AUG

August 23, 2005

Medicare Services
Attn. CMS-1502-P
P.O. Box 8017
Baltimore, MD 21244-8017

Gentlemen

Please change the status of Santa Cruz County California to an urban designation.

This is definately not a rural area .

We deserve to have doctors who will accept Medicare patients and be payed the same as other doctors just 25 miles away in Santa Clara County.

I just turned 65. I hope to continue living here and I hope to have access to quality health care and quality doctors in the future when I will need it most. I understand that nearly 15% of the local population is also dependent on Medicare coverage.

We are asking you to do the right thing and make this change.

Yours Truly,

Margaret Kotsi

Margaret Kotsi
623 Cedar St. Aptos, CA 95003

APTOS

CHAMBER OF COMMERCE & TOURIST INFORMATION CENTER
7605 #A Old Dominion Court, Aptos, CA 95003
(831) 688-1467 fax 688-6961 www.aptoschamber.com e-mail info@aptoschamber.com

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:

We are writing on behalf of the Aptos Chamber of Commerce to strongly support your proposed revision to physician payment localities in California recently published in the reference 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.

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

Sincerely,

Karen and John Hibble
Executive Directors
Aptos Chamber of Commerce

JACQUELINE BUIE
2607 Hensley Ln.
Santa Cruz, CA 95065
(831)465-1380 JaqBuie@Yahoo.com

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

To Whom It May Concern:

The current "rural" designation for the Santa Cruz area makes it difficult for senior citizens to find doctors who will accept Medicare patients. This area is certainly not rural, but a thriving county full of ongoing development and successful businesses. Homes are expensive, there is a branch of the University of California (also growing) and the economic climate is excellent.

Some of our first-rate doctors and medical-care people are moving away to "urban" areas and so I urge you to review and reconsider the Santa Cruz designation.

Sincerely,

Jacqueline Buie

AUG [illegible]

MARCUS R. KWAN, M.D., INC.
GENERAL AND LAPAROSCOPIC SURGERY

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

August 22, 2005

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 Federal Registry 8 August 2005.

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

This is 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. The other Locality 99 counties have used Sonoma and Santa Cruz's measured higher cost of providing care to enhance their reimbursements.

CMS acknowledges that they have the responsibility to manage physician payment localities. We 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.

Sincerely,

Marcus Kwan, MD, FACS

MRK/mrk

1595 SOQUEL DRIVE, SUITE 340 SANTA CRUZ, CALIFORNIA 95065 TELEPHONE (408) 476-3322

Graniterock.

AUG [illegible]

August 22, 2005

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

1992 Winner

Reference: CMS-1502-P

Ladies and Gentlemen:

I am writing to urge you to change Santa Cruz County's Medicare reimbursement designation from rural to urban. Historically, Santa Cruz County has received some of the lowest Medicare reimbursement rates.

These lower rates have caused hardship not only on the patients but the doctors as well. Doctors are leaving Santa Cruz County to practice in areas where they can receive higher reimbursement. In other instances doctors are abandoning their Medicare patients – is this fair treatment of Senior Citizens who have worked so diligently to build this Country?

Please give serious consideration to changing Santa Cruz County's Medicare status to URBAN. To remain a rural designation would be grossly unfair, as the cost of doing business in Santa Cruz County requires higher rent for office space, as well as paying competitive salaries for nurses and office staff.

Thank you.

Sincerely,

Graniterock

Bruce W. Woolpert

Bruce W. Woolpert
President & CEO

August 22, 2005

Dept. of Health and Human Services
Attention: CMS-1502-P

Dear Sir or Madam:

I am writing to support the change of designation for Santa Cruz County to urban rather than rural. The discrepancy between the rural reimbursements and the cost of living and health care in this area is astonishing, to say the least. We are losing competent physicians as a result- they cannot maintain their practice and purchase a home in this community with the lower reimbursement schedule.
The change for Santa Cruz is long overdue and I beseech you to change the designation for the health of our citizens and the livelihood of our doctors.
Thanks for your consideration.

Sincerely,

Joe Cook
105 Osprey Lane
Aptos, CA 95003

David J. Taff
1346 High School Rd.
Sebastopol, Ca., 95472

August 22, 2005

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

Re: GPCIs

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

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

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

Sincerely,

David J. Taff David Taff

cc: Two copies attached.

The Family Wellness Medical Center
James F. Yusuf Q. Erskine D.O.
Family Practice & Osteopathic Medicine
HIV/AIDS Medical Care
1141 Gravenstein Hwy South
Sebastopol, Ca. 95472
Phone (707) 829-5455

August 20, 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

As a physician practicing medicine in Sonoma County, California, I strongly support your proposal to create a new payment locality for Sonoma County. The new locality would lessen the current disparity between practice expenses and Medicare reimbursements.

This disparity has adversely affected our local health care system for several years. In many cases, Medicare reimbursements don't cover expenses, and a significant number of local physicians, to assure the economic viability of their practices, have stopped taking Medicare patients. Over fifty physicians have simply left the county, impacting access to care. The disparity has also hampered efforts to recruit new physicians to Sonoma County. I have personally tried to recruit an associate for my practice for several years. Cost of living, housing costs, and insufficient reimbursement has deterred recruitment.

This disparity does not only affect Medicare patient care. In addition, many health insurance companies set their reimbursement rates using the Medicare rates as their baseline. As a result, several medical groups and our largest HMO organization, other than Kaiser, have gone bankrupt over the past 7 years from insufficient reimbursement issues.

By creating a new payment locality for Sonoma County, you will help ensure the viability of physician practices in the county and will 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 yours,

James F. Yusuf Q. Erskine D.O.
cc: Two copies attached.

August 22, 2005

Centers for Medicare & Medicaid Services

Department of Health and Human Services

Attention: CMS-1502-P

PO Box 8017

Baltimore, MD 21244-8017

Re: GPCIs

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

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

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

Sincerely,

Michael Kunkle

5425 Santa Teresa Ave.

Santa Rosa, CA 95409

cc: Two copies attached.

Santa Cruz Community Healthcare Network Corporation

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 to strongly support your proposed revision to physician payment localities in California recently published in the reference rule. I have written previously to express my concern about the viability of the health care system which serves our residents. The great difference between the cost of medical practice in Santa Cruz County as measured by GAF cost values and the low rate of reimbursement due to being assigned to Locality 99 has made recruitment and retention of physicians willing to serve Medicare beneficiaries very difficult.

I was 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 a unique locality. 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 proposed rule is fair. Neighboring counties to Santa Cruz and Sonoma have some of the highest payment levels for physicians in the nation. The adjustment you propose appropriately addresses this payment imbalance. This revision would bring you closer to your goal of reimbursing physicians based on the cost of practice in their locality.

Sincerely,

Alan Buchwald, M.D.
President

200 Camino Aquajito, Monterey, California, 93940
831-657-1600
www.communityhealthplan.org

111

AUG

August 22, 2005

Centers for Medicare & Medicaid Services

Department of Health and Human Services

Attention: CMS-1502-P

PO Box 8017

Baltimore, MD 21244-8017

Re: GPCIs

I understand that Medicare is proposing to create a new payment locality for Sonoma County, 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,

Kathy A. Kunkle

5425 Santa Teresa Ave.

Santa Rosa, CA 95409

cc: Two copies attached

August 23, 2005

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

RE: GPCIs

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

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

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

Sincerely,

James Pedroncelli

James Pedroncelli
Pedroncelli Winery
1220 Canyon Road
Geyserville, CA 95441

Cc: Two copies attached

Date: 8/24/05

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

Re: GPCIs

I understand that Medicare is proposing to create a new payment locality for Sonoma County, 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,

Name: PAUL L SMITH M.D.
Address: 1194 MONTGOMERY DR
City, State, ZIP SANTA ROSA, CA 95405

cc: Two copies attached

Date: 8/24/05

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

Re: GPCIs

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

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

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

Sincerely,

Name: SUSAN THOMAS
Address: 1958 ROBINSON LANE
City, State, ZIP SANTA ROSA, CA 95403

cc: Two copies attached.

AUG

JOSEPHINE F. LITTLE

8/23/05

I am thrilled that a proposal to change the Medicare map of Santa Cruz County (CA)from rural to urban has been made. The urbanization of the County that has occured during the last decade and especially during the last few years has resulted incredible high costs for housing. The result is that young doctors cannot afford to live here and that many older ones are moving away. Nearly 15% of the County's population is dependent on Medicare for health coverage. It is easy to see what great benefits the change will make. I sincerely hope that this proposal will be passed. Thank you for your consideration of this issue.

Sincerely,

Josephine F. Little

753 OAKHILL ROAD, APTOS, CA 95003

J & R
REALTY CO.

MAIN OFFICE
1320 Marshall Street
Redwood City, CA 94063
(415) 366-2495

MAILING ADDRESS
P. O. Box 2289
Aptos, CA 95001
(408) 662-1709

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

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

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

Sincerely,

Alan Buchwald
Director and CFO

Community Hospital of the Monterey Peninsula®

Innovative healthcare with a human touch

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**

To Whom It May Concern:

I am writing to comment on the Proposed Rule governing the Physician Fee Schedule Calendar Year 2006 as printed in the *Federal Register* of August 8, 2005.

I oppose the proposed removal of California's Santa Cruz and Sonoma counties from Medicare reimbursement Locality 99. Doing this does not address the problems of other counties within Locality 99 who suffer from significant cost disparities close to those of Santa Cruz and Sonoma counties. By proposing that these two counties be removed from Locality 99 into their own localities, exacerbates the problems of the remaining Locality 99 counties—especially those of Monterey, San Diego, and Santa Barbara.

I am also concerned that nowhere in the proposed rule is it mentioned that this "two-county fix" is the beginning of a greater effort to move all counties in the state and nation into payment localities that truly reflect their respective costs of providing medical services.

The Centers for Medicare & Medicaid Services should be responsible for calculating new Geographic Area Factors and Geographic Practice Costs Indices and making immediate locality adjustments to all counties exceeding the so-called "5% threshold".

Sincerely,

J. Allen Miller, MD

Post Office Box HH, Monterey, California 93942-1085 ▪ (831) 624-5311

BIG CREEK
"Growing Redwoods for the Future"

August 24, 2005

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

To Whom It May Concern:

As an employer in Santa Cruz County, California, I strongly support removing Sonoma and Santa Cruz Counties from CA Locality 99 and assigning them to their own localities, effective 01/01/2006, as recommended by the California Medical Association.

Sincerely,

Ellen M. Rinde
Human Resources Manager
Big Creek Lumber Company

August 24, 2005

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

RE: CPCIs

To Whom It May Concern:

I am writing in support of an increase in the Medicare reimbursement rate for Santa Cruz County physicians. Our county has changed considerably since my wife and I moved here in 1974. It has become a very expensive place to live and I feel so sorry for both our aging population and for those who would want to move into our area. Young doctors are having a difficult time staying in the area, resulting in too much turnover in our pool of doctors. This creates difficulties for those of us who are trying to survive in this high cost of living area. It does not make sense that doctors in Santa Clara County receive a higher reimbursement than those in Santa Cruz County when housing costs in Santa Cruz are higher. Your attention to this matter will be greatly appreciated.

Yours truly,

William J. Raffo
119 Burton Drive
Santa Cruz, CA 95065

AUG 2 3

5/24/05

120

GPCIs

Santa Cruz County Should not be Classified as a rual County.

Please Take use out of the 1960s and increase The Medi Care reimbursment To our Doctors based On The cost-of-living. Not some 40-yeanold deignation That has nothing To do with Ours cost of living.

For The last Three years I have had To find a new doctor who would Take Medican reimbursemt because of low Tremeut and They have To wait so long for payment They move To a better paying area. Please Change our Classification

Vandalia Wilke

1140 Susan Lane

Santa Cruz, CA.

95062

Sally Blumenthal-McGannon, RN, MA, MFT
823 Cathedral Drive, Aptos, CA., 95003
(831)685-4728 ♥ FAX (831)689-0430
e-mail breathesally@comcast.net

re GPCIs

Dear people at Center for MediCare and Medicaid Services,

I live in Santa Cruz County, California. I moved here in 1979 with my husband. I am a nurse and therapist and my husband is an Emergency Physician. Over the years we have witnessed many changes here, some good, others not so good.

Now we are facing life- threatening issues here in re to medical care. Services are decreasing as needs increase. Doctors are leaving and new physicians can't afford to move here to fill the medical need.

Reimbursement is a huge part of this problem. We are no longer a rural community. Just over the hill from us, in Santa Clara County, reimbursement is vastly greater.

The cost of living in Santa Cruz is becoming prohibitive for people to live or move here.

Many health care recipients are uninsured or covered by MediCare or MediCal. The level of reimbursement does not cover the costs of their care.

Please help us to continue to be a community of caring and healthy individuals. Allow our medical providers to be able to stay or recruit additional physicians. Please pay them a greater fraction of what they are worth.

Providing quality healthcare creates a healthier lifestyle for everyone involved and improves quality of life for everyone. It becomes a win-win situation.

Thank you for your time and understanding.

Medicare Proposal

AUG 2 9 2005

PLEASE INCREASE THE MEDICARE PAYMENT STATUS TO SONOMA AND SANTA CRUZ COUNTIES TO JOIN THE OTHER EIGHT COUNTIES IN THE SANFRANCISCO BAY AREA IN AN URBAN DESIGNATION. THIS PROPOSAL WILL INCREASE PHYSICIAN PAYMENTS BY TEN PERCENT AFTER A TEN YEAR FREEZE, THANK YOU FOR THIS CHANGE, WE ALL NEED IT.

RORERT FONTAINE
221 SEGER PL.
SANTA CRUZ, CA.
95060

IT IS RIDICULOUS TO CALL SANTA CRUZ COUNTY RURAL ANYMORE. PLEASE BE FAIR AND CHANE ITS DESIGNATION TO URBAN. WE NEED TO KEEP GOOD DOCTORS HERE, IT'S JUST THAT SIMPLE. OTHERWISE CHANGE ALL THE COUNTIES IN THE USA TO RURAL. AT LEAST THAT WOULD ELIMINATE THE CURRENT DISCRIMINATION. THEN YOU WOULD HAVE THE WHOLE NATION PROTESTING!

ANN HARRIS

8-21-05

CENTER FOR MEDICARE & MEDICAID SERVICES.

TO WHOM IT MAY CONCERN:

PLEASE APPROVE THE CHANGE OF STATUS FOR SANTA CRUZ COUNTY, CALIF. FROM RURAL TO URBAN. THANK YOU. IT IS ONLY FAIR.

DRIVE ON OUR FREEWAY AND YOU CAN OBVIOUSLY SEE WE ARE URBAN (AND "SPRAWL") I HAVE BEEN HERE 35 YEARS AND IT HAS BEEN URBAN ALL THAT TIME. WHEN I BECAME A "MEDICARE" RETIREE AND BOUGHT A SUPPLEMENT, SECURE HORIZONS, IT COST $25 A MONTH HERE AND "0" IN SANTA CLARA COUNTY. IT WENT UP TO $99 A MONTH, CURRENTLY IT IS $65. ON TOP OF THAT EVERYTHING COSTS MORE HERE IN SANTA CRUZ COUNTY AS COMPARED TO SANTA CLARA COUNTY WHICH IS AJACENT TO US. ON TOP OF THAT SALARIES HERE HAVE ALWAYS BEEN LESS, THUS MY TEACHER RETIREMENT SALARY IS LESS BECAUSE IT IS BASED ON THE SALARY I RECEIVED HERE.

ALAN BUCHWALD, M.D., INC.
Medical Toxicology, Emergency Medicine and Occupational Medicine
DIPLOMATE AMERICAN BOARD OF MEDICAL TOXICOLOGY
DIPLOMATE AMERICAN BOARD OF EMERGENCY MEDICINE

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 to strongly support your proposed revision to physician payment localities in California recently published in the reference rule. I have written previously to express my concern about the viability of the health care system which serves our residents. The great difference between the cost of medical practice in Santa Cruz County as measured by GAF cost values and the low rate of reimbursement due to being assigned to Locality 99 has made recruitment and retention of physicians willing to serve Medicare beneficiaries very difficult.

I was 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 a unique locality. 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 proposed rule is fair. Neighboring counties to Santa Cruz and Sonoma have some of the highest payment levels for physicians in the nation. The adjustment you propose appropriately addresses this payment imbalance. This revision would bring you closer to your goal of reimbursing physicians based on the cost of practice in their locality.

Sincerely,

Alan Buchwald, M.D.
Past President, Santa Cruz County Medical Society

P.O. Box 2009 • Santa Cruz, CA 95063-2009 • (831) 761-0260

UNIVERSITY of VIRGINIA HEALTH SYSTEM

Department of Anesthesiology
Victor C. Baum, M.D.
Professor of Anesthesiology and Pediatrics
Executive Vice Chair, Dept. of Anesthesiology
Director, Cardiac Anesthesia

AUG 29 2005 125

August 21, 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

Sirs:

I am writing concerning the CMS anesthesiology teaching rule. I am sure that CMS will receive a variety of letters attesting to the rather odd capriciousness of the rule, such that teaching surgeons are reimbursed fully for covering two simultaneous rooms, but teaching anesthesiologists are reimbursed at half the usual rate. I am not one of those letter writers who dashes off an impassioned letter every time a request from some group crosses my desk. Let me, however, relate how this rule, combined with continuing limitations in Medicare reimbursement, has impacted my Department.

It is becoming more and more difficult to recruit faculty into academic departments. This is even worse when trying to recruit subspecialists (I speak as a subspecialist who does cardiac and pediatric anesthesia). When I entered the field, went to a national meeting and ran into an acquaintance, the first words were always social: "How are you, what have you been doing"? I can tell you that over the past few years the first comments have been almost uniformly "Do you know anyone [who is looking for a job]"? The answer is never "yes". We don't know of anyone, and if we did we'd hire them ourselves.

It is harder and harder to attract residents to academic anesthesiology. I have taken some masochistic pleasure more than once over the past few years in pointing out that our worst graduating resident has taken a position that would double my salary. It's hard to compete. We recruit every potential faculty applicant like they are a potential Nobel Prize winner, or maybe Heisman trophy winner, they are so golden. We have a strong academic department with a long history of outstanding faculty recruitment. I can only imagine what other departments are doing.

I urge you to reconsider modifying this rule.

Sincerely,

V. Baum

Victor C. Baum, M.D.
Professor of Anesthesiology and Pediatrics
Executive Vice Chair, Dept. of Anesthesiology

University of Virginia Health System, Box 800710 • Charlottesville, VA 22908-0710
Office: (434) 982-3889 • *Fax:* 434-982-0019 • *email:* vbaum@virginia.edu

126

AUG 29 2005

Date: August 21, 2005
To: Centers for Medicare and Medicaid Services
From: Tricia Pockey
Re: **TEACHING ANESTHESIOLOGISTS RULE**

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

Anesthesiology teaching programs are suffering severe economic losses that cannot be absorbed elsewhere. Academic research in anesthesiology is increasingly difficult to [illegible], as department budgets are broken by this arbitrary Medicare payment reduction.

The CMS anesthesiology teaching rule must be changed to allow academic departments to cover their costs. Please recognize the unique delivery of anesthesiology care and pay Medicare teaching anesthesiologists on par with their surgical colleagues.

Sincerely,

Tricia Pockey
Resident in Anesthesiology
Weill Cornell Medical College
New York Presbyterian Hospital

750 East Adams Street
Syracuse, NY 13210

Office of the Executive Director

127

Tel: 315.464.4223
Fax: 315.464.4233

www.universityhospital.org

SUNY Upstate Medical University

UniversityHospital

MEDICINE AT ITS BEST®

August 19, 2005

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

Dear Sir or Madam:

I am writing to you as the Interim Executive Director of SUNY Upstate Medical University Hospital in Syracuse NY to express my concern that the ***Proposed Rule for the 2006 Physician Fee Schedule*** does not include a correction of the discriminatory policy of paying teaching anesthesiologists only 50% of the fee for each of two concurrent resident cases.

Upstate Medical University Hospital is a teaching institution providing primary, secondary and tertiary care to a 17 county region in central New York State. Approximately 40% of our patients use Medicare as their primary insurance carrier. Data from the US Census Bureau reveal that in the year 2000, the number of people in the US greater than 65 years of age was 35 million, representing a 12% increase over 1990. It is projected that by 2025, the portion of the US population over age 65 will increase by a staggering 80%!! Our elderly population requires an increasing amount of health care to maintain quality of life. An ever growing number of patients over 65 years of age present for surgery, many of them to teaching hospitals such as ours. In 2004, Upstate University Hospital provided excellent anesthesia care to 2,700 Medicare patients.

Unfortunately, although we anticipate seeing an increase in the number of elderly patients in our operating rooms, there is currently a short fall nationally in the number of practicing anesthesiologists, and anesthesiology training programs are not able to train adequate numbers of physicians to meet the projected future need. Economic factors force salaries for teaching anesthesiologists to be less than those for anesthesiologists in the private sector, so attracting faculty to train the next generation is problematic. In fact, we currently have four (4) open faculty positions. The Medicare anesthesia conversion factor is less than 40% of the prevailing

commercial rates. Reducing that amount by another 50% for providing medical direction concurrently to two residents results in revenue stream which is grossly inadequate to cover faculty salaries.

At Upstate University Hospital, residents are involved in the care of all patients. The residents gain the experience they need to practice state of the art anesthesia upon completion of their residency and our elders receive cutting edge care. In 2/3 of the cases, a faculty anesthesiologist provides concurrent care to a second case for a portion of time. It is estimated that as a result of the discriminatory concurrency policy, the Upstate Department of Anesthesia will lose almost $300,000 in revenue. This clearly places an unfair burden on the anesthesiologist and the hospital.

It is important to note that surgeons are permitted to supervise residents performing two (2) overlapping surgical procedures and collect 100% of their fee for each case from Medicare. While internal medicine physicians can supervise residents in four (4) overlapping outpatient visits and collect 100% of the fee for each visit.

Reducing a teaching anesthesiologist's fee by 50% is neither fair nor reasonable. Failure to promptly correct this discriminatory policy will hinder the recruitment of anesthesiologists to the teaching hospitals and, in turn, adversely affect the training of residents in anesthesiology.

We can not afford to jeopardize the future care of our senior citizens by creating a shortage of well trained anesthesiologists. I, therefore, ask for your support in correcting the discriminatory policy of paying teaching anesthesiologists only 50% of the bill for each of two concurrent resident cases.

Sincerely,

Phillip S. Schaengold, JD
Interim Executive Director
University Hospital
SUNY Upstate Medical University
750 E. Adams Street
Syracuse, New York 13210

Cc: Congressman James Walsh
Senator Charles Schumer
Senator Hillary Rodham Clinton
American Society of Anesthesiologists, Washington Office
Colleen O'Leary, MD

STANFORD UNIVERSITY SCHOOL OF MEDICINE
Department of Anesthesia • Stanford, California 94305-5640

John G. Brock-Utne MA, MB, BCh, (TCD) MD Ph.D. (Bergen) FFA (SA)
Professor of Anesthesia

Tel (650) 723-6411
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Email: brockutn@stanford.edu

August 21, 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 Anesthesiologist". Why are we been treated so unfairly?

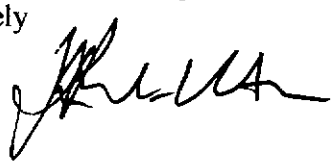
I am writing to ask for your strong support for the revision of the Medicare Physician payment rule, as applied to academic anesthesiology programs. The present payment schedule from Medicare is preventing academic anesthesiologist to pursue their mission, namely clinical service to all US citizens, training of future US anesthesiologist, and research. The latter is important as good clinical care requires good research to show that one technique is better than another. Without research we will be staying in the same place and even go backwards in our ability to provide good clinical care.

I ask you why it is that my surgical colleagues can supervise TWO overlapping cases and my internist colleagues can supervise FOUR concurrent outpatients visits and each receive 100% of the Medicare fee for each case? For anesthesiologist in academic practice, 50% of the funds are taken from us when we provide concurrent services to surgical cases. Why should that be? Are we so unimportant? The tragedy of this situation is that academic anesthesiologist is not recognized for the skill and the unique care and teaching that goes into taking care of the elderly. But maybe worse than that is the fact that less and less residents that finish their residency in anesthesiology choose to go into academic medicine. Why because the anesthetic departments are going broke with this unfair rule which makes us very uncompetitive in the market place for these young people. Who can blame them not going into academic anesthesiology?

So the ball is in your court. Do you want to have academic anesthesiology departments survive then you must strongly support the revision of the Medicare Physician payment rule as it applies to academic anesthesiology programs.

I will be happy to talk to you or anybody about this at any time and anywhere. As this is essential for the survival not only for academic anesthesiology departments but for all academic medicine. Why? Anesthesiologist provide more and more services all over the hospital. I don't think our senior citizens will like to go back to a situation during the civil war when there was no anesthesia. You may think this is ridiculous but I am in the frontline training anesthesiologist , something I have done for over 30 years, I see the recruitment to academic anesthesiology has gone to virtually nothing. If this is what is wanted, well you are getting it.

Yours sincerely



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UT SOUTHWESTERN
MEDICAL CENTER

William E. Johnston, M.D.
Professor and Chairman
Margaret Milam McDermott Distinguished Chair
in Anesthesiology and Pain Management

August 22, 2005

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

Attention: CMS-1502-P

Re: TEACHING ANESTHESIOLOGISTS

TO WHOM IT MAY CONCERN:

This letter is in response to the recent CMS decision regarding the anesthesia teaching payment policy in the proposed rule changes for the 2006 Medicare Fee Schedules. As a teaching anesthesiologist and chairman of a department of anesthesiology, I feel compelled to write and express my view.

The current policy whereby teaching anesthesiologists are paid only 50% of the fee for two concurrent resident cases is clearly unfair, unsustainable and discriminatory. It is essential in order to provide quality medical care and patient safety to an increasingly elderly Medicare population to recruit and train new physicians in Anesthesiology. Because of chronic underpayment from CMS for concurrent resident cases, academic centers with teaching anesthesiologists are threatened and unable to cover our expenses. As a consequence, academic research in anesthesiology is markedly decreasing since all effort must be redirected to the clinical arena.

A surgeon can supervise residents in two overlapping operations and collect 100% of the fee for each case from Medicare. An internist can supervise residents in four overlapping outpatient visits and collect 100% of the fee for each patient. However, an anesthesiologist can only collect 50% of Medicare fee when supervising two anesthesiology residents in cases. Why is there such a blatant discrepancy? The current policy is unfair, unreasonable, and clearly discriminatory. Medicare must realize the unique delivery of anesthesiology care and pay teaching anesthesiologists on par with our surgical colleagues. Already the Medicare anesthesia conversion factor is less than 40% of prevailing commercial rates and a further 50% reduction for teaching anesthesiologists will insure our inability to sustain the service, teaching, and research missions of academic anesthesia training programs. The current policy will help make anesthesia training programs extinct.

5323 Harry Hines Blvd. / Dallas, Texas 75390-9068 / (214) 648-5413 Telefax (214) 648-5461 / william.johnston@utsouthwestern.edu
www.utsouthwestern.edu

Your immediate assistance to address and correct this problem is requested. Thank you for your attention to this matter.

Sincerely,

William E. Johnston, M.D.
Professor and Chairman

WEJ:jcc

cc: American Society of Anesthesiologists
1101 Vermont Avenue, N.W.
Suite 606
Washington, D.C. 20005

August 10, 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 Colleagues,

It has come to my attention that Medicare is considering changing the teaching physician policy for anesthesiologists. As a member of the American Association of Nurse Anesthetists (AANA), I have significant concerns with any changes that would create further inequities in how the Medicare system treats teaching Certified Registered Nurse Anesthetists (CRNAs) and anesthesiologists, and, more importantly, present possible negative impacts on Medicare beneficiaries' access to safe anesthesia care.

CMS has already twice rejected a proposal to change the anesthesia teaching rules so that teaching anesthesiologists would be paid a full fee for each of two overlapping cases involving medical residents, a manner similar to certain teaching surgeons. Such a proposal provides major new incentives to teach anesthesiology residents, and severe disincentives to teach nurse anesthetists, and is not based on a consensus process that treats both nurse anesthetists and anesthesiologists equally.

I appreciate that Medicare is considering its options on this important policy issue. Nurse anesthesia is a success story. With anesthesia 50 times safer than 20 years ago, CRNAs' patient safety record is shown to be indistinguishable from that of physicians providing anesthesia. CRNAs assure patients access to safe anesthesia care, and predominate in rural and medically underserved America and the Armed Forces. Further, it has been shown CRNAs are educated more cost-effectively than are our colleagues and competitors. Yet, while Medicare Direct GME payments to residents and medical direction payment rules already discriminate against educating CRNAs, the nurse anesthesia profession has been successful at increasing the number of accredited educational programs and graduates to meet growing demand for safe anesthesia care for patients. Thus, changing the anesthesia teaching rules to further dramatically favor one type of anesthesia provider over another creates negative impacts against educating safe anesthesia providers such as CRNAs, harming the healthcare system and patients' access to healthcare services.

So that patients anywhere in the country will continue to have access to the safe anesthesia care that they need, I am requesting that CMS work with both nurse anesthetists and anesthesiologists in developing a consensus proposal to address issues in the anesthesia teaching rules.

Sincerely,

Signature

Print name: JAMES R. HALLIBURTON, CRNA, DNSc

Street address: 1951 CHESTERFIELD RIDGE CIRCLE

City/State/ Zip: CHESTERFIELD, MO. 63017

Bob Halliburton, CRNA, DNSc
1951 Chesterfield Ridge Circle
Chesterfield, MO 63017

9200 West Wisconsin Avenue
Milwaukee, WI 53226-3596

William D. Petasnick
President & Chief Executive Officer

Froedtert HOSPITAL
Froedtert & Community Health

414/805-2606 Tel
414/805-7955 Fax
wpetasni@fmlh.edu

August 18, 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: CMS-1502-P "TEACHING ANESTHESIOLOGISTS"

Dear CMS Administrators:

I am the President and Chief Executive Officer of Froedtert Memorial Lutheran Hospital, the major teaching hospital affiliated with the Medical College of Wisconsin. I am also the former chair of the Council of Teaching Hospitals of the Association of American Medical Colleges. I have been asked by the Chairperson of Anesthesiology to provide my comments to you regarding the Medicare Anesthesiology Teaching Payment Rule. I want you to know that this is a critical issue for our Anesthesiology Department and Hospital, and I believe revisions to the Policy are essential.

Quality medical care, patient safety, and an increasing elderly Medicare population requires that the United States have a pool of physicians trained in the subspecialty of anesthesiology. Anesthesiology residencies in the United States have gone unfilled, and there are faculty openings in many departments (including our own) because academic physician compensation is considerably less than that in the surrounding private community. In fact, our hospital subsidizes the department of Anesthesiology and part of the reason for this is because of inadequate reimbursement from Medicare due to the Anesthesiology Teaching Payment Rule. Anesthesiologists supervising two residents are reimbursed at 50%. This is of some interest in that the supervision of two residents in surgery by their faculty is reimbursed at 100%. An internist may supervise residents in four overlapping outpatient visits and collect 100% of the fee. Somehow these examples seem incongruous and unfair. The economic losses that the Anesthesiology Teaching Payment Rule creates are absorbed elsewhere, including through my hospital's subsidization of the department.

I believe that the Medicare Payment Rule should be changed and that reimbursement of teaching anesthesiologists should be on par with their surgical colleagues. This is more critical than ever as the demographics of our surgical population include more elderly each year. The Medicare Payment Rule threatens the existence of teaching programs in the United States.

Sincerely,

William D. Petasnick
President and CEO

August 10, 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 Colleagues,

It has come to my attention that Medicare is considering changing the teaching physician policy for anesthesiologists. As a member of the American Association of Nurse Anesthetists (AANA), I have significant concerns with any changes that would create further inequities in how the Medicare system treats teaching Certified Registered Nurse Anesthetists (CRNAs) and anesthesiologists, and, more importantly, present possible negative impacts on Medicare beneficiaries' access to safe anesthesia care.

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I appreciate that Medicare is considering its options on this important policy issue. Nurse anesthesia is a success story. With anesthesia 50 times safer than 20 years ago, CRNAs' patient safety record is shown to be indistinguishable from that of physicians providing anesthesia. CRNAs assure patients access to safe anesthesia care, and predominate in rural and medically underserved America and the Armed Forces. Further, it has been shown CRNAs are educated more cost-effectively than are our colleagues and competitors. Yet, while Medicare Direct GME payments to residents and medical direction payment rules already discriminate against educating CRNAs, the nurse anesthesia profession has been successful at increasing the number of accredited educational programs and graduates to meet growing demand for safe anesthesia care for patients. Thus, changing the anesthesia teaching rules to further dramatically favor one type of anesthesia provider over another creates negative impacts against educating safe anesthesia providers such as CRNAs, harming the healthcare system and patients' access to healthcare services.

So that patients anywhere in the country will continue to have access to the safe anesthesia care that they need, I am requesting that CMS work with both nurse anesthetists and anesthesiologists in developing a consensus proposal to address issues in the anesthesia teaching rules.

Sincerely,

Scott Pearson
Signature

Print name: Scott Pearson
Street address: 1721 Fern Ave.
City/State/ Zip: Windber PA, 15963

August 10, 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 Colleagues,

It has come to my attention that Medicare is considering changing the teaching physician policy for anesthesiologists. As a member of the American Association of Nurse Anesthetists (AANA), I have significant concerns with any changes that would create further inequities in how the Medicare system treats teaching Certified Registered Nurse Anesthetists (CRNAs) and anesthesiologists, and, more importantly, present possible negative impacts on Medicare beneficiaries' access to safe anesthesia care.

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So that patients anywhere in the country will continue to have access to the safe anesthesia care that they need, I am requesting that CMS work with both nurse anesthetists and anesthesiologists in developing a consensus proposal to address issues in the anesthesia teaching rules.

Sincerely,

Dennis P. Smith CRNA, BSN
Signature

Print name: Dennis P. Smith
Street address: 30 Eastfield Dr.
City/State/ Zip: Lebanon, Pa. 17042

INDIANA UNIVERSITY

SCHOOL OF MEDICINE

August 8, 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

In reference to: TEACHING ANESTHESIOLOGISTS'

To Whom It May Concern:

I have been a faculty member of the Department of Anesthesia of Indiana University School of Medicine for 18 years. During this time, I have cared for some of the most critically ill patients in the state and have helped to train the next generation of anesthesiologists. We are the only anesthesia residency program in the state, and roughly three quarters of the anesthesiologists practicing in Indiana were trained by our program.

Over the years, I have witnessed a steady decline in the health of academic anesthesia to the point that something must now be done. The financial health of these programs is poor due to the low levels of reimbursement. Teaching institutions shoulder the lion's share of Medicaid patients and are also penalized by concurrency rules for their care of Medicare patients. The income of teaching anesthesiologists across the United States averages at 50-60% of that of anesthesiologists in private practice despite comparable work hours and the added responsibilities of teaching young physicians. This has driven many anesthesiologists out of the academic setting into private practice. The result has been the closure of several residency programs in recent years. At the same time, there continues to be a national shortage of anesthesiologists coupled with a growing demand for their services fueled by our aging population.

This serious situation would be greatly helped by the elimination of the concurrency rules for teaching anesthesiologists which reduce payment when an anesthesiologist supervises more than one resident. No other acute care physician is penalized in such a way. For example, if a surgeon performs an operation with residents in one operating room (and is present for all the key parts of the procedure), then begins surgery on a second patient (while the residents finish the first procedure), the surgeon is paid his or her 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 including 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

I am appealing to you to correct this discriminatory and detrimental policy.

Sincerely,

Robert G. Presson, Jr., M.D.
Professor

DEPARTMENT OF ANESTHESIA

SECTION OF PEDIATRIC ANESTHESIA AND CRITICAL CARE

Riley Hospital for Children
Room 2001
702 Barnhill Drive
Indianapolis, Indiana
46202-5200

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317-274-8222
Fax: 317-274-0282

135

MOUNT SINAI
SCHOOL OF
MEDICINE
NEW YORK

One Gustave L. Levy Place
Box 1010
New York, NY 10029-6574

David L. Reich, MD
Horace W. Goldsmith Professor and Chair
Department of Anesthesiology

Phone (212) 241-8392
Fax (212) 876-3906
Email: david.reich@mountsinai.org

August 25, 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 21244-1850
http://www.cms.hhs.gov/regulations/ecomments

RE: File Code CMS-1502-P; "TEACHING ANESTHESIOLOGISTS"

Dear Sir or Madam:

As the Chair of the Department of Anesthesiology at the Mount Sinai School of Medicine in New York, NY, I have followed CMS policy regarding teaching anesthesiologists and wish to express very strongly that CMS policy must recognize the vital contributions of academic anesthesiology. The current reimbursement to teaching anesthesiologists is grossly unfair and has caused substantial damage to the profession of anesthesiology.

As a longtime academic anesthesiologist, I have observed a nationwide decrease in the academic productivity of the profession that coincided with the adoption of the current teaching anesthesiologist reimbursement policy. We were forced to strictly limit and often eliminate protected non-clinical time, and clinical anesthesia research has decrease concomitantly. Currently, we have 45 ACGME-approved anesthesiology resident slots and care for approximately 36,000 patients per year in the Mount Sinai system. With 29% of these patients in the Medicare program, I have severe fiscal limitations attributable to the teaching anesthesiologist policy. You must act promptly to reverse this illogical and destructive policy for the following reasons:

- The current Medicare teaching anesthesiologist payment rule is unwise, unfair and unsustainable.
- Quality medical care, patient safety and an increasingly elderly Medicare population demand that the United States have a stable and growing pool of physicians trained in anesthesiology.
- Anesthesiology teaching programs 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 drying up as department budgets are broken by this arbitrary Medicare payment reduction.
- A surgeon may supervise residents in two overlapping operations and collect 100% of the fee for each case from Medicare. An internist may supervise residents in four overlapping outpatient visits and collect 100% of the fee for each when certain requirements are met. A teaching anesthesiologist will only collect 50% of the Medicare fee if he or she supervises residents in two overlapping cases. This is not fair, and Medicare must recognize the unique delivery of anesthesiology care and pay Medicare teaching anesthesiologists on par with their surgical and other physician colleagues.

MOUNT SINAI
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One Gustave L. Levy Place
Box 1010
New York, NY 10029-6574

David L. Reich, MD
Horace W. Goldsmith Professor and Chair
Department of Anesthesiology

Phone (212) 241-8392
Fax (212) 876-3906
Email: david.reich@mountsinai.org

- 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.

While many certified registered nurse anesthetists (CRNA) oppose changes in the teaching rule policy, their reasons are solely political and indicate an agenda that discourages physician anesthesia trainee education. It is extraordinarily unfortunate that our nursing anesthesia colleagues oppose us in this dialogue, but we must see the overriding issue clearly. It is only by nurturing academic physician anesthesiologists that we will continue the remarkable advances in anesthesia patient safety that have been achieved over the last fifty years. Let us be clear that academic anesthesiologists were the root cause of these benefits to the Medicare population, and that anyone that seeks to hurt academic anesthesiology is short-sighted and an enemy of advancing patient safety and quality of care for the American public as a whole.

In conclusion, it is absolutely critical for the long-term health of the Medicare population that academic anesthesiology repair some of the damage that has been caused by unfair teaching anesthesiologist reimbursement. I am confident that you will make the correct decision in this matter.

Sincerely yours,

David L. Reich, M.D.
Horace W. Goldsmith Professor and Chair
Department of Anesthesiology

cc: Hon. Hillary Rodham Clinton
Hon. Charles Schumer
Hon. Jerome Nadler
Hon. Carolyn Maloney

INDIANA UNIVERSITY

SCHOOL OF MEDICINE

DEPARTMENT OF ANESTHESIA

SECTION OF PEDIATRIC ANESTHESIA AND CRITICAL CARE

Riley Hospital for Children
Room 2001
702 Barnhill Drive
Indianapolis, Indiana
46202-5200

317-274-9981
317-274-8222
Fax: 317-274-0282

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

In reference to: TEACHING ANESTHESIOLOGISTS'

To Whom It May Concern:

I write to you as an attending anesthesiologist and critical care practitioner, who specializes in the care of pediatric patients at Riley Hospital for Children in Indianapolis, Indiana. I am also a clinical professor of anesthesia at Indiana University School of Medicine. Academic anesthesiology departments such as ours are responsible for teaching medical students, resident physicians, nurses, paramedics, and oral surgeons to take care of tomorrow's patients. The IUSOM anesthesia department is the only anesthesia residency in the state. This department also has fellowships in pain and pediatric anesthesia.

There is a CRITICAL problem facing every academic anesthesiology department in the United States. Medicare/Medicaid treats teaching anesthesiologists (those of us who work with resident physicians) in a VERY different way from teaching physicians in other fields (including surgery, emergency medicine, and internal medicine). Specifically, if a surgeon performs an operation with residents in one operating room (and is present for all the key parts of the procedure), then begins surgery on a second patient (while the residents finish the first procedure), the surgeon is paid his or her full surgical fee for both patients. Teaching anesthesiologists are treated differently. Medicare/Medicaid reduces the fee paid to teaching anesthesiologists if the teaching anesthesiologist is covering more than one resident, even though NO OTHER acute care physician is treated this way! This rule is UNWISE and UNFAIR. This rule will ultimately lead to a continuing shortage of anesthesiologists, to the detriment of American patients.

Academic anesthesiology departments are generally in poor financial shape in the United States. Despite a continuing national shortage of anesthesiologists, several anesthesiology residency programs have closed in recent years. The income of teaching anesthesiologists across the United States averages at 50-60% of that of anesthesiologists in private practice, despite comparable hours and the added responsibilities of teaching young physicians. There is no reason for Medicare/Medicaid to add to our financial troubles. AND, for those of us in the pediatric world, with a high percentage of our patient population involved with MEDICAID, it is EVEN WORSE due to the painfully low amount of reimbursement this organization pays prior to cutting the payment in half due to concurrency rules. In some cases we are paying for the privilege to treat patients. It is becoming increasingly difficult to retain and attract physicians to continue the work that we do to train the next generation of practitioners. I fear the quality of care WILL suffer due to not being able to have the best and brightest in academics. Would you take on additional tasks or responsibilities if you did not have to do so? And if you would, would you do it for 50-60 % less than someone without the added responsibility? I do not believe many would, BUT that is what we as academic anesthesiologists have chosen to do because of dedication to education. Medicare/Medicaid punishes us for our commitment.

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

Sincerely,

Brandon T. Kibby, D.O.
Assistant Professor of Clinical Anesthesia
Indiana University School of Medicine Department of Anesthesia
Section of Pediatric Anesthesia and Critical Care
Riley Hospital for Children

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Estado Libre Asociado de Puerto Rico
Departamento de Salud

Oficina de Reglamentación y Certificación
de los Profesionales de la Salud

August 8, 2005

Mr. (Ms.) McClellean
Center for Medicare and Medicaid Services
Department for Health and Human Services
PO Box 8012
Baltimore, MD 21244-8012

Dear. Mr. (Ms.) McClellan:

The Puerto Rico Board of Physical Therapy Examiners support CMS for emitting a final regulation that established the standards for qualifications and administration for the individuals that provide Physical Therapy services to Medicare beneficiaries in offices owned by doctors.

Our Board supports the federal regulation that establishes the reimbursement of incidental Physical Therapy services to the medical professional services, only if the professional that offers the service upholds the standards and conditions that apply to physical therapy ambulatory services offered by a Physical Therapist, or by a Physical Therapy Assistant, under the direct supervision of the first one.

This federal regulation is in agreement with Law 114, of June 29, 1962, as it was amended, which regulates the practice of Physical Therapy in Puerto Rico.

This Act establishes that the Physical Therapy Assistant work under the direct supervision of the Physical Therapist. In some medical offices, where physical therapy services are offered by incidental professional medical service, the supervision of the Physical Therapy Assistant is being performed by the doctor, who is not authorized by Law 114. It's important to point out that the academic preparation of the Physical Therapy Assistant gives him/her the ability to assist the Physical Therapist in the application of some modalities and therapeutic procedures delegated by the Physical Therapist. This implies that when the doctor employs the Physical Therapy Assistant without the direct supervision of the Physical Therapist and mostly when the doctor pretends to supervise the Physical Therapy Assistant, he/she is depriving the patient from receiving a complete treatment, because the Physical Therapy Assistant is not authorized by law to practice all the modalities, and procedures which represents a full physical therapy service. This practice, besides affecting the quality and effectiveness of physical therapy service, adversely affects the components of security, economics, and free selection for the service consumer.

Our Board recognizes that this federal regulation is an achievement that will guarantee that the beneficiaries of Medicare in Puerto Rico will receive the Physical Therapy service that they deserve.

Cordially,

Lourdes R. Torres-Olmeda, M.A., T.F.L.
President
Puerto Rico Board of Physical Therapy Examiners

/jfl

Puerto Rico Board of Physical Therapy Examiners
Po Box 10200 Santurce, P.R. 00908-0200 Tel. (787) 725-8161 Fax (787) 725-7903 mbouet@salud

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Dennis L. Padget, MBA, CPA, FHFMA
President
ThePathAdvocate@bellsouth.net (email)

Ref: Comment_ProposedRule_2006MCarePhyFeeSchedule_Filed082505.doc

25 August 2005

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

Re: File Code CMS-1502-P
Medicare program; proposed revisions to payment policies under the physician fee schedule for calendar year 2006

Dear Sir or Madam:

This letter comments on the proposed rule by the U.S. Dept. of Health and Human Services' Centers for Medicare & Medicaid Services (CMS) published in the 8 August 2005 *Federal Register* entitled "Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule for Calendar Year 2006; Proposed Rule" (file code CMS-1502-P). I respectfully ask that you consider the comments and suggestions below when developing the final rule.

1. **Missing Practice Expense RVU for Codes 99241-99245 (Facility Column):** Addendum B lists codes 99241-99245 pertaining to office and other outpatient consultations, which includes hospital outpatient and emergency department settings according to *CPT 2005*. All five codes are active and valid for Medicare Part B payment to physicians and suppliers (Addendum B status indicator is A). Each has a nonzero relative value in the physician work, nonfacility practice expense, and malpractice expense columns.

What's unexpected is that none of the codes has a relative value in the facility practice expense or the facility total column: An 'NA' (not applicable) appears in those two columns for all five codes. This is a change compared to the 2000-2005 construction: In those six fee schedules, all five codes had a nonzero relative value in both the facility and nonfacility practice expense and total columns.

The preamble and the explanatory material accompanying Addendum B in the 8 August 2005 proposed rule offer no insight as to why the facility practice expense relative values may have been deleted for codes 99241-99245 for calendar year 2006. I can't help but believe this is an error or an oversight: Evaluation and management consultations by physicians are performed in hospital and related facility outpatient settings on a regular and ongoing basis, and nothing has changed in Medicare law or regulation that makes these services noncovered in a facility outpatient setting starting in 2006. I also note that the basic office visit codes (99201-99215) still have a nonzero relative value in the facility and nonfacility columns of Addendum B of the

proposed rule, which is further evidence that the 'NA' in the facility practice expense column for codes 99241-99245 is in error, given the kinship between the two code series.

I respectfully ask that an appropriate nonzero relative value be included in the Addendum B facility practice expense column for each code in the 99241-99245 series in the final rule for calendar year 2006. Alternatively, please explain in detail in the final rule why physicians can no longer use those codes for initial consultations for hospital and related facility patients that occur on an outpatient basis; additionally, please explain what alternate code(s) physicians should report to obtain payment for such services in the subject settings in calendar year 2006.

2. **Expanded Pub. 100-4, Chapter 12, §60E List Required:** Last year in my 20 Sept. 2004 comments on the then proposed rule for the 2005 Medicare physician fee schedule (file code CMS-1429-P), I asked CMS to formally recognize two new CPT codes that implicated the clinical laboratory test interpretive service provisions of 42 CFR 415.130(b)(4). The two codes are 84166, *Protein, electrophoretic fractionation and quantitation; other fluids with concentration (eg, urine, CSF)*, and 86335, *Immunofixation electrophoresis; other fluids with concentration (eg, urine, CSF)*. The text of my comment from 20 Sept. 2004 is enclosed as Attachment 1.

To assure that timely payment to pathologists would not be disrupted by the addition to CPT of the cited two codes, two things had to happen: (a) codes 8416626 and 8633526 with appropriate RVU values had to be added to the 2005 physician fee schedule; and (b) the "presumptive list" test table published at §60E, chapter 12, of the *Medicare Claims Processing Manual* (CMS IOM Pub. 100-4) had to be updated. The first action was taken by CMS: the final rule in November 2004 properly included both codes. However, the second action has yet to be taken by CMS, and practitioners here-and-there in the country report they're still being denied rightful payment for the subject interpretive services as a result.

According to testimony given at the 18 July 2005 public meeting held by CMS to gather input on "Payment for New Clinical Laboratory Tests for 2006," several new lab test codes are being added to *CPT 2006*. Four of these codes pertain to tests that are or may be interpreted and reported by a pathologist under circumstances anticipated by §60E, chapter 12, of the MCPM. They are identified below, using the descriptive information provided by CMS for the 18 July 2005 public meeting (the formal 2006 codes haven't been released to the general public yet).

8370x	Lipoprotein, blood; electrophoretic separation and quantitation
8370x	high resolution fractionation and quantitation of lipoproteins including subclasses when performed (eg, electrophoresis, ultra centrifugation)
8370x	quantification of lipoprotein particle numbers and lipoprotein particle subclasses (eg, by nuclear magnetic resonance spectroscopy)
8720x	Smear, primary source with interpretation; complex special stain (eg, trichrome, iron hematoxylin) for ova and parasites

I respectfully ask CMS to add the formal CPT version of each of these four codes to the final 2006 Medicare physician fee schedule. Only a physician professional component (modifier 26) line is needed in Addendum B for each test, because the technical component is payable to hospitals, independent labs, and related suppliers via the Medicare clinical laboratory test fee

schedule. The physician work, facility and nonfacility practice expense, and malpractice RVU values for the three 8370x codes will be appropriately crosswalked from code 8416526. The physician work, facility and nonfacility practice expense, and malpractice RVU value for code 8720x will be appropriately crosswalked from code 8831226, as that is the code the AMA now says to bill for physician interpretation of a complex special stain for microorganisms.

In addition, I respectfully ask CMS to act promptly to add the formal CPT version of each of these four codes, plus codes 84166 and 86335 carried over from the calendar year 2005 update, to the "presumptive list" table that's part of §60E, chapter 12, of the MCPM (CMS IOM Pub. 100-4). Experience in 2005 indicates having a 26-modified code in Addendum B of the Medicare physician fee schedule isn't sufficient: Some carriers won't pay a pathologist's professional fee for a clinical laboratory test interpretive service unless the test code is among those listed in the §60E table. The update will ideally be published via formal change request prior to 1 Jan. 2006.

3. **Status of HCPCS Level II Codes D0472-D0999:** HCPCS Level II codes D0472-D0999 are classified as dental procedures, even though they describe basic anatomic pathology procedures such as microscopic examination of tissue slides and cytology smears, decalcifications, and special stains. These items fundamentally duplicate procedures described by CPT codes in the 88104-88199 and 88300-88399 ranges.

Correspondence with CMS officials the past eight months indicate codes D0472-D0999 shouldn't be billed by anyone—not a pathologist, a hospital lab, nor an independent lab. Instead, providers should use the appropriate CPT code to report the anatomic pathology procedure that's been rendered, regardless of the type of surgery—dental vs. any other—that generated the specimen. For example, on Jan. 24, 2005 a CMS official wrote to me saying in pertinent part: "[Pathologists] should be instructed to bill from the CPT coding book for pathology services regardless of the 'type' of specimen [that is, dental vs. other].... The D-codes you referenced [D0472-D0999] are not for Medicare billing purposes." Then on Feb. 9, 2005, the same CMS official said via email: "I know of no example whereas a hospital would use a D-code [such as D0472-D0999] to bill for technical [histopathology or cytopathology] services."

While I fully concur that Medicare's intent is that codes D0472-D0999 aren't billable by providers of pathology services (regardless of specialty), my considerable research has uncovered no law, regulation, or program instruction that actually prohibits providers from billing those codes or forbids carriers from making payment against those codes. In fact, Addendum B of the 8 August 2005 proposed rule indicates that "special coverage instructions apply" to these codes, and they provide for "carrier-priced" payment (status indicator R).

Attachment 2 chronicles the correspondence I've had with CMS the past eight months about these HCPCS Level II codes. It's always confusing when two different codes or sets of codes describe essentially the same medical services. However, of greater concern is the potential for abuse of the Medicare program, plus Medicaid agencies and private insurers who adopt the annual Medicare physician fee schedule for their separate purposes. In particular, although in the past CMS reports receiving only a rare claim showing a code in the D0472-D0999 range, all that may change if providers figure out they can get more money from those codes compared to the generally accepted 88104-88199 and 88300-88399 CPT codes. It would be a shame for that to happen, especially since abuse prevention is so straightforward and inexpensive in this instance.

I respectfully ask CMS to take the following two actions vis-à-vis the final rule for the calendar year 2006 Medicare physician fee schedule. Both are necessary to forestall possible abuse of the program by providers who might inappropriately bill HCPCS Level II codes D0472-D0999.

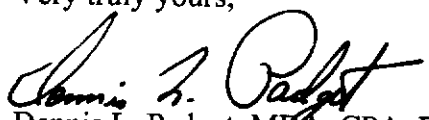
1. The status indicator for each code in the range D0472-D0999 should be I instead of R. The R status permits providers to be paid by carriers, even though that's clearly not CMS's intent, as demonstrated by recent correspondence (Attachment 2). Status indicator I correctly and much more clearly reflects CMS's true intent for these codes: "Not valid for Medicare purposes. Medicare uses another code for the reporting of, and the payment of these services." In this case, Medicare intends that codes 88104-88199 and 88300-88399 be used to report and pay the services described by HCPCS Level II codes D0472-D0999.

2. The coverage issues and claims processing manuals in the Internet-only manual system should be updated not later than 1 Jan. 2006 by formal change request to declare codes D0472-D0999 off-limits to billing by *all* providers (including, without limit, oral surgeons, oral pathologists, dental offices, hospitals, and independent labs), regardless of circumstances or whether the provider is billing the physician professional component, the facility technical component, or the total service (professional and technical components combined). They should be advised to report the CPT code (88104-88199 or 88300-88399) that accurately describes the medical service that's been rendered. Carriers and fiscal intermediaries should be instructed to summarily deny any claim for a D0472-D0999 service, regardless of the provider, the specialty of the provider, the diagnosis, or any other factor.

* * * * * * * * * *

I appreciate your attention to and consideration of the preceding comments and suggestions. Please call with questions or for added information on any topic addressed herein. Thank you.

Very truly yours,



Dennis L. Padget, MBA, CPA, FHFMA
President

Attachment 1

Excerpt from Padget's 20 Sept. 2004 Comments on the Medicare Proposed Rule for the 2005 Physician Fee Schedule (File Code CMS-1429-P)

5. **Expansion of Pathologist Clinical Interpretive Service Test List**: Section 415.130(b)(4) of the Code of Federal Regulations provides Medicare coverage for pathologist "Clinical laboratory interpretative services that...are specifically listed in program operating instructions." Said operating instructions appear in §60E of Chapter 12 of the *Medicare Claims Processing Manual* (CMS IOM Pub. 100-4). The instructions include a table of 18 clinical laboratory tests that may be interpreted and reported by a pathologist, and, if certain specified coverage conditions are fulfilled, Medicare will then pay the pathologist a professional fee (modifier 26) for interpreting the test. The instructions provide that "CMS periodically reviews this list and adds or deletes clinical laboratory codes as warranted."

According to the agenda sent out for CMS's "Laboratory Public Meeting: Payment [for] New Clinical Laboratory Tests" conducted July 26 in Baltimore, CPT-2005 will reflect two changes that directly implicate the table of eligible clinical lab tests in §60E of the aforementioned Manual. Specifically:

a. Current code 84165, *Protein, electrophoretic fractionation and quantitation*, will be broken-down into two codes: (1) *Protein, electrophoretic fractionation and quantitation; serum*; and (2) *Protein, electrophoretic fractionation and quantitation; other fluids with concentration (eg, urine, CSF)*.

b. Current code 86334, *Immunofixation electrophoresis*, will be broken-down into two codes: (1) *Immunofixation electrophoresis; serum*; and (2) *Immunofixation electrophoresis; other fluids with concentration (eg, urine, CSF)*.

Pathologists regularly interpret and report, under circumstances that meet the coverage criteria set forth in §60E of the subject Manual, protein and immunofixation electrophoresis tests on serum, urine, CSF and other human body fluids. Their professional services are regularly paid by Medicare Part B contractors, irrespective of the type of body fluid that is the specimen. Section 60E nowhere suggests that coverage for code 8416526 and/or 8633426 may depend on the type of specimen, nor should it.

I respectfully ask that CMS acknowledge in the final rule that the new CPT codes for *Protein, electrophoretic fractionation and quantitation; other fluids with concentration (eg, urine, CSF)* and *Immunofixation electrophoresis; other fluids with concentration (eg, urine, CSF)* will be added to the table of eligible lab tests per §60E of the subject Manual. (The specific codes to be assigned to these descriptors are not known to me as of this date.) Please also update the subject table in the applicable Manual effective January 1, 2005. If the acknowledgement and the update are not made by CMS, it is certain that pathologist charges for legitimate covered clinical interpretive services will be denied by carriers starting the first of the new year.

Attachment 2

Tissue Pathology and Cytology
Level II HCPCS D-Codes (Dentistry Section)

From: Heygster, Anita M. (CMS) [mailto:Anita.Heygster@cms.hhs.gov]
Sent: Thursday, June 09, 2005 2:42 PM
To: ThePathAdvocate
Cc: Menas, James P. (CMS); Lutz, Barbara A. (CMS); Sanow, Joan H. (CMS); Mason-Wonsley, Marsha M. (CMS)
Subject: RE: HCPCS D-Codes with Pathology Impact

We have considered your comments in the context of the forthcoming 2006 OPPS NPRM. When it is issued, you may want to review it and reply during the public comment period.

I can tell you, however, that I looked up the frequency of these codes in the claims data. In the data we used from over 4500 hospitals to set the 2005 OPPS rates, only 2 units of D0999 were billed and paid. None of the other codes you list were billed in the claims data for these hospitals in 2003.

In the 2004 claims data, also from over 4500 hospitals, only 3 units of D0999 were billed and paid. Again none of the other codes you list were billed and paid.

D0999 is the unspecified dental code and hence there is no way of knowing if the services furnished were comparable to any of the other codes you list.

From: ThePathAdvocate [mailto:thepathadvocate@bellsouth.net]
Sent: Thursday, June 09, 2005 9:37 AM
To: 'AHeygster@cms.hhs.gov'
Cc: Jim Menas; 'BLutz@cms.hhs.gov'
Subject: HCPCS D-Codes with Pathology Impact

Ms. Anita Heygster
Centers for Medicare & Medicaid Services

Dear Ms. Heygster:

I'm curious as to the status of the HCPCS Level II D-code issue described in detail below. Would you mind giving me a brief status report? Are these codes likely to be formally "outlawed" for billing by hospitals near-term? If so, do you have an idea when the announcement will be made?

Thank you for your kind attention.

Sincerely,
Dennis Padget
DLPadget Enterprises, Inc.
Simpsonville, Ky.
502/722-8873

Attachment 2

-----Original Message-----
From: Anita Heygster [mailto:AHeygster@cms.hhs.gov]
Sent: Thursday, March 10, 2005 5:12 PM
To: thepathadvocate@bellsouth.net
Cc: DONALD THOMPSON; James Menas
Subject: We are looking at the information you furnished regarding the dental codes and CPT codes with regard

We are looking at the information you furnished regarding the dental codes and CPT codes with regard to whether to change the payment status of these codes. Thanks for furnishing it.

Original Message

Dear Jim:

Thank you for getting back to me on this. Coincidently, I spoke with Ms. Barbara Lutz a little earlier this afternoon about this issue, because I thought you might be "snowed under" with other things at the moment.

The Level II HCPCS codes in question are D0472, D0473, D0474, D0480 and D0502. (There are 10 additional codes between D0474 and D0502, but all have a status indicator of B—not paid under OPPS—in the 2005 OPPS APC fee schedule, so they're not of particular concern.) These five codes have a status indicator of S in the 2005 OPPS APC fee schedule, meaning that they're "paid under OPPS; separate APC payment." Each crosswalks to APC 330 (Dental Procedure), which has a payment rate of $801. The counterpart CPT codes (e.g., 88300, 88305, 88307, 88104) pay $25-$40 in round numbers per the 2005 APC fee schedule. A year-by-year comparison is attached as an Excel file.

I've talked to Ms. Marsha Mason-Wonsley about these D-codes, and she assures me it's CMS's intent that a hospital shouldn't use them. I firmly believe Ms. Mason-Wonsley is accurately telling me CMS's intent, but I can't find where that policy is communicated anywhere that would make a difference. In other words, if I'm a hospital looking to code a biopsy from the mouth (oral biopsy), what's to stop me from reporting D0473 and getting $801 from Medicare instead of 88305 and getting $25? What I'm saying is, beyond what Ms. Mason-Wonsley has told *me* via email, there's nothing out there in a CMS policy manual, NCCI edict, etc. that tells me I can't use D0473 instead of 88305.

There's nothing special about oral biopsies that they should receive any different technical or professional payment than any other biopsy. The ADA says these D-codes exist so oral pathologists (yes, there is such a specialty!) will have them for use in billing their services. But skin pathologists (dermatopathologists), GI pathologists, etc. don't get paid more for their biopsies, so why should an oral pathologist be paid more? Similarly, why should a hospital or other lab get paid more for processing an oral biopsy vs. any other biopsy?

I think what's happened here is that a few dental codes—which CMS is bound to include in HCPCS by contract with the ADA—that fundamentally duplicate some pathology/lab service CPT codes have simply slipped through and become priced and payable by oversight. Nonetheless, I have to say it's really hard to convince a hospital that's looking to make an extra $750 by using these codes that it's not supposed to, because I can't point to anything *in writing* from CMS.

Anyway, that's where I'm at on this. Please let me know how I can help with this, if appropriate. Otherwise, I look forward to hearing back from someone soon.

Thanks for everything, Jim. Take care, and have a wonderful rest of the week.

Sincerely,

Dennis Padget
DLPadget Enterprises, Inc.
Simpsonville, Ky.
502/722-8873
502/722-5166
ThePathAdvocate@bellsouth.net

-----Original Message-----
From: James Menas [mailto:JMenas@cms.hhs.gov]
Sent: Tuesday, March 01, 2005 1:45 PM
To: thepathadvocate@bellsouth.net
Subject: Re: Need a Conference Call with You

Dennis,

Could you give me more details in terms of the specific HCPCS codes? The outpatient PPS staff would likely contact you to discuss this further.

Jim

>>> "ThePathAdvocate" <thepathadvocate@bellsouth.net> 02/18/05 03:11PM >>>

Mr. Menas,

I've come across a HCPCS Level II vs. CPT code matter that opens the door to hospitals to garner as much as 36 times the expected Outpatient Prospective Payment System APC fee schedule amount for a limited number of pathology technical procedures. From my extensive research, this is a loophole that hospitals can "drive through" with impunity, because there's nothing in Medicare policy to restrict their ability to report the HCPCS instead of the CPT codes for these services.

I'd like to discuss this matter with you, because I think you'll want to carry it forward through the CMS channels to prevent an unintended loss of program funds. It may take 15 minutes or so for me to describe my findings during a phone conference.

Please let me know which day and what time next week would be good for me to call you. Any day and time next week works for me, except Tuesday and Thursday afternoon. Just let me know. Oh, I'll need the phone number you want me to call.

Thanks for your attention, and I look forward to talking with you next week. Have a great weekend, and a fine holiday Monday.

Sincerely,
Dennis Padget
DLPadget Enterprises, Inc.
Simpsonville, KY
502/722-8873

From: ThePathAdvocate [mailto:thepathadvocate@bellsouth.net]
Sent: Thursday, February 10, 2005 10:45 AM
To: 'Marsha Mason-Wonsley'
Cc: 'ADavis3@cms.hhs.gov'; 'KTillman@cms.hhs.gov'
Subject: Still Need Answer, A Week Gone By

This is perfect! I wasn't looking for a particular answer—just interested in CMS policy, whichever way that went. Coincidently, the answers you've given are what I was expecting. But as a consultant, I've got to have something authoritative to rely on, not just my feelings or best guess.

Again, thank you very much for helping me out. We're all after the same thing—doing it right: It's just that sometimes it's harder to find out what's right than at other times.

Sincerely,
Dennis Padget

-----Original Message-----
From: Marsha Mason-Wonsley [mailto:Marsha.MasonWonsley@cms.hhs.gov]
Sent: Wednesday, February 09, 2005 4:49 PM
To: thepathadvocate@bellsouth.net
Cc: Conan Davis; Katherine Tillman
Subject: Still Need Answer, A Week Gone By

Dennis:
I know of no example whereas a hospital would use a D code to bill for technical services. I am sorry this may not be the answer you would like to hear but I have seen no Program memos or other documentation that advises hospitals to do so. You may want to check with your local Medicare carrier if there is any local Medical policy on this issue.

Marsha Mason-Wonsley
Health Insurance Specialist
Department of Hospital and Ambulatory Services
Division of Ambulatory Services
Center for Medicare and Medicaid Services

Attachment 2

>>> "ThePathAdvocate" 02/09/05 01:40PM >>>

Dear Ms. Mason-Wonsley
I'm sorry to keep bothering you, but I really need an answer to my Jan. 25 follow-up email. (See below.) I have several hospital clients who are pressing me for a definitive answer. I hesitate to recommend how a hospital should code its technical service based on the answer you earlier provided regarding a pathologist and the professional component: Medicare's expectations may be different for the hospital technical vs. the pathologist professional services.

I'll greatly appreciate you taking a moment to respond. Thank you very much for your help.

Sincerely,
Dennis Padget

From: ThePathAdvocate [mailto:thepathadvocate@bellsouth.net]
Sent: Wednesday, February 02, 2005 6:44 AM
To: 'Marsha Mason-Wonsley'
Cc: 'ADavis3@cms.hhs.gov'; 'KTillman@cms.hhs.gov'
Subject: Final Question on D-Codes

Dear Ms. Mason-Wonsley:
I still need an answer to my "last question" below. I understand what the pathologist is to do vis-a-vis his or her professional service, but conceivably the hospital might code its technical component (for preparing the oral tissue specimen) differently. Medicare sometimes requires physicians and hospitals to code differently for their respective—but related—services, and I need to know if this is one of those times.

Thank you again for your attention and assistance. Have a wonderful rest of the week, and take care.

Dennis Padget

Attachment 2

From: ThePathAdvocate [mailto:thepathadvocate@bellsouth.net]
Sent: Tuesday, January 25, 2005 6:23 PM
To: 'Marsha Mason-Wonsley'
Cc: 'ADavis3@cms.hhs.gov'
Subject: Final Question on D-Codes

Dear Ms. Mason-Wonsley:
Thank you so much for the advice below! Your answer eases my mind considerably; I couldn't see how a pathologist might legitimately use the D-codes for a microscopic tissue exam, but then again, I learn something new—and often surprising—every day.

LAST QUESTION: Does the answer you provided below apply as well to the technical component of a tissue biopsy or resection when the work is done by hospital personnel in a hospital lab? The reason I ask is because the same D-codes show up in the hospital Outpatient Prospective Payment System APC fee schedule.

Thank you ever so much for your attention to this matter and for your kind assistance. Take care, and have a wonderful rest of the week.

Sincerely,
Dennis Padget
DLPadget Enterprises, Inc.

-----Original Message-----
From: Marsha Mason-Wonsley [mailto:Marsha.MasonWonsley@cms.hhs.gov]
Sent: Monday, January 24, 2005 10:40 AM
To: thepathadvocate@bellsouth.net; Conan Davis
Cc: Katherine Tillman
Subject: Please Respond

Mr. Paget:
Your question on coding has been forwarded to me for additional assistance. Hospital pathologist should be instructed to bill from the CPT coding book for pathology services regardless of the "type" of specimen it has received. The D codes you referenced are not for Medicare billing purposes. Thank you for your inquiry.

Marsha Mason-Wonsley
Health Insurance Specialist
Department of Hospital and Ambulatory Services
Division of Ambulatory Services
Center for Medicare and Medicaid Services

Attachment 2

>>> "ThePathAdvocate" 01/21/05 08:55AM >>>

Dear Mr. Davis-I don't want to be a pest, but a response to my Jan. 11 follow-up (below) will be greatly appreciated. Thank you, and have a wonderful weekend.-Dennis Padget

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From: ThePathAdvocate [mailto:thepathadvocate@bellsouth.net]
Sent: Tuesday, January 11, 2005 11:18 AM
To: 'ADavis3@cms.hhs.gov'
Cc: 'KTillman@cms.hhs.gov'
Subject: Dental HCPCS Codes for Pathology Exams

Dear Mr. Davis:
Thank you for your Jan. 10 prompt response (reproduced below) to my inquiry last week about HCPCS codes D0472-D0999. If I understand correctly, if an oral surgeon were to perform a gingivectomy to remove a possibly cancerous lesion, the pathologist who examines the tissue should report the appropriate CPT code for the lab procedure, not one of the HCPCS codes in the range D0472-D0999. Similarly, the hospital at which the surgery was performed should report the appropriate CPT code for the technical component of the tissue preparation for pathologic examination. Is my understanding correct on both counts?

If I may impose, can you give me an example of a circumstance when a physician and a hospital would report one of the cited HCPCS codes instead of the applicable CPT code for a tissue exam?

I greatly appreciate your patience and your help with this matter. This is a rather puzzling aspect of HCPCS, and one that doesn't appear to be very obvious.

Sincerely,
Dennis Padget
DLPadget Enterprises, Inc.
Simpsonville, KY
502/722-8873
502/722-5166

Attachment 2

From: Conan Davis [mailto: ADavis3@cms.hhs.gov]
Sent: Monday, January 10, 2005
To: ThePathAdvocate [mailto:thepathadvocate@bellsouth.net]
Subject: Dental HCPCS Codes for Pathology Exams

Mr. Padget,
Let me say first that CMS has an agreement with the American Dental Association to include the CDT dental codes D0100-D9999 in HCPCS. The codes are primarily for use by dentists, oral surgeons, and other dental specialty groups.

Under most circumstances, when a physician is performing a medical procedure (even if in the mouth) it is more appropriate to use the CPT codes as you have suggested.

As you know Medicare does not cover dental services except in a very few instances.

I hope this helps.

Sincerely,
Conan Davis

From: ThePathAdvocate [mailto:thepathadvocate@bellsouth.net]
Sent: Tuesday, January 04, 2005 12:28 PM
To: 'KTillman@cms.hhs.gov'; 'ADavis3@cms.hhs.gov'
Subject: HCPCS Level II Pathology Codes

Ms. Kate Tillman and
Mr. Conan Davis
DHHS Centers for Medicare & Medicaid Services

Re: Level II HCPCS Codes for Histopathology Services

Dear Ms. Tillman and Mr. Davis:

I need your advice on a few Level II HCPCS codes in the D-series (dentistry). The codes, and my questions about them, are set forth below. If you'd rather I contact someone else at CMS on this matter, please let me know who that would be.

The codes of interest are in the range D0472-D0999. They describe primary histology or cytology lab services such as: gross exam of tissue; gross & microscopic exam of tissue; preparation and interpretation of exfoliative cytologic smears; and consultation on slides prepared elsewhere. Several secondary histology-type lab services are described in the range as well, such as: special stain for microorganisms; tissue in situ hybridization; and immunofluorescence.

These codes in the 2005 RBRVS physician fee schedule have an R-status, meaning that "special coverage instructions apply." The primary service codes (e.g., D0472-D0474 and

D0480) in the 2005 hospital outpatient prospective payment system APC fee schedule have an S-status, also meaning that "special coverage instructions apply." The secondary service codes don't appear in the APC fee schedule, apparently indicating that they're bundled for payment with the primary service.

These codes in the 2005 physician fee schedule are designated as "carrier-priced." The allowed charge in the hospital outpatient APC fee schedule is $801, which is something like **36 times more** than the counterpart CPT codes pay; for example, standard tissue biopsy gross and microscopic processing CPT code 88305 is priced at about $22 in the APC fee schedule.

I've familiarized myself with the basic Medicare policies on coverage of dental care. I know that most dental care is excluded from coverage, as is a diagnostic service (e.g., an x-ray or a lab test) that may arise in conjunction with such care. I also know that, contrary to the general rule, dental care that's aimed at diagnosing or treating a covered condition is covered by Medicare; for example, an oral biopsy to pinpoint an infection or suspected cancer in the mouth is a covered service, as is the pathologic examination of the biopsy.

What I'm confused about is: who's supposed to use these codes, and when? In particular, I can't figure out who would report a D0472-D0999 HCPCS Level II code for a histology or cytology lab service instead of an 88104-88399 CPT code, and in what circumstance they'd make the substitution. I can't find any guidance in these regards via the Medicare Learning Network and the various carrier Web sites I've visited the past several days. That's why I'm turning to you for help. Please respond to the following questions:

1. Assume a Medicare beneficiary is registered as an outpatient at Hospital A for a gingivectomy (excision of a portion of the gum) due to discovery of what may be a cancerous lesion. Surgery is performed by a general surgeon (not a doctor of dental surgery). The excised tissue is sent to the hospital's histology lab for processing and for microscopic examination by a pathologist. The pathologist examines the tissue and its margins, and issues a written report; she equates the exam from a work perspective to a *Soft tissue mass, biopsy/simple excision* (CPT 88307).

    a. How should Hospital A report the outpatient surgical procedure and the technical component of the gross and microscopic tissue exam on its UB-92 claim to the fiscal intermediary: (i) as CPT 41820 (*Gingivectomy, excision gingiva, each quadrant*) and CPT 88307; (ii) as CPT 41820 and HCPCS D0474 (gross & micro tissue exam, with margins); or (iii) as HCPCS D0474 alone? (The HCPCS table instructs that CPT 41820 is to be reported, because its HCPCS Level II equivalent isn't recognized by Medicare.)

    b. How should the pathologist report her professional service for diagnosing the tissue: (i) as CPT 88307-26; or (ii) as HCPCS D0474-26?

2. A Medicare beneficiary registers as an outpatient at Hospital B for a gingivectomy to remove a lesion that's possibly cancerous. Surgery is performed by a doctor of dental surgery. The excised tissue is sent to the hospital's histology lab for processing and for microscopic exam by a pathologist. The pathologist examines the tissue and its margins, and issues a written report; he equates the exam from a work perspective to a *Soft tissue mass, biopsy/simple excision* (CPT 88307).

a. How should Hospital B report the outpatient surgical procedure and the technical component of the gross and microscopic tissue exam on its UB-92 claim to the fiscal intermediary: (i) as CPT 41820 and CPT 88307; (ii) as CPT 41820 and HCPCS D0474; or (iii) as HCPCS D0474 alone?

b. How should the pathologist report his professional service for diagnosing the tissue: (i) as CPT 88307-26; or (ii) as HCPCS D0474-26?

3. A general surgeon performs a gingivectomy as an office procedure on a Medicare beneficiary due to the presence of a suspicious lesion. The excised tissue is sent to an independent laboratory for processing, microscopic examination, and diagnosis. How should the independent lab report this service: (i) as CPT 88307; or (ii) as HCPCS D0474?

4. A doctor of dental surgery performs a gingivectomy as an office procedure on a Medicare beneficiary due to the presence of a suspicious lesion. The excised tissue is sent to an independent lab for processing, microscopic exam, and diagnosis. How should the independent lab report this service: (i) as CPT 88307; or (ii) as HCPCS D0474?

5. If HCPCS Level II code D0474 is not reportable in any of the scenarios outlined above, please explain the circumstances under which that code would be reported to a Medicare contractor, and by whom (i.e., a hospital, an independent lab, some other legal entity, a physician who isn't a doctor of dental surgery or dental medicine, and/or a doctor of dental surgery or dental medicine).

I apologize for the large number of questions, due to several combinations of providers and circumstances that need to be considered. If there's one simple answer that covers all the questions, I don't have to have each question answered individually. Also, you're welcome to call me at 502/722-8873 to discuss this topic, if that's easier for you.

I greatly appreciate your attention to this inquiry. Thank you in advance for your kind assistance and advice. With gratitude, I am…

Dennis L. Padget
DLPadget Enterprises, Inc.
Simpsonville, Kentucky
ThePathAdvocate@bellsouth.net
January 4, 2005

BUCHWALD'S

C.A. STORAGE, INC.

P.O. BOX 142
WATSONVILLE,CALIF. 95077
PLANT #4 PH 831-722-4688
PLANT #1 PH 831-722-0512

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

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

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

Sincerely,

Alan Buchwald
Executive Vice President

San Joaquin County Medical Society
Comprising the counties of: Alpine • Amador • Calaveras • San Joaquin

SEP 7 2005

August 23, 2005

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

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

Dear Doctor McClellan:

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

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

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

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

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

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

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

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

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

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

Sincerely,

SAN JOAQUIN MEDICAL SOCIETY

H Padmesh MD.

Hosahalli Padmesh, MD, President

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

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August 24, 2005

SEP - 2 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,

Meral R. Jensen

Meral R. Jensen

143

LESCURE
ENGINEERS, INC.

Telephone: (707) 575-3427
Facsimile: (707) 542-2353
le@lescure-engineers.com
4635 Old Redwood Highway
Santa Rosa, California 95403

August 23, 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:

As employers we are concerned with the medical care crisis in Sonoma County. In order to attract and retain qualified civil engineers, land surveyors and technicians we must provide competitive medical benefits to our employees. Instability in our medical community, caused in no small measure by low reimbursement for care provided to Medicare recipients, has resulted in bankruptcy for medical provider groups and loss of physicians generally. These low reimbursement rates are driving up costs for everyone, especially employers.

We support your proposal to change Sonoma County's payment locality commensurate with the actual costs incurred by physicians in our community. Thank you for the opportunity to comment on this important issue.

Sincerely,

Peter J. Lescure, PE
Principal Civil Engineer

Demerus M. Lescure
Business Manager

Cc: Two copies attached

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SEP - 2 2005

UNC
SCHOOL OF MEDICINE
DEPARTMENT OF
ANESTHESIOLOGY

Philip G. Boysen, M.D.
Professor and Chair

Edward A. Norfleet, M.D.
Professor and
Executive Vice Chair

Robert Mueller, M.D., Ph.D.
Professor and Vice Chair

Peter Rock, M.D., M.B.A.
Professor and Vice Chair

Fred J. Spielman, M.D.
Professor and Vice Chair

August 25, 2005

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

Dear Dr. McClellan:

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

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

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

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

Sincerely,

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

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St. Luke's Hospital

University Hospital of
Columbia University College
of Physicians & Surgeons

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Tel: 212 523 2500
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E-Mail: dmt3@columbia.edu

www.WeHealNewYork.org

Daniel M. Thys, M.D.
Chairman, Department of Anesthesiology

Professor, Department of Anesthesiology
Columbia University College of Physicians & Surgeons

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August 19, 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 Sir/Madam,

As the Chairman of a large department and training program in anesthesiology I draw your attention to the fact that the current Medicare teaching anesthesiologist payment rule is unwise, unfair and unsustainable. At my institution, we provide anesthesia services to more than 25,000 patients per year, several thousands of whom are Medicare recipients. Since all our anesthesia services are provided in the teaching environment, the impact of the current rule is a loss of several hundred thousand dollars per year. Because we are located in Northern Manhattan, we also provide services to a large number of underprivileged patients for whom we are not compensated.

As a result of the above, the financial viability of this department is severely challenged. We are unable to add a sufficient number of faculty members to fulfill our academic as well as service obligations. Due to a shortage of faculty, we are unable to adequately teach our residents and they are continuously required to provide a very heavy service load, with inadequate time for study or research.

The current Medicare rule is particularly unfair in that it does not apply to other specialties. Surgeons are able, and frequently do, cover two overlapping operations without any reduction in fee. Our internal medicine colleagues can supervise up to four overlapping patient visits and still receive 100% of the fee for each of the patient encounters.

With the growth of the elderly population, it is critical that a sufficient number of anesthesiologists be trained. The current reimbursement rule heavily penalizes our specialty and most particularly the teaching programs in anesthesiology. Please reform the unfair anesthesia teaching payment policy for the benefit of our elderly citizens. Thanks.

Sincerely Yours,

Daniel M. Thys, M.D.

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EMORY
UNIVERSITY
SCHOOL OF
MEDICINE

Department of Anesthesiology
James R. Zaidan, M.D. M.B.A.
Professor and Chairman

SEP - 2 2005

August 25, 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 21244-1850

To Whom It May Concern:

This letter addresses file code CMS-1502-P and the specific issue identifier **TEACHING ANESTHESIOLOGIST.**

I am writing as the Chairman of the Department of Anesthesiology at Emory University School of Medicine, one of only two residency-training programs in Anesthesiology in the state of Georgia. I ask your support for changing the misguided and unfair policy under which Medicare financially supports our vitally important faculty members who provide hands-on teaching of medical residents who are training in Anesthesiology. Without proper support, these faculty members leave academic settings to enter private practice leaving our academic practice with too few educators in a specialty that is already short-handed.

Medicare's current anesthesiology teaching payment policy, which applies **only** to anesthesiology programs, has had a detrimental impact on the ability of our program to train the new anesthesiologists necessary to help alleviate the widely acknowledged shortage of anesthesiologists. This shortage will be exacerbated in coming years by the effect of aging baby boomers and their need for surgical services. The shortage is critical, and we will need anesthesiologists in the future.

Under current Medicare regulations, teaching surgeons and other teachers of "high-risk" medical specialties are permitted to work with residents on overlapping cases so long as the teacher is present for critical or key portions of the procedure. The teaching surgeon, for instance, may bill Medicare for full reimbursement for each of the two overlapping procedures, and a teaching internist may bill Medicare for four overlapping outpatient visits. I am asking for parity in the way Medicare applies its policy especially in regard to surgery training programs.

As suggested above, Anesthesiology is also a "high-risk" specialty. Anesthesiology faculty members work hard to teach our residents and are permitted to work with residents on overlapping cases so long as they are present at critical and key times and are immediately available during the entire procedure. However, **unlike** teaching surgeons, 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%, in addition to the lower reimbursement we already receive per unit worked. This penalty has had a significant financial impact. Georgia's training programs lose in excess of $1 million a year as a result of this discriminatory rule.

A correction of this inequity will assure a consistent application of Medicare's teaching payment rules across all complex or high-risk specialties and assure that anesthesiology teaching is reimbursed on par with reimbursement for surgery and other high-risk specialty teaching.

Thank you for your consideration.

Sincerely,

James R. Zaidan M.D. MBA

The Robert W. Woodruff Health Sciences Center
Emory University Hospital
1364 Clifton Road, N.E.
Atlanta, Georgia 30303
An equal opportunity, affirmative action university

Tel 404.778.3903
Fax 404.778.5405

University of California
San Francisco

UCSF

Department of Anesthesia and
Perioperative Care

Ronald D. Miller, M.D.
Professor and Chairman
Department of Anesthesia and
Perioperative Care

Professor of Cellular and
Molecular Pharmacology

521 Parnassus Avenue
Suite C455, Box 0648
San Francisco, CA 94143-0648
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email:
millerr@anesthesia.ucsf.edu

August 25, 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 21244-1850

RE: CMS-1502-P TEACHING ANESTHESIOLOGISTS

The current Medicare teaching anesthesiologist payment rule is unwise, unfair and unsustainable. Quality medical care, patient safety, and an increasingly elderly Medicare population demand that the United States have a stable and growing pool of physicians trained in anesthesiology. Right now, slots in anesthesiology residency programs are going unfilled, because of ill-conceived Medicare policy that shortchanges teaching programs, withholding 50% of their funds for concurrent cases.

We currently have 74 residents, 5 pain fellows, 6 critical care fellows, and 8 faculty openings (i.e., from faculty resignations) in the University of California San Francisco (UCSF) anesthesia residency. These vacancies create great inefficiencies in scheduling, personnel allocation, and case assignments. We are at the point of not being able to properly support UCSF's mission for clinical care, including the indigent in operating room anesthesia (surgery), critical care, and pain management. 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. Anesthesiology teaching programs, caught in the snare of this trap, are suffering severe economic losses that cannot be absorbed elsewhere.

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

A surgeon may supervise residents in two overlapping operations and collect 100% of the fee for each case from Medicare. An internist may supervise residents in four overlapping outpatient visits and collect 100% of the fee for each, when certain requirements are met. A teaching anesthesiologist will only collect 50% of the Medicare fee, if he or she supervises residents in two overlapping cases. This is not fair, and it is not reasonable.

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

Sincerely yours,

Ronald D. Miller, MD
Professor and Chairman of Anesthesia and Perioperative Care
Professor of Cellular and Molecular Pharmacology

RDM/dfm

MAYO CLINIC

SEP [illegible] 2005

148

13400 East Shea Boulevard
Scottsdale, Arizona 85259
480-301-8000

August 25, 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, file code CMS-1502-P

Dear CMS Staff:

As academic teaching anesthesiologists at the Mayo Clinic, we find the current Medicare teaching anesthesiologist payment rule to be unreasonable and unfair. This 1995 teaching rule is not consistent with teaching rules that apply to physicians that teach surgical and other high-risk procedures. Anesthesiologists that are present for all critical and key portions of concurrent procedures should be paid full reimbursement for both procedures, as occurs with teaching surgeons.

Surgeons 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 may collect only 50% of the Medicare fee if he or she supervises two concurrent resident cases. Fixing this unfair and illogical teaching anesthesiologist payment rule is necessary in order to train the anesthesiologist physicians of tomorrow.

Respectfully submitted,

Daniel J. Cole, M.D.
Chair, Department of Anesthesiology

Jeff T. Mueller, M.D.
Medical Director,
Perioperative Services

Renee E. Caswell, M.D.
Associate Dean
Mayo School of Graduate Medical Education

Terrence L. Trentman, M.D.
Vice-Chair
Dept. of Anesthesiology

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THE UNIVERSITY OF CHICAGO
Department of Anesthesia & Critical Care
5841 South Maryland Avenue; MC 4028
Chicago, Illinois 60637

Michael F. O'Connor, M.D.
Associate Professor

Telephone: (773) 702-0182
Facsimile: (773) 834-0063
8/29/05

To: Whom it may concern

Re: CMS-1502-P

Subject: TEACHING ANESTHESIOLOGISTS

The current Medicare payment to teaching anesthesiologists has precipitated the relentless decline of academic anesthesia in the US over the part 15 years, and is grossly unfair when compared to similar rules for supervision in any other medical specialty. My clinical practice exposes me to the different paradigms (ICU vs operating room), and affords me a relatively uncommon perspective.

As an anesthesiologist who practices critical care medicine, I am struck at how capricious and unfair these rules are to anesthesia practice in the OR. When I'm in the ICU, and can supervise a large number of residents and bill at a high level for the service my team provides. The inefficiencies of supervising trainees are offset by the improved compenstaion, to the point where my colleagues in medicine in this domain are at little or no economic disadvantage relative to their counterparts in private practice. This has permitted academic internal medicine and surgery (the two domains with which I am most familiar) to recruit and retain top-notch people. Consequently these specialties have continued to grow the quantity and quality of the service they provide, the quantity and quality of the teaching they provide to trainees, and sustain their research activities – all without sacrificing a great deal of income. The contrast between professional life under this paradigm and professional life arising from anesthesia compensation could not be more stark.

It is difficult for non-anesthesiologists to see and understand the role that this federal regulation has played in creating havoc in the provision of anesthesia service at most major academic medical centers. The combination of the typically worse payor mix at most academic centers and the hopelessly unfair Medicare teaching rules has made recruiting and retaining top-notch anesthesiologists into academic medicine increasingly difficult (and nearly impossible in many locales). Unlike their peer departments in medicine and surgery, most academic anesthesia departments struggle to provide the minimal quantity of the lowest of quality of anesthesia service. Whereas all other academic physicians can increase their revenue stream by supervising a greater number of residents or practitioners, federal rules specifically prevent anesthesiologists from doing this in the OR. Consequently, academic departments all offer the opportunity to work for low pay (30-70% reduction) and long hours doing difficult cases in a sometimes hostile and invariably high-liability environment. Compensation does not even scale with

Email: moc5@uchicago.edu

liability as operating room anesthesiologists supervise more residents – it stays flat. The reality is that most (but not all) academic anesthesia departments are heavily subsidized to offset the unfavorable economics. In spite of this, most departments struggle to meet their clinical service demands (both quantity and quality), and have limited non-clinical academic activities among their faculty (which is supposed to be the great strength of academic departments). The non-clinical productivity of all academic anesthesia departments in the US has fallen since the Medicare teaching rule was adopted, and unlike any other medical specialty, the majority of research in anesthesia is now conducted outside of the US. Patients in the US now await innovation from other countries, instead of being the beneficiaries of it directly.

Academic anesthesia jobs are not the best jobs in town – they are the worst. They don't get the best people in the specialty, even though they need them – most get the worst – people who can't get or keep jobs anywhere else. Program development is hampered by this, and some would even contend that Medicare subscribers die unnecessarily. The question is not whether there is a 'body count', but only how large it might be. This is a problem in patient safety for which there is only one fix – fixing the system that Medicare has made broken.

Recruiting to academic anesthesia departments and providing even a minimal level of clinical service has become impossible at a large number of academic medical centers. Because of this, a large number of chair positions have gone unfilled or been difficult or impossible to fill. Institutions which attract dozens of top-notch applicants for chair positions in every other specialty cannot get anyone with a brain or the sense that God gave Geese to become the chair of their anesthesia departments. Why? Because these jobs are prescriptions for years of incredible frustration, failure, and slow career suicide. The reason for this is the incredibly unfavorable economics of anesthesia relative to every other medical specialty. Departments with these problems have difficulty recruiting trainees, and more importantly, providing a quality training and educational experience for them.

Medicare made this mess with this unfair teaching rule. Medicare should fix it. If Medicare will not, then it should be prepared to explain its actions to its subscribers and their elected representatives. If you're not going to fix the rule for anesthesia, then you should subject the rest of the medical world to it and see what happens. Anesthesiologists don't want special treatment - we just want equipoise.

Sincerely,

Michael F. O' Connor
Associate Professor
Director, Critical Care Fellowship
Section Head, Critical Care Medicine
Department of Anesthesia and Critical Care

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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

August 23, 2005

SEP - 6 - dES

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,

Dana M Brock

Dana Brock, M.D.
Assistant Professor of Clinical Anesthesia

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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

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

SEP - 6

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. 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,

Michael P Croner

Michael Croner, M.D.
Assistant Professor of Clinical Anesthesia

152

SEP - 2

The Albany Medical College
47 New Scotland Avenue
Albany, New York 12208-3479

DEPARTMENT OF ANESTHESIOLOGY, MAIL CODE 131
(518) 262-4300
FAX: (518) 262-4736

August 24, 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 21244-1850

RE: Teaching anesthesiologist CMC-1502-P

Dear Sir or Madam,

I would like to offer some comments on my perspective on this matter. I am Vice-Chairman of an academic department and this involves scheduling of personnel for daily clinical assignments. Personnel consist of attending anesthesiologists as supervising physicians, and of CRNAs, trainee CRNAs, and physician residents as the supervised personnel. We believe in and practice a team approach in which the anesthesiologist plays an active part in the management of cases, but also in which other members of the team can develop their own skills and improve their care of patients. We are cognizant of the following factors in allocating staff:

- Strengths and weaknesses of each individual in the anesthesia team.
- Particular needs of individual patients, especially those with significant medical problems.
- The need to provide expeditious and quality care; we prefer to have one anesthesiologist cover two rooms which are each staffed by a CRNA or a resident.
- Learning needs of each member of the anesthesia team.
- The need to capture legitimate reimbursement for our services.

The last of these cannot be ignored, particularly in teaching centers, which often bear the brunt of poorly-reimbursing patients. We have to compete with non-teaching facilities for staff, who are easily attracted by higher salaries and benefits that can be offered at other institutions because of better reimbursement that they tend to receive. It therefore becomes essential that we do not lose dollars that we are entitled to earn, and this factor can mean that one needs to weigh reimbursement against the needs of trainees to learn and our ability to provide patients with appropriate attending anesthesiologist coverage.

The Albany Medical College
47 New Scotland Avenue
Albany, New York 12208-3479

DEPARTMENT OF ANESTHESIOLOGY, MAIL CODE 131
(518) 262-4300
FAX: (518) 262-4736

Anesthetizing patients on medicare is frequently very appropriate for a resident being supervised by an attending anesthesiologist, because of the learning value attached to these assignments. Failure to allocate such patients to a resident is detrimental to that individual's training. It could lead to graduating such a physician knowing that the learning process has been flawed and that his or her education is less complete that it should have been.

The alternatives are equally poor. We can give up the dollars, which are badly needed to maintain a competitive program, or allocate an attending only to the care of the resident's patient rather than cover two rooms, so meeting all these requirements, but that would result in having the other attendings cover more rooms than we feel is usually appropriate, and this is to the detriment of the care of other patients. We are, I believe, permitted to have an anesthesiologist cover up to four rooms, rather than the two that we prefer to have, but we believe that this not an appropriate way to practice safe medicine.

I would therefore urge you to consider dropping the penalty that we pay for covering residents doing medicare or medicaid cases while the anesthesiologist is also covering another room, as it causing us to have to make unhealthy choices regarding allocation of staff.

Sincerely,

David Trickey, M.B.
Associate Professor of
Anesthesiology

153

SEP 2 2005

JOHNS HOPKINS
MEDICINE
Division of Neurosciences Critical Care

Marek A. Mirski, M.D., Ph.D., Director, Vice-Chair ACCM
Anish Bhardwaj, M.D., Co-Director, Vice-Chair Neurology
Romergryko G. Geocadin, M.D.
Wendy C. Ziai, M.D
Robert Stevens, M.D
Juan Ricardo Carhuapoma, M.D.

Agnieszka Ardelt, M.D., Ph.D.
Paul Nyquist, M.D.
Jennifer Moran, M.S., C.R.N.P.
Marie S. Depew, M.S., C.R.N.P., C.N.R.N.
Karen Lane, C.M.A., Sr. Clinical Research Coordinator

August 25, 2005

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

Dear Dr. McClellan:

I am writing this letter to let my voice be heard and counted regarding the Centers for Medicare and Medicaid Services (CMS) provisions to change the Medicare anesthesiology teaching payment policy.

I am a senior Anesthesiology & Critical Care faculty member at Johns Hopkins Medicine, which has assumed the role of having the largest anesthesiology residency training program in the country. We faculty take our career responsibility of Clinical Excellence, Teaching, and Research very seriously, and I believe have an intelligent voice on matters that affect the future of academic medicine.

Anesthesiology training is the fundamental piece in ensuring high quality surgical services in this country. In addition, the crisis in Critical Care we read every day in the media support the increasing need for expert professional attention to be paid to the critically ill – a role that anesthesiology in the ICUs have traditionally satisfied along with the medical and surgical intensivists.

Our training of residents requires adequate reimbursement for the cases performed. None of the faculty are in this career path for monetary self-enrichment. All of us in a teaching university setting

could attain a greater professional compensation working in the private sector. Our programs nevertheless need to be fairly reimbursed to accommodate our task and high rate of indigent care that most urban teaching hospitals must deal with. Medicare's discriminatory payment arrangement, which applies only to anesthesiology teaching programs, has had a terrible impact on the ability of programs to retain skilled faculty.

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

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

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

I would very much enjoy discussing this matter further at your discretion. Thank you for your time and effort in this matter.

Sincerely,

M. Mirski

Marek A. Mirski MD, PhD
Vice-Chair, Dept. Anesthesiology & Critical Care Medicine
Director - Neuroscience Critical Care Unit
Chief - Division of Neuroanesthesiology
Associate Professor Anesthesiology & Critical Care Medicine
Neurology, Neurosurgery

MAM/gjwm

600 N. Wolfe Street, Meyer 8 / 140, Baltimore, MD 21287, Office: 410-955-7481 Fax: 410-614-7903

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

David O. Warner, M.D.
Professor and Vice-Chair
Department of Anesthesiology

August 24, 2005

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

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

Dear Sir or Madam;

I am a member of one of the country's largest anesthesiology training programs. Mayo Clinic's anesthesiology residency program has produced 72% of all practicing anesthesiologists in the state of Minnesota during the past decade. It has produced another 72 anesthesiologists during that same time period who work in other states of this country.

We are deeply 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 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.

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 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. We don't understand the distinction between surgeons, internists, and anesthesiologists as they provide needed services to our elderly patients.

At this time the Medicare anesthesia conversion factor is less than 40% of prevailing commercial rates. Reducing that factor by 50% for teaching anesthesiologists results in so little revenue that it is increasingly difficult to sustain the academic mission in our teaching programs.

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,

David O. Warner, M.D.

155

MASSACHUSETTS GENERAL HOSPITAL

HARVARD MEDICAL SCHOOL

Department of Anesthesia and Critical Care
55 Fruit Street, CLN3
Boston, Massachusetts 02114-2696
Tel: 617 726-3030, Fax: 617 726-3032
E-mail: zapol@etherdome.mgh.harvard.edu

Warren M. Zapol, M.D.
Anesthetist-in-Chief
Massachusetts General Hospital
Reginald Jenney Professor of Anesthesia
Harvard Medical School

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: Teaching Anesthesiologists

To whom it may concern:

The current Medicare teaching anesthesiologist payment rule is unwise, unfair and unsustainable. Quality medical care, patient safety and an increasingly elderly Medicare population demand that the United States have a stable and growing pool of physicians trained in anesthesiology. Right now, slots in anesthesiology residency programs are going unfilled because of ill-conceived Medicare policy that shortchanges teaching programs, withholding 50% of their funds for concurrent cases.

Since its inception, this reimbursement policy has weakened the Department of Anesthesia and Critical Care at Massachusetts General Hospital in the following ways:

- Resident slot vacancies
- High faculty vacancies and turnover
- Below market faculty compensation
- Multiple years of budget shortfalls (late 1990's through early 2000's)
- Faculty assigned to personally perform rather than supervise the provision of anesthesia (particularly in anesthetizing locations outside of the operating rooms)

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

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

A surgeon may supervise residents in two overlapping operations and collect 100% of the fee for each case from Medicare. An internist may supervise residents in four overlapping outpatient visits and collect 100% of the fee for each when certain requirements are met. A teaching anesthesiologist will only collect 50% of the Medicare fee if he or she supervises residents in two overlapping cases. This is not fair, and it is not reasonable.

Medicare must recognize the unique delivery of anesthesiology care and pay Medicare teaching anesthesiologists on par with their surgical colleagues. The Medicare anesthesia conversion factor is less than 40% of prevailing commercial rates. Reducing that by 50% for teaching anesthesiologists results in revenue grossly inadequate to sustain the service, teaching and research missions of academic anesthesia training programs.

Respectfully,

Warren M. Zapol

Warren M. Zapol, M.D.

WMZ/maf

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,

We 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.

We 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. We 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.

Sincerely,

Betty Blumenfeld

157

207 Via Concha
Aptos, CA 95003
August 28, 2005

Center for Medicare 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:

We are in support of the proposed revision to the physician payment localities in California that you published in the reference rule. We commend you for addressing an important issue for Medicare beneficiaries and for physicians in Santa Cruz County.

Living expenses in Santa Cruz County, particularly housing costs, are among the highest in the nation. It is, therefore, fair and important that physician payment levels reflect these costs. Our neighboring counties have some of the highest payment levels for physician services in the nation. We have seen an increase in physician exodus and an increasing problem of an access to medical care for seniors.

We understand that there have been no revisions to localities since 1996. We encourage you to support the proposed revisions.

Sincerely,

Carol Toney

Carol Toney

James Toney

158

SEP - 2 2005

Date 8/25/05

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

Re: File Code CMS 1502-P

Issue Identifier: GPCI's/Payment Localities

Dear Sirs,

I strongly support your proposed change to the physician payment localities in California, which is stated on page 92 in your recently published Revisions to Payment Policies Under the Physician Fee Schedule for Calendar Year 2006. This refers to your proposal to move Santa Cruz and Sonoma Counties from Locality 99 to their own unique localities. As you know, the cost of medical practice here in Santa Cruz county is more than 10% above the average cost of medical practice in Locality 99. Because of the relatively low rate of Medicare reimbursement, it is difficult to recruit new physicians and to retain established physicians in this area. Especially since our neighbor, Santa Clara county, has a 24% higher reimbursement rate for the same medical services, luring physicians to move to that area. Your proposed change appropriately addresses this payment imbalance and will help develop an adequate physician base in our area. This will improve access to health care services for all people, especially the senior population. I applaud your recommendation to correct this long-standing inequity.

Sincerely,

MD

JAMES E. RILEY, MD
13350 Big Basin Way
Boulder Creek, CA 95006
Lic #A063461 EID 770376900
Ph 831-338-6491

159

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

SEP - 2 2005

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

8/25/05
Boulder Creek, Ca

Centers for Medicare & Medicaid:

I have read that you are considering an increase in payments to doctors & medical institutions in Santa Cruz County - CA. We strongly go lead that you do so. The existing payment is too low.

As a result, it is very difficult to get and hold onto a doctor who will accept Medicare patients.

Santa Cruz County doctors receives apprec iably less than those of nearby San Francisco, San Mateo, & Santa Clara counties in spite of the fact that its cost of living is very high & is probably at least that of any of those 3 Counties.

This situation needs to be taken care of. Please do so.

Earl A Lofstrom
V/E Jeanne B Lofstrom

cc 2 copies

161

County of Santa Cruz

HEALTH SERVICES AGENCY

P.O. BOX 962, 1080 EMELINE AVENUE
SANTA CRUZ, CA 95061
(831) 454-4000 FAX: (831) 454-4770

HEALTH SERVICES AGENCY
ADMINISTRATION

SEP - 2

September 21, 2005

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

Re. File Code CMS1502-P

Issue Identifier: GPCI's / Payment Localities

Dear Sirs:

The Health Department of Santa Cruz County has a unique perspective on which to comment on the proposed rule for 2006. Our organization consists of 14 primary care physicians providing care to 48,000 low-income patients in Santa Cruz County. The payment differential between Santa Clara, San Mateo, and Santa Cruz County will be greater than 25% in 2006. Your proposed rule appropriately addresses this imbalance.

The Safety Net Clinics are pleased to see that your proposed rule would alleviate this problem by removing both Santa Cruz and Sonoma Counties from Locality 99 and placing them into unique localities. We 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. This revision would bring you closer to your goal of reimbursing physicians based on the cost of practice in their locality. The difference between Santa Cruz and our neighbors has impacted our recruitment of new physicians to our community, both in our clinics and in the specialty arena.

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

This proposed rule is the first fee schedule revision proposed by CMS since 1996. We sincerely applaud the leadership exhibited by CMS in addressing this issue. You have appropriately selected the two most disadvantaged counties in the nation and have restored payment equities to the ten counties in the San Francisco Bay Area.

Sincerely,

Poki Stewart Namkung, M.D.
Health Officer

162

Harold & Ellen McCann
225-119 Mt. Hermon Rd.
Scotts Valley, CA 95066

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

Gentlemen: GPCIs

As 86-year-old taxpayers and frequent beneficiaries of Medicare, we urge you to approve the proposed increase in reimbursement for physicians in Santa Cruz County, California. This county is a part of Silicone Valley residential area, contiguous to the entire San Francisco Bay region, with extremely high food costs and the third-highest- in- California cost of housing -- $800,000 is the current median price of a single- family 3 bedroom home.

Physicians in Santa Cruz county who accept Medicare/Medicaid patients are at an extreme disadvantage under the current rate for reimbursement, and we will not be able to retain them unless the proposed increase is granted.

Thank you.

Harold McCann 300-07-4948
Ellen McCann 282-12-5184

"CPCI s"

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

August 30, 2005

SEP - 2 2005

To Whom it May Concern:

I am a senior in Santa Cruz County, CA and I support the change in designation from rural to urban for Santa Cruz and Sonoma Counties. It is difficult to recruit doctors to our area with the high cost of living/real estate and the minimal reimbursement from Medicare.

We are so close to other areas that are designated as urban that it is much more appealing for doctors to leave our area for more favorable reimbursements.

Santa Cruz County is anything but rural. It is amusing for us who live here to think we live in a "rural" area.

Please support this proposal to change the designation for Santa Cruz and Sonoma county from rural to urban.

Gratefully

Sister Jeanne Burns, OP

Wesley E. Sims
7838 Tanias Court
Aptos, CA 95003
DeskinSims@aol.com
August 24, 2005

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

Greetings!

I'm writing to protest the federal government's designation of Santa Cruz as rural, for purposes of physician reimbursement for Medicare patients. The rural designation might have been appropriate when Medicare was established in the 1960's, but the economics of our county have greatly changed. The fertile farm land that once dominated south Santa Cruz County is being increasingly squeezed out by development. And Santa Cruz County's median home cost is second only to San Francisco; a fact that makes it increasingly difficult to attract and retain qualified physicians.

I strongly urge a change in the rules to allow for an increase in payments to doctors and other medical practitioners in Santa Cruz County to ensure a higher quality of health care in our senior years.

Sincerely,

Wesley E. Sims
831-688-6310

165

August 24, 2005

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

To Whom It May Concern:

This is to request your approval of Santa Cruz County's designation change from rural to urban in regards to reimbursements of medicare/medicaid payments to our doctors and hospitals.

I am extremely concerned as I approach my "golden" years that the level of medical services be adequate and affordable.

Thank You

K.D.W.

Kathleen D. Weigandt

Copy

166

August 24, 2005

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

To Whom It May Concern:

This is to request your approval of Santa Cruz County's designation change from rural to urban in regards to reimbursements of medicare/medicaid payments to our doctors and hospitals.

I am extremely concerned as I approach my "golden" years that the level of medical services be adequate and affordable.

Thank You

Harry S. Weigandt

COPY

David M. Meddaugh
6283 Melita Road
Santa Rosa, CA 95409

167

August 24, 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

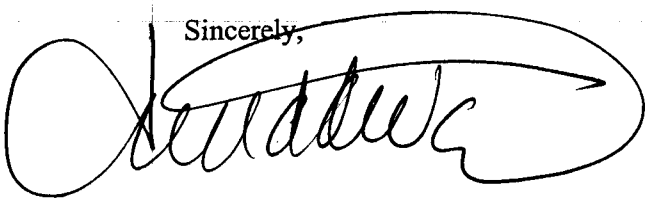
I am a longtime resident of Sonoma County, born and raised in Santa Rosa. As a parent with two children, the proposal to create a new payment locality for Sonoma County is of paramount importance to me. I know that Sonoma County is a very expensive location to both live and work. I have personal experience with seeing friends of mine in the medical field being forced to leave the area due to the current low reimbursement rate in Sonoma County.

The new proposed Medicare reimbursement rates would be more closely matched to our actual cost of living- we surely are not a "rural" community. Our housing and living costs are some of the highest in the nation.

The new locality (reimbursement rates) would help Sonoma County physicians improve the quality and quantity of care in our community to Medicare beneficiaries. The locality change would also benefit efforts to recruit and retain physicians in the county, which has a large Medicare population. While it would be too late for my friends in the medical field who have left the community- it would surely be a positive step in retaining and recruiting other physicians.

I FULLY support your proposal to change Sonoma County's payment locality and I urge you to make this happen as soon as possible. I appreciate the chance to comment on this important issue.

Sincerely,



cc: Two copies attached

168

As a resident of Santa Cruz County for the past 28 years, I have seen the County grow and I support the increase in the Medicare Reimbursement Rate for Santa Cruz County physicians. If there is no increase, we will continue to lose physicians willing to care for our elders.

Camille M. Chase
25 Aug 05

CPCIs

I'm in support of the increase in the Medicare reimbursement rate sor Santa Cruz County Physicians.

It is time that the classification of Rural be changed to Urban. I'm a 60 year old senior and have lived here all my life. We are no longer Rural!

Please approve the change in Medicare reimbursement!

Thank you

Ronald E. Tolles

P.S. Concerned Senior

Hospice Caring Project

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

Re: GPCI

To Whom It May Concern:

In August, CMS proposed to remove the two most disadvantaged counties from CA Locality 99 (Sonoma and Santa Cruz) and assign them to their own localities effective January 1, 2006. **This is an extraordinary development for our two counties!** We strongly support this proposed revision to the physician payment localities in California that you published in the reference rule.

Santa Cruz County has had the greatest physician cost/payment mismatch in the state for nine years. It has the widest boundary payment discrepancy in the nation. (A 25% difference between Santa Cruz and Santa Clara counties). This has led to a growing physician exodus and an increase in access problems for our seniors.

Medicare serves almost 15% of our residents – and those who consume the most health care. Most health plans tie payments to physicians based on the locality-adjusted Medicare fee schedule which compounds the uniquely negative position that Santa Cruz County has been in.

You are to be commended for addressing an important issue for physicians and Medicare beneficiaries in the San Francisco Bay Area.

Sincerely

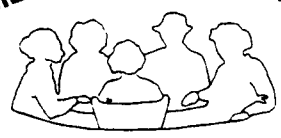
Ann Pomper
Executive Director

6851 Soquel Drive, Aptos, CA 95003
831-688-7684 / Fax: 831-688-5271 / Toll Free: 877-688-6144
E-mail: info@hospicesantacruz.org / Tax I.D. 94-2497618

SEP - 2

171

SENIORS COUNCIL
CONCILIO DE PERSONAS MAYORES



AREA AGENCY ON AGING
San Benito & Santa Cruz Counties

FOSTER GRANDPARENT/SENIOR COMPANION PROGRAM
Monterey, San Benito & Santa Cruz Counties

August 23, 2005

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

RE: Santa Cruz County, Locality 99

To Whom It May Concern,

I am writing on behalf of the Area Agency on Aging Advisory Council of Santa Cruz and San Benito Counties to support the proposed revision to the physician payment localities in California that you published in the reference rule.

Currently, there are very few physicians who are serving Medicare patients due to the low rate of reimbursement in Santa Cruz County. Doctors and hospitals are finding the Medicare rate does not cover expenses. This is forcing seniors to choose between paying for their medical care from very limited budgets or neglecting potentially life-threatening conditions. As rates are cut, fewer and fewer health care providers are available.

The Santa Cruz area has one of the three highest costs of living in the country, yet its reimbursement rate does not reflect that fact. The two hospitals in the county are currently having great difficulty staffing their emergency rooms because of the cost of living and some emergencies are currently being airlifted to Santa Clara County.

There have been no revisions to the localities since 1996. This revision addresses the current inequitable payment problem. We commend you for addressing this issue.

Sincerely,

George "Bud" Winslow

George "Bud" Winslow
Chair, AAA Advisory Council

234 Santa Cruz Avenue • Aptos, California 95003
PHONE: AAA – (831) 688-0400 OR (831) 476-6033 • FG/SCP – (831) 475-0816 • FAX: (831) 688-1225

SUPPORTED BY THE CORPORATION FOR NATIONAL SERVICES, THE CALIFORNIA DEPARTMENT OF AGING, LOCAL COUNTY & CITY GOVERNMENTS, & THE UNITED WAYS OF THE MONTEREY PENINSULA, THE SALINAS VALLEY, SAN BENITO COUNTY & SANTA CRUZ COUNTY.

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Susan A. Crovo

323 Keystone Ave
Santa Cruz, CA
95062

August 23, 2005

GPCI's

Dear Sirs:

I endorse the change of designation of Santa Cruz County from Medicare Rural to Medicare Urban.

Santa Cruz County is no longer a Rural County and it's designation is properly Urban/Medicare.

Thank you.

Susan A. Crovo

(Susan A. Crovo)

8/26/05

Attention: CMS 1502-P

I am writing this letter to voice my approval of the proposal to change the status of Santa Cruz County from 'rural' to 'urban'. I believe this will slow the exodus of Doctors from Santa Cruz County.

My wife and I are enrolled in Secure Horizons who assigned us to Western Medical Assoc. During the last 18 months we had six Doctors, three of which moved to higher paying locations out of the county.

During that time, medical advice was dispensed but we were left with a feeling of chaos and resultant insecurity.

To sum the above, a proposal to increase renumeration to doctors will without a doubt slow or stop the search for 'better pastures'.

Curson Kenter

Curson Kenter
629 Lupine Valley Rd
Aptos, Cal. 95003

August 29, 2005

Centers for Medicare & Medicaid
Dept. of Health & Human Services

To Whom it May Concern,

My husband and I implore you to change the rural status of Santa Cruz County to Urban Status. We are greatly affected by the exodus of Doctors in the county who can no longer afford to live here and work here. Our heath care has been affected negatively and our community is in dire need of change.

Housing is unaffordable for most people and recruitment of medical personnel is difficult. My parents, on Medicare have been switched to 5 different doctors in 16 months, due to doctors leaving the area. No doctor really has a relationship with my parents critical illnesses.

My husband and I will soon be of medicare age and are very concerned about health care in this county.

Please change the status from rural to urban. It will greatly affect us in a positive way.

Thank you,

Deborah & Roger Powers
627 Lupine Valley Road
Aptos, Ca. 95003

175

SEP - 2

Phyllis J. Casey
222 Elva Dr.
Aptos, CA 95003

Center for Medicare and Medicaid Services
Dept. of Health and Human Services

Att: CMS-1502-P

To Whom It May Concern:

I am writing on behalf of the Santa Cruz County Medicare and Medicaid payment system. It is my understanding we are still considered to be a rural area. True there are still farms and orchards in the area, but we are not really rural. It is very expensive to buy a house any more in this county. We are very close to San Jose and there are many people that commute, and we are on the coast which has become expensive in itself. It is getting hard to find a doctor if a patient is on Medicare or Medicaid. Many a person has to be transported by helicopter to a medical center as doctors are not available to take care of those emergencies. There are those of us that can not in some instances even get a doctor to take a new Medicare patient because the reimbursement is so low.

I urge you to reconsider the status of this county and upgrade our service here to urban so that we do get care. It is getting critical.

Sincerely.

Phyllis J. Casey

176

Capitola Physical Therapy, Inc.
1200 41st Avenue, Suite H
Capitola, CA 95010
v: (831) 475-1200 *f:* (831) 475-0142

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

August 26, 2005

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 providers and Medicare beneficiaries in Santa Cruz county. Without such a change increasing number of providers will restrict access to services for Medicare beneficiaries and increasing numbers will seek to work in adjacent counties with higher reimbursements by Medicare. Making the proposed changes is fair, it addresses historical inequities between Santa Cruz and neighboring Santa Clara county rates, it will promote access to health care, it will strengthen the provider community's ability to serve.

As a Medicare Participating Physical Therapist in private practice, I compete with neighboring Santa Clara county for staff. It is increasingly difficult to compete when Medicare reimburses me 25% less than them for the same services. My cost of rent and etc. is easily as high as theirs. As many other payers fix their reimbursement by the Medicare GPCI, the effect is amplified.

CMS has the responsibility to manage the physician payment localities. The current disparity caused by the inclusion of Santa Cruz County into Locality 99 needs to be addressed. I sincerely hope that you will do what is right and what is fair for seniors and providers who live in Santa Cruz county.

Thank you,

Jonathan Holtz, PT

177

Jay Pennock, MD
3000 Pleasure Point Drive
Santa Cruz, CA 95062
831-479-8240
pennocks@pacbell.net

Friday, August 26, 2005

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

Re: **File Code CMS – 1502 – P**

Issue: GPCI/Payment Locality/Oppose Proposed Rule Change

To Whom It May Concern:

I am writing to comment on the Proposed Rule governing the Physician Fee Schedule Calendar Year 2006 as printed in the Federal Register of August 8, 2005.

I oppose the proposed removal of California's Santa Cruz and Sonoma counties form Medicare reimbursement Locality 99. Doing this does not address the problems of other counties within Locality 99 who suffer from significant cost disparities close to those of Santa Cruz and Sonoma counties. By proposing that these two counties be removed from Locality 99 into their own localities, exacerbates the problems of the remaining locality 99 counties – especially those of Monterey, San Diego and Santa Barbara.

I am also concerned that nowhere in the proposed rule is it mentioned that this "two county fix" is the beginning of a greater effort to move all counties in the state and nation into payment localities that truly reflect their respective costs of providing medical services.

The Centers for Medicare and Medicaid Services should be responsible for calculating new Geographic Area Factors and Geographic Practice Costs Indices and making immediate locality adjustments to *all* counties exceeding the so-called "5% threshold".

Sincerely,

Jay Pennock, MD

178

SEP - 2

August 23, 2005

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

RE: File Code CMS 1502-P

Issue Identifier: GPCI's/Payment Localities

Dear Sirs:

I strongly support your proposed change to the physician payment localities in California, which is stated on Page 92 in your recently published Revisions to Payment Policies Under the Physician Fee Schedule for Calendar Year 2006. This refers to your proposal to move Santa Cruz and Sonoma Counties from Locality 99 to their own unique localities. As you know, the cost of medical practice here in Santa Cruz County is more than 10% above the average cost of medical practice in Locality 99. Because of the relatively low rate of Medicare reimbursement, it is difficult to recruit new physicians and to retain established physicians in this area. Especially since our neighbor, Santa Clara County, has a 24% higher reimbursement rate for the same medical services, luring physicians to move to that area. Your proposed change appropriately addresses this payment imbalance and will help develop an adequate physician base in our area. This will improve access to health care services for all people, especially the senior population. I applaud your recommendation to correct this long-standing inequality.

Sincerely,

Joanne M Wimmer

Joanne M. Wimmer
326 Gault Street, #D
Santa Cruz, CA 95062

179

August 23, 2005

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

RE: File Code CMS 1502-P

Issue Identifier: GPCI's/Payment Localities

Dear Sirs:

I strongly support your proposed change to the physician payment localities in California, which is stated on Page 92 in your recently published Revisions to Payment Policies Under the Physician Fee Schedule for Calendar Year 2006. This refers to your proposal to move Santa Cruz and Sonoma Counties from Locality 99 to their own unique localities. As you know, the cost of medical practice here in Santa Cruz County is more than 10% above the average cost of medical practice in Locality 99. Because of the relatively low rate of Medicare reimbursement, it is difficult to recruit new physicians and to retain established physicians in this area. Especially since our neighbor, Santa Clara County, has a 24% higher reimbursement rate for the same medical services, luring physicians to move to that area. Your proposed change appropriately addresses this payment imbalance and will help develop an adequate physician base in our area. This will improve access to health care services for all people, especially the senior population. I applaud your recommendation to correct this long-standing inequality.

Sincerely,

Mary M. Behl

154 Woodcrest Pl.
Santa Cruz, CA 95065

180

SEP - 9

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

8/19/05

I urge you to designate Santa Cruz County "urban" for Medicare reimbursement purposes. The cost of living here is the third highest in the state, behind San Francisco and Santa Barbara counties. Home costs are among the highest in the nation. Doctors continue to move from this county to the adjacent "urban" designations because they cannot afford to be disadvantaged by reimbursement schedules. As a result, Seniors in this county have difficulty getting in to see a doctor, in part because of the scarcity of doctors, and because many local doctors will no longer accept Medicare-funded patients. Please redress this wrong. John R. Hinton, retired educator.

John R. Hinton

John R. Hinton
1030 Clubhouse Drive
Aptos, CA 59003
Tlc2tor@sbcglobal.net
(831) 688-3654

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

SEP - 2 2005

This letter is in response to an Editorial published in the Santa Cruz Sentinel today, August 24, 2005 requesting those who are interested in increasing the amount of Medicare reimbursement given to local doctors write a letter to you.

My husband and I are seniors, having been on Medicare since 1990. We are fortunate in having a private health insurance plan which supplements Medicare. For the past 15 years, we have been very fortunate in the medical care we have received from the exceptional doctors and health care practioners here in Santa Cruz County. However, it is not for us that I am writing this letter, but I am making a statement of support because of our children and our grandchildren and their peers who will need the same sort of excellent medical doctors and personnel that have cared for us. The federal government who makes the reimbursement judgments needs to be aware of the changes in Santa Cruz County now: the increased cost of living for this area and the accompanying possibility of decreased attraction for good doctors and health care providers.

In a recent poll Santa Cruz was listed as third most unaffordable place to live in the entire nation! That's incredible, but we who live here are quite aware of it. We need help. Please do what you can. Thank you.

Sincerely,

June Peterson

4657 Freedom Blvd
Aptos CA 95003

June Peterson (Mrs. James W.)

182

CITY OF SCOTTS VALLEY

OFFICE OF THE CITY MANAGER
One Civic Center Drive • Scotts Valley • California • 95066
Phone (831) 440-5600 • Facsimile (831) 438-2793 • www.scottsvalley.org

August 23, 2005

SEP - 2

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

RE: GPCI

To Whom It May Concern:

We 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 Medicate 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 in ensuring access to care for health care services in our county.

We 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. We understand that there have not been revisions to the localities since 1996. You have selected the most important area in our state to begin to correct this problem.

Sincerely,

Paul Marigonda
Mayor

H:\Miscores\GPCI.wpd

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Pam Brouwer
363 Berkeley Way
Santa Cruz, CA 95062

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

August 26, 2005

RE: GPCIs

To Whom It May Concern,

I would like to add my voice to those requesting the reassignment of Santa Cruz County, California from "rural" to "urban." The cost of living in Santa Cruz is equally high to that of other Bay Area counties. Our doctors are unable to come here and survive financially because they are not reimbursed adequately by the federal government for their services. It simply costs too much to live and work in Santa Cruz County. It is no longer the rural county it once was. As a result of this financial crisis, it is becoming increasingly difficult to find a doctor or keep the ones we have. Please reconsider and reassign Santa Cruz County as the "urban" area it has become and increase the Medicare reimbursement rate for our county.

Sincerely,

P. Brouwer

Pamela Brouwer

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

I am writing in support of increasing the Medicare reimbursement rate for Santa Cruz County. The county is classified as rural and that may have been true in 1960, but not today.

What has changed? Some industry has moved into the county. That, by itself, is probably insufficient to change the classification. The major change comes from two things: commuters to Silicon Valley and Silicon Valley residences that retire and move to Santa Cruz County. I am an example of the latter. I grew up in Santa Cruz County, went to college, and then went to work and lived in Silicon Valley. When I retired, I moved back "home."

The expansion of Silicon Valley into neighboring counties is not limited to Santa Cruz County. Many workers are commuting from Monterey and San Benito Counties. In addition, Many retirees are moving to Monterey County.

I do not know your process, but please consider these points.

Thank you

Bill Beecher 8/26/05

Bill Beecher
1051 Clubhouse Dr.
Aptos, CA 95003

SEP - 2

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GPCIs,

I live in Santa Cruz County, California. We are losing our doctors & many will not take Medicare patients because our doctors receive less money for their services from Medicare because we are considered RURAL. We are no longer a rural county. The rules need to be changed

to URBAN. We are in our Medicare years now & will soon need doctors for health issues. We ask you to adopt new rules for our County before we lose more doctors to the next county which is too far for us to drive.

Thanking You,

Betty Byer
190 Byer Dr.
Watsonville, CA.
95076

186

A. KIRKHAM SMITH
118 ANTHONY STREET
SANTA CRUZ, CA 95060

August 25, 2005

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

GPCIs

We strongly urge you to reclassify Santa Cruz County as an urban county to reflect the significant change since its rural designation in the 1960s.

Santa Cruz County has changed dramatically during the last 40 years and has experienced a major increase in both population and cost of living, putting it on a par (or above) with Santa Clara and other neighboring counties, and making its present reimbursement rate of 50% obsolete.

As a result, our medical service is being compromised because doctors are understandingly reluctant to practice in Santa Cruz due to Medicare's higher rates in other counties. A modest increase from 50 to 55 percent would certainly be a step in the right direction, and we strongly support its implementation.

Sincerely,

A. Kirkham Smith

Patricia W. Smith

Two copies enclosed

GPCIs

SEP - 2

187

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

Att.: CMS-1502-P

Sirs:

We write to support the request for the change of payment of Medicare/Medicaid physicians to be reimbursed in the same schedule as physicians in our adjacent county of Santa Clara on the grounds that our county, Santa Cruz, is erroneously categorized as being "rural."

36 years after taking up residence in this county, the original designation of the county as "rural" has changed since it might have made sense but, considering our population growth and the many other aspects of everyday life, that designation has been long outdated. Our essential incorporation into the San Jose metropolitan area has changed everyday living from previously being quiet to the kind of hectic life experiences that most urban areas experience. This is reflected in housing prices, traffic congestion and parking, as well as other urban features. Our communities are finding it difficult to recruit young physicians and the recategorization of our county to urban may help in facilitating such recruitment.

As Medicare recipients, we have noted the aging of our physician population and urge that the CMS-1502-P be changed.

Sincerely,

William H. Friedland

Joan Friedland

William H. Friedland

Joan Friedland

238 Segre Place
Santa Cruz, CA 95060

Elizabeth Porter
505 Vista Del Mar Dr.
Aptos, CA 95003-4873

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August 25, 2005

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

Please change the designation for Santa Cruz County from rural to URBAN. We urgently need to attract and keep doctors in Santa Cruz County – listed as one of the most expensive places to live in the country. We citizens deserve quality medical care. Thank you.

Sincerely,

Elizabeth Porter

Elizabeth Porter

189

BILL BARNES
Private Investigator

CSL#3121

(831)
Ph & Fax (408) 475-4526

AUGUST 24, 2005

CENTER FOR MEDICARE & MEDICADE SERVICES
DEPT. OF HEALTH & HUMAN SERVICES
ATT'N: CMS 1502-P
P. O. BOX 8017
BALTIMORE, MD 21244-8017

MY WIFE, BARBARA AND I VERY MUCH SUPPORT THE INCREASE IN THE MEDICARE REIMBURSEMENT RATE FOR SANTA CRUZ COUNTY PHYSICIANS.

YOURS VERY TRULY,
William B. Barnes
Barbara J. Barnes
WILLIAM B. & BARBARA J. BARNES

850 Park Ave. #8A • Capitola, CA 95010

Aug. 25, 2005

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To: Centers for Medicare and Medicaid Services

From: Wendy Bernal

I have worked in Santa Cruz County California in the medical profession for 20 years and I highly support the proposal to remove our county from Locality 99.

I have lived in Santa Cruz for 30 years and have seen great changes in its population. We are <u>not</u> a rural community! Santa Cruz has had the greatest physician cost/payment mismatch in the state for 9 years. It was the widest boundary payment discrepancy in the nation. Our physicians are leaving the area and that has had a direct effect on access problems for our seniors.

Thank you for <u>finally</u> considering this issue!

Sincerely, Wendy Bernal

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GPCIs

24 Aug 05

SEP - 2 2005

Dear Sir or Madam:

It is essential, critical, and only fair that these five doctors be more fairly compensated for their professional caring service to Santa Cruz County. This area is one of the most expensive places in the entire country to live. We, personally, have seen wonderful doctors leave Santa Cruz Co for more affordable communities. It is a terrible loss. Please improve the compensation these doctors deserve.

Thank you.

Sincerely,

Patricia, John McElhiney

John E. Melsom
2494 N Rodeo Gulch Rd
Soquel, CA 95073-9141

GPCI

August 25, 2005

To whom it may concern;

I am writing to urge the change in designation of Santa Cruz County in terms of Medicare reimbursements to, at least, 55 percent. In 1960 Santa Cruz County was considered a rural area but that has changed drastically. Now, though there are some farm producing areas, most of the County is an urban area with manufacturing, national chains, computer industries, etc. as well as small businesses, a community college and a state university, It has become difficult for the average wage earner to live in this County. Home prices have skyrocketed - a 450 square foot home sells for $500,00 - gas prices are higher than Santa Clara County, as are groceries and household goods.

Doctors have been forced to move out of the area, some will not take patients from some health plans because the reimbursements are too low. Doctors spend many years getting a degree and often have large loans to repay. It is unfair to expect them to live in a 2005 economic area based on 1960 reimbursement scale.

Please make it possible for the citizens of this County to have decent medical coverage. The present reimbursement table is outdated and should be changed. Our lives depend on getting good medical care.

Sincerely,

Barbara J. Symons

Barbara J. Symons
225 Mount Hermon Road, Sp 162
Scotts Valley, CA 95066

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GPCIs

August 25, 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:

I am a 70 year old retired male living in Santa Cruz, Ca., and I am concerned that the cost of living here prohibits young medical doctors from staying here.

The median cost of a home in Santa Cruz is upward of $750,000, and most young doctors leave after a one year committment because of the cost of living that accompanies such a housing market.

When I heard that Medicare still rates this county as "rural," I was most surprised. This county's population is decidedly "unrural."

In this county approximately 32,000 people are elgible for Medicare. I personally have had 3 general practitioners in the past 3 years and am unable to secure a permanent general practitioner in Santa Cruz as the well established ones are not taking new patients. My last doctor left the first of this year, and I have not been able to get another which is unfortunate because I have high blood pressure which needs constant monitoring. As soon as I inform perspective doctors that I have Medicare, they tell me, "I will get back to you," but they do not. I implore you to raise the rate of payment to a urban rate rather than a rural one. Medicare payments to the physicians need to be higher here so that those seniors who rely on Medicare can obtain services at an equitable rate with other areas of dense populations.

Sincerely,

William P. Monaghan
301 Chace Street
Santa Cruz, Ca. 95060

Arlene Steele
465 Quail Ridge Road
Scotts Valley Ca. 95066

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

Dear Representative,

I support the proposed Medicare change to increase payments to doctors and other medical practitioners in Santa Cruz county to be equivalent to Santa Clara country and other Bay Area jurisdictions.

I have lived in this county for more than 18 years. Our housing prices, gas and other commodities are equal to and in some cases greater than people living in the Santa Clara county area. That area is designated as an urban area and gets more money for medicare services. It is difficult to find doctors that will support Medicare here because of the high cost of living.

Treating this county as an area similar in costs as Santa Clara will acknowledge that fact our medical costs are equivalent to urban counties.

Respectfully,

Arlene Steele

Arlene Steele

UNIVERSITY OF MINNESOTA

Richard C. Prielipp, M.D., MBA, FCCM
JJ Buckley Professor and Chair
E-mail: prielipp@umn.edu

Department of Anesthesiology
Twin Cities Campus

420 Delaware Street SE
B515 Mayo Memorial Building
MMC 294
Minneapolis, MN 55455-0392
Office: 612-624-9990
Fax: 612-626-2363

Friday, 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: reference file code CMS-1502- P
Issue identifier: "TEACHING ANESTHESIOLOGISTS"

Unfortunately, CMS chose not to correct the anesthesia teaching payment policy in the rules changes for the 2006 Medicare Fee Schedule, even as you simultaneously acknowledged the current policy is flawed. I ask you reconsider this action and go forward with a fix for this payment imbalance whereby teaching anesthesiologists are only paid 50% of the fee for each of two concurrent resident cases. This is inconsistent with CMS reimbursement policies for all other specialties. AS you know, 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 where requirements are met. However, a teaching anesthesiologist will only collect 50% of the Medicare fee if he or she supervises residents in two overlapping cases.
Clearly, the current Medicare policy is unwise, unfair, and directly threatens the viability of our nation's anesthesiology teaching programs.

As a Chairman of a major academic Anesthesiology program at the University of Minnesota, I know first hand that a majority of our nation's training programs are in financial distress – a large portion of the pressure is directly induced by this aberrant rule applied only to teaching anesthesiologists. The result is driving our best and brightest teachers away from the University programs. Indeed, I know personally of ten faculty who have abandoned their teaching careers in the last few years.

Other factors are also relevant to this discussion and include:

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

- The current CMS rule unfairly handicaps the viability of academic programs, at the very time increased graduates are needed. The anesthesiology program at the UM is currently on academic ACGME probation. This is in large part a result of the inability to recruit and retain highly qualified academic faculty to fulfill our education and research missions because of budget limitations.

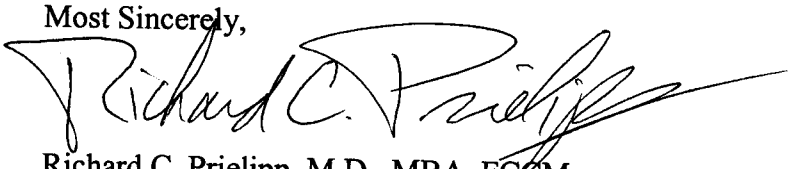
- Academic research in anesthesiology is also drying up as department budgets are broken by this imbalanced Medicare payment reduction rule.

- I and other academic Chairs have urged CMS for the anesthesiology teaching rule to be changed to at least put academic anesthesiology departments on equal financial footing with other medical specialties. As you know, the Medicare anesthesia conversion factor is already less than 40% of prevailing commercial rates. A further reduction of that by 50% for teaching anesthesiologists results in revenue grossly inadequate to sustain the service, teaching and research missions of academic anesthesia training programs. Many, many programs are now suffering as a result, and some are being voluntarily closed.

Therefore, given all these facts, I ask for an urgent remedy on this issue from CMS.

Thank you very much for your kind attention to these national health concerns.

Most Sincerely,



Richard C. Prielipp, M.D., MBA, FCCM
JJ Buckley Professor and Chair
Department of Anesthesiology
B515 Mayo Medical Building
420 Delaware Street S.E.
Minneapolis, MN
55455

196

AUG 3 [illegible]

24 August 2005
Department of Anesthesiology
Froedtert Memorial Lutheran Hospital—East
9200 West Wisconsin Avenue
Milwaukee, WI 53226-3596

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 Madam or Sir:

This is to ask that you please correct the flawed Medicare anesthesiology teaching payment rule.

Current CMS policy reimburses anesthesiologists at about 40% of the reimbursement provided by commercial carriers. Most other physicians receive Medicare reimbursement at about 80% of the reimbursement provided by commercial carriers. This discrepancy is exacerbated by the Medicare anesthesia teaching payment rule that cuts the reimbursement when a teaching anesthesiologist supervises residents in two overlapping cases. However, our colleagues in surgery and medicine are reimbursed fully when supervising overlapping cases or clinic visits.

This is simply not a sustainable situation for academic anesthesiology. I am an associate professor of anesthesiology, and I can assure you there is a shortage of academic anesthesiologists in part because of the disparity between academic salaries and the income available in private practice. The Wall Street Journal recently published an article about the improvements in patient safety made possible by the training that anesthesiologists receive. The current Medicare anesthesiology teaching payment rule puts this training in jeopardy.

Please modify your policy to permit full Medicare reimbursement for teaching anesthesiologists supervising overlapping procedures.

Thank you.

Sincerely,

Robert E Kettler MD

Robert E. Kettler, M. D.
Associate Professor of Anesthesiology

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,

We 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.

We 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. We 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.

Sincerely,

Mary M. Campanelli
(818) 685-3119

Mary M. Campanelli
1860 Via Pacifica Apt. 2106
Aptos, CA 95003

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AUG 31 2005

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 nurse midwife 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,

Timmi Pereira, CNM

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AUG 3 1 2005

Donald Steele
465 Quail Ridge Road
Scotts Valley Ca. 95066

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

Dear Representative,

I support the proposed Medicare change to increase payments to doctors and other medical practitioners in Santa Cruz county to be equivalent to Santa Clara country and other Bay Area jurisdictions.

I have lived in this county for more than 18 years. Our housing prices, gas and other commodities are equal to and in some cases greater than people living in the Santa Clara county area. That area is designated as an urban area and gets more money for medicare services. It is difficult to find doctors that will support Medicare here because of the high cost of living.

Treating this county as an area similar in costs as Santa Clara will acknowledge that fact our medical costs are equivalent to urban counties.

Respectfully,

Donald Steele

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AUG 3 1 2005

Bill Samsel
312 Escalona Dr.
Santa Cruz, CA 95060

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

August 27, 2005

Dear Sir/Madam:

I am writing in support of increasing the reimbursement rate for doctors practicing in Santa Cruz County who treat Medicare patients.

I have lived in Santa Cruz County for 30 years. Last year I moved both of my parents to Santa Cruz County so that I am able to assist them with obtaining the level of heath care they need. On a weekly basis they employ the medical services of several doctors and facilities in our community.

The cost of living in this county is equal to the greater San Francisco Bay area where they previously lived. Also, the total population has grown significantly since I moved here, as has the student population of the University of California at Santa Cruz, now at 15,000 students. The logical conclusion is to change the designation of Santa Cruz County from rural to urban thereby increasing the rate of medical reimbursement.

Yours,

Bill Samsel

Bill Samsel