Date: 09/21/2005

Submitter : **Dr. Edward Wang**

Organization : **Santa Rosa Memorial Emergency Department**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

21 September 2005

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

Re: GPCIs

I understand that Medicare is proposing to create a new payment locality for Sonoma County, California, which is an increasingly expensive place to live, work and practice medicine. 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 quality and quantity of care they deliver to Medicare beneficiaries and other patients as well. The locality change would also benefit efforts to recruit and retain physicians in the county, which has a large Medicare population. This has been a big problem for Sonoma County for many years. Many superb physicians have turned down offers to live and work in Sonoma County due, in part to the high costs of living, the high costs to practice medicine and the inappropriately low Medicare reimbursement. This has caused critical gaps in the coverage for patients and has created difficulties in access to care for Medicare patients and all patients alike. Many primary care doctors are restricting the amount of Medicare patients in their practices for these reasons. As a physician who has practiced in Sonoma County for many years I have personally witnessed this decline in care and I feel that your proposal to create a new Medicare locality for Sonoma County is the first step to correct this problem.

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

Sincerely,

Edward S.J. Wang, MD
Emergency Physician
Santa Rosa Memorial Hospital

Date: 09/21/2005

Submitter : Dr. Paolo Paciucci

Organization : Mount Sinai School of Medicine

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

I am deeply concerned that, without much-needed administrative action, community cancer care could face major losses in 2006. On January 1st, the 3% drug administration transition adjustment will fall to zero, the special funding CMS invested in 2005 in quality cancer care will end, and the physician fee schedule will be hit with a 4.3% cut.

These changes are projected to result in a net operating loss for community cancer care of $437,225,175 in 2006 (bad debt additional). In other words, Medicare payments for services provided to beneficiaries in 2006 will be more than half a billion dollars below the estimated cost of those services. This loss could imperil the community cancer care delivery system on which more than 4 out of 5 patients now depend.
To prevent this crisis, I urge CMS to consider the following proposals:

Provide compensation for the pharmaceutical management and related handling costs incurred by community cancer caregivers. CMS has proposed to compensate HOPDs for such costs by providing an additional 2% of ASP. To help prevent the access crisis discussed above and achieve equity among treatment settings, this payment should also be made available to community cancer care. This payment would increase funding for community cancer care by nearly $85 million next year and would offset nearly one-fifth of the $437,225,175 Medicare operating loss projected for 2006 (bad debt additional).

Continue the Agency?s investment in quality cancer care. This critical source of funding needs to be maintained for 2006, a step recently endorsed by the House Energy and Commerce Committee when it passed H.Res. 261. Doing so would offset nearly two-thirds of the $437,225,175 Medicare operating loss projected for 2006 (bad debt additional), while preventing patient access disruption in 2006 and supporting quality improvement efforts for cancer care.

Work with Congress to replace the SGR formula with annual fee updates. If the 4.3% cut in the Physician Fee Schedule can be corrected before it goes into effect on January 1st, the fix will offset over 8% of the $437,225,175 operating loss projected for 2006 (bad debt additional). In addition, correction of the SGR cut would also provide relief for the reductions that will also impact radiation oncology and physician evaluation and management services.

Refine the proposed revisions to the practice expense methodology. While I commend CMS for the changes it is proposing to make to Medicare practice expense payment policy, I am troubled by the decision to exclude drug administration services from these revisions. Instead, the Agency should include drug administration services in the phase-in of the bottom-up methodology in 2006 and ensure they are exempt from budget neutrality.

Refine the interpretation of ?Prompt Pay Discount.? CMS?s current view of MMA as requiring that all prompt pay discounts be netted out of ASP is reducing Medicare drug reimbursement from 106% of ASP to 104% of ASP. Congressional intent and Supreme Court case law direct that only prompt pay discounts received by the end user-purchasers of drugs should be netted out. Correcting this would restore nearly $85 million in Medicare reimbursement, offsetting one-fifth of the $437,225,175 Medicare operating loss projected for 2006 (bad debt additional).

Date: 09/21/2005

Submitter : Dr. ROY PAULSON

Organization : TEXAS ONCOLOGY PA

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

I AM GREATLY CONCERNED ABOUT THE IMPACT PENDING CUTS WILL HAVE ON THE OVERALL DELIVERY OF CANCER CARE IN THIS COUNTRY. THE 3% DRUG ADMINISTRATION MULTIPLIER WILL FALL TO ZERO, THE DEMONSTRATION PROJECT WILL END AND THE SGR FORMULA WILL RESULT IN A 4.3% CUT IN REIMBURSEMENT. THESE CUTS WILL RESULT IN AN APPROXIAMATE $437,000,000 NET OPERATING LOSS FOR CANCER CARE IN 2006.

PLEASE CONSIDER THE FOLLOWING:
1. COMPENSATE PHARMACEUTICAL MANAGEMENT AND RELATED HANDLING COSTS INCURRED IN COMMUNITY CANCER CENTERS. CMS HAS PROPOSED TO COMPENSATE HOPD FOR THESE COSTS BY ADDING 2% OF ASP. THIS ALONE WOUYLD MITIGATE 20% OF THE PROPOSED CUTS.
2. CONTINUE THE DEMONSTRATION PROJECT FUNDING. THIS WOULD OFFSET ALMOST 65% OF THE PROPOSED REDUCTIONS.
3. WORK WITH CONGRESS TO REPLACE SGR WITH ANUUAL FEE UPDATES
4. INCLUDE DRUG ADMINISTRATION SERVICES IN THE PROPOSALS TO REVISE PRACTICE EXPENSE METHODOLOGY.
5. "PROMPT PAY DISCOUNTS" RECEIVED BY THE USER IS THE THE ONLY PART OF THIS CALCULATION THAT SHOULD BE USED TO REDUCE PAYMENTS TO THE END USER. INTERMEDIARY DISCOUNTS SHOULD NOT BE NETTED OUT OF THE PAYMENTS AND FURTHER REDUCE ASP.
6. CONTIGUOUS BODY PARTS IMAGING IS NOT 50% CHEAPER FOR SUBSEQUENT SCANS. THIS SHOULD ALL BE RECONSIDERED.
7. CONSIDER CODES FOR IGRT.
8. TAKE STEEPS TO IMPROVE THE AVAILABILTY OF IVIG.

THANK YOU FOR YOUR ATTENTION.
BEST REGARDS, STEVE PAULSON MD

Date: 09/21/2005

Submitter : **Mrs. Ginger Rodriguez**

Organization : **act medical group**

Category : **Other Practitioner**

Issue Areas/Comments

GENERAL

GENERAL

I am a practicing oncology nurse in a community cancer clinic. I can verify that the changes in the medicare reimbursement has affected our patients. They certainly now have more out of pocket expenses, increased worries and the need to try and find care at multiple facilities, rather than our one stop shop, we had tried to provide for them. They are already burdened with cancer, fear, worry, fatigue and now an extra choice of trying to make decisions on whether they can afford to go into debt to live or give up any hope of life and choose to get their affairs in order. Quality cancer care will end and no one will be able to provide this much needed service. Thank you for the opportunity to voice my opinion. Ginger Rodriguez, RN

Date: 09/21/2005

Submitter : Dr. Brent Kane

Organization : Dr. Brent Kane

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

I just wanted to make a brief statement in support the revisions as stated for outpatient chemotherapy. I feel they are long overdue to an specialty in medicine that has been overcompensated for several years utilizing a flawed cost formula. This effects overall healthcare in this country when one area (Oncology) is so overpaid at the cost of other healthcare needs.

Date: 09/21/2005

Submitter : Dr. Jeffrey Berman

Organization : University of North Carolina

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

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

Dear Dr. McClellan:
As a teaching anesthesiologist at the University of North Carolina Hospitals I am writing to urge the Centers for Medicare and Medicaid Services (CMS) to change the Medicare anesthesiology teaching payment policy.
Since 1995 Medicare has applied a discriminatory payment schedule to anesthesiology teaching programs. This has had a seriously detrimental financial impact on these programs. Their ability to retain sufficient skilled faculty charged with the education and training of future anesthesiologists has been severely hampered. This in turn impedes progress necessary to alleviate the widely acknowledged shortage of anesthesia providers - a shortage that will be exacerbated in coming years by the aging of the baby boom generation and their need for surgical services.

Under current Medicare regulations, teaching surgeons and other practitioners are permitted to work with residents on overlapping cases and receive full payment provided that the teacher is present for critical or key portions of the procedure. Teaching surgeons may bill Medicare for full reimbursement for each of the two procedures in which he or she is involved. An internist may supervise residents in four overlapping office visits and collect 100% of the allowable fee when certain requirements are met.
Teaching anesthesiologists are also permitted to work with residents on overlapping cases under similar criteria. However, unlike teaching surgeons and internists the teaching anesthesiologists who meet the same criteria of supervision of residents on overlapping cases face a discriminatory payment penalty for each case. The Medicare payment for each case is reduced by 50%. This is an unfair, unreasonable and discriminatory penalty.

This inequity should be corrected to assure fair and consistent application of Medicare?s teaching payment rules across medical specialties. More importantly elimination of this discriminatory payment schedule will be a positive step toward stabilizing academic anesthesiology departments financial situations. The continued strength and quality of American medicine depends upon our postgraduate training programs. Continuation of the current discriminatory reimbursement rules jeopardizes academic programs ability to provide first-rate training by first-rate teaching anesthesiologists.

Please end the anesthesiology teaching payment penalty.

Sincerely yours,

Jeffrey M. Berman, MD, DABA, FAAP
Professor of Anesthesiology
CB# 7010, N2201 UNC Hospitals
University of North Carolina
Chapel Hill, NC 27599-7010

CMS-1502-P-1208

Date: 09/21/2005

Submitter : Dr. P Raich

Organization : Denver Health Medical Center

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

The current ASP needs to be fixed. It should pay for treatment planning and pharmacy facilities and costs. The demonstration project needs to be extended at the current funding levels. Without addressing these critical issues cancer care for the majority of US citizens will be severely curtailed.

Date: 09/21/2005

Submitter : **Mrs. Shirley Ward**

Organization : **Mrs. Shirley Ward**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

Re: GPCIs

I understand that Medicare is proposing to create a new payment locality for Sonoma County, which is an increasingly expensive place to live and work. 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.

Shirley Ward
3504 Hanover Place
Santa Rosa, CA 95404

CMS-1502-P-1211

Date: 09/21/2005

Submitter : **Joseph Muscato**

Organization : **Joseph Muscato**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

A crisis in cancer care and access is imminent. To continue adequate care to Medicare beneficiaries, I urge you to work with Congress to replace the SGR formula with annual fee updates. I would also urge you to work with Congress re H.Res 261. It is also important that prompt pay discounts be netted out of the ASP, since the providers do not get access to that discount, reducing the already meager 6% addition.

Thank you.

Date: 09/21/2005

Submitter : Dr. Carl Myers

Organization : Dr. Carl Myers

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

When we look at our practice data, although many of our patients see us without getting chemotherapy, the cost of our chemotherapy drugs alone is significantly more than our physicians salaries, all our nurses and front office salaries, and all of our administrative costs put together.
I know for myself (I am 54) the changes that are proposed are likely to send me into retirement from practice. It is not unusual to spend a half hour with a patient, get paid $82.16 from medicare(if the patient pays their 20% or has a supplement), and then have the drug bill for that one visit be well over $10,000. Then I see congress working to decrease the amount I am getting paid for my part- which of course includes phone calls which are not reimburseable between visits.
Must get back to patients.

Submitter : **Mrs. Mary Ferkaluk** **Date: 09/22/2005**

Organization : **USOncology Associates**

Category : **Other Health Care Professional**

Issue Areas/Comments

GENERAL

GENERAL

I am deeply concerned that, without much-needed administrative action, community cancer care could face major losses in 2006. On January 1st, the 3% drug administration transition adjustment will fall to zero, the special funding CMS invested in 2005 in quality cancer care will end, and the physician fee schedule will be hit with a 4.3% cut.

These changes are projected to result in a net operating loss for community cancer care of $437,225,175 in 2006 (bad debt additional). In other words, Medicare payments for services provided to beneficiaries in 2006 will be more than half a billion dollars below the estimated cost. This loss could imperil the community cancer care delivery system on which more than 4 out of 5 patients now depend.

I urge you to:

Provide compensation for the pharmaceutical management and related handling costs incurred by community cancer caregivers. CMS has proposed to compensate HOPDs for such costs by providing an additional 2% of ASP. To help prevent the access crisis discussed above and achieve equity among treatment settings, this payment should also be made available to community cancer care. This payment would increase funding for community cancer care by nearly $85 million next year and would offset nearly one-fifth of the $437,225,175 Medicare operating loss projected for 2006 (bad debt additional).

Work with Congress to replace the SGR formula with annual fee updates. If the 4.3% cut in the Physician Fee Schedule can be corrected before it goes into effect on January 1st, the fix will offset over 8% of the $437,225,175 operating loss projected for 2006 (bad debt additional). In addition, correction of the SGR cut would also provide relief for the reductions that will also impact radiation oncology and physician evaluation and management services.

Refine the proposed revisions to the practice expense methodology. While I commend CMS for the changes it is proposing to make to Medicare practice expense payment policy, I am troubled by the decision to exclude drug administration services from these revisions. Instead, the Agency should include drug administration services in the phase-in of the bottom-up methodology in 2006 and ensure they are exempt from budget neutrality.

Refine the interpretation of ?Prompt Pay Discount.? CMS?s current view of MMA as requiring that all prompt pay discounts be netted out of ASP is reducing Medicare drug reimbursement from 106% of ASP to 104% of ASP. Correcting this would restore nearly $85 million in Medicare reimbursement, offsetting one-fifth of the $437,225,175 Medicare operating loss projected for 2006 (bad debt additional).

Review the proposed reimbursement policy for imaging of contiguous body parts. The cost efficiencies that can be achieved through multiple scans in a single setting may total far less than the 50 percent factor proposed by CMS. As a result, the Agency should review this policy to assess whether a smaller reimbursement change would more closely track those overlapping costs that may occur.

Provide reimbursement for Image Guided Radiation Therapy. Image Guided Radiation Therapy (IGRT) has enabled significant progress in the quality of radiation oncology services by enabling treatment to be targeted on cancerous tissue, even if it moves. Because IGRT is so vital for maximizing the effectiveness and minimizing the side effects of radiation therapy, I urge CMS to establish a specific CPT code and provide coverage for this important technology.

Take action to increase access to Intravenous Immune Globulin (IVIG). IVIG plays a vital role in the care of patients with cancer. In light of the current supply shortage, I urge CMS to review the data on which the IVIG ASP is being calculated and revise the Agency?s Prompt Pay Discount interpretation in order to restore a portion of the Medicare reimbursement now lost as a result of the Agency s current interpretation

Thank you for this opportun

Submitter : Ms. Jennifer Mc Elroy

Date: 09/22/2005

Organization : Ms. Jennifer Mc Elroy

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

I am deeply concerned that,without much-needed administrative action, community cancer care could face major losses in 2006. On January 1st, the 3% drug administration transition adjustment will fall to zero, the special funding CMS invested in 2005 in quality cancer care will end, and the physician fee schedule will be hit with a 4.3% cut.

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To prevent this crisis, I urge CMS to consider the following proposals:

Provide compensation for the pharmaceutical management and related handling costs incurred by community cancer caregivers. CMS has proposed to compensate HOPDs for such costs by providing an additional 2% of ASP. To help prevent the access crisis discussed above and achieve equity among treatment settings, this payment should also be made available to community cancer care. This payment would increase funding for community cancer care by nearly $85 million next year and would offset nearly one-fifth of the $437,225,175 Medicare operating loss projected for 2006 (bad debt additional).

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Review the proposed reimbursement policy for imaging of contiguous body parts. The cost efficiencies that can be achieved through multiple scans in a single setting may total far less than the 50 percent factor proposed by CMS. As a result, the Agency should review this policy to assess whether a smaller reimbursement change would more closely track those overlapping costs that may occur.

Thank you for this opportunity to comment on this proposed rule.

Date: 09/22/2005

Submitter : Dr. Mark Fahey

Organization : Santa Rosa Memorial Hospital

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

see attachment

CMS-1502-P-1215-Attach-1.DOC

September 21, 2005

Center for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1052-P
PO Box 8017
Baltimore MD 21244-8017

RE: **GPCIs**

Dear Sirs:

I would ask for your immediate attention to a critical matter regarding appropriation of Medicare dollars in the state of California. I practice as an anesthesiologist in Sonoma County in Northern California at Santa Rosa Memorial Hospital. Over the past 10 years, the medical fabric of the county has been severely strained by the HMO model of medical care and the increasing disparity between our cost of living and our Medicare appropriation. Thankfully the HMO model of medical care has now been set aside for the more patient/doctor friendly model of fee-for-service. And I now ask you to rectify the ongoing disparity of Medicare's vision of Sonoma County and the reality of life in that county.

Sonoma County is not a rural community by the standards that most Americans would use to describe a rural area. I grew up in Wisconsin so I know what rural means in the Midwest. That concept of rural does not apply to Sonoma County, where the cost of housing grows every day and open land is replaced with shopping centers and car dealerships. Our population is a growing and sophisticated one, and also one that is increasing in age and therefore will be increasingly using Medicare services.

So please change the designation of Sonoma County so that physicians here can be reimbursed in a more fair and representative way to what it costs them to practice and live in Sonoma County. The proposed 8% increase in Medicare reimbursement will be a much needed economic incentive to maintain the quality of medical care in this county which will improve the medical opportunities for all of the citizens of Sonoma County and the surrounding communities.

Thank you for your attention.

Sincerely,

Dr. Mark R. Fahey
Board Certified Anesthesiologist
Former OR Medical Director
Santa Rosa Memorial Hospital
707-217-5589

Submitter : **Ms. Pat Poe** **Date: 09/22/2005**

Organization : **Cardiology Associates Inc**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

As a Billing Manager for a Cardiology facility, the office-based imaging is good patient care; and I oppose any legislative efforts that would limit our ability to diagnose and treat Medicare patients using office-based medical imaging.

The growth in medical imaging is helping patients through more efficient and non-invasive diagnosis and detection of disease, as well as more effective monitoring of post treatment outcomes.

Thank you for your consideration on this matter.

Submitter : **Dr. Tim Panella** **Date: 09/22/2005**

Organization : **Univ. of Tennessee**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

We have analyzed the fiscal impact that would result if the AgencI am deeply concerned that, without much-needed administrative action, community cancer care could face major losses in 2006. On January 1st, the 3% drug administration transition adjustment will fall to zero, the special funding CMS invested in 2005 in quality cancer care will end, and the physician fee schedule will be hit with a 4.3% cut.

These changes are projected to result in a net operating loss for community cancer care of $437,225,175 in 2006 (bad debt additional). In other words, Medicare payments for services provided to beneficiaries in 2006 will be more than half a billion dollars below the estimated cost of those services. This loss could imperil the community cancer care delivery system on which more than 4 out of 5 patients now depend.

CMS-1502-P-1218

Submitter : Mrs. Lois Carle

Date: 09/22/2005

Organization : Mrs. Lois Carle

Category : Health Care Provider/Association

Issue Areas/Comments

GENERAL

GENERAL

See attachment

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

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

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

Submitter : Dr. Alan Curle

Date: 09/22/2005

Organization : University of Rochester School of Medicine and Den

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

Dear Dr. Mark McClellan,
I am writing as a faculty member and concerned anesthesiologist from the University of Rochester School of Medicine and Dentristry in Rochester, NY to urge you to change the Medicare anesthesiology teaching payment policy.

Medicare's current policy, dating from 1995, is discriminatory to a specialty that is central to the safe delivery of a critical step in the care of our elderly and disabled population, namely anesthesia services. Our surgical and internal medicine colleagues, when supervising and teaching residents, are reimbursed their full fee for each case when they are present and available for 2 or 4 concurrent cases, respectfully. When a teaching anesthesiologist is fulfilling the same role supervising and teaching 2 concerrent cases, he or she sees their fee cut to 50% of each case. This is not only unfair, but unwise, as it decreases the resources for academic anesthesiology programs. These same programs and their physician anesthesiologists are the source of research that has, and will continue, to reduce the risk and ultimately the cost of care not only to the Medicare and Medicaid populations, but to any patient who requires anesthesia services. These programs cannot continue to see this loss of revenue and still allow time for the development through faculty research of new and safer techniques. It should be noted that Medicare alrady reimburses anesthesia services at only 40% of the average value of commercial insurance rates.

Correcting this Medicare inequity for teaching anesthesiologists 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 penalty. Thank you for your consideration and time.

Alan E. Curle, MD
Associate Professor of Clinical Anesthesiology
University of Rochester School of Medicine and Dentistry
601 Elmwood Avenue
Rochester, NY 14642

Submitter : Dr. Joseph Slappey

Organization : Forsyth Street Orthopaedic Suregry

Date: 09/22/2005

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

In response to the proposed rule to eliminate payment for casting supplies, (Temporary Q codes) I would like to make the following comments.

The practice expense associated to the fracture treatment codes has not been adjusted to reflect the expenses incurred by the physicians. Three scenarios will play out.

1) The physician will pass the expense along to the patient. (If CMS allows)

2) When quality of care allows, physicians will refer patients to DME suppliers for prefabricated splints and braces to limit the amount of overhead loss, in doing so this will actually increase the cost to the Medicare program

3) Increasingly higher payment reductions beyond the control of physicians will lend to physicians opting out of the Medicare program, creating additional hardship for the patient and the program.

As Medicare changes so do the private payers. By eliminating the payment for the Q-codes, physicians will lose from the private sector as well. Most all private payers are making appropriate reimbursement based on the descriptions of the Q codes. This change effects payment not only on the Medicare age but will dramatically effect the reimbursement for patients of all ages. By selecting casting supplies to be eliminated Medicare is effecting the physician?s total patient population. Cuts made by Medicare are better transitioned if they are associated with those items or procedures most commonly incurred by the Medicare population.

Payment cuts made to maintain a balanced budget should be shared equally across all specialties. The proposed elimination of payment for all casting supplies will only impact one specialty. As changes are made to maintain a balanced budget care should be given to create change that will result in smaller loss to all as opposed to significant loss to one specialty.

Treatment of trauma and urgent needs put the patient and the physician in situations that are beyond their control. As payment reductions are made, it is more appropriate to reduce payments for planned or ?scheduled? procedures / items thereby allowing more control on the physician and the patient when loss is concerned allowing the patient and physician involvement in the decision process.

Hopefully CMS will postpone this action and reconsider. Future plans for a balanced budget should be made with the considerations mentioned above.

CMS-1502-P-1221

Submitter : Mr. Craig Wise

Date: 09/22/2005

Organization : Mr. Craig Wise

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

I am deeply concerned that, without much-needed administrative action, community cancer care could face major losses in 2006. On January 1st, the 3% drug administration transition adjustment will fall to zero, the special funding CMS invested in 2005 in quality cancer care will end, and the physician fee schedule will be hit with a 4.3% cut.

These changes are projected to result in a net operating loss for community cancer care of $437,225,175 in 2006 (bad debt additional). In other words, Medicare payments for services provided to beneficiaries in 2006 will be more than half a billion dollars below the estimated cost of those services. This loss could imperil the community cancer care delivery system on which more than 4 out of 5 patients now depend.

To prevent this crisis, I urge CMS to consider the following proposals:

Provide compensation for the pharmaceutical management and related handling costs incurred by community cancer caregivers. CMS has proposed to compensate HOPDs for such costs by providing an additional 2% of ASP. To help prevent the access crisis discussed above and achieve equity among treatment settings, this payment should also be made available to community cancer care. This payment would increase funding for community cancer care by nearly $85 million next year and would offset nearly one-fifth of the $437,225,175 Medicare operating loss projected for 2006 (bad debt additional).

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Work with Congress to replace the SGR formula with annual fee updates. If the 4.3% cut in the Physician Fee Schedule can be corrected before it goes into effect on January 1st, the fix will offset over 8% of the $437,225,175 operating loss projected for 2006 (bad debt additional). In addition, correction of the SGR cut would also provide relief for the reductions that will also impact radiation oncology and physician evaluation and management services.

Refine the proposed revisions to the practice expense methodology. While I commend CMS for the changes it is proposing to make to Medicare practice expense payment policy, I am troubled by the decision to exclude drug administration services from these revisions. Instead, the Agency should include drug administration services in the phase-in of the bottom-up methodology in 2006 and ensure they are exempt from budget neutrality.

Refine the interpretation of ?Prompt Pay Discount.? CMS?s current view of MMA as requiring that all prompt pay discounts be netted out of ASP is reducing Medicare drug reimbursement from 106% of ASP to 104% of ASP. Congressional intent and Supreme Court case law direct that only prompt pay discounts received by the end user-purchasers of drugs should be netted out. Correcting this would restore nearly $85 million in Medicare reimbursement, offsetting one-fifth of the $437,225,175 Medicare operating loss projected for 2006 (bad debt additional).

Review the proposed reimbursement policy for imaging of contiguous body parts. The cost efficiencies that can be achieved through multiple scans in a single setting may total far less than the 50 percent factor proposed by CMS. As a result, the Agency should review this policy to assess whether a smaller reimbursement change would more closely track those overlapping costs that may occur.

Thank you for this opportunity to comment on this proposed rule.

Submitter : Dr. Peter Byeff

Date: 09/22/2005

Organization : Offices of Peter D. Byeff, M.D. and K. Smith, M.D.

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

If nothing is done to improve reimbursement for Medicare patients with cancer, our offices which provide cancer care for many of your constituents in Central Connecticut will simply not be able to afford to treat Medicare patients in 2006. The Medicare Demonstration Project needs to be continued at the same reimbrsement level, and we need reimbursement for Pharmacy services we provide to Medicare patients. Also, the ASP plus 6% needs to be increased, recognizing the costs we incur for maintaining a drug inventory, disposal of toxic waste, and spillage and breakage. If we cannot treat Medicare beneficiaries, who will provide these services? Please make certain that reimbursement is maintained at an adequate level for our offices and those of our colleagues to continue to provide treatment for cancer patients who are Medicare beneficiaries. If we do not provide these services in our offices, the cost to Medicare will be significantly higher.

Submitter : **Dr. Georg Burkhard Mackensen** **Date: 09/22/2005**

Organization : **Duke University Medical Center**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

G. Burkhard Mackensen, MD PhD
Department of Anesthesiology
Division of Cardiothoracic Anesthesia and Critical Care
Duke University Medical Center
Box 3094
Durham, NC 27710

Submitter : **Mr. Louis Rose** **Date: 09/22/2005**

Organization : **None**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

RE: GPCIs
I strongly support the proposal to create a new payment locality for Sonoma County, CA. One need live here only a short time to recognize that Sonoma is increasingly an expensive place to live and work (for doctors and patients alike). Establishing a revised payment locality for Sonoma County is essential if MEDICARE participants are to continue to receive requisite medical care. We need this incentive to help recruit and retain physicians in the county; which has a large MEDICARE population. Like any business, medical practices must be able to cover their expenses and yield reasonable 'profits'. Removing this ability by not increasing the physician fee schedule is not in anyone's best interest. I appreciate this opportunity to comment and again urge positive action on the proposal to create a new payment locality for Sonoma County.

Submitter : **Dr. Steven Ketchel**

Date: 09/22/2005

Organization : **Arizona Oncology Associates**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

On January 1st, the 3% drug administration transition adjustment will fall to zero, the special funding CMS invested in 2005 in quality cancer care will end, and the physician fee schedule will be hit with a 4.3% cut.

These changes are projected to result in a net operating loss for community cancer care of $437,225,175 in 2006 (bad debt additional). In other words, Medicare payments for services provided to beneficiaries in 2006 will be more than half a billion dollars below the estimated cost of those services. This loss could imperil the community cancer care delivery system on which more than 4 out of 5 patients now depend.

To prevent this crisis, I urge CMS to consider the following proposals:

Provide compensation for the pharmaceutical management and related handling costs incurred by community cancer caregivers. CMS has proposed to compensate HOPDs for such costs by providing an additional 2% of ASP. To help prevent the access crisis discussed above and achieve equity among treatment settings, this payment should also be made available to community cancer care. This payment would increase funding for community cancer care by nearly $85 million next year and would offset nearly one-fifth of the $437,225,175 Medicare operating loss projected for 2006 (bad debt additional).

Work with Congress to replace the SGR formula with annual fee updates. If the 4.3% cut in the Physician Fee Schedule can be corrected before it goes into effect on January 1st, the fix will offset over 8% of the $437,225,175 operating loss projected for 2006 (bad debt additional). In addition, correction of the SGR cut would also provide relief for the reductions that will also impact radiation oncology and physician evaluation and management services.

Refine the proposed revisions to the practice expense methodology. While I commend CMS for the changes it is proposing to make to Medicare practice expense payment policy, I am troubled by the decision to exclude drug administration services from these revisions. Instead, the Agency should include drug administration services in the phase-in of the bottom-up methodology in 2006 and ensure they are exempt from budget neutrality.

Refine the interpretation of ?Prompt Pay Discount.? CMS?s current view of MMA as requiring that all prompt pay discounts be netted out of ASP is reducing Medicare drug reimbursement from 106% of ASP to 104% of ASP. Congressional intent and Supreme Court case law direct that only prompt pay discounts received by the end user-purchasers of drugs should be netted out. Correcting this would restore nearly $85 million in Medicare reimbursement, offsetting one-fifth of the $437,225,175 Medicare operating loss projected for 2006 (bad debt additional).

Take action to increase access to Intravenous Immune Globulin (IVIG). As you know, IVIG plays a vital role in the care of patients with cancer. In light of the current supply shortage, I urge CMS to review the data on which the IVIG ASP is being calculated and revise the Agency?s Prompt Pay Discount interpretation in order to restore a portion of the Medicare reimbursement now lost as a result of the Agency?s current interpretation.

Thank you for this opportunity to comment on this proposed rule.

Submitter : Ms. Lynn Whisler

Date: 09/22/2005

Organization : Health Ventures of Central Iowa L.L.C.

Category : Other Health Care Provider

Issue Areas/Comments

GENERAL

GENERAL

Sec Attachment

CMS-1502-P-1226-Attach-1.DOC

CMS-1502-P-1226-Attach-2.DOC

September 21, 2005

Centers for Medicare and Medicaid Services (CMS), HHS
P.O. Box 8017
Baltimore, MD 21244-8017

Attention: CMS-1502-P
Issue Identifier: Nuclear Medicine Services

To whom it may concern:

These comments pertain to CMS's proposed change in the regulatory definitions to include both diagnostic and therapeutic applications of nuclear medicine and PET technology in the definition of a Designated Health Service. They are being submitted per CMS's request for comments from interested parties as to whether or how to minimize the impact on physicians who are currently parties to arrangements that involve nuclear medicine services and supplies. We would add that these comments also pertain to how to minimize the impact on hospitals who are currently parties to joint ventures with physicians that involve nuclear medicine services, specifically PET technology and supplies.

CMS argues that an increase in technical claims (TC) which occurred between 1999 and 2002 indicates that imaging procedures shifted to physician offices. This shift may, and in our case does, reflect a responsible and conscious decision to joint venture a PET scanner in rural Iowa to avoid duplication of expensive equipment and facilities and provide services considered to be standard of care, while remaining one of the lowest cost providers. The joint venture PET Imaging Center is the only PET scanner in our 13 county service area. Indeed without a joint venture, it is possible that both the physician partners (McFarland Clinic, PC) and the hospital (Mary Greeley Medical Center) would have each purchased a PET scanner.

Hospital/physician joint venture PET Imaging Centers reduce the cost of healthcare for patients in several ways. Patients, who would otherwise have to travel significant distances to receive a PET scan at a higher cost provider, are able to receive services locally. Nuclear medicine technologists are in short supply and consequently highly paid; thus sharing existing staff in a joint venture is more cost effective. The indications for PET scans are very limited and restricted, and our joint venture preauthorizes every exam against these stringent criteria, thus preventing over utilization. The strict limitations on

use make PET imaging an excellent service to joint venture, because it is a relatively low volume, expensive, but very crucial service.

We strongly encourage CMS to continue to exclude diagnostic and therapeutic nuclear medicine procedures, particularly PET services, as designated health services subject to the Stark Law. At a minimum, CMS should grandfather existing PET joint venture services in order to avoid duplication of costly yet needed services in the same community.

Respectfully,

Kimberly Russel, President and CEO
Mary Greeley Medical Center
1111 Duff Avenue
Ames Iowa, 50010

cc: Senator Charles Grassley
Senator Thomas Harkin
Representative James Nussle
Representative James Leach
Representative Leonard Boswell
Representative Tom Latham
Representative Steve King
Tracy Warner

Submitter : Ms. Lynn Whisler

Organization : Mary Greeley Medical Center, Ames Iowa

Category : Hospital

Date: 09/22/2005

Issue Areas/Comments

GENERAL

GENERAL

Sec Attachment

CMS-1502-P-1227-Attach-1.DOC

September 21, 2005

Centers for Medicare and Medicaid Services (CMS), HHS
P.O. Box 8017
Baltimore, MD 21244-8017

Attention: CMS-1502-P
Issue Identifier: Nuclear Medicine Services

To whom it may concern:

These comments pertain to CMS's proposed change in the regulatory definitions to include both diagnostic and therapeutic applications of nuclear medicine and PET technology in the definition of a Designated Health Service. They are being submitted per CMS's request for comments from interested parties as to whether or how to minimize the impact on physicians who are currently parties to arrangements that involve nuclear medicine services and supplies. We would add that these comments also pertain to how to minimize the impact on hospitals who are currently parties to joint ventures with physicians that involve nuclear medicine services, specifically PET technology and supplies.

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use make PET imaging an excellent service to joint venture, because it is a relatively low volume, expensive, but very crucial service.

We strongly encourage CMS to continue to exclude diagnostic and therapeutic nuclear medicine procedures, particularly PET services, as designated health services subject to the Stark Law. At a minimum, CMS should grandfather existing PET joint venture services in order to avoid duplication of costly yet needed services in the same community.

Respectfully,

Kimberly Russel, President and CEO
Mary Greeley Medical Center
1111 Duff Avenue
Ames Iowa, 50010

cc: Senator Charles Grassley
Senator Thomas Harkin
Representative James Nussle
Representative James Leach
Representative Leonard Boswell
Representative Tom Latham
Representative Steve King
Tracy Warner

Submitter : Dr. Lester Miller

Date: 09/22/2005

Organization : Dr. Lester Miller

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

This letter is in support of the proposed change to physician payment localities in California stated on page 92 of the recent Revisions to Payment Policies for Calendar Year 2006. You are proposing to move my county of Santa Cruz into a separate locality with the result being improved reimbursement for physicians practicing in this geographic area. Santa Cruz should never have been placed in area 99. This county has one of the highest costs of living and practice in the greater San Francisco Bay Area and Monterey Bay Area. We certainly have similar costs to Santa Clara County, an adjacent county to the Northeast that currently has a 24% higher reimbursement rate.

This re-classification of Santa Cruz into a separate category will go a long way to making reimbursement for medical services on a more equitable level. It will also improve access for seniors.

Thank you for considering my comments.

Lester D. Miller, M.D.
Rheumatologist
Specialist in Arthritis & Rheumatic Diseases

CMS-1502-P-1229

Submitter : Dr. james stone

Organization : James F. Stone,MD

Category : Physician

Date: 09/22/2005

Issue Areas/Comments

GENERAL

GENERAL

Many of us practicing physicians in Sonoma County will not much longer be able to shoulder the cost structure of the San Francisco Bay area while being reimbursed at Medicare rates appropriate for a rural area. We need to proposed adjustment for our practices to remain viable.

Submitter : **Dr. Ruben Sierra**

Organization : **CBHO**

Category : **Health Care Provider/Association**

Date: 09/22/2005

Issue Areas/Comments

GENERAL

GENERAL

I am deeply concerned that, without much-needed administrative action, community cancer care could face major losses in 2006. On January 1st, the 3% drug administration transition adjustment will fall to zero, the special funding CMS invested in 2005 in quality cancer care will end, and the physician fee schedule will be hit with a 4.3% cut.

These changes are projected to result in a net operating loss for community cancer care of $437,225,175 in 2006 (bad debt additional). In other words, Medicare payments for services provided to beneficiaries in 2006 will be more than half a billion dollars below the estimated cost of those services. This loss could imperil the community cancer care delivery system on which more than 4 out of 5 patients now depend.
There is much to be said, the reality is that our 5 providers group is having much difficulties with the current CMS payment, current and future.
At our office, in 91 of the reimbursed drugs and supplies, 48 % are paid bellow our cost. Yes, almost half.
CMS does not reimburse for many services/supplies that we provide, in many cases does not recognizes the services at all.
CMS give yearly bonuses to hospitals for disproportional payment for services, yet this is not recognized in our line of practice.
The CMS formula for payments of drugs and some supplies is flawed as ASP is not equal to small and large practices.
Small practices now are being closed, or sold to hospitals as they can no longer survive Medicare and Medicaid underpayments.
Mid-size practices like ours are struggling to provide services as we adjust to this ?Tango?.
It is unlikely we will refer our Medicare patients to the local hospital due to several issues:
1-They are not staffed, equipped and trained to take care of this large number of patients.
2-It is not cost efficient to see Medicare patients and referred them to the local hospitals for chemo, as we are responsible for the immediate complications. Most patients will call our nurses for support, questions, etc.Nurses that are not taking care of them, as they are going to the hospitals. This will increases my overhead significantly, my liability and office stress level.
3-We will not be able to fully staff our office with nursing, anscillary and medical personal if we do not keep an adequate number of patients.
4-We will not be able to absorbe new patients without that staffing, we rather down size , abandon Medicare participation and concentrate on private insurances.
In summary, cancer care is in crisis, at a crossroads, the future is uncertain.

Ruben Sierra, MD
Columbia Basin Hematology and Oncology
Kennewick, Wa 99336

Submitter : Dr. David Wilks

Organization : University of New Mexico Sch of Medicine

Category : Physician

Date: 09/22/2005

Issue Areas/Comments

GENERAL

GENERAL

Dear sirs:

I would like to support the proposed rule change which will allow Anesthesiologists to be reimbursed 100% for each case when supervising residents. This is in line with current practice in other specialties such as surgery and primary care teaching faculty. Primary care providers are reimbursed 100% for up to 4 supervised cases while surgeons are reimbursed 100% for up to 2 supervised cases. I support that Anesthesiology should only be 100% reimbursed for up to two cases as per Surgery due to the high intensity of patient care required in the specialty.

The reduced reimbursement has significantly threatened anesthesiology training programs in the United States. Academic departments are struggling to remain fiscally viable. At the current time, there is a great shortage of Anesthesia providers to serve our citizenry and I believe it is imperative that we support our academic departments of Anesthesiology.

Thank you for this opportunity to comment.

David Wilks MD

Submitter : Z. Rosenfeld

Date: 09/22/2005

Organization : Petaluma Health Care District

Category : Other Health Care Provider

Issue Areas/Comments

GENERAL

GENERAL

This letter is in support of the proposed increase in Medicare reimbursements for Health Care providers in Sonoma and other non-urban Califonia Counties. The quality of medical coverage in Sonoma County suffers due to the lower level of reimbursements in this area. This is an area with a high cost of living and Physicians, and insurance providers, have been driven out of business or to other locales, even just across county lines, in order to operate economically. We are just 35 miles form San Francisco and adjacent to Marin and Napa Counties, certainly in the Bay Area urban area of influence, where reimbursements for providers are higher. Please support our local Physicians and bring us up to equity with our neighbors.

Submitter : **Cheryl Allegro**

Organization : **Dominican Hospital**

Category : **Individual**

Date: 09/22/2005

Issue Areas/Comments

GENERAL

GENERAL

Date: September 22, 2005

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

Re: File Code CMS1502-P

Issue Identifier: GPCI?s / Payment Localities

Dear CMS Staff:

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. As an employee of Dominican Hospital, 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 community 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,

Name: Cheryl Allegro

Address: 388 Vega RD
Watsonville, CA 95076

Submitter : Ms. Barbara Freeland

Organization : Harper University Hospital

Date: 09/22/2005

Category : Nurse

Issue Areas/Comments

GENERAL

GENERAL

Telehealth - MNT:As a manager of a diabetes education program with more than 30 years experience in nursing, I feel telehealth MNT should be used only in very limited circumstances. The face to face interaction for assessment, to establish goals, and review written materials is essential. The same would be true for DSMT (I'm glad to see that is not being considered). I would agree with telehealth if there was no access to an educator within 50 miles or if a patient was truely homebound.

Submitter : **Dr. Andrea Styron**

Organization : **Duke University Medical Center**

Category : **Physician**

Date: 09/22/2005

Issue Areas/Comments

GENERAL

GENERAL

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

Dear Dr. McClellan:

I am writing as an anesthesiology resident at Duke University to urge the Centers for Medicare and Medicaid Services (CMS) to change the Medicare anesthesiology teaching payment policy.

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

Under current Medicare regulations, teaching surgeons and even internists are permitted to work with residents on overlapping cases and receive full payment so long as the teacher is present for critical or key portions of the procedure. Teaching surgeons may bill Medicare for full reimbursement for each of the two procedures in which he or she is involved. An internist may supervise residents in four overlapping office visits and collect 100% of the fee when certain requirements are met. Teaching anesthesiologists are also permitted to work with residents on overlapping cases so long as they are present for critical or key portions of the procedure. However, unlike teaching surgeons and internists, since 1995 the teaching anesthesiologists who work with residents on overlapping cases face a discriminatory payment penalty for each case. The Medicare payment for each case is reduced 50%. This penalty is not fair, and it is not reasonable.

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

Sincerely,

Andrea G. Styron M.D.
DUMC 3094
Durham, NC 27710
e-mail: styro002@mc.duke.edu

CMS-1502-P-1236

Submitter : **Dr. Tim Pile**

Organization : **private practice**

Date: 09/22/2005

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

There are two issues of great concern to me personally and to the general medical community re physician reimbusements. The first is equity of payment for the same service in the same economical community. This has become very skewed over time since the inception of Medicare as no {zero} updates have been made at all for evolving demographics. THis is inherently unjust and really is not sustainable for providers in my Sonoma County,California community.
The second concern is the still planned 5% per year reduction in payments over the next 5 years for Medicare patients. This will be the straw that collapsed the overburdened workhorse and the system will come to a place where doctors can't survive financially and patients will be unable to acsess care. Please consider your decisions carefully. Thank you for your hard work.
Sincerely, Tim Pile MD

CMS-1502-P-1237

Submitter :

Organization :

Date: 09/22/2005

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

I find the continual reduction and bundling of procedures will only force more and more physicians to either not accept Medicare patients or certainly maintain a continuous reduction. The cost of supply's and material continually rise. How does CMS expect physicians to stay in practice when reimbursement continually decreases?

If CMS is going to continue with its method of price consideration, it should also be required to limit the supply companies fee scale, the inflation index, cost of living increases, payroll, employee benefits, leasing fee's, phone service fee's, and definitely malpractice.

Submitter : **Ms. Joni Barnard**

Organization : **US Oncology**

Category : **Individual**

Date: 09/22/2005

Issue Areas/Comments

GENERAL

GENERAL

I am deeply concerned that, without much-needed administrative action, community cancer care could face major losses in 2006. On January 1st, the 3% drug administration transition adjustment will fall to zero, the special funding CMS invested in 2005 in quality cancer care will end, and the physician fee schedule will be hit with a 4.3% cut.

These changes are projected to result in a net operating loss for community cancer care of $437,225,175 in 2006 (bad debt additional). In other words, Medicare payments for services provided to beneficiaries in 2006 will be more than half a billion dollars below the estimated cost of those services. This loss could imperil the community cancer care delivery system on which more than 4 out of 5 patients now depend.

To prevent this crisis, I urge CMS to consider the following proposals:

Provide compensation for the pharmaceutical management and related handling costs incurred by community cancer caregivers. CMS has proposed to compensate HOPDs for such costs by providing an additional 2% of ASP. To help prevent the access crisis discussed above and achieve equity among treatment settings, this payment should also be made available to community cancer care. This payment would increase funding for community cancer care by nearly $85 million next year and would offset nearly one-fifth of the $437,225,175 Medicare operating loss projected for 2006 (bad debt additional).

Continue the Agency?s investment in quality cancer care. This critical source of funding needs to be maintained for 2006, a step recently endorsed by the House Energy and Commerce Committee when it passed H.Res. 261. Doing so would offset nearly two-thirds of the $437,225,175 Medicare operating loss projected for 2006 (bad debt additional), while preventing patient access disruption in 2006 and supporting quality improvement efforts for cancer care.

Work with Congress to replace the SGR formula with annual fee updates. If the 4.3% cut in the Physician Fee Schedule can be corrected before it goes into effect on January 1st, the fix will offset over 8% of the $437,225,175 operating loss projected for 2006 (bad debt additional). In addition, correction of the SGR cut would also provide relief for the reductions that will also impact radiation oncology and physician evaluation and management services.

Refine the proposed revisions to the practice expense methodology. While I commend CMS for the changes it is proposing to make to Medicare practice expense payment policy, I am troubled by the decision to exclude drug administration services from these revisions. Instead, the Agency should include drug administration services in the phase-in of the bottom-up methodology in 2006 and ensure they are exempt from budget neutrality.

Refine the interpretation of ?Prompt Pay Discount.? CMS?s current view of MMA as requiring that all prompt pay discounts be netted out of ASP is reducing Medicare drug reimbursement from 106% of ASP to 104% of ASP. Congressional intent and Supreme Court case law direct that only prompt pay discounts received by the end user-purchasers of drugs should be netted out. Correcting this would restore nearly $85 million in Medicare reimbursement, offsetting one-fifth of the $437,225,175 Medicare operating loss projected for 2006 (bad debt additional).

Review the proposed reimbursement policy for imaging of contiguous body parts. The cost efficiencies that can be achieved through multiple scans in a single setting may total far less than the 50 percent factor proposed by CMS. As a result, the Agency should review this policy to assess whether a smaller reimbursement change would more closely track those overlapping costs that may occur.

Provide reimbursement for Image Guided Radiation Therapy. Image Guided Radiation Therapy (IGRT) has enabled significant progress in the quality of radiation oncology services by enabling treatment to be targeted on cancerous tissu

Submitter : **Dr. Jon Kuzmic**

Organization : **Indiana University School of Medicine**

Category : **Physician**

Date: 09/22/2005

Issue Areas/Comments

GENERAL

GENERAL

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

I write to you as a new assistant Staff Anesthesiologist at Indiana University School of Medicine. My group practice is located at Wishard Hosptial. Anesthesia training occurs at one of four hospitals located on the IUPUI campus. Our hospital, while covering all aspects of medicine, is the primary indigent/trauma/obstetric inner city medical facility. Eight months ago I came to the teaching ranks from private practice. While it is exciting and rewarding to be a part of the educational process of our future anesthesiologists, it has been appalling to discover how our time and effort is currently being reimbursed. I find academic training very difficult and stressing. In private practice my focus was one patient, one operation. That in itself can be overwhelming at times. Our training and expertise prepares us to handle life-threatening emergency situations. For that and the other duties we perform as physicians, we are compensated at a certain customary level. Overseeing multiple operating rooms adds another level of challenge to an already randomly dangerous situation. I have seen both sides now. Our specialty has one of the largest components of it?s normal day being sudden unexpected life-threatening situations. I did not feel overcompensated for the level of care I gave when my focus was one patient, one operation; but to learn that my collegues in academia are dealing with 3-4 times these situations in a given time period and being paid less, is difficult to understand. This current Medicare teaching anesthesiologist payment rule is unfair.

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

Teaching anesthesiologists are also permitted to work with residents on overlapping cases so long as they are present for critical or key portions of the procedure. However, unlike teaching surgeons and internists, since 1995 the teaching anesthesiologists who work with residents on overlapping cases face a discriminatory payment penalty for each case. The Medicare payment for each case is reduced 50%. This penalty is not fair nor reasonable.

The country is now in situation where anesthesia residency programs are going unfilled. The ramifications of this current Medicare teaching anesthesiologist payment rule also creates a disincentive for residents to go into, and for staff to stay in academic anesthesia. Anesthesia programs cannot compete with private practice on a monetary basis because of laws that withhold 50% of their funds for concurrent cases. Academic research in anesthesiology, vitally important to the wellfare of our future is compromised as well. None of this is going to have any positive effect on the widely-acknowledged shortage of anesthesia providers -- a shortage that will be exacerbated in coming years by the aging of the baby boom generation and their need for surgical services.

Please end the anesthesiology teaching payment penalty.

Respectfully,

Jon P. Kuzmic M.D.
Department of Anesthesia
Indiana University School of Medicine
1001 West 10th Street, FM 400
Indianapolis, IN 46202

Submitter : Mrs. Micki Juip

Organization : Hurley Medical Center

Date: 09/22/2005

Category : Nurse

Issue Areas/Comments

GENERAL

GENERAL

I agree with the proposal to add individual MNT as represented by HCPCS codes G0270, 97802 & 97803 to the list of Medicare telehealth services. We currently do and have done telephone follow up with positive patient outcomes evidencing this format supports the patient to make changes after initial instruction. I would also support a proposal to add individual DSMT as represented by HCPCS code G0108 to the list of Medicare telehealth services after initial education has been provided. Similarly, we have done telephone follow up with positive patient outcomes after initial instruction. Currently BGM companies, pump companies guide patients over the phone for use of these types of devises,so this has been done. Telehealth should include telephone communications.

Submitter : **Eddie Atwell**

Date: 09/22/2005

Organization : **Georgia Bone**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

I am writing to protest the proposed fee schedule reductions for Orthopedists. Elimination of coverage for Q codes and overall reductions for orthopedics in general will present further hardship on surgeons trying to take care of the Medicare population. To continue to reduce reimbursements when physician costs and overhead continue to rise makes no economic sense. You cannot balance the budget on the backs of physicians and expect to continue to have people to take care of the elderly population who deserve to receive the best healthcare possible. As it stands now, the reimbursement for a total joint replacement is a losing proposition financially. It is a long and difficult procedure that most times requires two surgeons. It is, however, a life changing operation for many people which is why we continue to do it. How long, however, will surgeons be able to afford to do so? How many people would continue to do a job that year after year resulted in less income? How would our staff respond if we gave them a salary reduction every year instead of a raise? It is vital that the fee schedule not be reduced to ensure the continued care of our senior citizens and survival of physicians.
Sincerely,
Ed Atwell, M.D.

CMS-1502-P-1242

Submitter :

Date: 09/22/2005

Organization : Long Term Care Interagency Commission

Category : Local Government

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1502-P-1242-Attach-1.DOC

County of Santa Cruz

IN-HOME SUPPORTIVE SERVICES ADVISORY COMMISSION

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

September 22, 2005

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

SUBJECT: GPCI's

To Whom It May Concern:

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

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

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

Respectfully submitted,

Michael Molesky,
Chairperson

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

CMS-1502-P-1243

Submitter :

Organization :

Date: 09/22/2005

Category : Local Government

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

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

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

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

Submitter : **Dr. David Duggan** **Date: 09/22/2005**

Organization : **Dr. David Duggan**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

I am deeply concerned that, without much-needed administrative action, community cancer care could face major losses in 2006. On January 1st, the physician fee schedule will be hit with a 4.3% cut, and the 3% drug administration transition adjustment will fall to zero, the special funding CMS invested in 2005 in quality cancer care will end.

These changes are projected to result in a net operating loss for community cancer care of $437,225,175 in 2006 (bad debt additional). In other words, Medicare payments for services provided to beneficiaries in 2006 will be more than half a billion dollars below the estimated cost of those services. This loss could imperil the Central New York community cancer care delivery system.

To prevent this crisis, I urge CMS to consider the following proposals:

Provide compensation for the pharmaceutical management and related handling costs incurred by community cancer caregivers. CMS has proposed to compensate HOPDs for such costs by providing an additional 2% of ASP. To help prevent the access crisis discussed above and achieve equity among treatment settings, this payment should also be made available to community cancer care. This payment would increase funding for community cancer care by nearly $85 million next year and would offset nearly one-fifth of the $437,225,175 Medicare operating loss projected for 2006 (bad debt additional).

Continue the Agency?s investment in quality cancer care. This critical source of funding needs to be maintained for 2006, a step recently endorsed by the House Energy and Commerce Committee when it passed H.Res. 261. Doing so would offset nearly two-thirds of the $437,225,175 Medicare operating loss projected for 2006 (bad debt additional), while preventing patient access disruption in 2006 and supporting quality improvement efforts for cancer care.

Work with Congress to replace the SGR formula with annual fee updates. If the 4.3% cut in the Physician Fee Schedule can be corrected before it goes into effect on January 1st, the fix will offset over 8% of the $437,225,175 operating loss projected for 2006 (bad debt additional). In addition, correction of the SGR cut would also provide relief for the reductions that will also impact radiation oncology and physician evaluation and management services.

Refine the proposed revisions to the practice expense methodology. While I commend CMS for the changes it is proposing to make to Medicare practice expense payment policy, I am troubled by the decision to exclude drug administration services from these revisions. Instead, the Agency should include drug administration services in the phase-in of the bottom-up methodology in 2006 and ensure they are exempt from budget neutrality.

Refine the interpretation of ?Prompt Pay Discount.? CMS?s current view of MMA as requiring that all prompt pay discounts be netted out of ASP is reducing Medicare drug reimbursement from 106% of ASP to 104% of ASP. Congressional intent and Supreme Court case law direct that only prompt pay discounts received by the end user-purchasers of drugs should be netted out. Correcting this would restore nearly $85 million in Medicare reimbursement, offsetting one-fifth of the $437,225,175 Medicare operating loss projected for 2006 (bad debt additional).

Thank you for this opportunity to comment on this proposed rule.

Submitter : Ms. Gail Goudreau

Date: 09/22/2005

Organization : Ms. Gail Goudreau

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

This is in support of the proposed revision to the physician payment localties in California, specifically Santa Cruz County. It is becoming more and more difficult to find physicians that are able to accept new MediCal patients. It is totally inadequate the rates they are expected to receive.

Submitter : Ms. Barbara Epstein

Organization : Ms. Barbara Epstein

Category : Individual

Date: 09/22/2005

Issue Areas/Comments

GENERAL

GENERAL

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. In the new locality, the Medicare reimbursement rate would be more closely matched to actual practice expenses than it is now.

The locality change would benefit efforts to recruit and retain physicians in the county, which has a large Medicare population.

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

Submitter : Dr. Stephen Patteson

Organization : University Anesthesiologists

Category : Academic

Date: 09/23/2005

Issue Areas/Comments

GENERAL

GENERAL

see attachment

CMS-1502-P-1247-Attach-1.DOC

9/28/2005

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

File Code: CMS-1502-P
Issue Identifier: TEACHING ANESTHESIOLOGISTS

As a teaching anesthesiologist in an accredited university residency program and assigned to oversee our day to day business office, I am concerned about the lack of a correction in the discriminatory policy of paying teaching anesthesiologists only 50% of the fee for each of two concurrent resident cases. The gap between reimbursement in the private sector and university setting is widening and creating a situation in which it is becoming impossible to attract anesthesiologists into the academic setting. This will not allow the continued flow of qualified anesthesiologists to take care of Medicare patients and educate qualified residents for quality anesthesia care in the future. You have invited comments suggesting improvements to the current policy "that would allow it to be more flexible for teaching anesthesia programs". The proposed rule acknowledges that revisions are necessary.

1. The current Medicare teaching anesthesiologist payment rule is unwise, unfair and unsustainable.
2. 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.
3. 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.
4. Anesthesiology teaching programs, caught in the snare of this trap, are suffering severe economic losses that cannot be absorbed elsewhere.
5. The CMS anesthesiology teaching rule must be changed to allow academic departments

to cover their costs.

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

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

8. 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.

9. The Medicare anesthesia conversion factor is less than 40% of prevailing commercial rates. Revenue is grossly inadequate to sustain the service, teaching and research missions of academic anesthesia programs.

Thank you for your attention to this matter. Training residents by qualified teaching attending anesthesiologist is the only way to insure the continued level of medical care for Medicare patients.

Sincerely,

Dr. Stephen K. Patteson, MD

1905 Hickory Glen Rd

Knoxville, TN 37932

CMS-1502-P-1248

Submitter : **Dr. Jeffrey Schwartz**

Organization : **Yale University School of Medicine**

Category : **Physician**

Date: 09/23/2005

Issue Areas/Comments

GENERAL

GENERAL

Please see attachment 'cmsletter.doc'

CMS-1502-P-1248-Attach-1.DOC

September 22, 2005

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

Dear Dr. McClellan:

I am writing as an anesthesiologist at Yale University and Yale-New Haven Hospital to urge the Centers for Medicare and Medicaid Services (CMS) to change the Medicare anesthesiology teaching payment policy.

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

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

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

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

Please end the anesthesiology teaching payment penalty.

Jeffrey J. Schwartz, MD

Submitter : **Mr. Richard Hoover**

Organization : **Mr. Richard Hoover**

Category : **Individual**

Date: 09/23/2005

Issue Areas/Comments

GENERAL

GENERAL

"GPCIs"

As a senior citizen I urge you to change the current status of Santa Cruz County from rural classification. It is critical to the survival of our community because the present reimbursement is not equitable to the services rendered. It is difficult to recruit physicians and maintain services for the older residents. Please change the status for our community.
Thank you.

Submitter : Mrs. Michelle Boyer

Organization : santa cruz medical clinic

Date: 09/23/2005

Category : Nurse

Issue Areas/Comments

GENERAL

GENERAL

Please consider that the county of Santa Cruz has a huge patient population and a much smaller physician reimbursemtent due to our current Rural designation. Please consider changing the county of Santa cruz designation from Rural to City. Our county has had a significant population change and needs to be designated correctly. We will continue to loose many fine physicians unless these changes are made. These physicians can make up to 50% more in reimbursements by crossing the county line. Please take the patients in our county into consideration.
Thanks Michelle Boyer RN, BS

Submitter : **Mr. Phillip Forester**

Organization : **Mr. Phillip Forester**

Category : **Individual**

Date: 09/23/2005

Issue Areas/Comments

GENERAL

GENERAL

I am writing in support of revising the physician payment schedules for Sonoma County in California. Since I began working here in 1970, I have seen this county experience tremendous growth, I have become very aware of the cost of living here, especially for housing. Undoubtedly this was once a rural area, but it is no longer one. A revision of the schedule would more accurately reflect the present demographic and economic realities. I believe it would help us both to retain physicians and bring in new ones to meet the growing population.

Thank you for your taking up this important matter and for an opportunity to present my viewpoint.

Submitter :

Organization : **Palo Alto Medical Foundation** **Date: 09/23/2005**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

I support the change that removes Santa Cruz and Sonoma Counties from California's Locality 99.

Submitter : **Dr. Desmond Brown**

Organization : **Boston University School of Medicine** **Date: 09/23/2005**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

I am opposed to reducing payments for CPT codes 62367 and 62368. The use of implanted infusion pumps to treat severe spasticity has brought relief from pain and improved function to many children and adults. This technology requires a substantial time committment from the physician in order to learn how to evaluate patients for this therapy, and to administer it safely and effectively. Those of us who have chosen to do so must learn the technology, train office and hospital staff, discuss management with other providers such as physical therapists, maintain supplies for treatment, and be available to patients and their families to answer questions and respond to problems. The periodic pump refills and dosage adjustments are only one episode in the ongoing care of these patients; many of these other activities are not reimbursed under most payment systems. Because of the committment that continuous intrathecal therapy requires, relatively few physicians are willing to undertake it, and many patients are denied this effective treatment. Those of us who do utilize this therapy see patients with improved communications skills, improved ability to sit and stand, and less discomfort; and we receive the thanks of many grateful patients and caregivers. If payment for caring for these patients is reduced, it will be more difficult for physicians to justify the committment of time that is required, and it is likely that access to continuous intrathecal therapy will be reduced.
I would urge you to maintain or even increase reimbursement for this effective and life-changing therapy.

T. Desmond Brown, M.D.
Assistant Professor of Orthoapedic Surgery
Boston University School of Medicine

CMS-1502-P-1254

Submitter : Ms. Kathleen Fellabaum

Date: 09/23/2005

Organization : Harper University Hosp. Diabetes Education

Category : Dietitian/Nutritionist

Issue Areas/Comments

GENERAL

GENERAL

I am opposed to adding medical nutrition therapy as a telehealth service. It is very difficult to accurately assess cognitive levels, literacy levels, emotional state and motivation without seeing the patient. The majority of patients I see describe themselves as visual learners; even a videoconference would decrease effectiveness of intervention for visual learners and would limit other forms of teaching, such as kinesthetic methods. Ability to establish a helping relationship would be decreased. Finally, one must question the level of motivation of patients who are unwilling to keep an appointment. An exception might be a medically homebound patient for followup (not initial) appointments.

Submitter : **Mrs. Sandra Moritz**

Date: 09/23/2005

Organization : **Mrs. Sandra Moritz**

Category : **Consumer Group**

Issue Areas/Comments

GENERAL

GENERAL

September 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

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,

Sandra Moritz
4403 Hedge Court
Rohnert Park, CA 94928

Submitter : **Matthew Twetten**

Organization : **North American Spine Society**

Category : **Health Care Provider/Association**

Date: 09/23/2005

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1502-P-1256-Attach-1.PDF

NORTH AMERICAN SPINE SOCIETY
A NON-PROFIT CORPORATION
22 CALENDAR COURT, 2ND FLOOR, LA GRANGE, ILLINOIS 60525 USA
TOLL-FREE (877)SPINEDR PHONE (708)588-8080 FAX (708)588-1080 WWW.SPINE.ORG

September 23, 2005

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

Dear Doctor McClellan:

The North American Spine Society (NASS), a multidisciplinary 4,000+ member society representing Spine Care Providers, appreciates the opportunity to comment on the Notice of Proposed Rule for the 2006 Physician Payment Schedule, published in the August 8, 2005 *Federal Register.*

We would like to thank CMS for their ongoing leadership in developing and implementing the fee schedules for Physician providers and for being responsive to input from Physician groups. We will attempt to limit our comments to issues relevant to our membership, and we will also attempt to limit our comments in terms of redundant comments from the input provided by other organizations. However, we would remiss if we did not comment to CMS in reference to the proposed 4.3 percent reduction in Medicare payment rates, as required by the outdated and flawed SGR formula. A 4.3% reduction in payment will have a negative impact upon our Medicare patients in that it will result in fewer services being available to the Medicare population. We ask CMS to assert its broad regulatory authority to reverse this projected reduction and restore fair payment to physicians. Other providers like Hospitals, Medicare Advantage Plans, Nursing Homes, and Home Health providers, are all expected to see increases in reimbursement. To increase these areas of payment, while reducing physician rates only serves to reduce the overall quality of service available to patient populations and creates disincentives for the actual care providers.

Other issues of concern to NASS include the proposed changes to Practice Expense Inputs as recommended by CMS. As we read the proposed rule, CMS has proposed to use the direct practice expense data generated by the RUC and its Practice Expense Advisory Committee (PEAC) to determine direct practice expenses at the CPT code level in a "bottom-up" formula to replace the current "top-down" methodology.

There are several benefits to these changes that we welcome. Changes to a more consistent Practice Expense formula can help to develop an intuitive, stable, practice expense payment system that is consistent across all codes. Under the current PE system, there is a great deal of inconsistency and any movement in the direction of stability and uniformity will have positive effects across providers.

We also believe it is essential that the Practice Expense methodology, if changed, be applied fairly across ALL providers. Under the proposed rule, a group of providers and associations appear to be receiving disproportionate increases as a result of submitting individual surveys to CMS. While we applaud all these groups, such as Oncology, Dermatology, Gastroenterology and Urology, for their hard work in gathering useful data, we also believe that if all societies were provided an opportunity to replicate these surveys, it would result in a much more fair distribution of practice expense payments.

We request that CMS suspend the proposed practice expense changes until 2007, not because the methodology is flawed, but in order to allow all physicians an equal opportunity to submit data relevant to their specialties. It would be unfair to reduce practice expense reimbursement for providers such as Neurosurgeons and Orthopedic surgeons (who are projected to see 2.2% and 1.5% decreases respectively) without allowing those providers the opportunity to submit accurate data. Furthermore, as CMS has established a model for survey data that is acceptable, it would very easy to provide that model to all Medical Specialty societies, allow societies to survey their membership and submit the results, either directly to CMS, or indirectly through the Relative Valued Update Committee. By delaying implementation for a 12 month period, CMS will accomplish its goal of creating a fairer and accurate payment system without imposing cuts that currently appear arbitrary. We feel this is a simple solution that would be well received by all interested parties. NASS is willing to participate and lend our expertise to CMS or any advisory committee charged with dispersing, compiling and analyzing uniform practice expense surveys.

We would also like to commend CMS for seeking methods for updating the currently insufficient Professional Liability Insurance Relative Values. This is of particular interest to NASS as our membership consists largely of those most significantly affected by the continuing rise in liability insurance rates. However, we feel CMS has not gone far enough in changing the current formula and offering significant relief to physicians. While there is no simple solution, we believe CMS should adopt for 2006, the RUC recommended Dominant specialty approach. This approach would at least create a uniform approach that accurately distributes RVUs to those providing the listed procedure.

In addition, we ask CMS to correct PLI inputs for codes that have been identified by the RUC as assigned to incorrect specialties. This list has been thoroughly reviewed and prepared and these changes would provide appropriate and accurate payment to appropriate providers.

Finally, we would like to thank CMS for implementing the payment changes for LOCM to provide uniform reimbursement for physicians. This change will have a positive impact for spine care providers who prescribe LOCM to patients. NASS was happy to participate in the review of LOCM and appreciates CMS's attention to the matter.

Sincerely,

JJ Abitbol, MD
President, NASS

Greg Przybylski, MD
Co-Chair, NASS
Socioeconomic Affairs

Charles Mick, MD
Co-Chair, NASS
Socioeconomic Affairs

CC: Matthew Twetten
Eric Muehlbauer
Thomas Faciszewski, MD

Submitter : **Mr. Donald Ryan**

Date: 09/23/2005

Organization : **CareCore National**

Category : **Health Care Professional or Association**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1502-P-1257-Attach-1.DOC

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

September 28, 2005

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

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

Dear Mr. Kuhn:

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

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

Specifically:

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

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

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

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

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

Sincerely,

Don Ryan
President and Chief Executive Officer
CareCore National

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

---

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

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

Submitter :

Date: 09/23/2005

Organization :

Category : Health Care Professional or Association

Issue Areas/Comments

GENERAL

GENERAL

I am deeply concerned that, without much-needed administrative action, community cancer care could face major losses in 2006. On January 1st, the 3% drug administration transition adjustment will fall to zero, the special funding CMS invested in 2005 in quality cancer care will end, and the physician fee schedule will be hit with a 4.3% cut.

These changes are projected to result in a net operating loss for community cancer care of $437,225,175 in 2006 (bad debt additional). In other words, Medicare payments for services provided to beneficiaries in 2006 will be more than half a billion dollars below the estimated cost of those services. This loss could imperil the community cancer care delivery system on which more than 4 out of 5 patients now depend.

To prevent this crisis, I urge CMS to consider the following proposals:

Provide compensation for the pharmaceutical management and related handling costs incurred by community cancer caregivers. CMS has proposed to compensate HOPDs for such costs by providing an additional 2% of ASP. To help prevent the access crisis discussed above and achieve equity among treatment settings, this payment should also be made available to community cancer care. This payment would increase funding for community cancer care by nearly $85 million next year and would offset nearly one-fifth of the $437,225,175 Medicare operating loss projected for 2006 (bad debt additional).

Continue the Agency?s investment in quality cancer care. This critical source of funding needs to be maintained for 2006, a step recently endorsed by the House Energy and Commerce Committee when it passed H.Res. 261. Doing so would offset nearly two-thirds of the $437,225,175 Medicare operating loss projected for 2006 (bad debt additional), while preventing patient access disruption in 2006 and supporting quality improvement efforts for cancer care.

Work with Congress to replace the SGR formula with annual fee updates. If the 4.3% cut in the Physician Fee Schedule can be corrected before it goes into effect on January 1st, the fix will offset over 8% of the $437,225,175 operating loss projected for 2006 (bad debt additional). In addition, correction of the SGR cut would also provide relief for the reductions that will also impact radiation oncology and physician evaluation and management services.

Refine the proposed revisions to the practice expense methodology. While I commend CMS for the changes it is proposing to make to Medicare practice expense payment policy, I am troubled by the decision to exclude drug administration services from these revisions. Instead, the Agency should include drug administration services in the phase-in of the bottom-up methodology in 2006 and ensure they are exempt from budget neutrality.

Refine the interpretation of ?Prompt Pay Discount.? CMS?s current view of MMA as requiring that all prompt pay discounts be netted out of ASP is reducing Medicare drug reimbursement from 106% of ASP to 104% of ASP. Congressional intent and Supreme Court case law direct that only prompt pay discounts received by the end user-purchasers of drugs should be netted out. Correcting this would restore nearly $85 million in Medicare reimbursement, offsetting one-fifth of the $437,225,175 Medicare operating loss projected for 2006 (bad debt additional).

Review the proposed reimbursement policy for imaging of contiguous body parts. The cost efficiencies that can be achieved through multiple scans in a single setting may total far less than the 50 percent factor proposed by CMS. As a result, the Agency should review this policy to assess whether a smaller reimbursement change would more closely track those overlapping costs that may occur.

Provide reimbursement for Image Guided Radiation Therapy. Image Guided Radiation Therapy (IGRT) has enabled significant progress in the quality of radiation oncology services by enabling treatment to be targeted on cancerous tiss

Submitter : Dr. david green

Organization : Methodist Hospital Houston

Date: 09/23/2005

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

Mark McClellan, M.D., Ph.D.
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attn: CMS-1502-P/TEACHING ANESTHESIOLOGISTS
P.O. Box 8017
Baltimore, MD 21244-8017
Dear Dr. McClellan:
I am writing as an anesthesiologist at Methodist Hospital Houston to urge the Centers for Medicare and Medicaid Services (CMS) to change the Medicare anesthesiology teaching payment policy.
Medicare?s discriminatory payment arrangement, which applies only to anesthesiology teaching programs, has had a serious detrimental impact on the ability of programs to retain skilled faculty and to train the new anesthesiologists necessary to help alleviate the widely-acknowledged shortage of anesthesia providers -- a shortage that will be exacerbated in coming years by the aging of the baby boom generation and their need for surgical services.
Under current Medicare regulations, teaching surgeons and even internists are permitted to work with residents on overlapping cases and receive full payment so long as the teacher is present for critical or key portions of the procedure. Teaching surgeons may bill Medicare for full reimbursement for each of the two procedures in which he or she is involved. An internist may supervise residents in four overlapping office visits and collect 100% of the fee when certain requirements are met. Teaching anesthesiologists are also permitted to work with residents on overlapping cases so long as they are present for critical or key portions of the procedure. However, unlike teaching surgeons and internists, since 1995 the teaching anesthesiologists who work with residents on overlapping cases face a discriminatory payment penalty for each case. The Medicare payment for each case is reduced 50%. This penalty is not fair, and it is not reasonable.
Correcting this inequity will go a long way toward assuring the application of Medicare?s teaching payment rules consistently across medical specialties and toward assuring that anesthesiology teaching is reimbursed on par with other teaching physicians.
Please end the anesthesiology teaching payment penalty.
Name_David M. Green,MD
Address 7 pecan Gorge Ct.
SugarLand, TX 77479

Submitter : Dr. john Barwise

Date: 09/23/2005

Organization : Vanderbilt University Medical Center

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

Mark McClellan, M.D., Ph.D.
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attn: CMS-1502-P/TEACHING ANESTHESIOLOGISTS
P.O. Box 8017
Baltimore, MD 21244-8017
Dear Dr. McClellan:
I am writing as an anesthesiologist at Vanderbilt University Medical Center to urge the Centers for Medicare and Medicaid Services (CMS) to change the Medicare anesthesiology teaching payment policy.
Medicare?s discriminatory payment arrangement, which applies only to anesthesiology teaching programs, has had a serious detrimental impact on the ability of programs to retain skilled faculty and to train the new anesthesiologists necessary to help alleviate the widely-acknowledged shortage of anesthesia providers -- a shortage that will be exacerbated in coming years by the aging of the baby boom generation and their need for surgical services.
Under current Medicare regulations, teaching surgeons and even internists are permitted to work with residents on overlapping cases and receive full payment so long as the teacher is present for critical or key portions of the procedure. Teaching surgeons may bill Medicare for full reimbursement for each of the two procedures in which he or she is involved. An internist may supervise residents in four overlapping office visits and collect 100% of the fee when certain requirements are met.
Teaching anesthesiologists are also permitted to work with residents on overlapping cases so long as they are present for critical or key portions of the procedure.
However, unlike teaching surgeons and internists, since 1995 the teaching anesthesiologists who work with residents on overlapping cases face a discriminatory payment penalty for each case. The Medicare payment for each case is reduced 50%. This penalty is not fair, and it is not reasonable.
Correcting this inequity will go a long way toward assuring the application of Medicare?s teaching payment rules consistently across medical specialties and toward assuring that anesthesiology teaching is reimbursed on par with other teaching physicians.
Please end the anesthesiology teaching payment penalty.
Name John Allan Barwise
Address 1202 Hilmeade drive Nashville TN 37221

Submitter : **Dr. Pavel Illner**

Organization : **Weill Cornell Medical College**

Date: 09/23/2005

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Date: September 23, 2005
To: Centers for Medicare and Medicaid Services
From: YOUR NAME
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 sustain, as department budgets are severely strained by this arbitrary Medicare payment reduction. The current Medicare payment policy is unfair.

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

Sincerely,

Pavel Illner, MD
Weill Cornell Medical College
New York Presbyterian Hospital

CMS-1502-P-1262

Submitter : Dr. George Topulos

Organization : Brigham

Category : Physician

Date: 09/23/2005

Issue Areas/Comments

GENERAL

GENERAL

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

I am writing as an anesthesiologist at Brigham & Women?s Hospital, Harvard Medical School to urge the Centers for Medicare and Medicaid Services (CMS) to change the Medicare anesthesiology teaching payment policy.

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

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

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

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

Please end the anesthesiology teaching payment penalty.

Thank you,
George P. Topulos, M.D.
Associate Professor of Anaesthesia
Harvard Medical School
Director of Educational Programs
Department of Continuing Education

Brigham and Women's Hospital
75 Francis Street
Boston, MA 02115
assistant: 617-732-8749
page: 617-732-5700 #11087
email: Topulos@Zeus.BWH.Harvard.edu

Submitter : Dr. Stevin Dubin

Organization : Medical COllege of Georgia

Date: 09/23/2005

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

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

Name_Stevin Dubin
Address __1120 15th street Augusta GA 30912______________________

CMS-1502-P-1264

Submitter : Dr. Norman Cohen
Organization : Oregon Anesthesiology Group, P.C.
Category : Physician

Date: 09/23/2005

Issue Areas/Comments

GENERAL

GENERAL

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

Dear Dr. McClellan:

I am writing as an anesthesiologist at Good Samaritan Hospital in Corvallis, Oregon to urge the Centers for Medicare and Medicaid Services (CMS) to change the Medicare anesthesiology teaching payment policy.

Medicare?s discriminatory payment arrangement, which applies only to anesthesiology teaching programs, has had a serious detrimental impact on the ability of programs to retain skilled faculty and to train the new anesthesiologists necessary to help alleviate the widely-acknowledged shortage of anesthesia providers -- a shortage that will be exacerbated in coming years by the aging of the baby boom generation and their need for surgical services.
Under current Medicare regulations, teaching surgeons and even internists are permitted to work with residents on overlapping cases and receive full payment so long as the teacher is present for critical or key portions of the procedure. Teaching surgeons may bill Medicare for full reimbursement for each of the two procedures in which he or she is involved. An internist may supervise residents in four overlapping office visits and collect 100% of the fee when certain requirements are met.

Teaching anesthesiologists are also permitted to work with residents on overlapping cases so long as they are present for critical or key portions of the procedure. However, unlike teaching surgeons and internists, since 1995 the teaching anesthesiologists who work with residents on overlapping cases face a discriminatory payment penalty for each case. The Medicare payment for each case is reduced 50%. This penalty is not fair, and it is not reasonable.
Correcting this inequity will go a long way toward assuring the application of Medicare?s teaching payment rules consistently across medical specialties and toward assuring that anesthesiology teaching is reimbursed on par with other teaching physicians.
Please end the anesthesiology teaching payment penalty.

As an anesthesiologist in private practice, the rule does not directly affect me; however, the graying of America makes it essential that payments for teaching anesthesiologists are adequate so that the future supply of anesthesiologists will meet demand. Also, insufficient funding of academic programs is already leading to a dramatic decrease in research in my professional field. Without effective research, advances that have made anesthesia so much safer over the past 30 years will not occur, leading to the inability of anesthesia care to keep pace with the technological advances in other areas of medicine.

Norman A. Cohen, M.D.
5671 NW Foothill Place
Corvallis, OR 97330

Submitter : **Dr. John Eichhorn**

Organization : **University of Kentucky College of Medicine**

Category : **Physician**

Date: 09/23/2005

Issue Areas/Comments

GENERAL

GENERAL

September 23, 2005
Mark McClellan, M.D., Ph.D., Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attn: CMS-1502-P/TEACHING ANESTHESIOLOGISTS
P.O. Box 8017
Baltimore, MD 21244-8017

Dear Dr. McClellan:

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

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 ? and precisely this happens in our OR every single day. An internist may supervise residents in four overlapping office visits and collect 100% of the fee when certain requirements are met.

Teaching anesthesiologists are also permitted to work with residents on overlapping cases so long as they are present for critical or key portions of the procedure. However, unlike teaching surgeons and internists, since 1995 the teaching anesthesiologists who work with residents on overlapping cases face a discriminatory payment penalty for each case. The Medicare payment for each case is reduced 50%. This penalty is not fair, and it is not reasonable. Because of the patient population we serve at our large university teaching hospital, this policy has a dramatically adverse affect on our revenue used to pay faculty salaries and, thus, has contributed to our faculty shortage.

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.

John H. Eichhorn, MD

Professor of Anesthesiology
University of Kentucky, College of Medicine
Lexington, Kentucky 40536-0293
jeichhorn@uky.edu

CMS-1502-P-1266

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

Organization : **Stanford University**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

CMS-1502-P-1267

Submitter : Dr. Joseph Antognini

Organization : University of California, Davis

Category : Physician

Date: 09/23/2005

Issue Areas/Comments

GENERAL

GENERAL

See attachment

CMS-1502-P-1267-Attach-1.DOC

UNIVERSITY OF CALIFORNIA, DAVIS

BERKELEY • DAVIS • IRVINE • LOS ANGELES • MERCED • RIVERSIDE • SAN DIEGO • SAN FRANCISCO

SANTA BARBARA • SANTA CRUZ

SCHOOL OF MEDICINE
DAVIS, CALIFORNIA 95616

Joseph F. Antognini, M.D.
Professor of Anesthesiology and Pain Medicine
Professor, Section of Neurobiology, Physiology and Behavior
University of California, Davis TB-170
Davis, California 95616
530-752-7809 FAX: 530-752-7807
e-mail: jfantognini@ucdavis.edu

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

23 September 2005

Dear Dr. McClellan:

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

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

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

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

Please end the anesthesiology teaching payment penalty.

Sincerely,

Joseph Antognini

Submitter : **Dr. Martin Slodzinski** **Date: 09/23/2005**

Organization : **Johns Hopkins University**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

CMS-1502-P-1269

Submitter :

Date: 09/23/2005

Organization : **Johns Hopkins University**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

Name___Ralph J Fuchs, MD______________________________
Address ___600 North Wolfe Street, Meyer 297A
Baltimore, MD 21287

CMS-1502-P-1269-Attach-1.DOC

CMS-1502-P-1269-Attach-2.DOC

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

Dear Dr. McClellan:

I am writing as an anesthesiologist at [name of institution] to urge the Centers for Medicare and Medicaid Services (CMS) to change the Medicare anesthesiology teaching payment policy.

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

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

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

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

Please end the anesthesiology teaching payment penalty.

Name___Ralph J Fuchs, MD________________________________

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

Dear Dr. McClellan:

I am writing as an anesthesiologist at [name of institution] to urge the Centers for Medicare and Medicaid Services (CMS) to change the Medicare anesthesiology teaching payment policy.

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

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

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

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

Please end the anesthesiology teaching payment penalty.

Name___Ralph J Fuchs, MD______________________________

Submitter : **Dr. Christopher Bernards** **Date: 09/23/2005**

Organization : **Dr. Christopher Bernards**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Currently academic anesthesiologists are paid at approximately half the rate of private practice anesthesiologists. This salary discrepancy has a marked impact on retention of qualified academic teaching faculty and thereby threatens our ability to train physicians now and in the future. A major source of concern in this regard is the plan to reimburse academic anesthesiologists at 50% of the going rate when they are concurrently supervising two resident physicians. Too, given that academic programs are already overburdened with a disproportionate share of Medicare, medic aide, uninsured and under-insured patients the 50% reimbursement is especially onerous.

CMS-1502-P-1271

Submitter : Dr. Judy Kersten **Date:** 09/23/2005

Organization : Medical College of Wisconsin

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

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

The current Medicare practice of reducing reimbursement to 50% for each case, during concurrent involvement of a teaching anesthesiologist with 2 cases performed by residents, is discriminatory and unfair. The latter is obvious. What is not so obvious is the impact this practice will have on the training of physicians in Anesthesiology in the future. Academic Anesthesiology is in dire straights. Increasing fiscal pressure has caused academic physicians to spend less time pursuing necessary research that would advance the care of patients requiring surgery; fewer physicians are selecting academic anesthesiology as a career; and retention of academic physicians is increasingly difficult because of low reimbursement rates and low physician salaries compared to private practice settings. The outlook for the specialty of Anesthesiology and for the perioperative care of future patients (you and me) is dismal if these trends are not reversed. I urge you to act now to insure that the application of Medicare?s teaching payment rule is consistent across medical specialties and to assure that anesthesiology teaching is reimbursed on par with other teaching physicians.

Please end the anesthesiology teaching payment penalty.

Sincerely,

Dr. J. Kersten

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

Organization :

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Mark McClellan, M.D., Ph.D.
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attn: CMS-1502-P/TEACHING ANESTHESIOLOGISTS
P.O. Box 8017
Baltimore, MD 21244-8017
Dear Dr. McClellan:
I am writing as an anesthesiologist at [name of institution] to urge the Centers for Medicare and Medicaid Services (CMS) to change the Medicare anesthesiology teaching payment policy.
Medicare?s discriminatory payment arrangement, which applies only to anesthesiology teaching programs, has had a serious detrimental impact on the ability of programs to retain skilled faculty and to train the new anesthesiologists necessary to help alleviate the widely-acknowledged shortage of anesthesia providers -- a shortage that will be exacerbated in coming years by the aging of the baby boom generation and their need for surgical services.
Under current Medicare regulations, teaching surgeons and even internists are permitted to work with residents on overlapping cases and receive full payment so long as the teacher is present for critical or key portions of the procedure. Teaching surgeons may bill Medicare for full reimbursement for each of the two procedures in which he or she is involved. An internist may supervise residents in four overlapping office visits and collect 100% of the fee when certain requirements are met. Teaching anesthesiologists are also permitted to work with residents on overlapping cases so long as they are present for critical or key portions of the procedure. However, unlike teaching surgeons and internists, since 1995 the teaching anesthesiologists who work with residents on overlapping cases face a discriminatory payment penalty for each case. The Medicare payment for each case is reduced 50%. This penalty is not fair, and it is not reasonable.
Correcting this inequity will go a long way toward assuring the application of Medicare?s teaching payment rules consistently across medical specialties and toward assuring that anesthesiology teaching is reimbursed on par with other teaching physicians.
Please end the anesthesiology teaching payment penalty.
Yasmin B. Amin MD
17Hathaway Street, Jamaica Plain, MA 02130

Submitter : Dr. George Saviello

Organization : University of Wisconsin School of Medicine

Date: 09/23/2005

Category : Academic

Issue Areas/Comments

GENERAL

GENERAL

sce attachment

CMS-1502-P-1273-Attach-1.DOC

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

Dear Dr. McClellan:

I am writing as an anesthesiologist at the University of Wisconsin-Madison to urge the Centers for Medicare and Medicaid Services (CMS) to change the Medicare anesthesiology teaching payment policy.

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

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

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

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

Please end the anesthesiology teaching payment penalty.

George M. Saviello, M.D., M.B.A.
Director of Perioperative Services
Vice Chair of Clinical Operations
Department of Anesthesiology
University of Wisconsin-Madison
School of Medicine
600 Highland Avenue CSC B6/319
Madison, WI 53792-3272

Submitter : Dr. Peter Nagele
Organization : Washington University
Category : Physician

Date: 09/23/2005

Issue Areas/Comments

GENERAL

GENERAL

see attachment

CMS-1502-P-1274-Attach-1.DOC

Peter Nagele, M.D.
Instructor of Anesthesiology
Department of Anesthesiology, Washington University School of Medicine
660 S. Euclid Ave, Box 8054, St. Louis, MO 63110
Phone: 314-747-0670, E-mail: nagelep@morpheus.wustl.edu

September 28, 2005

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

CMS Medicare Anesthesiology Teaching Rule

Dear Dr. McClellan:

I am writing as an anesthesiologist at Washington University School of Medicine, the nation's #3 ranked medical school, to urge the Centers for Medicare and Medicaid Services (CMS) to change the Medicare anesthesiology teaching payment policy.

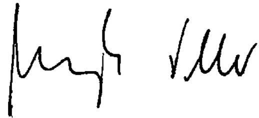
Medicare's discriminatory payment arrangement, which applies only to anesthesiology teaching programs, has had a serious detrimental impact on the ability of programs to retain skilled faculty and to train the new anesthesiologists necessary to help alleviate the widely-acknowledged shortage of anesthesia providers -- a shortage that will be exacerbated in coming years by the aging of the baby boom generation and their need for surgical services. For instance, from our current 2005 residency class, no resident has shown interest in staying in academic anesthesia because of lack of adequate salary compared to private practice.

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

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

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

Please end the anesthesiology teaching payment penalty!



Peter Nagele, MD

Dept of Anesthesiology, Washington University School of Medicine

660 S. Euclid Ave, Box 8054, St. Louis, MO 63110

Submitter : Dr. David Muzic

Organization : University of Chicago

Category : Physician

Date: 09/23/2005

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1502-P-1275-Attach-1.DOC

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

Dear Dr. McClellan:

I am a cardiac anesthesiology fellow at the University of Chicago. As I have seen in our program and have heard from others, academic programs already face difficult financial challenges in staffing adequate numbers of expertly trained anesthesiologist needed to train our future generations of anesthesiologists. Therefore, I am writing to urge the Centers for Medicare and Medicaid Services (CMS) to change the Medicare anesthesiology teaching payment policy.

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

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

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

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

Please end the anesthesiology teaching payment penalty.

Submitter : Eris Weaver

Organization : Eris Weaver

Date: 09/23/2005

Category : Other Health Care Professional

Issue Areas/Comments

GENERAL

GENERAL

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

The new locality would help Sonoma County physicians improve the quantity and quality of care they deliver to Medicare beneficiaries and other patients. Having worked for a local health care district for five years and looked at the budgets for the community clinic and the hospital, I could see the impact that these low reimbursement rates made on health services. The reimbursement rates can be lower than the actual cost of care, the community clinic that serves those in need is awash in red ink, docs are required to see TWENTY-FIVE patients a day just so the clinic can break even...

I've also witnessed our district's attempts to recruit new physicians as older docs retire; we have ended up diverting patients to hospitals in other areas as we go without specialists. The cost of living here is above what physicians expect to make, given the imbalance in reimbursement rates.

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

Submitter : Dr. Emily Ratner

Date: 09/23/2005

Organization : Stanford University School of Medicine

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

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

Emily Ratner, M.D.
Associate Professor of Anesthesia
Department of Anesthesia
Stanford University School of Medicine
300 Pasteur Drive
Stanford, Ca 94305

Submitter : Dr. Philip Lebowitz

Date: 09/23/2005

Organization : Montefiore Medical Center

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

Dear Sirs:

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. Please consider the effect that underfunding academic anesthesiology departments has and will have on the recruitment and retention of our future anesthesiologists' trainers and educators.
Please increase the CMS reimbursement for concurrent patient management to at least match that of our surgical colleagues.

Thank you.

CMS-1502-P-1279

Submitter : Dr. Charles Levine

Organization : Anesthesia Associates of York, PA, Inc

Category : Physician

Date: 09/23/2005

Issue Areas/Comments

GENERAL

GENERAL

Mark McClellan, M.D., Ph.D.
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attn: CMS-1502-P/TEACHING ANESTHESIOLOGISTS
P.O. Box 8017
Baltimore, MD 21244-8017
Dear Dr. McClellan:
I am writing as an anesthesiologist at York Hospital to urge the Centers for Medicare and Medicaid Services (CMS) to change the Medicare anesthesiology teaching payment policy.
Medicare?s discriminatory payment arrangement, which applies only to anesthesiology teaching programs, has had a serious detrimental impact on the ability of programs to retain skilled faculty and to train the new anesthesiologists necessary to help alleviate the widely-acknowledged shortage of anesthesia providers -- a shortage that will be exacerbated in coming years by the aging of the baby boom generation and their need for surgical services.
Under current Medicare regulations, teaching surgeons and even internists are permitted to work with residents on overlapping cases and receive full payment so long as the teacher is present for critical or key portions of the procedure. Teaching surgeons may bill Medicare for full reimbursement for each of the two procedures in which he or she is involved. An internist may supervise residents in four overlapping office visits and collect 100% of the fee when certain requirements are met.
Teaching anesthesiologists are also permitted to work with residents on overlapping cases so long as they are present for critical or key portions of the procedure.
However, unlike teaching surgeons and internists, since 1995 the teaching anesthesiologists who work with residents on overlapping cases face a discriminatory payment penalty for each case. The Medicare payment for each case is reduced 50%. This penalty is not fair, and it is not reasonable.
Correcting this inequity will go a long way toward assuring the application of Medicare?s teaching payment rules consistently across medical specialties and toward assuring that anesthesiology teaching is reimbursed on par with other teaching physicians.
Please end the anesthesiology teaching payment penalty.
Charles B. Levine, M.D.
755 Oakwood Drive
Red Lion, Pennsylvania 17356

Submitter : **Dr. Holly Muir**

Date: 09/23/2005

Organization : **Duke University**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

Duke University Medical Center
Durham, North Carolina, 27710

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

Organization : **UNC School of Medicine**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

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

Sincerely,
Robert Valley MD
UNC School of Medicine
Department of Anesthesiology
UNC at Chapel Hill
Chapel Hill, NC 27599

Submitter : Dr. Scott Boydman

Date: 09/23/2005

Organization : Anesthesia Associates of Northern Ohio, Inc. / ASA

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

Sec Attachment

CMS-1502-P-1282-Attach-1.RTF

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

Dear Dr. McClellan:

I am writing as an anesthesiologist at [name of institution] to urge the Centers for Medicare and Medicaid Services (CMS) to change the Medicare anesthesiology teaching payment policy.

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

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

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

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

Please end the anesthesiology teaching payment penalty.

Scott A. Boydman, D.O.
Anesthesiologist
Anesthesia Associates of Northern Ohio, Inc.
6125 South Broadway Suite West
Lorain, Ohio 44053

Submitter : Lee Perrin

Organization : Lee Perrin

Category : Physician

Date: 09/23/2005

Issue Areas/Comments

GENERAL

GENERAL

I am writing as an anesthesiologist at Caritas St. Elizabeth?s Medical Center of Boston, MA to urge the Centers for Medicare and Medicaid Services (CMS) to change the Medicare anesthesiology teaching payment policy.

Ten percent of our Department?s faculty are leaving in the next few months for higher paying positions in the private sector because they can earn substantially more money. It is difficult to retain faculty when expenses exceed clinical income. Our Medical Center?s budget is stretched and it is difficult for them to subsidize our practice.

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

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

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

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

Please end the anesthesiology teaching payment penalty.

Submitter : Dr. Ann Bailey

Organization : Dr. Ann Bailey

Category : Physician

Date: 09/23/2005

Issue Areas/Comments

GENERAL

GENERAL

I am a teaching anesthesiologist at UNC. I have been teaching residents and fellows the skills needed to be both general anesthesiologists and pediatric anesthesiologists for over 20 years. I have dedicated my life serving the children of North Carolina. I have never understood the reduced reimbursement for my services while training 2 residents simultaneously. I am present for all critical portions of the anesthesia and when necessary, I am present thruout most of the case. I do not feel that my services are in any way compromised by supervising 2 residents at the same time, yet my reimbursement is halved. All other physicians are not subject to this regulation. In fact, I supervise many of my cases much more diligently than the surgeons who may leave their residents to do much more of the case without supervision. There should never have been this ruling against teaching anesthesiologists, and for many of us in state institutions, the reimbursement is now putting us in a state of crisis. Without adequate reimbursement, we cannot pay competitive salaries to anesthesiologists. Many of us are "old-timers" who do this for the love of the patients, but we are an aging group and this will not last much longer. We need to be reimbursed for the work that we do, whether it is with a resident or not.
Thanks for hearing me

Submitter : Dr. Sanjay Jain
Organization : AAM
Category : Physician

Date: 09/23/2005

Issue Areas/Comments

GENERAL

GENERAL

Mark McClellan, M.D., Ph.D.
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attn: CMS-1502-P/TEACHING ANESTHESIOLOGISTS
P.O. Box 8017
Baltimore, MD 21244-8017
Dear Dr. McClellan:
I am writing as an anesthesiologist at Boston Medical Center to urge the Centers for Medicare and Medicaid Services (CMS) to change the Medicare anesthesiology teaching payment policy.
Medicare?s discriminatory payment arrangement, which applies only to anesthesiology teaching programs, has had a serious detrimental impact on the ability of programs to retain skilled faculty and to train the new anesthesiologists necessary to help alleviate the widely-acknowledged shortage of anesthesia providers -- a shortage that will be exacerbated in coming years by the aging of the baby boom generation and their need for surgical services.
Under current Medicare regulations, teaching surgeons and even internists are permitted to work with residents on overlapping cases and receive full payment so long as the teacher is present for critical or key portions of the procedure. Teaching surgeons may bill Medicare for full reimbursement for each of the two procedures in which he or she is involved. An internist may supervise residents in four overlapping office visits and collect 100% of the fee when certain requirements are met.
Teaching anesthesiologists are also permitted to work with residents on overlapping cases so long as they are present for critical or key portions of the procedure. However, unlike teaching surgeons and internists, since 1995 the teaching anesthesiologists who work with residents on overlapping cases face a discriminatory payment penalty for each case. The Medicare payment for each case is reduced 50%. This penalty is not fair, and it is not reasonable.
Correcting this inequity will go a long way toward assuring the application of Medicare?s teaching payment rules consistently across medical specialties and toward assuring that anesthesiology teaching is reimbursed on par with other teaching physicians.
Please end the anesthesiology teaching payment penalty.
Name:_Sanjay Jain, MD
Address: 135 Clark Street, Newton, MA 02459

Submitter : **Dr. L. Michele Noles** **Date: 09/23/2005**

Organization : **Oregon Health**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

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. Without the staff anesthesiologist, the case could NOT be done because the resident in still IN TRAINING and needs back up. The staff anesthesiologist is present for the highest risk elements of the case: putting the patient to sleep, securing the airway, invasive monitoring and waking the patient up.

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

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

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

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

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

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.

Sincerely
L Michele Noles, MD

Submitter : **Dr. Russell McAllister**

Date: 09/23/2005

Organization : **Texas A**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Mark McClellan, M.D., Ph.D.
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attn: CMS-1502-P/TEACHING ANESTHESIOLOGISTS
P.O. Box 8017
Baltimore, MD 21244-8017
Dear Dr. McClellan:
I am writing as the Residency Program Director for the Department of Anesthesiology of Texas A&M University Health Science Center-Scott & White Hospital to urge the Centers for Medicare and Medicaid Services (CMS) to change the Medicare anesthesiology teaching payment policy.
Medicare?s discriminatory payment arrangement, which applies only to anesthesiology teaching programs, has had a serious detrimental impact on the ability of programs to retain skilled faculty and to train the new anesthesiologists necessary to help alleviate the known shortage of anesthesia providers -- a shortage that will be worsened in coming years by the aging of the baby boom generation and their need for surgical services.
Under current Medicare regulations, teaching surgeons and even internists are permitted to work with residents on overlapping cases and receive full payment so long as the teacher is present for critical or key portions of the procedure. Teaching surgeons may bill Medicare for full reimbursement for each of the two procedures in which he or she is involved. An internist may supervise residents in four overlapping office visits and collect 100% of the fee when certain requirements are met.
Teaching anesthesiologists are also permitted to work with residents on overlapping cases so long as they are present for critical or key portions of the procedure.
However, unlike teaching surgeons and internists, since 1995 the teaching anesthesiologists who work with residents on overlapping cases face a discriminatory payment penalty for each case. The Medicare payment for each case is reduced 50%. This penalty is not fair, and it is not reasonable.
Recruitment of quality faculty becomes increasingly difficult as many opt for private practice. Budget shortfalls lead to financial strain of academic anesthesiology departments. Many of these departments are unnecessarily being required to receive assistance in order to remain afloat. As this vicious cycle continues, many of the best teachers will be lost and will never return to the academic setting. This is a terrible loss to our profession that will be felt for many years to come.

I truly love academic anesthesiology and receive great pleasure in helping to train our excellent residents. However, our field is being treated in a manner that is not equivalent to our colleagues in Internal Medicine and Surgery. I urge you to correct this as soon as possible before the damage is too much to recover from.
Correcting this inequity will go a long way toward assuring the application of Medicare?s teaching payment rules consistently across medical specialties and toward assuring that anesthesiology teaching is reimbursed on par with other teaching physicians.
Please end the anesthesiology teaching payment penalty.

Sincerely,
Russell McAllister MD
Residency Director-Dept of Anesthesiology
Texas A&M Health Science Center-Scott & White Hospital
2401 South 31st Street
Temple TX 76508

Submitter : **Dr. Anthony Passannante**

Date: 09/23/2005

Organization : **UNC Anesthesiology Residency Program**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Mark McClellan, M.D., Ph.D.
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attn: CMS-1502-P/TEACHING ANESTHESIOLOGISTS
P.O. Box 8017
Baltimore, MD 21244-8017
Dear Dr. McClellan:
I am writing as the Residency Program Director of the Anesthesiology residency program at the University of North Carolina to urge the Centers for Medicare and Medicaid Services (CMS) to change the Medicare anesthesiology teaching payment policy. I have been the Residency Program Director for a decade, and I have watched the fiscal condition of our Department continually erode as the 1994 change in reimbursement policy makes it impossible for us to both take excellent care of Medicare recipients and maintain financial solvency. As a result, our department is now insolvent.
Medicare's discriminatory payment arrangement, which applies only to anesthesiology teaching programs, has had a serious detrimental impact on the ability of programs to retain skilled faculty and to train the new anesthesiologists necessary to help alleviate the widely-acknowledged shortage of anesthesia providers -- a shortage that will be exacerbated in coming years by the aging of the baby boom generation and their need for surgical services.
Under current Medicare regulations, teaching surgeons and even internists are permitted to work with residents on overlapping cases and receive full payment so long as the teacher is present for critical or key portions of the procedure. Teaching surgeons may bill Medicare for full reimbursement for each of the two procedures in which he or she is involved. An internist may supervise residents in four overlapping office visits and collect 100% of the fee when certain requirements are met.
Teaching anesthesiologists are also permitted to work with residents on overlapping cases so long as they are present for critical or key portions of the procedure. However, unlike teaching surgeons and internists, since 1995 the teaching anesthesiologists who work with residents on overlapping cases face a discriminatory payment penalty for each case. The Medicare payment for each case is reduced 50%. This penalty is not fair, and it is not reasonable.
Please end the anesthesiology teaching payment penalty. Unless the desired result is a serious decline in the quality of residency programs in Anesthesiology nationwide, elimination of this reimbursement penalty must occur soon.
Name: Anthony N. Passannante MD, Associate Professor and Residency Program Director
Address: Department of Anesthesiology, UNC-Chapel Hill, N2201 UNC Hospitals, Campus Box 7010, Chapel Hill, N.C. 27599-7010

Submitter : **Dr. shailesh gandhi**

Organization : **Dr. shailesh gandhi**

Category : **Physician**

Date: 09/23/2005

Issue Areas/Comments

GENERAL

GENERAL

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

Shailesh Gandhi

Submitter : **Dr. Robert Seymour**

Organization : **Dr. Robert Seymour**

Date: 09/23/2005

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

Submitter : Ms. Nicole Webster **Date:** 09/23/2005

Organization : Cancer Care Northwest

Category : Health Care Professional or Association

Issue Areas/Comments

GENERAL

GENERAL

Refine the interpretation of ?Prompt Pay Discount.? CMS?s current view of MMA as requiring that all prompt pay discounts be netted out of ASP is reducing Medicare drug reimbursement from 106% of ASP to 104% of ASP. Congressional intent and Supreme Court case law direct that only prompt pay discounts received by the end user-purchasers of drugs should be netted out. Correcting this would restore nearly $85 million in Medicare reimbursement, offsetting one-fifth of the $437,225,175 Medicare operating loss projected for 2006 (bad debt additional).

Submitter : Dr. David Goodman

Organization : Dr. David Goodman

Date: 09/23/2005

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

Teaching anesthesiologist.
Mark McClellan, M.D., Ph.D.
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attn: CMS-1502-P/TEACHING ANESTHESIOLOGISTS
P.O. Box 8017
Baltimore, MD 21244-8017
Dear Dr. McClellan:
I am writing as an anesthesia resident at Brigham and Woman?s Hospital, Harvard Medical School to urge the Centers for Medicare and Medicaid Services (CMS) to change the Medicare anesthesiology teaching payment policy.
Medicare?s discriminatory payment arrangement, which applies only to anesthesiology teaching programs, has had a serious detrimental impact on the ability of programs to retain skilled faculty and to train the new anesthesiologists necessary to help alleviate the widely-acknowledged shortage of anesthesia providers -- a shortage that will be exacerbated in coming years by the aging of the baby boom generation and their need for surgical services.
Under current Medicare regulations, teaching surgeons and even internists are permitted to work with residents on overlapping cases and receive full payment so long as the teacher is present for critical or key portions of the procedure. Teaching surgeons may bill Medicare for full reimbursement for each of the two procedures in which he or she is involved. An internist may supervise residents in four overlapping office visits and collect 100% of the fee when certain requirements are met.
Teaching anesthesiologists are also permitted to work with residents on overlapping cases so long as they are present for critical or key portions of the procedure.
However, unlike teaching surgeons and internists, since 1995 the teaching anesthesiologists who work with residents on overlapping cases face a discriminatory payment penalty for each case. The Medicare payment for each case is reduced 50%. This penalty is not fair, and it is not reasonable.
Correcting this inequity will go a long way toward assuring the application of Medicare?s teaching payment rules consistently across medical specialties and toward assuring that anesthesiology teaching is reimbursed on par with other teaching physicians.
Please end the anesthesiology teaching payment penalty.
Sincerely,
David Goodman MD
476 Mass. Ave #1, Boston, MA 02118

Submitter : **Dr. Rena Beckerly** **Date: 09/23/2005**

Organization : **Brigham and Women's Hospital**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

Dear Dr. McClellan:
We are writing as anesthesiologist residents at the Brigham and Women?s Hospital in Boston, Massachusetts to urge the Centers for Medicare and Medicaid Services (CMS) to change the Medicare anesthesiology teaching payment policy.

As residents at an academic medical center, we cannot stress the importance of exceptional teachers and mentors at this stage of our careers. The practices and habits we develop during these years will impact the quality and efficacy of our ability to take care of patients in the future. The mentors we have now are the most crucial element of our training as anesthesiologists. Changes in reimbursement have already had a large impact on anesthesiology training programs. The current teaching payment penalty is unfair. If it continues, it WILL further encourage quality anesthesiologist to secure private practice careers over academic ones. Who will train the future anesthesiologists?
Please end the anesthesiology teaching payment penalty.
Sincerely,

Dr. Rena Beckerly
Dr. Sibinka Bajic

CMS-1502-P-1294

Submitter : Dr. Stephanie Jones

Date: 09/23/2005

Organization : Beth Israel Deaconess Medical Center

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

see attachment

CMS-1502-P-1294-Attach-1.DOC

Submitter : Dr. Eileen Begin

Organization : Washington Hospital Center

Category : Physician

Date: 09/23/2005

Issue Areas/Comments

GENERAL

GENERAL

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

Dear Dr. McClellan:

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

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

Under current Medicare regulations, teaching surgeons and even internists are permitted to work with residents on overlapping cases and receive full payment so long as the teacher is present for critical or key portions of the procedure. Teaching surgeons may bill Medicare for full reimbursement for each of the two procedures in which he or she is involved. An internist may supervise residents in four overlapping office visits and collect 100% of the fee when certain requirements are met. Teaching anesthesiologists are also permitted to work with residents on overlapping cases so long as they are present for critical or key portions of the procedure. However, unlike teaching surgeons and internists, since 1995 the teaching anesthesiologists who work with residents on overlapping cases face a discriminatory payment penalty for each case. The Medicare payment for each case is reduced 50%. This penalty is not fair, and it is not reasonable.

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

Please end the anesthesiology teaching payment penalty.

Sincerely,
Eileen Begin, M.D.
Washington Hospital Center
Washington, D.C. 20010

CMS-1502-P-1297

Submitter : Dr. Leonard Horwitz **Date:** 09/23/2005

Organization : Dr. Leonard Horwitz

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

Dear Honorable Sirs:
I agree with the assessment and recommendations of Us Oncology (with whom I am not affiliated). Thank you for your consideration.
Sincerely, Leonard J. Horwitz, M.D.

Submitter : **Dr. Lisa Councilman-Gonzales** **Date: 09/23/2005**

Organization : **Scott**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Mark McClellan, M.D., Ph.D.
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attn: CMS-1502-P/TEACHING ANESTHESIOLOGISTS
P.O. Box 8017
Baltimore, MD 21244-8017
Dear Dr. McClellan:
I am writing as an anesthesiologist at Scott & White Memorial Hospital / Texas A&M University Health Science Center, Temple, TX to urge the Centers for Medicare and Medicaid Services (CMS) to change the Medicare anesthesiology teaching payment policy.
Medicare?s discriminatory payment arrangement, which applies only to anesthesiology teaching programs, has had a serious detrimental impact on the ability of programs to retain skilled faculty and to train the new anesthesiologists necessary to help alleviate the widely-acknowledged shortage of anesthesia providers -- a shortage that will be exacerbated in coming years by the aging of the baby boom generation and their need for surgical services.
Under current Medicare regulations, teaching surgeons and even internists are permitted to work with residents on overlapping cases and receive full payment so long as the teacher is present for critical or key portions of the procedure. Teaching surgeons may bill Medicare for full reimbursement for each of the two procedures in which he or she is involved. An internist may supervise residents in four overlapping office visits and collect 100% of the fee when certain requirements are met. Teaching anesthesiologists are also permitted to work with residents on overlapping cases so long as they are present for critical or key portions of the procedure. However, unlike teaching surgeons and internists, since 1995 the teaching anesthesiologists who work with residents on overlapping cases face a discriminatory payment penalty for each case. The Medicare payment for each case is reduced 50%. This penalty is not fair, and it is not reasonable.
Correcting this inequity will go a long way toward assuring the application of Medicare?s teaching payment rules consistently across medical specialties and toward assuring that anesthesiology teaching is reimbursed on par with other teaching physicians.
Please end the anesthesiology teaching payment penalty.
Sincerely,
Lisa M. Councilman-Gonzales, MD, Assistant Professor of Anesthesiology
Scott & White Memorial Hospital, 2401 S. 31st St., Temple, TX 76508

CMS-1502-P-1299

Submitter : **Dr. Stuart Forman** **Date: 09/23/2005**

Organization : **Massachusetts General Hospital**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

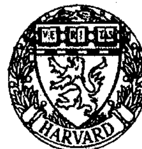
See attachment

CMS-1502-P-1299-Attach-1.PDF

DEPARTMENT OF ANESTHESIA
AND CRITICAL CARE

MASSACHUSETTS GENERAL HOSPITAL
HARVARD MEDICAL SCHOOL

Stuart A. Forman, M.D., Ph.D.
Associate Professor of Anesthesia



Telephone: (617) 724-5156
Facsimile: (617) 724-8644
E-mail: saforman@partners.org

September 23, 2005

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

Dear Dr. McClellan;

I am an academic/teaching anesthesiologist at Massachusetts General Hospital and I am writing to urge CMS to end the unfair policy of paying teaching anesthesiologists only half of the Medicare fee for two concurrent cases.

The United States has a shortage of anesthesiologists, which is likely to worsen as the demand for surgical services and other invasive procedures grows with our aging population. At the same time, academic anesthesiology programs are struggling to recruit and keep talented clinician-teachers. One reason that academic careers are rejected by so many anesthesiologists is that reimbursement of anesthesiologists who are supervising two residents was significantly reduced under 1995 Medicare rules.

Internists can supervise up to four trainees and still receive 100% Medicare reimbursement for each case. Surgeons are allowed to supervise two trainees, and as long as they are present during critical portions of these cases, they are reimbursed 100% for each case. Anesthesiologists are also allowed to supervise two trainees concurrently, and indeed we usually must do this in order to cover our operating rooms, but Medicare only reimburses us 50% of the fee for each case. The half-fee Medicare rule is highly discriminatory, as it only applies to teaching anesthesiologists and not other teaching physicians.

Correcting the inequity implicit in the Medicare reimbursement rules for anesthesiologists will make Medicare fees to teaching physicians fair. It will also help stabilize the workforce of teaching anesthesiologists, who can in turn train the next generation of anesthesiologists.

Yours,

Stuart A. Forman

Stuart A. Forman

Submitter : Dr. Srinivasa Raja

Date: 09/23/2005

Organization : Johns Hopkins University

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

see attachment