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SEP 27 2005

Baystate Medical Center
A Member of Baystate Health System

Baystate Medical Center/
Tufts University School of Medicine

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Chief, Acute Pain Service

Ananth Kashikar, M.D.
Chief, Post Anesthesia Care Unit (PACU)

Katharine O. Freeman, M.D.
Chief, Shriners Hospital, Department of Anesthesia

Henry Godek, M.D.
Chief, Franklin Medical Center, Department of Anesthesia

Peter Kaskel, M.D.
Chief, Mary Lane Hospital, Department of Anesthesia

Istvan Pulai, M.D.
Chief, Maple Surgery Center
Section Chief, Bariatric & Regional Anesthesia

Jordan L. Blinder, M.D.
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Alan Kulig, M.D.
Section Chief, Vascular Anesthesia

Vijay Gandevia, M.D.
Section Chief, Remote Site Anesthesia

Wagdy Zakhary, M.D.
Section Chief, Orthopedic Anesthesia

Tanya Lucas, M.D.
Section Chief, Obstetrical Anesthesia
Section Chief, Student Affairs

September 15, 2005

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

Re: TEACHING ANESTHESIOLOGISTS

An important concern is facing academic anesthesiology departments throughout the country. Teaching institutions are facing severe shortages in federal funding. If allowed to continue, this may potentially cause inadequate access to services by patients in need.

Speaking as a physician in a teaching institution, one cause for this problem can be attributed to the CMS rules for Part B reimbursement in that reimbursement for anesthesia residents is not cover by a full fee unless supervised on a one-to-one basis. This same rule does not apply to our colleagues performing surgery. They are allowed full payment for supervision of overlapping cases as long as they are present for a critical portion of the procedure. This rule, along with the cuts to teaching institutions in the Balanced Budget Act of 1997, have made it difficult to fund our academic environment and provide adequate services to all patients. Medicare and Medicaid patients are hit the hardest by this rule as the inadequate funding makes it difficult for them to access quality patient care.

Anesthesiologists at teaching institutions should be allowed to supervise overlapping cases involving residents and receive a full fee for each case. The current CMS rule is discriminatory and does not allow teaching programs adequate federal support. Please consider improvements to the Medicare reimbursement structure by allowing this rule change. Future anesthesiologists and patients can only benefit in the long run. Thank you for your considered support.

Sincerely,

Alan C. Weintraub MD

Alan C. Weintraub, MD
Vice-Chairman
Department of Anesthesiology
Baystate Medical Center
Assistant Professor of Anesthesiology
Tufts University School of Medicine

AW:ab

SEP 27 2005

602

Deborah J. Bautista
1737 Glenbrook Dr.
Santa Rosa, CA 95401

September 9, 2005

Centers for Medicare & Medicaid Services
Dept. of Health & Human Services
Atten: CMS 1052-P
P O Box 8017
Baltimore, MD 21244-8017

Re: Geographic Practice Cost Indices

Dear Sir or Madam

For many years Medicare has classified Sonoma as a "rural" county and has reimbursed the county's doctors at much lower rates than doctors in so-called "urban" counties. Sonoma County is no longer a rural area. We have close to a half million people in Sonoma County, and Santa Rosa has become a major city.

Medical expenses in Sonoma County are much higher than in other "rural" counties. The Medicare reimbursement rate does not just impact those covered by Medicare. Many health plans base their reimbursement or per capital to doctors based on the Medicare reimbursement rate. The current "rural" rate used in Sonoma County in no way keeps pace with the cost of care.

This disparity between expenses and reimbursements has seriously affected our local health system. Several physician groups and Health Plan of the Redwoods went bankrupt. I personally have had to change doctors numerous times because my doctors left the area when they were no longer able to afford to practice medicine in Sonoma County.

I urge you to adjust the Medicare reimbursement rate for Sonoma County to truly reflect the cost of care, so that we can keep good doctors practicing medicine in Sonoma County.

Sincerely,

Deborah J. Bautista

UNIVERSITY OF CALIFORNIA, SAN DIEGO

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SANTA BARBARA • SANTA CRUZ

GERARD R. MANECKE, JR., MD
CLINICAL PROFESSOR, INTERIM CHAIR AND
PROGRAM DIRECTOR

UCSD MEDICAL CENTER
DEPARTMENT OF ANESTHESIOLOGY
200 WEST ARBOR DRIVE
SAN DIEGO, CA 92103-8812
(619) 543-3162 FAX: (619) 543-6162

September 20, 2005

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

Dear Dr. McClellan:

I am writing as Anesthesiologist-in-Chief and Residency Program Director at the University of California San Diego (UCSD) 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. Because of the severe budgetary disadvantages imposed by this unfair rule, our teaching program, and our ability to care for these patients in a timely, humane way are in jeopardy. A large portion of our patient population at UCSD is Medicare and MediCal funded. We have, as both a department and institution, adopted the policy that we will care for these patients regardless of the extremely poor compensation, simply because the patients need the care and have nowhere else to go. Because of the resulting low financial compensation for the faculty, our department is suffering poor faculty retention and difficulty recruiting. Over the past two months alone we have lost four strong, bright young faculty because of an inability to compensate them adequately. All four have gone to practices in which there is no residency training, and a lower proportion of Medicare. All these faculty were good teachers, so our program is now suffering both a decreased ability to provide clinical care and decreased capacity to provide high quality education. Simultaneously, our department is suffering a severe, accumulating budget deficit. If you question whether these problems can be traced to poor Medicare/MediCal reimbursement, consider this: 45% of our patient population is either Medicare or MediCal. The current average yield for Anesthesiology services in California is $52/ASA unit. Our contract floor at UCSD is $46/unit. The Medicare conversion factor in California is only $17.55/unit. ***Because of the teaching rule, our yield on Medicare anesthetics is an astoundingly low $9.64/unit.*** In fact, because the cost of providing the care far exceeds the reimbursement, the more Medicare anesthetics we provide, the greater our budget deficit.

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

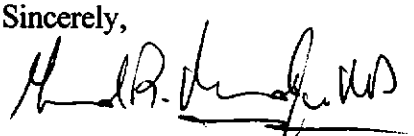
reimbursement for each of the two procedures in which he or she is involved. An internist may supervise residents in four overlapping office visits and collect 100% of the fee when certain requirements are met.

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%. Remember, when Anesthesiologists simultaneously cover two anesthetizing locations, they assume 100% of the medical responsibility and 100% of the medico-legal risk for those anesthetics. Why should they then receive only half of what already is an extremely low reimbursement? 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,



Gerard R. Manecke Jr., M.D
UCSD Medical Center

SEP 27 2005 604

R. LAWRENCE SULLIVAN, JR., M.D., F.A.C.A.
DIPLOMATE AMERICAN BOARD OF ANESTHESIOLOGY

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FAX (650) 327-7301

DEPARTMENT OF ANESTHESIOLOGY
O'CONNOR HOSPITAL
2105 FOREST AVENUE
SAN JOSE, CALIFORNIA 95128
(408) 298-3218 SCHEDULING
(800) 955-8818 BILLING

September 9, 2005

Center 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

To whom it may concern:

It is my understanding that attempts to correct the unreasonable policy of paying teaching anesthesiologists only 50% of the usual fee for anesthesia services when working on two concurrent resident cases remains unresolved within the Centers of Medicare and Medicaid Services (CMS)

I URGE CMS TO PROVIDE FULL PAYMENT FOR ALL PATIENTS CARED FOR BY TEACHING ANESTHESIOLOGISTS WORKING WITH RESIDENTS.

Until a few years ago, Medicare had paid teaching anesthesiologists their full fee in compliance with the Medicare Fee Schedule. Since adopting the policy of paying only 50% of the requisite fee when teaching anesthesiologists are working with residents on two concurrent cases, academic anesthesia departments across the United States have experienced severe, unwarranted, and unfair budget shortfalls. The result of this folly has been:

* non-competitive salaries for anesthesia faculty resulting in many anesthesiologists leaving academic practice.

* unfilled anesthesia residency slots due to inadequate funding and/or insufficient faculty thus contributing to an already established shortage of newly trained anesthesiologists.

* insufficient number of faculty members resulting in reduced opportunities for research in anesthesiology.

* inability to attract and retain anesthesia faculty to meet the anesthesia needs of academic centers resulting in inefficient scheduling and economic losses. Academic

centers tend to have a greater share of Medicare and Medicaid beneficiaries than non-academic settings.

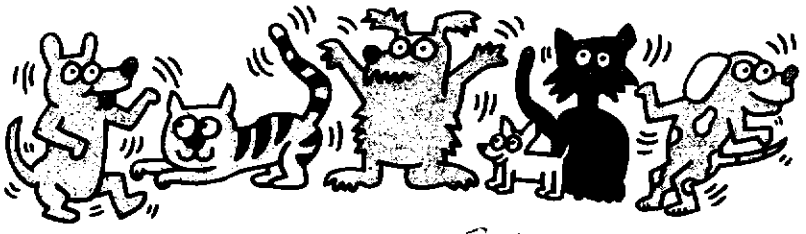
CMS currently reimburses surgeons 100% when working with residents on overlapping cases. Anesthesiologists should receive the same full fee consideration as surgeons. It should also be emphasized that Medicare pays a much lower percentage of usual and customary fees to anesthesiologists than to other physician specialists (25-40% vs 50-70%), thus exacerbating the financial impact of the current rule on anesthesiology training programs.

Sincerely,

R. Lawrence Sullivan, Jr., M.D.

cc. Senator Barbara Boxer
Senator Dianne Fienstein
Congresswoman Anna Eshoo
Congressman Sam Farr
Congresswoman Zoe Lofgren

605



SEP 27 2005

Sept 19-05

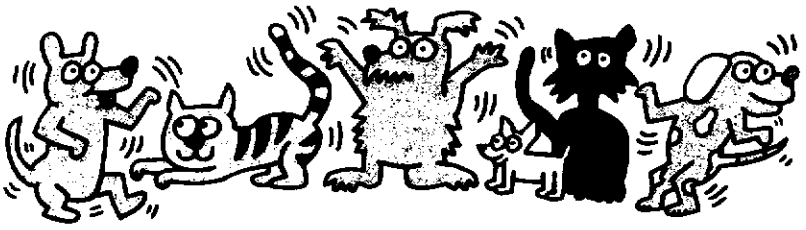
To whom it may concern -
I support your proposal.
I am a victim of your
rules at this time - I
live in Sonoma ca - and I
cannot find a primary care
Doctor - I need one - I do not
run to the Dr. with every
little thing and never
have done so - But I am
56 years old in October
and I need a primary care

Doctor from time to time -

I live on SSI and have to manage my money with great care. I pay over half in rent -

Right now I have several problems and want to talk to a Doctor -

I don't want to sound like a whining person but I do hope you will really do the "right thing" for payment to the Doctor. So that Doctors can receive their proper dues. not treated as second class people -



Thank you Ann, please.
We right by the Doctors
Why not??? It's fair!
Rita Booth
Sincerely

Rita Booth
18789 Beatrice Dr.
Sonoma, CA 95476

SEP 27 2005

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SHADOWBROOK
Romance in Dining Since 1947
CROW'S NEST

Post Office Box 65 • Capitola, CA 95010 • (831) 475-1222

September 16, 2005

Center for Medicare and Medicaid Services
Dept. of Health and Human Services
Attention: CMS-1502-P
Post Office Box 8017
Baltimore, MD 21244-8017

RE: File Code CMS1502-P

Issue Identifier: GPCI Payment Localities

Dear Member of the CMS Staff:

Physicians in Santa Cruz County receive reimbursement levels approximately 25% less than physicians in two of our neighboring counties. I have been informed that current payments are about 10% less than they should be, given the county's current GAF. Clearly, they do not reflect the extraordinarily high cost of practice within our community, which is adjacent to the San Francisco/Bay Area region.

Thus, I am in strong support of the proposed revision to physician payment localities in California that you published earlier this month. It is my hope, and that of other longtime residents and employers of Santa Cruz County, that this rule be adopted in November as final.

My experience as a member of the Dominican Hospital Foundation has allowed me to follow the issues surrounding the inclusion of Santa Cruz County within Locality 99 for all too long. More importantly, my vantage point as a member of the hospital's foundation has allowed me to witness first hand that as our physicians age, retire, or just move away, our community struggles to attract new physicians to take their place. Thus, I welcome enthusiastically the opportunity to support your proposed solution to the current inequitable payment policy.

I do realize that there will be some self-serving objections for proposing a rule that addresses this problem for both the physicians and residents of Santa Cruz County. However, I do expect that you will act fairly and appropriately in face of these objections in order to ensure reasonable access to high quality care for all who work and reside in this community.

Sincerely,

Ted Burke

Ted Burke
Co-Owner

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SEP 27 2005

Baystate Medical Center
A Member of Baystate Health System

Baystate Medical Center/
Tufts University School of Medicine

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Section Chief, Orthopedic Anesthesia

Tanya Lucas, M.D.
Section Chief, Obstetrical Anesthesia
Section Chief, Student Affairs

September 15, 2005

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

Re: TEACHING ANESTHESIOLOGISTS

Teaching institutions across the country urge your support to increase federal funding for academic anesthesiology departments. Current CMS rules make it difficult for departments like ours to survive.

Under current guidelines, cases involving residents can only be reimbursed a full fee if they are supervised on a one-to-one basis. It does not allow for overlapping cases to each realize a full fee for services. Surgeons at teaching institutions are not restricted by the same rules. They collect the full fee as long as they are present for the key portions of the procedures. This puts academic anesthesiology departments such as ours at a disadvantage as we cannot collect the full fees for reimbursement of similar cases. Patients, especially those covered by Medicare and Medicaid will potentially have difficulty accessing adequate patient care if this practice is allowed to continue.

The more flexible rule allowed for surgeons, if applied to anesthesiologists in teaching institutions, would go a long way toward improving funding for our programs and increase patient satisfaction. I urge you to consider recommending this change for the enhancement of teaching facilities and improvement of quality patient care.

Sincerely,

Robert B. Steinberg, Ph.D., M.D.
Director of Pain Management Services
Department of Anesthesiology
Baystate Medical Center
Assistant Professor of Anesthesiology
Tufts University School of Medicine

SEP 27 2005

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County of Santa Cruz

HEALTH SERVICES AGENCY

POST OFFICE BOX 962, 1080 EMELINE AVENUE SANTA CRUZ, CA 95061-0962

(831) 454-4120 FAX: (831) 454-4272 TDD: (831) 454-4123

EMERGENCY MEDICAL SERVICES PROGRAM

September 14, 2005

Center for Medicare & Medicaid Services
Department of Health & Human Services
Attention CMS 1502-P
P.O. Box 8012
Baltimore, MD 21244-8012

Re: File Code CMS 1502-P

I am writing on behalf of the Santa Cruz County Emergency Medical Care Commission to strongly support your proposed revision to physician payment localities in California recently published in the reference rule. Our Commission is responsible for advising the Board of Supervisors, the medical community, and the public regarding issues that pertain to emergency medical services. The commission is very concerned about the health of our medical care system. Because our seniors struggle to find primary care physicians, many must resort to seeking care in our emergency departments, leading to serious overcrowding in the county's emergency rooms. Some patients need hospital admission for conditions that may have been treated on an outpatient basis if they had had access to a primary care physician. Furthermore, some critically ill patients must be transported out of the county for care because the hospitals do not have the necessary medical specialists on staff.

The Santa Cruz County Emergency Medical Care Commission has written you previously to express our concern about the viability of the health care system which serves our residents. The great difference between the cost of medical practice in Santa Cruz County as measured by GAF cost values and the low rate of reimbursement due to being assigned to Locality 99 has made recruitment and retention of physicians willing to serve Medicare beneficiaries very difficult.

We were pleased to see that your proposed rule would alleviate this problem by removing Santa Cruz and Sonoma Counties from Locality 99 and placing them into unique localities. We laud your efforts to rectify this long-standing inequity. Your proposal will be of great help in ensuring access to necessary health care services. The proposed rule is fair. Neighboring counties to Santa Cruz and Sonoma have some of the highest payment levels for physicians in the nation. The adjustment you propose appropriately addresses this payment imbalance. This revision would bring you closer to your goal of reimbursing physicians based on the cost of practice in their locality.

Sincerely,

Terry Lapid MD
Chair, Emergency Medical Care Commission

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SEP 27 2005

2258 Coventry Court
Santa Rosa, CA 95401

September 21, 2005

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

Dear Sir/Madam:

I am writing to urge you to increase the reimbursement rate for Sonoma County physicians.

I am a resident of SonomaCounty, presently on Medicare (age 75), and have a primary care physician from Sonoma County.

When I was forced to change Medical Insurance Companies several years ago, there was only one group of primary care physicians in the plan who were accepting new patients.

I have been informed from many sources that there is a shortage of primary care physicians in this area partly because of the inadequate Medicare reimbursement rate. Since living costs and other expenses in this area are among the highest in the state, it seems to me clearly unfair--and harmful to patients--to have a reimbursement rate lower than other expensive urban areas.

Thank you for your attention to this matter.

Sincerely,

Eugene Gerard

Eugene Gerard

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SEP 27 2005

GPCIs

SEPT. 21, 2005

CENTER FOR MEDICARE AND MEDICAID SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES
ATTENTION CMS-1502-P
P.O. BOX 8017
BALTIMORE, MD 21244-8017

TO WHOM IT MAY CONCERN:

I HAVE BEEN MADE AWARE THAT THE CMS HAS PROPOSED TO REMOVE SONOMA AND SANTA CRUZ COUNTIES FROM CA LOCALITY 99. THESE TWO (2) MOST DISADVANTAGED COUNTIES DESERVE BETTER LOCALITIES OF THEIR OWN, TO IMPROVE HIGHER AND BETTER MEDICARE FEE SCHEDULES, FOR COUNTY PHYSICIANS.

I AM WRITING TO REQUEST AFFIRMATIVE ACTION ON THE PROPOSAL TO REMOVE SANTA CRUZ AND SONOMA COUNTIES FROM CA LOCALITY 99. AN INCREASE IN MEDICARE FEE SCHEDULE OF PAYMENTS TO PHYSICIANS, WOULD DECREASE THE APPARENT AND POSSIBLE MASS EXODUS OF PHYSICIANS TO BETTER MEDICARE FEE SCHEDULE COUNTIES.

PLEASE APPROVE THE CMS REQUEST!

SINCERELY
Michael R. Casal

MICHAEL C. CASAL
111 BEAN CREEK RD. #57
SCOTTS VALLEY, CA 95066

ARMA
ARIZONA MEDICAL ASSOCIATION
Arizona Physicians Committed to Quality Care

SEP 27 2005

611

Leonard F. Ditmanson, MD
President

Chic Older
Executive Vice President

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September 20, 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: Discriminatory Medicare Anesthesiology Teaching Rule

I am writing on behalf of the Arizona Medical Association (ArMA) and at the request of Arizona Society of Anesthesiologists to comment on the CMS Medicare anesthesiology teaching rule. An enclosed fact sheet from the American Society of Anesthesiologists describes the issue, which our research has verified. In summary, Medicare reimbursement is reduced for anesthesiologists supervising and teaching resident physicians.

Other physicians are not subjected to such Medicare reimbursement reductions. As you know, academic medicine is experiencing significant financial challenges. This is of grave concern to ArMA as Arizona is confronting a major physician shortage. Added to this, the arbitrary and unreasonable Medicare fee reduction for teaching anesthesiologists makes it very difficult or impossible to train future anesthesiologists.

We believe correcting the problem of inequitable Medicare reimbursement for teaching anesthesiologists is necessary to ensure an adequate number of anesthesiologists in the future. We urge you to apply the same teaching rules consistently to all high-risk specialties, including anesthesiology.

I trust this information will be of use to you. Should you have questions, please do not hesitate to contact me personally.

Respectfully,

David Landrith, Vice President
Policy and Political Affairs

Enclosures

cc: Brenda Gentz, M.D., President, Arizona Society of Anesthesiologists
Jeff Mueller, M.D., Vice President, Arizona Society of Anesthesiologists

611-Attachment

AMERICAN SOCIETY
OF ANESTHESIOLOGISTS

Office of Governmental Affairs
1101 Vermont Avenue, N.W., Suite 606 • Washington, DC 20005
(202) 289-2222 • Fax (202) 371-0384 • mail@ASAwash.org

Fact Sheet: Medicare Discriminatory Anesthesia Teaching Policy

BACKGROUND. Under the Medicare program anesthesiologists who train anesthesia residents are reimbursed under the Part B teaching reimbursement rules. Historically, anesthesia training reimbursement was guided by HCFA Intermediary Letter 372 which permitted teaching anesthesiologists to oversee two concurrent resident cases and bill for full reimbursement for each case if an "attending physician" relationship was established in each case. Most carriers routinely approved full reimbursement.

In 1995 as part of the physician payment rule, new teaching reimbursement rules for all specialties was released generically stating that the teaching physician must be present for the key portion of any service or procedure in order to receive full reimbursement. In the case of "surgical, high-risk or other complex procedures, the teaching physician must be present during all critical portions of the procedure and must be immediately available to furnish services during the entire service or procedure". For anesthesiology teaching, however, the rule allowed full reimbursement only for a single case involving a single resident, thereby reducing reimbursement for anesthesiology training by 50% from that historically allowed.

ISSUE. The 1995 anesthesiology teaching rule is not consistent with teaching rules that apply for teaching surgical and other complex or high-risk procedures. HCFA at that time justified its decision to pay a teaching anesthesiologist full reimbursement only for one-on-one cases on the grounds that teaching surgeons were subject to the same or an "analogous" limitation. However, this was not true then and it is not true now.

The current CMS instructions to Medicare carriers provide that in order for a surgeon to bill Medicare for full reimbursement for two overlapping surgeries, the teaching surgeon must be present only during the critical or key portions of both procedures. There is no requirement that teaching surgeons train, as is required for teaching anesthesiologist, only one resident on a single case in order to receive full reimbursement.

The 1995 teaching rules have had a devastating negative effect on already-strapped anesthesia teaching programs attempting to retain skilled faculty and train new anesthesiologists to help alleviate the widely-acknowledged shortage of anesthesia providers. A 2003 survey of anesthesia departments disclosed that four out of five had open faculty positions, that 25% had closed anesthetizing locations due to lack of faculty, and that the average institutional operating support per department was $3.4 million – an increase of *43%* per faculty FTE over 2002.

ASA has urged CMS to apply the teaching rules consistently across all complex or high-risk specialties, so that anesthesiology teaching is reimbursed on par with reimbursement for surgery and other high-risk specialty teaching.

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SEP 27 20

College of Medicine
Department of Anesthesiology

THE UNIVERSITY OF
ARIZONA.
HEALTH SCIENCES CENTER

P.O. Box 245114
Tucson, AZ 85724-5114
(520) 626-7221
FAX: (520) 626-6943

September 1, 2005

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

Dear Dr. McClellan:

I am writing to you to ask for your assistance in our efforts to fix the flawed Medicare anesthesiology teaching payment rule. As academic "teaching" anesthesiologists, we were deeply disappointed that changes to the Teaching Rule (CMS-1502-P) were not included in the August 1, 2005 version of the Medicare Fee Schedule for 2006. We feel that the current Medicare teaching anesthesiologist payment rule is unfair and unsustainable.

As you may be aware, University Medical Center in Tucson, Arizona is the only trauma center located between Phoenix and the U.S. - Mexico border. As academic physicians, we manage patients with complex and difficult health issues. Many of these patients are referred to us by community physicians and facilities that feel unable to treat the patient adequately. As "teaching" anesthesiologists, we train resident physicians to care for these sick and elderly individuals. Our mission is to train resident doctors so that they are able to return to their communities and provide the same level of care. As academic physicians, we also participate in research and developing standards and guidelines that benefit both our patients and the anesthesiology community.

We, as an academic department, are under significant stress as we try to maintain balance between the provision of clinical care, teaching and research. The Medicare Teaching Rule (CMS-1502-P) unfairly singles out anesthesiologists who remain in academic institutions. A surgeon, working in the same operating room, 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 burden is carried in addition to the current Medicare anesthesia conversion factor that is less than 40% of prevailing commercial rates. In our institution, 62% of our patients are insured by federal payers.

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. In order to train these doctors to provide the excellent care that Medicare patients have come to expect, "teaching" anesthesiologists must be retained and not driven out of academic medicine because salaries cannot be supported by department budgets. We are asking for your support to protect our academic anesthesiology program. Please correct the anesthesia teaching payment policy.

Thank you.

Melinda Hayes, M.D.

cc: ASA Board of Directors
Sen. John McCain
Sen. Jon Kyl

613

SEP 27 2005

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

September 1, 2005

Dear Dr. McClellan:

I am writing to you on behalf of the Arizona Society of Anesthesiologists to ask for your assistance in our efforts to fix the flawed Medicare anesthesiology teaching payment rule. We support the academic anesthesiology teaching programs in our state and understand that they are facing significant stress. We were deeply disappointed that changes to the Teaching Rule (CMS-1502-P) were not included in the August 1, 2005 version of the Medicare Fee Schedule for 2006. We feel that the current Medicare teaching anesthesiologist payment rule is unfair and unsustainable. The state of Arizona relies on the anesthesiology programs within its borders to educate anesthesiologists to provide care for its citizens.

As you may be aware, University Medical Center in Tucson, Arizona is the only trauma center located between Phoenix and the U.S. - Mexico border. Mayo Medical Center in Phoenix, Arizona is world renowned for its excellent care. As academic physicians, these doctors manage patients with complex and difficult health issues. Many of the patients are referred by community physicians and facilities that feel unable to treat the patient adequately. The mission of these institutions is to train resident doctors so that they are able to return to their communities and provide the same level of care. As academic physicians, these same doctors participate in research and developing standards and guidelines that benefit both our patients and the anesthesiology community.

These academic departments are under significant stress as they try to maintain a balance between the provision of clinical care, teaching and research. The Medicare Teaching Rule (CMS-1502-P) unfairly singles out anesthesiologists who remain in academic institutions. A teaching anesthesiologist will only collect 50% of the Medicare fee if he or she supervises residents in two overlapping cases. This burden is carried in addition to the current Medicare anesthesia conversion factor that is less than 40% of prevailing commercial rates. At both the University of Arizona and Mayo Medical Center, 62- 71 % of patients carry federal insurance.

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. In order to train these doctors to provide the excellent care that Medicare patients have come to expect, "teaching" anesthesiologists must be retained and not driven out of academic medicine because salaries cannot be supported by department budgets. As members of the Arizona Society of Anesthesiologists, we are asking for your support to protect our academic anesthesiology program. Please correct the anesthesia teaching payment policy.

Thank you.

Brenda A. Gentz M.D.

Brenda A. Gentz, M.D.
President, Arizona Society of Anesthesiologists

614

Ombudsman/Advocate, Inc.

525 Laurel St. Ste. 140
Santa Cruz, CA 95060
(831) 429-1913 (831) 636-1638 Fax 429-9102

SEP 27 20

Protect, through advocacy, education and intervention, the rights of facility-placed seniors and disabled persons, and individuals with mental health needs.

September 20, 2005

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

Re: GPCIs

To Whom It May Concern:

Ombudsman/Advocate, Inc, an independent nonprofit housing the Long-Term Care Ombudsman Program and the Patients' Rights Advocate Program for Santa Cruz and San Benito Counties, strongly supports the proposed revision to the physician payment localities in California that you published in the referenced rule.

Your action to address this issue for physicians in Santa Cruz County will greatly assist the seniors and disabled eligible for Medicare in accessing medical care by providing a more comparable reimbursement rate to our County's physicians. San Francisco and Santa Clara Counties are our neighbors and they receive some of the highest payment levels for physician services in the nation. The populations we serve have experienced closed censuses and physicians exiting our community due to the low reimbursement rate in the third highest cost of living county in the nation. The adjustment that you propose appropriately addresses this current inequity and fundamental issue of fairness.

We understand that CMS has made no revisions to the localities since 1996. We appreciate you selecting the most important area in our state to begin to correct this problem.

Sincerely,

Richard Hill, President
Ombudsman/Advocate, Inc.
Santa Cruz, California

Supported by: Individual Contributions • City of Capitola • City of Santa Cruz • City of Scotts Valley • City of Watsonville
Mental Health of San Benito County • Mental Health of Santa Cruz County • Santa Cruz County
Seniors Council of Santa Cruz & San Benito Counties • United Way of San Benito County & United Way of Santa Cruz County

Member

615

GORDON E. LEE, M.D.
GASTROENTEROLOGY
1505 Soquel Drive - Suite 8
Santa Cruz, California 95065
(831) 476-4230

SEP 27 2005

September 23, 2005

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

RE: GPCIs

Dear CMS Staff,

I am a physician practicing in Santa Cruz County, California and I understand that there is finally a proposal to create a new payment locality for Santa Cruz County. This is something that should have been implemented long ago. Because of the high cost of practice expenses in this area, Medicare reimbursement has been inadequate to compensate physicians for treating Medicare patients, and as a result more and more physicians, including myself, are having to limit or discontinue seeing Medicare patients.

This proposal to create a new payment locality for Santa Cruz County will be an important step in correcting existing inequities, and help insure continuing access to medical care for Medicare patients.

Thank you for your attention to this important matter.

Sincerely,

Gordon E. Lee

Gordon E Lee, M.D.
1505 Soquel Drive Suite 8
Santa Cruz, Ca 95065

Administrator Mark McClellan
Center for Medicare and Medicaid Services
U.S. Department of Health and Human Services
P.O. Box 8017
Baltimore, MD 21244-8017

Denise Kappler
11000 Lake Blvd.
Felton, CA 95018

Dear Administrator McClellan:

I write to express my very strong support for CMS' proposed revision to the physician payment localities for Santa Cruz and Sonoma counties.

There is currently a large payment discrepancy for physicians in Santa Cruz and Sonoma counties due to their being classified as "rural" counties. Counties neighboring Santa Cruz and Sonoma counties have some of the highest payment levels for physicians in the nation. The discrepancy is causing physicians to leave Santa Cruz and Sonoma counties, and quality health care has suffered as a result. This reassignment will help the counties provide sufficient health care services for its residents.

I commend CMS for acknowledging the discrepancy in payment for physicians, and for proposing this change to correct the situation. Should you have any questions, please feel free to contact me in my San Jose Office. Thank you for your consideration.

Sincerely,

Denise Kappler

Denise Kappler

SEP 27 2005 617

September 24, 2005

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

Re: File Code CMS-1502-P

Issue Identifier: GPCI's/Payment Localities

To Whom It May Concern:

I am a retired optometrist and a Medicare beneficiary. I live in Santa Cruz County California. I am fortunate to receive care from a fine physician. I understand that this rule modification will remove my county from the "Rest of California" designation and will reimburse physicians on par with other counties in the San Francisco, San Jose greater Bay Area.

I appreciate your attention to this important issue. I strongly support the proposed changes you have made.

Sincerely:

Wayne Zimmerman, O.D.

618

SEP 27 2005

Walter Muelken
313 Florence Ave.
Sebastopol, CA 95472
Tel 707 829-6417
Fax 707 829-6418

September 19, 2005

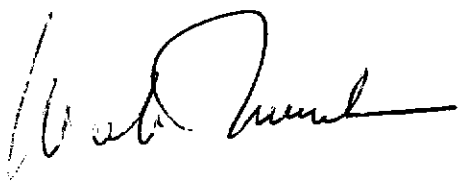
Dear Friends,

The purpose of this letter is to urge you to increase the Medicare reimbursement rates for doctors here in Sonoma County, California.

I have been concerned for a number of years that low Medicare reimbursements for doctors here in Sonoma County would cause them, usually the best, to leave, or those who stayed not to accept Medicare patients.

So please raise the Medicare reimbursement rates for doctors here in Sonoma County, California.

Thank you for your consideration.



619

SEP 27

September 19, 2005

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

Re: GPCIs

I am a pediatrician, thus I am not directly affected by Medicare financing. I am however in a good position to comment on some general trends in the Sonoma County (California) medical community. I speak from the vantage point of 28 years medical practice in this town.

Sonoma County and Santa Rosa have some of the highest housing costs not only in California but also in the Nation. It becomes difficult to recruit physicians, but just as important, all medical staff including nurses and other office personnel are adversely impacted. I have seen the resultant decline in the availability of medical care.

A new payment locality is needed to replace the archaic, unrealistic present situation. There is an urgent need to correct the injustice, which is threatening the provision of care for Medicare beneficiaries, of which my mother is one. I too will join their ranks in six years. Please act NOW.

Sincerely,

David L. Smith MD
1077 Vallejo Street
Santa Rosa, California 95404

cc 2 copies attached

620

SEP 27 2005

CITY OF SANTA CRUZ

MAYOR AND CITY COUNCIL

809 Center Street, Room 10, Santa Cruz, CA 95060 • (831) 420-5020 • Fax: (831) 420-5011 • citycouncil@ci.santa-cruz.ca.us

September 20, 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

To Whom It May Concern:

At its meeting on September 13, 2005, the Santa Cruz City Council adopted the attached resolution endorsing the Department of Health and Human Services Centers for Medicare and Medicaid Services' (CMS) proposed rule to designate Santa Cruz County as a unique Medicare payment locality.

The reassignment of Santa Cruz County to a unique locality will have a positive impact on Santa Cruz County's physicians and medical practitioners across the public, private and non-profit sectors. Santa Cruz County physicians will receive an increase in reimbursement rates of 10 percent, bringing total reimbursement to about 55 percent. The enhanced reimbursement rates will allay the financial pressure of serving Medicare patients, therefore helping to ensure that Santa Cruz County maintains sufficient quantity and quality of physicians for the County's Medicare population.

It is our understanding that the costs of the reassignment will be distributed across the counties that remain in the Rest of California payment locality. However, due to a planned increase in reimbursement to the Rest of California payment locality, the other counties will not suffer a reduction in payments. We therefore support CMS' proposed rule to designate Santa Cruz County as a unique Medicare payment locality and urge your favorable consideration of this proposal.

Sincerely,

Mike Rotkin
Mayor

Attachment

cc: City Clerk

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620 Attachment

COPY

RESOLUTION NO. NS-27,007

RESOLUTION OF THE CITY COUNCIL OF THE CITY OF SANTA CRUZ ENDORSING THE DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTER FOR MEDICARE & MEDICAID SERVICES' PROPOSED RULE TO DESIGNATE SANTA CRUZ COUNTY AS A UNIQUE MEDICARE PAYMENT LOCALITY THEREBY INCREASING MEDICARE REIMBURSEMENT RATES FOR SANTA CRUZ COUNTY PHYSICIANS AND URGING CITY RESIDENTS TO SUBMIT COMMENTS OF SUPPORT

WHEREAS, since its creation by the Social Security Act in 1965, Medicare has been a vital program for Americans over 65 years of age and those with disabilities and advanced renal disease; and

WHEREAS, Medicare offers health insurance for the approximately 32,000 eligible Santa Cruz County residents; and

WHEREAS, since 1992, as directed by the Social Security Act, Medicare has paid for physicians' services under a payment schedule based upon geographical standards for reasonable charges and costs to provide care; and

WHEREAS, the Department of Health and Human Services' Center for Medicare & Medicaid Services (CMS), which administers the Medicaid program, assigned the County of Santa Cruz to rural status in 1967, relegating the county to designation in the Rest of California payment locality, an amalgamation of rural and smaller counties that face much lower costs of health care provision than Santa Cruz County; and

WHEREAS, the number of physicians and medical practitioners accepting Medicare insurance is declining in Santa Cruz County as the current Medicare reimbursement rates are not keeping pace with health care costs due to the Rest of California payment locality reimbursement benchmark; and

WHEREAS, CMS found that Santa Cruz County's county-specific geographic adjustment factor, a measure of differences of cost to provide health care across jurisdictions, is 10 percent higher than the Rest of California payment locality geographic adjustment factor; and

WHEREAS, the disparity between the geographic adjustment factors in Santa Cruz County and the Rest of California payment locality prompted CMS to issue a proposed rule on August 8, 2005 to place Santa Cruz in a unique payment locality; and

WHEREAS, the assignment to a unique payment locality would provide Santa Cruz County physicians and medication practitioners a 10 percent increase in Medicare reimbursement rates to about 55 percent; and

WHEREAS, the increase in reimbursement rate will allay the cost to provide health care to Medicare patients and will equally benefit public, private and non-profit health care providers; and

SEP 27 2005 621

Drug Abuse Alternatives Center
Turning Lives Around

Administrative Offices
225 Indian Creek Drive
Santa Rosa, CA 95409
Telephone (707) 571-2233 Fax (707) 571-2238
Tax ID #94-1694676
www.daacinfo.org

September 21, 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, California. I would like to address some specific concerns from the perspective of DAAC – Drug Abuse Alternatives Center.

- Santa Rosa now ranks with retirement destinations such as Clearwater, St. Petersburg, and Miami, Florida.
- Among cities with a population of 100,000 or more, Santa Rosa is sixth in the United States for the highest percentage of people 85 and older.
- According to State of California Department of Finance, seniors 60 and older represent 16.6% of the total population in Sonoma County, with a projected rate of change of 196% by 2020.

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

- The number of practicing physicians in Sonoma County has not kept pace with local population growth. From 1995 to 2002, the population increased 13%, but the number of practicing physicians increased by only 4%.
- As of July 2005, 60% of Sonoma County primary care physicians were NOT accepting new Medicare patients.
- Many physicians are leaving our county to practice where reimbursement is more favorable. As a result, many specialties are under-supplied. For example, we have only two gerontologists in the county for more than 76,000 seniors.

The new locality would increase the Medicare reimbursement rate to more closely match actual practice expenses, helping Sonoma County physicians improve the quantity and quality of care they deliver to Medicare beneficiaries and other patients. The locality change would also aid efforts to recruit and retain physicians in the county, which has a large Medicare population. I fully support your proposal to change Sonoma County's payment locality, and I appreciate the opportunity to comment on this important issue.

Sincerely,

Michael Spielman
Executive Director
DAAC – Drug Abuse Alternatives Center
225 Indian Creek
Santa Rosa, CA 95409

cc: Two copies attached

Palo Alto Medical Foundation
A Sutter Health Affiliate
Community Based, Not For Profit

622

SEP 2 7 2005

795 El Camino Real
Palo Alto, CA 94301
(650) 853-4878
Fax (650) 853-6050
www.pamf.org

Office of the President

September 23, 2005

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

Re. File Code CMS1502-P

Issue Identifier: GPCI's / Payment Localities

Dear Sirs:

The Palo Alto Medical Foundation has a unique perspective on which to comment on the proposed rule for 2006. Our organization consists of 650 physicians providing care to 500,000 patients in four counties in the San Francisco Bay Area. These are: Santa Clara, San Mateo, Alameda and Santa Cruz Counties.

Three of these counties reside in unique physician fee schedule areas and are appropriately reimbursed for services provided to Medicare beneficiaries based on the actual costs within those counties. Santa Cruz County, however, is currently included in the "Rest of " California Locality 99 designation. Santa Cruz County has been the highest cost/most disadvantaged individual county in California's Locality 99 since CMS last reconfigured the national localities in 1996. Furthermore, the boundary payment difference between Santa Cruz and its adjoining counties is substantial (as was addressed in your proposed rule). Your proposed rule appropriately addresses this imbalance.

We were pleased to see that your proposed rule would alleviate this problem by removing both Santa Cruz and Sonoma Counties from Locality 99 and placing them into unique localities. We applaud your efforts to rectify this long-standing inequity. Your proposal will of great help in ensuring access to necessary health care services. The proposed rule is fair. This revision would bring you closer to your goal of reimbursing physicians based on the cost of practice in their locality. We note that this rule change will produce essentially no decrease in payments to the 45 California counties remaining in Locality 99.

We understand the importance of receiving an opinion to the proposed rule from the California Medical Association. We recognize the tremendous efforts made by the CMA over the past three years in attempting to reach an equitable solution for this problem. We also recognize (as CMS states in the proposed rule) that the ultimate responsibility for managing physician fee schedule areas was delegated by Congress to CMS, not to individual state medical societies.

This proposed rule is the first fee schedule locality revision considered by CMS since 1996. We sincerely applaud the leadership exhibited by CMS in addressing this issue. You have appropriately selected the two most disadvantaged counties in the nation and have restored payment equities to the ten counties in the San Francisco Bay Area. We welcome future revisions to the California fee schedule areas to address other counties who may deserve their own payment localities.

Sincerely yours,

David Druker, M.D.
President and CEO

cc. Mark McClellan, M.D. Administrator, CMS

623

Brain Saving Technologies, Inc.
70 Walnut Street
Wellesley Hills, MA 02481

781.239.7580 phone
781.239.7584 fax

SEP 2 - 20

September 22, 2005

Marc H. McClellan, M.D., Ph.D.
Administrator, Centers for Medicare and Medicaid Services (CMS)
Department of Human Services
P.O. Box 8012
Baltimore, Maryland 21244-8012

RE: Comments Regarding Centers for Medicare and Medicaid Services Proposed Rule: "Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule for Calendar Year 2006"

File Code CMS-1502-P.

Issue Identifier: "Submitted Requests for Addition to the List of Telehealth Services"

Dear McClellan:

Brain Saving Technologies (BST) and Tele-Physicians, P.C. are submitting comments to the proposed physician fee schedule for calendar year 2006. BST provides a real-time telemedicine service to hospital emergency departments to bring expert, cost, and time sensitive care to all acute stroke patients. In effect, this fully interactive technology brings expert stroke neurologists in real-time to ER patients' and allows real-time interaction between the emergency physician, patient, family, and consulting stroke neurologist.

More than 700,000 patients suffer from stroke disease every year, making acute stroke the third leading cause of death in the United States and a leading cause of long-term disability. Lee Schwamm, et al[1] write that 50% to 70% of stroke patients that survive regain functional independence; however, 15% to 30% are permanently disabled and 20% require institutional care. According to the 2002 U.S. Health Care Utilization Project's[2] "Hospital Characteristics for Acute Stroke Patients," approximately 28% of the people who suffered acute stroke were under 64 years of age. Of those 158,563 victims, 41,000 (26%) required long term institutional care. These incidents have a devastating effect on the work force as well as to the educational, vocational rehabilitation, and social security disability operational budgets.

Today, stroke costs the United States health care system $53.6 billion annually in direct and indirect health care costs. As of 2003, lifetime costs for ischemic stroke survivors who are 65 years old and older are $95,000 (corrected for inflation), for hemorrhagic stroke survivors, $255,000. These incidents have a devastating effect

on families, the work force as well as on the educational, vocational rehabilitation, and social security disability operational budgets.

Unfortunately, the approach to stroke care remains highly inconsistent because of fragmented physician knowledge, practice capabilities, as well as because of the lack of standardized procedures. Effective stroke treatment requires that assessment and treatment commence as close as possible to the actual event. Beyond three hours, resuscitation of injured brain cells becomes increasingly unlikely, thus leading to brain damage and functional disabilities. The majority of stroke patients present first to a local community hospital, which often are hard-pressed or unable to provide the urgent care required for saving lives or preventing devastating disability.

Two additional factors bear mentioning. First, today, 25% of the U.S. population lives in rural areas that lack easy access to hospitals. Consequently, distance and time remains the enemy of rapid intervention. Rural hospital emergency departments often lack immediately available neurologists, the scanning equipment, and the technologists necessary to operate it. Thus patients who manage to reach a rural or suburban hospital may experience excessive treatment delay because of physician unavailability and/or they often need to be transferred – another time consuming, treatment protracting process. There simply are not enough essential health care personnel currently available to provide around the clock stroke intervention within community hospitals.

Second, neurologists presently comprise between 2% and 3% of medical specialists. In most rural areas, the percentage of neurologists is further reduced. Given that this 2%-3% figure represents general neurology, and that neuro-critical care specialists comprise an extremely small proportion of the specialty, it is no wonder that acute stroke care remains extremely fragmented, uneven, and overwhelming to the majority of physicians. Unfortunately, stroke care today is where acute cardiac care was fifteen years ago. In summary, not only have many localities received the rural HPSA designation, but critical care neurology represents a specialty that is experiencing a critical shortage.

To combat the devastation stroke brings to the individual patient and family, current state-level legislation (Massachusetts, New Jersey, and Florida) attempts to standardize and upgrade the level of acute stroke care. This certification and annual review process formally recognizes a hospital's capacity to treat acute stroke patients and receive patients brought to them by ambulance. To satisfy these requirements medical providers must adopt new approaches for providing quality care for stroke patients. BST's digital video medicine meets Medicare requirements that telemedicine be provided using visual and audio two-way real-time interaction between the physician at the distant site and those at the originating site. In addition to bringing the stroke expert "to the bedside," such telemedicine services can allow more patients to remain in their community. This encourages greater family involvement in patient care, discharge planning, and referral to local health care and rehabilitation systems for ongoing follow-up. Currently, the need to transfer patients to distant hospitals removes them from their families, extended support systems, and makes after-care planning, rehabilitation and follow-up treatment less easy to arrange as well as monitor.

The telemedicine services provided for stroke care include outpatient and inpatient consultation. These are in the list of allowable telehealth services as defined in Section 1842(b) of the Social Security Act. However, the current requirements for providing telehealth services also require that they be provided either in a rural health professional shortage area as defined in section 332(a)(1)(A) of the Public Health Service Act (42 U.S.C. 254e(a)(1)(A) or in a county that is not included in a Metropolitan Service Area (MSA).

The services provided by BST include service areas that are not located in either a HPSA or in a non-MSA

location. However, we feel that the stroke care services using interactive telemedicine supports the provision of essential care for underserved populations. As indicated above, there are insufficient stroke care experts to provide the necessary care in the majority of hospital emergency departments.

Telemedicine has been validated within a community hospital network setting in Southern Germany.[3] Community hospitals are connected to tertiary stroke centers of excellence (sponsoring hospitals) and form a consortium that provides 24/7 time sensitive stroke coverage. Experts at the sponsoring hospital (distant site) examine the stroke patient, consult with the emergency medical physician and family, review CT scans, and provide rapid and effective treatment recommendations. Audebert et al.[ibid] report that of the stroke patients suitable to receive r-tPA, 29% did. This number exceeds any percentages reported to date in the U.S. Additionally 90-day follow-up contacts with these patients indicated that their health status was no different than patients who had been treated at the bedside in either of the University Hospitals.

Audebert et al also reports that acute stroke care provided via telehealth consultation only exhibits similar complication rates to those reported in the National Institute of Neurological Disorders and Stroke trial. Guntram Ickenstein, a BST founder, and current Neurology Director of Dresden Germany's Helios Hospitals reports further amplification of the telemedicine stroke service.[4]

Telemedicine is a means to an end: it is a method for bringing the expert physician from a distant site to an originating hospital's ED. Through the genius and ingenuity of the twenty-first century we are able to ameliorate a shortage in experts and expertise; and it is for the reasons embedded in these comments that we respectfully request that CMS consider classifying remote stroke care provided in <u>all</u> community hospitals as being a qualified telemedicine service under the Medicare program.

Sincerely yours,

Colin T. McDonald, MD
Chief Executive Officer
Brain Saving Technologies

REFERENCES

1. Schwamm, Lee H., MD; Arthur Pancioli, MD; Joe E. Acker III, EMT-P, MPH, MS; Larry B Goldstein, MD; Richard D. Zorowitz, MD; Timothy J. Shephard, PhD, CNRN, CNS; Peter Moyer, MD, MPH; Mark Gorman, MD; S. Claiborne Johnson, MPH, MD, PhD; Pamela W. Duncan, PhD; Phil Gorelick, MD; Jeffrey Frank, MD; Steven K. Stranne, MD, JD; Renee Smith, MA; William Federspiel, BA; Katie B. Horton, RN, JD; Ellen Magnis, MBA; Robter J. Adams, MD, "Recommendations for the Establishent of Stroke Systems of Care. Recommendations from the American Stroke Association's Task Force on the Development of Stroke Systems" Stroke, 2005 36:690-703.

2. Internet Citation: HCUPnet, Healthcare Cost and Utilization Project. Agency for Healthcare Research and Quality, Rockville, MD. http://www.ahrq.gov/HCUPnet/.

3. Audebert, Heinrich J., MD; Christian Kukla, MD; Stephen Clarmann con Claranau, MD; Johannes Kuhn, MD; Bijan Vatankhah, MD; Johannes Schenkel, MD; Guntram W. Ickenstein, MD; Roman L. Haberl, MD; Markus Horn, MD; on behalf of the Tempis Group, "Telemedicine for Safe and Extended Use of Thrombolysis in Stroke: The Telemedic Pilot Project for Integrative Stroke Care (TEMPIS) in Bavaria", Stroke, 2005 Februrary 2005, 287—291

4. Ickenstewin, Guntram W. M Horn, J Schenkel, B. Vatankhah, U. Bogdahn, R. Haberl, and H.J. Audebert. "The Use of Telemedicine in Combination With a New Stroke-Code-Box Significantly Increases t-PA Use in Rural Communities. Neurocritical Care 2005:3:27-32.

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SEP 27 2005

H. LEE MOFFITT Cancer Center & Research Institute

The End Of Cancer Begins Here.

A National Cancer Institute
Comprehensive Cancer Center
At the University of South Florida

Anesthesiology Program

Hector Vila, Jr., M.D.
Program Leader

Voytek Bosek, M.D.
John Downs, M.D.
Allan Escher, D.O.
Jinhong Liu, M.D.
Alonso Mesa, M.D.
Sunil Panchal, M.D.
Kejia Rosenfeld, M.D.
David Thrush, M.D.

September 13, 2005

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

Dear Dr. McClellan:

I am writing as an Academic Anesthesiologist at the H. Lee Moffitt Cancer Center in Tampa, Florida to urge the Centers for Medicare and Medicaid Services (CMS) to change the Medicare anesthesiology teaching payment policy.

Our institution, trains both Anesthesiology Residents and Certified Registered Nurse Anesthetist (CRNA) students and we therefore are fully aware of the economic impact of Medicare's discriminatory payment arrangement. It applies only to anesthesiology teaching programs, and has had a serious detrimental impact on the ability of our anesthesiology residency program to retain skilled faculty and to train the new anesthesiologists necessary to help alleviate the widely-acknowledged shortage of anesthesia providers -- a shortage that will be exacerbated in coming years by the aging of the baby boom generation and their need for surgical services.

The proposed policy revision will not affect in any way the education of Certified Registered Nurse Anesthetist (CRNA) students or the number of CRNA students trained at our institution.

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.

12902 Magnolia Drive, Suite 2184
Tampa, Florida 33612-9497
Phone: (813) 745-8486
Fax: (813) 745-3064
www.moffitt.usf.edu

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

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

Please end the anesthesiology teaching payment penalty.

Sincerely yours,

Alonso Mesa

Alonso Mesa, M.D.

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SOUTH TEXAS RADIOLOGY GROUP

September 22, 2005

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

Re: Medicare Program: Proposed Revisions to the Medicare Physician Fee Schedule for Calendar Year 2006

Dear Sir or Madam:

These comments are directed to you in response to the proposed changes to the physician fee schedule ("PFS") for calendar year 2006, as published in the Federal Register on August 8, 2005. I work in a radiology physician group practice that provides services in in the San Antonio area. These services are provided in hospitals and also in a network of free standing imaging centers.

I am directing to you comments on the following topics:

1. **PRACTICE EXPENSE PROPOSALS FOR CALENDAR YEAR 2006--** Mammography Room Costs
2. **MULTIPLE PROCEDURE REDUCTION** for Diagnostic Imaging
3. **NUCLEAR MEDICINE SERVICES**—Physician referrals when a financial relationship exists

Page 45779- PRACTICE EXPENSE PROPOSALS FOR CALENDAR YEAR 2006
(6) Miscellaneous PE Issues, Imaging Rooms, + Mammography Room

The cost allowance of $168,214 is very appropriate for a standard **analog** mammography room. However, there are also digital mammography rooms that cost approximately 3 to 4 times this amount. Conclusions from recently released research data (see enclosed reference from The New England Journal of Medicine) point to a need to quickly expand the installed base of digital mammography equipment to provide better diagnostic services. Thus the $168,214 cost should be specified as being for an analog mammography room and a **separately identified and more appropriate cost should be established for a digital mammography room.**

Page 45849- MULTIPLE PROCEDURE REDUCTION for Diagnostic Imaging
While it is true that some aspects of the exam processes are not repeated when scanning more than one body part during the same visit, the efficiencies are unlikely to approach 50% of the technical component. For instance, in Table 14 of this proposed rule you have set forth expense rates per hour for radiology as $18.60 for administrative time and $16.50 for office expense. If we assume one-quarter of an hour reduction in each of these activities for the second exam, the reduction in cost is approximately $8.78. In your example on page 45850 you show a proposed reduction of $264.00 when two CT scans are performed on the same date. The disparity is obvious and inappropriate. You are striving to develop a "bottom up" approach to practice expenses using sound survey data, yet this proposed 50% reduction is an arbitrary slash that bears no relationship to actual costs. The APC Advisory Panel fielded testimony related to this proposed 50% reduction at its August, 2005 meeting. The panel has recommended delaying by one year any such reduction to allow CMS additional time for research. This research should yield a conclusion supporting a more realistic measurement of actual cost reductions when multiple studies are performed. I wholeheartedly support further study and abandoning any attempt to implement an arbitrary 50% reduction in 2006.

Page 45854- NUCLEAR MEDICINE SERVICES—Physician referrals when a financial relationship exists
Without question, diagnostic nuclear medicine services need to be considered DHS. Numerous recent studies of the effects of self-referral in imaging have been reported. These studies have repeatedly shown that when physicians have an investment interest in imaging equipment and have the opportunity to self-refer, their utilization is significantly higher than among other physicians who refer their patients to a provider in which the referring physician has no financial interest. Moreover, it has been clearly shown that the majority of recent increases in the utilization of imaging are attributable to non-radiologists who self-refer. Identifying diagnostic nuclear medicine services as a DHS will help alleviate the chronic problem of self-referral and may contribute to a higher level of care for Medicare beneficiaries. These services should have been included in the original listing, because the potential for abuse is no different than for CT scans or MRI scans. For the past several years there have been many anecdotal stories about entrepreneurs, lawyers and medical oncologists developing business ventures for P.E.T. scanning that are, in all likelihood, exacerbating the growth rate in such services simply because there is monetary gain for the referring physician.

You have asked for comments regarding mitigating the financial effects on current physician investors, should you proceed with categorizing nuclear medicine services as DHS. No mitigation is needed. If these investment arrangements have business foundations that are substantive, then the investors will have very little trouble divesting

their interests. If no solid business foundation exists, then any financial difficulties suffered by the referring physicians are appropriate. The only accommodation that is indicated is a relatively short period of time for divestiture to be accomplished. I suggest that June 30, 2006 is an appropriate deadline. That date will have been nearly 11 months since the publication of this proposed rule. **Under no circumstances should any grandfathering of existing arrangements be allowed.** There is no precedent for grandfathering these abusive ventures relative to other DHS.

Thank you for considering the above comments.

Sincerely,

Philip J. Russell, CMPE
Chief Executive Officer

ORIGINAL ARTICLE

Diagnostic Performance of Digital versus Film Mammography for Breast-Cancer Screening

Etta D. Pisano, M.D., Constantine Gatsonis, Ph.D., Edward Hendrick, Ph.D., Martin Yaffe, Ph.D., Janet K. Baum, M.D., Suddhasatta Acharyya, Ph.D., Emily F. Conant, M.D., Laurie L. Fajardo, M.D., Lawrence Bassett, M.D., Carl D'Orsi, M.D., Roberta Jong, M.D., and Murray Rebner, M.D., for the Digital Mammographic Imaging Screening Trial (DMIST) Investigators Group*

ABSTRACT

BACKGROUND

Film mammography has limited sensitivity for the detection of breast cancer in women with radiographically dense breasts. We assessed whether the use of digital mammography would avoid some of these limitations.

METHODS

A total of 49,528 asymptomatic women presenting for screening mammography at 33 sites in the United States and Canada underwent both digital and film mammography. All relevant information was available for 42,760 of these women (86.3 percent). Mammograms were interpreted independently by two radiologists. Breast-cancer status was ascertained on the basis of a breast biopsy done within 15 months after study entry or a follow-up mammogram obtained at least 10 months after study entry. Receiver-operating-characteristic (ROC) analysis was used to evaluate the results.

RESULTS

In the entire population, the diagnostic accuracy of digital and film mammography was similar (difference between methods in the area under the ROC curve, 0.03; 95 percent confidence interval, −0.02 to 0.08; P=0.18). However, the accuracy of digital mammography was significantly higher than that of film mammography among women under the age of 50 years (difference in the area under the curve, 0.15; 95 percent confidence interval, 0.05 to 0.25; P=0.002), women with heterogeneously dense or extremely dense breasts on mammography (difference, 0.11; 95 percent confidence interval, 0.04 to 0.18; P=0.003), and premenopausal or perimenopausal women (difference, 0.15; 95 percent confidence interval, 0.05 to 0.24; P=0.002).

CONCLUSIONS

The overall diagnostic accuracy of digital and film mammography as a means of screening for breast cancer is similar, but digital mammography is more accurate in women under the age of 50 years, women with radiographically dense breasts, and premenopausal or perimenopausal women. (clinicaltrials.gov number, NCT00008346.)

From the Departments of Radiology and Biomedical Engineering, the Biomedical Research Imaging Center, and the Lineberger Comprehensive Cancer Center, University of North Carolina at Chapel Hill, Chapel Hill (E.D.P.); the Center for Statistical Sciences, Brown University, Providence, R.I. (C.G., S.A.); the Department of Radiology, Feinberg School of Medicine, Northwestern University, Chicago (E.H.); the Departments of Medical Imaging (M.Y., R.J.) and Medical Biophysics (M.Y.), University of Toronto, Toronto; the Department of Radiology, Beth Israel Deaconess Medical Center, Boston (J.K.B.); the Department of Radiology, University of Pennsylvania Medical School, Philadelphia (E.F.C.); the Department of Radiology, University of Iowa, Iowa City (L.L.F.); the Department of Radiology, University of California at Los Angeles, Los Angeles (L.B.); the Department of Radiology, Emory University, Atlanta (C.D.); and the Department of Radiology, William Beaumont Hospital, Royal Oak, Mich. (M.R.). Address reprint requests to Dr. Pisano at etta_pisano@med.unc.edu.

*Members of the DMIST Investigators Group are listed in the Appendix.

N Engl J Med 2005;353.

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UnitedHealthcare

A UnitedHealth Group Company

5901 Lincoln Drive Edina MN 55436

September 19, 2005

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

Re: UnitedHealthcare comments on: **Federal Register** / Vol. 70, No. 151 / August 8, 2005 / Proposed Rules / pages 45764-46064, **Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule for Calendar Year 2006**

Dear Sir or Madame:

UnitedHealthcare respectfully submits the following comments in reply to your invitation to comment on the above referenced **Federal Register** publication on proposed revisions to the 2006 physician fee schedule.

Please feel free to contact me if you have questions or require additional information.

Sincerely,

Elena McFann, Vice President Physician Network Management
UnitedHealth Networks, a UnitedHealth Group Company
5901 Lincoln Drive, MN012-S204
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elena_j_mcfann@uhc.com

Enclosure: One original and two copies

CC: Robert Holman, Director, Fee Schedule Administration
Steve Affield

UnitedHealthcare Comments

Comment 1 [RESOURCE-BASED PRACTICE EXPENSE (PE) RVUS]

UnitedHealthcare comments
UnitedHealthcare has a stake in CMS RVUs which are used to build commercial fee schedules. While supporting the "bottom-up" PE RVUs calculation method conceptually, UnitedHealthcare has the following concerns regarding its implementation:

- Aggregate budget neutrality is more difficult to control using a "bottom-up" approach than using "top-down" because in the case of "top-down," aggregate costs are the starting point of the process.
- UnitedHealthcare requests that all budget neutrality adjustments are applied to the PE RVUs rather than to either only the conversion factor, or to a combination of the PE RVUs and the conversion factor. Applying such adjustments to the PE RVUs alone is necessary in order for commercial payers to manage the medical expense spend impact of CMS RVU fee schedules.
- It would simplify the commercial fee schedule construction process and ease administrative burden if during the 2006 to 2008 PE RVU blend period CMS would publish the blended RVUs for each year rather than publishing the current and "bottom-up" PE RVUs separately accompanied by the blended RVU derivation formula.
- There is a significant difference in medical case mix between Medicare and commercial claims data. Budget neutrality factors calculated exclusively based on Medicare data may not be budget neutral when applied to commercial data. UnitedHealthcare requests that CMS incorporate commercial payer claims data into RVU budget neutrality calculations.

Comment 2 GEOGRAPHIC PRACTICE COST INDICES [GPCIs]

UnitedHealthcare comments
UnitedHealthcare disagrees with the need to increase the number of California Geographic Practice Cost areas, and will suggest as an alternative to reduce the number of California payment areas from 10 to 3. Adding geographic payment areas increases Medicare medical spend and administrative cost. Medicare payment areas should not be increased in number unless the need for them is unequivocal.

Adding Medicare physician payment areas is contrary to long range goals expressed in CMS physician fee schedule publications dating back to the 1990s. In the years immediately following implementation of the Medicare physician fee schedule, CMS reached out to state medical societies to consolidate geographic payment localities into statewide areas. States such as Minnesota, Ohio and others acted on this CMS leadership and converted to single statewide Medicare payment localities.

As part of operations, UnitedHealthcare builds fee schedules to align with Medicare locality-based fee schedules. Maintaining more geographic payment localities than necessary increases the number of fee schedules to be built and maintained, and increases commercial payer administrative burden.

Information presented in the proposed rule Addendum E- Proposed Geographic Adjustment Factors (GAFs) indicates that the percentage difference in cost between California several payment areas is less than the accuracy of the cost measurement process. In addition, some of the California payment areas presented are within common metropolitan labor and medical service delivery market area boundaries.

Addendum E GAFs do not support the need for additional California payment localities; on the contrary, they offer a basis for consolidating the 10 existing California payment localities into the following 3:

Suggested locality 1: (Marin/Napa 03), (San Francisco 05), (San Mateo 06), (Oakland 07) and (Santa Clara 09)

Suggested locality 2: (Ventura 17), (Los Angeles 18) and (Anaheim 26)

Suggested locality 3: Rest of California

If the three suggested California localities presented above were adopted, variation in practice cost (based on Addendum E published GAFs) within suggested locality 1 would be less than 10 percent and within suggested locality 2 would be less than 7 percent.

Comment 3: [CODING-CONTRACTOR PRICING] Ending RVU assignment of Unlisted Therapy Modalities and Procedures

UnitedHealthcare comments
UnitedHealthcare supports discontinuing RVU assignment of unlisted therapy modalities and procedures, and the proposal to carrier price CPTs 97039 and 97139. The logic behind this support is that if an unlisted code can be used to represent more than one service or procedure, then there is no rational basis for assigning the code a fee schedule rate.

Comment 4 [TEACHING ANESTHESIOLOGISTS] ASA Requested Payment Changes for Teaching Anesthesiologists

UnitedHealthcare comments
UnitedHealthcare requests CMS consideration for the establishment of a new HCPCS anesthesia claim modifier rather than continuation and/or building on the revised policy announced in the November 7, 2003 PFS final rule that provides the alternate form for reporting the supervision of two residents.

UnitedHealthcare requests a new HCPCS anesthesia modifier that a teaching anesthesiologist could report to denote that the service performed was medical direction of two concurrent cases involving either two residents or one student nurse anesthetist and one resident. Payment for the physician's medical direction of two concurrent cases involving two residents or one student nurse anesthetist and one resident should be determined on the basis of a percentage greater than 50% of the allowance for the service performed by the physician alone.

UnitedHealthcare recognizes that the supervision of residents, student nurse anesthetists and/or interns requires a greater risk and intensity than the medical direction of other qualified individuals such as AAs or CRNAs because the attending anesthesiologist must be able to intervene immediately due to the inexperience of the person being supervised. Therefore, UnitedHealthcare is in support of a greater reimbursement allowance than the current modifier QK.

Comment 5 [PAYMENT FOR COVERED OUTPATIENT DRUGS AND BIOLOGICALS]

UnitedHealthcare comments
UnitedHealthcare supports refinements to CMS payment methodologies that meet five criteria:
1. **Understandable:** Drug rate methodologies are clear and readily understood by persons with health care industry knowledge
2. **Transparent:** Drug rate setting validity is backed up in the public domain with detailed drug fee rate calculations
3. **Reasonable**: Drug rates do not either over-compensate or under-compensate
4. **Credible**: Rate setting is based on widely accepted health care industry standards
5. **Timely:** Rate setting is based on up-to-date pricing.

In the context of credible drug rates, UnitedHealthcare is concerned about how well Widely Available Market Price (WAMP) and Average Manufacturer Price (AMP) rates are understood across the healthcare industry.

Comment 6 [INHALATION DRUGS AND DISPENSING FEE]

UnitedHealthcare comments
UnitedHealthcare has a stake in CMS drug dispensing rates because they establish payer industry norms and place upward pressure on commercial rates. The current CMS fee for E0590, (dispensing fee covered drug administered through DME nebulizer) appears high. UnitedHealthcare prefers dispensing to be included in the equipment acquisition rate.

Comment 7 [SUPPLYING FEE]

UnitedHealthcare comments
Current CMS fees for G0369 Pharmacy supply fee for initial immunosuppressive drug(s) first month following transplant, and G0370 Pharmacy supply fee for oral anti-cancer, oral anti-emetic or immunosuppressive drug(s), appear high. UnitedHealthcare has a stake in CMS drug dispensing rates because they establish payer industry norms and place upward pressure on commercial rates.

Comment 8 [MULTIPLE PROCEDURE REDUCTION]

UnitedHealthcare comments
UnitedHealthcare supports the proposed rule regarding multiple procedure reduction for diagnostic imaging. UnitedHealthcare recognizes that the performance of multiple procedures, performed in a subsequent fashion, consume a limited amount of human (technical labor) and supplementary material resources. Reimbursement of the technical component should be adjusted to reflect this practice.

Comment 9 [NDC TIMEFRAMES]

UnitedHealthcare comments
UnitedHealthcare finds the proposed 6 month / 9 month timeline acceptable.

Comment 10 [NUCLEAR MEDICINE SERVICES]

UnitedHealthcare comments
UnitedHealthcare supports expansion of the Stark self-referral rule to include nuclear medicine services. The proliferation of imaging units in non-hospital environments has contributed significantly to the increase in diagnostic imaging costs. While the advancement of PET technology has proven to be a clinically effective diagnostic imaging tool, there should be equal extension and universal application of the Stark rule to all imaging providers. UnitedHealthcare would favor a reasonable delayed effective date (e.g., 3 to 6 months) versus a grandfather approach to the extension of this proposed rule.

UnitedHealthcare uses CMS PET RVUs to build commercial fee schedules. Currently CMS does not publish either TC or global RVUs for PET services. The implied reason for not publishing TC or global RVUs is that PET is delivered in the facility setting.

Implementing CMS PET TC and global RVUs is supported by CMS statements indicating that PET is commonly performed in non-hospital settings. CMS publication of PET TC and global RVUs would decrease commercial health coverage payer operating cost and administrative burden associated with creating CMS RVU-based fee schedules.

Comment 11 [SGR]

UnitedHealthcare comments
UnitedHealthcare supports the President's goal of improving quality without increasing cost or disrupting MMA implementation and recommends implementing best practices toward deterring excessive utilization driven cost increases.

UnitedHealthcare recommends that CMS examine use of evidence-based medicine and consensus-based measures to promote higher quality care by physicians; including measures endorsed by the National Quality Foundation, National Committee for Quality Assurance, and Clinical Society-based rules. UnitedHealthcare recommends that CMS consider evaluating use of clinical episode cost as a resource efficiency measurement.

SEP 28 2005

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livenutrition

Margaret Davis, MS RD LD FADA CDE

Fellow of the American Dietetic Association
Registered Dietitian

September 23, 2005

Dr. Mark McClellan
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Attention: CMS-1502-P
Baltimore, MD 21244-8012.

Dear Dr. McClellan:

The Massachusetts State Dietetic Association (MDA)is pleased to comment on the Revisions to Payment Polices Under the Physician Fee Schedule for Calendar Year 2006. The MDA represents nearly 1500 food and nutrition professionals who serve the public by providing Medical Nutrition Therapy and by promoting optimal health through nutrition.

MDA has two main areas of interest with the proposed rule: (1) the agency's methodology for calculating practice expense for medical nutrition therapy (MNT) codes, and (2) the proposed changes for Medicare telehealth services. These two items impact the provision of MNT services, a covered Medicare service for eligible beneficiaries with diabetes and kidney disease.

Our specific comments follow:

1. **II.A. 2.—Practice Expense Proposals for Calendar Year 2006**
   The new methodology used to determine code values (RVUs) for non-physician practitioner services does not appropriately recognize the professional RD provider work effort within the practice expense (PE) values. We urge CMS to be receptive to approaches that deal with the work of non-physicians (e.g. registered dietitians) where the statute authorizes such services, such as MNT services. In addition, we request that CMS work with the American Dietetic Association to determine an alternative methodology for establishing PE for the MNT codes. While discussions of such alternatives occur, we suggest the agency delay implementation of the 2006 PE values for the MNT codes, and instead use the 2005 values until a satisfactory methodology is determined.

2. **II.D. Telehealth.**
   MDA supports CMS' recommendation to recognize individual medical nutrition therapy (MNT) as a Medicare telehealth service. We also support CMS' proposed rule to add registered dietitians and qualified nutrition professionals to the list of practitioners who are authorized to furnish and receive payment for telehealth services. We realize that this technology is currently used by certain authorized Medicare health professionals in rural health areas with a shortage of healthcare professionals. Including MNT in the list of approved telehealth services, and extending this to RD

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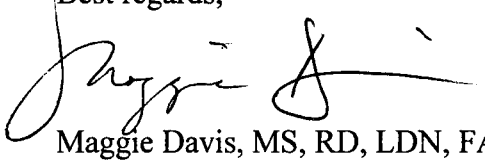
Medicare providers will improve access and services for patient/clients in remote areas where traditional MNT services may not be readily available. Many areas of Massachusetts such as the far western counties and my own area of Cape Cod are representative of the rural areas in which Medicare subscribers would benefit from telehealth services - this past winter with heavy snows severely limited the access to Medical Nutrition Therapy of many elderly in Massachusetts. Many of my own patients had to postpone office visits even when they were in need of MNT for uncontrolled diabetes and end-stage renal disease. They would have been maintained in better control and experienced fewer complications with the provision of telehealth services from their Dietitian.

Thank you for considering these comments in CMS' revisions to the 2006 Physician Fee Schedule. Please contact me if I can be of further help in clarifying my comments.

Best regards,



Maggie Davis, MS, RD, LDN, FADA, CDE
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cc: The American Dietetic Association Policy Initiatives and Advocacy Group
Ann Marie Gennari, President, Massachusetts Dietetic Association

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Thoracic Cardiovascular Institute

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September 28, 2005

Mark McClellan, M.D., Ph.D.
Administrator, Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1502-P
Mail Stop C4-26-05
Baltimore, MD 21244-8150

Re: Comments on 2006 Physician Fee Schedule Proposed Rule (CMS-1502-P)

Dear Dr. McClellan:

I am writing to you to express my strong concerns with the proposed payment rates under the physician fee schedule for certain codes for First Pass imaging services – Current Procedural Terminology (CPT) codes 78481 and 78483. With the proposed change in practice expense methodology, I understand that when the change is fully implemented, the practice expensive values for these codes will decrease by as much as 60%. I also understand that much of this decrease is the result of the data the Centers for Medicare and Medicaid Services (CMS) will use to set the rates, which reflect that there are no equipment costs for these services. I use these codes in my practice and I know that equipment is used in furnishing the services billed under 78481 and 78483 because I incur the cost of the dedicated camera used to conduct the First Pass imaging service. I urge CMS to consider the equipment costs when determining the practice expense relative value units (RVUs) used to set the 2006 payment rates for these codes.

Thoracic & Cardiovascular Institute (TCI) provides nearly two thirds of the cardiology services in the greater Lansing, Michigan area. Within the past year we have evaluated the usefulness and efficacy of the First Pass imaging and, based on that evaluation, we have invested heavily in the equipment and training necessary to provide this valuable service to our patients. The cost of each of our first pass cameras was more than $250,000. In addition, we have invested in two addition nuclear technicians and training for each of our existing technicians. There are clearly cost associated with the installation and maintenance of our special first pass cameras.

Clinically, we found the addition of rest/stress RNA to perfusion imaging has increased our diagnostic accuracy and sensitivity for detecting coronary artery disease. We have several examples of patients who have had normal perfusion imaging, but had abnormal stress ejection fractions and it turns out that the patient has had severe three-vessel coronary artery disease. It is well known that balanced ischemia can give you a false-negative perfusion study. We have also found the stress RNA to be useful in reducing our number of false-positive perfusion studies, particularly in women with breast attenuation. Again, we have several examples of patients who have had what appears to be ischemia and areas of attenuation who have had normal stress RNA's. In these situations, we have actually avoided having to send patients in for catheterizations to confirm their normal coronaries. As I am sure you are aware, a heart catheterization, by the time it is all said and done, is much more expensive than the stress RNA.

As you can see, there are, in fact, equipment costs that I and my colleagues incur when performing First Pass imaging tests. It is surprising that the data you are using to set the payment rates for these codes contain no costs for equipment. I respectfully ask the agency to fix this when finalizing the 2006 payment rates. Without appropriate reimbursement, my practice will no longer be able to provide this valuable diagnostic test to the cardiac patients in the greater Lansing area. This would truly be a step backward for the cardiac patients in our community.

For these reasons, I ask that CMS reassess the equipment costs for CPT codes 78481 and 78483. At the very least, CMS can use the equipment costs for other codes, such as 78465, to quantify the equipment costs used in these procedures and to then compute the 2006 payment rates for the codes utilizing this information.

Thank you for your consideration of this matter. I look forward to a favorable resolution to the payment rates in the final rule. If you have questions, please do not hesitate to contact me at (517) 483-7550.

Sincerely,

Daryl Melvin, MD, FACC

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SEP 28 2005

Sutter Santa Cruz

A Sutter Health Affiliate

2025 Soquel Avenue
Santa Cruz, CA 95062

September 26, 2005

Mark McClellan, M.D.
Herb Kuhn
Steve Phillips
7500 Security Blvd.
Baltimore, Maryland 21244

Re: GPCIs

Dear Sirs:

We have been closely involved with the California Medical Association over the past four years addressing inequities in GPCI reimbursement at the county level that result from the current payment locality configuration. We have met with former Administrator Scully and with Mr. Kuhn suggesting solutions for the California problem. In addition, we have worked with Med PAC and Ways and Means staff to identify national solutions. We would like to commend you for taking the first credible steps in a decade toward addressing this problem. We would also like to commend you for making those steps so that no appreciable reductions in payment to our colleagues would occur. We understand that you have inherited from your predecessors a very divisive issue; we remain committed to working with you to find a comprehensive and permanent national solution to this issue.

In 1996 when HCFA proposed the current 89-physician fee schedule areas there were no provisions for automatic review of those areas. While it was recognized that future revisions might be considered if significant relative practice expense changes were to occur, it is clear that such changes now require the unanimous consent of all affected parties with the full support of the state medical society. In effect, no revisions will ever occur without legislative action.

With each three-year cycle of GPCI review, many of these 89 localities have seen a disproportionate inflation of costs. With each cycle, the goal to distribute payments to providers based on geographic variations in costs in an equitable manner becomes more distant. In essence, the problem worsens each year and the resolution to the problem becomes more and more elusive.

We agree that Congress has left you with little discretion as to how to affect changes to the fee schedule areas. The innovative 2004 CMA compromise proposal was problematic insofar as cost indexing within our state would have varied from other areas. Therefore, revisions to established fee schedule areas will always be perceived as a takeaway by many counties within, even though those takeaways are relative overpayments.

The mismatch between the management of geographic areas for payments to facilities and to providers is unexplainable. The use of MSA-derived expense data in the calculations of the GPCIs only further confuses this issue. We believe that the ultimate solution to the physician fee schedule area problem may be to configure the physician localities based on MSAs. This would eliminate the need for CMS and state medical societies to

concentrate limited resources on such an inherently divisive issue. MSAs are not defined by CMS therefore revisions to fee schedule areas would neither require oversight by CMS nor state medical societies.

This, of course, would require Congressional action and an appropriate transition period to mitigate against disruptive reductions in payment to many providers.

The August proposed rule (the two county California proposal) is the only possible avenue available to CMS to manage this problem without forcing payment reductions. You appropriately chose the only state and the only metropolitan area where budget neutrality rules could allow for an incremental change without decreasing payments to other providers. This proposal has caught the attention of the oversight committees in Congress as well as the attention of many other state medical societies. Med PAC is attempting to develop a comprehensive legislative solution to present to the appropriate Congressional committees.

We believe that if CMS were to respond to opponents of the proposed rule by withdrawing the two county proposal, the wrong message would be sent. Such action de-emphasizes the problem and gives integrity to the status quo. It prefers increasing redistributive payments within Locality 99 and greater payment error. It places the value of a 0.4% GPCI increase over the value of corrective action without payment reduction. It ignores the high costs and inequities. It shows disregard to the intent of geographic adjustment. The inclusion of the CA two county solution in the final 2006 rule would clearly state that CMS has done all that it conceivably can under the constraints of the SSA. There is appropriate recognition that the boundary payment problem between the two SF Bay Area counties and the current adjoining five localities deserves immediate attention. The urgency of action and limited scope emphasizes your problem and will undoubtedly encourage development of a legislative solution to the national problem so that significant payment reductions are not incurred in a final solution. Such action is taken at little cost.

Current law has placed CMS in a no win position. Congress is critical of CMS for its inaction on this issue and yet existing law limits options. It would be inappropriate for Congress to object to the only reasonable revision that CMS could implement under constraints of current law. Your proposed rule exemplifies these constraints. If the two county proposal is withdrawn, CMS will have lost an important opportunity to demonstrate the limited opportunities for revision available to CMS at this time. We therefore respectfully request that you implement the CA two county proposal.

Sincerely,

George Wolfe, M.D.
Public Health Officer
Retired
Santa Cruz County

Edward Bentley, M.D.
Santa Barbara Co Med Society
Immediate Past President

Larry deGhetaldi, M.D.
CEO Sutter Health Affiliates
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cc: Secretary Michael Leavitt
Member of Congress Sam Farr
Member of Congress Anna Eshoo

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SEP 28 2005

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September 26, 2005

Mark McClellan, M.D., Ph.D.
Administrator, Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1502-P
Mail Stop: C4-26-05
Baltimore, MD 21244-8150

Dear Dr. McClellan:

I am writing to you to express my strong concerns with the proposed payment rates under the physician fee schedule for certain codes for First Pass imaging services – Current Procedural Terminology (CPT) codes 78481 and 78483. With the proposed change in practice expense methodology, I understand that when the change is fully implemented, the practice expensive values for these codes will decrease as much as 60%. I also understand that much of this decrease is the result of the data the Centers for Medicare and Medicaid Services (CMS) will use to set the rates, which reflect that there are no equipment costs for these services. I use these codes in my practice and I know that equipment is used in furnishing the services billed under 78481 and 78483 because I incur the cost of the dedicated camera used to conduct the First Pass imaging service. I urge CMS to consider the equipment costs when determining the practice expense relative value units (RVUs) used to set the 2006 payment rates for these codes.

I am a sole practitioner Cardiologist. I have been using First Pass in my practice for the last six months. It has greatly enhanced my myocardial perfusion imaging testing sensitivity and specificity. It has affected patient treatment and management in a very positive way and I feel I most certainly have picked up significant cardiac perfusion issues that would not have been picked up with plain myocardial perfusion imaging alone.

As you are aware the technology and the equipment does not come without a significant price and I feel that First Pass is an extremely important diagnostic tool but if reimbursements were to decline, I would not be able to continue the operation because of expense.

As you can see, there are, in fact, equipment costs that I and my colleagues incur when performing First Pass imaging tests. It is surprising that the data you are using to set the payment rates for these codes contain no costs for equipment. I respectfully ask the agency to fix this when finalizing the 2006 payment rates.

I ask that CMS reassess the equipment costs for CPT codes 78481 and 78483. At the very least, CMS can use the equipment costs for other codes, such as 78465, to quantify the equipment costs used in these procedures and to then compute the 2006 payment rates for the codes utilizing this information.

Thank you for your consideration of this matter. I look forward to a favorable resolution to the payment rates in the final rule. If you have questions, please do not hesitate to contact me at (802) 773-1128.

Sincerely,

Michael E. Robertello, M.D.

MER/cjm

631

SEP 28 2005

September 27, 2005

Mark B. McClellan, MD, PhD
Administrator
Centers for Medicare & Medicaid Services
Room 445-G
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, D.C. 20201

VIA FED EX

Re: CMS-1502-P -- Comments on the Proposed Rule for Calendar Year 2006 Payment Policies Under the Physician Fee Schedule

I. INTRODUCTION

MMS appreciates this opportunity to submit comments to the Centers for Medicare and Medicaid Services (CMS) concerning the proposed rule revisions to the payment policies under the Medicare Physician Fee Schedule for calendar year 2006 (the Proposed Rule).[1] Specifically, we wish to comment on the Proposed Rule's treatment of three-dimensional pre-operative and post-operative computer-aided measurement planning and simulation (3D-CAMPS) technology, which currently is reported by physicians under G0288: "Reconstruction, computed tomographic angiography of aorta for preoperative planning and evaluation post vascular surgery."

As we have conveyed to CMS in a number of other contexts, 3D-CAMPS refers to a specific and unique type of health information technology service that enables vascular surgeons to deliver the highest form of treatment for abdominal aortic aneurysms (AAAs) and thoracic aortic aneurysms (TAAs). Our product Preview® was the first commercially marketed 3D-CAMPS service. Significantly, 3D-CAMPS and Preview are not synonymous; rather, 3D-CAMPS is a non-proprietary generic term that refers to a software technology that delivers precise anatomical measurements and three-dimensional modeling in conformance with a specific suite of measurements endorsed by the Society for Vascular Surgery and recognized by

[1] See Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule for the Calendar Year 2005, 70 Fed. Reg. 45,764 (August 8, 2005).

the Food and Drug Administration (FDA) as adequate for postmarketing surveillance of stent grafts.

We have two principal comments on the Proposed Rule. First, the descriptor for G0288, the creation of which CMS announced in the calendar year 2003 Physician Fee Schedule final rule, fails to describe 3D-CAMPS technology with adequate specificity and accuracy. Second, we acknowledge that the proposed payment level for G0288, while still below the acquisition cost for Preview, is stable relative to the CY2005 payment. But we suggest that any significant alteration in the current value should be done only after analysis and acquisition of an accurate database of resource inputs to ensure that payment for G0288 is accurate and that Medicare beneficiaries and their physicians can continue to benefit from the use of 3D-CAMPS technology.

II. BACKGROUND ON 3D-CAMPS

Before the development of 3D-CAMPS technology, the primary tool for surgical planning and post-procedure monitoring for AAAs and TAAs was an angiogram, which is a costly, invasive procedure that presents significant health risks to Medicare patients. 3D-CAMPS provides physicians with detailed anatomic measurements and a far more accurate picture of a patient's condition compared to angiograms, at significantly less cost to the health care system. 3D-CAMPS's measurements, along with its highly accurate multi-model object planning tool, are the basis for physicians to execute AAA and TAA surgical planning and post-operative evaluation.

The development of 3D-CAMPS was driven largely by FDA's concerns with serious complications reported with stent grafts.[2] Shortly after issuing a public notification on these devices in 2001, FDA began consultations with representatives from the Society for Vascular Surgery ("SVS"), MMS, and stent graft manufacturers to develop a system that would enable post-surgical monitoring of AAA patients. Through this collaborative process, a suite of anatomical measurements was developed that was deemed by FDA to be the standard of care for post-operative monitoring of stent graft implantation, including to assess the need to correct graft migration or loss of exclusion of aortic pressure from the aneurysm sac. This suite of measurements, along with other functionality specifications (including the ability to perform

[2] On April 27, 2001, FDA issued a Public Health Notification expressing concerns with reports of serious adverse events with stent grafts thought to be associated with sub-optimal graft placement, endoleak, graft migration, problems with device integrity, and aneurysm anatomy. See Food and Drug Administration, "FDA Public Health Notification: Problems with Endovascular Grafts for Treatment of Abdominal Aortic Aneurysm (AAA)" (April 27, 2001); see also Food and Drug Administration, "FDA Public Health Notification: Updated Data on Mortality Associated with Medtronic AVE AneuRx® Stent Graft System" (December 17, 2003). In the notification, FDA said it is "critical that physicians who evaluate and treat AAA patients have the information needed to make informed decisions on patient selection, device selection, and follow-up management." FDA said it would work with manufacturers to "obtain relevant data that will help us understand how these problems affect the overall risk/benefit assessment of this product."

multi-object three-dimensional modeling), became the basis of 3D-CAMPS technology, which was first developed by MMS in the form of its Preview product.[3]

In addition to its central role in AAA and TAA postmarketing surveillance, 3D-CAMPS also has emerged as the standard of care for pre-surgical treatment planning, and the most effective means of meeting the stent graft labeling requirements for pre-operative measurement. The precise measurements provided by 3D-CAMPS greatly enhance a surgeon's ability to plan the intervention, and thereby minimize the incidence of complications attributable to improper patient or graft selection and incorrect graft placement.

III. PROBLEMS WITH PROPOSED RULE AND RECOMMENDATIONS

A. Descriptor for G0288

Since 2003, physicians have reported 3D-CAMPS using G0288, "Reconstruction, computed tomographic angiography of aorta for preoperative planning and evaluation post vascular surgery."[4] The descriptor for this code does not describe 3D-CAMPS technology accurately or with adequate specificity. First, and most importantly, the code should specify that it may be used only for 3D-CAMPS technologies capable of generating the measurements and modeling deemed essential by SVS. In addition, the code descriptor should not be limited to services that use computed tomography angiography (CTA). Many hospitals do not perform CTA on-site, and some patients who must undergo vascular surgery of the aorta cannot tolerate the contrast material used to generate a CTA. Under such circumstances, 3D-CAMPS can process data from computed tomography (CT) or magnetic resonance (MR) images.

Accordingly, CMS should revise the descriptor for G0288 so that it reads as follows: **"Three-dimensional pre-operative and post-operative computer-aided measurement planning and simulation in accordance with measurements and modeling specifications of the Society for Vascular Surgery."**

B. Valuation for G0288

CMS proposes a non-facility total relative value of 10.81 units for G0288, which yields a payment for the service of $392.06 (10.81 [RVUs] x $36.2679 [CF]). Because all physician practices that use 3D-CAMPS purchase the service from an outside entity, the practice expenses for G0288 should equal physicians' actual acquisition cost for the service. MMS's Preview 3D-

[3] Because of the expense of establishing an information technology infrastructure capable of performing 3D-CAMPS, most physicians currently obtain this service on a contract basis with MMS. Nevertheless, a small (and we expect increasing) number of larger institutions are capable of providing genuine 3D-CAMPS services in-house, and it is a distinct possibility that another entity will emerge to compete with MMS in providing 3D-CAMPS on a contract basis.

[4] Upon its introduction, the code was described as "Reconstruction, computed tomographic angiography of aorta for surgical planning for vascular surgery." In response to comments by MMS, CMS subsequently changed the descriptor to encompass use of the code for post-operative monitoring.

CAMPS product currently comprises the overwhelming majority of the market for 3D-CAMPS, and according to MMS's sales data the known physicians' median acquisition cost for 3D-CAMPS is $ 476.22, which exceeds the proposed physician fee schedule payment for G0288 by $84.16, or 21.5%. Even though a discrepancy between the valuation of G0288 and the actual cost to physicians to obtain this service will persist in CY2006, we acknowledge that the payment will be stable relative to CY2005.

However, we suggest that any significant alteration in the current value for G0288 should be done only after an analysis and acquisition of an accurate database of resource inputs to ensure that payment for G0288 is accurate and that Medicare beneficiaries and their physicians can continue to benefit from the use of 3D-CAMPS technology.

* * *

We appreciate the opportunity to provide these comments and are eager to work with CMS to ensure that physicians and patients continue to realize the clinical benefits offered by 3D-CAMPS. Please let me know if I can be of further assistance.

Sincerely,

M. Weston Chapman (MWC)

M. Weston Chapman
Chairman and Chief Executive Officer

12 Commerce Avenue | West Lebanon, NH 03784 | p: 603.298.5509 | f: 603.298.5055 | www.medicalmetrx.com

SEP 28 2005 632

University Orthopaedics and Sports Medicine
30 E. Apple Street, Suite 5250
Dayton, Ohio 45409
937/208-2091

September 26, 2005

Centers for Medicare & Medicaid Services
Attn: CMS-1502-P, Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, Maryland 21244-1850

Dear Sirs:

I am in receipt of your recent proposed changes to the Federal Register, Volume 70, No. 151. dated Monday, August 8, 2005, specifically, page 45778 item 5, copy attached, pertaining to Payment for Splint and Cast Supplies.

I object to the "Direct Practice Expense Inputs" section of the proposed regulations for the proposed bundling of casting supplies with the surgical codes.

I am an orthopaedist and see many trauma surgical patients who routinely obtain **multiple** casts during their postoperative global period both 10 day and 90 day surgical period. Casting can be either short and long arm or short and long leg casts. The average fracture patient could utilize three casts during their global period and the average surgical, non fracture, patient could utilize two during their global period of which currently the first is included.

As you know, the cost of almost every item available to a physician's office for casting supplies changes frequently and to have my office absorb these costs without increase and be reimbursed for these charges on a **regular** basis would be prohibitive. The cost would have to be passed on by increasing surgical fees.

At this time, I request that you re-consider your revision to this specific regulation and not change the current policy.

Sincerely,

Ronald Lakatos, M.D.
University Orthopaedics and Sports Medicine
30 E. Apple Street, Suite 5250
Dayton, Ohio 45409

SEP 28 2005 633

University Orthopaedics and Sports Medicine
30 E. Apple Street, Suite 5250
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937/208-2091

September 26, 2005

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Sincerely,

Richard T. Laughlin, M.D.
University Orthopaedics and Sports Medicine
30 E. Apple Street, Suite 5250
Dayton, Ohio 45409

SEP 28 2005 634

University Orthopaedics and Sports Medicine
30 E. Apple Street, Suite 5250
Dayton, Ohio 45409
937/208-2091

September 26, 2005

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Sincerely,

Michael Prayson MD

Michael Prayson, M.D.
University Orthopaedics and Sports Medicine
30 E. Apple Street, Suite 5250
Dayton, Ohio 45409

SEP 28 2005 635

University Orthopaedics and Sports Medicine
30 E. Apple Street, Suite 5250
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Sincerely,

Corey Russell, DPM

Corey Russell, D.P.M.
University Orthopaedics and Sports Medicine
30 E. Apple Street, Suite 5250
Dayton, Ohio 45409

SEP 28 2005 636

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30 E. Apple Street, Suite 5250
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At this time, I request that you re-consider your revision to this specific regulation and not change the current policy.

Sincerely,

Matthew Lawless, M.D.
University Orthopaedics and Sports Medicine
30 E. Apple Street, Suite 5250
Dayton, Ohio 45409

University Orthopaedics and Sports Medicine
30 E. Apple Street, Suite 5250
Dayton, Ohio 45409
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At this time, I request that you re-consider your revision to this specific regulation and not change the current policy.

Sincerely,

Lynn A. Crosby

Lynn Crosby, M.D.
University Orthopaedics and Sports Medicine
30 E. Apple Street, Suite 5250
Dayton, Ohio 45409

638

SEP 28 2005

Sonoma County Medical Association

September 26, 2005

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

RE: "GPCIs"

On behalf of the Sonoma County Medical Association (SCMA), I am writing to express our support for CMS's proposed revision to the physician payment localities for Sonoma County, which has suffered under the strain in inadequate medical compensation for many years.

In 1967, Medicare grouped Sonoma County with the North Coast Region. That region was later combined with other 'rural' counties into Locality 99, which has the lowest Medicare reimbursement rate in California. Medicare has since said the designation was flawed and has acknowledged that Sonoma County should have been included in one of the San Francisco Bay Area localities. The designation to Locality 99 does not reflect the changing demographics of Sonoma County. Although historically agricultural, today the county shares many similarities with neighboring counties in the Bay Area, including the highest cost of living in the country and an increasingly large population of seniors.

Among cities with a population of 100,000 or more, Santa Rosa is sixth in the United States for the highest percentage of people 85 and older. According to State of California Department of Finance (July 2000), seniors 60 and older represent 16.6 percent of the total population in Sonoma County. From 2000 to 2020, the number of seniors is projected to increase 196 percent.

Sonoma County physicians are reimbursed 13.7 percent less than physicians providing the same services in neighboring counties. This discrepancy has caused physicians to leave Sonoma County, and quality health care has suffered as a result. The number of practicing physicians in Sonoma County has not kept pace with local population growth—over a seven-year period (1995-2002), the population increased 13 percent and the number of physicians practicing increased by only 4 percent. Many specialties are under-supplied. In fact, we have only two gerontologists in the county for a population of more the 76,000 seniors. According to a recent survey, 60 percent of the primary care physicians in private practice in Sonoma County are NOT

3033 Cleveland Ave., Suite 104, Santa Rosa, CA 95403 • 707-525-4265 • FAX 707-525-4328 • www.scma.org

accepting new Medicare patients. (Sixty-five percent of physicians practicing in Sonoma County are in private practice, and 45 percent of those are primary care physicians.)

Congress delegated CMS to administer payment localities. The GPCI formula is intended to reimburse physicians appropriately for geographical differences in the cost of providing medical care. Sonoma County's current designation (to Locality 99) does not reflect the county's changed demographics. We commend CMS for acknowledging the reimbursement discrepancy and for proposing a change to correct the situation.

The Sonoma County Medical Association—representing 61 percent of actively practicing local physicians—supports the two-county proposal. The change of locality will increase the Medicare reimbursement rate to more closely match actual practice expenses, helping Sonoma County physicians improve the quantity and quality of care they deliver to Medicare beneficiaries and other patients. The locality change will also aid efforts to recruit and retain physicians in the county, which has a large Medicare population.

Thank you for your consideration.

Sincerely,

Leonard Klay, MD
President

Two copies attached.

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COPY

Medical Imaging Contrast Agent Association

SEP 28 2005

September 27, 2005

Mark B. McClellan, M.D., Ph.D.
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Attn: CMS-1502-P
7500 Security Boulevard
Baltimore, Maryland 21244

RE: CMS-1502-P: Proposed Revisions to Medicare Payment Policies Under the Physician Fee Schedule for Calendar Year ("CY") 2006

Dear Dr. McClellan:

The Medical Imaging Contrast Agent Association ("MICAA") is pleased to submit comments regarding the Proposed Revisions to Medicare Payment Policies Under the Physician Fee Schedule for Calendar Year ("CY") 2006 (the "Proposed Rule"), 70 Fed. Reg. 45,764 (Aug. 8, 2005). MICAA is a national non-profit association comprised of developers, suppliers, and manufacturers of medical imaging contrast agent drugs. Medical imaging contrast drugs are increasingly important to accurately diagnose and effectively manage Medicare patients with serious conditions. They enable health care providers to have better information and make more informed treatment decisions.

In brief, our comments are as follows:

- MICAA supports a delay in the proposed 50 percent reduction in payment for certain multiple imaging procedures.
- MICAA supports the Centers for Medicare & Medicaid Services ("CMS") proposal to establish separate payment for High Osmolar Contrast Media ("HOCM"), and we urge CMS to issue guidance to carriers on the new policy and payment changes.
- MICAA requests that CMS clarify that separate payment is available for all magnetic resonance ("MR") medical imaging drugs.

- MICAA recommends that CMS not adopt its proposed changes in how manufacturers must treat direct versus indirect sales for purposes of Average Sales Price ("ASP") calculations.

- CMS should not require ASP reports to include the first marketing date, since it does not bear on Medicare reimbursement. If CMS does collect marketing date information, the term "date first marketed" must be clearly defined, and CMS should clarify that the information would be submitted once with the first data submission for a drug.

- Likewise, CMS should clarify that its proposal to include expiration date information on ASP reports would be submitted only when the manufacturer has ceased production of a particular drug.

I. Discussion and Recommendations

A. MICAA supports a delay in the proposed 50 percent reduction in payment for certain multiple imaging procedures.

CMS is proposing a multiple procedures reduction for certain diagnostic imaging services when two or more services within the same family of imaging codes (by contiguous body region) are performed. The multiple procedure reduction would apply to the technical component of 11 families of procedures. This provision parallels a proposal set forth in CMS's Proposed Changes to the Hospital Outpatient Prospective Payment System and Calendar Year (CY) 2006 Payment Rates[1] (the "OPPS Proposed Rule").

As we stated in our formal comments on the OPPS Proposed Rule, MICAA agrees with the recommendation of the APC Advisory Panel and the American College of Radiology that the OPPS Proposed Rule's reduction in payments for certain multiple imaging procedures should be delayed for one year. Such a delay would enable CMS to develop more appropriate and accurate data on which to base any payment changes.

Likewise, we are concerned that CMS is making unjustified assumptions in its development of the proposed multiple procedure reduction under the Medicare physician fee schedule system. CMS assumes that there will be a 50 percent reduction in costs associated with performing a second imaging procedure on a contiguous body part, but the agency provides no firm data to support that assumption. In fact, CMS states that imaging involving contiguous body areas will "potentially" yield savings in certain administrative areas, and that its discounting policies are "based on the expectation" that facilities can achieve savings when performing second imaging procedures.

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[1] 70 Fed. Reg. 42,674 (July 25, 2005).

We are concerned that a payment reduction of this magnitude will result in inadequate compensation for providers and jeopardize beneficiary access to high-quality care. Thus, before instituting a drastic payment reduction, CMS should ensure that it has substantial evidence of the magnitude of resource savings, if any, associated with performing multiple imaging procedures. Until such data is available for public review and comment, CMS should delay implementation of the multiple imaging procedure payment reduction.

B. MICAA supports CMS's proposal to establish separate payment for HOCM and urges education about the change. CMS should clarify that separate payment is available for all MR agents.

Separate Medicare payment for low osmolar contrast media ("LOCM") currently is available through the use of Q codes. Payment for HOCM currently is included as part of the practice expense component under the physician fee schedule. In the Proposed Rule, CMS notes that effective January 1, 2006, Medicare will instead reimburse HOCM separately, using the Q-codes that have been established specifically for HOCM. MICAA strongly endorses separate reimbursement for HOCM, and recommends adoption of this policy in the final rule. Moreover, to avoid confusion among carriers and facilitate payment to providers, CMS should issue guidance to carriers on the new policy and payment changes, such as through issuance of a program transmittal.

Likewise, MICAA requests that CMS clarify that all MR imaging contrast drugs (i.e., codes Q9952-Q9954) also are eligible for separate reimbursement to ensure continued beneficiary access to all the various types of medical imaging contrast agents. We have confirmed vis-à-vis review of the supply inputs for the MR procedures that the costs of MR drugs have not been included in the payment for the procedure. Therefore, we believe that CMS should clarify that the physician fee schedule payment for the MR procedure does not include payment for the MR drugs. Further, we request that CMS instruct carriers that separate payment is available for MR drugs through the billing of the appropriate Q code.

C. MICAA recommends changes to CMS's proposed revisions to the ASP calculation methodology.

In the Proposed Rule, CMS proposes certain changes to the Part B prescription drug ASP calculation methodology. Currently, CMS allows manufacturers to calculate a rolling average of price concessions included in the calculation of ASP where data is available on a lagged basis. In the Proposed Rule, CMS proposes to refine the rolling average methodology to require manufacturers to separately calculate a weighted average of lagged price concessions related to direct sales and lagged price concessions related to indirect sales, and then combine the calculations to determine the rolling average of all lagged price concessions that the manufacturers will include in their ASP calculations. CMS proposes to define direct sales as sales directly from the manufacturer to the provider (for example, physician or other health care provider or supplier) and indirect sales as from the manufacturer to a

wholesaler, distributor, or similar entity that sells to others in the distribution chain. Indirect sales also would include any sale subject to the ASP reporting requirements that is not a direct sale.

Although CMS states that this change would improve the accuracy of ASP calculations "particularly for NDCs with significant fluctuations in the percentage of sales that are direct sales," we are concerned that this requirement would impose significantly increased accounting and reporting burdens on manufacturers. Many manufacturers do not currently allocate rebates and ASP-exempt sales based on whether sales are indirect or direct, thereby necessitating changes to accounting systems. Moreover, for many manufacturers the ratio of direct to indirect sales is relatively stable. In such cases, the ASP is unlikely to change significantly under the proposed methodology change, making the associated new accounting and reporting obligations unjustified.

We therefore recommend that CMS not adopt the proposed changes in calculating direct versus indirect sales. If CMS does decide to address indirect and direct sales, however, it should adopt a proposal that focuses only on "significant fluctuations," such as by requiring direct and indirect sales to be segregated only if the proportion of such sales varies by more than an established threshold in a quarter.

D. MICAA recommends modifications to CMS's proposed new ASP reporting requirements.

In the Proposed Rule, CMS outlines proposed revisions to the format manufacturers use to submit ASP data. CMS provides additional information on the proposed requirements in a separate information collection notice published on August 19, 2005 ("Information Collection Notice").[2] Among other things, CMS is now proposing to collect the date the NDC was first marketed. We believe that this additional information is unnecessary and, as drafted, could increase confusion about reporting obligations.

For instance, CMS states in a document issued as part of the Information Collection Notice package that it is seeks "the date the NDC was first marketed and the date of the first sale (for NDCs first marketed or sold on or after October 1, 2005) because we must identify the initial period during which the payment is based on WAC." Note, however, that wholesale acquisition cost, or WAC, is not dependent on a marketing date. Under Section 303(c) of the Medicare Modernization Act ("MMA"), WAC may be used:

> In the case of a drug or biological during an initial period (not to exceed a full calendar quarter) in which data **on the prices for sales** for the drug or biological is not sufficiently available from the manufacturer to compute an average sales price for the drug or biological. (Emphasis added.)

Moreover, the conferees explained in the MMA conference report that:

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[2] 70 Fed. Reg. 48,770.

> The Secretary will be able to disregard the average sales price **during the first quarter of a new drug's sales** if the price data is not sufficient to determine an average amount payable. (Emphasis added.)

Thus, the statute requires only that CMS consider drug sales for WAC purposes; marketing information does not affect when WAC is used. CMS therefore needs to collect only the date of first sales, not marketing date information.

We would also point out that should CMS nevertheless decide to collect marketing data, it must clearly define the "date first marketed," since different manufacturers may consider different activities to be marketing activities. Moreover, CMS should clarify in the final rule that any information on the first date of marketing or the first date of sales would be submitted "once with the first data submission for new NDCs." While this limitation is clearly provided in the Information Collection Notice, it was omitted in the Proposed Rule.

Likewise, CMS should clarify its requirement for information on the expiration date of the last lot manufactured. CMS seeks expiration date information because manufacturers would no longer report ASP data for an NDC beginning the reporting period after the expiration date of the last lot manufactured. Because this information would be available only when the manufacturer has ceased production of a particular NDC, however, CMS should clarify in the final rule that the expiration date would be required only beginning with reports submitted after the date the last lot is manufactured, and ending when all sales made before the expiration date of the drug have been reported. In other words, the manufacturer would not need to predict the final expiration date prior to manufacturing the final lot of the NDC.

* * * *

We would be pleased to discuss any of these issues with CMS in greater detail and will contact the agency to follow-up on these recommendations.

Sincerely,

Jane Majcher
Jane Majcher
Co-Chair
MICAA Health Care Committee

Jay Schafer
Jay Schafer
Co-Chair
MICAA Health Care Committee

cc: Jim Hart
Joan Sanow
Sabrina Ahmed
MICAA members (via email)
Pamela Kassing, ACR
Diane Millman, ASE

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SEP 28 2005

UW Medicine

VICE PRESIDENT FOR MEDICAL AFFAIRS AND
DEAN OF THE SCHOOL OF MEDICINE

September 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

Dear Dr. McClellan:

We write to strongly 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 our ability 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, along with the impending retirements of anesthesiologists within this generation.

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

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

Paul G. Ramsey, M.D.

C-314 Health Sciences Center, University of Washington, Box 356350, Seattle, WA 98195-6350 206-543-7718 Fax: 206-685-8767 pramsey@u.washington.edu

HARBORVIEW MEDICAL CENTER / UNIVERSITY OF WASHINGTON MEDICAL CENTER / UNIVERSITY OF WASHINGTON SCHOOL OF MEDICINE / NEIGHBORHOOD CLINICS

The University of Washington Anesthesiology training program is only one of two physician teaching programs servicing the five states region of Washington, Wyoming, Alaska, Montana, and Idaho. Our three year program currently has sixty resident trainee positions, ten one-year post-graduate fellow trainee positions and a faculty complement of ninety teaching physicians. A number of our graduates choose to practice in the region and underserved areas of greatest need.

Medicaid's adoption of the Medicare payment rules essentially imposes a double penalty. With a Medicare and Medicaid sponsor mix of 21% and 22%, respectively, the 50% reduction penalty has a significant effect on our ability to generate sufficient revenues to recruit and retain teaching anesthesiologists. For the Seattle locality, the 2005 Medicare anesthesia conversion factor is $17.89 per anesthesia unit. The 50% reduction drops the conversion factor to $8.95. The combined impact of over $1 million per year is associated with Medicare and Medicaid usage of the 50% payment formula.

A growing and continuing threat to the financial viability of anesthesiology teaching programs is the contention of some private insurance companies that their reimbursement policies should mirror Medicare practices. Within the past two years, we have had to confront this issue with a number of payors. The impact of such extensions of a flawed reimbursement model could essentially mean the closure of anesthesiology teaching programs.

The UW Department of Anesthesiology seeks your support for the correction of the anesthesiology teaching payment penalty, as proposed by the American Society of Anesthesiologists. The perpetuation of a flawed reimbursement model will only have a disastrous financial impact as our Medicare and Medicaid sponsor mix increases over time.

Sincerely,

Paul G. Ramsey, M.D.
Vice President for Medical Affairs and
Dean of the School of Medicine

Frederick W. Cheney, M.D.
Professor and Chair
Department of Anesthesiology

cc: Senator Patty Murray (WA)
Senator Maria Cantwell (WA)
Senator Michael Enzi (WY)
Senator Craig Thomas (WY)
Senator Ted Stevens (AK)
Senator Lisa Murkowski (AK)
Senator Max Baucus (MT)
Senator Conrad Burns (MT)
Senator Larry Craig (ID)
Senator Mike Crapo (ID)
Congressional Delegations from
Washington, Wyoming, Alaska, Montana, and Idaho

SEP 28 2005 641

SANTA BARBARA COUNTY MEDICAL SOCIETY

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

September 20, 2005

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

Re: "GPCIs"

Dear Sirs,

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

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

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

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

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

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

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

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

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

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

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

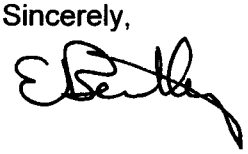
We applaud CMS for taking this unprecedented action in addressing California's locality problem without forcing payment reductions. Opposing this proposal ignores that precedence, ignores the difficulties of the two counties, and places the value of a 0.4% GPCI increase over the value of locality revision.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

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

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

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

Sincerely,



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

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SEP 28 2005

SANTA BARBARA COUNTY MEDICAL SOCIETY

5350 Hollister Avenue, Suite A-4
Santa Barbara, California 93111
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September 20, 2005

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

Re: "GPCIs"

Dear Sirs,

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

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

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

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

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

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

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

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

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

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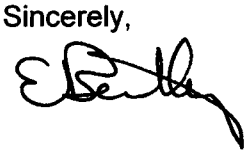
Sincerely,



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

SEP 28 2005

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Sonoma County Medical Association

September 26, 2005

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

RE: "GPCIs"

I am writing as an individual on behalf of 2,574 Sonoma County residents—Medicare beneficiaries and patients with other types of insurance—in support of CMS's proposed rule to change Sonoma County's Medicare payment locality.

Recognizing that inadequate reimbursement of Sonoma County physicians affects everyone in our community, the Sonoma County Medical Association (SCMA)—representing 61 percent of physicians currently practicing in Sonoma County—launched a community-wide educational effort to encourage comments in support of the proposed rule during the "public comment" period ending Sept. 30.

SCMA is aware of over 4,000 residents' support of the proposed rule by way of letters, e-mails and signatures on petitions. Because the Sept. 30th deadline is upon us, I am hoping you will consider the attached petitions representing 2,574 Sonoma County residents who are unable to send their own letter or e-mail. It was their intent, by way of a signature, to comment in support of the CMS proposed rule pertaining to GPCIs.

Thank you for your consideration.

Sincerely,

Cynthia Melody
Executive Director

Two copies attached.

3033 Cleveland Ave., Suite 104, Santa Rosa, CA 95403 • 707-525-4265 • FAX 707-573-4124 • www.scma.org

SEP 28 2005 643

Congress of the United States

U.S. House of Representatives

COMMITTEE ON WAYS AND MEANS
1102 LONGWORTH HOUSE OFFICE BUILDING
(202) 225-3625
Washington, DC 20515-6348
http://waysandmeans.house.gov

September 28, 2005

The Honorable Mark McClellan
Administrator
Centers for Medicare and Medicaid Services
Hubert Humphrey Building, Room 314-G
200 Independence Avenue, SW
Washington, D.C. 20201

Dear Administrator McClellan:

I am strongly opposed to a particular provision in the proposed rule *Revisions to Payment Policies under the Physician Fee Schedule for Calendar Year 2006*. This provision would implement two changes to the California geographic practice cost indices (GPCI) payment localities for Santa Cruz County and Sonoma County. These two counties would be removed from the "Rest of California" payment locality, and become two separate payment localities. Finally, increases in payments for these two new localities would be offset by a reduction in payment, not insignificant, to the remaining counties in the "Rest of California" payment locality.

As justification for these changes, the proposed rule states that CMS "received many comments from physicians and individuals in Santa Cruz County expressing the opinion the Santa Cruz County should be removed from the "Rest of California" payment locality and placed in its own payment locality." The proposed rule does not report receipt of comments from physicians and individuals in Sonoma County expressing support for change.

CMS notes higher costs in Santa Cruz and Sonoma than in other counties in the "Rest of California" payment locality. The county-specific geographic adjustment factor (GAF) of Santa Cruz County is 10 percent higher than the "Rest of California" locality GAF, and the county-specific GAF of Sonoma County is 8 percent higher than the "Rest of California" locality GAF. CMS omits to mention that other California counties also have county-specific GAFs that are higher than the "Rest of California" GAF – for example, Monterey County's GAF is about 7 percent higher. What criteria did you use to separate out Santa Cruz and Sonoma, but not Monterey?

CMS cites borders shared with higher GAF counties as a possible rationale for proposing a change. While Santa Cruz is adjacent to Santa Clara and San Mateo counties (which have two of the highest GAFs in the nation), and Sonoma borders Marin and Napa (which have the fourth

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09/22/05

To Whom It May Concern:

I strongly urge the SUPPORT of a new "payment locality" for Sonoma County, California. This would increase the local Medicare reimbursement to our local doctors by eight percent. This should have happened LONG before this. Some of our fine doctors are leaving the county, and the county can't attract new ones. I certainly don't want to lose my excellent doctors because the current reimbursement rate is so low.

Please do whats fair for our doctors and their patients.

Thank you.

Sincerely—
Carol R. Nelson

Carol Nelson
817 Josephine Ln.
Healdsburg, CA 95448-3726

(707) 433-6216

SEP 28 2005

645

Jeanne L. Crump, D.O.
Osteopathic Manipulative Therapy

1211 College Ave.
Santa Rosa, CA 95404-3907
Telephone: 707-544-4334
Fax: 707-544-9165

September 20, 2005

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

Re: GPCI

I am a practicing Physician in Sonoma County, California, and it has come to my attention that Medicare is proposing to create a new payment locality for Sonoma County, 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.

I strongly support a new locality, which would help Sonoma County physicians improve the quantity and quality of care they deliver to Medicare beneficiaries. Sonoma County physicians deliver the same quality of service delivered in large metropolitan areas and we live and practice in a county which is no longer considered rural. The locality change would also benefit efforts to recruit and retain physicians in the county, which has a large Medicare population and has been losing physicians at a rapid rate. Many physicians no longer accept Medicare patients.

Please take this matter of a new locality seriously. I appreciate the opportunity to comment on such an important issue.

Sincerely,

Jeanne L Crump DO.

SEP 28 2005 646

Jeanette L. Lebell
685 Snow Road
Sebastopol, CA 95472
(707) 824-2858

September 21, 2005

GPCIs
Center for Medicare & Medicaid Services
Dept. of Health and Human Services
Attn: CMS-1052-P
P.O. Box 8017
Baltimore, MD 21244-8017

Dear Administrators:

I want to express my strong support for CMS' proposed revision to the physician payment localities for Santa Cruz and Sonoma County. As a long-time resident of Sonoma County I am acutely aware of some of the problems the current system has inflicted upon us all. I have been personally affected by this as I was a happy member of Health Plan of the Redwoods before it went belly-up due to inadequate reimbursement rates under Medicare.

The cost of living in Sonoma County is extremely high despite the fact that the county still enjoys a rural ambience. Sonoma County also has a very high percentage of seniors, and elders over 85 years of age. The large discrepancy between physician payment rates here and in neighboring counties has exacerbated the flight of doctors from Sonoma County. Many primary care doctors just cannot afford to stay and make their practice survive in the current economic environment. Quality health care is suffering for everyone when the remaining physicians are extremely overworked and underpaid. This federal guideline change will help bring medical costs in line with the actual costs here in Sonoma County and hopefully this will help stem the flow of physicians out and keep the medical services affordable for those of us who are not yet dependent on any federally subsidized program.

This proposed change is long overdue. Please do whatever is necessary to make this change as quickly as possible. Our ability to access healthcare is in your hands.

Sincerely,

Jeanette L. Lebell

647

SEP 28 2005

September 19, 2005

To: Centers for Medicare and Medicaid Services

From: Marianne Estournes
Occupational Therapist

Re: Medicare Reimbursement increase by 8% for Sonoma County

I am writing to appeal to you on behalf of the doctors, hospitals and health professionals in Sonoma County who treat our geriatric population and rely on Medicare reimbursements to support their endeavors.

Sonoma County has a large geriatric population and it is steadily growing as our "baby-boom" generation reaches retirement. These people are in the medical system and need good preventative care and appropriate intervention when they become ill. Good doctors are needed to provide these services and they need appropriate reimbursement for these services. We also have a large population of younger patients who are on Medicare due to some disability such as renal failure, drug addiction, diabetes or a disabling back injury. These younger patients often are very ill and use an enormous amount of services.

Many physicians have left Sonoma County due to poor reimbursement for the excellent services they provide, leaving the rest of the medical community overburdened. Many may close their practice to new Medicare patients, leaving these patients without access to adequate medical care.

Sonoma County is no longer a rural area. Santa Rosa Memorial is the largest hospital between San Francisco and the Oregon border and performs many specialized services. Generally, Santa Rosa is an urbanized town with over 150,000 citizens, excellent medical services available and wonderful physicians who deserve to be adequately reimbursed for their services. The cost of living in Sonoma County is high. Doctors and hospitals need to be paid to reflect the true cost of living and doing business in this community assure quality care, retain the medical community we have and the attract the best and the brightest to come here to serve the our needs.

I appeal to you to PASS this proposal to increase the reimbursement rate for Sonoma County by 8%. This will help towards stabilizing our medical community an assure that our citizens have enough doctors and professionals to serve their needs.

Sincerely,

Marianne Estournes, OTR

Marianne Estournes
Occupational Therapist

SEP 28 2005

648

W. Kenneth Johnson
1713 Solano Dr.
Santa Rosa, CA 95404-5330

Sept 17, 2005

Medicare,

I am 76 years old & covered unda Medicare. Medical costs have risen faster here & are, on the average about 8% higher than similar counties.

There are a lot of seniors here in Sonoma County & lots of them are having trouble accessing health care.

Medicare has proposed an increase in the reimbursement rate for Sonoma County by 8%. This will bring Sonoma County back in line with current Medicare reimbursement standards & help stabilize our medical community.

Correct reimbursement to Sonoma County now!

Thank.

Sincerely,

W. Kenneth Johnson

649

SEP 28 2005

September 22, 2005

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

To Whom It May Concern:

I am writing to express my strong support for the proposed new rule for Medicare that would increase the reimbursement rate for Sonoma County, California, by 8%. In the 15 years I have lived in this county I have seen significant reductions in the choice of medical practitioners available to citizens; medical plans and doctors groups have gone bankrupt and the population is growing much faster than the growth of physicians.

I am now age 65 and find that I am one of a rather large percentage (16.6%) of the county's population of "seniors." I have friends who have had great difficulty in finding a practice which would accept them as a patient. This may once have been a rural county, but it is no longer and the cost of living is quite high. I urge the implementation of the proposed new reimbursement rate for Sonoma County.

Sincerely,

Judith A. Hunt

Judith A. Hunt
513 Yellowstone Court
Petaluma, CA 994954

650

SEP 28 2005

170 Laguna Cir
Santa Rosa, CA
95401

Sept. 23, 2005

Dear Sirs:

Please pass this proposal that will bring Sonoma County back in line with current Medicare reimbursement standards - which will help stabilize our medical community.

We want our doctors to stay in Sonoma County!

Thank you - Yours truly

Madine Kruse

651

Santa Cruz County Medical Society

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

September 23, 2005

Re: GPCI. Support removal of two counties from Locality 99

To Whom It May Concern,

The Santa Cruz County Medical Society strongly supports the proposed revision to the physician payment localities in California that you published in the Federal Registry 8 August 2005.

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

Continuing status quo and ignoring of the growing inequity that exists within the present Locality 99 would be unwise. The adjustment that you propose appropriately addresses the current inequitable payment problem. The other Locality 99 counties have used Sonoma and Santa Cruz's measured higher cost of providing care to enhance their reimbursements.

Although there are another 8 counties similarly affected, your plan to remove the most affected using new dollar increases thus essentially holding harmless those negatively impacted is a good strategy and is sustainable if further increases would be used in a similar manner.

Sincerely,

Marcus Kwan, MD
Executive Director, Santa Cruz County Medical Society

MRK/mrk

1595 Soquel Drive, Suite 340 Santa Cruz, CA 95065 (831)479-7226 Fax(831)479-7223

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

September 21, 2005

To whom it may Concern:

I am a senior citizen and Medicare recipient living in Santa Cruz, CA. This city is the home of a branch of the University of California. It is a beach side community with one of the most expensive housing areas in the state. Many retirees leave here because they can't afford to live here, once retired and because their homes are worth so much money they find it very profitable to sell and relocate where housing is less expensive. Young people in our town find it very hard to buy homes because the demand exceeds supply and they are just not affordable. Even young professionals, such as doctors, find it hard to afford housing here. The rental market is not very affordable either because of the demands of the university. The median price of a house here is well over a half million. Since 1998 I have had five doctors, two of them primary care physicians leave town, retire or both. Many of the remaining ones don't want to take Medicare patients because of the reimbursement deficit here. To classify Santa Cruz County as rural is a joke! Granted there is some agriculture in the South County beyond Watsonville and some North of the city but we are not RURAL. The clogged and inadequate freeway could tell you that.

If you don't start reimbursing our doctors here better we could have a real health crisis on our hands.

Thank you.

Lois Carle

Lois Carle

PeTiTiOn!!! SEP 28 2005 653

It is extremely important to me – a senior living on a prescribed income – that Medicare increase the rates for medical reimbursements in Sonoma County

This County has an urgent need for stabilization of our medical provider community. Without increased reimbursements to these professionals many more health plans and health care providers will leave Sonoma County causing a shortage of services as the number of seniors living in Sonoma County increases.

It is estimated an increase of up to 196% in the senior population will occur by 2020. This increase will take place in a County where a standing of the sixth lowest reimbursement rate for Medicare is the position the County occupies, of all Counties existing in the entire United States.

This financial unsettlement for seniors must be addressed and corrected to avoid losing a standard of medical coverage which Sonoma County enjoyed at one time in its past. That standard is in severe jeopardy today.

We urge implementation of a new Medicare rule which would increase medical reimbursement rates for Sonoma County seniors who could face projected medical premium increases as many medical plans and medical providers become unable to exist as rates stand now and find they must move out of the area, in order to provide quality service to all patients.

653
attachm

Signatures from residents of
Vintage Chateau Apts.
333 N McDowell Blvd.
Petaluma CA 94954

Betty West
Darlene Maschmeier
A M Johnson
J. L. Martini
H H McNeil
Sharon L. Combs
A. Kirschenstein
Lorene Juvera
Doris McClellan
Virginia I Cuyala
Cynthia Gotton
Rose M. DeGeorge
Marco DeGeorge
Virginia I. Cuyala
D Iris Singleton
Ethel C g r
Gladys Sapford
Cheryl Burling
Mary Rodenstein
Georga Bodeke
Alida Hyna.
Barbara Pomin
Judy Jone
Donna Dowery
Rose Senkel
Harold Senkel
Grace Barber
Alice Chong

SEP 2 0 2005

654

September 21, 2005

GPCIs
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1052P
P O Box 8017
Baltimore, MD 21244-8017

My husband and I support the proposal as written by the medical community in Sonoma County. It isn't reasonable to consider Sonoma County "rural" when all expenses incurred by citizens are consistent with Marin and bay area counties. There has been great difficulty in finding doctors to work in our County, many WILL NOT accept new Medicare patients. When doctors leave to practice in other areas, we are left with doctors that are not accepting new patients. Many patients, particularly those on Medicare or without insurance are having difficulty finding health care.

Please accept this proposal and make Sonoma County consistent with Bay Area counties.

Thank you.

Bruce Sharrow
Phyllis Sharrow

Bruce and Phyllis Sharrow
823 Madison Street
Petaluma, CA 94952

SEP 2 9 2005 6055

September 21, 2005

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

SUBJECT: Medicare Reimbursement in Sonoma County

I have recently been diagnosed with breast cancer. I had a mammogram, a sterotactic biopsy, and a lumpectomy. I am now receiving radiation therapy.

I received the BEST of care at every step of the way.

Then the reimbursement notices started coming in. I absolutely could not believe what Medicare paid my EXCELLENT doctors.

Then I picked up the paper and read that our doctors in Sonoma County do do get reimbursed as much as doctors in Napa and Marin counties. WHY???

The cost of living is similar in the three counties, as is the cost of office space, staff, workers' compensation and a dozen other variables.

The low reimbursement rate has driven doctorsout of Sonoma County and has prevented needed specialists from moving here.

If we did not have the GREAT doctors we have in Sonoma County, we would be forced to travel elsewhere and this would be an additional hardship on senior citizens.

I STRONGLY support the proposal to increase the reimbursement rate for our <u>great</u> doctors in Sonoma County.

Thank You

Katherine R. Ulibarri

1716 Kearny St.
Petaluma, CA 94954

SEP 28 2005

656

September 21, 2005

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

SUBJECT: Medicare Reimbursement in Sonoma County

My wife has ~~I have~~ recently been diagnosed with breast cancer. She ~~I~~ had a mammogram, a sterotactic biopsy, and a lumpectomy. She is ~~I am~~ now receiving radiation therapy.

She ~~I~~ received the BEST of care at every step of the way.

Then the reimbursement notices started coming in. I absolutely could not believe what Medicare paid her ~~my~~ EXCELLENT doctors.

Then I picked up the paper and read that our doctors in Sonoma County do do get reimbursed as much as doctors in Napa and Marin counties. WHY???

The cost of living is similar in the three counties, as is the cost of office space, staff, workers' compensation and a dozen other variables.

The low reimbursement rate has driven doctors out of Sonoma County and has prevented needed specialists from moving here.

If we did not have the GREAT doctors we have in Sonoma County, we would be forced to travel elsewhere and this would be an additional hardship on senior citizens.

I STRONGLY support the proposal to increase the reimbursement rate for our <u>great</u> doctors in Sonoma County.

Thank You

Samuel L. Kilbarri

1716 Kearny St.
Petaluma, CA 94954

SEP 28 2005 657

Mrs. Walter J. McElroy
469 Oak Vista Drive
Santa Rosa, CA 95409

September 20, 2005

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

To Whom It May Concern:

I am always shocked to see how little reimbursement my wonderful doctors in Sonoma County receive for their services. I've been blessed with kind, caring doctors.

Please note for your new rule to reimburse our doctors

September 20, 2005

SEP 28 2005 658

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

To Whom It May Concern:

I am always shocked to see how little reimbursement my wonderful doctors in Sonoma County receive for their services. I've been blessed with kind, caring doctors.

Please vote for new rule to reimburse our doctors at least 8%. They truly deserve it.

Sincerely,
Roberta McElroy

Sept. 20, 2005

SEP 28 2005

659

Dear Medicare,

I am a resident of Sonoma County and a senior citizen on medicare. We need access to good doctors as much as the folks in Napa and Marin do. This county has increased by more than 13% in the last decade with a large proportion of senior citizens and we have experienced fewer doctors willing to accept medicare patients. Please correct the injustice to doctors and senior citizens living in Sonoma County by increasing the reimbursement rate by the proposed 8%.

Sincerely,
Sheila O'Brien

Sheila B. O'Brien
1407 Townview Ave. Apt. 214
Santa Rosa, CA 95405

SEP 28 2005

660

Beverly J. Kruse
4376 Winfield Lane
Sebastopol, CA 95472

September 21, 2005

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

REQUEST FOR INCREASE IN SONOMA COUNTY MEDICARE REIMBURSEMENT

I am writing to request that you correct Medicare reimbursement in Sonoma County now by increasing the reimbursement rate here by 8% as proposed.

Reasons for this request include the following facts:

1. Sonoma County has the lowest Medicare reimbursement rate in California
2. Many doctors have left the county because of low reimbursement
3. Medical costs in Sonoma County are, on average, 8% higher than similar counties
4. In July 2005 six out of 10 Sonoma County primary care physicians were not accepting new Medicare patients
5. Thousands of patients on Medicare or without insurance are having trouble accessing health care

Respectfully yours,

Beverly J. Kruse

Beverly J. Kruse
Enc: 2 copies

SEP 20 2005

661

H. LEE MOFFITT
CANCER CENTER
& RESEARCH INSTITUTE
At the University of South Florida

September 13, 2005

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

Dear Dr. McClellan:

I am writing as an Academic Anesthesiologist at the H. Lee Moffitt Cancer Center in Tampa, Florida to urge the Centers for Medicare and Medicaid Services (CMS) to change the Medicare anesthesiology teaching payment policy.

Our institution, trains both Anesthesiology Residents and Certified Registered Nurse Anesthetist (CRNA) students and we therefore are fully aware of the economic impact of Medicare's discriminatory payment arrangement. It applies only to anesthesiology teaching programs, and has had a serious detrimental impact on the ability of our anesthesiology residency program to retain skilled faculty and to train the new anesthesiologists necessary to help alleviate the widely-acknowledged shortage of anesthesia providers -- a shortage that will be exacerbated in coming years by the aging of the baby boom generation and their need for surgical services.

The proposed policy revision will not affect in any way the education of Certified Registered Nurse Anesthetist (CRNA) students or the number of CRNA students trained at our institution.

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

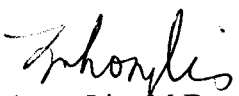
12902 Magnolia Drive
Tampa, Florida 33612-9497
(813) 972-HOPE
(813) 972-4673
FAX: (813) 972-8495

teaching anesthesiologists who work with residents on overlapping cases face a discriminatory payment penalty for each case. The Medicare payment for each case is reduced 50%. This penalty is not fair, and it is not reasonable.

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

Please end the anesthesiology teaching payment penalty.

Sincerely yours,



Jinhong Liu, M.D.

SEP 28 2005 662

GREGORY A. HOGLE, D.O.
COLUMBINE OTOLARYNGOLOGY • HEAD AND NECK SURGERY

MELVIN & ELAINE WOLF SURGICAL BLDG.
4600 HALE PARKWAY, SUITE 450
DENVER, COLORADO 80220
TELEPHONE 303/333-2119
FAX 303/333/2016

September 21, 2005

Mark B. MCClellan, M.D., PhD.
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
CMS-1502-P
PO Box 8017
Baltimore, MD 21244-8017

Re: CMS-1502-P

Dear Dr. McClellan:

As clinic manager for an ENT office, I am writing to express my concern about the Centers for Medicare and Medicaid Services' (CMS) proposed Medicare Physician Fee Schedule, which would reduce Medicare reimbursement for specialty physicians by as much as 21 percent over a four-year period beginning in 2006. All physicians, not only specialists, are dramatically affected by this proposal. Simply, stated, physicians may not be able to continue to offer services to Medicare beneficiaries unless CMS develops an equitable reimbursement rate for services.

Adequate and fair reimbursement rates for physician and specialty physician's services are essential for covering the expenses physicians incur in performing services for Medicare beneficiaries and working with audiologists in performing hearing and vestibular services. Hearing loss is a common malady of the aging population. As the lifespan of America's seniors increases, a greater need for ENT/audiology services will develop.

I respectfully request that you work with the necessary entities to develop solutions to address the negative impact lower reimbursements on the physician community.

Thank you for your considerations.

Sincerely,

Katie Elliott

Katie F. Elliott
Clinic Administrator

SEP 28 2005

663

PAUL KAMINS, M.D.

ORTHOPAEDIC SURGERY AND SPORTS MEDICINE

151 BROADWAY

BANGOR, MAINE 04401

TELEPHONE (207) 945-9461

FAX (207) 945-3241

September 19, 2005

Centers for Medicare and Medicaid Services
Dept. of Health and Human Services
Attn. CMS-1502-P
PO Box 8017
Baltimore, Maryland 21244-8017

RE: Bundle cast materials and supplies

Dear Medicare and Medicaid Officials:

I have become very concerned about your upcoming plan to bundle cast and splint supplies into relevant procedure codes. I find that appropriate care of fractures will vary depending on the particular fracture and often require numerous cast changes for appropriate care. For example, if a person fractures their ankle and the first cast can only be placed as the patient's pain will tolerate, often the cast will be in a toes pointed downward fashion. If left this way for a long period of time, the patient will develop a contracture which will require months of physical therapy. More appropriate treatment is to see the patient back on two week intervals and each time, forced their ankle up towards a more neutral alignment. By the six week mark, the contracture has been taken out by cast changes thus avoiding the need for extensive physical therapy. I can guarantee you that several extra casts and the expense of those are much less than months of physical therapy and I am sure that you know that. If we are restricted by one global fee, by nature we will be forced to avoid cast changes as we deem appropriate in an attempt to work within the global package and not be paying out of pocket for what we think is appropriate care. What I am trying to portray is the fact that patient's care will suffer in our attempts as orthopedists to work within a constrictive global package if the casting supplies are limited. This is only one example but could be extended into any part of the body. Please take my concern for the patient's care, which I am sure would be limited by the orthopedist's concern for lack of reimbursement by additional casting, as a serious matter which ultimately will compromise the patient's optimal care. Please do not proceed to bundle cast materials into the global package. I would be glad to discuss this in person with any of your officials if requested to do so.

Sincerely,

Paul Kamins, M.D./dhpwr

 664

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

Re: GPCI

To Whom It May Concern:

I am a totally disabled Medicare parson whose whole SS Disability Check goes to pay my rent for a crummy falling apart house.I have no savings,no medical insurance and my medical bills are around $500.00 a month.I get a pension from when I was teaching before I had to go out on disability when I was 48 years old. It doesn't cover my utilities,medical bills, food etc. and I have had to go through bankruptcy, etc.. We can't keep Dr.'s here as Santa Cruz County is one of the highest places to live. They don't get their fair share of medicare reimbursement and some of them have even had to buy my medicine for me out of the kindness of their hearts.We Can't keep any Dr.'s here as they can't afford to live here either.They come and go in a year.

I don't remember if I was to write a letter to you or not. If I was here it is.

Sincerely,Brook E. Hoffman

Brook E. Hoffman

September 18. 05

665

I am writing to support an increase in the Medicare reimbursement rate for Santa Cruz County.

A personal experience prompts this letter. My gynecologist has moved his practice away from Santa Cruz because of the financial difficulties maintaining an office and caring for Medicare patients

Sincerely,

Billie E. Trawle

2 Copies enclosed

 666 1.

1990 orchard St.
Santa Rosa, Ca.
95404-
2446

Sept. 21, 2005

C.M.S.'s
Centers for Medicare & Medicaid Services
Department of Health & Human Services

attention: CMS-1052-P
P.O. Box 8017
Baltimore, MD 21244-8017

Please consider the importance of increasing the Medicare Reimbursement Rate for Sonoma County, California by 8%.
It really is vital for we Seniors in this area and the stability of our medical resources and professionals. Our elderly population increases steadily while our doctors are not keeping up. We desperately need to hold on to our current medical professionals and encourage new ones to come to our area as we have lost so many. It has created a very bad situation. I personally lost 2 of my Doctors who quit private practice.

Our county has the lowest reimbursement rate in California, I can't believe it but I know it's true. Our doctors are not accepting new Medicare patients. Some of us have great difficulty getting appointments, and the necessary time allotted to us to adequately receive the help we need.

This is a serious problem and we need your help in Sonoma County.

Thank you.

Sincerely,

Sylvia M. Busch
(age - 76)

Ms. Sylvia M. Busch
1990 Orchard St.
Santa Rosa, CA 95404-2446

Enc. - 2 copies

SEP 28 2005

SEP 28 2005 667

Sept. 21. 2005

A Special Note —

Please Listen Up!

Sonoma County has suffered under the strain of inadequate Medical Compensation. Several medical groups have gone bankrupt. Medical costs in Sonoma County have risen much faster than other areas, on average 8% higher than similar Counties. Among cities with population of 100,000 or more, Santa Rosa is 6th in the United States for the highest percentage of people 85 or older. Many physicians are leaving our county to practice where reimbursement is more favorable. Medicare Please

Correct Reimbursement in Sonoma County

Carol Deghi
2421 Glaha Dr.
Santa Rosa, Ca. 95404

H.LEE
MOFFITT
Cancer Center & Research Institute
The End Of Cancer Begins Here.
A National Cancer Institute
Comprehensive Cancer Center
At the University of South Florida

668

SEP 28 2005

Anesthesiology Program

Hector Vila, Jr., M.D.
Program Leader

Voytek Bosek, M.D.
John Downs, M.D.
Allan Escher, D.O.
Jinhong Liu, M.D.
Alonso Mesa, M.D.
Sunil Panchal, M.D.
Kejia Rosenfeld, M.D.
David Thrush, M.D.

September 13, 2005

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

Dear Dr. McClellan:

I am writing as an Academic Anesthesiologist at the H. Lee Moffitt Cancer Center in Tampa, Florida to urge the Centers for Medicare and Medicaid Services (CMS) to change the Medicare anesthesiology teaching payment policy.

Our institution, trains both Anesthesiology Residents and Certified Registered Nurse Anesthetist (CRNA) students and we therefore are fully aware of the economic impact of Medicare's discriminatory payment arrangement. It applies only to anesthesiology teaching programs, and has had a serious detrimental impact on the ability of our anesthesiology residency program to retain skilled faculty and to train the new anesthesiologists necessary to help alleviate the widely-acknowledged shortage of anesthesia providers -- a shortage that will be exacerbated in coming years by the aging of the baby boom generation and their need for surgical services.

The proposed policy revision will not affect in any way the education of Certified Registered Nurse Anesthetist (CRNA) students or the number of CRNA students trained at our institution.

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.

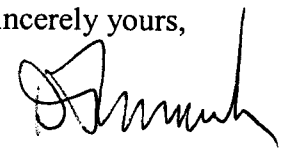
12902 Magnolia Drive, Suite 2184
Tampa, Florida 33612-9497
Phone: (813) 745-8486
Fax: (813) 745-3064
www.moffitt.usf.edu

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

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

Please end the anesthesiology teaching payment penalty.

Sincerely yours,



David Thrush, M.D.

SEP 28 2005

9-22-05

Dear Administrator McClellan: 6069

I support this letter to you from Senator Barbara Boxer. This payment discrepancy is unfair & shameful. Thank you for your attention.

Sincerely,

Anne L. Shuki

Administrator Mark McClellan
Center for Medicare and Medicaid Services
U.S. Department of Health and Human Services
P.O. Box 8017
Baltimore, MD 21244-8017

Dear Administrator McClellan:

I write to express my very strong support for CMS' proposed revision to the physician payment localities for Santa Cruz an Sonoma counties.

There is currently a large payment discrepancy for physicians in Santa Cruz and Sonoma counties due to their being classifie as "rural" counties. Counties neighboring Santa Cruz and Sonom counties have some of the highest payment levels for physician in the nation. The discrepancy is causing physicians to leave Santa Cruz and Sonoma counties, and quality health care has suffered as a result. This reassignment will help the counties provide sufficient health care services for its residents.

I commend CMS for acknowledging the discrepancy in payment for physicians, and for proposing this change to correct the situation. Should you have any questions, please feel free to contact Jennifer Tang in my San Francisco Office. Thank you fc your consideration.

Sincerely,

Barbara Boxer
United States Senator

SEP 28 2005

670

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

Re: GPCI

To Whom It May Concern:

My husband and I have been Medicare beneficiaries, since reaching retirement age, and have received care from excellent physicians. Early this summer, before my husband's death, the care from 'on call' doctors over the week of July 4, 2005, at our Santa Cruz hospital, (San Francisco Bay Area), was remarkable.

I understand that a proposed rule will remove our county from the Rest of California physician payment locality designation.
I also understand that the physicians in my community will now receive payments from Medicare on par with other counties in the San Francisco Bay Area, commensurate with the high cost of living in this area.

We greatly appreciate your attention to this very important issue; *and* wholeheartedly support the proposed changes that you have made.

Sincerely,

Melva J. Johnson
16385 Two Bar Rd.
Boulder Creek, CA 95006

671

SEP 28 2005

Sept 19, 2005

Re: Medicare

The low reimbursement given to doctors in Sonoma County, California, is causing many doctors to leave our County or stop taking Medicare Patients.

The cost of living here has grown over the years - office space, staff, workers Compensation, and many other Costs.

It is only fair that our doctors are reimbursed as other doctors are in Counties with growth and Cost of living sure as ours -

Sincerely

Del Waldaw + Pat Waldaw

81 years. 71 years -

672

Sept. 20, 2005

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

Dear Sirs:

Sonoma County, California has suffered medical care because compensation to medical providers has been inadequate. We have an unusually high persent of people 85 and older! Seniors 60 and older are 16.6 % of our population. In spite of this our Medicare reimbursement is lowest in California.

In July 2005, 6 out of 10 Sonoma, Co. primary care physicians were not accepting new patients. Many physicians are leaving the county.

I urge that the new rule Medicare has proposed for an increase of 8% in reimbursement be approved. This proposal will help stabilize our medical community and serve our people in need.

Mary G. Olsen
6282 Old Redwood Hwy.
Santa Rosa, CA. 95403

SEP 28 2005

673

5095 Chiquita Way
Soquel, CA. 95073
September 19, 2005

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

RE: 6-PCI

To whom it may Concern:

Last year, I wrote and requested that doctors in our area be reimbursed at the urban level. I'm happy to see that physicians in our community will receive payments from Medicare on a par with other counties in the San Francisco Bay area with this proposed rule.

This is a really important rule for citizens in our area. Thank you so much for your consideration.

Sincerely,
Catherine V. Pereira

Enc. 2 copies per request

SEP 28 2005 674

JAMES ROSEWALL CONSTRUCTION

GENERAL BUILDING CONTRACTOR
1300 WEST BEACH STREET
POST OFFICE BOX 2345
WATSONVILLE, CALIFORNIA 95077-2345
TELEPHONE: 831-728-5330
FACSIMILE: 831-722-0559
CA LICENSE NO: 474599

September 22, 2005

Administrator Mark McClellan
Center for Medicare and Medicaid Services
U.S. Department of Health and Human Services
P.O. Box 8017
Baltimore, MD 21244-8017
United States of America

Dear Mark McClellan,

Thank you very much for removing Santa Cruz County from the 'rural' designation and providing a designation more compatible that cost of living the area.

I have lost one physician because of the inadequate compensation and your action should prevent the loss of another...

James Rosewall

675

SEP 28 2005

Fern Selzer

1824 - 48th Avenue
Capitola, CA 95010
(831) 479-1384

Sept. 19, 2005

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

Re: File Code CMS-1502-P
Issue Identifier: GPCI's/ Payment localities

I **strongly support** proposed rule changes concerning the physician payment schedule and locality revisions for Santa Cruz County, California for the calendar year 2006. Santa Cruz is currently designated in Locality 99, which results in payments well below the actual cost of maintaining a practice in this area. Specifically, Santa Cruz has a Geographic Adjustment Factor (GAF) of 1.125, or 12.5% above the national average, well in excess of the 105% rule. Reimbursement in neighboring Santa Clara County (Locality 9) is 25.1% more for the exact same medical service. The cost of living, property, etc., is just as high, if not higher, here.

It is really difficult for my clients to find physicians who are willing to accept Medicare, because they lose money on office visits. Recently, they had to stop doing chemotherapy at Watsonville Hospital because the doctors had lost so much money treating there that they stopped. Also, many physicians who have come to town over the last few years leave soon when they realize they will never be able to buy a house because of the amount of money they are making.

The original idea of designating localities was to fairly compensate practitioners based on geographic costs of practice. The Locality 99 designation for Santa Cruz County has provided disproportionately low compensation to doctors here for many years, and it is time to rectify the situation. I am pleased CMS is looking into correcting this unfortunate situation. Placing Santa Cruz in a separate Locality with physician reimbursements appropriate to the current geographic practice costs is the right thing to do.

Thank you for your efforts to create a fair and equitable solution for 2006.

Sincerely yours,

Fern Selzer

676

SEP 28 2005

Jan F. Zlotnick, R.N.
685 Snow Road
Sebastopol, CA 95472
(707) 824-2858

September 21, 2005

GPCIs
Center for Medicare & Medicaid Services
Dept. of Health and Human Services
Attn: CMS-1052-P
P.O. Box 8017
Baltimore, MD 21244-8017

Dear Administrators:

I want to express my strong support for CMS' proposed revision to the physician payment localities for Santa Cruz and Sonoma County. As a long-time resident of Sonoma County I am acutely aware of some of the problems the current system has inflicted upon us all.

The cost of living in Sonoma County is extremely high despite the fact that the county still enjoys a rural ambience. Sonoma County also has a very high percentage of seniors, and elders over 85 years of age. As my elderly mother also lives in Sonoma County, I've seen first hand how hard it can be for seniors to get the medical care that they need. The large discrepancy between physician payment rates here and in neighboring counties has exacerbated the flight of doctors from Sonoma County. Many primary care doctors just cannot afford to stay and make their practice survive in the current economic environment. Quality health care is suffering for everyone when the remaining physicians are extremely overworked and underpaid. This federal guideline change will help bring medical costs in line with the actual costs here in Sonoma County and hopefully this will help stem the flow of physicians out and keep the medical services affordable for those of us who are not yet dependent on any federally subsidized program.

This proposed change is long overdue. Please do whatever is necessary to make this change as quickly as possible. Our ability to access healthcare is in your hands.

Sincerely,

Jan F. Zlotnick

September 22, 2005

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

Re: GPCIs

I wish to express my support for Medicare change of Sonoma County, California from a "rural" to special payment locality to increase Medicare payments for medical care in this county. Median home prices in Sonoma County are in the $650,000 range; we can in no way be considered "rural," and thus cheaper, than the bay area counties adjacent to us.

I am one of the over 15% of age 60+ individuals who comprise the population of this county, and I need and want all of us—and the projected even larger percentage in the near future—to have ready access to high quality medical care. Currently, physicians are refusing to take new Medicare patients because of the low reimbursement rate.

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

Sincerely,

Martha Rapp Ruddell
PO Box 787
Bodega Bay, CA 94923

cc: Two copies attached

SEP 28 2005 678

TOL Associates
990 Sunset Drive
Healdsburg, CA 95448

September 22, 2005

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

Re: GPCIs

I understand that Medicare is proposing to create a new payment locality for Sonoma County, California. I would like to address some specific concerns from the perspective of TOL Associates, a local employer:

- Santa Rosa now ranks with retirement destinations such as Clearwater, St. Petersburg, and Miami, Florida.
- Among cities with a population of 100,000 or more, Santa Rosa is sixth in the United States for the highest percentage of people 85 and older.
- According to State of California Department of Finance, seniors 60 and older represent 16.6% of the total population in Sonoma County, with a projected rate of change of 196% by 2020.

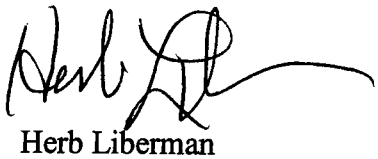
Amid the astounding growth in our elder population, Sonoma County is facing strains on the health care delivery network that are unacceptable to Medicare recipients:

- The number of practicing physicians in Sonoma County has not kept pace with local population growth. From 1995 to 2002, the population increased 13%, but the number of practicing physicians increased by only 4%.
- As of July 2005, 60% of Sonoma County primary care physicians were NOT accepting new Medicare patients.
- Many physicians are leaving our county to practice where reimbursement is more favorable. As a result, many specialties are under-supplied. For example, we have only two gerontologists in the county for more than 76,000 seniors.

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

efforts to recruit and retain physicians in the county, which has a large Medicare population. I fully support your proposal to change Sonoma County's payment locality, and I appreciate the opportunity to comment on this important issue.

Sincerely,



Herb Liberman
President, TOL Associates

cc: Two copies attached

SEP 28 2005 679

9/21/05

CPCIs
Centers for Medicare & Medicaid Services
Dept. of Health & Human Services
Attn: CMS-1052-P
P.O. Box 8017
Baltimore, MD 21244-8017

Dear Administrator,

As a Medicare recipient in Sonoma County I am very concerned about the reimbursement rates paid to Doctors here. I have had 2 primary care physicians leave their practice because of their low fees and I found it very difficult to find a new Doctor who would accept Medicare patients.

I urge you to increase the rate by 8% which will put us level with Napa and Marin counties. Sonoma County has a very high level of senior and also a high cost of living.

We need doctors that are paid fairly.

Sincerely,

Mary Ann Crandell

680

SEP 28 2005 9.21.05

GPOIs
Centers for Medicare
ATTN: CMS-1502P
P.O. Box 8017
Baltimore, MD. 21244-8017

Please, Please. Our Doctors in Sonoma County NEED MORE MONEY. We are losing Doctors to less Expensive living areas.

We are retired, receive Medicare and we live in Sonoma County, Cloverdale. We can't afford to lose any more Doctors to MarinD or L.A. Counties.

THANKS

Tanya Hunter

681

September 19, 2005

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

I am writing in support of the proposal to increase Medicare reimbursement by 8% to Sonoma County. I am a 12-year resident of Sonoma County. I work in healthcare, but not as a Medicare provider.

Since moving to Sonoma County from Los Angeles, I have held several jobs that allowed me to see the need for changing the formula that Medicare uses to reimbursement for medical services and treatment in this county. I have worked as a medical social worker in both hospital and home health settings. I have worked as a case manager for the largest psychological corporation in our county. I have managed capitation contracts. All of this has given me a close-up view of the inadequacy and inequity of present reimbursement levels.

Our county is extremely expensive to live in. In turn, it offers a wonderful quality of life. We have a very fine family practice residency program at a local hospital. Unfortunately, we have difficulty retaining their graduates in our community, because the cost of living is so high (the median price of a home in the county is $539,000) and the reimbursement to physicians is so low. Working inside 3 hospitals locally, I have seen the struggle of hospitals to break even. The community has now adopted two of our smaller hospitals, temporarily, in order to keep their doors open. DRGs as well as other factors are making it impossible to meet expenses. Home healthcare has been significantly impacted. Very few agencies are left operating here, and given the semi-rural nature of the area and the long drive between communities, it is hard to take care of patients, pay the high costs of nurses and other services at current rates.

Discharge planning is likewise affected. Fewer doctors and specialty providers are willing to take Medicare. I cannot count the number of physicians who have left. Many patients have to commute the 1 ½-2 hours each way to San Francisco to find providers who will see them. This is unacceptable for people with severe illness, such as cancer patients. This is a direct result of inadequate reimbursement from Medicare.

We all know that other insurance follows the lead of Medicare. If Medicare rates were brought up, other health plans would follow and the financial balance could be restored in our community.

Thank you for your consideration of this proposal and community input.

Sincerely,

Judith Bernstein

Judith Bernstein, LCSW
5557 Yerba Buena Rd.
Santa Rosa, CA 95409

ISSUE IDENTIFIER
GPCI.

6385 STONE BRIDGE RD.
SANTA ROSA, CA 95409

SEPTEMBER 19, 2005

CENTERS FOR MEDICARE & MEDICAID SERVICES.
DEPT. HEALTH & HUMAN SERVICES
ATTENTION CMS 1502 P
PO BOX 8017
BALTIMORE, MD. 21244-8017

I HAVE BEEN A MEDICARE BENEFICIARY FOR 7 YEARS AFTER WORKING 50+ YEARS AS AN R.D. I AM APPALLED AT HOW DIFFICULT IS TO FIND A PHYSICIAN WILLING TO TAKE "NEW" MEDICARE PTS! OUR COUNTY REIMBURSEMENT IS WAY OUT OF LINE WITH WHAT OUR MD'S ARE ACTUALLY PRACTICING.

AN INCREASE IN REIMBURSEMENT WILL STOP THE EXODUS OF PHYSICIANS & ATTRACT NEW PHYSICIANS TO OUR AREA.

PLEASE ADDRESS THIS ISSUE.

SINCERELY,
FRANCES K. TODD

683

SEP 28 2005

P.O. Box 1130
Rohnert Park, CA 94927
Phone: (707) 523-2100
Fax: (707) 569-8809

September 14, 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, California. I would like to address some specific concerns from the perspective of SunCar Rentals Corp:

- Santa Rosa now ranks with retirement destinations such as Clearwater, St. Petersburg, and Miami, Florida.
- Among cities with a population of 100,000 or more, Santa Rosa is sixth in the United States for the highest percentage of people 85 and older.
- According to State of California Department of Finance, seniors 60 and older represent 16.6% of the total population in Sonoma County, with a projected rate of change of 196% by 2020.

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

- The number of practicing physicians in Sonoma County has not kept pace with local population growth. From 1995 to 2002, the population increased 13%, but the number of practicing physicians increased by only 4%.
- As of July 2005, 60% of Sonoma County primary care physicians were NOT accepting new Medicare patients.
- Many physicians are leaving our county to practice where reimbursement is more favorable. As a result, many specialties are under-supplied. For example, we have only two gerontologists in the county for more than 76,000 seniors.

The new locality would increase the Medicare reimbursement rate to more closely match actual practice expenses, helping Sonoma County physicians improve the quantity and quality of care they deliver to Medicare beneficiaries and other patients. The locality change would also aid efforts to recruit and retain physicians in the county, which has a large Medicare population. I fully support your proposal to change Sonoma County's payment locality, and I appreciate the opportunity to comment on this important issue.

Sincerely,

Daniel Hiltebrand
President

cc: Two copies attached

TELL MEDICARE

TO CORRECT REIMBURSEMENT IN SONOMA COUNTY

684

AUG 28 2005

One-time Opportunity to Change Federal Guidelines

Sonoma County has suffered under the strain of inadequate medical compensation for more than a decade. Several medical groups have gone bankrupt, Health Plan of the Redwoods has shut down, employers have faced significant increases in health insurance premiums, and many doctors have left the county because of low reimbursement. I have seen all the bulleted points below, and heard many times that our catagory for reimbursement is way out of date. I work with discouraged Doctors and Discharge Planners at Petaluma Valley Hospital. Please change the guidelines so we can do a better job for the elderly and less fortunate

In addition:

- Medical costs in Sonoma County have risen much faster than other areas and are, on average, 8% higher than similar counties.
- Among cities with a population of 100,000 or more, Santa Rosa is sixth in the United States for the highest percentage of people 85 and older.
- Seniors (60 and older) represent 16.6% of total population in Sonoma County with a projected rate of change of 196% from the year 2000 to 2020.

And, amid that astounding growth in elder population, Sonoma County has the lowest Medicare reimbursement rate in California:

Annie D Conrad RN BSN

- The number of practicing physicians in Sonoma County has not kept pace with local population growth – over a seven-year period (1995-2002) the population increased 13 percent and the number of physicians practicing increased by only 4 percent.
- In July 2005, six out of 10 Sonoma County primary care physicians were NOT accepting new Medicare patients.
- Many physicians are leaving our county to practice where reimbursement is more favorable.

The result: thousands of patients, particularly those on Medicare or without insurance, are having trouble accessing health care.

Medicare has proposed a new rule that would increase the reimbursement rate for Sonoma County by 8%. This proposal will bring Sonoma County back in line with current Medicare reimbursement standards, which will help stabilize our medical community.

685

SEP 28 2005

706 Hill Street
Capitola, CA 95010
September 26, 2005

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

Gentlemen:

We, 2 Senior Citizens, wish to support the relocation of Santa Cruz and Sonoma Counties into their own localities and have them taken out of CA Locality 99

Santa Cruz County borders Santa Clara County and is the bedroom for this County. Our housing is very high and very costly, as well as other costs of living. Our excellent doctors and hospitals need higher remuneration for this County, otherwise, they will be leaving us for a more lucrative area.

Please reclasify our County of Santa Cruz out of CA Locality 99

Yours truly

George L. Applegate

George L. Applegate

Margaret K Applegate

Margaret K. Applegate

SEP 28 2005

686

422 Locust St.
Santa Cruz, Ca.
95060

Sept. 25, 2005

GPCIs

We support increasing Medicare reimbursement for Santa Cruz County (CA.) physicians. From personal experience, we can verify that they are deserving. We do not want to lose our competent physicians, and we would hope that more physicians will believe that it is financially feasible to practice in our county.

Sally Sumpf (Mrs. Edward)

Edward C. Sumpf

687

JAMES A. NEE
2262 Seventh Ave.
Santa Cruz, CA 95062
Phone (831) 464-7340
naturboy@cruzio.com

September 24, 2005

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

Re: GPCI

Ladies & Gentlemen;

please change Santa Cruz County's designation from a rural county to an urban county for purposes of reimbursement of doctors treating Medicare patients.

Certainly, we are just as urban as our next-door neighbor Santa Clara County. I have lived and worked in Santa Cruz County for 17 years. The county has not been rural for many years, despite expensive housing and tight zoning restrictions. Our seaside location and ideal weather have propelled growth beyond any reasonable definition of rural.

I am a Medicare beneficiary and my doctor is excellent. I want him to be rewarded equitably when treating me and other Medicare patients.

Thank you for your attention.

Sincerely,

JAMES A. NEE

688

September 25, 2005

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

316 Northgate Ave.
Daly City, CA 94015

"GPCI"

I am writing in favor of eliminating the mismatch of the physician/provider cost/payment by Medicare in Santa Cruz County, California. The lower payments are causing a physical exodus of the health care providers and making it more difficult for seniors to access medical help. And more and more seniors are moving to Santa Cruz County adding to the serious problem. I would appreciate a favorable consideration of rectifying this problem. Thank you.

Sincerely yours,

Evelyn Ballard, M.D.

Evelyn Ballard, M.D.
Retired Physician

689

AKDHC

September 22, 2005

VIA EMAIL AND POSTAL MAIL
www.cms.hhs.gov/regulations/ecomments
Department of Health and Human Services
ATTN: CMS – 1502-P
PO Box 8017
Baltimore, MD 21244-8017

RE: Federal Register Publication 8/8/05

Comments SUPPORTING the following proposed rule:

1. Individual Nutritional therapy allowed via Telehealth
   Our practice visits 9 remote clinics and cares for thousands of patients that are hundreds of miles from our epicenter. We have physicians that fly to these locations monthly to render nephrology services to patients in these areas. If Medical Nutrition Therapy were allowed via telehealth, the patients would be able to receive the nutrition therapy they so desperately need as part of their care plan. Please retain the proposal for Medical Nutrition Therapy in a telehealth setting.

690

AKDHC

September 22, 2005

VIA EMAIL AND POSTAL MAIL
www.cms.hhs.gov/regulations/ecomments
Department of Health and Human Services
ATTN: CMS – 1502-P
PO Box 8017
Baltimore, MD 21244-8017

RE: Federal Register Publication 8/8/05

Comments OPPOSING the following proposed rules:

1. **Multiple-Procedure Discount for Certain Diagnostic Imaging Services**

   Proposal:
   The reduction is reimbursement is proposed due to the assumption of "We do not believe these same inputs are needed to perform subsequent procedures. When multiple images are acquired in a single session, most of the clinical labor activities and most supplies are not performed or furnished twice."

   Rebuttal:
   The opposite is true. Most clinical labor activities and most supplies ARE furnished twice for multiple procedures such as film, supplies, and staff time. While intake secretarial time is diminished, procedure time is unchanged. In addition, supplies within the room are usually not reduced nor supplies needed during the procedure. Time of usage of the equipment is usually not reduced. A 50 % reduction does not reflect the reality of the situation. Our practice does not support the proposed multiple-procedure discount for certain diagnostic imaging services.

2. **Overall conversion factor decrease to 4.3% for Nephrology**

   The specialty of nephrology continues to bear the brunt of Medicare cuts. The nephrology patient population medical complexity is second to none, and we endure more cuts than most specialties. Our practice does not support continued cuts to such a complex and valuable specialty.

3. **Decrease of 5% in 90935 –Inpatient Dialysis Visit Code**

   Proposal:

90935 proposed allowable	$69.37
99233 proposed allowable	$75.74

Medicare's proposed reimbursement would mean that a 90935 payment would be 8% below that of a 99233.

Rebuttal:

However, the Nephrologist is required to consider all those components of a 99233 and in addition consider:

- The function of the machine
- The adequacy of the dialysis
- The state of the vascular access
- The clinical stability of the patient before, during and after the dialysis
- The effect of the dialysis itself upon all the components that are covered in the 99233 visit

The Medical Decision Making is more complex, and payment is lower. Please reconsider the reduction proposed for a 90935 visit due to the facts stated above.

SEP 28 2005

691

Alvin L & Wanda M. Nance

225-208 Mt. Hermon Road, Scotts Valley, CA 95066 -- (831) 438-6479 (summer)

E-mail: shalom.aln@juno.com

September 26, 2005

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

Re: GPCI

TO WHOM IT MAY CONCERN:

We are under Medicare and residents of Santa Cruz County, California. Sometime ago, it came to our attention that doctors in this area receive payments for services rendered to Medicare patients under "rural" classification. This is definitely not rural area and, according to statistics we have seen, is one of the least-affordable areas to live in the whole country.

We understand there is a proposed rule to remove Santa Cruz County from the designation of so-called "Rest of California" physician payment locality. Though we have a primary care physician at the present time, he will probably retire in the not-too-far-distant future. From reports we have read, it is becoming more and more difficult to find primary care doctors who will accept Medicare patients, due to the non-compensatory payments received from Medicare. That issue is of concern to us.

A newspaper story for Sunday, September 25, went into this situation in detail.

We wholeheartedly support doctors receiving Medicare payments in this county the same as doctors in other counties of the San Francisco Bay area.

Sincerely yours,

Alvin L. Nance

Wanda M Nance

SEP 28 2005

692

Ria Ericson
148 S Temelec Cir.
Sonoma, CA 95476-8341

September 21, 2005

Dear Reader:

It is imperative that you raise the Medicare reimbursement in Sonoma County California.

I strongly urge you to implement this proposal because the cost of Medicare has risen faster in the county than any other nearby areas by an average of 8 percent.

I live in the town of Sonoma. The population is appox. 9,000 + and one-third of the citizens are Seniors.

Appox. 20 miles away, Santa Rosa, with a population of over 100,00 is sixth in the United States to have a percentage of the population that are 85 years and older.

In July of this year 6 out of 10 Sonoma County doctors were not accepting new Medicare patients. In addition, between 1995 – 2002 the population increased 13 percent, while the physicians increased by only 4 percent.

Your new proposed rule will bring the county standards up and will help stabilize both sides of the medical community: Seniors as well as their Medical Care Givers.

Most sincerely,

Ria Ericson

Ria Ericson

693

Orthopaedic Specialty Clinic of Spokane, PLLC

David F. Scott, M.D.
Arthritis Surgery
Total Joint Replacement

Amaryllis J. Scott, M.D.
Sports Medicine & Shoulder Surgery

Antoine G. Tohmeh, M.D.
Back & Neck Surgery
Complex Spine Surgery

Craig R. Barrow, M.D.
Foot & Ankle Surgery

Robert B. Bazzano, PA-C

Kathleen S. Schindele, PA-C

Chad D. Bailey, ARNP

September 21, 2005

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

RE: Proposed changes for casting supplies

Dear Reader:

I have recently been informed through our local Orthopaedic National Society (BONES) that there is a cut planned for reimbursement for cast materials in the 2006 fee schedule.

PLEASE RECONSIDER THIS! Many physicians have stopped taking Medicare patients and as more and more of us age, finding physicians will become harder and harder. Medicine is a business-more so than in the past and we all have to be very aware of our bottom line. With continuing reimbursement cuts, unfortunately the very people who have worked so hard all there lives will be the ones greatly affected.

Casting materials may seem like a small item to you, but it is just one more expenditure that we have in running our business and it adds up tremendously when you consider the volumes a casting an orthopedic office likes ours has.

Again-please reconsider avoiding cutting the reimbursement for casting supplies, injectibles and anything else out there being considered. We want to stay in the business of health care. Please help us do so!

Respectfully,

Marsha Pinat

Marsha Pinat, CMPE
Office Administrator

785 E. Holland Rd. • Spokane, WA 99218 • 509-466-6393 • Fax 509-466-5163 • 877-464-1829
www.orthospecialtyclinic.com

694

9/22/05

Medicare Representative

SEP 28

I want to encourage you to increase the reimbursement rate for Sonoma County, California.

The number of physicians here, is not keeping pace with population increase. Six out of ten physicians are <u>not</u> accepting medicare patients now. The cost of living here is very high. Please act responsibly.

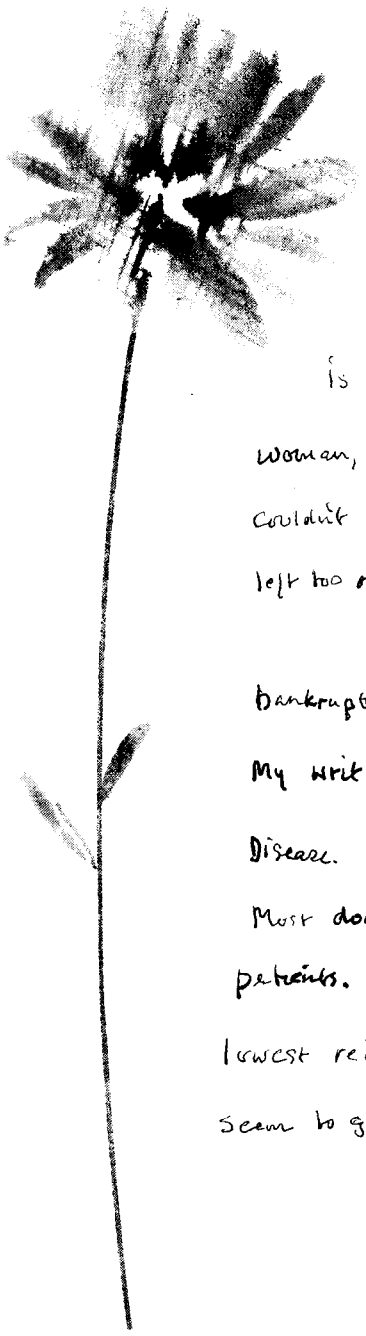
Sincerely,
D H Wilcox (70 years-old)

Yvonne A. Wilcox
684 North Main Street
Sebastopol
CA 95472

Sonoma County

695

SEP 28 20[illegible]



Dear CMS

The median price for a house here is over 700,000 dollars. My doctor, a young woman, had to leave the county because she couldn't afford to stay. Her husband, also an MD, left too of course.

My medi-gap insurance (UHR) went bankrupt. We have a high percentage of seniors here. My writing is so bad because I have Parkinson's Disease. I have only Medicare, since UHR is bankrupting. Most doctors here (60%) will not take Medicare patients. We have, in Sonoma County, the lowest reimbursement rate in all California. We seem to get forgotten here.

Regards

yvonne wilcox

I used to have nice handwriting

Sally & Edward Lobb
9217 Lakewood Dr.
Windsor, CA 95492
Sept 22, 2005

GPCIs
Centers for medicare & medicaid Service
Dept. of Health and Human Services
Attention CMS-1052-P
P.O. Box 8017
Baltimore, MD 21244-8017

696

We support the proposed correction in medicare reimbursement in Sonoma County in order to make more equitable the compensation our physicians receive.

Sonoma County's demographics are similar to those of marin County and the Bay Area and some of our doctors are being forced to move elsewhere due to the high cost of living and the low rate of medicare reimbursement here. Others (6 out of 10 primary care M.D.s) are not accepting medicare patients. Seniors now represent 16.6% of total population in Sonoma Co. with a projected rate of change of 196% from the year 2000 to 2020.

We urge you to approve the increase for Sonoma County without delay.

Sincerely,
Sally and Edward Lobb

County of Santa Cruz

697

SENIORS COMMISSION

PO BOX 1320, SANTA CRUZ, CA 95061
(831) 454-4864 FAX (831) 454-4290
CHARLES MOLNAR, CHAIR

SEP 28 2005

September 21, 2005

Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1502-P
P.O. Box 8017
Baltimore MD 21244-8012

SUBJECT: GPCI's

To Whom It May Concern:

The Seniors Commission is pleased to write this letter in support of the proposed revision to the physician payment in the San Francisco Bay Area. The request to change the current rural designation is definitely required to make the important change to ensure access to health care services in our county.

The County of Santa Cruz ranks among the highest in California and the nation in which to live. The discrepancy in reimbursement rates and the economics of the area have resulted in many physicians actually leaving, others refusing new Medicare patients, and many actually opting out of participation in HMOs and Medicare. Recruitment of new physicians treating the older population is reaching a crisis level.

The Seniors Commission has been following the process of the re-designation for the last couple of years. Without the availability and accessibility of quality medical care in our County, the seniors are at great risk of not only declining health status, but increased preventable dependence upon higher levels of care. Thank you for your commitment to quality Medicare and Medicaid services and for the opportunity to provide this request for changes to our rural status.

Respectfully submitted,

Charles Molnar

Charles Molnar,
Chairperson

cc: Santa Cruz Board of Supervisors
Cecilia Espinola, Human Resources Agency Director
Rama Khalsa, County Health Services Director

County of Santa Cruz

698

IN-HOME SUPPORTIVE SERVICES ADVISORY COMMISSION

1400 EMELINE AVE., 3rd FLOOR, SANTA CRUZ, CA 95060
(831) 454-4401 FAX (831) 454-4290
MICHAEL MOLESKY, CHAIR

SEP 28 2005

September 22, 2005

Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1502-P
P.O. Box 8017
Baltimore MD 21244-8012

SUBJECT: GPCI's

To Whom It May Concern:

The In-Home Supportive Services Advisory Commission recently voted to write this letter in support of the proposed revision to the physician payment in the San Francisco Bay Area. The request to change the current rural designation is definitely required to make the important change to ensure access to health care services in our county.

The County of Santa Cruz ranks among the highest in California and the nation in which to live. The discrepancy in reimbursement rates and the economics of the area have resulted in many physicians actually leaving, others refusing new Medicare patients, and many actually opting out of participation in HMOs and Medicare. Recruitment of new physicians treating the older population is reaching a crisis level.

The Commission has been following the process of the re-designation for the last couple of years and is optimistic that this new designation will be approved. Without the availability and accessibility of quality medical care in our County, the seniors are at great risk of not only declining health status, but increased preventable dependence upon higher levels of care. Thank you for your commitment to quality Medicare and Medicaid services and for the opportunity to provide this request for changes to our rural status.

Respectfully submitted,

Michael Molesky/ss

Michael Molesky,
Chairperson

cc: Santa Cruz Board of Supervisors
Cecilia Espinola, Human Resources Agency Director
Rama Khalsa, County Health Services Director

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County of Santa Cruz

LONG TERM CARE INTERAGENCY COMMISSION

1400 EMELINE AVE., 3rd FLOOR, SANTA CRUZ, CA 95060
(831) 454-4864 FAX (831) 454-4290
LARRY FRIEDMAN, CHAIR

SEP 28 2005

September 20, 2005

Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1502-P
P.O. Box 8017
Baltimore MD 21244-8012

SUBJECT: GPCI's

To Whom It May Concern:

The Long Term Care Interagency Commission is pleased to write this letter in support of the proposed revision to the physician payment in the San Francisco Bay Area. The request to change the current rural designation is definitely required to make the important change to ensure access to health care services in our county. This adjustment will help to appropriately address the current inequitable payment for Medicaid services.

The County of Santa Cruz ranks among the highest in California and the nation in which to live. The discrepancy in reimbursement rates and the economics of the area have resulted in many physicians actually leaving, others refusing new Medicare patients, and many actually opting out of participation in HMOs and Medicare. Recruitment of new physicians treating the older population is reaching a crisis level.

We are extremely pleased that you have selected Santa Cruz County as one of the most important areas to begin to correct the problem of lower reimbursement rates for Medicaid services. Without the availability and accessibility of quality medical care in our County, the seniors are at great risk of not only declining health status, but increased preventable dependence upon higher levels of care. Thank you for your commitment to quality Medicare and Medicaid services and for the opportunity to provide this request for changes to our rural status.

Respectfully submitted,

Larry Friedman,
Chairperson

cc: Santa Cruz Board of Supervisors
Cecilia Espinola, Human Resources Agency Director
Rama Khalsa, County Health Services Director

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CareCore National, LLC
169 Myers Corners Road
Wappingers Falls, NY 12590
845-298-8155
800-918-8924
fax: 845-298-8384

CareCore NATIONAL

September 23, 2005

Herb Kuhn
Director, Center for Medicare Management
Centers for Medicare & Medicaid Services (CMS)
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, D.C. 20201

Re: Multiple Procedure Reduction for Diagnostic Imaging in Proposed Rule on Revisions to Payment Policies under the Physician Fee Schedule for Calendar Year 2006 (CMS-1502-P)

Dear Mr. Kuhn:

On August 8, 2005, the Centers for Medicare and Medicaid Services (CMS) published its proposed revisions to payment polices under the physician fee schedule for 2006 in the *Federal Register,* including revising how Medicare pays for imaging procedures that are done during the same physician visit and performed on a contiguous body part of a patient.[1] CareCore National broadly supports CMS' proposal on this and other efforts to rationalize Medicare's payment policies for imaging services. We have previously submitted data to CMS that reflects our company's extensive experience managing imaging services.

CareCore National provides comprehensive, customized programs to health plan clients that seek to mitigate soaring diagnostic imaging costs while improving imaging excellence and ensuring patient convenience. CareCore National's innovative and quality-driven approach to radiology utilization management has made it the country's fastest-growing outpatient diagnostic imaging utilization management services provider, covering over 12 million national subscribers.

Specifically:

CareCore endorses and supports CMS' plans to apply a multiple Medicare payment reduction to the technical component of multiple diagnostic imaging services. Our experience in the private sector is that such reductions are appropriate adjustments in payment policy and health plans, employers, and most practicing radiologists have taken

[1] 70 *Fed. Reg.* 45764 (August 8, 2005).

these adjustments in stride. We support CMS' plans to make full payment on the highest priced procedure but only pay fifty percent of the practice expense for additional procedures performed within the same family. We have considerable experience in implementing virtually identical policies with commercial insurers, and believe that the proposed CMS approach is entirely justified, rational, and consistent with current private sector expectations.

CareCore strongly supports CMS' plans to include nuclear medicine procedures as designated health services under the Stark law. Both the medical literature and our data demonstrate that non-radiologists who own imaging equipment tend to order and perform more tests than those who refer their diagnostic imaging to radiologists. We were pleased to present our findings to MedPAC in 2004, and believe that this change will promote utilization that is more appropriate. This "self-referral" issue is particularly acute in the area of nuclear medicine, and we are supportive of CMS initiatives in this area.

As you know, MedPAC's March 2005 analysis showed that the growth in utilization of diagnostic imaging is largely attributable to dramatically increased use imaging technologies by non-radiologists. From 1993 to 1999, radiologists performed 4% fewer procedures, while non-radiologists' utilization increased 25%.[2] Radiologists accounted for only one-half of Medicare imaging spending in 2000.[3] CMS' proposal is a critical step to rationalizing utilization of imaging and we look forward to working with you as the efforts continue.

Sincerely,

Don Ryan
President and Chief Executive Officer
CareCore National

cc: Tom Gustafson, Deputy Director, Center for Medicare Management
Liz Richter, Director, Hospital and Ambulatory Payment Group
Amy Bassano, Director, Division of Ambulatory Services
Ken Marsalek, Center for Medicare Management

[2] "Practice Patterns of Radiologists and Non-radiologists in Utilization of Noninvasive Diagnostic Imaging Among the Medicare Population, 1993-1999," Maitano, Levin, et al., Radiology 2003; 228:795-80

[3] Medicare Payment Advisory Commission, October 28, 2004 meeting, staff presentation. Transcript available at www.medpac.gov