990s saw a dramatic decrease in residents matching into anesthesiology (3). This reduction in resident numbers has subsequently produced a workforce shortage facing the specialty in the United States (U.S.) that may last for the next 5–10 yr (4–6). The current shortage of anesthesiologists has made it difficult for academic

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medical centers to recruit and retain adequate numbers of faculty (7). Many specialties at academic medical centers face problems of decreased reimbursement for their professional fees, but departments of anesthesiology are also met with the additional threat of being unable to compete financially for faculty because of the improving quality and quantity of job offers in private practice. Medicare's disproportionately poor reimbursements for anesthesia care and the large cost of overhead have been two other factors that have placed academic anesthesia departments in financial jeopardy (8,9). Because of the adverse consequences these pressures may have on U.S. training programs, the Society of Academic Anesthesiology Chairs/Association of Anesthesiology Program Directors (SAAC/AAPD)[1] council commissioned a white paper to be written to provide background information regarding these threats to the specialty. This paper "Surviving the Perfect Storm: the Financial Environment of Academic Medical Centers" was presented at this society's meeting in October 2000 (10,11). The intent of this report was not only to provide a framework by which academic chairs could plan for the future, but also to have information regarding the issues facing the specialty available to medical school deans and hospital administrators. To generate the data required for this report, two surveys were sent to the program directors of the U.S. training programs between February and August of 2000. As a follow-up to this report, two more surveys were sent in August of 2001 and 2002. The purpose of this current paper is to present the results of these four surveys and discuss their implications with respect to the future financial stability of the U.S. training programs in anesthesiology.

Methods

Four surveys were sent to the program directors of the anesthesiology training programs in the U.S. in February 2000 and in August 2000, 2001, and 2002. The purpose of these surveys was to assess the current financial and workforce status of the training programs in the U.S. The February 2000 survey requested information regarding departmental demographics with respect to personnel, budgeted support, reimbursement, revenue, and expenses (Appendix I: SAAC/AAPD Financial Survey). In August 2000, a brief survey was conducted of the same group of programs, requesting their current workforce needs with respect to faculty and certified registered nurse anesthetists (CRNAs). In August 2001, a third survey was conducted asking the same workforce questions and also requesting the departments' financial margins for the fiscal year ending June 30, 2001 (Appendix II: SAAC/AAPD Financial Survey). The fourth survey was conducted in August 2002 asking the same questions as the 2001 survey and included questions regarding institutional support (Appendix II). The purpose of these follow-up surveys was to determine if there were trends with respect to workforce needs or financial conditions that were not captured in the first survey. The February 2000 survey was sent by mail with reminders sent by email, fax, and telephone. The follow-up surveys in August 2000, 2001, and 2002 were sent by e-mail with e-mail reminders. All surveys were sent to the current program directors listed in the SAAC/AAPD directory.

The SAAC are the program directors in anesthesia departments within medical schools. The AAPD direct the training programs in the U.S. Therefore, the SAAC members are a large subset of the AAPD. The AAPD members who are not members of SAAC are the program directors in institutions that do not have medical schools. Organizationally, these distinctions became moot over 20 yr ago when both groups merged to form the SAAC/AAPD, but the distinction becomes relevant when analyzing the financial data because of the differences in taxation and institutional support. For the purposes of this paper, we will refer to the non-SAAC members as AAPD. Another distinction can be made with respect to departments that are budgeted as an expense in larger institutions and therefore may not have detailed revenue and expense information. Because of these differences in financial structure, some portions of the financial survey were analyzed by dividing departments into three categories. The first category consists of those departments in academic medical centers with medical schools; they are financially responsible for their revenue and expenses; those departments in general receive support funds from the medical school and hospital and in turn pay taxes and group practice overhead expenses; this group will be referred to as the academic medical center model (AMC Model). The second group consists of departments that are more fully integrated into hospitals or group practices in which they are budgeted within the overall finances of the institution; for these departments it was not possible to complete much of the financial portion of the survey; this second group will be referred to as the budgeted department model (Budgeted Model). The third group includes the departments that are almost completely independent with respect to their finances and more analogous to private practice departments; they

[1] The Society of Academic Anesthesiology Chairs/Associate of Anesthesia Program Directors is a joint organization of the training program directors in Anesthesiology in the United States. The SAAC members are those program directors (department chairs) in institutions with medical schools, whereas the AAPD is the organization for all anesthesia program directors whether they are at an institution with or without a medical school. There are 142 SAAC/AAPD members.

pay little or no taxes and in turn receive little or no support from the hospitals; we will refer to this third group as the independent department model (Independent Model). In the following report, we will present overall data and group specific data, where appropriate, for each of these models.

Results

The survey in Appendix I was distributed by mail to 142 program directors (113 SAAC institutions) with follow-up reminders sent by e-mail, fax, and telephone. An 80% response rate was achieved from the SAAC members (90 of 113) and a 34% response rate from AAPD members (10 of 29). Two AAPD departments reported that they no longer had residencies and therefore were excluded from this survey analysis. Seventeen surveys were returned with insufficient data to be included in the analysis, leaving a final usable response rate for SAAC member departments of 66% and 21% for AAPD departments, with an overall response rate of 56%. The response rates for the August 2000, 2001, and 2002 follow-up surveys were 66.2%, 72.5%, and 63.8%, respectively.

The overall demographic data are presented in Table 1. On average, the programs have 36 anesthetizing locations (23% of which are non-operating room [OR] locations) and 36 clinical faculty full-time equivalents (FTE). The departments average 30 residents in the 3 clinical anesthesia years, which is a 1:1.2 faculty-to-resident ratio. They conducted an average of 19,929 cases per year or 554 per faculty member. Sixty-nine percent of these departments direct preoperative clinics, and these departments see approximately 37% of all surgical patients in those clinics. The anesthesiology departments also manage chronic pain clinics and acute pain services (Table 1). Forty-one percent of the institutions manage the anesthesia service at Veteran's Administration Hospitals and 38% of those do so at a financial deficit to the department that averages $326,644/yr or $9,129/FTE (Table 2).

Faculty spends approximately 69% of their time clinically, 16% in teaching assignments, 8% in research, and 7% in administration (Table 3). Table 4 presents the expenses for the trainees' salaries. In no departments surveyed were all of the residents' salaries paid with departmental funds. In 50.6%, the departments paid for no residents, whereas in the remaining 49.4%, the departments paid for some residents. Table 5 presents the findings of the non-Accreditation Council for Graduate Medical Education (ACGME) approved fellows (cardiac anesthesia, neuro anesthesia, obstetrical anesthesia, and research). Fifty-seven percent of programs have an average of 4.4 non-ACGME fellows. Fifty-four percent of non-ACGME approved fellows (research and clinical) are paid for completely by the departments, whereas 21.7% of departments pay for some, and 23.9% pay for none.

Eighty-five percent of the programs employ CRNAs, 44.1% of which are paid for totally by the department (averaging 14.6 CRNAs per department), whereas 33.8% are paid totally by the hospital (averaging 23.6 CRNAs per department) (Table 6a). Of the departments that split the CRNA funding between the hospital and anesthesiology departments, the average split is 47% hospital and 53% department (Table 6b).

Institutional (hospital-medical school) support for clinical, administrative, and teaching activities are presented in Tables 7a–c for both the 2000 survey and the

Table 1. Demographics (all institutions)

	Mean ± SD
No. ORs n = 80	28.3 ± 17.8
No. other anesthesiology locations n = 76	7.9 ± 8.0
No. of cases with anesthesia per yr n = 79	19,929 ± 12,330
No. OB deliveries w/anesthesia per yr n = 72	2842 ± 3006
No. pain clinic visits per yr n = 74	4308 ± 3277
No. preop clinic visits per yr n = 55	7431 ± 5382
No. clinical FTEs n = 80	36 ± 21.5
No. of full time research FTEs n = 62	3.5 ± 3.0
No. of residents n = 80	30.1 ± 21

ORs = operating rooms; OB = obstetric; Preop = preoperative; FTE = full time equivalent.

Table 2. Veterans Association (VA) Hospital Staffing
n = 68

VA staffing responsibility	yes = 41%	no = 59%
If yes, financial deficit?	yes = 38%	no = 62%
If financial deficit, how much?	mean	$326,644
	mean/FTE	$9129

FTE = full time equivalent.

Table 3. MD Faculty Activity, Percent Time (all institutions)

	Mean ± SD
Clinically n = 80	69% ± 17
Teaching n = 80	16% ± 12
Research n = 79	8% ± 7
Administration n = 78	7% ± 4

Note: Not all departments responded in all categories.

Table 4. Accreditation Council for Graduate Medical Education Approved Resident Salary Funding

	Department $n = 79$ total	Hospital $n = 79$ total	Medical school $n = 79$ total	Other $n = 79$ total
Pay for all	0%	44.3%	2.5%	1.3%
	$n = 0$	$n = 35$	$n = 2$	$n = 1$
Pay partially	49.4%	49.4%	8.9%	19%
	$n = 39$	$n = 39$	$n = 7$	$n = 15$
Pay for none	50.6%	6.3%	88.6%	79.7%
	$n = 40$	$n = 5$	$n = 70$	$n = 63$

Table 5. Non-Accreditation Council for Graduate Medical Education (ACGME) Approved Fellows Funding (all institutions)

	Department pays $n = 46$	Hospital pays $n = 46$
Pay for all	25/46 = 54.3%	7/46 = 13.2%
	$n = 25$	$n = 7$
Pay for partially	10/46 = 21.7%	4/46 = 8.7%
	$n = 10$	$n = 4$
Pay for none	11/46 = 23.9%	35/46 = 76.1%
	$n = 11$	$n = 35$

Note: Thirty-four of 80 institutions do not have a non-ACGME approved fellowship program. Forty-six of 80 institutions have an average of 4.4 non-ACGME approved fellows.
$n = 80$.

Table 6a. Certified Registered Nurse Anesthetist (CRNA)/Anesthesia Assistant (AA) Funding

		No. of CRNAs
Yes: CRNAs/AAs	85%	68
No: CRNAs/AAs	15%	12
100% funded by the department	30/68 = 44.1%	14.6
100% funded by the hospital	23/68 = 33.8%	23.6
Percent partially funded	15/68 = 22.1%	

$n = 80$.

Table 6b.

Partially funded breakdown	Percent	No. of CRNAs
Funded by department	53	17.2
Funded by hospital	47	21.7

CRNA = certified registered nurse anesthetist; AA = anesthesia assistant.

2002 follow-up survey. Some institutions receive an overall support budget that is not itemized; therefore, the funds allocated to each area of potential support is the average number of dollars for which those itemized data were provided. Overall, departments received an average of $1,235,474/yr, which represents $34,319/faculty in 2000 (Table 7c). The AMC Model receives substantially more support than the Independent Model ($34,987/FTE versus $17,034/FTE) (Table 7a). Although by the year 2002 40% of the departments had an increase in support and 24% had a decrease, the average of overall support increased by 89% to $2,329,748 or $59,906/FTE (Tables 7, b and c).

Table 8 presents payor mix and collection rates. In 2000, on average, departments charged $62.00 per unit and had an average collection rate of 42.5% or a net collections of $26.35 per unit. The average unit charge increased to $65.90 in 2001.

Table 9 and Table 10a present itemized revenue and expense data by percent of total dollars for the AMC and Independent Models. The financial data for the Budgeted Model department are incomplete and therefore not presented in this analysis. The revenue per FTE in the AMC Model is similar to that of the Independent Model, $403,611 and $411,067, respectively. The combination of taxes to deans, university presidents, overheads (e.g., rent), and group practice overheads (including billing and malpractice) totaled 20% for the AMC Model and 10% for the Independent Model (Table 10b).

In 2000, approximately half of the AMC departments had an operating profit averaging $1.95 million or $54,426/FTE, whereas nearly 46% lost approximately $900,000 or $25,000/FTE (Table 11). The Independent Model departments had a similar trend, only to a lesser degree. Table 12 presents the margin analysis over the last 3 yr. The percentage of departments with a positive margin remained relatively constant at 53% until 2002 when they increased to 65%. The overall margin and margin per FTE decreased from 2000 to 2001 but then increased in 2002, which coincided with an increase in institutional support of (overall average) $1,094,274 (Table 7c). During the same time period, the number of departments with a negative margin has progressively decreased, but the amount of the negative margin has increased from approximately $850,000 (or $24,000/FTE) in the years 2000 and 2001 to over $1.5 million (or $40,000/FTE) in 2002 (Table 12).

In 2000, of the 85 (91.5%) departments that were seeking more faculty, there were 326 open faculty positions or 3.8 faculty per department (10% shortage). The percent of departments needing faculty has progressively decreased over the past 3 yr to 78%; these departments are now seeking an average of 3.4 faculty per department (Table 13). Departments had similar needs for CRNAs (Table 13).

Discussion

Although there are some financial data regarding academic practices available from the Medical Group Management Association (MGMA) and data regarding residency positions from the Residency Review Committee and the American Board of Anesthesiology, this paper presents the first data describing the

Table 7a. Hospital/Medical School/State Support

	Operating room	Obstetric	Intensive care unit	Preoperative	General administration	Other[a]	Total institutional support: 2000 total support	Total institutional support: 2000 support per full-time equivalent
All institutions	65%	18%	36%	30%	61%	61%	100%	$34,319
$n = 66$	225,073	194,046	212,226	107,899	431,841	798,394	1,235,474	
AMC classified	70%	20%	41%	32%	61%	61%	100%	$34,987
$n = 59$	225,849	194,046	212,266	111,735	455,919	863,500	1,329,510	
Independent classified	29%	0%	0%	14%	57%	57%	100%	$17,034
$n = 7$	201,150			35,000	215,138	212,442	$442,884	

AMC = academic medical center.
[a] Numbers represent institutions that reported itemized breakdowns.

Table 7b. Percentage Change in Institutional Support from Fiscal Year 2000 to 2002

Increased	40%	($n = 34$)
Decreased	24%	($n = 10$)
Unchanged	36%	($n = 31$)

Table 7c. Average Institutional Support from Fiscal Year 2000 to 2002

	2000	2002	Dollar increase	Percent increase
Total support	$1,235,474	$2,329,748	1,094,274	89
Support/FTE	$ 34,319	$ 59,906	25,587	75[a]

[a] Percent increase per full time equivalent (FTE) is not the same as percent of dollar increase because of the different number of faculty in departments over the 2-yr period.

Table 8. Reimbursement Payor Mix (all institutions)

Payor	Mean (%)
Medicare	8.5
Medicaid	8.6
HMO	22.6
Insurance	27.4
Self pay	12.5
Other	20
Overall collection rate	42.5
Full amount of charge per unit 2000	$62.60
Full amount of charge per unit 2001	$65.90

$n = 80$.

U.S. anesthesiology training programs from a demographic, service, and financial point of view. The impetus for this survey was the culmination of adverse financial and workforce issues facing the U.S. anesthesiology training programs as a result of the changes in the 1990s, including professional fees, hospital reimbursement, and the decrease in size of residency classes (1,3,7). The primary survey (2000) provided a snapshot in time of the U.S. anesthesiology training programs, and the follow-up surveys provided information regarding the trends in finances and workforce. It is interesting to note that the average department has a number of faculty approximately equaling the number of anesthetizing locations, and 22% of those locations are non-ORs. That means that each anesthetizing location needs to generate sufficient revenue to support a faculty FTE with administrative overhead and some academic time. Given that offsite locations generally provide less revenue and that surgical times are usually longer at teaching institutions, it may be a challenge to meet these revenue expectations. Survey results demonstrate that the revenue per FTE was approximately $407,000, 8% of which ($34,000) was from institutional support payments in the year 2000; in this year, 44% of the departments had negative margins, whereas 53% had healthy positive margins. Within a year, the positive margin had been reduced by nearly 70%. During the same time period, the workforce survey demonstrated an approximate 10% open faculty positions. This was also the same time when the number of graduating residents was at a low point, and job opportunities were prevalent throughout the country (4,7). It would seem that between the years 2000 and 2002 many program directors requested additional support from their institutions to retain and recruit faculty during this workforce shortage. This is demonstrated by a nearly doubling of institutional support reaching almost $60,000 per faculty in the year 2002. It also seems that this increased revenue to the departments was used to increase faculty salaries to facilitate recruitment and retain faculty. Table 14 contains the salary data from the SAAC Salary Survey of the years 2000 and 2002 (Rebecca Lovely, University of Florida, personal communication, 2002). These data demonstrate a substantial increase in salary, especially at the lower levels. Instructor salaries have increased 40%, and assistant, associate, and professor salaries have increased 14%,

Table 9. Revenues

	Clinical care	Research	Teaching and administration	Endowment and investments	Other	Mean total revenue per institution	Revenue per FTE ± SD
All institutions $n = 66$	Mean 79% $n = 66$	Mean 6% $n = 57$	Mean 10% $n = 61$	Mean 2% $n = 47$	Mean 7% $n = 46$	Mean $n = 66$ $14,952,350	$407,420
AMC classified $n = 59$	Mean 78% $n = 59$	Mean 6% $n = 54$	Mean 10% $n = 56$	Mean 2% $n = 45$	Mean 7% $n = 40$	Mean $n = 59$ $15,458,319	$403,611
Independent classified $n = 7$	Mean 91% $n = 7$	Mean 1% $n = 3$	Mean 4% $n = 5$	Mean 3% $n = 2$	Mean 6% $n = 6$	Mean $n = 7$ $10,687,754	$411,067

AMC = academic medical center; FTE = full time equivalent.

Table 10a. Expenses

	Total overhead	Compensation	Research	Other
All institutions $n = 65$	Mean 19% $n = 65$	Mean 69% $n = 65$	Mean 4% $n = 48$	Mean 6% $n = 58$
AMC classified $n = 58$	Mean 20% $n = 58$	Mean 68% $n = 58$	Mean 4% $n = 45$	Mean 6% $n = 52$
Independent classified $n = 7$	Mean 10% $n = 7$	Mean 80% $n = 7$	Mean 3% $n = 3$	Mean 6% $n = 6$

AMC = academic medical center.

Table 10b. Itemized Overhead

	Taxes	Overhead	Group practice
All institutions $n = 65$	Mean 7% $n = 56$	Mean 4% $n = 60$	Mean 8% $n = 61$
AMC classified $n = 58$	Mean 7% $n = 56$	Mean 4% $n = 54$	Mean 9% $n = 55$
Independent classified $n = 7$	0% $n = 0$	Mean 3% $n = 6$	Mean 7% $n = 6$

AMC = academic medical center.

10%, and 1%, respectively. If the average department of 36 FTE is assumed to have a distribution of faculty at ranks as presented in the SAAC survey, then the overall cost of these salary increases would be approximately $923,000. If one assumes a 20% benefit rate, it would require approximately $1,100,000 for a department to provide these salary increases. Coincidentally, from 2000 to 2002, the increase in average departmental support from the institutions was approximately $1,100,000 (Table 7c). Starting salaries in academic departments have increased dramatically, most likely to be more competitive with private practice. It seems this strategy has worked because the number of faculty openings in the training departments has decreased; this would either imply that the departments are able to compete effectively with private practice or that the overall job market is saturating nationwide. Recent data would not suggest the latter (6).

Academic faculty do not expect to have the same salary as private practitioners, but they do expect academic support and academic time. This may not be the salary expectation of all specialties. Interestingly, Figure 1 demonstrates that academic salaries for anesthesiologists at all levels are smaller relative to private practice salaries compared with other procedural and nonprocedural disciplines. Note that even at the full professor rank, academic anesthesiologist salaries never reach those of private practice, whereas general internal medicine, general surgery, and pediatrics professor salaries exceed those of private practice salaries. Even in heavily procedure-oriented specialties, such as orthopedic surgery, academic salaries reach nearly 90% of the private practice salary when orthopedists attain the rank of professor, whereas anesthesiologists reach only 83% of their private practice counterparts (12–14). This explains why it may be more difficult to recruit academic anesthesiologists at the assistant professor level and even more difficult to retain anesthesiologists when they see that their future compensation will always lag behind private practice salaries. The other major academic specialties that face similar compensation difficulties are radiology, pathology, cardiology, and hematology/oncology (12–14).

Although the overall response rate for this study is only 56%, it compares favorably with the 25%–31% response rate for MGMA reports (12–14). This is surprising given the length and complexity of the current survey compared with the data presented from the MGMA reports. This relatively large response rate

Table 11. Margin Analysis for the Year 2000

	All institutions $n = 66$	AMC classified $n = 59$	Independent classified $n = 7$
Positive margin	35 of 66 = 53% Mean = $1,817,299 $50,481/FTE	31 of 59 = 52.5% Mean = $1,959,323 $54,426/FTE	4 of 7 = 57% Mean = $716,610 $19,906/FTE
Negative margin	29 of 66 = 44% Mean = $−857,306 $−23,814/FTE	27 of 59 = 45.8% Mean = $−901,954 $-25,054/FTE	2 of 7 = 28.6% Mean = $−254,554 $−7,071/FTE
Break even	2 of 66 = 3%	1 of 59 = 1.7%	1 of 7 = 14.4%

AMC = academic medical center; FTE = full time equivalent.

Table 12. Margin Analysis Fiscal Years 2000, 2001, and 2002

Department margin	2000	2001	2002
Positive margin	53%	53%	65%
	$1,817,299	$577,666	$1,102,719
	$50,481/FTE	$15,202	$28,354/FTE
Negative margin	44%	38%	33%
	$847,306	$840,400	$1,572,021
	$23,814/FTE	$21,491	$40,423/FTE
Response rate	66.2%	72.5%	63.8%

FTE = full time equivalent.

Table 13. Current Workforce Needs in Academic Departments August 2000/2001/2002

	2000	2001	2002
Response rate	66.2%	72.5%	63.8%
Departments needing additional faculty	91.5%	83.5%	78.4%
Average no. per department	3.8	3.9	3.4
Departments needing additional certified registered nurse anesthetists	66.5%	75%	67.1%
Average no. per department	4.0	4.4	3.6

Table 14. Society of Academic Anesthesia Chair (SAAC) Salary Data[a] For Academic Years Starting 2000 and 2002

	2000	2002	Dollar increase	Percent increase
Instructor	$144,250	$201,528	$57,278	39.7
Assistant professor	$183,000	$209,000	$26,000	14.2
Associate professor	$210,000	$231,496	$21,000	10.0
Professor	$239,182	$242,156	$ 2971	1.1

[a] Data for national average for stipends only. SAAC Salary Survey, Rebecca Lovely, Department of Anesthesiology, University of Florida, P.O. Box 100254, Gainesville, FL 32610.

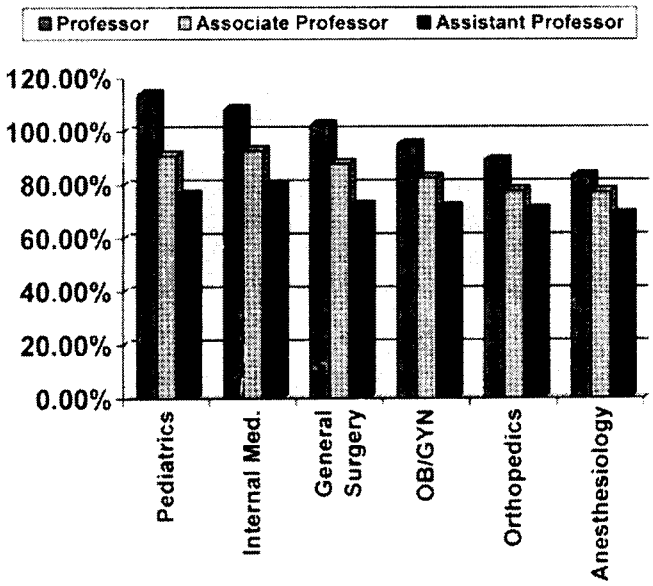

Figure 1. This histogram graphs academic salaries at three levels (assistant, associate, and full professor) for six specialties as a percentage of private practice income. These data are from the Medical Group Management Association (MGMA) (12,13).

was most likely because of two reasons. First, the initial mailings of these surveys were followed up multiple times by letter, e-mail, and contact by phone to encourage responses. Second, the respondents had an interest in receiving the data from the survey because it relates directly to their jobs, and the respondents were informed that the results of the survey would be distributed at the Fall 2000 meeting of the SAAC/AAPD. Despite this encouraging response rate, the data may be flawed by having a selection bias with respect to the respondents and nonrespondents, thereby not having the results reflect the average department. One way of attempting to assess accuracy of the results is to compare the findings with those of another survey that includes the same question. For example, the average number of clinical faculty from this survey was 36 FTEs, which compares favorably with the number of faculty reported by the SAAC Salary Survey for the year 2000 of 38.7 FTEs (Rebecca Lovely, University of Florida, personal communication, 2002). This salary survey is distributed to the SAAC departments by the Department of Anesthesiology at the University of Florida, Gainesville, each year, and the results are sent to all SAAC departments. In the year 2000, this salary survey was sent to the 113 program directors of the SAAC departments and had

88 respondents (78% response rate) (Rebecca Lovely, University of Florida, personal communication, 2002). If the data from the SAAC members within this current report are analyzed, one finds that there are 38.3 faculty, which is nearly identical to the SAAC salary survey number of 38.7. In addition, the MGMA academic survey for 2002 (based on 2001 data) found that the average department had 42 faculty. This MGMA report had a response rate of only 26.3%; therefore, although the number of faculty is close to that found in this current report, with the small response rate, it would not be expected to be the same (12). Also, this current report found that the average number of residents in anesthesiology programs was 30.2. The American Board of Anesthesiology reported an average of 29.3 residents for the 134 programs they had approved during the 2000 academic year. The close agreement of resident and faculty numbers suggests that current survey data represent national results (4).

A second concern with any survey is the accuracy of the responses. This accuracy is not because of the respondents knowingly providing inaccurate data but more to the respondents not interpreting the question as intended. For example, clinical FTEs in Table 1 may have been interpreted as anesthesiologist faculty time assigned clinically as opposed to the number of employed FTE faculty anesthesiologists. Hopefully, respondents answered this correctly, especially given the questions that appear on page 2 of this survey, which requests information regarding the percent of time that MD faculty spend in clinical service versus teaching, research, or administration. Nevertheless, it is possible that many of the questions were interpreted differently by respondents, thereby potentially affecting the accuracy of the results.

Finally, it should be stated that the results are presented as mean values, thereby reflecting the average department but not necessarily reflecting the large variation between departments. This became very clear when analyzing the financial data, which required analysis of the departments in the three categories: AMC Model, Budgeted Model, and Independent Model. Most of the data in the financial section are from the AMC Model departments, so these results would probably most closely reflect the true situation of these departments on average.

In summary, although the number of applicants to U.S. training programs and resident class size have increased over the past two years, the workforce shortage in the U.S. seems to be here for at least the next half decade (4–6). During the next few years, it will be crucially important that academic anesthesiology departments remain solvent and be able to recruit and retain qualified faculty to train the increasing number of residents. Academic departments pay larger overhead expenses not only to support their academic missions but the academic missions of their institutions and their group practices, as well (9). For many specialties within an academic medical center, the group practice experience rates are less than the expenses in the private environment (1,9). This averaging of practice expenses places academic anesthesia departments at a disadvantage relative to other specialties within their institutions (9). Because the anesthesia faculty in this survey spent approximately 70% of their time providing clinical service, there is little time left for the other aspects of academic life. If this time is further reduced to support more clinical income, their jobs will seem to be little different than that of a private practitioner. As anesthesiology departments face deficit budgets, they are also faced with the difficult problem of retaining faculty to provide the breadth of educational opportunity and services requested by their institutions. If these departments functioned as corporations, they would consider eliminating money-losing ventures, which in the case of anesthesiology departments might be offsite anesthesia locations, pain clinics, preoperative clinics, and services in labor and delivery. An alternative approach of asking for increased institutional support seems to have been effective in nearly half of the departments surveyed in this study. Overall, the anesthesiology training programs have received a significant increase in support that coincides with a substantial increase in faculty salaries, especially at the instructor and assistant professor levels. It is hoped that this support will continue to allow departments to recruit and retain qualified faculty and to provide them with sufficient time to develop academic careers. The viability of the specialty of anesthesiology depends upon these individuals to train the next generation of practitioners and to be the source of discovery of new knowledge.

Appendix I: 2000 SAAC/AAPD SURVEY

HOSPITAL / INSTITUTION SUPPORT

Please return completed survey to Jenny Mace (jenmace@umich.edu) or fax to the Department of Anesthesiology, University of Michigan Health System at (734)-936-9091.

INSTRUCTIONS: ***All questions here refer to Fiscal Year 1999 or your medical school's most recently completed twelve-month fiscal period for the hospital in which you do the majority of your resident teaching and you have primary fiscal responsibility.***

DEMOGRAPHIC DATA:

Name of Program (Optional): _____

Region (Circle One): Midwestern Northeastern Southern Western

Hospital Type:
- University _____
- Private _____
- Public/County _____
- VA _____

Number of Beds. . . . . _____

Number of ORs. . . . . _____

Number of Other Anesthetizing Locations. . . . . _____

Number of Cases *with Anesthesia* Per Year (not including OB). . . . . _____

Number of OB Deliveries in which Anesthesia is involved Per Year. . . . . _____

Number of ICU Beds Managed. . . . . _____

Pain Clinic Visits Per Year. . . . . _____

Pre-Op Clinic Visits Per Year (Staffed by an Anesthesiologist). . . . . _____

Acute Pain Service - Number of Epidurals per year. . . . . _____

PCA's managed by Anesthesia per year. . . . . _____

Number of Clinical Faculty FTE's . . . . . _____

Number of Full Time Research Faculty (PhD or not clinically active MD, ie, does no clinical work) . . . . . _____

VA Hospital: Are you responsible for staffing a VA? Yes_____ No_____

If yes, do you run at a financial deficit? Yes_____ No_____

If yes, how much? $_____

PERSONNEL

House Staff		Dept Pays		Hospital Pays		Med School Pays		Other Pays
Interns #_____	=	#_____	+	#_____	+	#_____	+	#_____
CA 1-3 #_____	=	#_____	+	#_____	+	#_____	+	#_____
Fellows ACGME #_____ (Peds, Pain, CCM)	=	#_____	+	#_____	+	#_____	+	#_____

House Staff (Salary) Expense Deficit to Department. . . . . $_____

		Dept Pays		Hospital Pays		Med School Pays		Other Pays
Non-ACGME Fellows #_____	=	#_____	+	#_____	+	#_____	+	#_____
Research Fellows #_____	=	#_____	+	#_____	+	#_____	+	#_____
CRNAs or AAs #_____	=	#_____	+	#_____	+	#_____	+	#_____

MD FACULTY ACTIVITY: Average over the Department (The Department is defined as those faculty working at the primary teaching hospital)

% of time spent clinically. . . . . _____

% of time spent teaching. . . . . _____

% of time spent in research and/or grant management. . . . . _____

% of time spent in administration. . . . . _____

100%

BUDGET

Are You Funded by an Annual Budgeting Process by a County or a Group Practice in Such a Way that the Following Financial Data are Difficult to Determine? **YES_____** **NO_____**
If yes, fill out only what you can.

Do You Receive Hospital/Medical School Support for:

OR Management	Yes____	No_____	Amount Received	$_____
OB	Yes____	No_____	Amount Received	$_____
ICU	Yes____	No_____	Amount Received	$_____
Pre Op	Yes____	No_____	Amount Received	$_____
General Administrative (Include GME funds)	Yes____	No_____	Amount Received	$_____
Other	Yes____	No_____	Amount Received	$_____

TOTAL HOSPITAL SUPPORT RECEIVED. . . . . $_____

REIMBURSEMENT

Payor Mix	**% of Payor Mix**		**Collection Rate as % of Full Charges**
Medicare	_____	Medicare	_____
Medicaid	_____	Medicaid	_____
HMO/Managed Care	_____	HMO/Managed Care	_____
Indemnity Insurance	_____	Indemnity Insurance	_____
Self Pay	_____	Self Pay	_____
Other	_____	Other	_____
TOTAL =	**100%**	**Overall Collection Rate**	_____%

Full Amount of Charge $_____ per unit

REVENUE

REVENUE:	$ (Dollars)	% (Percent)
Clinical Care	_____	_____
Research	_____	_____
Teaching	_____	_____
Administration	_____	_____
Endowment/investment	_____	_____
Other	_____	_____
TOTAL	$_____ =	100%

REVENUE BY SOURCE	$ (Dollars)	% (Percent)
Practice of Anesthesia (Clinical Care)		
• Physician Fees	_____	_____
• CRNA	_____	_____
• VA Contract	_____	_____
• Other	_____	_____
Research		
• Federal Funding	_____	_____
• Industrial Research	_____	_____
• Other Research	_____	_____
Other Support (Teaching & Administrative)		
• Medical School Support	_____	_____
• State Support	_____	_____
• Hospital	_____	_____
• Other	_____	_____
• Non-operating Income (Endowments, Investments, Gifts)	_____	_____
TOTAL	$_____ =	100%

EXPENSES

EXPENSES	$ (Dollars)	% (Percent of Revenue)
TAXES		
• Dean		
• President		
• Other		
OVERHEAD (rent, etc)		
• Hospital		
• Med School		
• Malpractice		
PROFESSIONAL GROUP PRACTICE		
• Clinic overhead		
• Other Practice Overhead		
• Billing & collections including compliance		
COMPENSATION		
• Faculty (including bonuses)		
• House Staff		
• Fellows		
• CRNA		
• Other Personnel		
Research ($ from operating fund)		
Other (travel, supplies, etc)		
TOTAL OPERATING EXPENSES		

Appendix II: 2000, 2001 and 2002 Follow-Up SAAC/AAPD Surveys

This is another BRIEF follow-up survey to the Perfect Storm Report.

Please reply by following the directions below:
1. Select "Reply" to this e-mail message.
2. Scroll down and answer the questions by clicking in between the parenthesis.
3. Send/Return this email to me.

I. Staffing

Do you have open faculty positions? Yes ( ) No ( )
If yes, how many? ( )
How many full-time equivalent MD faculty do you have total? ( )

Do you have CRNAs? Yes ( ) No ( )
If yes, what percentage does the department fund? ( )%
What is the department's cost? ($)

Do you have open CRNA positions? Yes ( ) No ( )
If yes, how many? ( )

II. Department Finance (for fiscal year ending 6/30/02)*

Did your department have a positive margin? Yes ( ) No ( )
(not including gifts or investments)
If yes, approximately how much? ($), ( )% of budget

Did your department have a negative margin? Yes ( ) No ( )
(not including gifts or investments)
If yes, approximately how much? ($), ( )% of budget

III. Departmental Financial Support from Hospital, Medical School or other sources.+

How many faculty anesthesiologists do you have (FTE)? (_____)

Has your department had a change in institutional financial support (all sources: hospital, medical school, state, other) since fiscal year ending June 2000?

(_____increase)
(check one) (_____decrease)
(_____stayed the same)

If you have had an increase, what is the approx. amount of total support?($_____)
what is this as an approx.% of your budget? (_____%)

* *These questions were added to the 2001 survey*
\+ *These questions were added to the 2002 survey*

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ECONOMICS, EDUCATION, AND HEALTH SYSTEMS RESEARCH
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Faculty and Finances of United States Anesthesiology Training Programs: 2002–2003

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Between February, 2000 and August, 2002 three surveys have been submitted to the program directors of the anesthesiology training programs in the United States (U.S.) to assess the departments' needs for faculty and financial support from their institutions. In this article we present the results of a fourth follow-up survey. This survey also asked questions regarding the need for additional support to meet the new 80-h workweek resident requirement and asked the average academic time offered to faculty. The average department has 40 faculty members with 3.7 open faculty positions in the 78% of departments with open positions. Only 25% of the departments planned to add personnel to comply with the 80-h resident workweek. Fifty-one percent of the departments had a positive financial margin of $15,908/full-time equivalent (FTE) faculty anesthesiologist (faculty FTE), whereas 34% had a negative margin of $42,603/faculty FTE. The overall institutional support was $85,607/faculty FTE, which is a 43% increase over the previous year. The average academic time provided to faculty was 13.8%, a decline from 20% in 2000. Twenty-five percent of departments have closed an anesthetizing location as a result of a lack of faculty in 2003. Open faculty positions in U.S. training programs have remained fairly constant at 8% to 10% from 2000 to 2003. Institutional support for training departments has more than doubled since 2000, reaching approximately $85,000/faculty in 2003.
(Anesth Analg 2004;99:1185–92)

The past decade has seen dramatic swings in the number of medical students entering anesthesiology training programs in the United States (U.S.) (1). Because of a real or perceived excess of anesthesiologists in this country, there was a substantial decline in resident class size in the mid-1990s. The graduating class size decreased from 1796 in 1995 to 934 in 2000 (1,2). This reduction in practitioners entering the U.S. anesthesiology workforce has resulted in a nationwide shortage that may last more than 5 years (2–4). The decrease in supply of anesthesiologists has caused a significant increase in demand and salaries in both private practice and in teaching departments (2003 Society of Academic Anesthesiology Chairs Salary Survey, personal communication with Rebecca Lovely, University of Florida, Gainesville, 2003) (5,6). The resulting competitive salary environment has acutely affected the finances of academic training departments (2). As faculty salaries have increased, academic departments' finances have been compromised, placing in jeopardy their ability to train more residents and to conduct an academic program (2,7). In the year 2000, a committee of the Society of Academic Anesthesiology Chairs and Association of Anesthesiology Program Directors (SAAC/AAPD) produced a white paper that reviewed the financial and workforce problems facing anesthesiology training programs in the U.S. (2,7,8). A portion of this white paper included a comprehensive survey of the U.S. training departments to determine the current status of faculty and finances in the year 2000. Follow-up surveys were conducted in 2001 and 2002 to determine the trends with respect to workforce needs and financial status (2,3). The purpose of this current article is to report the results of the most recent follow-up survey and to compare these data with that of the 3 previous years.

Methods

For the past 4 years, e-mail surveys have been sent to the program directors of the U.S. anesthesiology training programs (2). The follow-up surveys conducted in

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0003-2999/04

Table 1. Anesthesiology Departments' Clinical Workforce

Response rate 65%	Mean ± SD	Median	Minimum	Maximum
Faculty	40.3 ± 23.0	34.3	11	107
Residents	39.4 ± 19.8	36	12	90
CRNAs	25.9 ± 37.4	15	1	205

10% of residents are funded by departments. 90% of departments have certified registered nurse anesthetists (CRNAs). 58% of CRNAs are funded by the departments.

2001, 2002, and 2003 have focused on workforce needs: open faculty positions and open Certified Registered Nurse Anesthetist (CRNA) positions, departmental financial margins, and the amount of institutional support received. This current survey, distributed in August of 2003, also included questions regarding support for resident salaries and questions relating to anesthesia practitioners that were added as a result of the recently implemented Accreditation Council of Graduate Medical Education (ACGME) resident 80-h workweek (9). Additionally, program directors were asked the percentage of nonclinical time provided to faculty. (APPENDIX I) The email survey was sent in August; email reminders were sent every 2 weeks for the next 8 weeks to those who did not respond. In October of 2003, an additional email survey was distributed that asked if the departments had closed anesthetizing locations as a result of a lack of faculty or CRNAs and what was their anesthesia unit charge. (APPENDIX II) This survey was redistributed by email to all program directors and then weekly for the next 2 weeks to the nonresponders.

Results

The survey in Appendix I was distributed by email to 135 SAAC/AAPD program directors. An overall response rate of 65% (n = 88) was achieved. The results are presented in Tables 1–5. The average department has 40 faculty and 39 residents. For the 90% (n = 78) who have CRNAs, departments employ an average of 26. Seventy-eight percent of departments have an average of 3.7 open faculty positions whereas 21% (n = 18) of departments have no open positions. Overall, departments provided faculty with 13.8% nonclinical time where 1 day per week is considered 20%. For the departments who have CRNAs, 64% (n = 56) have an average of 3.9 open positions (Table 2).

Twenty-five percent of the departments anticipate recruiting new personnel to comply with the ACGME mandates for resident work hours. These departments have or will be adding residents, CRNAs, or faculty to fulfill these requirements (Table 3). Departments, on average, pay for four of their 39 residents and 58% (n = 51) of their CRNAs.

From a financial funds flow model, U.S. training departments can be divided into three types: "Academic Medical Center Model" (AMC Model) programs are those with departments within medical schools, "Budgeted Department Model" (Budgeted Model) are those in which departments are part of a larger clinical enterprise which manages the finances, and the "Independent Department Model" (Independent Model) wherein departments are structured like a private practice group (2). Because of the funding mechanism for Budgeted Model departments, they are unable to provide the financial data requested in these surveys and are therefore not included in the financial portion of the results (2).

For the fiscal year ending June 30, 2003, of the 78 program directors who responded to this question, 58% (n = 45) of departments had a positive financial margin whereas 38% (n = 30) had a negative financial margin, with 4% breaking even. For those departments with a positive margin, the mean margin was $636,338 or $15,908 per faculty full-time equivalent (FTE) (Table 4, Fig. 1a). Those departments with a negative margin had an average loss of $1,704,139 or $42,603 per faculty FTE (Table 4, Fig. 1a). When these data are compared with the last 3 years, they demonstrate that the percent of departments with positive and negative margins are similar, but that the positive margins are decreasing and the negative margins are increasing (Table 4, Fig. 1a).

The average institutional support totaled $3,424,296 or $85,607 per faculty FTE (Table 5, Fig. 1b). Fifty-nine percent of this support was received from the hospital whereas 18% and 23% were received from the medical school or other sources, respectively. When these data are compared with the previous survey results it appears that total institutional support per FTE has increased by 75% between the years 2000 and 2002 and then by another 43% in 2003.

The second survey in 2003 noted that 25% of departments had closed anesthetizing locations as a result of a lack of faculty and 14% had done so as a result of a lack of CRNAs. The average anesthesia unit charge was $74.80 ($n$ = 75) (Table 5).

Discussion

During the late 1980s and early 1990s, anesthesiology in the U.S. was a very popular choice for U.S. medical students and the training programs progressively increased the size of their classes (7). The

Table 2. Open Faculty and Certified Registered Nurse Anesthetist Positions

	2000	2001	2002	2003
Open faculty positions (No.)	3.8	3.9	3.4	3.7
Departments w/ open positions (%)	91.5	83.5	78.4	78.4
Open CRNA positions (No.)	4.0	4.4	3.6	3.9
Departments with open positions (%)	66.5	75.0	67.18	63.6

2000–2002 data are from Tremper et al. (2) Anesth Analg 2003;96:1432–6. The response rate for 2003 was 65%. 90% of departments have certified registered nurse anesthetists (CRNAs).

Table 3. Additional Personnel Needed to Comply with 80 H Resident Workweek

	Percentage (Number) of departments adding	Number added	Number needed
Residents	28% (25)	0.2 ± 0.6	2.3 ± 3.0
CRNAs	28% (25)	0.7 ± 1.0	3.2 ± 5.1
Faculty	25% (22)	1.5 ± 1.9	2.5 ± 2.9

CRNAs = certified registered nurse anesthetists.
25% of departments added (will add) residents; 75% do not need to add personnel.

Table 4. Department Margin Analysis Fiscal Years 2000–2003

Department Margin	2000	2001	2002	2003
Positive margin	53%	53%	65%	58%
	$1,817,299	$577,666	$1,102,719	$636,338
	$50,481/FTE	$15,202/FTE	$28,354/FTE	$15,908/FTE
Negative margin	44%	38%	33%	38%
	$847,306	$840,400	$1,572,021	$1,704,139
	$23,814/FTE	$21,491/FTE	$40,423/FTE	$42,603/FTE
Response rate	66.2%	72.5%	63.8%	65%

FTE = full-time equivalent.
25% of departments added (will add) residents; 75% do not need to add personnel.

Table 5. Average Institutional Support and Anesthesia Unit Value

Year	2000	2002	2003
Total support	$1,235,474	$2,329,748	$3,424,296*
Support/FTE	$ 34,319	$ 59,906	$ 85,607*
Support/FTE median	$ 19,444	$ 30,223	$ 58,750
Support/FTE maximum	$ 161,073	$ 514,271	$ 380,354
Support/FTE minimum	$ 833	$ 5,143	$ 3,000
Anesthesia unit value charge	$ 62.60	n/a	$ 74.80†

FTE = full-time equivalent.
* Response rate 65%; † response rate 61%.

American Society of Anesthesiologists became concerned that the numbers of graduating residents would be larger than the national need and consequently commissioned a manpower analysis to be done by Abt Associates, Inc (10). This analysis reported in 1994 that although there may have been a considerable oversupply of anesthesiologists, this prediction depended upon a variety of assumptions, including growth rate of surgical procedures and the degree to which anesthesia was provided in the care team mode with supervision of CRNAs (10). Also in the mid-1990s, recommendations were being made that U.S. medical schools should be producing 50% specialists and 50% primary care providers. This recommendation was based on the expected need for primary care gatekeepers for the managed care and capitated programs of the future. In addition, a reduction in specialists would be appropriate given the anticipated reduction in subspecialty care and surgical procedures. On March 17, 1995, an article appeared in the *Wall Street Journal* that received significant attention in the medical school

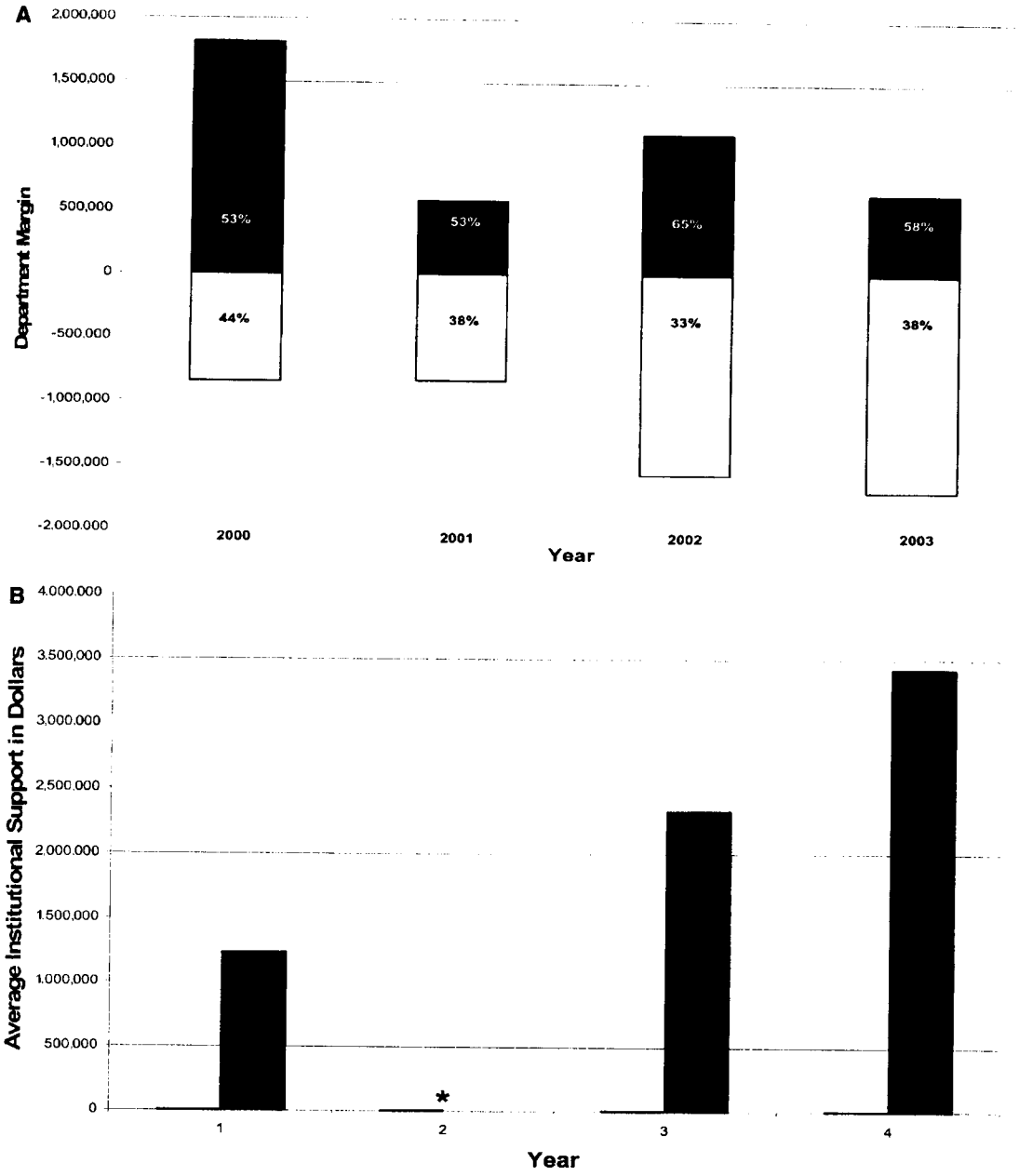

Figure 1. a. This figure illustrates the trends in financial margins of the departments (not including the Budgeted Model departments) over the 4 yr, 2000–2003. The margins are normalized to the number of faculty in each department. The percentage reported within the bars are the percentage of the departments with positive and negative margins respectively (1). b. These are the average department's institutional support dollars for the years 2000, 2002, and 2003. *These data were not surveyed in 2001.

community. This article recounted the difficulties that a recent anesthesiology graduate had in finding employment (11). All of these forces directed medical students away from selecting a career in anesthesiology. The result was a dramatic decrease in the number of U.S. medical graduates entering into the match for anesthesiology in 1996.

It now appears that there is a substantial shortage of anesthesiologists that may persist for the next 5 to 10 years (3,4). Future needs in the U.S. anesthesia workforce have been proven to be very difficult to predict (3). United States workforce needs depend not only on estimated surgical caseload and practitioner retirement rate (which in turn may be dependent on the state of the economy) but also on the average work hours per practitioner and the percentage of anesthesiologists who will be working out of the operating room (OR), e.g., pain and critical care (3).

It is well documented that the salaries of faculty anesthesiologists who work in training programs are less than those of their private practice counterparts (2003 SAAC salary survey, personal communication with Rebecca Lovely, University of Florida, Gainesville, 2003) (5,6). Anesthesiologists who choose academic careers have the opportunity to teach and participate in academic pursuits and consequently have an expectation to have academic time to participate in these nonclinical activities. When the number of faculty in a training department decreases, the department chair must either limit academic time or reduce coverage for the OR. Because most hospitals rely heavily on OR revenue, it is extremely difficult for an anesthesiology department to close ORs for the purposes of maintaining academic time for its faculty. From the results of this survey it appears that departments have both closed anesthetizing locations and reduced academic time. The survey demonstrates that 25% of departments have closed an anesthetizing location as a result of a lack of faculty.

In the 2000 survey, the average academic time was 20%, which has been reduced to 13.8% in 2003. As academic time is reduced, the job of a faculty in a training department becomes more similar to that of a private practitioner except for a smaller salary. For this reason, faculty may ultimately be recruited to better paying positions in private practice unless academic time is provided or salaries are maintained at a more competitive level. As the number of faculty openings in academic departments has been relatively constant over the past 4 years and the institutional support and academic salaries have increased significantly, it is clear that the training hospitals have realized the difficulty in recruiting and retaining the faculty without augmenting salaries (Table 5; 2003 SAAC salary survey, personal communication with Rebecca Lovely, University of Florida, Gainesville, 2003). This does not address the problem of insufficient faculty and inadequate academic time, but it appears to have stabilized the faculty shortage in the academic departments.

It has also been noted that in recent years the percent of articles submitted to *Anesthesiology* and *Anesthesia & Analgesia* from U.S. departments has decreased compared with international departments (personal communications with Ronald Miller, MD, editor, *Anesthesia & Analgesia* and Michael Todd, MD, editor, *Anesthesiology*). Although this decrease in submission rate to the two primary U.S. anesthesiology journals does not in itself prove that academic productivity in U.S. departments is decreasing, it is a concerning trend. Additionally, should the number of anesthesiologists increase relative to demand, the hospitals would most likely reduce the current level of support, causing an acute decrease in salaries. Because over the short term increasing salaries cannot increase the number of anesthesiologists but only add to the workforce by reducing the number of retirees and increasing the number of hours worked per practitioner, the supply and demand effect on salaries may continue.

Survey data, in general, may misrepresent reality because of a small response rate, a skewed response population, or errors in the respondents understanding of the survey questions. The 65% response rate of this current survey compares favorably with the 25%–31% response rate of the Medical Group Management Association reports (5,6). In addition, because this is the fourth consecutive year of surveying the same population regarding a similar topic, it is likely that these data are at least consistent and potentially improved over the previous 3 years. The large response rate achieved in this survey is likely attributable to the fact that the respondent program directors were informed that they would receive the results of this survey at their national meeting and these results may be useful to them in managing their departments. This survey also compares well with the results of the most recent SAAC Salary Survey, which noted the average department had 39.5 faculty, whereas this current survey noted 40.3 faculty (personal communication with Rebecca Lovely, University of Florida, Gainesville, 2003). This same SAAC survey noted 266 funded faculty vacancy positions in the 86 responding departments. The current survey notes 69 of the 88 responding departments had an average of 3.7 faculty openings or 255 open faculty positions. This excellent agreement between these two surveys provides some evidence of accuracy or at least consistency.

It is possible that, although the response rate has been relatively consistent, the demographics of the respondents over time could have shifted and thus influenced the year-to-year comparison of mean values. Figure 2 presents the number of responding departments by faculty size over the 4-year period. There is no statistically significant change in distribution of responding departments by faculty size. Figure 3 presents the number of respondents by department funding category, i.e., AMC, Budgeted, and Independent Models. Although there were a significantly decreased number of Budgeted Model respondents after the year 2000, none of these departments are included in the financial analysis because of a lack of financial data for that group (2). The Independent Model and AMC Model responding departments have remained relatively constant over the 4 years (Fig. 3).

The institutional support per faculty FTE presented in Table 5 demonstrates a large variation between departments. One explanation for this wide range may be the expenses of CRNA salaries. The CRNAs may be employed by the hospital in some institutions and the expenses will not be part of the department expenses. In other departments the CRNA expenses are part of the department budget and these salary expenses may require significant support from the hospital. The 2000 survey found that 44% ($n = 30$) of the departments fully

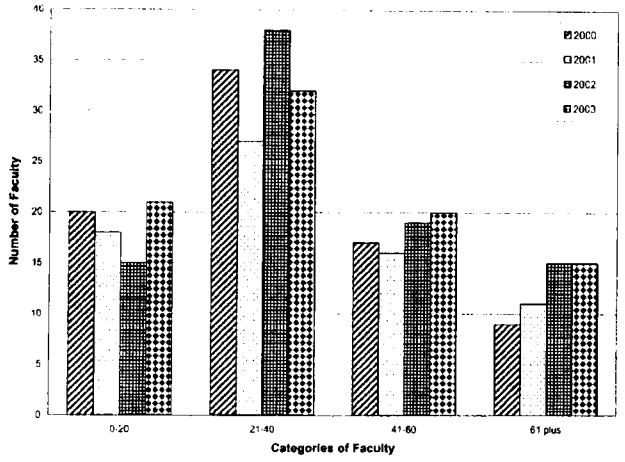

Figure 2. This figure illustrates the number of responding departments in 4 groups by faculty size (0–20, 21–40, 41–60, more than 60) over 4 yr. χ^2 analysis revealed no differences in the distribution of responding programs between the 2000 and 2003 surveys.

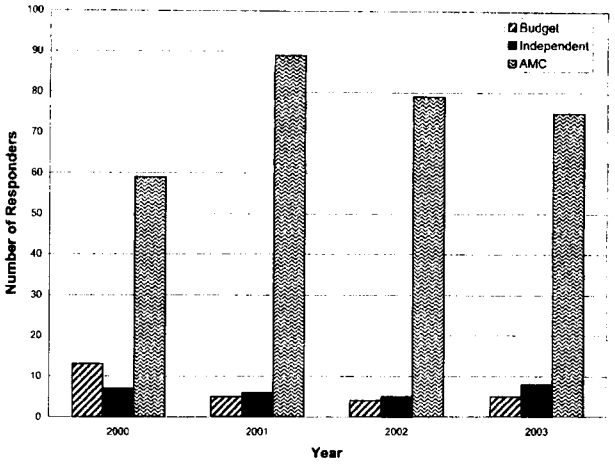

Figure 3. This figure illustrates the number of responding departments by department funding category (Academic Medical Center Model [AMC], Budgeted Model, and Independent Model). Although there appears to be a decrease in responding departments in the Budgeted Model, these departments did not contribute financial data.

funded their CRNA salaries with 22% (n = 15) only partially funded their CRNA salaries. Thirty-four percent (n = 23) of CRNAs were completely funded by the hospital. The details of CRNA support dollars were beyond the scope of the three follow-up surveys, so the reason for the wide variation in hospital support cannot be definitively linked to CRNA costs.

We conclude that the current shortage of anesthesiologists in the U.S. has resulted in significant salary increases for faculty in the U.S. training programs and thus, departments have become increasingly dependent on institutional support to provide those salaries. Despite this increased funding, the financial condition of the U.S. departments is deteriorating, academic time is decreasing, and 25% of departments have closed an anesthetizing location because of a lack of faculty. These trends may gradually reverse as the size of the graduating residency class increases over the next 5 years.

Appendix 1.

2003 Follow-Up SAAC/AAPD Survey

This is a follow-up survey to the Perfect Storm Report.
Please reply by following the directions below:
1. Select "Reply" to this e-mail message.
2. Scroll down and answer the questions by clicking in between the parenthesis.
3. Send/Return this email to me.

I. Staffing

How many employed FTE faculty anesthesiologists do you have? __
Do you have open faculty positions? Yes ( ) No ( )
If yes, how many? ( )
Do you have CRNAs? Yes ( ) No ( )
If yes, how many CRNAs do you have in total? __
If yes, how many does the department pay for? __
Do you have open CRNA positions? Yes ( ) No ( )
If yes, how many? ( )

II. Residents and the 80 hour workweek

How many residents are in your program? __

How many residents are paid by the department? __
Do you anticipate having to hire/recruit additional personnel because of the new Residency Review Committee (RRC) mandated resident work rules?
Yes ( ) No ( )
If yes, if adding residents is an option for you, how many additional residents have you added? __ How many still needed? __
If yes, how many additional CRNAs have you added? __ How many still needed? __
If yes, how many additional faculty anesthesiologists have you added? __
How many still needed? __
III. Department Finance (for fiscal year ending 6/30/03)
Did your department have a positive margin? Yes ( ) No ( )
(not including gifts or investments)
How much $__ Percentage of total budget__%
Did your department have a negative margin? Yes ( ) No ( )
(not including gifts or investments)
How much $__ Percentage of total budget__%
IV. Departmental Financial Support from Hospital, Medical School or other sources.
What is your annual support for your department from all sources (hospital, medical school, state, etc)
How much from the Hospital? $__ Percent of total budget__%
How much from the Med School? $__ Percent of total budget__%
How much from Other sources? $__ Percent of total budget__%
V. Faculty Academic Time.
What is the average amount of non-clinical (academic) time per faculty, not counting the day after in-hospital call? (one day per week = 20%).__%

Appendix 2.

Mini-survey in follow-up to August 2003 survey

Thank you for completing the 2003 Follow-Up SAAC/AAPD Survey. Below are three additional questions that we would like to add to the results. It would be greatly appreciated if you would take a few moments to complete the questions.
Please reply by following the directions below:
1. Select "Reply" to this e-mail message.
2. Scroll down and answer the questions by clicking in between the parenthesis.
3. Send/Return this email to me.
What is your unit value charge for anesthesia? $__ per unit
Have you reduced or closed any anesthetizing locations (OR or offsite) due to lack of faculty?
Yes ( ) No ( )
Have you reduced or closed any anesthetizing locations (OR or offsite) due to lack of CRNAs?
Yes ( ) No ( )
Thank you for taking the time to complete this e-mail.
Sincerely,

Kevin K. Tremper, PhD, MD
Robert B. Sweet Professor and Chair
Department of Anesthesiology
University of Michigan

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Trends in Financial Status of United States Anesthesiology Training Programs: 2000 to 2004

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Running Title: Faculty and Finances: Trends 2000-2004

Abstract:

The decrease in resident applicants for United States anesthesiology training programs in the mid 1990s has resulted in a national anesthesiologist shortage. This shortage has been associated with increased salaries for anesthesiologists in academic institutions. Salary increases have placed the financial condition of academic training departments in jeopardy, requiring increasing support from their institutions. In the year 2000, a nationwide survey of the financial status of the U.S. anesthesiology training programs was conducted. Follow-up surveys have been conducted each year thereafter. We present the results of the fifth such survey. One-hundred-twenty-eight departments were surveyed, with a response rate of 73%. The average department employs 45 faculty and 81% of those departments have an average of 3.3 open positions. Of the 91% of departments who employ Certified Registered Nurse Anesthetists (CRNAs) (an average of 25 CRNAs/dept), 73% have an average of 4.2 open CRNA positions. The average department received $3,787,835 (or $97,621/faculty) in institutional support, which is an increase over the 2003 amount of $85,607/faculty. In 36.6% of the departments a portion of these support dollars ($1,888,111) was provided to support CRNA salaries. Therefore, the support to departments for faculty averaged $81,696/faculty, after the CRNA dollars were removed. Faculty academic time averaged 16% (where 20% is one day/week) and departments billed an average of 11,954 anesthesia units/faculty/year. These results demonstrate a continued shortage of anesthesiology faculty and continued institutional support to keep these training programs financially viable.

Keywords: 1) Education: faculty; academic, shortage

2) Economics: medical center support

3) Statistics: survey

Implication Statement: United States anesthesiology training programs continue to have open faculty positions. The institutional support continues to grow averaging $97,621/faculty in 2004, which is a 63% increase over the support in 2002.

INTRODUCTION

In the late 1990's there was a dramatic decrease in the number of medical students entering anesthesiology training programs in the United States (U.S.).(1) The entering residency class size, not only decreased to less than half its previous size, but half of those residents in training were international medical graduates (IMG). Since many IMG residents train in the U.S. on J-1 visas, they are required to return to their home country at the completion of their training, and therefore, cannot enter the U.S. workforce for at least two years.(2,3) Starting in the year 2000 it became evident that there was a significant national shortage of anesthesiologists that could persist for more than a decade. (2,3) This shortage of anesthesiologists affected not only community practice, but also the ability of academic training programs to recruit and retain faculty. (4-6) Competition for qualified anesthesiologists resulted in increasing salaries for faculty, which placed academic programs in financial jeopardy at a time when managed care had reduced professional fee income and academic medical centers (AMC) were also struggling to control costs. (4-9) In the fall of 1999, the Society of Academic Anesthesiology Chairs/Associate of Anesthesiology Program Directors (SAAC/AAPD) Counsel commissioned a white paper to be written to provide background information regarding these financial threats to the U.S. training programs.(5) Data for this report were derived from a variety of sources, including a survey of the U.S. anesthesiology training programs conducted in the summer of 2000 and presented at the fall 2000 SAAC/AAPD National Meeting. (4,5) Follow-up surveys have been conducted in the fall of 2001, 2002, and 2003; all have demonstrated a continued shortage of faculty and a progressive increase in financial support from their institutions. (6,10) The purpose of this current article is to report the results of the most recent follow-up survey (fall of 2004) and compare these data to those of the previous four years.

METHODS

For the past five years, email surveys have been sent to program directors of U.S. anesthesiology training programs. (10) The follow-up surveys conducted in 2001, 2002, and 2003 have focused on: open faculty positions, open certified registered nurse anesthetist (CRNA) positions, department financial margins, and the amount of institutional support received. In the previous surveys it was not determined whether the financial support from the institution included support for the salaries of CRNAs. Since the budgeting of CRNA salaries may occur under the hospital or the department, and may be funded independently or as a portion of the department's overall institutional support, it is important to clarify the accounting of these funds. With these additional data, the institutional support for faculty and academic programs can be determined. Therefore, the 2004 survey asked specifically if the institutional support includes funds used to pay for CRNA salaries and, if so, what is that dollar amount? (APPENDIX I) After their Fall 2004 meeting, SAAC/AAPD leadership requested that the total number of anesthesia units billed by a department per year, also be surveyed. (APPENDIX II) The first email survey was sent in September and email reminders were sent approximately every 2 weeks for the next 16 weeks to those who did not respond. The anesthesia unit survey was sent in November and email reminders were sent to nonresponders every two weeks for the next 12 weeks.

RESULTS

The surveys in APPENDIX I and II were distributed by email to 128 SAAC/AAPD member department chairs. An overall response rate of 73% (94/128) was achieved. The results are presented in Tables 1-6. The average department has 45 faculty and for 91% of those departments who have CRNAs, they have 25 CRNAs. (Table 1) There are an average of 3.3 open faculty positions in the 81% of responding

departments who have open positions. Of the 91% of responding departments who employ CRNAs, 73% had an average of 4.2 open CRNA positions. (Table 2) Overall, the departments' provide faculty with 16.1% nonclinical time (Table 6), where one day per week is considered 20%. (APPENDIX I) If faculty are not required to start clinical responsibilities until the afternoon, that pre-call day is considered nonclinical (academic) time.

From a financial funds flow perspective, U.S. anesthesiology training departments can be divided into three types: Academic Medical Center (AMC) Model programs are those with departments within medical schools; "budgeted departmental model" (Budgeted Model) are those in which departments are part of a larger clinical enterprise which manages the finances; and the "independent department model" (Independent Model) where the departments are structured like private practice groups. (6) The financial data for this report are from the AMC Model and Independent Model departments, since the financial data are unavailable in the Budgeted Model.

For the purposes of this survey a faculty full-time equivalent (FTE) is an anesthesiologist who is on the department's budget. (APPENDIX I) For the fiscal year ending June 30, 2004, 55% of departments responded that they had achieved a positive margin of $949,386 ($27,416/FTE) while 42% responded they had a negative margin of $1,566,700 ($35,521/FTE). (Table 3) These margins were determined after the inclusion of institutional support which averaged $3,787,835 or $97,621/faculty FTE. (Table 4, Figures 1a, 1b) For 36.6% of the respondents this support included funds used to pay CRNA salaries, which averaged $1,888,111. Therefore, the institutional support for departments after CRNA support dollars are removed average $3,210,295 or $81,696/faculty FTE. (Table 4, Figures 1a, 1b) The majority

of this support is being provided by the hospital; average hospital support = $2,968,068, medical school support = $745,035, and support from other sources = $1,064,207. (Table 5)

The average anesthesia unit value charge was $75.96 and the average number of units billed by a department was 483,747 units or 11,954/faculty FTE. (Table 4)

DISCUSSION

Although there appears to be a continued shortage of anesthesiologists nationwide, data from this most recent survey reveal a slight decrease in open faculty positions per department from 3.7 in 78% of departments in 2003 to 3.3 open faculty positions in 81% of departments in 2004. This decrease in open positions is consistent with the results of the annual survey of the Society of Academic Anesthesiology Chairs (SAAC) which reported 192 open positions (or 2.4 positions/dept) in 2004 where there were 266 open positions (or approximately 3.1 positions/dept) for the survey in 2003. (2004 SAAC Salary Survey, personal communication with Rebecca Lovely, University of Florida Gainesville, FL) (8) This may be due to a greater availability of anesthesiologists or a larger percentage of graduating residents choosing an academic career. The progressive increases in academic salaries may make recruiting faculty easier. In the year 2000, according to the SAAC Salary Survey, an assistant professor paid at the 50th percentile received $183,000/year. This increased to $209,000 in 2002, $226,000 in 2003, and $242,821 in 2004. (8) Over the last 4 year period the average institutional support/FTE has increased from approximately $34,000 to more than $97,000. (Table 4, Figure 1b) This $63,000 increase in institutional support is very similar to the salary increase of the average assistant professor over the same period of time. The salary increase found in the SAAC Salary Survey shows a similar trend as that found in the Association of American Medical Colleges (AAMC) and Medical Group Management Association (MGMA) Salary

Reports. Although both of these reports lag one year behind the SAAC Salary Survey reports because of the time associated with data retrieval and publication. (7-9) Although the average support for departments per faculty increased in the past year from $85,607 to $97,621, it is clear that in some departments a portion of the support has been used for CRNA salaries. It is unclear how much of the support to departments from previous years was attributed to CRNA salaries, but it is unlikely that the departmental support has decreased in 2004. It is more likely that a significant proportion (15 to 20%) of the support to departments in previous years had been associated with the support of CRNA salaries. From these most recent data, approximately one-third of the departments received support for CRNA salaries included in their overall departmental support, whereas two-thirds have CRNA salaries funded through another mechanism e.g. they are hospital employees. The largest portion of department support is provided by the hospital and has increased over the past 5 years.(Table 5) This willingness of the hospital to provide support to anesthesiology departments is most likely due to the hospital's financial imperative to maintain operating room productivity and revenues. Without anesthesiology faculty this could not be accomplished. It is also clear that there is great variability between institutions and departments in their financial status and institutional support. (Figure 1a.) These data are also not normally distributed with mean support well above the median. The institutional support per faculty FTE has a mean of $97,621, a median of $75,000, and a 25% and 75% range of $37,467 and $127,087. (Figure 1b., Table 4)

In addition to a slight decrease in the number of open faculty positions, it appears the average amount of academic time may have also increased slightly in the past year from 13.8% nonclinical time in 2003 to 16.1% in 2004, where one day/week is considered 20% time.(Table 6) The average anesthesia charge has increased only $1.16 or 1.6% over the past year, where it had increased 19.5% between 2000 and

2003. This survey did not request any information regarding payor mix or collection rate. Since most payor reimbursements are unrelated to charges, these data should not be interpreted as significantly affecting department revenue.

The number of anesthesiology units billed per faculty may be only a crude measure of the ability of a faculty to generate professional fees sufficient to cover their expenses. The net income associated with that professional fee effort is to a much greater extent dependent on the payor mix of the patients cared for and the overhead associated with the practice. Neither of these crucial financial measures was within the scope of this follow-up survey. It has also been demonstrated that the number of anesthesiology units generated by a faculty member is not a good measure of faculty productivity. (11-14) It is a better measure of faculty and operating room (OR) utilization. (11-14) That is, if the ORs to which a faculty is assigned are well utilized by the surgical staff, then that faculty anesthesiologist will be able to generate more units, especially if there are more cases of shorter duration. (11-14) If faculty are assigned to out of OR locations, such as, radiology, electrophysiology, and labor and delivery then, although the faculty time is consumed, the ability to generate anesthesia professional fees is greatly reduced. Billable hours of anesthesia service may be a better measure of anesthesiologist productivity but that was also beyond the scope of this survey. (13,14) Anesthesiology units/FTE/year also does not account for faculty time and fees generated in non OR areas, such as, critical care units and pain management centers. These anesthesia unit data are provided here to give a rough guide of the relative utilization of anesthesiology faculty for OR services.

Survey data, in general, may misrepresent reality because of a small response rate, a skewed response population, or errors in the respondents understanding of the survey questions. The 73% response rate

of this current survey compares favorably with the 25%-31% response rate of the MGMA reports. (7-9) The large response rate achieved in this survey is likely attributed to the fact that the respondent program directors were informed that they would receive the results of this survey at their national meeting and these results may be useful to them in managing their departments. In addition, because this is the fifth consecutive year of surveying the same population regarding a similar topic, it is likely that these data are at least consistent and potentially improved over the previous 4 years.

A critical number in this analysis is the faculty count, i.e. "employed FTE faculty anesthesiologist." (APPENDIX I) This was meant to be the number of employed faculty anesthesiologists, not their clinical commitment. If the individual filling out the survey misinterprets this question then all the subsequent data, which are normalized to the faculty FTE count, would be in error. The average number of faculty per department of 45.3 from this survey is similar to 43.2 faculty from the 2004 SAAC survey, providing some confirmatory data. All the results of the survey, as with all surveys, are dependent upon the respondents understanding what is being asked.

We conclude from this fifth survey that the U.S. anesthesiology training programs still require substantial support to maintain financial viability. The average department is receiving nearly $82,000/faculty in institutional support after the expenses of CRNAs are removed. In spite of this support, on average, the departments continue to have a negative margin. It also appears that the faculty shortage in academic departments may be easing slightly, possibly due to increased salaries and a small increase in academic time.

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Table 1. Faculty and Certified Registered Nurse Anesthetists (CRNA) Staffing.

2004	Mean ± SD	High	Low	Median
Faculty (N=88)	45.3 ± 25.4	132.60	8.0	40.88
CRNA (N=86) *	24.8 ± 41	252.0	1.0	13.38

*91% of Departments have CRNAs

Table 2. Open Faculty and Certified Registered Nurse Anesthetist (CRNA) Positions

	2000	2001	2002	2003	2004
Open faculty positions (No.)	3.8	3.9	3.4	3.7	3.3
Number of faculty	35.8	37.6	38.9	39.7	45.3
Departments with open positions (%)	91.5	83.5	78.4	78.4	81
Open CRNA positions (No.)	4.0	4.4	3.6	3.9	4.2
Number of CRNA	17.6	*	*	25.1	24.8
Departments with open positions (%)	66.5	75.0	67.18	63.6	73

*2001 and 2002 surveys did not request these data.

Table 3. Department Margin Analysis Fiscal Years 2000-2004

Department Margin	2000 N=100	2001 N=81	2002 N=88	2003 N=90	2004 N=94
Positive Margin	53% (n=35) $1,817,299 $50,481/FTE*	53% (n=44) $577,666 $15,202/FTE	65% (n=56) $1,102,719 $28,354/FTE	58% (n=47) $636,338 $15,908/FTE	55% (n=46) $949,386 $27,416/FTE
Negative Margin	44% (n=29) $847,306 $23,814/FTE	38% (n=20) $840,400 $21,491/FTE	33% (n=28) $1,572,021 $40,423	38% (n=31) $1,704,139 $42,603/FTE	42% (n=35) $1,566,700 $35,521/FTE
Total Margin	$936,786 (n=66) $37,308/FTE	-$116,528 (n=69) -$4,844/FTE	$32,803 (n=86) -$495/FTE	-$460,760 (n=82) -$14,759/FTE	-$215,901 (n=84) -$1,309/FTE
Response Rate	66.2%	72.5%	63.8%	65%	73%

*FTE = full-time equivalent

Table 4. Average Institutional Support, Anesthesia Unit Value, and Anesthesia Units Billed/Full-Time Equivalent (FTE)

Year	2000 (N=100) +	2002 (N=88)	2003 (N=90)	2004 (N=94)
Total Support	$1,235,474 (n=77)	$2,329,748 (n=46)	$3,424,296 (n=70)	$3,787,835 (n=85)
25%	$204,772	$562,500	$1,210,000	$1,700,000
Median	$500,000	$1,175,388	$2,350,000	$2,700,000
75%	$1,747,433	$2,500,000	$4,934,351	$5,500,000
Support/FTE	$34,319 (n=77)	$59,906 (n=46)	$85,607 (n=70)	$97,621 (n=85)
25%	$9,366	$14,464	$30,067	$37,467
Median	$18,669	$30,223	$70,684	$75,000
75%	$54,282	$64,284	$133,413	$127,087
Total Support Less CRNA Support*	†	†	†	$3,210,295 (n=85)
25%				$1,318,093
Median	†	†	†	$2,397,220
75%				$4,491,252
Total Support Less CRNA Support/FTE*	†	†	†	$81,696 (n=85)
25%				$31,250
Median	†	†	†	$63,750
75%				$100,361
Anesthesia unit value charge	62.60 (n=78)	◊	74.80 (n=76)	75.96 (n=79)
Anesthesia units/FTE	◊	◊	◊	11,954 (n=79)
25%				$8,458
Median	†	†	†	$11,156
75%				$13,566

+2000 support data only represents hospital support.

*36.6% of departments received an average of $1,888,111 of support for Certified Registered Nurse Anesthetist (CRNA) salaries.

† 2000, 2002, 2003 surveys did not ask for specific CRNA support data.

◊ Data were not requested on these surveys.

Table 5. Itemized Institutional Support: Hospital, Medical School and Other

Year	2000 (N=100)	2002 (N=88)	2003 (N=90)	2004 (N=94)
Hospital Support	$1,235,474 (n=77)	†	$2,396,983 (n=73)	$2,968,086 (n=81)
	†	†	18.6% (n=75)	14.87% (n=81)
Medical School Support	†	†	$613,919 (n=75)	$745,035 (n=81)
	†	†	5.4% (n=77)	5.56% (n=81)
Other Support	†	†	$901,787 (n=70)	$1,064,207 (n=80)
	†	†	8.36% (n=75)	4.85% (n=80)
Total Support	$1,235,474 (n=77)	$2,329,748 (n=46)	$3,424,296 (n=70)	$3,787,835 (n=85)

† 2000 and 2002 surveys did not ask for these data.

Table 6. Faculty Academic Time

	2000 (N=100)	2003 (N=90)	2004 (N=94)
Faculty Academic Time (%)	20.0 (n=80)	13.8 (n=84)	16.1 (n=87)

20% = 1 day/week

LEGENDS

Figure 1a. This figure presents total institutional support for anesthesiology departments from the years 2000 to 2004. For each year the high and low lines are the 90^{th} percentile and 10^{th} percentile, the edges of the boxes are the 75^{th} and 25^{th} percentile, and the line in the middle of the box is the median value. Note the box on the far right represents the institutional support to the department with the CRNA salary support subtracted.

Figure 1b. This figure presents the total institutional support per faculty anesthesiologist FTE from the years 2000 to 2004. For each year the high and low lines are the 90^{th} percentile and 10^{th} percentile, the edges of the boxes are the 75^{th} and 25^{th} percentile, and the line in the middle of the box is the median value. Note the box on the far right represents the institutional support per faculty FTE with the CRNA salary support subtracted.

Society of Academic Anesthesiology Chairs/Association of Anesthesia Program Directors (SAAC/AAPD) 2004 Follow-Up Survey
Please Fax responses to: Amy Shanks at 734-763-8125

Note: All information is confidential. The fax number is the private fax of Amy Shanks and the information submitted will only be viewed by Amy.

Name:_____

Institution:_____
(This information is only used for tracking purposes. It is never reported with the results.)

I. Staffing

How many employed FTE faculty anesthesiologists do you have? _____
(These are faculty anesthesiologists who are on your budget)

How many open faculty positions do you have? _____

How many CRNAs do you have? _____

How many open CRNA positions do you have? _____

II. Department Finance (for fiscal year ending 6/30/04)

What is your department's total budget? $_____

Was your department margin* positive? ( ) or negative? ( ).
By how much?$_____ Percentage of total budget_____%
(*not including gifts or investments)

III. Departmental Financial Support from Hospital, Medical School or other sources.

What is the annual institutional support for your department from all sources (hospital, medical school, state, etc*) $_____
(*this does not include pro-fee income, research grant, gift or endowment income.)

How much from the Hospital? _____
Percent of total budget _____%

How much from the Med School? $_____
Percent of total budget _____%

How much from Other sources? $_____
Percent of total budget _____%

Does your institution support include funds which are used to pay for CRNA salaries?
Yes ( ) No ( )
If yes, how much? $_____

IV. Faculty Academic Time

What is the average amount of non-clinical (academic) time per faculty, not counting the day after in-hospital call? (one day per week = 20%). _____% (for this calculation, if your faculty start late on the day they are on in-hospital call, count this as an academic day)

If your faculty start late on the day of in-hospital call, do you ordinarily count this day as an academic day? Yes ( ) No ( )

V. Unit Value Charge

What is your unit value charge for anesthesia? $_____

Thank you for taking the time to complete this survey.

KKT:as:11/02/04

APPENDIX II

Follow-Up Question to SAAC/AAPD Sent via Email on November 17, 2004:

It has become very important to know how many units per faculty are being billed by each of our departments. Since the rest of our medical schools and institutions use RVUs (relevant value units) and for the vast majority of our income we use anesthesia units, it is difficult for us to compare ourselves with other specialties. Therefore, data that compares us amongst ourselves can be very valuable. Please answer the following question:

How many anesthesia units did you bill last year, (July 1, 2003-June 30, 2004)? _____ total units.

For example, the Department of Anesthesiology at the University of Michigan billed 737,328 total units, (total units = base units and time units).

As before, hit the reply to message button and type your number in the space provided. You will receive this information along with an update of all the other responses in the near future.

Thank you.

Kevin K. Tremper, PhD, MD
Robert B. Sweet Professor and Chair
Department of Anesthesiology
University of Michigan

Figure 1a. Total Institutional Support

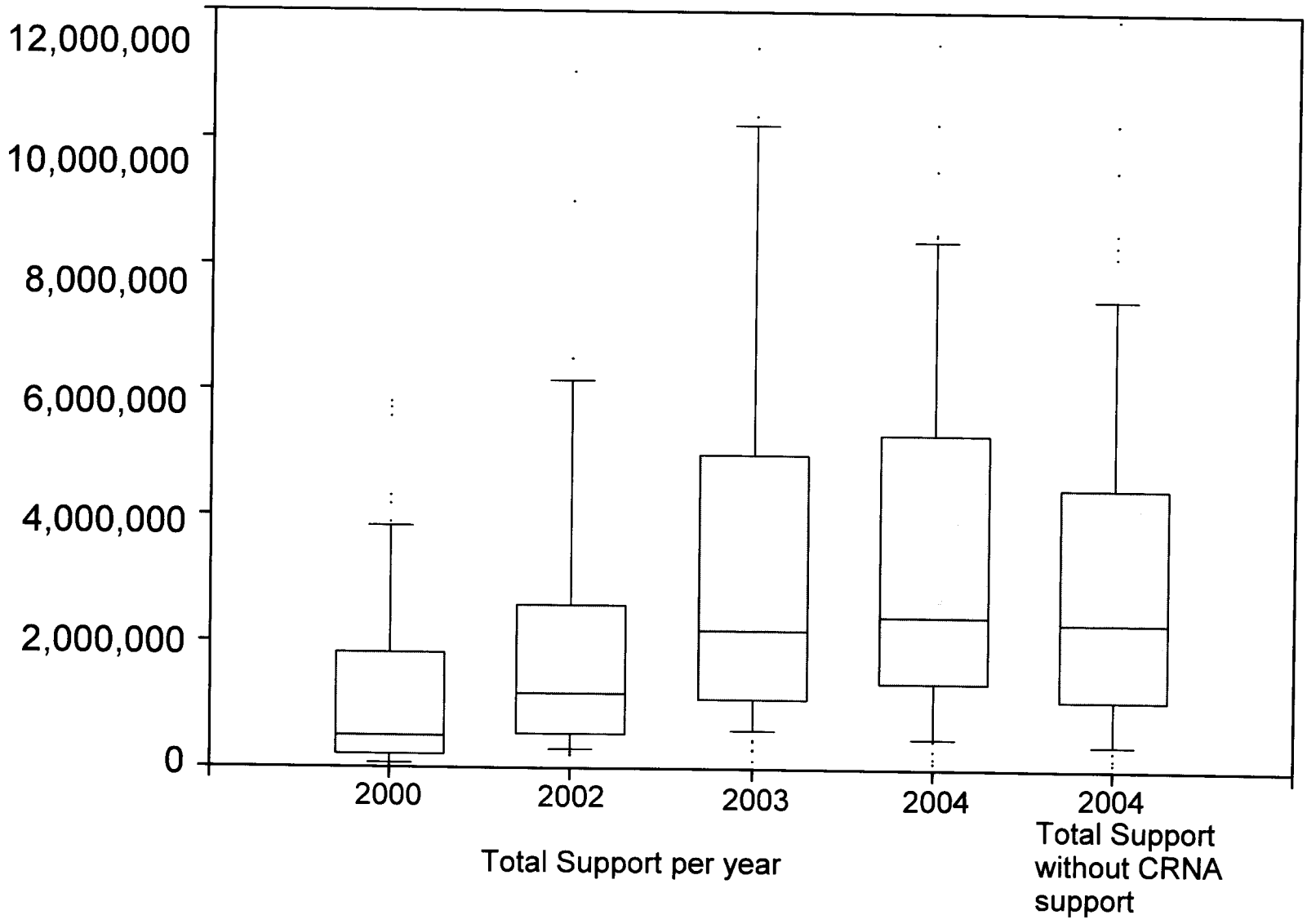
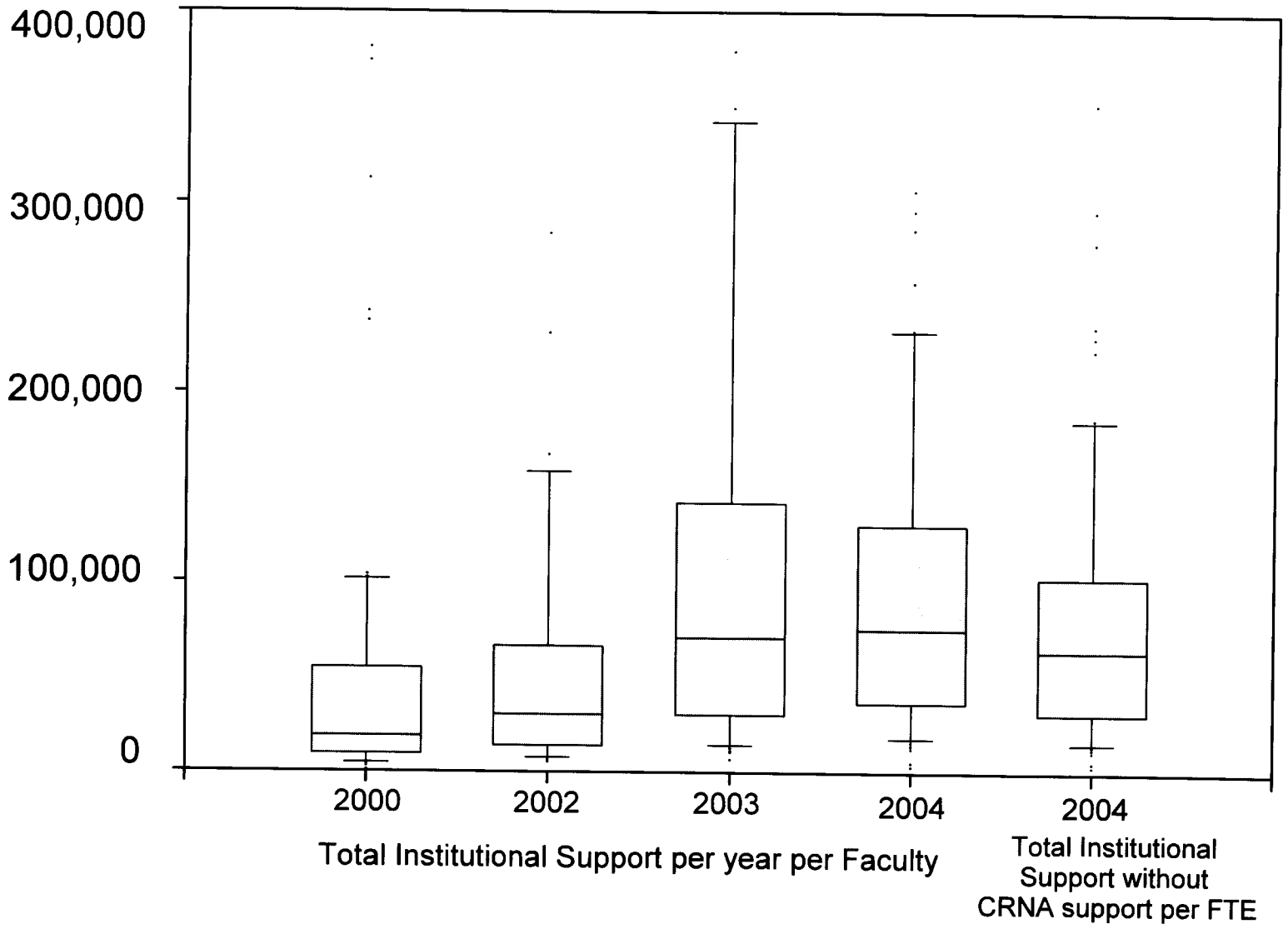


Figure 1b. Total Institutional Support per Faculty



Submitter : Mrs. Kathy Mann **Date:** 08/29/2005

Organization : Mrs. Kathy Mann

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

GPCIs Please increase reimbursement payments to Santa Cruz County, California physicians & surgeons commensurate with surrounding counties. Santa Cruz County is no longer "rural". Thank you.

Submitter : Mrs. Stacie Fontinell **Date:** 08/29/2005

Organization : Mrs. Stacie Fontinell

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

Please change the rural status of Santa Cruz County to urban. While we do have a lot of trees, it is no way rural. The cost of living is higher then Santa Clara County. Housing is exorbitant. It doesnt seem fair that we have to go "over the hill" to find specialist care. This can be very hard on our older population. Please help us keep our qualified doctors who can not afford to live in Santa Cruz!

Submitter : **Judith Burseth** **Date: 08/29/2005**

Organization : **Judith Burseth**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

I feel strongly that Santa Cruz County, CA should have an Urban designation for Medicare payments. Our county is growing and thriving. It is important for us to be classified as urban, when our population continues to grow and neighboring Urban areas are coming closer and closer.
Thank you,
Judy Burseth

Submitter : Ms. Susan Bowie **Date:** 08/29/2005

Organization : St.mary's Regional Medical Center

Category : Device Association

Issue Areas/Comments

GENERAL

GENERAL

Apligraf,being a bioengineered tissue product,has significantly decreased the amount of time to heal for our compromised diabetic patients which in turn can significantly decreased the amputation rate. Reimbursement for apligraf at the current proposed outpatient rate would significantly jeopardize patient access and hospital purchase of this product.
We petition CMS to correct the error in the proposed ruling and ensure that Apligraf and Dermagraft are reimbursed as a specified covered drug,at ASP+8%.
Thank you for allowing this comment.

Sincerly,

Susan E.Bowie,Nursing Director
St. Mary's Regional Medical Center
Wound Center

Submitter : **Dr. Randall Malchow** **Date: 08/29/2005**

Organization : **Brooke Army Medical Center**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

Submitter : Dr. Edward Nemergut **Date:** 08/29/2005

Organization : University of Virginia

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1502-P-366-Attach-1.DOC

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

Dear Dr. McClellan:

I am writing to urge the Centers for Medicare and Medicaid Services (CMS) to immediately 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 increased need for surgical services.

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

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

This past week, I personally provided anesthesia care for two medicare patients undergoing simultaneous neurosurgical procedures with the same surgeon. How can it be fair for the surgeon to collect 100% of his fee for both patients while I am penalized to collect only 50% on each patient when we are both working with the same patients? This discriminatory practice is beyond ridiculous.

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,

Edward C. Nemergut MD
Assistant Professor of Anesthesiology and Neurosurgery
University of Virginia Health System
Department of Anesthesiology
PO Box 800710
Charlottesville, VA 22908-0710
T (434) 924-2283
F (434) 982-0019
en3x@virginia.edu

Submitter : Dr. Timothy Martin **Date:** 08/29/2005

Organization : University of Arkansas for Medical Sciences

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

See attachment.

CMS-1502-P-367-Attach-1.DOC

August 29, 2005

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

RE: TEACHING ANESTHESIOLOGISTS (CMS-1502-P)

To whom it may concern:

As a physician and anesthesiologist who has been involved in the education and training of anesthesia residents for my entire career, I am writing to express my frustration and dissatisfaction with the existing CMS rules for the reimbursement of teaching anesthesiologists who are concurrently supervising and teaching two anesthesia residents. Under the existing rules, even if two residents who are supervised by one attending anesthesiologist have anesthesia cases that overlap by as little as one minute, the Medicare fee for BOTH entire cases is reduced by 50%. This practice is unfair and unsustainable, and has already created significant financial distress for most of this nation's academic anesthesiology departments in recent years. The financial distress has been magnified by the ongoing severe shortage of anesthesiologists, which itself has been perpetuated in part by inadequacies in teaching anesthesiologist reimbursement.

At the hospital and university where I practice (Arkansas Children's Hospital and the University of Arkansas for Medical Sciences), we care for some of the sickest and poorest patients in the state and this region of the U.S. The existing teaching anesthesiologist rules have aggravated an already difficult financial situation for the hospital and the university. We have experienced significant difficulty in recruiting enough appropriately trained faculty anesthesiologists to meet burgeoning clinical demands at our three affiliated teaching hospitals. At this time, the hospitals and university must subsidize the clinical revenues of the anesthesiology department to the tune of approximately $120,000 per faculty member to compensate for the inadequacies of teaching anesthesiologist reimbursement.

The irony of the teaching anesthesiologist reimbursement rules is that a faculty surgeon may supervise surgery residents in two overlapping operations and collect 100% of the Medicare fee for each case from Medicare. An internist may supervise medicine residents in four overlapping outpatient visits and collect 100% of the fee for each visit when certain requirements are met. Again, and with as little as one minute of overlap, a teaching anesthesiologist may only collect 50% of the Medicare fee when supervising two anesthesia residents with overlapping cases. Make no mistake: when a teaching anesthesiologist must supervise two residents for overlapping cases, he or she has incurred added liability and risk, and much greater stress. It is truly a wonder that many

teaching anesthesiologists have refused to accept responsibility for more than one patient at a time when working with residents. I suspect it is a desire to help the patient flow of busy operating rooms and to attempt to meet the huge demand for clinical services in our nation's teaching hospitals that most teaching anesthesiologists have continued to care for concurrent patients with anesthesia residents, even if it is to the financial detriment of the department, university or hospital.

The academic anesthesiology financial problems are further compounded by the fact that the Medicare anesthesia conversion factor is less than 40% of commercial reimbursement rates for anesthesia services, which creates a far wider Medicare-commercial reimbursement rate gap than exists for most other physician services. The CMS teaching anesthesiologist reimbursement rules add insult to injury when the fees are reduced by 50% for the teaching anesthesiologist who supervises two anesthesia residents. In many locales, CMS teaching anesthesiologist reimbursement is less than what one might collect driving a taxicab for a comparable amount of time!

I strongly urge correction of the seriously flawed teaching anesthesiologist reimbursement methodology.

Sincerely,

Timothy W. Martin, MD, MBA
Professor of Anesthesiology
Vice Chair for Education and Administration
Department of Anesthesiology
UAMS College of Medicine

Chief, Division of Pediatric Anesthesia
Arkansas Children's Hospital

Submitter : Dr. Hugh Hemmings **Date:** 08/29/2005

Organization : Weill Cornell Medical College

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

See attachment

CMS-1502-P-368-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:

As a Professor of Anesthesiology at a major metropolitan medical center, I am writing to urge the Centers for Medicare and Medicaid Services (CMS) to change the Medicare anesthesiology teaching payment policy.

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

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

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

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

Please end the anesthesiology teaching payment penalty.

Vice Chair for Research in Anesthesiology
Director, Institute for Neuronal Cell Signaling

Professor of Anesthesiology and Pharmacology
Department of Anesthesiology, Box 50, LC-203
Weill Medical College of Cornell University
525 E. 68th Street
New York NY 10021

Submitter : Dr. Alan Kuhel **Date:** 08/29/2005

Organization : Cleveland Clinic Foundation

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. Dan Biggs **Date:** 08/29/2005

Organization : University of Oklahoma

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

Dear Dr. McClellan,

I am writting the CMS to urge you to change the discriminatory payment method that Medicare applies to anesthesiology teaching programs. Unlike surgery or medicine, whose attending physicians are allowed to work with residents on concurrent procedures, as long as the attending is present for the key portions of each, they are paid full charges for several at the same time. eg. surgeons can bill for 2 concurrent procedures. Anesthesiologists, when working with 2 redidents each on a differnt case, has the Medicare payment reduced by 50% for each procedure. This is not fair. We should be treated the same as other specialties.

This inequity results in a decrease in revenue to our department of approximately 1/2 million dollars. It has a serious detremental effect on recruiting and retaining quality faculty needed to train residents.

I am only requesting that anesthesia teaching be treated like everyone else.
Please end the anesthesiology teacying payment penalty.

Dan Biggs, M.D.
Department of Anesthesiology
University of Oklahoma
920 Stanton L. Young
Oklahoma City, OK 73104

Submitter : **Dr. Brian Vaughan** **Date: 08/29/2005**

Organization : **Dr. Brian Vaughan**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

Dear Dr. McClellan:
I am writing to urge the Centers for Medicare and Medicaid Services (CMS) to change the Medicare anesthesiology teaching payment policy.
Medicare's discriminatory payment arrangement, which applies only to anesthesiology teaching programs, has had a serious detrimental impact on the ability of programs to retain skilled faculty and to train the new anesthesiologists necessary to help alleviate the widely-acknowledged shortage of anesthesia providers -- a shortage that will be exacerbated in coming years by the aging of the baby boom generation and their need for surgical services.
Under current Medicare regulations, teaching surgeons and even internists are permitted to work with residents on overlapping cases and receive full payment so long as the teacher is present for critical or key portions of the procedure. Teaching surgeons may bill Medicare for full reimbursement for each of the two procedures in which he or she is involved. An internist might 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.
Brian Vaughan
29 Locust Hill Road
Cincinnati, OH 45245

Submitter : Dr. Gloria Walters **Date:** 08/29/2005

Organization : Mayo Clinic

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

see attachment

CMS-1502-P-372-Attach-1.DOC

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

Dear Dr. McClellan:

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

Medicare's discriminatory payment arrangement, which applies only to anesthesiology teaching programs, has had a serious detrimental impact on the ability of programs to retain skilled faculty and to train the new anesthesiologists necessary to help alleviate the widely-acknowledged shortage of anesthesia providers -- a shortage that will be exacerbated in coming years by the aging of the baby boom generation and their need for surgical services. Even the most altruistic of practitioners has to give pause to a difference of greater than 50% in their pay, not to mention a longer, more burdensome work day [made so by a dearth of fellows with whom to share the load].

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

Teaching anesthesiologists are also permitted to work with residents on overlapping cases so long as they are present for critical or key portions of the procedure. However, unlike teaching surgeons and internists, since 1995 the teaching anesthesiologists who work with residents on overlapping cases face a discriminatory payment penalty for each case. The Medicare payment for each case is reduced 50%. This penalty is not fair, and it is not reasonable. Continued over time, this policy will erode the ability of teaching institutions to sustain competitive and vital anesthesiology residency programs.

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,

Gloria Walters, M.D., M.Arch.

Mayo Clinic

Rochester, MN

Submitter : Dr. Alan Marco **Date:** 08/29/2005

Organization : Medical University of Ohio

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

see attachment

CMS-1502-P-373-Attach-1.DOC

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

Dear Dr. McClellan:

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

Medicare's discriminatory payment arrangement, which applies only to anesthesiology teaching programs, has had a serious detrimental impact on the ability of programs to retain skilled faculty and to train the new anesthesiologists necessary to help alleviate the widely-acknowledged shortage of anesthesia providers. In my practice, Medicare and Medicaid account for about 41% of our activities and the unfair reimbursement practice has seriously affected my ability to recruit new faculty (I have two current openings out of 15 and we are building four more operating rooms to handle our increased volume). Additionally, I have been unable to arrange learning opportunities with our community partner hospitals specifically because of the economic disadvantage of the 50% fee reduction when working with residents.

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 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.

Funds that could be used for furthering the research mission of our department are being diverted to support clinical activities because of the inequity in teaching anesthesiologist

reimbursement. Fixing this inequity will help ensure that the United States maintains its leadership position in medical research.

Correcting the inequity in teaching anesthesiologists' reimbursement 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,

Alan P. Marco, MD, MMM
Associate Professor and Chairman
Department of Anesthesiology
Medical University of Ohio
Hospital, Room 2195
3000 Arlington Avenue
Toledo, OH 43614-2598

Submitter : Dr. Steven Deem **Date:** 08/29/2005

Organization : Dr. Steven Deem

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

Dear Dr. McClellan:
I am an anesthesiologist at the University of Washington, Harborview Medical Center, Seattle, WA. Harborview is the only Level 3 trauma center in a 5 state area of the Pacific Northwest, and also provides care to a large underserved population in King County, WA. As I am sure you are aware, academic medicine is facing large financial difficulties, as the struggle to train new physicians is met my increasing strains on the national health care budget. In regards to Anesthesiology in particular, the ability to generate income sufficient to cover practice expenses is seriously compromised by the current Medicare anesthesiology teaching payment policy.
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. 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, for teaching anesthesiologists who work with residents on overlapping cases the Medicare payment for each case is reduced 50%. This is neither fair nor reasonable.
Fairness suggests that Medicare?s teaching payment rules be applied consistently across medical specialties and that academic anesthesiologists be reimbursed for clinical services rendered just as other teaching physicians are. Please end the anesthesiology teaching payment penalty.

Sincerely,

Steven Deem, MD

Submitter : Dr. Hedwig Schroeck **Date:** 08/29/2005

Organization : UNC

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

see attachment

CMS-1502-P-375-Attach-1.DOC

CMS-1502-P-375-Attach-2.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

August 29, 2005

Dear Dr. McClellan:

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

Medicare's discriminatory payment arrangement, which applies only to anesthesiology teaching programs, has had a serious detrimental impact on the ability of programs to retain skilled faculty and to train the new anesthesiologists necessary to help alleviate the widely-acknowledged shortage of anesthesia.

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

This discriminatory payment policy has already led to a shortage of teaching anesthesiologist on certain institutions. On my own institution, the University of North Carolina, a number of outstanding faculty members have already left the program to seek better reimbursement in private practice. This is probably true for other top anesthesia programs as well. In the long run, this will impact the ability to keep our high educational standards at those programs, since there will be a lack of skilled teaching aesthesiologists if this unfortunate regulation persists.

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.

Hedwig Schroeck, M.D.

UNC Hospitals
N2201 UNC Hospitals, CB# 7010
Chapel Hill, NC 27599-7010

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

August 29, 2005

Dear Dr. McClellan:

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

Medicare's discriminatory payment arrangement, which applies only to anesthesiology teaching programs, has had a serious detrimental impact on the ability of programs to retain skilled faculty and to train the new anesthesiologists necessary to help alleviate the widely-acknowledged shortage of anesthesia.

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

This discriminatory payment policy has already led to a shortage of teaching anesthesiologist on certain institutions. On my own institution, the University of North Carolina, a number of outstanding faculty members have already left the program to seek better reimbursement in private practice. This is probably true for other top anesthesia programs as well. In the long run, this will impact the ability to keep our high educational standards at those programs, since there will be a lack of skilled teaching aesthesiologists if this unfortunate regulation persists.

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.

Hedwig Schroeck, M.D.

UNC Hospitals
N2201 UNC Hospitals, CB# 7010
Chapel Hill, NC 27599-7010

Submitter : Mr. Alan Kostelnik **Date:** 08/29/2005

Organization : Private Citizen

Category : Ambulatory Surgical Center

Issue Areas/Comments

GENERAL

GENERAL

I support creating a new 'Payment Locality' for Sonoma County and increasing the Medicare reimbursements to Sonoma County by 8%. Please inact this change to insure that our area will receive adequate medical care and quality physicians.

Submitter : Dr. Silver Dwinell **Date:** 08/29/2005

Organization : University of Virginia Dept of Anesthesiology

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

See attachment

CMS-1502-P-377-Attach-1.DOC

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

Dear Dr. McClellan:

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

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

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

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

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

As a resident in Anesthesiology, I see the direct impact of decreased reimbursement. An example of this effect is an increase in workload for our attending and resident anesthesiologist in attempt to compensate for the shortfall. The result from this is a clear loss in educational time, an essential aspect to the training of any physician. Should this continue, the detriment to the field of

anesthesia will be devastating. Another example of this effect is that the department struggles when competing to hire new faculty due to the nature of the workforce; private practice reimbursement and payment is much more appealing to the majority of program graduates, especially when academic faculty are working so many clinical hours that they do not have time for the "academic" pursuits (research, lecturing, etc.). This to contributes to the demise of resident education. Poor resident education only results in poor patient care and in the end, the patients are the true reason this policy must be changed.

Please end the anesthesiology payment penalty.

Sincerely,

Silver C Dwinell, MD

UVa Health System
Department of Anesthesiology
PO Box 800710
Charlottesville, VA 22908-0710

Submitter : Ms. Joyce Rice **Date:** 08/30/2005

Organization : Ms. Joyce Rice

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

I have lived here since 1983 and watched Santa Cruz grow and change. A house costing $100,000 in the 80's is now $600,000 or more. All of the rural areas of Santa Cruz now have sidewalks and the horse pastures all have new homes built on them. As the baby boomer generation works harder and longer, the rising needs of our future is upon us- including our health care. I have personally seen many doctors leave town because of rising housing costs and low reimbursement rates for their services. I value our health care and would like to see our town paired with like communities of the SF Bay Area. We are not Benito County or some other small town rural area anymore. Let's get with the program and pay our UCSC employees and our health workers and doctors a fair wage. They deserve it.

Submitter : Dr. Derek Goffstein **Date:** 08/30/2005

Organization : Medical College of Georgia

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

I am writing to urge the Centers for Medicare and Medicaid Services (CMS) to change the Medicare anesthesiology teaching payment policy, as I am a Resident in a program in which we do not have enough attendings and are having difficulty in hiring. Our teaching programs cannot compete with private sectors of medicine due to the Medicare anesthesiology teaching payment policy.
Please end the anesthesiology teaching payment penalty.

Derek Goffstein D.O.
2553 Carriage Creek
Augusta, Ga 30909

CMS-1502-P-379-Attach-1.DOC

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

Dear Dr. McClellan,

I am writing to urge the Centers for Medicare and Medicaid Services (CMS) to change the Medicare anesthesiology teaching payment policy, as I am a Resident in a program in which we do not have enough attendings and are having difficulty in hiring. Our teaching programs cannot compete with private sectors of medicine due to the Medicare anesthesiology teaching payment policy.

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

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

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

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

Please end the anesthesiology teaching payment penalty.

Derek Goffstein D.O.
2553 Carriage Creek
Augusta, Ga 30909

Submitter : Emmett Whitaker **Date:** 08/30/2005

Organization : University of Rochester

Category : Other Practitioner

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1502-P-380-Attach-1.DOC

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

Dear Dr. McClellan:

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

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

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

Teaching anesthesiologists are also permitted to work with residents on overlapping cases so long as they are present for critical or key portions of the procedure. However, unlike teaching surgeons and internists, since 1995 the teaching anesthesiologists who work with residents on overlapping cases face a discriminatory payment penalty for each case. The Medicare payment for each case is reduced 50%. This penalty is not fair, and it is not reasonable. This is affecting each institution's ability to recruit and retain excellent clinical instructors, simply because attending anesthesiologists are not able to collect adequate reimbursement and naturally, they gravitate towards higher paying private practice positions.

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. In addition, it will continue to ensure that American anesthesiologists, like other American medical specialists, are receiving the best training in the world.

Sincerely,

Emmett E Whitaker

University of Rochester School of Medicine and Dentistry

Submitter : **Ms. Daphne Roe** **Date: 08/30/2005**

Organization : **Ms. Daphne Roe**

Category : **Federal Government**

Issue Areas/Comments

GENERAL

GENERAL

GPCI

Please change our county designation from rural to one that allows for greater reimbursement of medi-care physicians. Our counties cost of living is very high and the medical care is becoming low quality.

Thank you,

D. Roe

Submitter : Mrs. Marion Denton **Date:** 08/30/2005

Organization : Mrs. Marion Denton

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

I am a 70 year old on Medicare in Santa Cruz County. I STRONGLY SUPPORT the recommended changes to have Santa Cruz moved out of Locality 99, so our doctors can get paid more fairly and they will stay in town, and new doctors can be attracted as well. I have had difficulty finding specialists to treat conditions associated with my recent cancer surgery, often because nobody in this county feels capable (e.g. inserting a nose tube for nutrition), and I have had to go to San Francisco, instead. I can't go through that again. I have had to wait a long time to get an appointment, and then have long waits in waiting rooms because the doctors whom I do see are overscheduled. Twice I went to the emergency room here and had to wait several hours to receive treatment. The delay was so long when my nose feeding tube was plugged up that it could not be cleared and it had to be pulled out. Sometimes I have been too ill to get to San Francisco for an emergency, and one time I could not get there by ambulance because they are not allowed to go across county lines. There are not enough doctors for some specialties, and our emergency rooms are overcrowded. Many doctors do not want to see patients on Medicare because of low reimbursement, and some have left town, or don't take Medicare any more. I have had to change doctors more than once because of insurance problems.

Please do something about these problems. I think it would help a lot if Santa Cruz could be in a different locality than 99, so our doctors could be paid more fairly. Then they would stay in town, and more highly qualified doctors could be attracted to this area. We then might even have enough doctors so it wouldn't be so hard to get in to see them. Please help us seniors get the medical care we need in our own county.

Submitter :

Date: 08/30/2005

Organization : University of Chicago

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

TEACHING ANESTHESIOLOGISTS
I would like to express my concern regarding the effects of the proposed Medicare Fee Schedule for 2006 on the future of the teaching anesthesia programs. The reimbursement rates for teaching anesthesiologists supervising two concurrent resident cases place an undue economic burden on the academic anesthesia departments and will result in further decrease in resident enrollment in anesthesia as well as in decrease in the quality of training. It will also affect the academic research. Additionally, the rates of reimbursement are much lower for teaching anesthesiologists compared to the other teaching physicians such as surgeons and internists, and, therefore, are unfair and place the anesthesiology specialty at significant disadvantage. I appreciate your attention to these issues.

Submitter : **Dr. Virgil Manica** **Date: 08/30/2005**

Organization : **Pratt 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 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.
Our teaching program of 20 residents suffers tremendously from the 50% decrease in reimbursement fees when we medically direct two residents, to the point that our department has about 3-4 attending short staffing, due to this financial deficit.
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: Virgil S. Manica, M.D.
Address: Pratt Anesthesiology Associates
Tufts-New England Medical Center
Department of Anesthesiology
750 Washington Street
Boston, MA 02111

Submitter : Dr. Hardeep Dhadha **Date:** 08/30/2005

Organization : IUPUI

Category : Academic

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, MD21244-8017
Dear Dr. McClellan:

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

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

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

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

Please end the anesthesiology teaching payment penalty.

Name_Hardeep k Dhadha M.D
4561 chase oaks ct Zionsville ; IN 46077

Submitter : **Dr. Hardeep dhadha** **Date: 08/30/2005**

Organization : **IUPUI**

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, MD21244-8017
Dear Dr. McClellan:
I am writing to urge the Centers for Medicare and Medicaid Services (CMS) to change the Medicare anesthesiology teaching payment policy.
Medicare?s discriminatory payment arrangement, which applies only to anesthesiology teaching programs, has had a serious detrimental impact on the ability of programs to retain skilled faculty and to train the new anesthesiologists necessary to help alleviate the widely-acknowledged shortage of anesthesia providers -- a shortage that will be exacerbated in coming years by the aging of the baby boom generation and their need for surgical services.
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Teaching anesthesiologists are also permitted to work with residents on overlapping cases so long as they are present for critical or key portions of the procedure. However, unlike teaching surgeons and internists, since 1995 the teaching anesthesiologists who work with residents on overlapping cases face a discriminatory payment penalty for each case. The Medicare payment for each case is reduced 50%. This penalty is not fair, and it is not reasonable.
Correcting this inequity will go a long way toward assuring the application of Medicare?s teaching payment rules consistently across medical specialties and toward assuring that anesthesiology teaching is reimbursed on par with other teaching physicians.
Please end the anesthesiology teaching payment penalty.
Name_Hardeep k Dhadha M.D
4561 chase oaks ct Zionsville ; IN 46077

Submitter : **Joan Burns** **Date: 08/30/2005**

Organization : **Joan Burns**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

The county in which I live is among the most expensive of any in our country. Yet it is most difficult to attract good young doctors because they can make so much more money elsewhere. I urge you to support the reclassification of our county from rural to a higher lever of reimbursement for our doctors. That is not the complete answer to the problem but is a small step in the right direction. Thank you.

Submitter : **Mr. Marvin Mai** **Date: 08/30/2005**

Organization : **Retired USAF**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

Date: August 28, 2005

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

Re: GPCIs

I am a Medicare beneficiary who receives medical care from a physician in Sonoma County, California. I understand that Medicare is proposing to create a new payment locality for Sonoma County, which is an increasingly expensive place to live and work. (Currently the median home prices are in excess of $575,000) In the new locality, the Medicare reimbursement rate would be more closely matched to actual practice expenses than it is now.

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

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

Sincerely,

Marvin F. Mai
4743 Woodview Drive
Santa Rosa, CA, 95405-8754

Submitter : Dr. Benjamin Paul, M.D., Ph.D. **Date:** 08/30/2005

Organization : University of California, San Francisco

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

See Attached Letter

CMS-1502-P-389-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:

The Centers for Medicare and Medicaid Services (CMS) need to change the Medicare anesthesiology teaching payment policy.

Medicare's policy is a discriminatory payment arrangement. Why does it only apply to anesthesiology teaching programs? Academic departments of anesthesiology are presently unable to offer a livable salary or research time because of this biased compensation plan.

As an example, I am a graduate of a Medical Scientist Training Program. My Ph.D. is in Pharmacology. I cannot earn enough to support my family as an academic anesthesiologist; therefore, I will be going into private practice.

Under the current Medicare regulations, an academic surgeon is permitted to work with residents on overlapping cases and to receive full payment. Teaching surgeons may bill Medicare for full (100%) reimbursement for each of the two procedures. Academic internists supervise multiple residents) in many overlapping office visits (four or more) and collect 100% of the fee.

Since 1995, academic anesthesiologists who work with residents on overlapping cases are financially penalized. The Medicare payment for each case is reduced 50%. This is not fair. It makes no sense. Is this a policy that was designed to destroy the academic practice of anesthesiology?

Please correct this wrong. To do so will go a long way toward assuring the application of Medicare's teaching payment rules consistently across medical specialties. Academic anesthesiologists should be reimbursed on par with other teaching physicians.

Please end the anesthesiology teaching payment penalty.

Name Benjamin Paul, M.D., Ph.D.

Address 1676 Funston Ave., San Francisco, CA 94122

Submitter : Dr. John Lawrence **Date:** 08/30/2005

Organization : University of Cincinnati Department of Anesthesia

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

I am writing to support changing the CMS payment methodology for teaching anesthesiologists. The current reduction of 50% payment for working with two residents concurrently is unfair to anesthesiologist training programs and is not consistent with CMS payment policies to other teaching physicians, such as surgeons. This reduction is unwise, unfair, and unsustainable. I would make the following points:

1. Academic anesthesiology programs are struggling financially, due in large part to their generally high volume of Medicare patients
2. The CMS reimbursement for anesthesia is about 35% of commercial payment in Ohio. A 50% reduction in this already insufficient amount is not economically viable for any institution.
3. A surgeon may supervise two residents concurrently for invasive surgery and receive full CMS payment. It is obviously unfair and discriminatory to pay teaching anesthesiologists differently than other teaching physicians.

Medicare recipients of the future will rely heavily on the expertise, experience and scientific research into anesthesiology that academic programs provide. The crippling effect of the adverse reimbursement policy has a direct impact on these programs and their future.

The anesthesiologists at the University of Cincinnati fulfill 2 very important and unique roles. We educate the future workforce for anesthesia for the Metro Tri-state area (Southwestern Ohio, Northern Kentucky, and Southeastern Indiana), and provide care to the most needy of citizens. The University Hospital provides: 1.) All Level 1 trauma care, 2.) The only solid organ transplant program (Heart, Liver, Kidney, and Pancrease), 3.) The most Complex Oncologic care, and 4.) The most advanced neurosurgical services, for the entire region. A revision to the CMS payment methodology for teaching physicians will help us continue to fulfill our mission.

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

JP Lawrence, MD
Assoc Professor of Anesthesia
Program Director, Anesthesiology Residency
Program Director, Cardiothoracic Anesthesia Fellowship
University of Cincinnati

Submitter : **Dr. Rhonda Berney** **Date: 08/30/2005**

Organization : **Dr. Rhonda Berney**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

RE: GPCIs

I practice, solo, in Sonoma County, family practice and geriatrics. I strongly support the proposal to create a new payment locality in this county. The current level of reimbursement is inadequate, given the cost of practice here. I have seen the growing disparity during my eight years of solo practice. Physician recruitment and retention is a problem in my town, due to the disparity between cost of living and practice, and reimbursement. Medicare reimbursement also affects reimbursement for many private insurance contracts.

I am concerned about current andfuture access to care, including specialist care, for my medicare patietns if the reimbursement rate is not modified. Please create a new payment locality for this area.

Rhonda Berney, MD

Submitter : Dr. Lee Fleisher **Date:** 08/30/2005

Organization : University of Pennsylvania

Category : Academic

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1502-P-392-Attach-1.DOC

UNIVERSITY OF PENNSYLVANIA HEALTH SYSTEM

Department of Anesthesiology and Critical Care

Lee A. Fleisher, M.D., F.A.C.C.
Robert Dunning Dripps Professor and Chair
of Anesthesiology and Critical Care
Professor of Medicine

August 29, 2005

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

RE: Teaching Anesthesiologists (reference file code CMS-1502-P)

To Whom It May Concern:

I am writing this letter as Chair of the Department of Anesthesiology and Critical Care at the University of Pennsylvania regarding the current Medicare teaching anesthesiologist's payment rule which is unwise, unfair and unsustainable. Quality medical care, patient safety and an increasingly elderly Medicare population demand that the United States have a stable and growing pool of physicians trained in anesthesiology. The importance of anesthesiologists and anesthesia research has recently been highlighted by the SCIP (Surgical Care Improvement Project) which is headed by David Hunt and has CMS as a primary partner. As a member of the steering committee for SCIP, I am impressed by the importance that Medicare has placed on reducing surgical complications by 25% over the next five years. Many of these strategies involve anesthesiologists both in the operating room and outside of the operating room. They require subspecialty trained physicians including intensivists which are exclusively derived from the physician pool. Additionally, chronic pain is increasingly common in the Medicare population, and anesthesiology is one of the primary routes by which physicians are further trained in pain management.

Currently, slots in anesthesiology resident programs are going unfilled because of ill conceived Medicare policy that shortchanges teaching programs, withholding 50% of their funds for concurrent cases. The Department of Anesthesiology and Critical Care at the University of Pennsylvania School of Medicine currently trains 72 residents and approximately 10 additional fellows in critical care, chronic pain management and cardiovascular anesthesiology. We have a faculty of over 62 physicians, with several faculy openings. The University of Pennsylvania Health System provides support (2.7 million at the Hospital of the University of Pennsylvania) in order to attract and retain these high quality subspecialty trained physicians in order to provide the highest quality of care, as evidenced by our consistent ranking among the best hospitals in the country. This budgetary shortfall, can directly be attributed to the current Medicare teaching anesthesiology policy and would continue to erode our ability to provide the highest quality of care, retain subspecialty trained physicians (who can make 50-100% higher salaries in private practice), and continue a robust research program.

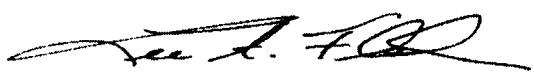
As outlined above, the Medicare teaching anesthesiologist rule significantly impacts our academic departments and their ability to sustain economic viability. This has driven most research and

3400 Spruce Street • Philadelphia, PA 19104-4283 • 215-662-3738 • FAX: 215-349-5341 • fleishel@uphs.upenn.edu

advancement out of the academic departments. As the Institute of Medicine report has recently emphasized, anesthesiology is a field which has shown the greatest improvement in patient safety. As CMS is well aware, quality of care is usually cost effective and although intraoperative adverse advents directly attributable to anesthesiology have decreased, anesthesiologists continue to perform research which would effect the entire perioperative continuum and decrease overall complication rates. The Veterans Administration has shown the ability to decrease surgical complications through the National Surgical Quality Improvement Project. The surgical care improvement project, jointly sponsored by CMS, has focused on numerous interventions which on initial inspection does not appear to be directly attributable to the anesthesiologist but further evaluation demonstrates the importance of anesthesiologist care in implementing many of these best practices including such interventions as appropriate antibiotic timing, perioperative glucose control, and numerous interventions to reduce pulmonary complications. Again, many of these strategies are targeted at the highest risk and most vulnerable patients who seek teaching hospitals as the most appropriate venue for care. Therefore, this arbitrary Medicare payment reduction, which is not in line with the surgical fee schedule in which the surgeon receives 100% of the fee for each case in Medicare, will lead to stagnation in perioperative advancements which could improve patient care and theoretically reduce overall healthcare costs.

CMS must recognize the unique delivery of anesthesia 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. The net result will be a reduction in advancements in quality of care that have been the hallmark of academic anesthesia during the last 50 years. If you have any questions, please feel free to contact me.

Sincerely yours,



Lee A. Fleisher, M.D.
Robert D. Dripps Professor and Chair
Department of Anesthesiology and Critical Care
Professor of Medicine

LAF:ms

Submitter : Mr. Arthur Auer **Date:** 08/30/2005

Organization : San Joaquin Medical Society

Category : Other Association

Issue Areas/Comments

GENERAL

GENERAL

See attachment

CMS-1502-P-393-Attach-1.DOC

SAN JOAQUIN COUNTY MEDICAL SOCIETY

3031 WEST MARCH LANE, SUITE 201W, STOCKTON, CALIFORNIA 95219-6568
TELEPHONE: (219) 952-5299, FAX: (219) 952-5298

August 23, 2005

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

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

Dear Doctor McClellan:

CMS recently unveiled its physician payment rules for 2006 and its proposal to move two California counties (Santa Cruz and Sonoma) out of payment Locality 99, "Rest of California" at the cost of reducing reimbursement to the remaining Area 99 counties. The proposed rule would result in a 0.4% cut in physician reimbursement for the physicians of CMA's District VI (**Alpine***, **Amador***, **Calaveras***, Fresno, Kern, Kings, Madera, Mariposa, Merced, **San Joaquin***, Stanislaus, Tulare and Tuolumne Counties) in 2006. This reduction would be in addition and on top of the planned 4.7% sustainable growth rate formula.
*The counties represented by our San Joaquin Medical Society.

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

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

The District VI Delegation and the county medical societies comprising the region oppose the proposed rule in favor of supporting the August 8, 2005 recommendation of the CMA Executive Committee and subsequently unanimously approved by the CMA GPCI Task Force:

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

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

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

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

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

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

Sincerely,

SAN JOAQUIN MEDICAL SOCIETY

H Padmesh MD.

Hosahalli Padmesh, MD, President

cc:

Michael O. Leavitt, Secretary, US Department of Health & Human Services
Jeff A. Flick, Regional Administrator, CMS Region IX
US Senator Diane Feinstein
US Senator Barbara Boxer
US Congressman Dennis Cardoza
US Congressman Richard Pombo
California Medical Association District VI Component Medical Societies
California Medical Association Executive Committee

Submitter : Dr. Kenneth Gwirtz **Date:** 08/30/2005

Organization : Teaching Anesthesiolgist at Indiana University Sch

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

I write to comment about the current reduction of payments [under existing Medicare concurrency rules] to anesthesiologists working in academic training centers.

In the United States, there are 132 academic training programs at medical schools that are responsible for training all of the nation?s new anesthesiologists. Currently, there is a shortage of providers, and so the country benefits greatly from these training programs.

Sadly, most academic medical centers are also where a very large percentage of indigent, Medicare, and Medicaid patients are cared for, as the more affluent clientele often frequent private, for profit, boutique hospitals in the suburbs (where no training is even allowed).

Those of us in academic anesthesia programs are under increasing productivity pressures, and given an ever less affluent payer mix, our departments are becoming more economically frail.

At present, we suffer at least a 50% reduction of Medicare revenue when we direct two concurrent cases?cases that we are constantly engaged in and where this is clearly documented to federal standards. The surgical departments also have concurrent cases, without the same level of documentation, but they have no reduction in payment and are paid fully for both cases.

With other ongoing economic stressors to academic anesthesia programs, these existing Medicare concurrency reductions are creating an unsustainable situation for our nation?s best training centers, a policy not imposed on the surgical specialty practicing concurrently in the very same operating rooms.

Medicare payment is already well below national compensation levels, barely enables us to cover our expenses, and we here in academic medicine already serve a higher percentage of these patients. These patients often have complex and complicated illnesses and have been sent to us form other hospitals.

We ask that you kindly end these concurrency reductions for our specialty so that we may continue our training programs and serve this patient population.

Ken Gwirtz, MD
Indiana University Medical Center
Department of Anesthesia

Submitter : Dr. Matthew Salomone **Date:** 08/30/2005

Organization : University of Virginia

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

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

Dear Dr. McClellan:

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

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

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

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

Please end the anesthesiology teaching payment penalty.

Sincerely,
Matthew M. Salomone, MD
Assistant Professor
Department of Anesthesiology
University of Virginia
PO Box 800710
Charlottesville, VA 22908

Submitter : Dr. susan cymbor **Date:** 08/30/2005

Organization : Cleveland Clinic

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

TEACHING ANESTHESIOLOGISTS:

I am writing to support changing the CMS payment methodology for teaching anesthesiologists. The current reduction of 50% payment for working with two residents concurrently is unfair to anesthesiologist training programs and is not consistent with CMS payment policies to other teaching physicians, such as surgeons. This reduction is unwise, unfair, and unsustainable. I would make the following points:

Academic anesthesiology programs are struggling financially, due in large part to their generally high volume of Medicare patients
The CMS reimbursement for anesthesia is about 35% of commercial payment in Ohio. A 50% reduction in this already insufficient amount is not economically viable for any institution.
A surgeon may supervise two residents concurrently for invasive surgery and receive full CMS payment. It is obviously unfair and discriminatory to pay teaching anesthesiologists differently than other teaching physicians.
Medicare recipients of the future will rely heavily on the expertise, experience and scientific research into anesthesiology that academic programs provide. The crippling effect of the adverse reimbursement policy has a direct impact on these programs and their future.

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

Submitter : **Dr. Howard Schapiro** **Date: 08/30/2005**

Organization : **Fletcher Allen Health Care**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

August 30, 2005

To Whom It May Concern:

RE: CMS-1502-P Teaching Anesthesiologists

I write to you today to urge you to change your policy regarding payment for teaching anesthesiologists. This is an important issue for academic medicine and specifically the teaching of anesthesiology residents in our state.

The current Medicare teaching anesthesiologist payment rule is unwise, unfair and unsustainable. The current policy causes a financial burden on both the Anesthesiology Department and this academic medical center. This ill-conceived policy shortchanges teaching programs by withholding 50% of their funds for concurrent cases. Therefore, Anesthesiology teaching programs are suffering severe economic losses that cannot be absorbed elsewhere. Specifically, in our institution, the average reimbursement for all payers is 26 dollars per ASA unit. According to national figures (?MGMA Cost Survey for Anesthesia Practices 2004?, the median reimbursement for all payers is over 34 dollars per ASA unit. A good portion of the difference relates directly to the teaching rule. This rule must be changed to allow academic departments to cover their costs.

Academic research in anesthesiology is also suffering as department budgets are tightened to attempt to cover their costs. Anesthesiology is a specialty whose research has had direct benefits in lowering the risk of surgical intervention for the Medicare population.

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 conversion factor is less than 40% of prevailing commercial rates. To reduce that by 50% for teaching anesthesiologists results in revenue grossly inadequate to sustain the service, teaching and research missions of academic anesthesia training programs. We estimate that the cost to Fletcher Allen Health Care to support the teaching mission of the Anesthesiology Department is at least 2.5 million dollars.

Many of our graduating residents go on to serve the peri-operative and chronic pain needs of the Medicare population in our rural State. It is important to have a stable and growing pool of physicians trained in anesthesiology so we can continue to provide quality medical care for a growing population of Medicare recipients. Thank you.

Howard M. Schapiro, M.D.
Chairman, Department of Anesthesiology
University of Vermont College of Medicine
Fletcher Allen Health Care
Burlington, Vermont
802-847-2415

Submitter : Dr. Gerald Eliaser **Date:** 08/30/2005

Organization : Sutter Medical Center of Santa Rosa

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

Issue Identifier: GPCIs. I am the medical director of Sutter Medical Center of Santa Rosa/ Family Practice Residency Program/ Family Practice Center. We are part of the local safety net and have been working with other community clinics in the Redwood Community Health Coaltiton to find specialty access for our Medicare and Medical patients. We have had a very difficult time due to the low pay schedule for these plans.

Raising the reimbursement will help these patients to be seen.

Submitter : Dr. Allen Bashour **Date:** 08/30/2005

Organization : Cleveland Clinic Foundation

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

TEACHING ANESTHESIOLOGISTS:

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

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

Submitter : **Dr. Thomas McDowell** **Date: 08/30/2005**

Organization : **Dr. Thomas McDowell**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

My comments are attached as a MS Word document.

CMS-1502-P-400-Attach-1.RTF

8-30-05

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

Dear Dr. McClellan:

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

I am an Associate Professor of Anesthesiology at the University of Wisconsin Hospital. We have over 30 faculty anesthesiologists and over 36 anesthesiology residents in our training program. When I supervise two residents, I am penalized by Medicare's reimbursement policy. Low reimbursement rates have threatened our program's survival and only by receiving temporary "hand-outs" from our hospital and physician group are we able to attract and maintain quality faculty and residents.

Medicare's policy has no doubt had a similar adverse impact on the ability of other anesthesiology training programs around the country to retain skilled faculty and to train the new anesthesiologists. A decrease in the number of new anesthesiologists coming out of our training programs would lead to a nationwide medical crisis in light of the widely-acknowledged shortage of anesthesiologists predicted to occur in the coming years.

Under current Medicare regulations for other specialties, 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 my supervise residents in four overlapping office visits and collect 100% of the fee when certain requirements are met.

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

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,

Thomas S. McDowell, MD PhD
3420 Blackhawk Drive
Madison WI 53705