GTL+

8/24/2005

201

AUG 31 2005

To whom it may concern,

I am writing to urge you to redesignate Santa Cruz County in terms of medicare reimbursements to, at least, a level of 55 percent. During the 1960's Santa Cruz may have been considered rural, but that is certainly not true today. It's difficult for the average wage earner to live here. Gas is higher, and goods for the home are higher. Homes are only for those with large incomes. A 450 square foot house is selling for $500,000!

Under my Blue Cross plan, I lost two doctors who refused to accept payments from them because they were too low. Doctors spend many years getting their degrees, and they usually have large loans to repay. You can't expect them to live on what insurance companies or the government doles out. They'll go somewhere where they are paid what they're worth.

Please make it possible for us to have decent medical coverage here. Sincerely, Jean Williams

202

AUG 31 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

To Whom It May Concern:

First of all, I am aghast to learn from the Santa Cruz Sentinel that Medicare and Medicaid patients in San Francisco and New York and Boston are valued more as human beings than those in Santa Cruz, California...where the cost of living is commensurate with these larger communities, but where the doctors aren't reimbursed as much, thanks to our designation as a rural community. If you could spend just five minutes in this community, you would never – not even in your wildest dreams – classify this busy, diverse, university town as rural. While you were here, maybe you'd pick up the real estate ads and balk at the prices...or simply overhear a common café conversation about how prohibitively expensive it is to live here. Then, maybe if you were a doctor, you'd decide to leave...knowing you could make more in towns just on the other side of the mountains.

I hope you can help prevent good doctors from leaving my town. In fact, I hope you can encourage them to come here. Please act to reclassify Santa Cruz in such a way that our Medicare and Medicaid plans reimburse practitioners at a higher, non-rural rate. Then, after that, please take further steps to eliminate a system that values urbanites more than farmers.

Thank you,

Rebecca Green
1007 North Branciforte Avenue
Santa Cruz, CA 95062

203

AUG 31 2005

August 23, 2005

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

As a resident of Santa Cruz, Calif. since 1968, I have seen this city grow in population And the high cost of living.

I worked for 21 yrs. for a local Family Physician and have seen the dynamics of medical Care change drastically. Many Medicare patients and the disabled are being refused by some Physicians and Medical Groups due to the lower rate of reimbursement .

As older Physicians retire, it is more difficult to replace them due to this factor. It is Also a deterrent for new doctors to choose our area to practice or for some already here to move away.

I strongly urge that more consideration be given to change Santa Cruz County from A Rural rate to an Urban rate status.

Sincerely,
Jeanne R. Hougardy

Ms. Jeanne R. Hougardy
133 Kenny Court
Santa Cruz, Ca. 95065

204
AUG 3 1

CMS

8-24-05

Dear Medicare,

This letter is sent to urge you to increase the reimbursement levels for doctors in Santa Cruz County, CA for treatment of their Medicare patients. Basic health care will be protected if the reinforcement levels are increased in Santa Cruz County.

Santa Cruz County is not a rural county and should be on a level with Santa Cruz's neighbors: Santa Clara Co. and other Bay Area counties. Presently the cost of living in Santa Cruz Co. is as high or higher than it is in neighboring counties. In order to keep doctors and to attract good new doctors an increase in the reimbursement levels is necessary.

Thank you for your support.

Sincerely,

Viola M. Dixon
340 Arthur Ave.
Aptos, CA
95003

(831) 688-4801

RON DORRIS ELECTRIC, INC.

3100 Dutton Avenue, #144E, Santa Rosa CA 95407
(707) 578-0678 voice/(707) 578-2448 fax
CA License #784130

205

AUG

August 26, 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: GPCIs

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

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

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

Sincerely,

Ronald Dorris
President, Ron Dorris Electric, Inc.

cc: Two copies attached

"ANYTHING...ELECTRICAL"
LICENSED, BONDED AND INSURED
AMERICAN EXPRESS, DISCOVER, MASTERCARD, VISA
1 YEAR SAME AS CASH FINANCING, O.A.C.

GPCI,

206

505 Vista Del Mar
Aptos CA 95003
August 24, 2005

Center for Medicare
and Medical Services,
Department of Human Services:

I urge you to please change the designation for Santa Cruz County from Rural to Urban.

Sincerely,
Margaret Ann Porter

MICHAEL L McGANNON, M.D., F.A.C.E.P.
823 Cathedral Drive
Aptos, California 95003

AUG 3 1

August 24, 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; GPCIs, Santa Cruz County, California

Dear Sir or Madame,

I am writing to sincerely ask for your help. We have great difficulty in recruiting and retaining physicians in Santa Cruz County, which this month was again named one of the least affordable places to live and rent in the U.S. Despite extremely high practice costs and cost of living, Santa Cruz County has for years been designated by Medicare as a rural county, with physician reimbursement rates much less than neighboring Santa Clara County and other San Francisco Bay area jurisdictions with similar and lower practice and living costs.

We have a markedly aging physician population. Practices are routinely refusing or restricting further Medicare patients, as physicians regretfully say they cannot afford to see these patients. Some physicians live here but commute to other counties because of the reimbursement disparity.

I am an emergency physician, and I daily see the difficulty our patients have in finding primary care physicians and specialty care. I respectfully ask that you do all that is possible to appropriately raise the Medicare physician reimbursement rate for Santa Cruz County. The present rural designation is obviously archaic, and a change is truly important for patient care in our county.

Thank you very much for your help.

Sincerely,

Michael L. McGannon, M.D.

208

AUG 31 2005

Ochsner
CLINIC FOUNDATION

DEPARTMENT OF ANESTHESIOLOGY

Alan C. Santos, M.D., M.P.H.
Chairman

Orin F. Guidry, M.D.
Chairman, 1999-2004

James R. Douglas, Jr., M.D., Ph.D.
Chairman, 1982-1999

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Brian M. Evans, M.D.
Donald R. Ganier, M.D.
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W. David Sumrall, M.D.
Connie E. Taylor, M.D.
Leslie C. Thomas, M.D.
Mack A. Thomas, M.D.
Claude A. Vachon, M.D.
Donald R. Webre, M.D.
Jimmy J. Windsor, M.D.
Elizabeth T. Young, M.D.

August 25, 2005

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

FILE CODE: CMS-1502-P
TEACHING ANESTHESIOLOGISTS

Dear Sirs:

I am writing to express grave concern regarding CMS's refusal to compensate teaching anesthesiologist in a fair and non-discriminatory manner. The current policy of reducing an anesthesiologists' revenue by 50% if teaching two residents in two separate rooms has had, and will continue to have, serious adverse public health effects.

First, the policy is discriminatory because other specialties, such as surgery and medicine, are able to collect 100% of their fees when supervising more than 1 resident. In the case of medicine, 100% of the fee is recoverable supervising up to 4 residents!

Secondly, the rule has an adverse public health effect in causing academic medical centers and anesthesiology departments to reconsider training residents in anesthesiology. This is important for several reasons. There is already a shortage of qualified anesthesiologists in the United States to care for an ever increasing cohort of elderly patients with complicated medical problems. The 50% teaching rule results in anesthesiology residency slots going unfilled because the teaching programs are being short-changed. For instance, in our own program, we have estimated that the 50% teaching rule results in a budget shortfall of approximately 2 million dollars a year for our total of 18 residents. This budget shortfall also affects our ability to not only provide high quality clinical care to our senior citizens but also diminishes the amount of scholarly work we can do to enhance the clinical care of patients in the long run.

Further consider that the CMS conversion factor is already 40% that of accepted commercial rates, another 50% reduction in that fee if an anesthesiologist covers two residents is crippling to the specialty and local health care systems.

I hold a degree in Public Health and fully understand the complexities of funding. However, the effects of the CMS 50% rule on teaching anesthesiology programs is staggering. I believe that we should be paid fairly for the outstanding services we provide to CMS patients, the teaching of future generations of physician anesthesiologist to care for those patients and as important, the ability to develop new techniques for enhancing the clinical care of the elderly, in a safe, efficient, cost-conscious manner. Not to do so is unfair and discriminatory considering that CMS provides full reimbursement for teaching physicians in other specialties, such as surgery and internal medicine, when they cover two or more residents. Not to do so is also undermining the public health interest of the very people you represent, the elderly.

I hope that CMS will reconsider the 50% reduction in rates for teaching anesthesiologist covering two residents. Not to do so is going to create a future public health dilemma that will be attributable right back to CMS policies.

Sincerely,

Alan C. Santos, MD, MPH
Chairman

209
AUG 31 2005

mayo

Mayo Clinic
200 First Street SW
Rochester, Minnesota 55905
507-284-2511

Niki M. Dietz, M.D.
Department of Anesthesiology

August 25, 2005

CMMS, Department of HHS
PO Box 8017
Baltimore, MD 21244-8017

Re: Reference file code CMS-1502-P (Teaching Anesthesiologists)

To Whom It May Concern:

I work as an academic anesthesiologist in one of the country's largest anesthesiology training programs. Not only do I teach resident trainees in the operating rooms, I am intimately involved in the organization of our training program. Mayo Clinic's anesthesiology residency program has a strong history of producing extremely well-qualified doctors who have gone on to provide excellent care to citizens all over the United States. I am very proud of these fine men and women, some of whom have subsequently taken care of my friends and family members.

I am confused and troubled by the reluctance of CMS to correct the discriminatory policy of paying teaching anesthesiologists only 50% of the fee for each of two concurrent resident cases. This course is not fair to anesthesiology academic teaching programs and will, over time, reduce the number and quality of anesthesiologists who are trained, an exceedingly bad idea at a time that patients are becoming older, sicker, and more in need to surgical and diagnostic interventions under anesthesia.

This policy seems even more unfair when reimbursement of other teaching doctors is considered. Teaching surgeons may supervise trainees in two overlapping operations and collect 100% of the fee for each case from Medicare. An internist may supervise trainees in four overlapping outpatients visits and collect 100% of the fee for each when certain requirements are met. A teaching anesthesiologist can collect only 50% of the Medicare fee if he or she supervises trainees in two overlapping cases. I don't understand the distinction between surgeons, internists, and anesthesiologists as they provide necessary care to our elderly patients.

In addition to working in operating rooms, I work in a research laboratory committed to furthering our understanding of how the autonomic or "automatic" part of the human body works, in an effort to make anesthesiology and medicine safer. Over the past decade, I have seen the amount of support dedicated to important medical research decline, and there is no doubt in my mind that it will decline even further as my anesthesiology department struggles to make up

for the losses incurred by Medicare's underpayment of teaching anesthesiologists. Over the past thirty years, it has been medical research by doctors in academic centers that has made anesthesiology remarkably safe, even in sick and elderly individuals. It seems very shortsighted to jeopardize this progress when the population requiring anesthesia services rapidly becomes older and sicker.

I urge you to correct this unjust policy and allow teaching anesthesiologists equity with our colleagues in surgery and medicine. There is no logical reason for this payment difference between teaching physicians. Continuation of the policy will further hinder our ability to produce anesthesiologists at a crucial time in the demographic changes that are occurring in our country.

Sincerely,

Niki M. Dietz, MD

mayo

SEP - 2 20[illegible]

210

Mayo Clinic
200 First Street SW
Rochester, Minnesota 55905
507-284-2511

James R. Munis, M.D., Ph.D.
Department of Anesthesiology

August 26, 2005

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

Re: Reference file code CMS-1502-P (Teaching Anesthesiologists)

Dear Sir/Madame:

I am an academic anesthesiologist on the clinical faculty of the Mayo Clinic, and on the teaching faculty of the Mayo Clinic College of Medicine. In addition, I spend a great deal of time teaching resident physicians in our anesthesiology training program.

Many of us who spend our days caring for patients and teaching residents and medical students in an academic setting are naïve to reimbursement issues, but one issue in particular is so important, and so nonsensical, that it demands immediate attention. As you know, current CMS rules for reimbursement in anesthesiology provide that an anesthesiologist covering a resident physician while supervising more than one operating room receive only 50% of the usual fee. Worse yet, that "usual fee" is already discounted to less than 40% of prevailing commercial rates.

In contrast, academic surgeons receive 100% of the usual fee while supervising surgical residents in multiple operating rooms; and internists receive 100% of their fee while supervising up to four residents in an outpatient setting. This discriminatory practice against academic anesthesiology makes no logical sense, is patently unfair, and has the effect of discouraging the training of anesthesiologists at a time when our country is facing an aging population and an increasing need for our services. The very last thing that either our specialty or America's aging population needs is an exacerbation of the shortage of trained anesthesiologists by reimbursement rules that discriminate against a critical specialty that is already in short supply.

Because the current rule stands in such stark and unfair contrast to other specialties, and because it runs so counter to the common sense goal of providing for the future of our country's health needs, I'm certain that it is the result of an oversight. Nonetheless, even oversights develop their own inertia and require attention before they are changed. Please make every effort to address this disparity.

Respectfully,

James Munis, M.D., Ph.D.
Chair, Division of Neuroanesthesia
Assistant Professor of Anesthesiology
Assistant Professor of Physiology and Biophysics
Mayo Clinic College of Medicine

JRM:srm

211

SEP - 2 [illegible] August 30, 2005

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

Dear Sir:

I write in support of the Medicare proposal of a new rule that would increase the reimbursement rate for Sonoma County by 5% or even more.

We had a difficult time finding a doctor who would accept Medicare patients. Our original medical group, Health Plan of the Redwoods went bankrupt. Please help stabalize our medical community.

Sincerely,
Verna Lee Wilson
7553 Oak Leaf Dr. Santa Rosa, CA.

VERNA LEE WILSON
7553 OAK LEAF DR.
SANTA ROSA, CA 95409

212

SEP _ 2

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

GPCIs

To Whom It May Concern:

The designation of Santa Cruz county, California and Sonoma county California as rural areas in determining the payment our doctors receive for Medicare and Medicaid patients does not take into account the actual cost of living in these counties. The average price of homes here in Santa Cruz county is over $700,000, which makes it difficult for average citizens to maintain a home, and also for doctors!

Sonoma county was formerly my home and I now live in Santa Cruz. I know many people considered middle income who cannot afford medical care and also I know there are doctors who must leave the area for financial concerns and others who can no longer accept Medicare patients.

The cost of living in these counties should be reflected in the payment to our doctors. Please treat us fairly.

In appreciation of your thoughtful consideration,

Lorraine J. Miner

Lorraine J. Miner
2956 Leotar Cr.
Santa Cruz, CA 95062

phone: 831-479-7813
email: hormann@cruzio.com

213

Dennis & Julie Jacobsen
P.O. Box 1004
Aptos, CA 95001
831-722-5466 Phone
831-768-1254 Fax

SEP

August 29, 2005

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

RE: GPSIs

To Whom it May Concern:

As long time residents of Santa Cruz County, CA, we continue to be concerned by the rural designation assigned to this county many years ago. We are no longer rural, but definitely urban, as verified by our clogged freeways, for one.

Please acknowledge this fact in your current status for our county by **changing our Medicare reimbursement rate for Santa Cruz County, CA from rural to urban,** so that physicians may be reimbursed more fairly and accurately, and therefore more likely able to work and live here, as well.

Thank you,

Julie Jacobsen

Julie Jacobsen

214

SEP

August 28, 2005

Center for Medicare and Human Services
Attn: CMS-1502-P
P.O. Box 8017
Baltimore, MD 21244-8017

To Whom It May Concern:

My wife and I are in concurrence with increasing the Medicare reimbursement rate for Santa Cruz County physicians and other practitioners. Clearly, the appropriate answer is to adopt different rules. Santa Cruz is not the same place it was forty years ago when it was classified as a rural county. As nearly everyone knows, the cost of living is as high or higher in Santa Cruz County than it is in neighboring counties. Yet treatment is reimbursed at a rate ten percent less.

Obviously, the designation makes no sense. One could argue that the federal government should make reimbursement judgments based on current cost of living information and some forty year old designation that has nothing to do with the current situation in 2005. But the issue now is the need for redesignation.

Right now, Medicare reimbursement for local doctors is fifty percent. With redesignation this would increase to fifty-five percent . That is not great, but it is better. It seems plausible that the extra five percent increase could attract good young doctors. The cost of living in Santa Cruz County makes it difficult as they can make a lot more money elsewhere. Yet Santa Cruz County is a great place to live and with just a little encouragement and a little more money, perhaps these needed physicians and practitioners will emerge.

Redesignation and appropriate reimbursement are important for all 32,000 Santa Cruz residents, particularly those who are getting older and in need of good medical care.

We are sending this letter to support the increase in Medicare reimbursement rate for Santa Cruz County physicians.

Sincerely,

Edward and Diane Smalley
Santa Cruz County Residents

SEP - 2

August 30, 2005

Dear Sirs,

Sonoma County desperately needs at least a 8% increase in the medicare reimbursement rate. Not only have we lost M.D specialists but general practioners as well - Costly living in the county are very high and several physicians have decided to practice where reimbursements are more favorable -

As you probably know Santa Rosa has a very big percentage of people over 85 many of us moved here years ago, when it was cheaper to do so. That is no longer true and now we are losing dedicated caring a doctor who will accept Medicare patients

Thank you

Mario Hawley
5555 Montgomery Dr F201
Santa Rosa Ca 95409

August 20, 2005

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

216

SEP - 2 20

Re: GPCI's

Dear Sirs:

I am a patient and a Medicare beneficiary living in Sonoma County, California. My doctor practices here in Sonoma County where it has become an increasingly more expensive place to live and work.

I fully support the CMS proposal to create a new locality for Sonoma County and to establish a new Geographic Adjustment Factor that recognizes the cost of practice here. I want my doctor to be fairly compensated so he can remain in practice here and be available when I need to see him.

Yours truly,

Leonard J. Klay

Mr. Len Klay
1927 E Foothill Dr.
Santa Rosa, CA 95404

217

SEP 2

J. Tal Pomeroy, M.D.
Jennifer Choate, M.D.
3035 Main Street
Soquel, CA 95073
831 421 0127

29 August 2005

Re: GPCI'S

Sirs and Madams,

I am the administrator of a two doctor Oncology office in the county of Santa Cruz, California. I am writing in support of the proposed increase in the Medicare reimbursement rate for Santa Cruz County physicians. It is impossible to compete with other areas of the country when recruiting a physician to our town. We are simply not a rural community. A very modest home in our area costs well over a half million dollars and when coupled with our low reimbursement rates, most physicians considering our area chose to settle elsewhere. This affects not only the physicians who live her (they are tired!) but, it affects the many people who cannot find a primary doctor because physicians have closed their practices to new patients.

The change of status from rural to urban is long overdue. Please accept this proposed change immediately.

Thank You,

Cathy Dobyns
Office Manager

218

SEP

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

Re: GPCIs

To Whom It May Concern,

I strongly support the proposed revision to the physician payment localities in California that you published in the reference rule.

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.

I understand this also to be a fundamental issue of fairness. Neighboring counties to Santa Cruz and Sonoma Counties have some of the highest payment levels for physician services in the nation. The adjustment that you propose appropriately addresses the current inequitable payment problem.

CMS acknowledges that they have the responsibility to manage physician payment localities. I understand that there have no been revisions to the localities since 1996. You have selected the most important area in our state to begin to correct this problem.

I understand that CMS is interested in the opinion of the California Medical Association as it pertains to this proposed rule. I am a practicing physician assistant in Santa Cruz. The opinion of the state medical association is important for you to consider. However, they do not represent many of the health professionals who care for Medicare beneficiaries. CMS should implement this rule because it is the correct thing to do for all health care professionals and Medicare beneficiaries in California.

Sincerely,

Thomas J. Halderman PA-C
Santa Cruz Medical Foundation

219

SEP - 2 2005

August 24, 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

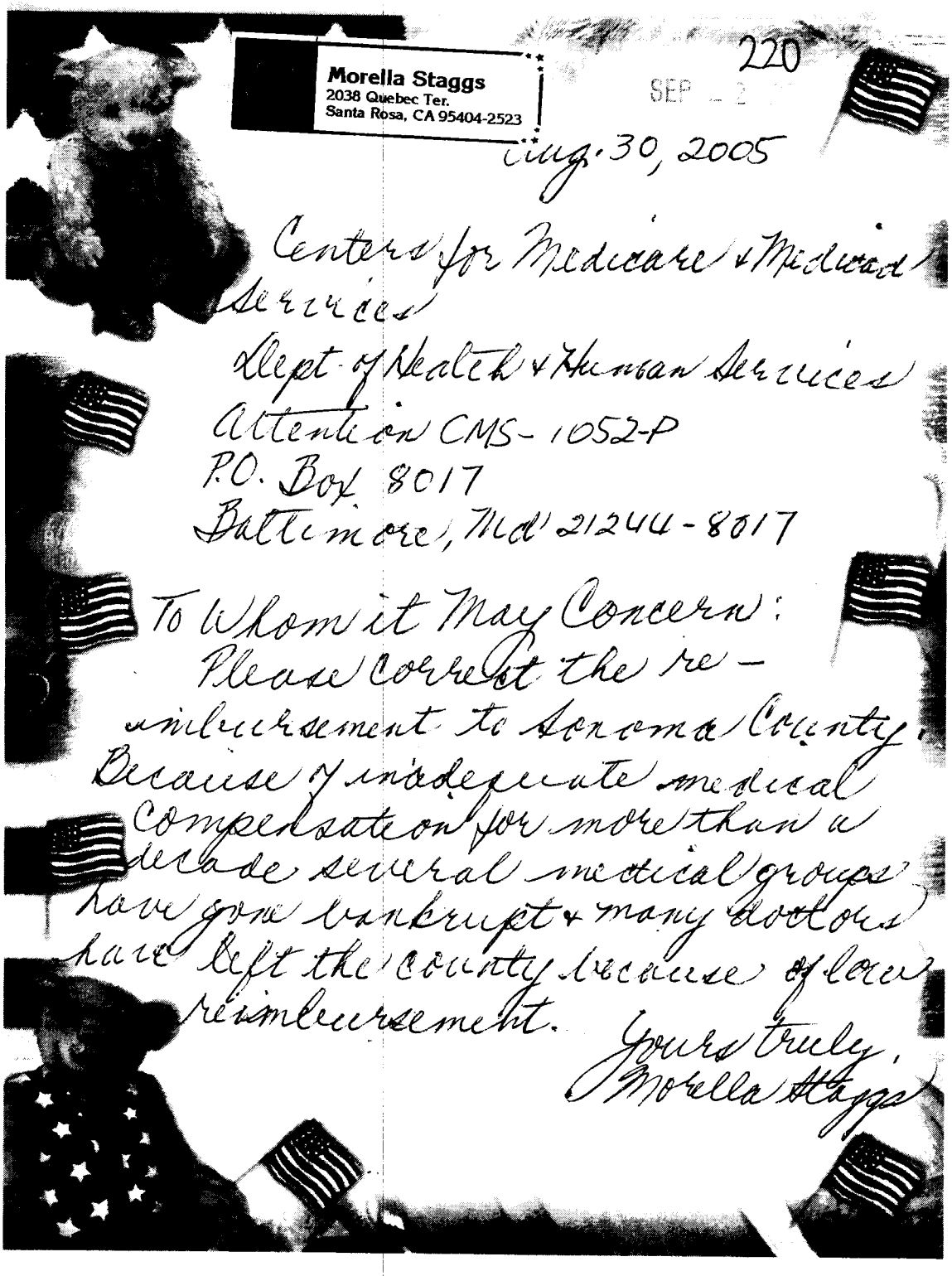
TO WHOM IT MAY CONCERN:

This letter is to show my support for an increase in Medicare reimbursement rate for Santa Cruz County physicians.
Seniors require good doctors and good medical care.
Santa Cruz County is a very expensive area to live.
An increase in the reimbursement level would attract more good young physicians, and enable us to keep the good doctors we already have in our county.

Thank you for your attention in this matter.

Sincerely,

Pauline Womack



Morella Staggs
2038 Quebec Ter.
Santa Rosa, CA 95404-2523

220

SEP - 2

Aug. 30, 2005

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

To Whom it May Concern:
Please correct the re-imbursement to Sonoma County. Because of inadequate medical compensation for more than a decade several medical groups have gone bankrupt & many doctors have left the county because of poor reimbursement.

Yours truly,
Morella Staggs

221

SEP - 2 2

THOMAS PAUL MILES, M.D.

DIPLOMATE AMERICAN BOARD OF ORTHOPAEDIC SURGERY
A MEDICAL CORPORATION

1310 G PRENTICE DRIVE
HEALDSBURG, CA 95448
(707) 473-2840

500 DOYLE PARK DR., STE 105
SANTA ROSA, CA 95405
(707) 577-8383

August 26, 2005

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

RE: GPCIs

Dear Gentle Persons:

I have been practicing orthopaedic surgery since 1980 in the Sonoma County. I have watched the gradual loss of physicians in our area directly as a consequence of diminished Medicare reimbursements in our locality. There is a great disparity in our county, which is far more industrial than other counties that receive higher reimbursements. I strongly support your proposal to create a new payment for our locality in Sonoma County.

Medicare reimbursements often do not cover my expenses. It is hard for me to obtain Medicare coverage in some circumstances. Because of this disparity, we have a physician shortage and we cannot recruit new physicians due to the decreased reimbursements. As you know, private insurers will pay Medicare rates and therefore as a consequence of the lowered Medicare reimbursements, we receive less reimbursement across the board.

Our county has shown a gradual erosion of medical services over the past two years and while this cause may be multifactorial, I am certain that the number one cause for same is due to decreased reimbursements for local Medicare providers.

Access to Medicare beneficiaries has been affected too.

Your proposal will correct, hopefully, the uneven payments in our area.

Thank you for your consideration.

Sincerely,

Thomas P. Miles, M.D.
1310 G Prentice Drive
Healdsburg, CA 95448

TPM/mka

cc: Two copies attached

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

Attn: CMS

GPCIs

222

SEP 6 2005

To whom it may concern:

I am a senior citizen (81) and want to support the increase in the Medicare reimbursement rate for Santa Cruz county physicians. I understand you have Santa Cruz County classified as a rural county. It has not been rural for many years and should be classified as urban. Please increase the level of reimbursement for physicians in Santa Cruz County - Thank You -

Sincerely

Frances J. Tollen
304 Prospect Hgts
Santa Cruz, CA 95065-
3 1331

SEP 6 2005

Sept.1,2005

To: Centers For M & M Services
Dept.Health & Human Services
Att:CMS-1052-P
PO Bx 8017
Baltimore,MD. 21244-8017

Gentlemen:
A few days ago I visited a cariologists'office at the recommendation of my Family Practice medical office and I was told that they will not accept new patients,Medicare allowance is too small. We read in our local newspaper that physicians are avoiding Sonoma County and moving out because they cannot prosper here.

Sincerely,
Harold M. Hill
Harold M.Hill
Social Security # 547 07 8370

GPC 1b
A note from... SEP 6 2005

224

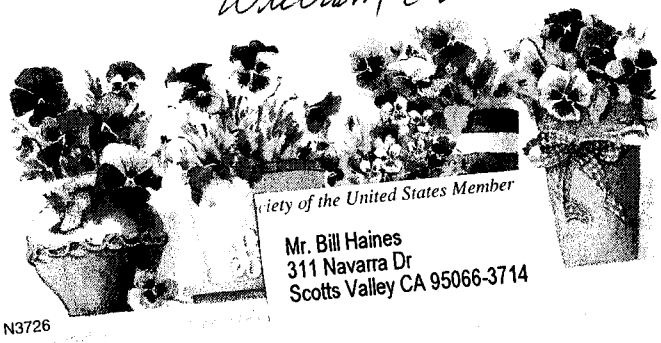
William Haines
326 24 1271

8/31/2005

Dear Sir:

I am writing this note to request that you change the Medicare payment system for Santa ~~Cruz~~ CRUZ, Cal. from rural to the next system (URBAN) this would mean better support for our doctors -

Sincerely
William E Haines



225

MARY E. HALLOCK
2404 Grace Drive
Santa Rosa CA 95404

SEP 6 2005

GPCIs
Centers for Medicare and Medicaid Services
Department of Health and Human Services
PO Box 8017
Baltimore MD 21244-8017

Attention: CMS—1052—P

Dear Sirs:

Sonoma County, California ranks sixth in the nation for the highest percentage of people 85 and older. Those 60 and older are expected to increase by 196% in the next fifteen years.

In spite of this, Sonoma County has the lowest Medicare reimbursement rate in the State of California.

This is so unfair that many physicians are leaving the area, new physicians are not coming here in sufficient numbers to serve the population, and most physicians are not accepting new Medicare patients.

PLEASE GIVE YOUR ATTENTION AND SUPPORT TO THE PROPOSED NEW RULE THAT WOULD INCREASE THE REIMBURSEMENT RATE FOR SONOMA COUNTY BY 8%. This increase will bring Sonoma County back into line with current Medicare standards, thus helping to stabilize our medical community.

Yours truly,

Mary E. Hallock

Mary E. Hallock

226

PAJARO VALLEY
COMMUNITY
HEALTH TRUST

August 30, 2005

SEP 6 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 CMS-1502-P

Issue Identifier: GPCI's / Payment Localities

Dear Sirs:

I am writing on behalf of the Pajaro Valley Community Health Trust (Trust) in Watsonville, California, to strongly support your proposed revision to physician payment localities in California. The Trust is a 501 (c) 3 public benefit health care foundation serving residents in the southern most part of Santa Cruz County.

Our health care foundation is governed by a diverse cross section of community leaders from the fields of finance, education, agriculture and health care. In our role as advocates for high quality, accessible health care services, we are very concerned about the viability of the health care system in our county.

As you are aware, 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 in our community very difficult. This long-standing payment imbalance between Santa Cruz and its neighboring counties threatens both the availability and the quality of health care services for residents of our community.

We are encouraged by your proposed rule that would remove Santa Cruz and Sonoma Counties from Payment Locality 99 and assign them to unique localities. You are to be commended for addressing this important issue for physicians and Medicare beneficiaries in our county. You have proposed relief for the two most problematic counties in California, and made an important change that will be significant in ensuring access to necessary health care services for our residents.

We believe your proposed rule is fair in addressing the current inequities in Medicare payments, and that it will move you closer to your goal of having physician payments reflect the actual costs of practice as determined by CMS.

Sincerely,

Kathleen A. King
Chief Executive Officer

85 Nielson Street, Watsonville, CA 95076 • PHONE: 831.761.5639 • FAX: 831.763.6084 • E-MAIL: info@pvhealthtrust.org • WEB: www.pvhealthtrust.org

227

August 31st, 2005

SEP

CPCIs
Centers for Medicare & Medicaid Services
Department of Health and Human Services
ATT: CMS-1052-P
PO Box 8017
Baltimore, MD 21244-8017

Dear Sirs:

My husband and I are both retired seniors. We are living on our moderate pensions and we both have physical problems. We keep hearing from friends that more and more doctors in our area are refusing to take medicare patients because their reimbursement from medicare is so low. Also, because of this our medical costs are rising.

We strongly support Medicare's current proposal that would increase the reimbursement rate for us in Sonoma County by 8 percent. We truly need this and ask that Medicare reimbursements in Sonoma County be corrected.

Very truly yours,

Mr. & Mrs. Keith Barnhart

Mr. And Mrs. Keith Barnhart
~~PO Box 668~~
Cloverdale, Ca
95425

E-mail: barny@sonic.net

228

SEP 6 2005

Medi-Cal Consultants

Phone
& FAX: 707/537-8882

5166 Parkhurst Dr.
Santa Rosa, CA 95409

August 31, 2005

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

RE: GPCIs

I work with seniors who are Medicare beneficiaries and receive medical care from physicians in Sonoma County, California. I understand that Medicare is proposing to create a new payment locality for Sonoma County, which is an increasingly expensive place to live and work. In the new locality, the Medicare reimbursement rate would be more closely matched to actual practice expenses than it is now.

The new locality would help Sonoma county physicians improve the quantity and quality of care they deliver to my clients, family members and other Medicare beneficiaries. The locality change would also benefit efforts to recruit and retain physicians in the county, which has a large Medicare population. Several physician groups and Health Plan of the Redwoods have gone bankrupt, and local Medicare patients are having a difficult time accessing care.

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

Sincerely,

cc: Two copies attached.

SCOTT & WHITE

229

SEP 6 2005

August 25, 2005

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

RE: CMS 1502-P "TEACHING ANESTHESIOLOGISTS"

Dear Sir or Madam:

I would like to comment on the Medicare Anesthesiology Teaching Rule, which is part of the Centers for Medicare and Medicaid Services' (CMS) proposed changes to the 2006 Medicare Fee Schedule. Unfortunately, the proposed Anesthesiology teaching rule does not include a correction of the inequitable policy of paying teaching anesthesiologist only 50 percent of the fee for each of two concurrent resident cases.

Scott & White and teaching hospitals across the United States have residency programs that help develop a stable and growing pool of physicians trained in anesthesiology. Because of the need for anesthesiologist, we are in the process of expanding our program. We currently have 25 residents in our program.

However, the proposed rules are a detriment to expanding our anesthesiology program. Surgeons may supervise residents in two overlapping operations and collect 100 percent of the fee for each case from Medicare. An internist may supervise residents in four overlapping outpatient visits and collect 100 percent of the fee for each when certain requirements are met. Unfortunately, teaching anesthesiologist will only collect 50 percent of the Medicare fee if he or she supervises residents in two overlapping cases.

This is not a fair or reasonable rule. Medicare must recognize the unique delivery of anesthesiology care and pay Medicare teaching anesthesiologist on par with their surgical colleagues. If positive changes are made to the proposed rule, this will help to ensure that the United States will have a steady supply of qualified anesthesiologist in our healthcare workforce.

Office of the President and Chief Executive Officer
2401 South 31st Street · Temple, Texas 76508 · 254-724-1912 · Fax 254-724-4483

Thank you for your attention to this issue.

Sincerely,

Alfred B. Knight, M.D.
President & CEO

231

SEP 6 2005

UAMS
COLLEGE OF MEDICINE
DEPARTMENT OF ANESTHESIOLOGY
UNIVERSITY OF ARKANSAS FOR MEDICAL SCIENCES

4301 W. Markham St., #515
Little Rock, AR 72205-7199

501-686-6114
501-686-8139 (fax)

www.uams.edu/com

August 29, 2005

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

Re: CMS-1502-P Medicare Teaching Anesthesiologists Payment Rule

To Whom It May Concern:

As an Anesthesiologist with the University of Arkansas for Medical Sciences, I am writing in reference to the CMS Medicare Fee Schedule for 2006 which contains the current policy of paying teaching anesthesiologists only 50% of the fee for each of two concurrent resident cases. I find that this "Medicare teaching anesthesiologist payment rule" is unfair to both physicians and patients and needs to be changed. Our elderly Medicare population is growing and these patients demand quality medical care and patient safety. Because of the policy in place, our department is having needed faculty positions unfulfilled, as well as, decreasing funding for academic research. The severe economic loss under these current rules cannot be absorbed elsewhere. The rule must be changed so that we have the ability to cover our costs.

Please forgive me if I state the obvious, but currently, a teaching anesthesiologist will only collect 50% of the Medicare fee if he/she supervises residents in two overlapping cases. A surgeon can supervise residents in two overlapping operations and collect 100% of the fee for the case from Medicare. An internist may supervise residents in four overlapping outpatient visits and collect 100% of the fee when certain requirements are met. Not only is this not fair, but it is unreasonable that these specialties are handled differently. Medicare must recognize the unique delivery of anesthesiology care and pay Medicare teaching anesthesiologists on par with their surgical colleagues.

To compound the fiscal hardship this rule brings to bare on academia, the Medicare anesthesia conversion factor is less than 40% of prevailing commercial rates. By reducing that conversion factor 50% for teaching anesthesiologists, this results in revenues grossly inadequate to sustaining the service, teaching, and research missions of academic anesthesia training programs.

I am requesting that the current Medicare rule be revised as soon as possible so that we can provide quality care to the patient while covering our costs. Anesthesiologists deserve a fair and workable policy equal to that of our colleagues in surgery – 100% of the Medicare fee for each of two overlapping procedures involving resident physicians.

Although I recognize that a redistribution of the "pie chart" will result in the decrease of other services' share, the time for acknowledging the equal contribution provided by the academic anesthesiologist and anesthesiologist in general, in the care of the Medicare patient, is long overdue.

Thank you for your consideration in this matter.

Sincerely,

Charles A. Napolitano, M.D., Ph.D.
Associate Professor
Director, Division of Cardiothoracic Anesthesia
Co-Director, Residency Program

232

WAKE FOREST
UNIVERSITY
SCHOOL of MEDICINE
THE BOWMAN GRAY CAMPUS

Raymond C. Roy, Ph.D., M.D.
Professor and Chair
Department of Anesthesiology
rroy@wfubmc.edu

September 1, 2005

Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attn: CMS-1502-P
Mail Stop C4-26-05
7500 Security Blvd.
Baltimore, MD 21244-8017

RE: Teaching Anesthesiologists

To-Whom-It-May-Concern:

I am Chair of the Department of Anesthesiology at the Wake Forest University School of Medicine and Medical Director of the School of Nurse Anesthesia at North Carolina Baptist Hospital in Winston-Salem, North Carolina. We graduate 15-16 anesthesiologists and 19-20 nurse anesthetists each year. I employ 55 anesthesiologists and intensivists. The average salary of my physicians is half of what the private practice anesthesiologists make in the surrounding area.

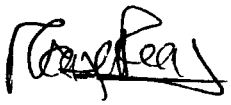
Academic medical centers contribute to the delivery of health care in the United States by providing medical care to a high percentage of those patients who are economically disadvantaged patients or on a fixed income. These patients also tend to be more difficult to take care of because they tend to have more co-morbidities than patients with private insurance.

The current fee schedule disadvantages my recruiting and retaining anesthesiologists in several ways. First, the fee schedule for one-on-one provision of anesthesia is thirty to forty percent of what Blue Cross Blue Shield and other third party payors provide. Thus, we have a bizarre system in which we are reimbursed far less for taking care of sicker patients than for taking care of healthier ones. Second, the current fee schedule reimburses teaching anesthesiologists 50% of the Medicare Fee Schedule for each two concurrent resident cases. This means that we are now reimbursed only fifteen to twenty percent what BCBS and other third party payors provide. What makes this particularly unfair is that surgeons with whom we work are not penalized for supervising residents in two overlapping rooms.

There is already a shortage of anesthesia providers in this country. Perpetuating the current reimbursement system will make it less likely that the shortage will corrected at a time when our population is growing older and needing more surgery.

Thank you for your consideration of my thoughts on this matter and thank you for being willing to address the situation on a national level.

Sincerely,



Raymond C. Roy, Ph.D., M.D.
Professor and Chair
Department of Anesthesiology
Wake Forest University School of Medicine
Winston-Salem, North Carolina

mayo

SEP 6 2005 233

Mayo Clinic
200 First Street SW
Rochester, Minnesota 55905
507-284-2511

Gary M. S. Vasdev, M.B., B.S.
Department of Anesthesiology

August 30, 2005

CMMS, Department of HHS
PO Box 8017
Baltimore, MD 21244-8017

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

Dear Madame/Sir:

As a member of the country's largest anesthesiology training program, we contribute significantly to the future of Anesthesia in the United States. Our program has produced 72% of all practicing anesthesiologists in the state of Minnesota during the past decade. During that same time period, our program has produced another 72 anesthesiologists who work in other states of this country.

We are alarmed by the reluctance of CMS to correct the discriminatory policy of paying teaching anesthesiologists only 50% of the fee for each of two concurrent resident cases. This course is not congruent to the growth and quality of anesthesiology academic teaching programs. This will, over time, reduce the number of anesthesiologists who are trained, an exceedingly bad idea at a time when patients are older, sicker, and more in need of surgical and diagnostic interventions under anesthesia.

Why do we believe your current policy is unfair? Teaching surgeons may supervise trainees in two overlapping operations and collect 100% of the fee for each case from Medicare. An internist may supervise trainees in four overlapping outpatient visits and collect 100% of the fee for each when certain requirements are met. A teaching anesthesiologist can collect only 50% of the Medicare fee if he or she supervises trainees in two overlapping cases. We don't understand the distinction between surgeons, internists, and anesthesiologists as they provide needed services to all our older patients.

At this time the Medicare anesthesia conversion factor is less than 40% of prevailing commercial rates. A reduction of this factor by 50% for teaching anesthesiologists will result in decreased revenue to sustain the academic mission in our teaching program.

I urge you to correct this unjust policy and allow teaching anesthesiologists equity with our colleagues in surgery and medicine. There is no logical reason for this payment difference between teaching physicians. Continuation of the policy will further hinder our ability to produce anesthesiologists at a crucial time in the demographic changes that are occurring in our country.

Sincerely,

Gurinder M. Vasdev, M.D.

GMV:jh

WESTERN MEDICAL ASSOCIATES, Inc.

Medical Group

234

SEP 6 2005

Internal Medicine
1595 Soquel Drive
Santa Cruz, CA 95065

Suite 400
Phone (831) 475-1111
FAX (831) 476-5020

Elizabeth Brennan, MD
Satish Chandra, MD, F.A.C.P.
Vernon Loverde, MD
Suzy Nassralla, MD
Lawrence Rosenbaum, MD
Michael Sepulveda, MD

Suite 411
Phone (831) 465-7778
FAX (831) 475-0351

Laura Garvin, MD
Robert Keet, MD, F.A.C.P.
Blanca Ochoa, MD
Sharon Tapper, MD

Endocrinology
Jeffrey Williams, MD PhD

Family Practice
528 Capitola Avenue
Capitola, CA 95010
Phone (831) 475-1630
FAX (831) 475-1629

Robert Chen, MD
Nancy Greenstreet, MD
Kevin Hasenauer, MD
Maria Mead, MD
Jill McBride, MD

Internal Medicine & Pediatrics

Allison Herman, MD

13350 Big Basin Way
Boulder Creek, CA 95006
Phone (831) 338-6491
FAX (831) 338-2767

Maria Greaves, MD
Andrew Mihalik, MD
James Riley, MD
Rebecca Small, MD
Amy Solomon, MD

Pediatrics
1820 41st Avenue, Suite D
Santa Cruz, CA 95010
Phone (831) 476-3000
FAX (831) 476-9009

Beth Abidi, MD
Marion Santora, MD
Kent Thompson, MD
Krista Willman, MD
Robert Moler, MD

Surgery
603 Capitola Avenue
Capitola, CA 95010
Phone: (831) 4765403

Brian Waddle, MD

Administration
1595 Soquel Drive, Suite 330
Santa Cruz, CA 95065

Donald Pretre, Executive Director
Phone (831) 465-7761
FAX (831) 475-1156

August 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:

I am writing on behalf of the physicians and patient of Western Medical Associates, Inc., in Santa Cruz California, to strongly support your proposed revision to physician payment localities in California recently published in the reference rule.

Western Medical Associates, Inc. is the largest primary care medical group in Santa Cruz County. Our 30 physicians serve over 50,000 patients. We have 12 Internists with two Board Certified Geriatricians serving the senior community. [We have the only Geriatricians in Santa Cruz County]

Our ability to continue to serve the senior community have been threatened by 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.

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 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.

For our group it will make the difference that will allow us to continue to serve our senior community.

Sincerely,

Robert Keet, MD FACP – President, WMA Inc.

235

August 30, 2005

SEP 6 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

We are aware that Medicare is proposing to create a reimbursement rate change for Sonoma County, a reimbursement rate that would be more closely matched to actual practice expenses. This would be a very important change, considering that Santa Rosa (among cities of population 100,000 or more) is sixth in the United States for the highest population of people 85 and over. Yet, in July of 2005 six of every 10 Sonoma County primary care physicians were NOT accepting new Medicare patients.

Creating the new payment locality for Sonoma County, which is an increasingly expensive place to live and work, would help our efforts to recruit and retain physicians.

We fully support your proposal to change Sonoma County's payment locality, and we appreciate the opportunity to comment on this important issue. We are nearing Medicare age hope to see changes that are fair to our hard working physicians.

Sincerely,

Mike Steinberg

Jolee Steinberg

236

SEP 6 2005

August 30, 2005

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

Re: GPCIs

I am aware that Medicare is proposing to create a reimbursement rate change for Sonoma County, a reimbursement rate that would be more closely matched to actual practice expenses. This would be a very important change, considering that Santa Rosa (among cities of population 100,000 or more) is sixth in the United States for the highest population of people 85 and over. Yet, in July of 2005 six of every 10 Sonoma County primary care physicians were NOT accepting new Medicare patients.

Creating the new payment locality for Sonoma County, which is an increasingly expensive place to live and work, would help our efforts to recruit and retain physicians.

I fully support your proposal to change Sonoma County's payment locality.

Sincerely,

Joseph Steinberg

237

SEP 6 2005

August 24, 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

TO WHOM IT MAY CONCERN:

This letter is to show my support for an increase in Medicare reimbursement rate for Santa Cruz County physicians.
Seniors require good doctors and good medical care.
Santa Cruz County is a very expensive area to live.
An increase in the reimbursement level would attract more good young physicians, and enable us to keep the good doctors we already have in our county.

Thank you for your attention in this matter.

Sincerely,

Pauline Womack

Mary M. Lenz
8452 Petaluma Hill Rd.
Penngrove, CA 94951

30 August 2005

CPCI s
Center for Medicare and Medicade Service
Dept of Health and Human Services
Attn: CMS-1052-P
P.O. Box 8017
Baltimore, MD 21244-8017

SEP 6 2005

Gentlemen,

This is to state my support of Medicare's proposal to increase the reimbursement rate for Sonoma County.

I am 77 and Medicare is my only health insurance. I'm comfortable with this, but I know the Doctors in Sonoma County are not getting what they should. Sonoma County is no longer just a rural area by and large. It has grown as more people retire up here.

I would encourage you to increase the doctors compensation for Medicare patients. It is the right thing to do.

I do not have a computer or typewriter, so please excuse the handwritten letter.

Sincerely,

Mary M. Lenz.

239

126 Bradley Drive
Santa Cruz, CA 95060
SEP 6 2005
September 1, 2005

REF: GPCIs

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

Dear Sirs/Madames:

I write to strongly support the proposed change in the designation of Santa Cruz County, California from a rural designation to an **urban designation**.

Santa Cruz County is now a part of the greater Silicon Valley region, with a decidedly urban character, much like nearby San Jose. However, our physicians receive much less remuneration for treating Medicare patients like myself, compared to San Jose and Santa Clara County, only a few miles away. Consequently, our county is starting to lose some highly qualified physicians, while other physicians are becoming reluctant to accept Seniors on Medicare like myself as new patients.

Please support our community in this request.

Sincerely,

Robert E. Garrison

Robert E. Garrison

SEP 6 2005 Reg. 11/05 240

To Whom It May Concern,

I have lived in Santa Cruz County for 65 years and I do believe the Doctors here should get the same pay as those in San Mateo & other counties. The cost of living is very high here & they need the money.

Sincerely

Sally Gleason

Hard Copy

1502-P

~~CMS-3017-IFC-6~~

241

SEP 7 2005

Submitter : **Dr. liang fan** **Date: 08/31/2005**

Organization : **SUNY at Buffalo**

Category : **Physician**

Issue Areas/Comments

GENERAL

~~GENERAL~~

Re: CMS-1502-P Teaching Anesthesiologists

Dear Sir/Madam:

I was profoundly disappointed that CMS officials did not appreciate the deleterious impact that CMS-1502-P has caused academic medical centers with respect to this disparity in payment among physicians in surgical specialties. The current Medicare teaching anesthesiologist payment rule has been shown to be unwise, unfair and unsustainable.

Quality medical care, patient safety and an increasingly elderly Medicare population demand that the United States have a stable and growing pool of physicians trained in anesthesiology. Right now, slots in anesthesiology residency programs are going unfilled because of ill-conceived Medicare policy that shortchanges teaching programs, withholding 50% of their funds for concurrent cases. At the University at Buffalo, we train 36 residents who fall victim to the inefficiencies in scheduling, personnel allocation, case assignments, and budget shortfalls that are directly attributed to the current Medicare teaching anesthesiologist policy. Anesthesiology teaching programs, caught in the snare of this trap, are suffering severe economic losses that cannot be absorbed elsewhere.

The CMS anesthesiology teaching rule must be changed to allow academic departments to cover their costs and meet their mission goals. Academic research in anesthesiology is also drying up as department budgets are broken by this arbitrary Medicare payment reduction.

A surgeon may supervise residents in two overlapping operations and collect 100% of the fee for each when certain requirements are met. A teaching anesthesiologist will only collect 50% of the Medicare fee if he or she supervises residents in two overlapping cases. This is not fair, and it is not reasonable. Medicare must recognize the unique delivery of anesthesiology care and pay Medicare teaching anesthesiologists on par with their surgical colleagues. Moreover, the Medicare anesthesia conversion factor is less that 40% of prevailing commercial rates. Reducing that lower payment by an additional 50% for teaching anesthesiologists results in revenue grossly inadequate to sustain the service, teaching and research missions of academic anesthesia training programs.

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

Sincerely,
liang fan, MD

242

Re: CMS-1502-P Teaching Anesthesiologists

SEP 7 2005

Dear Sir/Madam:

I was profoundly disappointed that CMS officials did not appreciate the deleterious impact that CMS-1502-P has caused academic medical centers with respect to this disparity in payment among physicians in surgical specialties. The current Medicare teaching anesthesiologist payment rule has been shown to be unwise, unfair and unsustainable.

Quality medical care, patient safety and an increasingly elderly Medicare population demand that the United States have a stable and growing pool of physicians trained in anesthesiology. Right now, slots in anesthesiology residency programs are going unfilled because of ill-conceived Medicare policy that shortchanges teaching programs, withholding 50% of their funds for concurrent cases. At the University at Buffalo, we train 36 residents who fall victim to the inefficiencies in scheduling, personnel allocation, case assignments, and budget shortfalls that are directly attributed to the current Medicare teaching anesthesiologist policy. Anesthesiology teaching programs, caught in the snare of this trap, are suffering severe economic losses that cannot be absorbed elsewhere.

The CMS anesthesiology-teaching rule must be changed to allow academic departments to cover their costs and meet their mission goals. Academic research in anesthesiology is also drying up as department budgets are broken by this arbitrary Medicare payment reduction.

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

Sincerely,

Robert Carl Tick MD

Robert Tick, MD
University of Buffalo

ROBERT SHELDON
ELEANOR SHELDON
9148-BENNY GOODMAN WAY
WINDSOR, CA 95492

243

SEPTEMBER 1, 2005

SEP 7 2005

GPCIs
CENTERS FOR MEDICARE & MEDICAID SERVICES
DEPT. OF HEALTH & HUMAN SERVICES
ATTN.: CMS-1052-P
P.O. BOX 8017
BALTIMORE, MD 21244-8017

GENTLEMEN, AND LADIES,

Over five years ago that Sonoma County was suffering under the strain of inadequate medical compensation for Medicare and Medicaid patients. To date to my knowledge the situation has grown worse.

We wrote letters to our Congress Person and state Senators and HCFA. asking that they look into this inadequacy.

We warned that Doctors were leaving the area and hospitals were reducing services and care. Two years later two of the Medical groups we had enrolled in went bankrupt and another firm with drew its services in Sonoma County

continued:

We were forced to enroll in Kaiser Permanente Medical H.M.O. which is a not for profit organization.

As home owners we are being taxed $150 a year for Northern Sonoma Co Hospital in Healdsburg for them to be able to continue. They provide no service or care for us.

Furthermore, deductions from our Social Security checks for Medicare have gone up 72% during those previous five years. We understand that MEDICARE has proposed a new rule that would increase Sonoma county's reimbursement by eight percent. Big deal! We pay out 72% more and to date the 8% has not yet been seen by our medical services community.

This reminds me of the error in calculation that was made in our Social Security payments twenty years ago that affected those born between 1917 and 1926

continued

continued:

and has since been referred to as the "NOTCH" years, which still hasn't been corrected. Those born in those years were the madority that fought in World War II. Legislator Harry Reid, Nevada is still trying to get this injustice corrected. Delay long enough and we will all be gone.

So getting back to Sonoma County's financial problem of inadequate medical compensation we would indeed appreciate that you increase our County's medical compensation as quickly as possible. Don't wait another 10 or 20 years. Do it now! Please!

Thank you for your cooperation

Robert H Sheldon

Eleanor F Sheldon

Mr. & Mrs. Robert Sheldon
9148 Benny Goodman Way
Windsor, CA 95492-7567

PLUS - 2 - COPIES.

244

Santa Rosa Memorial Hospital
ST. JOSEPH HEALTH SYSTEM

1165 Montgomery Drive
Santa Rosa, CA 95405-4801

P.O. Box 522
Santa Rosa, CA 95402-0522

707.546.3210 Tel

August 30, 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

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

The new locality would help Sonoma County physicians improve the quantity and quality of care they deliver to Medicare beneficiaries and other patients. The locality change would also benefit efforts to recruit and retain physicians in the county, which has a large Medicare population. In discussions with local physicians over the past five years this has been a major problem that needs to be resolved.

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

Sincerely,

Don Miller

Don Miller, CFO, Santa Rosa Memorial Hospital
1165 Montgomery Drive
Santa Rosa, CA. 95405

cc: Two copies attached

245

Please increase the Medicare reimbursement rate in Sonoma County.

While the total land area of the county is mostly rural the vast majority of the population resides in the urban area more dense than Marin & Napa county. Our medical prices are at least as high as San Francisco County a completely urban county.

I have been turned down by 4 family doctors because I am a medicare patient. That is unacceptable!

K. Hetchler
M. Hetchler

KEN & MARGE HETCHLER
461 Pythian Road
Santa Rosa, CA 95409

August 31, 2005

GPCIs
Centers for Medicare & Medicaid Services
Dept. of Heath and Human Services
Attention: CMS-1052-P
PO Box 8017
Baltimore, MD 21244-8017

To Whom It May Concern:

We are in favor of the new rule that Medicare has proposed to increase the reimbursement rate for Sonoma County by 8%. Our county has the lowest Medicare reimbursement rate in California.

We don't want our doctors to leave the county or to quit accepting new Medicare patients due to inadequate medical compensation.

Please approve the new rule increasing the reimbursement rate for Sonoma County by 8%.

Sincerely,

Ted & Dolores Miller

Ted & Dolores Miller
721 Natalie Drive
Windsor, CA 95492

247

Gloria Fanning
619 Cayuga Street
Santa Cruz, CA 95062

7 2005

August 31, 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

Dear Sir or Madam:

I support a change in rules that would increase payments to doctors and other medical practitioners in Santa Cruz County.

The cost of living in our county is equal to if not higher than our neighboring counties where reimbursement is higher. Please assign Santa Cruz County to its own locality and remove its classification as a rural county.

Sincerely,

Gloria Fanning

Gloria J. Fanning

248

William H. Ramsey, M.D., Inc.
Orthopedic Surgery
95 Montgomery Dr., Suite 104 Santa Rosa, CA 95404
Phone (707) 527-9760
Fax (707) 527-1052

September 1, 2005

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

To Whom It May Concern:

I am a practicing physician and soon-to-be Medicare beneficiary in Sonoma County, California. I understand that Medicare is proposing to create a new payment locality for Sonoma County, which is an increasingly expensive place to live and work. The current disparity between practice expenses and Medicare reimbursements has adversely affected our local health care system for several years. Many local physicians, including myself, have stopped taking Medicare patients or have simply left the area.

The new locality would help Sonoma County physicians improve the quantity and quality of care they deliver to Medicare beneficiaries. The locality change would also benefit efforts to recruit and retain physicians in the county, which has a large Medicare population. By creating a new payment locality for Sonoma County, you will help ensure the viability of physician practices in the county and improve access to care for local Medicare beneficiaries. Your proposal will correct existing payment inequities and will help you achieve your goal of reimbursing physicians based on the cost of practice in their locality.

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

Sincerely,

William H. Ramsey, M.D.

cc: Two copies attached

August 31, 2005

Marcia Kellam
721 Charles Street
Santa Rosa, CA 95404

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

Re: GPCIs

Dear Center:

I am not myself a Medicare recipient, but I am increasingly interested in what is happening in the medical community as costs soar, especially for those like myself who cannot afford insurance. Therefore, I feel impelled to write on behalf of my fellow citizens about the new proposal Medicare is making. I understand Medicare wants to create a new payment locality for Sonoma County, which is an increasingly expensive place to live and work. In the new locality, the Medicare reimbursement rate would be more closely matched to actual practice expenses than it is now.

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

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

Sincerely,

M Kellam

Marcia Kellam

cc: Two copies attached

250

FRANCES E DUCHEMIN
218 WALNUT CIR
ROHNERT PARK CA 94928-2618

To whom it may Concern:

I live in Sonoma County & realize we need help

We must keep our doctors as they refuse to accept the Amount Medicare will pay.

Please increase 8% amount as we live in our old age; need you desperately.

Thank you.

Frances
E.
DuChemin

251

Nephrology Associates

Diseases of the Kidneys, Dialysis,
Hypertension, Renal Transplantation

Gopa B. Green, M.D.
Desmond J. Shapiro, M.D.
Benjamin A. Fritz, M.D.
James S. Robertson, M.D.

August 25, 2005

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

RE: GPCIs

Ladies and Gentlemen:

I am a nephrologist who practices in Sonoma County, California. I have lived elsewhere in the San Francisco Bay Area as well, and therefore have some perspective on the cost of living and practicing here in Santa Rosa, as opposed to elsewhere in this region, and I wish to share my own perspective that the disparity between practice expenses and living expenses between here and the South Bay, for example, does not match the disparity between Medicare reimbursement here and there.

This disparity has adversely affected our local health care system for several years. Many of my most dedicated and competent colleagues have abandoned medical practice completely, moved to other areas, or retired early while they still had productive years left. Recruiting new people to add vigor and talent to our community has been difficult.

The creation of a new payment locality for Sonoma County will help ensure the viability of physician practices here and no doubt improve access to care for local Medicare beneficiaries. Your proposal will correct existing payment inequities and will help you achieve your goal of reimbursing physicians based on the cost of practice in their locality.

Thank you for the opportunity to comment on this important issue.

Sincerely,

James S. Robertson, M.D.

JSR:jt

Park Center No. 3 • 1265 North Dutton Ave. • Santa Rosa, CA 95401 • (707) 526-2027 • Fax (707) 526-2096

252

County of Santa Cruz

BOARD OF SUPERVISORS

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FIRST DISTRICT	SECOND DISTRICT	THIRD DISTRICT	FOURTH DISTRICT	FIFTH DISTRICT

August 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 CMS-1502-P

ISSUE IDENTIFIER: GPCI's/Payment Localities

Dear Sirs:

I am writing on behalf of the Santa Cruz County Board of Supervisors to strongly support the proposed revision to physician payment localities published in the referenced rule. Our Board has written to you previously regarding our concerns that under-reimbursement of physicians in our county places our residents in jeopardy of experiencing a deterioration of our health care system. We believe that your proposed revision of payment localities would address those concerns and we laud your efforts at rectifying the current, damaging situation. The rule as proposed would make an important change that would substantially help to ensure access to health care services in our county.

Santa Cruz County believes that this is a fundamental issue of fairness. Neighboring counties to Santa Cruz and Sonoma have some of the highest payment localities in the nation. The adjustment you propose is appropriate and fair in achieving your goal of reimbursing physicians based on the cost of practice in their locality.

Sincerely,

TONY CAMPOS, Chairman
Board of Supervisors

TC:ted

cc: Clerk of the Board Health Services Agency Director

3289A6

253

ReedSmith

Gail L. Daubert
Direct Phone: 202.414.9241
Email: gdaubert@reedsmith.com

1301 K Street, N.W.
Suite 1100 – East Tower
Washington, D.C. 20005-3373
202.414.9200
Fax 202.414.9299

August 31, 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: CMS-1502-P
Comments on Proposed Physician Fee Schedule for CY 2006
CPT Values for Stereotactic Radiosurgery

Dear Dr. McClellan:

CMS will be valuing new CPT codes for stereotactic radiosurgery, effective January 1, 2006. I am pleased to forward comments from Roger Macklis, M.D., on valuing cobalt-based and linear accelerator-based stereotactic radiosurgery for CMS's consideration. Please see attached.

Thank you

Sincerely,

Gail L. Daubert

GLD:clr

Attachment

THE CLEVELAND CLINIC FOUNDATION

Roger M. Macklis, M.D.
Professor and Chairman
Department of Radiation Oncology / T28
Office: 216/444-5570
Appointments: 216/444-5571
Fax: 216/445-7595
E-mail: macklr@ccf.org

August 29, 2005

Trish Crishock, Director, Health Policy and Economics,
Jenna Kappel, Assistant Director of Health Care Policy & Economics
The American Society for Therapeutic Radiology and Oncology
12500 Fair Lakes Circle
Suite 375
Fairfax, VA 22033-3882

RE: Price / Cost Inputs for New CPT codes for SRS Treatment Delivery
Price of Cobalt-based and LINAC-based SRS systems are Nearly Identical

Dear Ms. Crishock and Ms. Kappel:

I recently learned that the American Society for Therapeutic Radiology and Oncology (ASTRO) is currently developing recommendations for two new CPT codes for stereotactic radiosurgery (SRS) treatment delivery (complete course of treatment of cerebral lesion(s) consisting of one session)—one for multi-source Cobalt-based and one for linear accelerator/LINAC-based. I also understand that these codes will be for the technical component (equipment costs) only and that ASTRO has requested pricing information for the equipment.

We are fortunate to have both Cobalt-based and LINAC-based delivery systems at our institution and so I am familiar with the pricing/costs for both systems. I think it is important to point out that the prices for the Cobalt and LINAC systems are nearly identical. Further, the price differences between the two systems are so minimal most clinical experts, myself included, feel strongly that there should not be any distinction, especially for the purposes of recommending a payment rate for the technical component.

Medical technology for stereotactic radiosurgery is advancing at a rapid pace and providing substantial clinical benefits to a wide variety of patients for ever growing indications. For this reason, we appreciate ASTRO's taking the lead in obtaining appropriate codes for the technology so that providers are reimbursed and there are no financial barriers to patient access. The CPT/RUC process, however, should not be

protracted by debate and decisiveness over minimal differences in pricing for Cobalt and Linac based systems. It is far more important to view these technologies from a global perspective and work to ensure that overall hospitals receive appropriate reimbursement for all services related to stereotactic radiosurgery.

In closing, I appreciate ASTRO's involvement in the CPT process and please feel free to contact me at (216) 444-5576 if you have any questions or if I can provide any additional information.

Sincerely,

Roger M. Macklis, M.D.

RM/pm

CCDF CLARK COUNTY DIALYSIS FACILITY

247 South Burnett Road, Suite 110, Springfield, Ohio 45505
Phone: 937/328-8921, Fax: 937/328-8784

251

August 29, 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: ESRD Composite Rate Wage Index

To Whom It May Concern:

My name is Jeffrey Spiers. I am a registered nurse and I currently serve as the administrative director of 3 independent, freestanding dialysis facilities in Ohio. I am writing to voice my concern with the ESRD specific provisions of the proposed Physician Fee Schedule for Calendar Year 2006 (CMS-1502-P). In particular I am concerned with the proposed cuts to the composite rate (as a result of the adjusted wage index) as well as the proposed cuts in EPO reimbursement. However, before I tell you about these concerns, I would like to tell you about our programs.

As I mentioned earlier, we operate 3 independent, freestanding dialysis facilities. One of our facilities, Clark County Dialysis Facility (CCDF), is a non-profit facility that has been in operation since 1983. This facility is located on the Southeast side of Springfield and serves a patient population that is largely low income. CCDF currently serves 64 chronic dialysis patients. For the year ending December 31, 2004 CCDF had an average cost per treatment of $149.12. This cost is taken from our 2004 Medicare cost reports. I could argue that this cost is understated because of CMS' cost reporting rules, but that is a subject for another time. The point is, and you have access to the data to confirm this, CCDF's average cost per treatment is below the national average. Despite this fact, CCDF lost more than $17 per Medicare treatment last year because our composite payment rate was only $132.03. And despite the fact that Congress mandated a 1.6% increase in our composite rate this year, our net per-treatment revenue is only up 0.4% due to other cuts that offset the increase to the composite rate. While we are grateful to get any increase at all, a 0.4% increase is not going to cover the increase in costs that we are experiencing this year.

Community Physicians Dialysis Center of Springfield (CPDC-S) is located on the North side of town and serves patients from both Springfield and Champaign County (about 15 miles to the North). This facility serves approximately 105 chronic patients. CPDC-S's average cost per treatment in 2004 was $144.10; again, well above the Medicare payment rate of $132.03.

Finally, we have Community Physicians Dialysis Center of Fairborn (CPDC-F). This facility is located approximately 15 miles West of Springfield and serves 22 patients. CPDC-F's average cost per treatment in 2004 was $202.32. Much of the high cost at CPDC-F is admittedly due to the relatively low volume of patients, but we chose to build a facility in this area because we saw an underserved population. And because of the demographics in this area (high percentage of elderly patients), we saw the potential for an explosion in the number of ESRD patients in this area in future years. Not having the capacity to absorb such growth at our other facilities, we opened this facility in 2002 knowing that we could expect to lose money for several years. However, the cuts in reimbursement that CMS is proposing all but assure that this facility will have to close.

That brings me to the point of my letter which is to explain to you that I believe the reimbursement cuts that you have proposed will be devastating to our patients and facilities. I have clearly shown to you that Medicare payments for dialysis are inadequate and I have further demonstrated to you that this is not the result of inefficient operations. If you take our costs per treatment and compare them to any other program, you will find that we operate efficiently despite our relatively small size. We already lose money on every Medicare treatment because Medicare payments for dialysis are inadequate. Medicare payments are inadequate because Medicare providers are the only providers reimbursed under the prospective payment system who do not receive regular updates.

Under your proposals, you suggest implementing an adjustment to the wage index portion of the composite rate. If these proposals were implemented, our two Springfield, Ohio dialysis facilities would receive an 11% cut to the composite payment rate over the next 2 years. Our current payment is just over $134. By 2007, your proposals would lower our payment to just over $119. This would guarantee a loss of $25-30 per treatment (at our current costs). Multiply that by the nearly 19,000 Medicare dialysis treatments that our Springfield facilities performed last year and we can easily expect to lose more than $500,000/year on Medicare dialysis treatments by 2007. We would also receive more than a 5% cut in our payment for EPO. This would result in a financial loss for every single dose of this medication because the reimbursement you propose is well below our cost for acquiring this drug. Of course, we simply cannot absorb these kinds of losses and hope to maintain the same quality of care that we provide now.

Under your proposals, our Fairborn facility (and every other Dayton area facility) would receive a cut in the composite rate of nearly 8% over the next 2 years. First, I have to tell you that it makes absolutely no sense that our Springfield facilities would receive a lower payment rate (based on the wage index) than Dayton area facilities. In the past, the Dayton/Springfield area has always had the same payment rate and there is no logical way to justify changing this now. We have to compete with facilities in Dayton for the limited pool of dialysis nurses and dialysis technicians available. These staff members are highly trained, highly mobile, and highly sought-after. If we don't pay the same amount of money that a Dayton facility does, we will not be able to retain these staff. So how can you justify paying us less than a Dayton facility? But I digress. The point is still

this: No dialysis facility in this area can afford to take a payment cut, let alone an 8%-11% payment cut and still hope to provide high quality patient care.

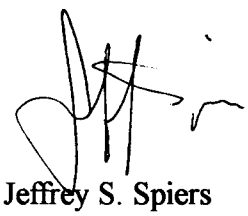
Your proposal indicates that Congress did not mandate an update to the wage index but that you felt compelled to adjust it now. You further indicate that you do not have the authority to increase program costs. Therefore, I would respectfully submit to you that all you are doing is "robbing Peter to pay Paul". That is to say, you are going to provide a higher composite rate to those facilities located in higher wage areas by cutting the payment rates of providers in lower wage areas. I could never argue against the fact that a dialysis provider in New York City or Los Angeles should be paid at a higher rate than a provider in Springfield, Ohio. But if being able to afford such an increase for the larger metropolitan area providers means cutting the already inadequate rates of other providers, what have you accomplished except to put the other providers and patients at risk? Quite simply the problem is not the wage index. The problem is that payment rates are too low and changing the wage index without increasing the total dollars for provider payments is, at best, an exercise in futility! But I believe it is much more serious than that. I believe what you propose will result in devastating financial losses for most providers and a sharp decline in the quality of care for the patients treated at these facilities.

As someone who has worked in this industry for more than 13 years, I am very disturbed about the lack of foresight that CMS and Congress continue to display towards the payment rates to dialysis providers. I believe the Medicare ESRD system is built on a very shaky foundation and that foundation continues to erode each year because the powers that be refuse to acknowledge the fact that provider payments are inadequate. Even before these cuts in the composite rate were proposed I believed that, without increased funding, we would soon start to see a decline in the quality of care that U.S. dialysis patients receive. That is to say, the progress that we have all worked so hard to achieve during recent years would soon reverse as providers are forced to cut clinical staff, put off the purchase of new technology, and ration resources in order to maintain positive margins. The proposals that you have set forth will ensure that this worst-case scenario occurs and occurs much faster than any of us had anticipated.

I think that a little perspective will help you to understand where I am coming from. The average dialysis patient in our facilities undergoes treatment for approximately 3 ½ hours three days per week. During each treatment, we are *legally required* as part of the Medicare Conditions of Coverage to provide the following professional staff members: Physician Director; Administrator; at least 1 registered nurse; registered dietician; masters prepared social worker; medical records supervisor; and transplant coordinator. Besides the staff that are legally required, we must have enough technicians and support personnel to provide the dialysis treatments, maintain the equipment and facilities, bill for the services provided and navigate the endless hurdles that payers erect, file all of the paperwork that Medicare and the Networks requires, and so on. Our payment must also cover the costs of our rent, utilities, all of the medical supplies needed for each treatment, malpractice insurance, capital equipment, etc. And for all of this, the proposed payment will be $119? How can we be expected to provide a 3-½ hour complex medical procedure with all of the staff required for $119? It simply cannot be done!

I implore you to exercise the discretion that Congress has given you and postpone the implementation of the proposed wage adjusted composite payment rates. I believe that any major changes to the composite rate should be postponed until Congress provides enough funding to ensure that providers are at least kept whole during the implementation of said changes. But at the very least, you should postpone the implementation of your proposals until you have had the chance to study the impact they will have on patients and providers, particularly providers in Ohio. Thank you for considering my comments.

Most Respectfully,



Jeffrey S. Spiers
Administrator

Clark County Dialysis Facility (Provider Number 362510)
Community Physicians Dialysis Center Springfield (Provider Number 362592)
Community Physicians Dialysis Center Fairborn (Provider Number 362645)

Cc: Representative Dave Hobson
Senator Mike Dewine
Senator George Voinovich

255
SEP 7 2

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Timothy W. Martin, MD, MBA, FAAP
Professor / Chief

Michael L. Schmitz, MD
Professor / Vice Chief

J. Michael Vollers, MD
Professor / Vice Chief

Patti J. Kymer, MD
Associate Professor / Vice Chief

E. F. Klein, Jr., MD, FCCM
Professor

J. Grady Crosland, MD
Associate Professor

Persis K. Shroff, MD
Associate Professor

Hatem A. Al-Takrouri, MD
Assistant Professor

Jesus Apuya, MD
Assistant Professor

Shirley N. D'Souza, MD
Assistant Professor

Agata El-Bayoumi, MD
Assistant Professor

Leonardo Gendzel, MD
Assistant Professor

Abid Ul Ghafoor, MD
Assistant Professor

Judith Harea, MD
Assistant Professor

Denisa M. Haret, MD
Assistant Professor

Shahid Hussain, MD, FAAP
Assistant Professor

Shireen Mohiuddin, MD
Assistant Professor

Julio R. Olaya, MD
Assistant Professor

Tariq Parray, MD
Assistant Professor

Mohammad Qasim, MD
Assistant Professor

Anna Maria Onisei, MD
Assistant Professor

Shailesh R. Shah, MD
Assistant Professor

M. Saif Siddiqui, MD
Assistant Professor

Suresh T. Thomas, MD
Assistant Professor

Sana Ullah, MD
Assistant Professor

W. Bryan Watkins, MD
Assistant Professor

Luis M. Zabala, MD
Assistant Professor

August 29, 2005

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

RE: TEACHING ANESTHESIOLOGISTS (CMS-1502-P)

To whom it may concern:

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

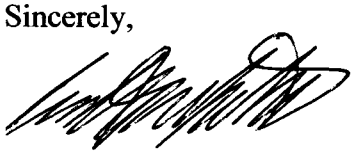
At the hospital and university where I practice (Arkansas Children's Hospital and the University of Arkansas for Medical Sciences), we care for some of the sickest and poorest patients in the state and this region of the U.S. The existing teaching anesthesiologist rules have aggravated an already difficult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

The irony of the teaching anesthesiologist reimbursement rules is that a faculty surgeon may supervise surgery residents in two overlapping operations and collect 100% of the Medicare fee for each case from Medicare. An internist may supervise medicine residents in four overlapping outpatient visits and collect 100% of the fee for each visit when certain requirements are met. Again, and with as little as one minute of overlap, a teaching anesthesiologist may only collect 50% of the Medicare fee when supervising two anesthesia residents with overlapping cases. Make no mistake: when a teaching anesthesiologist must supervise two residents for overlapping cases, he or she has incurred added liability and risk, and much greater stress. It is truly a wonder that many teaching anesthesiologists have refused to accept responsibility for more than one patient at a time when working with residents. I suspect it is a desire to help the patient flow of busy operating rooms and to attempt to meet the huge demand for clinical services in our nation's teaching hospitals that most teaching anesthesiologists have continued to care for concurrent patients with anesthesia residents, even if it is to the financial detriment of the department, university or hospital.

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

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

Sincerely,



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

Chief, Division of Pediatric Anesthesia
Arkansas Children's Hospital

256

SEP - 7 2005

WAKE FOREST
SCHOOL of MEDICINE
THE BOWMAN GRAY CAMPUS

Raymond C. Roy, Ph.D., M.D.
Professor and Chair
Department of Anesthesiology
rroy@wfubmc.edu

September 1, 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

To-Whom-It-May-Concern:

I am Chair of the Department of Anesthesiology at the Wake Forest University School of Medicine and Medical Director of the School of Nurse Anesthesia at North Carolina Baptist Hospital in Winston-Salem, North Carolina. We graduate 15-16 anesthesiologists and 19-20 nurse anesthetists each year. I employ 55 anesthesiologists and intensivists. The average salary of my physicians is half of what the private practice anesthesiologists make in the surrounding area.

Academic medical centers contribute to the delivery of health care in the United States by providing medical care to a high percentage of those patients who are economically disadvantaged patients or on a fixed income. These patients also tend to be more difficult to take care of because they tend to have more co-morbidities than patients with private insurance.

The current fee schedule disadvantages my recruiting and retaining anesthesiologists in several ways. First, the fee schedule for one-on-one provision of anesthesia is thirty to forty percent of what Blue Cross Blue Shield and other third party payors provide. Thus, we have a bizarre system in which we are reimbursed far less for taking care of sicker patients than for taking care of healthier ones. Second, the current fee schedule reimburses teaching anesthesiologists 50% of the Medicare Fee Schedule for each two concurrent resident cases. This means that we are now reimbursed only fifteen to twenty percent what BCBS and other third party payors provide. What makes this particularly unfair is that surgeons with whom we work are not penalized for supervising residents in two overlapping rooms.

There is already a shortage of anesthesia providers in this country. Perpetuating the current reimbursement system will make it less likely that the shortage will corrected at a time when our population is growing older and needing more surgery.

Thank you for your consideration of my thoughts on this matter and thank you for being willing to address the situation on a national level.

Sincerely,

Raymond C. Roy, Ph.D., M.D.
Professor and Chair
Department of Anesthesiology
Wake Forest University School of Medicine
Winston-Salem, North Carolina

251

SEP 7

Tufts-New England Medical Center

The principal teaching hospital for
Tufts University School of Medicine

September 1, 2005

Department of Anesthesia
Tel: 617-636-6044
Fax: 617-636-8384
Email: hwurm@tufts-nemc.org

W. Heinrich Wurm, MD
Chairman
Department of Anesthesia
Tufts University School of Medicine

Anesthetist-in-Chief
Tufts-New England Medical Center

Mark McClellan, MD, PhD
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attn: CMS-1502-P
PO Box 8017
Baltimore, MD 21244-8017

Re.: CMS-1502-P "Teaching Anesthesiologists"

Dear Dr. McClellan:

I am Chair of an academic anesthesia department in Boston and I am writing to urge CMS to change the Medicare anesthesiology teaching payment policy.

Teaching resident physicians the art and science of anesthesiology is a highly responsible task which I have enjoyed doing for 30 years. Over the last decade, the financial burden of training physicians in anesthesiology has become a serious detriment to the future of our specialty. This occurs at a time when life expectancy and surgical options to improve quality of life for the aged has made huge advances. Those advances rely heavily on the availability of well trained anesthesiologists. However, maintaining viable residency programs in anesthesiology has become a fiscal challenge for teaching hospitals, anesthesia departments and physician organizations.

At Tufts-New England Medical Center we graduate 6 residents annually with a faculty of 18 and an annual case load of 16,000 anesthetics. In addition to training residents, we work with and train nurse anesthetists as we believe that the role of nurse anesthetists under the direction of well trained and responsible anesthesiologists is a highly efficient and safe practice mode which has stood the test of time over decades. Yet, the current Medicare payment rules which rigidly reimburses the teaching anesthesiologist only 50% of the fee for directing two concurrent resident cases even when they are only overlapping are creating an untenable financial situation for us. We are now heavily dependent on the hospital and other practices to support us. Financial support required to sustain viability is far in excess of federal funds earmarked for Administration, Supervision and Teaching (AS&T) and is a drain on institutional resources.

Tufts-New England Medical Center
Established 1796

750 Washington Street
Tufts-NEMC #298
Boston, Massachusetts 02111

It appears that teaching anesthesiologists have been singled out for this reduction in reimbursement unfairly. Surgeon and other interventionalists are allowed to supervise multiple overlapping procedures while submitting 100% of charges.

I ask you to review this issue urgently on two fronts: (1) This issue has a serious impact on Anesthesiology as a discipline which includes Critical Care, Pain Management and specialties like Pediatric Anesthesia. Our ability to provide Americans with the kind of service they expect and deserve is in jeopardy if residency programs are fiscally unstable. (2) Academic anesthesia departments like mine must remain competitive and retain teaching anesthesiologists with adequate pay. These are physicians who not only teach residents but deal with the sickest of patients undergoing the most complex procedures.

Please feel free to write or call for additional comment or elucidation.

Sincerely,

W. Heinrich Wurm, MD

Chair, Department of Anesthesiology

Tufts University School of Medicine

Anesthesiologist-in-Chief

Tufts-New England Medical Center

Cc: American Society of Anesthesiologists, Washington Office

College of Medicine
Department of Anesthesiology

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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.

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

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

College of Medicine
Department of Anesthesiology

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259

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

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Thank you.

Ann Carlson, M.D.

Ann Carlson, M.D.

cc: ASA Board of Directors
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Sen. Jon Kyl

260

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Department of Anesthesiology

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Thank you.

Daniel Ferry, M.D.

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

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Department of Anesthesiology

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Thank you.

Peter Lichtenthal, M.D.

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

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September 1, 2005

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

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Thank you.

Steven J. Barker, M.D., Ph.D.

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

SEP 7 2005

263

VIRGINIA MASON

Medical Center

Department of Anesthesiology

Stephen M. Rupp, MD, Chief
Peter Y. Ackerman, MD
Hugh W. Allen, MD
M.S. Batra, MD
Christopher M. Bernards, MD
Robert A. Caplan, MD
Wendy G. Carlyle, MD
Patricia A. Cone, MD
James D. Helman, MD
Traci W. Janssen, MD
Raymond S. Joseph, MD
Dan J. Kopacz, MD
Spencer S. Liu, MD
Susan B. McDonald, MD
Douglas G. Merrill, MD
Michael F. Mulroy, MD
Joseph M. Neal, MD
Brian D. Owens, MD
Julia E. Pollock, MD
Karen J. Roetman, MD
Francis V. Salinas, MD
Lila Ann A. Sueda, MD
Julie S. Vath, MD
Carol E. Wiley, MD

Emeritus
L. Donald Bridenbaugh, MD
William G. Horton, MD
Daniel C. Moore, MD
Gale E. Thompson, MD

August 31, 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: File Code CMS-1502-P
Teaching Anesthesiologists

Dear CMS:

I write today to strongly request the correction of the discriminatory policy of paying teaching anesthesiologists only 50% of the professional fee when supervising two concurrent resident cases. Virginia Mason Medical Center has an outstanding anesthesiology training program with 24 residents and 19 faculty. We are facing a critical faculty shortage, with our most recent departure of a valued anesthesiologist and seasoned teacher who departed academic anesthesia for private practice and a higher salary. Unfortunately, the availability of qualified anesthesiologists in the United States continues to be low. Market forces have driven the costs of anesthesiologists to record levels. Now, hospitals support academic anesthesia departments on an average of $2.5M per year, where previously the anesthesia departments were self-sustaining.

The discriminatory practice toward anesthesiologists is exemplified by the fact that an internist can supervise four overlapping outpatient visits and collect 100% of the fee for each visit when meeting certain requirements. Additionally, a surgeon can supervise two overlapping operations with residents and collect 100% of the fee if they are present for the key portions of the cases. However, anesthesiologists who comply with the strict rules of medical direction can only collect 50% for concurrent cases even if they overlap for a very short period of time. The effect of this discriminatory practice is compounded by the fact that the anesthesia conversion factor is outside of RBRVS and is already undervalued compared to RBRVS by approximately 40%. According to the Medicare fee schedule, in the state of Washington a full anesthesia unit is worth $17.80. This value is now divided by 2 resulting in actual reimbursement from Medicare of $8.90/unit when supervising concurrent cases. Thus, my value to an elderly or disabled patient is

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P.O. Box 900
Seattle, WA 98111
Telephone (206) 223-6980
FAX (206) 223-6982

approximately $35.66/hour for my time. In comparison, we pay our housekeepers $50/hour at our home. Clearly, the stakes and the responsibilities of the work in this example are simply not comparable.

I only ask that we be treated the same as surgeons and internists and be allowed to be reimbursed at 100%/unit for medically directing two concurrent resident cases while fulfilling the rules of medical direction with documentation by the letter of the law.
Thank you very much for your help in this regard.

Sincerely,

Stephen M. Rupp

Stephen M. Rupp, MD
Chief, Department of Anesthesiology

SMR/jt

THE UNIVERSITY OF MISSISSIPPI MEDICAL CENTER
2500 North State Street
JACKSON, MISSISSIPPI 39216-4505

Claude D. Brunson, M.D.
Professor and Chairman
Department of Anesthesiology
Administrator - Perioperative Services
University Hospitals and Clinics

Telephone (601) 984-5900
Fax (601) 984-5912

August 26, 2005

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

Re: CMS-1502-P Teaching Anesthesiologists

Dear Sir/Madam:

The current Medicare teaching anesthesiologist payment rule is unsustainable and a threat to academic anesthesiology training programs. Quality medical care, patient safety and an increasingly elderly Medicare population demand that the United States have a stable and growing pool of physicians trained in anesthesiology. Presently, faculty slots in anesthesiology residency programs are going unfilled because of a Medicare policy that shortchanges teaching programs, withholding 50% of their funds for concurrent cases. This had a direct and negative impact on training the nation's future anesthesiologists.

We currently have 33 residents, two pain fellow positions and three faculty openings in the University of Mississippi Medical Center Department of Anesthesiology. We further have need to hire an additional six teaching anesthesiologists to provide a quality education environment for our physician trainees. This creates great inefficiencies in scheduling, personnel allocation, and case assignments. It is very difficult for us to recruit and retain faculty due to budget shortfalls and non-competitive salaries that can be directly attributed to the current Medicare teaching anesthesiologist policy. Our teaching hospitals subsidize the anesthesia program with payments of $4.8 million annually, which is non-sustainable for our hospitals! Anesthesiology teaching programs, as a result, are suffering severe economic losses that cannot be absorbed elsewhere.

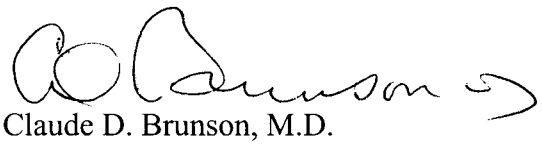
The CMS anesthesiology teaching rule must be changed to allow academic departments to cover their costs. Academic research in anesthesiology is also suffering as department budgets are broken by this Medicare payment reduction.

A surgeon may supervise residents in two overlapping operations and collect 100% of the fee for each case from Medicare. An internist may supervise residents in four overlapping outpatient visits and collect 100% of the fee for each when certain requirements are met. A

teaching anesthesiologist will only collect 50% of the Medicare fee if he or she supervises residents in two overlapping cases. This is not fair, and it is not reasonable.

Medicare must recognize the unique delivery of anesthesiology care and pay Medicare teaching anesthesiologists on par with their surgical colleagues.
The Medicare anesthesia conversion factor is less than 40% of prevailing commercial rates. Reducing an already grossly inadequate reimbursement fee by 50% for teaching anesthesiologists will make us unable to sustain the service, as well as teaching and research missions of academic anesthesia training programs.

Sincerely,



Claude D. Brunson, M.D.
Chairman and Program Director
University of Mississippi Medical Center
Anesthesiology Residency Program

CDB:pp

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Department of Anesthesiology

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Worcester, MA 01655
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stephen.heard@umassmed.edu
www.umassmemorial.org

Stephen O. Heard, MD
Chairman
Professor of Anesthesiology and Surgery

August 29, 2005

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

Re: Teaching Anesthesiologists and CMS-1502-P

As a Chairman of an academic Anesthesiology Department, I writing you to express my concern and protest that the proposed change to Medicare Fee Schedule for 2006 which was released on August 1, 2005 did not correct the discriminatory policy of paying teaching anesthesiologists only 50% of the fee for each of two concurrent resident cases.

The current Medicare teaching anesthesiologist payment rule is discriminatory. For example, a surgeon may supervise residents in two overlapping operations and collect 100% of the fee for each case from Medicare. Moreover, an internist may supervise residents in four overlapping outpatient visits and collect 100% of the fee for each when certain requirements are met. I am befuddled as to why a teaching anesthesiologist will only collect 50% of the Medicare fee when supervising residents in two overlapping cases.

The specialty of Anesthesiology has been in the forefront of patient safety for the last 25 years. With an increasing Medicare population, it is vital that the United States have a stable and growing pool of physicians trained in the field of anesthesiology to provide quality medical care and to maintain patient safety. Many anesthesiology departments are having difficulty recruiting faculty because of the economic consequences of the CMS teaching rule. Many anesthesiology training programs have unfilled slots because of the Medicare policy that shortchanges anesthesiology teaching programs. Indeed, in the Anesthesiology Department at the University of Massachusetts Medical School, we have 5 unfilled faculty positions and have not filled our residency in the match for 5 out of the last 6 years. Medicare needs to recognize the unique delivery of anesthesiology care in academic departments and pay Medicare teaching anesthesiologists on par with their surgical colleagues.

Finally, I must point out that the Medicare anesthesia conversion factor is less than 40% of prevailing commercial rates. Reducing that rate by 50% for teaching anesthesiologists results in revenue that is too meager to sustain the service, teaching and research missions of academic anesthesia training programs.

Thank you for attention to this vital matter.

Sincerely,

Stephen O. Heard, MD
Chair, Department of Anesthesiology
Professor of Anesthesiology and Surgery

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OF MEDICINE

University of Iowa Health Care

Department of Anesthesia

Michael M. Todd, M.D.
Professor and Head
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Iowa City, Iowa 52242-1009
319-356-2382 Tel
319-356-4130 Fax
www.uihealthcare.com

August 29, 2005

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

RE: TEACHING ANESTHESIOLOGISTS

Dear Sirs,

I am writing in response to the Medicare supervisory rule that is currently under consideration. I'm asking that this rule be changed.

I am the new Chairman of the Department of Anesthesia at the University of Iowa. I have been a faculty member in the College of Medicine since 1986 and have been an active clinician and researcher throughout my professional career. I am also the Editor-in-Chief of the journal *Anesthesiology*, the official journal of the American Society of Anesthesiologists (our profession's largest professional publication, with a circulation of nearly 40,000). I've also been an NIH-funded investigator most of my career. In these various positions, I have seen the detrimental effects of the current supervisory rule on our profession, and as a new Chairman, I'm confronted by the enormous financial burdens that this rule creates.

Basically, the rule is hugely unfair and unwise. While all other academic physicians are paid a full fee for supervising two concurrent procedures, only anesthesiologists have been singled out for unique treatment. The surgeons at the University of Iowa can easily supervise residents working on two concurrent cases, simply by certifying that they were present for the critical portions of the cases - and receive full payment for each. By contrast, payment to anesthesiologists for identical activity results in a 50% reduction in payment for each case. Since the conversion factor for anesthesiology is already only 40% of what is paid by some private carriers, the impact is enormous.

The result of this rule has been devastating for the academic anesthesia community. At a time when quality care, patient safety and a growing Medicare population demand that we have vigorous and viable academic training programs, the financial constraints imposed by the rule has resulted in a progressive decrease in the number of high-quality academic programs across the country. I can give you a very graphic example. When I took over as the Editor of *Anesthesiology*, roughly 70% of the research manuscripts submitted to the

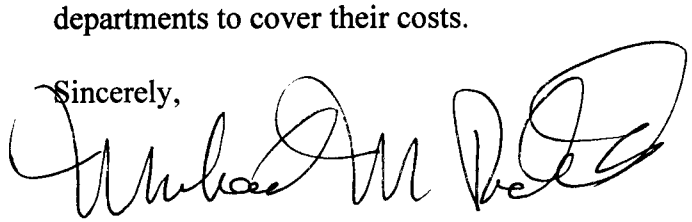
Journal came from US departments. At the present time, this number has fallen to 40%. Why? Because in Department after Department, financial resources have become so constrained as a result of the rule (and its adoption by private carriers such as Wellmark) that fewer and fewer faculty are able to devote any time to academic endeavors. With faculty being asked to work longer and longer hours for less money, many previously strong academic departments have simply given up any pretext of trying to maintain their academic missions. As faculty lose their ability to teach and create new knowledge, residents in training see their frustration and quickly conclude that there is no future in academic medicine, something that has resulted in fewer and fewer of them choosing academic careers.

This situation has been particularly problematic here in Iowa. At one time, departments of anesthesia were self-sufficient; they could meet their salary and staffing requirements with the revenues derived from clinical practice. This is no longer the case. A recent survey showed that academic practices now required subsidies from their hospitals in excess of $100,000 per faculty member - money that is not easily provided. For example, in the course of my negotiations, it became apparent that our professional billings/collections were insufficient by nearly $8,000,000 a year - money that must be provided by a hospital/college that itself is increasingly strapped for funds. This stems in part from the supervisory rule (we have roughly 45 residents and do over 25,000 anesthetics per year), from the fact that Wellmark (our largest private payer) uses the Medicare supervisory rules, and because Iowa is one of the lowest Medicare reimbursed states in the country. The impact is not imaginary. At present, we are short roughly 10 faculty members - and hiring more is becoming more and more difficult due to these financial constraints.

Once upon a time, there seemed to be plenty of money from other sources to make up these shortfalls. This is no longer the case. Anesthesiology teaching programs, caught in the snare of this trap, are suffering severe economic losses that cannot be absorbed elsewhere. The result is a loss of faculty, and the disappearance of the bright young individuals who are needed as the teachers of the next generation of Anesthesiologists. Without a correction in this situation, the future of academic anesthesiology is truly in jeopardy. In fact, as noted above, we are well into this situation.

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

Sincerely,



Michael M. Todd, M.D.
Professor and Head, Department of Anesthesia
Editor-in-Chief, *Anesthesiology*

P.S. You are also receiving letters from CRNAs, encouraged by the American Association of Nurse Anesthetists, suggesting that a change in the supervisory rule would adversely impact CRNA education. That is simply nonsense. Iowa has a large Student Nurse

Anesthesia program. My faculty are doing much of the teaching in that program, and the current rule is already imposing constraints on the time they have available to teach. The only "adverse consequence" that might occur is that we might be able to staff more operating rooms with residents (paid $50,000/yr for working 80hrs) than with CRNAs (who can be supervised without running afoul of the supervisory rule) who are paid $175,000/yr and work only 40hrs. To replace residents with CRNAs is economically foolish.

MMT/jrw

cc: Senator Chuck Grassley
Senator Tom Harkin
Representative Jim Nussle
Representative James Leach
Representative Leonard Boswell
Representative Tom Latham
Representative Steve King
Dean Jean Robillard, University of Iowa Carver College of Medicine
Donna Katen-Bahensky, CEO, University of Iowa Health Care

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267

August 30, 2005

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

Re: CMS-1502-P Medicare Teaching Anesthesiologists Payment Rule

To Whom It May Concern:

I am the Co-Director of the Anesthesiology Residency Program in the Department of Anesthesiology at the University of Arkansas for Medical Sciences and the Medical Director of the Intensive Care Unit at John L. McClellan Memorial Veteran's Hospital. I am aware of Medicare policies affecting our programs. The CMS' proposed changes to the Medicare Fee Schedule for 2006 as it currently stands is unwise, unfair and unsustainable. I am asking that the policy be amended to correct the discriminatory policy of paying teaching anesthesiologists only 50% of the fee for each of two concurrent resident cases.

Our elderly Medicare population demands a stable and growing pool of anesthesiology trained physicians to provide quality medical care and patient safety. Current Anesthesiology programs such as ours are having slots unfulfilled because of the rule of withholding 50% of funds for concurrent cases. In addition, academic research dollars are being reduced as our department budget is divided up. Changing the CMS anesthesiology teaching rule will allow academic departments such as ours to cover their costs.

We are only asking that anesthesiologists be allowed equality with that of other specialties. For instance, a surgeon can supervise residents in two overlapping operations and collect 100% of the fee for the case from Medicare. In addition, an internist may supervise residents in four overlapping outpatient visits and collect 100% of the fee when certain requirements are met. A teaching anesthesiologist will only collect 50% of the Medicare fee if he/she supervises residents in two overlapping cases. Medicare must recognize the unique delivery of anesthesiology care and pay Medicare teaching anesthesiologists on the same level as their surgical colleagues.

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

The current Medicare rule must be revised as soon as possible so that we can provide the quality of care that the patient deserves. Anesthesiologists also deserve a fair and equitable policy in line with colleagues in surgery - that of 100% of the Medicare fee for each of two overlapping procedures involving resident physicians.

Thank you for your consideration in this important policy matter.

Sincerely,

Muhammad Jaffar, M.D.
Co-Director of the Anesthesiology Residency Program
Associate Professor in Anesthesiology and Surgery
Director of the Preoperative Evaluation Center
Medical Director of the Intensive Care Unit (John L. McClellan Memorial Veteran's Hospital)

MJ/cp

268

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STUART R. PAUL, M.D.
Anterior Segment and Refractive Surgery

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Optometry

MICHAEL NEUNZIG, O.D.
Optometry

August 22, 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: **File Code CMS-1502-P**

Issue: GPCIs/Payment Locality/Oppose Proposed Rule Change

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Sincerely,

Stuart R. Paul, M.D.

622 ABBOTT STREET • SALINAS, CALIFORNIA 93901 • (831) 771-3900 • FAX (831) 424-7835

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Sincerely,

Asit Pruthi, M.D.

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Matthew R. Jones, M.D.

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Sincerely,

Richard U. Kim, M.D.

272

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Sincerely,

Ming Lu, M.D.

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Sincerely,

Steven R. Sanislo, M.D.

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Sincerely,

Christopher M. DeBacker, M.D.

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Sincerely,

Michael Neunzig, O.D.

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SEP - 1 2005

271

August 21, 2005
Aptos, Ca. 95003

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

I support the proposal to change the status of both Sonoma and Santa Cruz Counties, California from rural to an urban designation. This will permit this geographic area to join the eight other counties in the San Francisco Bay area as an urban designation.

The cost of living and the price of housing in Santa Cruz County has and is exploding. Houses in this area sell for $750,000 to over $1,000,000.00.
Physicians are dropping Medicare patients or are just not taking any new Medicare patients.

Many of the residents of this area came here as part of their retirement planning. But if they cannot get physicians to take them as patients they will have to move.

Changing this designation is long overdue. Please consider and support this change of designation for this area, Santa Cruz, County, California.

Yours Truly,

Robert M. Pechner
213 Wixon Ave.
Aptos, Ca. 95003
E-mail address: bpechner@aol.com

cc:Dr. Larry deGhetaldi
Sutter Santa Cruz

Congressman Sam Farr
Santa Cruz Office

INDIANA UNIVERSITY

SCHOOL OF MEDICINE

DEPARTMENT OF ANESTHESIA

Fesler Hall 204
1120 South Drive
Indianapolis, IN
46202-5115

317-274-0275
FAX: 317-274-0256

218

August 23, 2005

SEP 7 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

Reference: TEACHING ANESTHESIOLOGISTS

To Whom It May Concern:

I am a member of the faculty of the Department of Anesthesia, Indiana University School of Medicine, a position I have held for a number of years. During this time I have cared for some of the most critically ill patients in the state and have helped educate the next generation of anesthesiologists. Indiana University Department of Anesthesia is the only anesthesia residency program in the state, and approximately seventy-five percent of the anesthesiologists practicing in Indiana were educated by this program.

In the past few years, there has been a steady decline in the health of academic anesthesia, now reaching the point where it is vital that something be done. The financial health of these programs is poor due to the low levels of reimbursement. Teaching institutions shoulder the largest share of Medicaid patients and are also penalized since 1996 by concurrency rules for their care of Medicare patients. The income of teaching anesthesiologists across the Nation averages 50-60% of that of the private practice anesthesiologist, despite comparable work hours and the added responsibilities of teaching young physicians. As a result, many anesthesiologists have been driven out of the academic setting and into private practice. This has resulted in the closure of several residency programs in recent years. Now there is a national shortage of anesthesiologists, coupled with a growing demand for their services fueled by our aging population.

This very serious situation would be greatly helped by the elimination of the concurrency rules for teaching anesthesiologists which reduces payment when an anesthesiologist supervises more than one resident. The anesthesiologist is the only acute care physician penalized in such a way. For example, if a surgeon performs an operation with a resident in one operating room (and is present for all the key parts of the procedure), then begins surgery on a second patient (while the resident finishes the first procedure), the surgeon is paid the full surgical fee for both patients. In contrast, teaching anesthesiologists are reimbursed at a reduced rate even though they perform the pre-anesthetic examination and evaluation, prescribe the anesthetic plan, personally participate in the most demanding procedures of the anesthetic included induction and emergence, monitor the course of anesthesia administration at frequent intervals, remain physically present and available for immediate diagnosis and treatment of emergencies, and provide indicated post-anesthesia care for each patient.

This rule is both inequitable and unwise, and will ultimately lead to a continuing shortage of anesthesiologists, to the detriment of American patients.

I urge you, in the strongest possible way, to correct this discriminatory policy against teaching anesthesiologists, relative to other teaching physicians.

Sincerely,

Fernando Perez-Majul, M.D.
Assistant Professor of Clinical Anesthesia

SEP 7 2005

1120 South Drive
Fesler Hall #204
Indianapolis, IN 46202-5115
26 August, 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

To Whom It May Concern:

I am a faculty member of the Department of Anesthesia, Indiana University School of Medicine, a position I have held for 23 years. During this time my colleagues and I have cared for some of the most critically ill patients in the state and have helped educate the next generation of anesthesiologists. In recent years the well-being and viability of academic anesthesia departments nationwide has seriously deteriorated due to inadequate levels of payment for patient care. Teaching institutions bear a disproportionate burden of meeting the medical needs of Medicaid patients; their anesthesiologists have, since 1996, been additionally penalized by concurrency rules for their care of Medicare patients. It is well known that teaching hospitals routinely serve as a haven of last resort for patients who have exhausted the ability or willingness of other practitioners to treat them. A recent study indicates that Indiana University Hospital physicians treat patients with one of the highest average levels of acuity (medical severity) in the United States. The income of teaching anesthesiologists across the nation averages 50-60% of that of private practice anesthesiologists, despite comparable work hours and the added responsibilities and liabilities incurred by teaching new physicians. As a result, many anesthesiologists have been driven out of the academic setting. This has resulted in the closure of anesthesia residency programs in recent years.

This worsening situation would be substantially alleviated by the elimination of the concurrency rule for teaching anesthesiologists, a punitive rule which reduces payment when an anesthesiologist supervises more than one resident. The anesthesiologist is the **only** acute care physician penalized in this manner. If a surgeon performs an operation with a resident in one operating room (and is present for all

the key parts of the procedure), then begins surgery on a second patient (while the resident finishes the first procedure), the surgeon is paid the full surgical fee for both operations. The teaching anesthesiologist, however, is reimbursed at a severely reduced rate even when he is present for all the key parts of the anesthetic and is personally responsible (as well as professionally and financially liable) for the entire anesthetic plan and management. This concurrency rule is unjust and will ultimately lead to a continuing decline in the education and availability of future anesthesiologists, to the detriment of American patients. I therefore urge you to reverse this policy that discriminates against teaching anesthesiologists.

Sincerely,

Mark D. Tasch, M.D.
Associate Professor of Clinical Anesthesia
Indiana University School of Medicine

INDIANA UNIVERSITY

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280

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Nancy Zinni

Nancy Zinni, M.D.
Assistant Professor of Clinical Anesthesia

INDIANA UNIVERSITY

SCHOOL OF MEDICINE
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SEP 7 2005

August 23, 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

Reference: TEACHING ANESTHESIOLOGISTS

To Whom It May Concern:

I am a member of the faculty of the Department of Anesthesia, Indiana University School of Medicine, a position I have held for a number of years. During this time I have cared for some of the most critically ill patients in the state and have helped educate the next generation of anesthesiologists. Indiana University Department of Anesthesia is the only anesthesia residency program in the state, and approximately seventy-five percent of the anesthesiologists practicing in Indiana were educated by this program.

In the past few years, there has been a steady decline in the health of academic anesthesia, now reaching the point where it is vital that something be done. The financial health of these programs is poor due to the low levels of reimbursement. Teaching institutions shoulder the largest share of Medicaid patients and are also penalized since 1996 by concurrency rules for their care of Medicare patients. The income of teaching anesthesiologists across the Nation averages 50-60% of that of the private practice anesthesiologist, despite comparable work hours and the added responsibilities of teaching young physicians. As a result, many anesthesiologists have been driven out of the academic setting and into private practice. This has resulted in the closure of several residency programs in recent years. Now there is a national shortage of anesthesiologists, coupled with a growing demand for their services fueled by our aging population.

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DEPARTMENT OF ANESTHESIA

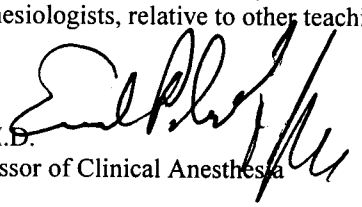
Fesler Hall 204
1120 South Drive
Indianapolis, Indiana
46202-5115

317-274-0275
Fax: 317-274-0256

This rule is both inequitable and unwise, and will ultimately lead to a continuing shortage of anesthesiologists, to the detriment of American patients.

I urge you, in the strongest possible way, to correct this discriminatory policy against teaching anesthesiologists, relative to other teaching physicians.

Sincerely,



Emil Pelech, M.D.
Assistant Professor of Clinical Anesthesia

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282

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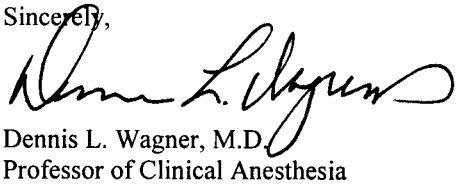

Dennis L. Wagner, M.D.
Professor of Clinical Anesthesia
Director, Adult Pain Clinic

283

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Sincerely,

Leighan B. Latham, M.D.
Assistant Professor of Clinical Anesthesia

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Sincerely,

Francis X. Dillon, M.D.
Assistant Professor of Clinical Anesthesia

285

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Sincerely,

Jerry V. Young, M.D.
Professor of Clinical Anesthesia

286

Klamath Orthopedic Clinic

2200 Bryant Williams Drive #1 • Klamath Falls, Oregon 97601
(541) 884-7746 • (541) 884-3677 • (800) 515-1655
www.klamathbones.com

Michael J. Casey, M.D., P.C.
Board Certified
American Board Orthopaedic Surgery
Member American Society for Surgery of the Hand

Karl C. Wenner, M.D., P.C.
Board Certified
American Board Orthopaedic Surgery
North American Spine Society

Miguel Schmitz, M.D., P.C.
Board Certified
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Member American Orthopaedic Society for Sports Medicine
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Jeannette Gansberg
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Specializing in:

Shoulder

Elbow

Hand

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Total Joint Replacement

Arthritis

Musculoskeletal Trauma

Knee

Foot & Ankle

Sports Medicine

Arthroscopy

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1502-P
P.O. Box 8017
Baltimore, MD 21244-8014

To Whom It May Concern:

I am a practicing Orthopaedic Surgeon in Southern Oregon, whose practice currently constitutes 35% of patients whose primary insurance is Medicare. I have always cherished the opportunities that I have had to care for the surgical and non-surgical musculoskeletal health needs of the Medicare population. Overall, the Medicare patient population has been grateful for what orthopaedics as had to offer them throughout the years.

Over the last 30 some years this clinic has not had a policy of restricting the percentage of Medicare patients that it is willing to treat within the practice. Recently I have been informed of several alarming proposals from the CMS that may force me and other practices/practitioners to monitor the amount of Medicare patients that we can treat. Simply put, the cost of administering care to this group of patients would likely exceed the reimbursement for treatment of these patients under the 2006 proposal. This is especially true since the federal government has failed to pass meaningful tort reform, thereby driving up the costs of our "malpractice" insurance. Naturally, this suits the greedy trial attorneys just fine. By most accounts, medical malpractice claims and the resulting medicolegal system have consumed at least 10% of medical funds. This estimate neglects to consider the cost of defensive medicine, which has been estimated to be ten times the raw tort costs.

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Of course, there is also the issue of the ever-increasing administrative burden foisted on physicians and surgeons for handling insurance claims of all sorts, not just Medicare. In this rural community, there is a medical draw of 80,000 people with 5.5 full-time equivalent orthopaedic surgeons to serve this population base. This could produce a considerable backlog in the management of fractures and chronic conditions within the Medicare population. Of course, we could choose to *not* take Medicare patients at all because there is already a backlog of non-Medicare patients. As you would well imagine this would not be in the best interest of our rural community, but we have to remain financially viable too.

There are several areas of concern in the 2006 Medicare part B proposal. First, it has been proposed that there is a 4.3% across-the-board cut to the conversion factor. For orthopaedics, the cut is proposed to be 4.4%. Second, there is the proposed elimination of the Q codes for casting and splinting supplies. This latter proposal is particularly unfair and onerous to orthopaedics because there is not just the cost of the raw casting and brace materials but also the cost of securing and storing the materials. Taken to the logical end, this would imply that hospitals should not charge for intravenous antibiotics when coding for "intravenous antibiotic therapy", as one of many examples. Of course, this problem could be solved by discontinuing fracture care. Very few orthopaedic surgeons would balk at the opportunity to stop taking emergency room call through which fracture cases are generated. Instead, they would relish the concept of opening a specialty hospital without an emergency room and without evening and weekend fracture cases.

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The best option for our Medicare patients, the physicians, and the CMS is to eliminate any cuts in the conversion factors and the Q-codes. I believe that the solution to the budget problems have to do with the lack of tort reform and the lack of federal guidelines that could protect treating physicians from withholding excessive medical involvement for hopeless end-of-life cases that absorb an inordinate amount of monetary resources. It has been observed, for instance, that 50% of the average person's lifetime medical expenditures are spent in the last 2 WEEKS of life. Obviously, the real solution to the Medicare budget dilemma is complex, but I do not see an adequate solution in the current 2006 proposal because it simply leverages too much on the Medicare patients and the treating physicians. The treating physicians have taken serious cuts to treat and care for the Medicare population for many years. The solution cannot always be the reduction of payment to the treating physician, because we are barely covering costs as it is, and in many cases, we are operating at a loss.

I agree that something needs to be done to fix the budget but I do not believe that the 2006 proposal adequately provides the solutions to the rising cost of treating the Medicare population.

Sincerely,

Miguel Schmitz, MD

Please Read ☺ 281

7 2005

PERFECT OFFICE SOLUTIONS, INC.
429 N PALMETTO STREET
LEESBURG FL 34748
PHONE: 352-787-7869
FAX: 352-787-7867

www.perfectofficesolutions.com

August 31, 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:

You may receive hundreds of forms letters in support of changing the current, inequitable Medicare anesthesiology teaching payment policy. This is not a form letter, although it is to the point!

I am writing as legislative liaison of Florida Anesthesia Administrators Association to urge the Centers for Medicare and Medicaid Services (CMS) to change the current structure for another reason.

Private insurance (for profit) companies are trying to implement the same rules and penalties, while not providing any graduate medical education funds to teaching facilities. While I understand the insurance companies are entitled to self-determine how they process and pay claims, they look to CMS as a role model. Please be a good one!

Kindest Regards,

Kelly Dennis

Kelly Dennis, CPC, ACS-AP

Legislative Liaison

B Margaret E. Bertaina
8094 Washington Ave
Sebastopol, CA 95472-3112

288

9-1-07

Please note:

I endorse the proposed new rule that would increase the reimbursement rate for Sonoma County by 8%.

Medical and living costs in Sonoma County are constantly rising, and the Senior population is increasing- we need relief now, at least in Medicare decisions.

Margaret E Bertaina

289

Marilyn Azevedo
820 Fallon Rd.
Petaluma, Ca 94952
707-778-2134
e-mail ih2odog@pacbell.net

SEP 7 2005

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

Dear GPCIS,

I am hoping you will forward this letter on to the appropriate committee which is now evaluating the need for readjustment for Medicare payments in Sonoma County.
As someone who has worked in the medical field as an operating room nurse, hospice nurse and lastly as a patient advocate for more than a quarter of a century I have increasingly been concerned with the leaching away of quality medical care in Sonoma County. Classifying Sonoma County as rural by Medicare has been the lead in most of the lowered payments problems, followed as it is by insurance company reimbursement rates.
I am concerned that if this situation is not rightly corrected, Sonoma County will continue to loose specialists and those physicians who wish to start up their practice here. There are also those who end up leaving the county because they can not make a living with the current reimbursement system.
Sonoma County is a beautiful place to live, but the population density is certainly not consistent with a rural county. If the situation is not corrected, the people of this county will continue to loose qualified medical specialists and suffer at the hands of an archaic and unjust system that has not corrected itself in decades. Our county is not static and neither should the system that cares for it's elderly.

Sincerely,

Marilyn Azevedo

Palo Alto Medical Foundation
A Sutter Health Affiliate

290

7 2005

September 1, 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: GPCIs / Payment Localities

To whom it may concern:

I am writing as a resident of San Mateo County, California, a healthcare executive, and as a member of the Board of Directors of Sutter Maternity & Surgery Center in Santa Cruz to strongly support your proposed revision to physician payment localities in California recently published in the referenced rule. 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.

I believe that the proposed rule would alleviate this problem by removing Santa Cruz and Sonoma Counties from Locality 99 and placing them into unique localities. I 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 adjustment you propose appropriately addresses this payment imbalance. This revision would bring Medicare closer to your goal of reimbursing physicians based on the cost of practice in their locality.

Sincerely,

Cecilia C. Montalvo
Vice President

Neuro-Communication Services
A&D.
Audio Vestibular Care
www.betterhearing.net

Eric N. Hagberg, Au.D.
Erin L. Miller, Au.D.

291

September 2, 2005

Adult and Pediatric Audiology

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Vestibular Disorders

BPPV Treatment

Auditory Processing

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Otoacoustic Emissions

Video-Nystagmography

Cerumen Management

Hearing Aids

Assistive Listening Devices

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Southbridge West
Building C-1
Boardman, Ohio 44512
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Fax: 330.726.8612

Liberty
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Churchill Park Plaza #2
Liberty, Ohio 44505
Phone: 330.759.9907
Fax: 330.759.2131

Toll Free: 1.800.824.3957
E-Mail: ncsinc01@sceinet.com

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BOARD CERTIFICATION IN AUDIOLOGY

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

Re: CMS-1502-P

Dear Dr. McClellan:

As an audiologist, I am writing to express my concern about the Centers for Medicare & Medicaid Services' (CMS) proposed Medicare Physician Fee Schedule, which would reduce Medicare reimbursement for audiology services by as much as 21 percent over a four-year period beginning in 2006. No other specialty is as dramatically affected by the proposed elimination of the non-physician work pool (NPWP) and the new methodology to calculate the practice expense relative value units. Simply stated, audiologists may not be able to continue to offer services to Medicare beneficiaries unless CMS develops an equitable reimbursement rate for these services.

Adequate and fair reimbursement rates for audiology services are essential for covering the expenses audiologists incur in performing hearing and vestibular services for Medicare beneficiaries. Hearing loss is a common malady of the aging population. As the lifespan of America's seniors increases, a greater need for audiology services will develop. For these Medicare patients, the benefits of having qualified and licensed audiologists who are trained to evaluate and care for them are immeasurable.

I respectfully request that you work with the audiology community and the American Academy of Audiology to develop solutions to address the negative impact of the elimination of the non-physician work pool. Working together, we can develop a fair and equitable reimbursement rate for audiology procedures and ensure Medicare beneficiaries' access to these vital services.

Thank you for your consideration.

Sincerely,

Eric N. Hagberg, Au.D.
Doctor of Audiology

Cc: Mr. Herb Kuhn, Director, Center for Medicare Management

Direct Reply To: 292

Kellen Ann Rogan
1960 N. Lincoln Park West, Unit #410
Chicago, IL 60614

membership@ilaudiology.org

Illinois Academy of Audiology
The Voice of Audiology in Illinois
1000 Central Street, Suite 717 Evanston, IL 60201 1-847-328-5180 www.ilaudiology.org

September 2, 2005

Mark B. McClellan, M.D., Ph.D.
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Adequate and fair reimbursement rates for audiology services are essential for covering the expenses audiologists incur in performing hearing and vestibular services for Medicare beneficiaries. Hearing loss is a common malady of the aging population. As the lifespan of America's seniors increases, a greater need for audiology services will develop. For these Medicare patients, the benefits of having qualified and licensed audiologists who are trained to evaluate and care for them are immeasurable.

I respectfully request that you work with the audiology community and the American Academy of Audiology to develop solutions to address the negative impact of the elimination of the non-physician work pool. Working together, we can develop a fair and equitable reimbursement rate for audiology procedures and ensure Medicare beneficiaries' access to these vital services.

Thank you for your consideration.

Sincerely,

Kellen A Rogan, M.S., CCC-A, FAAA

Cc: Mr. Herb Kuhn, Director, Center for Medicare Management

Josephine Z. Helmbrecht, Au.D.
15201 Quicksilver Street Northwest
Ramsey, MN 55303
(763) 767-0695

293

September 2, 2005

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

Re: CMS-1502-P

Dear Dr. McClellan:

As an audiologist, I am writing to express my concern about the Centers for Medicare & Medicaid Services' (CMS) proposed Medicare Physician Fee Schedule, which would reduce Medicare reimbursement for audiology services by as much as 21 percent over a four-year period beginning in 2006. No other specialty is as dramatically affected by the proposed elimination of the non-physician work pool (NPWP) and the new methodology to calculate the practice expense relative value units. Simply stated, audiologists may not be able to continue to offer services to Medicare beneficiaries unless CMS develops an equitable reimbursement rate for these services.

Adequate and fair reimbursement rates for audiology services are essential for covering the expenses audiologists incur in performing hearing and vestibular services for Medicare beneficiaries. Hearing loss is a common malady of the aging population. As the lifespan of America's seniors increases, a greater need for audiology services will develop. For these Medicare patients, the benefits of having qualified and licensed audiologists who are trained to evaluate and care for them are immeasurable.

I respectfully request that you work with the audiology community and the American Academy of Audiology to develop solutions to address the negative impact of the elimination of the non-physician work pool. Working together, we can develop a fair and equitable reimbursement rate for audiology procedures and ensure Medicare beneficiaries' access to these vital services.

Thank you for your consideration.

Sincerely,

Josephine Z. Helmbrecht, Au.D., FAAA
Doctor of Audiology

Cc: Mr. Herb Kuhn, Director, Center for Medicare Management

294

WAKE FOREST

SCHOOL of MEDICINE
THE BOWMAN GRAY CAMPUS

Department of Anesthesiology

August 29, 2005

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 Sirs:

I have only practiced anesthesiology for 10 years, but I have already watched almost every one of my mentors leave academic anesthesiology for less stressful and higher reimbursed work in the private sector.

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

I believe that Medicare's payment to anesthesiology teaching programs is discriminatory. This policy has had a direct and detrimental impact on the ability of my teaching program to retain skilled faculty and to train the new anesthesiologists necessary to help alleviate the widely-acknowledged shortage of anesthesia providers.

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

Teaching anesthesiologists are also permitted to work with residents on overlapping cases so long as they are present for critical or key portions of the procedure. However, 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 consistent between disciplines, nor is it reasonable.

I ask that you correct this inequity and help make a step toward assuring that anesthesiology teaching is reimbursed on par with other teaching physicians.

Please end the anesthesiology teaching payment penalty.

Sincerely,

JC Gerancher MD

Associate Professor and Section Head Regional Anesthesia and Acute Pain Management

Wake Forest University Health Sciences
Medical Center Boulevard • Winston-Salem, North Carolina 27157
(336) 716-4498 • fax (336) 716-8190 • www.wfubmc.edu/anesthesia

295

SEP 8 2005

GD

ARCHITECTURE INTERIOR DESIGN LIGHTING
GREBMEIER DESIGN

September 3, 2005

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 changing the designation of **Santa Cruz County** from 'rural' to 'urban'. This change is warranted by the county's proximity to the Silicon Valley and San Francisco Bay area and the county's extremely high cost of living.

Thank you

Charles Grebmeier ASID

Organization: Dominican Hospital Foundation
Category: Individual

345 SOQUEL AVENUE N 53
SANTA CRUZ CA 95062
V 831.429.1923 F 429.8278
INFO@GREBMEIERDESIGN.COM
WWW.GREBMEIERDESIGN.COM
WWW.DESIGNFINDER.COM/GREBMEIER

ROBERT N. WHITEHEAD 296
MARY LOUISE WHITEHEAD

1230 Old San Jose Road
Soquel California 95073

CENTERS FOR MEDICARE AND MEDICAID SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES
ATTN: CMS-1502
PO BOX 8017
BALTIMORE
MARYLAND, 21244 8017

SEP 8 2005

We , the undersigned, urgently request the Department of Human Services to adjust the standards of rural and urban designation to allow the County of Santa Cruz, State of California, to be more equal to adjacent counties which receive as much as 25% greater reembursement.

Present societal and economic circumstances make it difficult to retain or recruit medical services to care for our substantial number of senior citizens and midically indigent.

Respectfully

ROBERT N. WHITEHEAD

Mary Louise Whitehead
MARY LOUISE WHITEHEAD

SEP 8 2005

297

PRACTICE LIMITED TO FAMILY LAW

Family + Law = Solutions

WARREN S FOREST
ATTORNEY AT LAW

September 3, 2005

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

Dear Madam/Sir:

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

Very truly yours,

FAMILY + LAW = SOLUTIONS

Warren S. Forest
Attorney at Law

Cc: Betty Elward

FAMILY + LAW = SOLUTIONS
5521 SCOTTS VALLEY DR.
SUITE 115
SCOTTS VALLEY, CA 95066

PHONE (831) 440-9909
FAX (831) 440-9949

9/1/05

SEP 8 2005

298

We are writing to urge Medicare to increase the re-imbursement rate by the proposed 8% thus bringing Sonoma County back in line with current standards.

With rising medical costs & a rapidly increasing older population we need to be able to encourage growth in the number of primary care physicians in Sonoma County who will accept Medicare patients — by increasing Medicare re-imbursements.

Sincerely

1508 Eric Ct.
Petaluma CA 94954
(707) 778-9105

299

SEP 8 2005

126 Bradley Drive
Santa Cruz, CA 95060
September 1, 2005

REF: GPCIs

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

Dear Sirs/Madames:

Please support the proposed change in the designation of Santa Cruz County, California from a rural designation to an urban designation. This change would recognize the reality that Santa Cruz County is part of the Greater San Francisco Bay Area, with similar costs of living and similar populations. It is thus unfair to both the citizens and physicians of Santa Cruz County to be classified as "rural" when it in fact is as "urban" in all respects as the adjacent Bay Area.

Thank you for your consideration.

Sincerely,

Jan E. Garrison

from the desk of

Theresa Wasilewski
4538 Flores Ave.
Rohnert Park, CA 94928

SEP 8 2005

300

TO GPCIs

9-3-05

We, who live in Sonoma County need help NOW!
Please change the Federal Guidelines to correct re-imbursement in this growing county.
We must keep our good Sonoma County M.D's -- they deserve an increase of 8% Help!!!

Yours truly,
Theresa J Wasilewski