Submitter : LAIDE MUSSO

Organization : LAIDE MUSSO

Category : Individual

Date: 09/26/2005

Issue Areas/Comments

GENERAL

GENERAL

LAIDE MUSSO
7397 CIRCLE DR
ROHNERT PARK, CA 94928

MEMORANDUM

DATE: September 20, 2005

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

FROM: Gicela Barajas

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

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

Submitter : STACY CARR

Organization : STACY CARR

Category : Individual

Date: 09/26/2005

Issue Areas/Comments

GENERAL

GENERAL

STACEY CARR
1192 GUAYMAS ST
SANTA ROSA, CA 95401

MEMORANDUM

DATE: September 20, 2005

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

FROM: Gicela Barajas

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

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

Submitter : YVONNE BROONER

Organization : YVONNE BROONER

Category : Individual

Date: 09/26/2005

Issue Areas/Comments

GENERAL

GENERAL

YVONNE BROONER
2161 RACHEL DR.
SANTA ROSA, CA 95401

MEMORANDUM

DATE: September 20, 2005

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

FROM: Gicela Barajas

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

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

Submitter : JOAN RASHTI

Organization : JOAN RASHTI

Category : Individual

Date: 09/26/2005

Issue Areas/Comments

GENERAL

GENERAL

JOAN RASHTI
609 CLOVER DR
SANTA ROSA, CA 95401

MEMORANDUM

DATE: September 20, 2005

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

FROM: Gicela Barajas

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

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

Submitter : BETH FITZGERALD
Organization : BETH FITZGERALD
Category : Individual
Date: 09/26/2005

Issue Areas/Comments

GENERAL

GENERAL

BETH FITZGERALD
2024 BANJO DR
SANTA ROSA, CA 95407

MEMORANDUM

DATE: September 20, 2005

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

FROM: Gicela Barajas

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

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

Submitter : PETER MCCORMICK
Organization : PETER MCCORMICK
Category : Individual
Date: 09/26/2005

Issue Areas/Comments

GENERAL

GENERAL

PETER McCORMICK
2360 FAIRBANKS DR
SANTA ROSA, CA 95403

MEMORANDUM

DATE: September 20, 2005

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

FROM: Gicela Barajas

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

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

Submitter : Dr. Ravindra Prasad
Organization : Univ of N Carolina School of Medicine
Category : Physician
Date: 09/26/2005

Issue Areas/Comments

GENERAL

GENERAL

See attachment

CMS-1502-P-1557-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 North Carolina Hospitals 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. In fact, a significant number of our faculty have left academia in the past year, partly due to the financial limitations of academic practices.

Under current Medicare regulations, teaching surgeons and internists are permitted to work with residents on overlapping cases and receive full payment so long as the teacher is present for critical or key portions of the procedure. Teaching surgeons may bill Medicare for full reimbursement for each of the two procedures in which he or she is involved. An internist may supervise residents in four overlapping office visits and collect 100% of the fee when certain requirements are met. Teaching anesthesiologists, however, must face a discriminatory penalty when supervising residents on similarly overlapping cases. Although anesthesiologists are also present for critical or key portions of the procedure, the Medicare payment for each case is reduced to 50%!

This penalty is neither fair nor 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.

Ravindra Prasad, MD
Assistant Professor of Anesthesiology
University of North Carolina School of Medicine
N2201 North Wing, UNC Hospitals
Chapel Hill, NC 27599-7010

Submitter : CHRISTINE GAREIS

Organization : CHRISTINE GAREIS

Category : Individual

Date: 09/26/2005

Issue Areas/Comments

GENERAL

GENERAL

CHRISTINE GAREIS
7209 CIRCLE DR
ROHNERT PARK, CA 94928

MEMORANDUM

DATE: September 20, 2005

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

FROM: Gicela Barajas

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

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

Submitter : Dr. Anthony Milliano

Organization : Dr. Anthony Milliano

Category : Other Health Care Professional

Date: 09/26/2005

Issue Areas/Comments

GENERAL

GENERAL

September 26, 2005

RE: CMS-1502-P

As a private practice doctor of audiology I am writing to object to the proposed dramatic and historic deep reduction in the reimbursement for audiologists. The sudden elimination the ?non-physician zero work pool? codes without any consideration of practice expense or patient management factors is inappropriate. This is especially egregious in view of your considerations for other non-physician practitioners.

CMS has not recognized nor collected data for audiologic care that would justify this change of policy that has existed for decades.

I would think that in view of the proposed policy change which results in a four times greater reduction for audiologists? reimbursement than any other profession, that CMS should impose a moratorium on reimbursement changes for audiologists. A moratorium would allow for collection of data to justify or refute the current reimbursement levels to audiologists. As you are aware, your proposed change affects more than the 40 million Medicare subscribers. CMS?s rates are used almost universally by other health care insurers.

In view of this massive impact on hearing and balance care services to all Americans, it would seem reasonable to request a period of study. As a private practice doctor of audiology, a cut of this proportion would potentially be the difference between keeping my doors open or closing my practice. It would certainly have a negative impact on my ability, and that of most audiologists to provide the type of care my patients deserve. Thus, I respectfully request that CMS impose a moratorium be place on audiologists? reimbursement reductions in its most recent proposed physician fee schedule.

Sincerely,

Tony Milliano, Au.D., FAAA
Doctor of Audiology

Submitter : NORMAN SPIVAK

Organization : NORMAN SPIVAK

Category : Individual

Date: 09/26/2005

Issue Areas/Comments

GENERAL

GENERAL

NORMAN SPIVAK
735 WHITE OAK DR
SANTA ROSA, CA 95405

MEMORANDUM

DATE: September 20, 2005

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

FROM: Gicela Barajas

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

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

Submitter : MABEL HURD

Organization : MABEL HURD

Category : Individual

Date: 09/26/2005

Issue Areas/Comments

GENERAL

GENERAL

MABEL HURD
4295 HESSEL RD
SEBASTOPOL, CA 95472

MEMORANDUM

DATE: September 20, 2005

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

FROM: Gicela Barajas

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

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

Submitter : Dr. Dianne Byerly

Organization : University of Wisconsin, Madison

Category : Physician

Date: 09/26/2005

Issue Areas/Comments

GENERAL

GENERAL

September 26, 2005
21 Pleasant Oak Ct.
Oregon, WI 53575
September 26, 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 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.

I firmly believe in the above arguments. Medicare must recognize the unique delivery of anesthesiology care and pay Medicare teaching anesthesiologists on par with their surgical colleagues. Please end the anesthesiology teaching payment penalty.

Sincerely,
Dianne M. Byerly, M.D.

Submitter : Dr. Mark Comunale

Date: 09/26/2005

Organization : Saint louis University School of Medicine

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

SEE ATTACHMENT

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

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

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

Submitter : JANE OLSON

Organization : JANE OLSON

Category : Individual

Date: 09/26/2005

Issue Areas/Comments

GENERAL

GENERAL

JANE OLSON
180 OAK ISLAND DR
SANTA ROSA, CA 95405

MEMORANDUM

DATE: September 20, 2005

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

FROM: Joyce Coughlin

Re: GPCIs

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

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

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

Submitter : Dr. David DeKriek

Organization : Hearing Associates

Category : Other Practitioner

Date: 09/26/2005

Issue Areas/Comments

GENERAL

GENERAL

RE: CMS-1502-P

To whom it May Concern:

I am writing to object to the proposed reduction in the reimbursement rates for audiologists, which CMS has included in its proposed fee structure.I am writing to object to the proposed reduction in the reimbursement rates for audiologists, which CMS has included in its proposed fee structure. The sudden elimination of the ?non-physician zero work pool? codes without any consideration of practice expense or patient management factors is inappropriate. CMS has not recognized nor collected data for audiologic care that would justify this change to a policy that has existed for decades. This is especially egregious in view of CMS? considerations for other non-physician practitioners.

In view of this proposed policy change that results in a four times greater reduction for audiologists? reimbursement than any other profession, CMS should impose a moratorium on reimbursement changes for audiologists. A moratorium would allow for collection of data to justify or refute the current reimbursement levels to audiologists. As you are aware, your proposed change would affect more than 40 million Medicare subscribers today, particularly as CMS? rates are used almost universally by other health care insurers. The number of those impacted will only increase as America?s population grows and ages.

In view of this massive change on hearing and balance care services for such a large number of Americans, it would seem reasonable to request such a period of study. As a practicing audiologist, a cut of this proportion would negatively impact my ability ?and that of most audiologists ?to provide the type of care patients deserve. Thus, I respectfully request that CMS impose a moratorium on audiologists? reimbursement reductions in its most recent proposed physician fee schedule.

Sincerely,

David J DeKrick, Au.D.

Submitter : **Ms. Mary DuPont**

Date: **09/26/2005**

Organization : **Radiology Associates**

Category : **Other Health Care Professional**

Issue Areas/Comments

GENERAL

GENERAL

Dear Centers for Medicare & Medicaid Services ? Comment Division:

As an employee of a radiology group practicing in Florida, I appreciate the opportunity to comment on the 2006 Medicare proposed fee schedule and the associated multiple-procedure discount for certain diagnostic imaging services. Our organization is a group with 20 radiologists, four outpatient imaging centers and outpatient hospital services. We provide Medicare services that are based on the best clinical decisions for our patients and not on administrative decisions driven by costs and reimbursement.

We vigorously oppose the multiple services grouping reimbursement for this reason: Performing multiple tests requires additional time, skill, power, and resources and directly affects both patients and staff. Grouping procedures to justify a lower reimbursement provides no medical or monetary benefit to the patients and is ultimately detrimental to overall long-term patient care.

Florida has a large elderly population ? in the areas we serve, approximately 60% or greater of the population are Medicare eligible. Twenty-five percent of our practice supports the Medicare population ? imposing a 4.3% reduction in Medicare reimbursement and instituting a multiple procedure discount results in a combined revenue decrease of 6% while operating and practice expenses continue to rise. This decrease will create budget reductions in staffing, customer services, embracing new technology and other items critical to providing quality patient care and comfort.

We strongly urge you to reconsider the proposed physician payment cuts for 2006 and ask that you design a new payment system that would more appropriately reflect the cost of practicing good medicine.

Sincerely,

Mary DuPont

Submitter : Ms. Debra Kiley **Date:** 09/26/2005

Organization : Community Hospitals of Eastern Middlesex Inc

Category : Other Health Care Provider

Issue Areas/Comments

GENERAL

GENERAL

The CHEM Center for MRI, a nonprofit clinic in Massachusetts, is writing to commment on proposed changes to the Medicare fee schedule 2006 with regard to multiple procedures subject to discount.

The CHEM Center objects to the methodology used by CMS to predict savings accrued to a technical provider for same day service to MRI patients. CMS has identified savings of 50% for the second scan which is a significant overstatement of any savings experienced at our facility. For example, although one patient gown is used, a patient must be repositioned for a second scan and of course the time the patient spends in the MRI unit is not 50% less than for the first scan. It is a complete second test. Although obtaining a consent is only done once, a patient history must comprise all the details around both scans, not just one. Additionally, filming,documentation and reporting is done for two complete tests not one and 1/2.

We urge staff to study any actual savings prior to implementing such a signficant reduction which appears to be arbitrary rather than a careful analysis of the costs involved.

Thank you for the opportunity to comment.

Sincerely yours,

Debra Kiley
Vice President, CHEM

Submitter : Dr. Kay Krebs

Date: 09/26/2005

Organization : Acadamy of Dispensing Audiologists

Category : Other Practitioner

Issue Areas/Comments

GENERAL

GENERAL

RE: CMS-1502-P
To Whom it May Concern:
I am writing to object to the proposed reduction in the reimbursement rates for audiologists, which CMS has included in its proposed fee structure. The sudden elimination the non-physician zero work pool codes without any consideration of practice expense or patient management factors is inappropriate. CMS has not recognized nor collected data for audiologic care that would justify this change to a policy that has existed for decades. This is especially egregious in view of CMS considerations for other non-physician practitioners.

In view of this proposed policy change that results in a four times greater reduction for audiologists reimbursement than any other profession, CMS should impose a moratorium on reimbursement changes for audiologists. A moratorium would allow for collection of data to justify or refute the current reimbursement levels to audiologists. As you are aware, your proposed change would affect more than the 40 million Medicare subscribers today, particularly as CMS rates are used almost universally by other health care insurers. The number of those impacted will only increase as America's population grows and ages.

In view of this massive change on hearing and balance care services for such a large number of Americans, it would seem reasonable to request such a period of study. As a practicing audiologist, a cut of this proportion would negatively impact my ability andthat of most audiologists to provide the type of care patients deserve. Thus, I respectfully request that CMS impose a moratorium on audiologists reimbursement reductions in its most recent proposed physician fee schedule.

Sincerely,
Dr. Kay D. Krebs

Submitter : Dr. Judson Somerville

Organization : Dr. Judson Somerville

Category : Physician

Date: 09/26/2005

Issue Areas/Comments

GENERAL

GENERAL

As a Office based Pain Management physician who does both medical and interventional pain management my cost to povide interthecal pain management are very expensive. First the cast of all the personell to run my office, type my notes and letters to fight for my patients medical care and assure I can pay them to stay open. By the time I pay for the C-arm, code cart, defibulator, new computors(10) every 3 years, training new employees, insurance for those employees, malpractice insurance($26,000)per year(only because I have a $10,000 deductable, mantainance on my office(paint,cleaning,carpet,ect), supplies, conferances to keep up to date,storage of charts and cost of charts, answering service 24 hours a day 7 days a week. This does not include my own time. I do all the refills and reprogramming my self which takes time as mistakes could be deadly. The cost of the refill kit is expensive and I do not get reimbursed. The cost of the medication for the pump is more than my cost and yes I could send in the reciept to be repayed but that is just one more peice of paper that I have to have some one handle and I can not afford to hire more staff for this as those I have are already overtaxed. Yes there are bad apples in every group but don't put me out of bussiness by continuelly lower reimbursement as it only really hurts the ligitamit physicians. I am sure there are other costs I bear to provide interthecal theraipy particullary codes 62367 and 62368 but I have a practice to run and can not spend more time on this issue no matter how important. Thank you for your time.
Judson Somerville MD

Submitter : **Mr. Albert J. Fernandez** **Date: 09/26/2005**

Organization : **Mr. Albert J. Fernandez**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

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 Couty physicians improve the quantity and quality of care they deliver to Medicare beneficiaries and other patients. The locality change would also bebefit 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 appreceiate the opportunity to comment on this important issue.

Sincerely,

Albert J. Fernandez
855 Green Way
Santa Rosa, Ca. 95404

Submitter : Mr. Philip Swetin

Date: 09/26/2005

Organization : Mr. Philip Swetin

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

To accurately reflect the deomgraphics of Sonoma County, I ask that Medicare reimbursement rates be upwardly revised. We cannot continue to assure our seniors that we are concerned about their healthcare while not reimbursing our physicaians at a sustainable rate.
It is obvious that a "locality 99" designation is inapropriate. Please make the suggested rule change.

Submitter : JANE OLSON **Date:** 09/26/2005

Organization : JANE OLSON

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

JANE OLSON
180 OAK ISLAND DR
SANTA ROSA, CA 95405

MEMORANDUM

DATE: September 20, 2005

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

FROM: Joyce Coughlin

Re: GPCIs

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

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

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

Submitter : Dr. David DeKriek
Organization : Hearing Associates
Category : Other Practitioner
Date: 09/26/2005

Issue Areas/Comments

GENERAL

GENERAL

RE: CMS-1502-P

To whom it May Concern:

I am writing to object to the proposed reduction in the reimbursement rates for audiologists, which CMS has included in its proposed fee structure.I am writing to object to the proposed reduction in the reimbursement rates for audiologists, which CMS has included in its proposed fee structure. The sudden elimination of the ?non-physician zero work pool? codes without any consideration of practice expense or patient management factors is inappropriate. CMS has not recognized nor collected data for audiologic care that would justify this change to a policy that has existed for decades. This is especially egregious in view of CMS? considerations for other non-physician practitioners.

In view of this proposed policy change that results in a four times greater reduction for audiologists? reimbursement than any other profession, CMS should impose a moratorium on reimbursement changes for audiologists. A moratorium would allow for collection of data to justify or refute the current reimbursement levels to audiologists. As you are aware, your proposed change would affect more than 40 million Medicare subscribers today, particularly as CMS? rates are used almost universally by other health care insurers. The number of those impacted will only increase as America?s population grows and ages.

In view of this massive change on hearing and balance care services for such a large number of Americans, it would seem reasonable to request such a period of study. As a practicing audiologist, a cut of this proportion would negatively impact my ability ?and that of most audiologists ?to provide the type of care patients deserve. Thus, I respectfully request that CMS impose a moratorium on audiologists? reimbursement reductions in its most recent proposed physician fee schedule.

Sincerely,

David J DeKriek, Au.D.

Submitter : Ms. Mary DuPont **Date:** 09/26/2005

Organization : Radiology Associates

Category : Other Health Care Professional

Issue Areas/Comments

GENERAL

GENERAL

Dear Centers for Medicare & Medicaid Services ? Comment Division:

As an employee of a radiology group practicing in Florida, I appreciate the opportunity to comment on the 2006 Medicare proposed fee schedule and the associated multiple-procedure discount for certain diagnostic imaging services. Our organization is a group with 20 radiologists, four outpatient imaging centers and outpatient hospital services. We provide Medicare services that are based on the best clinical decisions for our patients and not on administrative decisions driven by costs and reimbursement.

We vigorously oppose the multiple services grouping reimbursement for this reason: Performing multiple tests requires additional time, skill, power, and resources and directly affects both patients and staff. Grouping procedures to justify a lower reimbursement provides no medical or monetary benefit to the patients and is ultimately detrimental to overall long-term patient care.

Florida has a large elderly population ? in the areas we serve, approximately 60% or greater of the population are Medicare eligible. Twenty-five percent of our practice supports the Medicare population ? imposing a 4.3% reduction in Medicare reimbursement and instituting a multiple procedure discount results in a combined revenue decrease of 6% while operating and practice expenses continue to rise. This decrease will create budget reductions in staffing, customer services, embracing new technology and other items critical to providing quality patient care and comfort.

We strongly urge you to reconsider the proposed physician payment cuts for 2006 and ask that you design a new payment system that would more appropriately reflect the cost of practicing good medicine.

Sincerely,

Mary DuPont

CMS-1502-P-1567

Submitter : Ms. Debra Kiley **Date:** 09/26/2005

Organization : Community Hospitals of Eastern Middlesex Inc

Category : Other Health Care Provider

Issue Areas/Comments

GENERAL

GENERAL

The CHEM Center for MRI, a nonprofit clinic in Massachusetts, is writing to commment on proposed changes to the Medicare fee schedule 2006 with regard to multiple procedures subject to discount.

The CHEM Center objects to the methodology used by CMS to predict savings accrued to a technical provider for same day service to MRI patients. CMS has identified savings of 50% for the second scan which is a significant overstatement of any savings experienced at our facility. For example, although one patient gown is used, a patient must be repositioned for a second scan and of course the time the patient spends in the MRI unit is not 50% less than for the first scan. It is a complete second test. Although obtaining a consent is only done once, a patient history must comprise all the details around both scans, not just one. Additionally, filming,documentation and reporting is done for two complete tests not one and 1/2.

We urge staff to study any actual savings prior to implementing such a signficant reduction which appears to be arbitrary rather than a careful analysis of the costs involved.

Thank you for the opportunity to comment.

Sincerely yours,

Debra Kiley
Vice President, CHEM

CMS-1502-P-1568

Submitter : Dr. Kay Krebs

Date: 09/26/2005

Organization : Acadamy of Dispensing Audiologists

Category : Other Practitioner

Issue Areas/Comments

GENERAL

GENERAL

RE: CMS-1502-P
To Whom it May Concern:
I am writing to object to the proposed reduction in the reimbursement rates for audiologists, which CMS has included in its proposed fee structure. The sudden elimination the non-physician zero work pool codes without any consideration of practice expense or patient management factors is inappropriate. CMS has not recognized nor collected data for audiologic care that would justify this change to a policy that has existed for decades. This is especially egregious in view of CMS considerations for other non-physician practitioners.

In view of this proposed policy change that results in a four times greater reduction for audiologists reimbursement than any other profession, CMS should impose a moratorium on reimbursement changes for audiologists. A moratorium would allow for collection of data to justify or refute the current reimbursement levels to audiologists. As you are aware, your proposed change would affect more than the 40 million Medicare subscribers today, particularly as CMS rates are used almost universally by other health care insurers. The number of those impacted will only increase as America's population grows and ages.

In view of this massive change on hearing and balance care services for such a large number of Americans, it would seem reasonable to request such a period of study. As a practicing audiologist, a cut of this proportion would negatively impact my ability andthat of most audiologists to provide the type of care patients deserve. Thus, I respectfully request that CMS impose a moratorium on audiologists reimbursement reductions in its most recent proposed physician fee schedule.

Sincerely,
Dr. Kay D. Krebs

Submitter : Dr. Judson Somerville

Organization : Dr. Judson Somerville

Category : Physician

Date: 09/26/2005

Issue Areas/Comments

GENERAL

GENERAL

As a Office based Pain Management physician who does both medical and interventional pain management my cost to povide interthecal pain management are very expensive. First the cast of all the personell to run my office, type my notes and letters to fight for my patients medical care and assure I can pay them to stay open. By the time I pay for the C-arm, code cart, defibulator, new computors(10) every 3 years, training new employees, insurance for those employees, malpractice insurance($26,000)per year(only because I have a $10,000 deductable, mantainance on my office(paint,cleaning,carpet,ect), supplies, conferances to keep up to date,storage of charts and cost of charts, answering service 24 hours a day 7 days a week. This does not include my own time. I do all the refills and reprogramming my self which takes time as mistakes could be deadly. The cost of the refill kit is expensive and I do not get reimbursed. The cost of the medication for the pump is more than my cost and yes I could send in the reciept to be repayed but that is just one more peice of paper that I have to have some one handle and I can not afford to hire more staff for this as those I have are already overtaxed. Yes there are bad apples in every group but don't put me out of bussiness by continuelly lower reimbursement as it only really hurts the ligitamit physicians. I am sure there are other costs I bear to provide interthecal thearipy particullary codes 62367 and 62368 but I have a practice to run and can not spend more time on this issue no matter how important. Thank you for your time.
Judson Somerville MD

Submitter : Mr. Albert J. Fernandez

Organization : Mr. Albert J. Fernandez

Category : Individual

Date: 09/26/2005

Issue Areas/Comments

GENERAL

GENERAL

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 Couty physicians improve the quantity and quality of care they deliver to Medicare beneficiaries and other patients. The locality change would also bebefit 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 appreceiate the opportunity to comment on this important issue.

Sincerely,

Albert J. Fernandez
855 Green Way
Santa Rosa, Ca. 95404

CMS-1502-P-1571

Submitter : Mr. Philip Swetin

Organization : Mr. Philip Swetin

Category : Individual

Date: 09/26/2005

Issue Areas/Comments

GENERAL

GENERAL

To accurately reflect the deomgraphics of Sonoma County, I ask that Medicare reimbursement rates be upwardly revised. We cannot continue to assure our seniors that we are concerned about their healthcare while not reimbursing our physicaians at a sustainable rate.
It is obvious that a "locality 99" designation is inapropriate. Please make the suggested rule change.

Submitter : Dr. Mark Comunale
Organization : Saint Louis University
Category : Physician
Date: 09/26/2005

Issue Areas/Comments

GENERAL

GENERAL
SEE ATTACHMENT

CMS-1502-P-1572-Attach-1.WPD

September 26, 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 Professor and Chairman, Department of Anesthesiology at Saint Louis 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.

Since the 1995 reduction in Medicare fees for teaching has taken effect, programs such as mine, can no longer generate enough dollars to cover market competitive salary and benefits for anesthesiologists who want to remain in academic practice. The first response

to the reduction in CMS rates for teaching was to reduce non-clinical time for faculty in order to try to generate enough clinical revenue to cover salary and benefits. Faculty now had more pressure to be in the operating room generating clinical revenue instead of preparing lectures and teaching. Indeed, many programs now have very little faculty non-clinical time. The upward pressure on salaries due to the current nationwide shortage of anesthesiologists, has only exacerbated the problem. At many institutions including Saint Louis University, an anesthesiologist working full time clinically cannot generate enough revenue to cover his or her salary and benefits. The result has been a steady drain on talented anesthesiologists away from academic medicine and into lucrative private practice community jobs. It is my opinion that without a change in CMS reimbursement policy for the teaching anesthesiologist, a career in academic anesthesiology is unsustainable and the crisis in anesthesia training programs will only become worse.

Correcting this inequity in the CMS anesthesiology teaching payment 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,

Mark E. Comunale, M.D.
Professor and Chairman
Department of Anesthesiology and Critical Care
Saint Louis University School of Medicine
3635 Vista Ave at Grand Blvd.
St. Louis, MO 63110-5102

Submitter : Dr. Granville Brady, Jr.

Organization : Audiologist

Category : Health Care Professional or Association

Date: 09/26/2005

Issue Areas/Comments

GENERAL

GENERAL

RE: CMS-1502-P

I am writing to oppose the reduction in reimbursement for audiology services, which CMS has included in the proposed fee schedule. The sudden eliminaiton of the "non-physician work pool" codes without considering the practice expenses or patient managment factors proposes a hardship on audiologists who provide hearing related, non-physician supplied services to Medicare recipients. CMD has not collected data, nor has it recognized the value of audiologic care that has been provided to recipients for decades. This poses a unique hardship on audiologists and discriminates against them when compared with other non-physician practitioners. Furthermore, the reduction in fees paid to audiologists discriminates againt women, who make up the majority of audiologists in the United States.

In view of the proposed policy change that results in a four times greater reduction for audiologists' reimbursement than for any other profession, CMS should impose a moratorium on reimbursement changes for audiologists. A mortorium would allow for colleciton of data to justify or refute the current reimbursemnt levels to audiologists. The proposed chanes would affect more than 40 million Medicare subscribers today, particularly since the CMS rates are used almost universally by other health insurance providers. This number will increase as more Americans demand hearing care.

In view of this massive change on hearing and balance care services for such a large number if Medicare subscribers, it would seem reasonable to request a period of study. As a practicing audiologist, a reduction of this proportion would negativly impact my ability--and that of most audiologists---to provide the type of care patients deserve. I therefore respectfully request that CMS impose a moratorium on audiologists' reimbursement reductions in its most recent proposed physician fee schedule.

Granville Y. Brady, Jr., Au.D.
Doctor of Audiology

Submitter : Dr. Jim Tozzi **Date:** 09/26/2005

Organization : Center For Regulatory Effectiveness

Category : Other Association

Issue Areas/Comments

GENERAL

GENERAL

See attachment

CMS-1502-P-1574-Attach-1.PDF

Center for Regulatory Effectiveness
Suite 700
11 Dupont Circle, N.W.
Washington, DC, 20036-1231
Tel: (202) 265-2383 Fax: (202) 939-6969
secretary1@mbsdc.com www.TheCRE.com

This is a comment on the Proposed Rule, "Medicare Program; Revisions to Payment Policies under the Physician Fee Schedule for Calendar Year 2000" (**CMS–1502–P**), 70 Fed. Reg. 45764 (August 8, 2005). This comment relates to "ESRD – Drugs and Biologicals" (70 Fed. Reg. 45790) and "Payment for ESRD Drugs" (70 Fed. Reg. 45845).

A WAY TO MAKE THE COST OF ESRD DIALYSIS INJECTABLES MORE ACCURATE

In this comment, this proposed rule is referred to as the "PPFS rule." This comment is from the Center for Regulatory Effectiveness (CRE), Suite 700, 11 Dupont Circle, N.W., Washington DC 20036-1231, September 26, 2005.

1. THE NEED FOR UNIFORM ESRD PRICING

a. The ESRD Program.

Program expenditures for End Stage Renal Disease (ESRD) consumed 6.7% of the Medicare budget for 2002 – up from 4.9 percent a decade earlier.[1] Total ESRD program expenditures reached $25.2 billion in 2002, an 11.5% increase over the previous year – Medicare spending accounted for $17 billion of this total. This continued growth is related primarily to increases in use of dialysis injectables such as EPO (erythropoietin), IV vitamin D, and IV iron. EPO treats the chronic anemia associated with ESRD.

In 2002, Medicare expenditures for EPO were $1.4 billion, twice the cost of all other injectables combined. In 2005, CMS estimates that Medicare expenditures for EPO will soar to $2.206 billion, and for other injectables, $890 million.[2] In just three years, EPO is ballooning in overall cost by 58% while the other injectables are going up by 31%.

---

[1] For detailed statistics concerning the ESRD Program, see the United States Renal Data System (http://www.usrds.org/atlas.htm), developed by the National Institutes of Health.

[2] See, 70 Fed. Reg. 45791 (August 8, 2005).

In 2002, 308,910 patients – 72 percent of the total in the ESRD program – were undergoing dialysis. Total Medicare expenditures for only dialysis in 2002 were $13.4 billion, or $60,000 per patient year, nearly ten times the annual Medicare payment of $6,200 per-Medicare enrollee. In 2005, the Medicare expenditure for the drug, EPO, for each ESRD patient will itself exceed the annual Medicare payment per-Medicare enrollee.

b. The Hodge-Podge of ESRD Dialysis Pricing.

The Medicare expenses for most ESRD dialysis patients are covered through a mix of mechanisms within the traditional fee-for-service payment system, including:

1. A composite rate, covering outpatient maintenance services, including dialysis and associated supplies, that are "routinely" furnished to each patient;

2. A monthly capitation payment, reimbursing the physician (often a nephrologist) who prescribes and monitors the patient's dialysis; and

3. The separately billed injectables (mostly EPO) and non-routine laboratory tests.

Moreover, the composite rate differs, depending on whether the composite rate is paid to a hospital-based dialysis facility or to an independent dialysis center. In 2005, the specific composite rate is $132.41 for hospital-based facilities, and $128.35 for independent dialysis centers – on average, $4.00 more for hospital-based facilities. This difference arises from the Omnibus Budget Reconciliation Act of 1981, in which the Congress mandated separate rates for the two types of facilities.

In 2005, the ways in which Medicare pays for dialysis injectable drugs also varies – both by the nature of the drug and by the institution from which it is dispensed.

1. For the "top 10 drugs" (including EPO) dispensed at independent dialysis centers, Medicare pays providers using an "average acquisition price" (AAP), based on a 2003 survey conducted by the HHS Office of Inspector General (OIG). To calculate the 2005 rates for these drugs, CMS updated the 2003 values by using the producer price index (PPI).

2. The cost for other drugs dispensed at independent dialysis centers is derived from the "average sales price" (ASP), plus 6 percent, reported by manufacturers to CMS every quarter.

3. For drugs dispensed at hospital-based facilities, payment is based on a "reasonable cost" estimated by CMS, except for EPO, for which CMS pays the same AAP rate as that paid at independent dialysis centers.

c. The Counter-Incentives Created by Previous ESRD Dialysis Pricing.

While reimbursing the costs of drugs based on three different methodologies appears discordant and inconsistent, it needs to be acknowledged that this is an improvement over what had existed before. Previously, the reimbursement for separately billed ESRD drugs was based, at least in part, upon what purported to be 95 percent of "average wholesale price." The problems with this were that **many providers,** through discounts and other special arrangements, obtained the separately billed drugs for less than the amount paid by Medicare, and thus **arranged to be overpaid by Medicare**. On the other hand, the composite rate paid by Medicare for "routine" services did not cover the costs incurred. As CMS described, in a 2003 report to Congress:

> "This fragmentation of the reimbursement system for services received by ESRD patients, with some covered by the composite rate while others are paid for separately, **has created incentives for manipulation in the provision of services, depending on their profitability**. It has also led to **reimbursement distortions in which payments for separately billable services are subsidizing the cost of composite rate services**. ... Although average composite payments do not cover composite rate costs, separately billable payments exceed separately billable costs to make up the shortfall and provide an overall 1.4% margin." (p. 5)

In other words, a miscalculated overpayment by Medicare cross-subsidized a Medicare underpayment – as long as the private dialysis providers were able to make up the difference by prescribing (over-prescribing?) enough of the expensive injectables and eliminating enough "routine" laboratory tests and other services.

d. Incomplete Efforts to Establish Uniform, Accurate ESRD Pricing.

In 2003, Congress made an effort to correct the counter-incentives created by the 95 percent of "average wholesale price" reimbursement rate. It did so by seeking to establish uniform ESRD pricing by, as a general matter, requiring Medicare to adopt, instead, an "average sales price" methodology" (ASP) and to encourage payment of even lower prices through adopting a "competitive acquisition" program (the CAP program).[3]

---

[3] Specifically, Congress is requiring Medicare to adopt the "Use of average sales price payment methodology" (§ 1847A of the Social Security Act (SSA), 42 U.S.C. 1395w-3a) and to reduce drug sales prices by passing the "Competitive acquisition of outpatient drugs and biologicals" (§ 1847B of the SSA, 42 U.S.C. 1395w-3b), the CAP program. Congress further amended the "End stage renal disease program" (§ 1881, 42 U.S.C. 1395rr) to require that ESRD injectables be reimbursed in 2006 and subsequent years at either the "average acquisition cost" as determined by the OIG or the "average sales price" (ASP), as reported quarterly by manufacturers.

However, as part of the same legislation, Congress also, in effect, codified this cross-subsidization, and thus continued the counter-incentives created by the previously existing overpayment. Congress continued to use the source of the prior manipulations in drug cost overpayments – the 95% of "average wholesale price" – as a benchmark on which to base a drug cost adjustment add-on to the composite rate. As CMS summarized, in its January 2005 newsletter:

> "[The new statute] requires [a drug cost] adjustment add-on to the composite rate to account for the drug spread, which amounts to an increase of 8.7 percent or $11.17 for independent facilities and $11.52 for hospital-based facilities. ... **The drug spread is the difference between the payments under the old composite payment system for separately billable drugs (95 percent of [average wholesale price]) and payments based on the revised drug pricing methodology.**"[4]

To put this drug cost adjustment add-on into context, CMS raised the composite rate 1.6 percent in 2005. This 8.7 percent add-on brings the total percentage increase in 2005 to a 10.3 percent increase. The Payment Policies Proposal, upon which CRE is commenting, accepts that this drug cost adjustment add-on will continue and proposes an add-on of 8.9 percent for 2006.[5]

e. Upcoming Expansion of the ESRD Monthly Composite Rate.

Recognizing the need to need to develop a prospective payment system for the separately billable ESRD injectables and non-routine services, in 2003 Congress directed CMS to explore expanding the existing monthly composite rate – the prospective payment system for ESRD patients – to include the directly billed injectables and non-routine services. Specifically, Congress requires CMS to submit a report to Congress, no later than October 1, 2005. This report is to detail "the elements and features for the design and implementation of a bundled prospective payment system ... including, to the maximum extent feasible, bundling of drugs, clinical laboratory tests, and other items that are separately billed by such facilities."[6] Presumably, this report will describe the statutorily required three-year demonstration project for this expanded composite rate that is to start in January 1, 2006.

---

[4] For the statutory basis of this codified cross-subsidization, see § 1881, 42 U.S.C. 1395l(b)(12)(B)(ii) and (C).

[5] "(3) Proposed Drug Add-On Adjustment for CY 2006. With the recalculated CY 2005 add-on to the per treatment composite rate being 8.1 percent and with the additional increment for expenditures in CY 2006 being 0.7 percent, we combine them to produce one drug add-on adjustment for CY 2006 that would be 8.9 percent" (70 Fed. Reg. 45792).

[6] Section 623(f) of P.L. 108-173, 117 Stat. 2316. Included in this report are to be "the following elements and features of a bundled prospective payment system: (A) Bundle of Items and Services ..., (B) Case Mix..., (C) Wage Index..., (D) Rural Areas..., (E) Other Adjustments..., (F) Update Framework...., (G) Additional Recommendations ...."

The Center for Regulatory Effectiveness (CRE) supports improving the regulatory process and making regulatory programs more efficient. Specifically, CRE supports having ESRD pricing policies be uniform, accurate, cost-effective and rationally based. CRE encourages Medicare to adopt the ASP pricing methodology on a uniform basis. CRE also urges Medicare to expand the ESRD composite rate to include separately billed injectables (including EPO), as well as the other non-routine laboratory tests and other separately billed dialysis services.

2. MEDPAC RECOMMENDATIONS FOR UNIFORM PRICING

In a June 2005 Report to Congress discussing the ESRD dialysis program,[7] MedPAC stated basic principles underlying its recommendations:

> **"1. Medicare should pay the same rate for the same services across different settings**; (p.88)
>
> **"2. Payment should reflect the costs of efficient providers and should be adjusted to reflect the costs of factors that are beyond providers' control."** (p. 89)

Consistent with these basic principles, MedPAC recognizes the hodge-podge of ESRD pricing policies for separately billed injectables and urges, instead, the use of a uniform pricing policy:

> "Under current law, ... the Secretary pays dialysis providers differently depending on the specific drug and the site of care. ... **MedPAC recommends rationalizing payment policy by (a) paying for all dialysis drugs using the same methodology (that is, the same method used for other Part B providers) and (b) periodically checking the ASP data to verify its appropriateness.**" (p. 91)
>
> "Before the [2003 amendments to section 1395rr], payment for injectable drugs also varied depending on the site of care and on the specific drug. The payment methods – a rate for erythropoietin set in statute and average wholesale price (AWP) for drugs other than erythropoietin – generated excessive profits for these drugs. Through the [2003 amendments], the Congress addressed this overpayment issue by requiring a new payment approach." (p. 91)

MedPAC then evaluated the different payment rate methodologies:

---

[7] In June 2005, the Medicare Payment Advisory Commission (MedPAC) issued a Report to Congress, "Issues in a modernized Medicare program." In Chapter 4, "Payment for dialysis," MedPAC made a number of recommendations related to the ESRD dialysis program and the drugs provided under it.

"**Through the [2003 amendments], the Congress intended that the payment rates for dialysis drugs more closely approximate the costs that providers incur.** Results from a MedPAC-sponsored survey and the OIG suggest that different types of providers use different approaches to purchase drugs, and this sometimes results in different prices." (p. 92)

"The three different approaches – ASP [average sales price], AAP [average acquisition cost], and reasonable cost – all try to estimate the above costs. Paying reasonable cost is probably the least accurate approach, as it may reflect the facilities' charging and accounting practices. In our discussion below, we contrast the two other methods and find that they attempt to measure the same concept. However, **ASP shows several advantages over AAP in that the Secretary already collects ASP data for all drugs and ASP data are more up to date.**" (p. 92)

"MedPAC concludes that:

- **"Medicare's current method of paying for separately billable drugs should not vary between provider types.**
- "Both ASP and AAP aim to determine the purchase price of drugs (which is the net of all rebates and discounts); thus, CMS should derive a similar price from either data source.
- "Similar incentives exist for providers to obtain the best possible purchase price under both ASP and AAP.
- **"CMS regularly collects ASP data and uses it to pay for other Part B injectables**. By contrast, CMS does not regularly collect AAP data and does not use this data source to pay for other Part B injectables.
- "CMS updates ASP data regularly to reflect actual transaction prices; thus **ASP data would better reflect the prices paid by dialysis providers over time** than would AAP data." (p. 94)

As a result, MedPAC formally recommends that Medicare use the ASP for pricing all ESRD injectables.

"The Secretary should: ...

- **"use average sales price data to base payment for all injectable dialysis drugs** that are separately billable in 2006." (p. 94)

We should note, at this point, that the PPFS rule, upon which CRE is commenting, agrees in principle with this MedPAC recommendation, but would implement it only in part:

> "While we [CMS] acknowledge MedPAC's recommendations, we are proposing to make payment using the ASP +6 percent methodology for all separately billed ESRD drugs furnished in freestanding facilities and for EPO furnished in hospital-based facilities. ... While we are not proposing to pay for drugs other than EPO furnished in hospital-based facilities under the ASP +6 percent methodology at this time, we are interested in moving to this approach. We believe that it is more appropriate to pay for separately billed drugs furnished in hospital-based facilities under the ASP +6 percent methodology rather than on a reasonable cost basis, as we believe there should be consistency across sites in payment for the same item or service. However, we have not made this proposal due to the lack of data regarding drug costs and expenditures associated with hospital-based ESRD payments. ... While we have not proposed to pay hospital-based facilities under the ASP +6 percent methodology for 2006, we seek comments about the potential method we have discussed to accomplish this policy." * * *
>
> "[As discussed a little earlier on the same page –] Further, we contend that relying on the ASP +6 percent as the payment rate for all separately billable ESRD drugs when billed by freestanding ESRD facilities for CY 2006 is a more reliable indicator of the market transaction prices for these drugs. The ASP is reflective of manufacturer sales for specific drug products and is more indicative of market and sales trends for those specific products than the 2002 OIG acquisition cost data."[8]

We should further note that CMS has recently sought public comment on an information collection request entitled, "Manufacturer Submission of Average Sales Price (ASP) Data for Medicare Part B Drugs and Biologicals and Supporting Regulations in 42 CFR 414.804", Form No. CMS-10110 (OMB #0938-0921), (70 Fed. Reg. 48771 (August 19, 2005)). In this notice, CMS states that "CMS will utilize the ASP data to determine the drug payment amounts for CY 2005 and beyond." However, as quoted above, CMS also states that it is not proposing in the PPFS rule "to pay for drugs other than EPO furnished in hospital-based facilities ... due to the lack of data regarding drug costs and expenditures associated with hospital-based ESRD payments" (70 Fed. Reg. 45846). As the ESRD program statute permits the use of ASP methodology in determining the payments for ESRD in 2006 (42 U.S.C. 1395rr(b)(13)(A)(3)), it is anomalous that CMS is not proposing to use this form to collect data regarding drug costs and expenditures associated with hospital-based ESRD payments that CMS apparently lacks.

---

[8] 70 Fed. Reg. 45846.

3. CRE RECOMMENDATIONS

1. **Medicare should use the ASP cost methodology for all ESRD drugs (including EPO).**

2. **CRE urges CMS to apply the ASP cost methodology to pay for all the drugs provided in hospital-based dialysis facilities in CY 2006, even if the reimbursements have to be based upon data obtain from freestanding ESRD facilities.**

3. **If CMS needs additional information to obtain "data regarding drug costs and expenditures associated with hospital-based ESRD payments," then CMS should collect ASP data from both providers and manufacturers.**

4. PROGRAMMATIC JUSTIFICATION FOR CRE RECOMMENDATIONS

CRE agrees with MedPAC, and the rationale that MedPAC presents.

- ASP data is the most accurate and up-to-date that CMS collects.
- The efficiency of service provided, not the institutional setting, should determine how CMS sets the composite pay rate.
- Pricing for injectables would become more uniform and consistent.
- Uniform pricing methodology will allow competition to thrive, thus ensuring cost-savings to Medicare and providing greater treatment options to ESRD patients for anemia management.
- Allowing uniform reimbursement methodology across all Medicare settings will remove the artificial commercial barriers and create a more competitive marketplace.
- This would create a level playing field for all of those involved – whether well-established providers and manufacturers, or newcomers offering new services or products.
- A fully competitive marketplace, with possible new entrants or possible new alternative injectables, will offer patients advances in treatment options over older drugs and through competition, reduce the costs for dialysis injectables.

Submitter : Marjorie Grossman **Date:** 09/26/2005

Organization : Marjorie Grossman

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

Sonoma County, CA doctors need an increase in Medicare reimbursement rates ASAP. Doctors are leaving the area because they are currently paid at a low (rural)rate although this is no longer a rural county and has a very high cost of living. Many seniors are unable to find new doctors or stay with their current doctors because the physicians are not accepting new Medicare patients due to current reimbursement rates. I strongly support an increase in these rates.

Submitter : Ms. Carol Jonas **Date:** 09/26/2005

Organization : Spartanburg ENT

Category : Other Practitioner

Issue Areas/Comments

GENERAL

GENERAL

Audiologists are more than qualified to provide patient management, especially with balance and hearing problems. Most physicians defer to audiologists for patient care in those areas. By forcing patients to go through a physician for help with these problems, the CMS is increasing the cost of medical care in a country struggling to pay over-whelming medical bills as it is.

CMS should reconsider the reduction in payments to audiologists and should not reduce the reimbursement rates as planned.

Submitter :

Date: 09/26/2005

Organization :

Category : Other Technician

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.

Submitter : Ms. Bennette Fisher **Date:** 09/26/2005

Organization : N/A

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

I am writing to urge the Centers for Medicare and Medicaid Services (CMS) to change the Medicare anesthesiology teaching payment policy.
Medicare?s discriminatory payment arrangement, which applies only to anesthesiology teaching programs, has had a serious detrimental impact on the ability of programs to retain skilled faculty and to train the new anesthesiologists necessary to help alleviate the widely-acknowledged shortage of anesthesia providers -- a shortage that will be exacerbated in coming years by the aging of the baby boom generation and their need for surgical services.
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. Larry deGhetaldi **Date:** 09/26/2005

Organization : Dr. Larry deGhetaldi

Category : Health Care Professional or Association

Issue Areas/Comments

GENERAL

GENERAL

See attachment

CMS-1502-P-1579-Attach-1.DOC

CMS-1502-P-1579-Attach-2.DOC

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

Re: "GPCIs"

Dear Sirs:

I am writing on behalf of the Sutter Health affiliates in Santa Cruz County, California in support of the August proposed rule. I represent a licensed acute care hospital, the Sutter Maternity and Surgery Center, a home health agency (the Visiting Nurses Association of Santa Cruz), and the Santa Cruz health care division of the Palo Alto Medical Foundation, which consists of 130 providers (physicians, podiatrists, audiologists, nurse practitioners, physical and occupational therapists, optometrists, and speech pathologists).

My perspective is unique because of the varied components of my organization. I have addressed CMS staff in person on numerous occasions and have been most appreciative of the openness of CMS in sharing source documents and in being receptive to our suggestions when we have had differing views of this issue.

In general, I feel that the proposed rule is an extraordinarily positive statement by CMS on many levels. It demonstrates true and courageous leadership addressing a long-standing and divisive issue.

The following is how I sense that different stakeholders view this issue:

CMS

The 1996 rule that reconfigured the pre-existing 210 localities into the current 89 localities was flawed. The pre-existing localities, which had been originally configured in the 1960s, formed the basis for the 'new' localities. Three states (MA, PA, and MO) had slight changes made to those localities. CMS should have applied the iterative 5% rule to individual counties in each state rather than to the pre-existing localities. Further, CMS should have not paved the way for ongoing disputes between providers, CMS, Congress, beneficiaries, and state medical societies by requiring future locality revisions to be directly linked to the wishes of physician professional organizations. CMS has not revised any localities since 1996 and is well aware at this time that the locality problem is in need of substantial reform.

The August rule acknowledges for the first time that CMS bears the ultimate responsibility for managing physician fee schedule areas. It is ironic that Congress has delegated to CMS the mandate to do so and, after nine years of inaction by CMS, that many representatives from California are in opposition to the proposed rule.

CMS appropriately selected the most problematic region in the nation (the SF Bay Area) and appropriately proposed a rule change, which would have a negligible impact on the remaining counties within California's locality 99. The current leadership of CMS deserves credit for addressing a problem whose origins date to first years of Medicare.

CMS must work with Congress, MedPAC, and provider organizations to create a long-term solution to this problem. It is important that CMS acknowledge that the two-county CA solution is the first step in a broader and more comprehensive solution to the fee schedule area problem.

Multi-locality Versus Single-locality States

It is prudent at this time to concentrate on payment discrepancies in multi-locality states prior to resolving such disparities in single-locality states. Large "Rest-of State" localities in multi-locality states redistribute dollars from high cost counties to lower cost counties. This also occurs in single locality states. However, in large heterogeneous states such as Texas and California this redistribution of payments from urban to rural areas is inconsistent. Santa Cruz and Sonoma currently support payments to rural CA counties. The urban localities in the SF Bay Area do not. Revisions to the current localities when instituted as you have proposed in an incremental manner must begin in those multi-locality states with the largest payment discrepancies.

The locality problem (commonly referred to as the "GPCI problem") is nevertheless a national problem. Broader solutions to these issues on a national level will certainly arise from Congress. We applaud the leadership of CMS for initiating the solution in the most problematic multi-locality state, California.

CMA

The CMA has unfairly been delegated the authority to craft a CA solution. The 2004 CMA proposal was widely praised but apparently was inconsistent with how CMS interprets its authority to institute changes to payment localities. The CMA will respond to CMS' request for response to the proposed rule by recommending for a legislative solution to the problem. CMA had no other choice but to decline to directly comment on the two-county proposal. CMA's silence on the two-county proposal should not be interpreted as non-support but rather a statement that this state medical society is no longer willing to be inappropriately designated as the decision-maker in a matter of federal policy. The CMA knows full well that it is an important voice as it represents half of California's physicians. It also is aware that it does not represent a dozen or so of the other types of providers eligible to bill CMS for services to Medicare beneficiaries.

CMS must develop a process for future revisions that no longer necessitates that state medical societies must initiate and approve any proposed changes to fee

schedule areas. CMS must clearly identify the process for these revisions and they should be automatically applied at each three-year recalculation of the GPCIs.

California County Medical Societies

CMS will receive very positive responses from Sonoma and Santa Cruz Counties' Medical Societies. It will also receive mixed responses from other county professional societies. If the proposed rule had clearly identified that the two county proposal was meant to establish a process that would precede the necessary development of a process that would guarantee to other CA counties then you would received congratulatory comments rather than comments engendered by the divisiveness of the current process. The comments that you received from the Santa Barbara County Medical Society are the most thoughtful and incisive that you will receive. It is important to note that Santa Barbara County represents a "losing" county as defined by the CMS 1996 rule.

The California Delegation

The 2004 CMA proposal was widely applauded by the CA delegation. The two-county proposed rule has understandably elicited a more polarized response. Congress has imposed on CMS the requirement to manage fee schedule areas under the constraints of budget neutrality. We applaud the comments of Senator Boxer, as the only statewide federally elected official, who supports the two county proposal. Members of House who oppose your proposed rule should redefine the rules established by Congress that have tied the hands of CMS and the CMA over the past ten years rather than decry the first locality revision proposed by CMS in a decade.

Other Providers

CMS chose not to implement the CMA 2004 proposal as a demonstration project because of its effect on non-physician providers. CMS has acknowledged the fact that the CMA should really only have input on fee schedule changes as they relate to changes in payments to its member physicians. CMA does not represent the majority of types of licensed providers that currently provide services to Medicare beneficiaries. These include: speech pathologists, occupational therapists, physician therapists, licensed clinical social workers, clinical psychologists, optometrists, physical therapists, audiologists, optometrists, nurse practitioners, and physician assistants. CMS should consider the responses to this rule from state medical societies acknowledging that organized physicians groups must not be inappropriately empowered by CMS to overrule proposed rule changes that affect these other types of providers.

Beneficiaries

CMS will hear from many beneficiaries who receive care in Sonoma and Santa Cruz Counties. Access is eroding in these two counties as more and more providers re-locate to adjoining counties. The boundary discrepancies between Sonoma and Marin Counties, and between Santa Cruz and Santa Clara Counties, have real and deleterious effects on the beneficiaries of our two counties. It is incomprehensible to our beneficiaries why this decision is controversial. It is well understood that the proposed rule would decrease payments to the providers in the remaining 47 counties in Locality 99 by considerably less than 0.1%. This actually translates to less than two cents for a 99213 established office visit.

MedPAC

MedPAC is analyzing this problem from a national perspective. MedPAC and Congress are considering revisions either based on the 5% (or other) threshold applied to all counties or to a transition to MSA-based physician payment localities congruent to the hospital-based localities currently utilized by CMS. CMS should acknowledge that this issue is widely recognized to be substantive and unlikely to be resolved by the two-county proposal. It would be to CMS' credit if it were to implement the two-county proposal AND to express a willingness to work with all stakeholders to develop a comprehensive solution to this issue during 2006.

Santa Cruz County

Since 1999, this county has been the most disadvantaged county in California's Locality 99. It has persistently had the highest boundary payment between it and adjoining counties in the nation. And, it has led the debate on identifying the problem and in the creation of an equitable and comprehensive solution. The 2004 proposed rule, which assigned the highest GAFs to Santa Clara and San Mateo Counties in the nation, exacerbated our problem. Our northernmost incorporated city, Scotts Valley, has two dozen primary care providers. It is situated less than seven miles from Silicon Valley (Santa Clara County) where providers receive 24% more for the same services. Acknowledging this fact as the basis for the proposed rule, and why a solution must begin in Santa Cruz County and why it must begin in 2006, brings credibility to CMS.

Thank you for working with our providers and our beneficiaries in bringing this important issue to a resolution,

Sincerely,

Larry deGhetaldi, M.D.
Sutter Santa Cruz CEO
President SC Division Palo Alto Medical Foundation

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

Re: "GPCIs"

Dear Sirs:

I am writing on behalf of the Sutter Health affiliates in Santa Cruz County, California in support of the August proposed rule. I represent a licensed acute care hospital, the Sutter Maternity and Surgery Center, a home health agency (the Visiting Nurses Association of Santa Cruz), and the Santa Cruz health care division of the Palo Alto Medical Foundation, which consists of 130 providers (physicians, podiatrists, audiologists, nurse practitioners, physical and occupational therapists, optometrists, and speech pathologists).

My perspective is unique because of the varied components of my organization. I have addressed CMS staff in person on numerous occasions and have been most appreciative of the openness of CMS in sharing source documents and in being receptive to our suggestions when we have had differing views of this issue.

In general, I feel that the proposed rule is an extraordinarily positive statement by CMS on many levels. It demonstrates true and courageous leadership addressing a long-standing and divisive issue.

The following is how I sense that different stakeholders view this issue:

<u>CMS</u>

The 1996 rule that reconfigured the pre-existing 210 localities into the current 89 localities was flawed. The pre-existing localities, which had been originally configured in the 1960s, formed the basis for the 'new' localities. Three states (MA, PA, and MO) had slight changes made to those localities. CMS should have applied the iterative 5% rule to individual counties in each state rather than to the pre-existing localities. Further, CMS should have not paved the way for ongoing disputes between providers, CMS, Congress, beneficiaries, and state medical societies by requiring future locality revisions to be directly linked to the wishes of physician professional organizations. CMS has not revised any localities since 1996 and is well aware at this time that the locality problem is in need of substantial reform.

The August rule acknowledges for the first time that CMS bears the ultimate responsibility for managing physician fee schedule areas. It is ironic that Congress has delegated to CMS the mandate to do so and, after nine years of inaction by CMS, that many representatives from California are in opposition to the proposed rule.

CMS appropriately selected the most problematic region in the nation (the SF Bay Area) and appropriately proposed a rule change, which would have a negligible impact on the remaining counties within California's locality 99. The current leadership of CMS deserves credit for addressing a problem whose origins date to first years of Medicare.

CMS must work with Congress, MedPAC, and provider organizations to create a long-term solution to this problem. It is important that CMS acknowledge that the two-county CA solution is the first step in a broader and more comprehensive solution to the fee schedule area problem.

Multi-locality Versus Single-locality States

It is prudent at this time to concentrate on payment discrepancies in multi-locality states prior to resolving such disparities in single-locality states. Large "Rest-of State" localities in multi-locality states redistribute dollars from high cost counties to lower cost counties. This also occurs in single locality states. However, in large heterogeneous states such as Texas and California this redistribution of payments from urban to rural areas is inconsistent. Santa Cruz and Sonoma currently support payments to rural CA counties. The urban localities in the SF Bay Area do not. Revisions to the current localities when instituted as you have proposed in an incremental manner must begin in those multi-locality states with the largest payment discrepancies.

The locality problem (commonly referred to as the "GPCI problem") is nevertheless a national problem. Broader solutions to these issues on a national level will certainly arise from Congress. We applaud the leadership of CMS for initiating the solution in the most problematic multi-locality state, California.

CMA

The CMA has unfairly been delegated the authority to craft a CA solution. The 2004 CMA proposal was widely praised but apparently was inconsistent with how CMS interprets its authority to institute changes to payment localities. The CMA will respond to CMS' request for response to the proposed rule by recommending for a legislative solution to the problem. CMA had no other choice but to decline to directly comment on the two-county proposal. CMA's silence on the two-county proposal should not be interpreted as non-support but rather a statement that this state medical society is no longer willing to be inappropriately designated as the decision-maker in a matter of federal policy. The CMA knows full well that it is an important voice as it represents half of California's physicians. It also is aware that it does not represent a dozen or so of the other types of providers eligible to bill CMS for services to Medicare beneficiaries.

CMS must develop a process for future revisions that no longer necessitates that state medical societies must initiate and approve any proposed changes to fee

schedule areas. CMS must clearly identify the process for these revisions and they should be automatically applied at each three-year recalculation of the GPCIs.

California County Medical Societies

CMS will receive very positive responses from Sonoma and Santa Cruz Counties' Medical Societies. It will also receive mixed responses from other county professional societies. If the proposed rule had clearly identified that the two county proposal was meant to establish a process that would precede the necessary development of a process that would guarantee to other CA counties then you would received congratulatory comments rather than comments engendered by the divisiveness of the current process. The comments that you received from the Santa Barbara County Medical Society are the most thoughtful and incisive that you will receive. It is important to note that Santa Barbara County represents a "losing" county as defined by the CMS 1996 rule.

The California Delegation

The 2004 CMA proposal was widely applauded by the CA delegation. The two-county proposed rule has understandably elicited a more polarized response. Congress has imposed on CMS the requirement to manage fee schedule areas under the constraints of budget neutrality. We applaud the comments of Senator Boxer, as the only statewide federally elected official, who supports the two county proposal. Members of House who oppose your proposed rule should redefine the rules established by Congress that have tied the hands of CMS and the CMA over the past ten years rather than decry the first locality revision proposed by CMS in a decade.

Other Providers

CMS chose not to implement the CMA 2004 proposal as a demonstration project because of its effect on non-physician providers. CMS has acknowledged the fact that the CMA should really only have input on fee schedule changes as they relate to changes in payments to its member physicians. CMA does not represent the majority of types of licensed providers that currently provide services to Medicare beneficiaries. These include: speech pathologists, occupational therapists, physician therapists, licensed clinical social workers, clinical psychologists, optometrists, physical therapists, audiologists, optometrists, nurse practitioners, and physician assistants. CMS should consider the responses to this rule from state medical societies acknowledging that organized physicians groups must not be inappropriately empowered by CMS to overrule proposed rule changes that affect these other types of providers.

Beneficiaries

CMS will hear from many beneficiaries who receive care in Sonoma and Santa Cruz Counties. Access is eroding in these two counties as more and more providers re-locate to adjoining counties. The boundary discrepancies between Sonoma and Marin Counties, and between Santa Cruz and Santa Clara Counties, have real and deleterious effects on the beneficiaries of our two counties. It is incomprehensible to our beneficiaries why this decision is controversial. It is well understood that the proposed rule would decrease payments to the providers in the remaining 47 counties in Locality 99 by considerably less than 0.1%. This actually translates to less than two cents for a 99213 established office visit.

MedPAC

MedPAC is analyzing this problem from a national perspective. MedPAC and Congress are considering revisions either based on the 5% (or other) threshold applied to all counties or to a transition to MSA-based physician payment localities congruent to the hospital-based localities currently utilized by CMS. CMS should acknowledge that this issue is widely recognized to be substantive and unlikely to be resolved by the two-county proposal. It would be to CMS' credit if it were to implement the two-county proposal AND to express a willingness to work with all stakeholders to develop a comprehensive solution to this issue during 2006.

Santa Cruz County

Since 1999, this county has been the most disadvantaged county in California's Locality 99. It has persistently had the highest boundary payment between it and adjoining counties in the nation. And, it has led the debate on identifying the problem and in the creation of an equitable and comprehensive solution. The 2004 proposed rule, which assigned the highest GAFs to Santa Clara and San Mateo Counties in the nation, exacerbated our problem. Our northernmost incorporated city, Scotts Valley, has two dozen primary care providers. It is situated less than seven miles from Silicon Valley (Santa Clara County) where providers receive 24% more for the same services. Acknowledging this fact as the basis for the proposed rule, and why a solution must begin in Santa Cruz County and why it must begin in 2006, brings credibility to CMS.

Thank you for working with our providers and our beneficiaries in bringing this important issue to a resolution,

Sincerely,

Larry deGhetaldi, M.D.
Sutter Santa Cruz CEO
President SC Division Palo Alto Medical Foundation

Submitter : Dr. Stephen Robinson

Organization : Dr. Stephen Robinson

Category : Physician

Date: 09/26/2005

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 OHSU 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 Stephen Robinson, MD
Address 7627 SE 30th Avenue
Portland, OR 97202

Submitter : Dr. Margaret Conover

Organization : Dr. Margaret Conover

Category : Physician

Date: 09/26/2005

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 to urge the Centers for Medicare and Medicaid Services (CMS) to change the Medicare anesthesiology teaching payment policy. I currently teach residents from 2 anesthesia residency programs in Kansas.
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 Margaret Ann Conover,MD
Address 5100 West 102nd Street
Overland Park, KS 66207

Submitter : Mrs. Barbara Baron

Organization : New York State Dietetic Association

Category : Dietitian/Nutritionist

Date: 09/26/2005

Issue Areas/Comments

GENERAL

GENERAL

The New York State Dietetic Association, Inc.
PO Box 30953, New York, NY 10011 ? (212) 691-7906 ? Fax (212) 741-9334

September 26, 2005

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

Dear Dr. McClellan:

The New York State Dietetic Association (NYSDA) is pleased to comment on the Revisions to Payment Policies Under the Physician Fee Schedule for Calendar Year 2006. The NYSDA represents nearly 5,000 food and nutrition professionals who serve the public by providing Medical Nutrition Therapy and by promoting optimal health through nutrition.

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

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

2. II.D. Telehealth.
NYSDA supports CMS? recommendation to recognize individual medical nutrition therapy (MNT) as a Medicare telehealth service. We also support CMS? proposed rule to add registered dietitians and qualified nutrition professionals to the list of practitioners who are authorized to furnish and receive payment for telehealth services. We realize that this technology is currently used by certain authorized Medicare health professionals in rural health areas with a shortage of healthcare professionals. Including MNT in the list of approved telehealth services, and extending this to RD Medicare providers will improve access and services for patient/clients in remote areas where traditional MNT services may not be readily available or patients/clients are physically incapable to receive MNT in an office setting.

Thank you for considering these comments in CMS? revisions to the 2006 Physician Fee Schedule.

Best regards,

Barbara Baron,MS,RD,CDN
President of NYSDA

CC: The American Dietetic Association
Policy Initiatives and Advocacy Group

Submitter : Dr. Larry deGhetaldi

Date: 09/26/2005

Organization : Sutter Santa Cruz

Category : Health Care Professional or Association

Issue Areas/Comments

GENERAL

GENERAL

I am writing on behalf of the Sutter Health affiliates in Santa Cruz County, California in support of the August proposed rule. I represent a licensed acute care hospital, the Sutter Maternity and Surgery Center, a home health agency (the Visiting Nurses Association of Santa Cruz), and the Santa Cruz health care division of the Palo Alto Medical Foundation, which consists of 130 providers (physicians, podiatrists, audiologists, nurse practitioners, physical and occupational therapists, optometrists, and speech pathologists).

My perspective is unique because of the varied components of my organization. I have addressed CMS staff in person on numerous occasions and have been most appreciative of the openness of CMS in sharing source documents and in being receptive to our suggestions when we have had differing views of this issue.

In general, I feel that the proposed rule is an extraordinarily positive statement by CMS on many levels. It demonstrates true and courageous leadership addressing a long-standing and divisive issue.

The following is how I sense that different stakeholders view this issue:

CMS

The 1996 rule that reconfigured the pre-existing 210 localities into the current 89 localities was flawed. The pre-existing localities, which had been originally configured in the 1960s, formed the basis for the 'new? localities. Three states (MA, PA, and MO) had slight changes made to those localities. CMS should have applied the iterative 5% rule to individual counties in each state rather than to the pre-existing localities. Further, CMS should have not paved the way for ongoing disputes between providers, CMS, Congress, beneficiaries, and state medical societies by requiring future locality revisions to be directly linked to the wishes of physician professional organizations. CMS has not revised any localities since 1996 and is well aware at this time that the locality problem is in need of substantial reform.

The August rule acknowledges for the first time that CMS bears the ultimate responsibility for managing physician fee schedule areas. It is ironic that Congress has delegated to CMS the mandate to do so and, after nine years of inaction by CMS, that many representatives from California are in opposition to the proposed rule.

CMS appropriately selected the most problematic region in the nation (the SF Bay Area) and appropriately proposed a rule change, which would have a negligible impact on the remaining counties within California?s locality 99. The current leadership of CMS deserves credit for addressing a problem whose origins date to first years of Medicare.

CMS must work with Congress, MedPAC, and provider organizations to create a long-term solution to this problem. It is important that CMS acknowledge that the two-county CA solution is the first step in a broader and more comprehensive solution to the fee schedule area problem.

Multi-locality Versus Single-locality States

It is prudent at this time to concentrate on payment discrepancies in multi-locality states prior to resolving such disparities in single-locality states. Large ?Rest-of State? localities in multi-locality states redistribute dollars from high cost counties to lower cost counties. This also occurs in single locality states. However, in large heterogeneous states such as Texas and California this redistribution of payments from urban to rural areas is inconsistent. Santa Cruz and Sonoma currently support payments to rural CA counties. The urban localities in the SF Bay Area do not. Revisions to the current localities when instituted as you have proposed in an incremental manner must begin in those multi-locality states with the largest payment discrepancies.

The locality problem (commonly referred to as the ?GPCI problem?) is nevertheless a national problem. Broader solutions to these issues on a national level will certainly arise from Congress. We applaud the leadership of CMS for initiating

Submitter : **Alexander Milotich** **Date: 09/26/2005**

Organization : **Alexander Milotich**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

Date:

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1502-P

Re: GPCIs

We are pleased to hear that Medicare is proposing to create a new payment locality for Sonoma County, which is an increasingly expensive place to live and work, and which has seen a flight of physicians. 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 (over 16.6%).

As Medicare recipients who have had a very difficult time finding a general care physician in Sonoma Valley (our previous doctor left the county for financial reasons), we fully support your proposal to change Sonoma County?s payment locality, and I appreciate the opportunity to comment on this important issue.

Sincerely,

Alexander and Jane Milotich

Submitter : Kathy Hayes

Organization : Kathy Hayes

Category : Individual

Date: 09/26/2005

Issue Areas/Comments

GENERAL

GENERAL

I am writing to express my support for the proposed increase in the Medicare reimbursement rate for Sonoma County. As someone who works in the real estate industry, Sonoma County has one of the highest standard of living in the country. Physicians need to be provided a reimbursement rate that allows them to live and work in Sonoma County. As a parent and a consumer, I am also aware that many other reibursement formulas are tied to the Medicare reimbursement rate. I have a child with serious health issues, I need the medical personnel and resources available to me locally to allow my child to live. If reimbursement rates are kept artificially low with no cap on other costs of living, who is going to take care of my child when there are no physicians left. This is a quality of life issue for all residents of Sonoma County, not just seniors.

I urge you to support the increased reimbursement rate for Sonoma County.

Submitter : Mr. Patrick Fry

Date: 09/26/2005

Organization : Sutter Health

Category : Health Care Provider/Association

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1502-P-1586-Attach-1.DOC

Sutter Health
With You. For Life.

2200 River Plaza Drive
Sacramento, CA 95833
(916) 286-6000
(916) 286-6000 Fax

September 26, 2005

Honorable Mark B. McClellan, M.D., Ph.D.
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Room 443-G
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, D.C. 20201

REF: CMS-1502-P

RE: Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule for Calendar Year 2006; Proposed Rule

Dear Dr. McClellan:

Sutter Health is pleased to submit the following comments on the notice of proposed rulemaking (NPRM) on the Medicare Program: Revisions to Payment Policies Under the Physician Fee Schedule for Calendar Year 2006 (*Federal Register*, Volume 70, Number 151, Page 45764, published August 8, 2005.

Sutter Health, one of the country's leading not-for-profit networks of community health care services, serves more than twenty Northern California counties. Sutter Health provides care for more inpatients than any other network in Northern California, and is the region's largest provider of maternity services; orthopedics, pediatrics and cancer care services. Sutter Health has care centers in more than 100 Northern California communities; more than two dozen acute care hospitals; graduate medical education programs, medical research facilities, region-wide home health, hospice and occupational health networks, and long term care centers. This experience provides us with unique insights into the practical impact of Medicare's physician fee schedule.

We want to focus on your invitation for comments regarding the proposal that Santa Cruz and Sonoma Counties be removed from the Rest of California payment locality and that each would become its own payment locality.

Geographic Practice Cost Indices (GPCIs)

Sutter Health strongly supports and endorses the proposal to remove Santa Cruz and Sonoma Counties from the Rest of California payment locality and that each would be its own payment locality.

Sutter Health commends CMS for this proposal. The proposed removal of Santa Cruz and Sonoma Counties from the Rest of California payment locality effectively addresses the two largest inequities of the current payment locality policies. As Sutter Health has consistently raised in correspondence and meetings with CMS officials, these two counties have county-specific geographic adjustment factors (GAFs) that are substantially above the GAF for the Rest of California payment locality. As noted by CMS, "the county-specific GAF of Santa Cruz County is 10 percent higher than the Rest of California locality GAF. . .[and] . . . the county-specific GAF of Sonoma is 8 percent [greater]."

We are mindful that this proposal, if adopted in the final rule, while providing a higher GAF for Santa Cruz and Sonoma counties, will, as required by current law, result in a 0.1 percent (one tenth of one percentage point) reduction in the GAF for the Rest of California payment locality for 2006 compared to 2005. That is, in 2005 the Rest of California GAF is 1.012. If the proposal is adopted in the 2006 final rule, the Rest of California GAF would be 1.011. And while Santa Cruz and Sonoma counties are in Sutter Health's service areas, the Rest of California locality, as revised, will still include many counties also in Sutter Health's service area that will have inadequate and inequitable reimbursement. Nonetheless, given the gross disparities under existing policies and the very minimal adverse impact of this proposal, we feel that the proposed approach for Santa Cruz and Sonoma counties is clearly warranted and appropriate.

We applaud CMS for taking this unprecedented action in addressing California's locality problem without forcing payment reductions. We strongly recommend support of the proposal and continued cooperation for a complete resolution to the payment inequities within the GPCI. Towards that end, while we understand and appreciate the consequences, we would encourage CMS to consider the California Medical Association proposal that would more broadly address locality revision and bring more equitable payments to all counties adversely impacted in the future.

In closing, we want to again commend CMS for its sensitivity to this issue and the reasonableness of its proposal. If this proposal is adopted in the final rule it should arrest any diminution in the availability and accessibility of physicians services to Medicare beneficiaries.

Sincerely,

Patrick E. Fry
President and CEO

Submitter : Mr. William Morrissey

Date: 09/26/2005

Organization : Mr. William Morrissey

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

My wife and I support these and any other revisions that will help assure that more doctors will accept Medicare. We have been driving twenty miles out of our way for several years to see doctors in our former neighborhood because we are afraid we will not find doctors who will accept new patients on Medicare in Santa Rosa.

Submitter : Mrs. MARLEEN POPOVIC **Date: 09/26/2005**

Organization : ILLINOIS ONCOLOGY LTD

Category : Health Care Professional or Association

Issue Areas/Comments

GENERAL

GENERAL

As the administrator for a practice that serves a semi-rural area,I forsee a problem in being able to provide treatments to those patients who cannot pay their copay with each treatment- it will be very difficult with these cuts to permit patients to carry large balances that in all likelihood will never be paid.Also the costs of every item/supply that is used in providing that treatment has increased as well as employee salaries-so how does one "carry on as usual" when these cuts are so significant-Our practice is treating mor and more patients who have no insurance/medicaid and it's no secret that to be able to to this requires that a practice be profitable in the medicare/commercial sector.We cannot send patients to the hospital for treatment because they are a financial risk to our practice-I would really appreciate if CMS could advise us on how to tell patients they cannot be treated because the practice cannot afford to buy their drugs and take a loss.Also the predominant medicare hmo in our area leaves the patient with the 20% copay on all drugs-along with the below cost "allowed payment" this is a very dismal outlook for 2006.As has been stated many times before,we need to be compensated for all the services we provide i.e. pharmacy services similar to HOPPD and also supplies costs which continue to rise.The " vendor system " does not appear to be an option due to too many unknowns- it appears to be an alternative that creates problems rather than fixes them. I hope the proposed cuts will be reconsidered. Thank you.

Submitter : **Dr. Randy Rosett** **Date: 09/26/2005**

Organization : **University of New Mexico**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

1 University of New Mexico
Albuquerque, New Mexico 87131-0001
Telephone (505)272-2610
FAX (505)272-1300

September 26, 2005

Re: Teaching Anesthesiologists
CMS-1502-P - Revisions to Payment Policies Under the Physician Fee Schedule for Calendar Year 2006

To Whom It May Concern,
I am asking you to reconsider the proposed changes that do not include a correction of the discriminatory policy of paying teaching Anesthesiologists only 50% of the fee for each of two concurrent resident cases. This payment rule is unfair and unwise. It will diminish the quantity and quality of physicians trained in Anesthesiology at a time when there will be an increasing elderly Medicare population demand. The Medicare anesthesia conversion factor is currently less than 40% of the 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 Anesthesiology training programs.
I practice in one of the poorest states in the nation, and I have noticed the impact that this reduction will produce. Our academic department has and will continue to have financial difficulties that will make recruiting and retention of staff all but impossible. It will also increase the difficulty Medicare patients will have in accessing care. I am very worried about the effect this will have on both patients and physicians alike, and I urge you to reconsider this most important matter.

Sincerely,

Randy Rosett, MD
Medical Director, Outpatient Surgical Services

Submitter : **Dr. Kevin Bucol** **Date: 09/26/2005**

Organization : **Dr. Kevin Bucol**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

I am writing to urge CMS to provide just compensation to teaching anesthesiologists. I am a cardiac anesthesiologist in private practice in St.Louis, and our heart surgery team does complicated procedures on mostly Medicare patients. Patient safety is of utmost importance and requires a high level of training. My anesthesiology residency and cardiac fellowship training I received at Washington University in St. Louis benefits my patients daily in the operating room and the intensive care unit.

I found out today that CMS is planning to pay an anesthesiologist half of the normal fee if he or she is supervising two residents, while surgeons and internists receive full pay for overseeing two residents simultaneously. This is clearly unfair. Teaching anesthesiologists are vital to the future of my specialty. Besides clinical duties with patients and teaching residents, many are involved in research to further the safety of patients, which especially benefits the Medicare patient since the over 65 year old patient is at much higher anesthetic risk than the under 65 year old patient.

In the last fifty years, the number of anesthesiologists has increased markedly as the mortality associated with the administration of anesthesia has dropped dramatically. Now is not the time to reverse this trend.

Thank you,

Kevin D. Bucol, MD
St. Louis, MO

Submitter : Dr. Suzanne Gillam **Date:** 09/26/2005

Organization : ADA

Category : Other Health Care Professional

Issue Areas/Comments

GENERAL

GENERAL

RE: CMS-1502-P To Whom it May Concern: I am writing to object to the proposed reduction in the reimbursement rates for audiologists, which CMS has included in its proposed fee structure. The sudden elimination the ?non-physician zero work pool? codes without any consideration of practice expense or patient management factors is inappropriate. CMS has not recognized nor collected data for audiologic care that would justify this change to a policy that has existed for decades. This is especially egregious in view of CMS? considerations for other non-physician practitioners. In view of this proposed policy change that results in a four times greater reduction for audiologists? reimbursement than any other profession, CMS should impose a moratorium on reimbursement changes for audiologists. A moratorium would allow for collection of data to justify or refute the current reimbursement levels to audiologists. As you are aware, your proposed change would affect more than the 40 million Medicare subscribers today, particularly as CMS? rates are used almost universally by other health care insurers. The number of those impacted will only increase as America?s population grows and ages. In view of this massive change on hearing and balance care services for such a large number of Americans, it would seem reasonable to request such a period of study. As a practicing audiologist, a cut of this proportion would negatively impact my ability?and that of most audiologists?to provide the type of care patients deserve. Thus, I respectfully request that CMS impose a moratorium on audiologists? reimbursement reductions in its most recent proposed physician fee schedule. Sincerely,
Suzanne Gillam, AuD
Doctor of Audiology

Submitter :

Date: 09/26/2005

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 St Joseph Medical Center in Kansas City, Mo 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.

Respectfully

CR Venneman II MD

Submitter : **Dr. Douglas Rehder** **Date: 09/26/2005**

Organization : **Rehder Hearing Clinic, Inc.**

Category : **Other Practitioner**

Issue Areas/Comments

GENERAL

GENERAL

RE: CMS-1502

To Whom It May Concern:

I am writing to object to the proposed reduction in the reimbursement rates for audiologists, which CMS has included in its proposed fee structure. The sudden elimination of the ?non-physician zero work pool? codes without any consideration of practice expense or patient management factors is inappropriate. CMS has not recognized nor collected data for audiological care that would justify this change to a policy that has existed for decades. This is especially egregious in view of CMS? considerations for other non-physician practitioners.

In view of this proposed policy change that results in a four times greater reduction for audiologists? reimbursement than any other profession, CMS should impose a moratorium on reimbursement changes for audiologists. A moratorium would allow for collection of data to justify or refute the current reimbursement levels to audiologists. As you are aware, your proposed change would affect more than the 40 million Medicare subscribers today, particularly as CMS? rates are used almost universally by other health care insurers. The number of those impacted will only increase as America?s population grows and ages.

In view of this massive change on hearing and balance care services for such a large number of Americans, it would seem reasonable to request such a period of study. As a practicing audiologist, a cut of this proportion would negatively impact my ability-and that of most audiologists- to provide the type of care patients deserve. We are in the process of considering the purchase of additional equipment and space for the purpose of improving and expanding our vestibular evaluations and treatment services. Your proposed cut makes this expansion of much needed services financially impossible. Thus, I respectfully request that CMS impose a moratorium on audiologists? reimbursement reductions in its most recent proposed physician fee schedule.

Sincerely,

Douglas E. Rehder, Au.D.

Submitter : **Dr. Joy Nilsson** **Date: 09/26/2005**

Organization : **Academy of Dispensing Audiologists**

Category : **Other Health Care Professional**

Issue Areas/Comments

GENERAL

GENERAL

RE: CMS-1502-P

I am writing to object to the proposed dramatic and historic deep reduction in the reimbursement for audiologists. The sudden elimination the 'non-physician zero work pool' codes without any consideration of practice expense or patient management factors is inappropriate. This is especially egregious in view of your considerations for other non-physician practitioners.

CMS has not recognized nor collected data for audiologic care that would justify this change of policy that has existed for decades.

I would think that in view of the proposed policy change which results in a four times greater reduction for audiologists' reimbursement than any other profession, that CMS should impose a moratorium on reimbursement changes for audiologists. A moratorium would allow for collection of data to justify or refute the current reimbursement levels to audiologists. As you are aware, your proposed change affects more than the 40 million Medicare subscribers. CMS's rates are used almost universally by other health care insurers.

Furthermore, we live in a world where the cost of doing business continues to increase and reimbursement for those services is decreasing. Our reimbursement from CMS is already far below what our usual and customary charges are. An additional cut in reimbursement would be devastating. Audiology is moving towards a profession with the majority of its members at a doctoral level of education. We deserve better incomes than what we are seeing. This is, in part, due to the lack of value placed on the profession as well as low reimbursement for services. Look at the average income numbers for audiologists. This is ludicrous and should be considered.

In view of the massive impact that this will have on hearing and balance care services to all Americans, it would seem reasonable to request a period of study. Thus, I am requesting a moratorium be placed on audiologists' reimbursement reductions. I strongly urge you to consider this information in your decision making. Thank you for your consideration of this matter.

Sincerely,

Joy Nilsson, Au.D., CCC-A
Doctor of Audiology

Submitter : **John Vallerga** **Date: 09/26/2005**

Organization : **John Vallerga**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

John Vallerga
307 Greens Dr.
Healdsburg, CA 95448

MEMORANDUM

DATE: September 26, 2005

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

FROM: John Vallerga

Re: GPCIs

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

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

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

Submitter : **Jack McCarley** **Date: 09/26/2005**

Organization : **Jack McCarley**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

Jack McCarley
1040 Sunset Dr.
Healdsburg, CA 95448

MEMORANDUM

DATE: September 26, 2005

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

FROM: Jack McCarley
Re: GPCIs

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

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

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

Submitter : Dr. Victor Filadora **Date:** 09/26/2005

Organization : Roswell Park Cancer Institute

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

see attachment

CMS-1502-P-1597-Attach-1.DOC

CMS-1502-P-1597-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 Roswell Park Cancer Institute 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.

Victor A. Filadora II, M.D.
Assistant Professor of Anesthesiology
Roswell Park Cancer Institute
Department of Anesthesiology
Buffalo, NY 14224

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 Roswell Park Cancer Institute 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.

Victor A. Filadora II, M.D.
Assistant Professor of Anesthesiology
Roswell Park Cancer Institute
Department of Anesthesiology
Buffalo, NY 14224

Submitter : **Douglas Vadnais** **Date: 09/26/2005**

Organization : **Douglas Vadnais**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

Douglas Vadnais
251 Orchard St.
Healdsburg, CA 95448

MEMORANDUM

DATE: September 26, 2005

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

FROM: Douglas Vadnais

Re: GPCIs

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

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

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

Submitter : **Thomas Colbert** **Date: 09/26/2005**

Organization : **Thomas Colbert**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

Thomas Colbert
14716 Chalk Hill Rd.
Healdsburg, CA 95448

MEMORANDUM

DATE: September 26, 2005

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

FROM:Thomas Colbert

Re: GPCIs

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

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

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

Submitter : **Richard Norgrove** **Date: 09/26/2005**

Organization : **Richard Norgrove**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

Richard Norgrove
186 Barrio Way
Healdsburg, CA 95448

MEMORANDUM

DATE: September 26, 2005

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

FROM: Richard Norgrove

Re: GPCIs

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

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

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