Submitter : **Connie Wood**

Organization : **Connie Wood**

Category : **Individual**

Date: **09/28/2005**

Issue Areas/Comments

GENERAL

GENERAL

Connie Wood
191 Verano #108
Sonoma Ca 95476

MEMORANDUM

DATE: September 28, 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: Connie Wood

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 : **Joann Bertolucci**

Organization : **Joann Bertolucci**

Category : **Individual**

Date: **09/28/2005**

Issue Areas/Comments

GENERAL

GENERAL

Joann Bertolucci
430 Anza Dr.
Sonoma Ca 95476

MEMORANDUM

DATE: September 28, 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: Joann Bertolucci

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 : **Barbara Buhr**

Organization : **Barbara Buhr**

Category : **Individual**

Date: **09/28/2005**

Issue Areas/Comments

GENERAL

GENERAL

Barbara Buhr
610 Anthony Ct.
Sonoma Ca 95476

MEMORANDUM

DATE: September 28, 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: Barbara Buhr

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 : **Antoinette Agosti** **Date: 09/28/2005**

Organization : **Antoinette Agosti**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

Antoinette Agosti
754 E. Macarthur St.
Sonoma Ca 95476

MEMORANDUM

DATE: September 28, 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: Antoinette Agosti

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. Dana Day **Date: 09/28/2005**

Organization : Arizona Balance

Category : Health Care Professional or Association

Issue Areas/Comments

GENERAL

GENERAL

I am happy to read that CMS is welcoming comments and concerns from the Audiology community prior to making such a drastic change in reimbursement that will, if approve, significantly impact a patients ability to obtain quality services for difficulties with hearing and balance. I am an audiologist, who in the last 20 years have spent a considerable amount of time and money to position myself in the community to provide excellent care to individuals with hearing and balance concerns. Recently, in an effort to continue to provide the highest level of care to my community I ventured into a private practice setting. My professional strengths are in pediatric testing and Balance testing. I have gained the respect of my colleagues in the Medical field and work very closely with physicians in my area. I provide one of the highest levels of balance diagnostic care in the southwest, from testing, to rehab, to report writing. I am not a "button pusher" and I don't take my services door to door. When patients leave my office they are well informed of their condition and are given information to impower them to take control of their own health care needs. As an audiologist I continue to struggle for the respect of third party payors and CMS. Audiologists are not considered profcssionals, but simply technicians that work for physicians. That is certainly not the case for myself and a substantial drop in reimbursement will force me to leave an area of health care that I really enjoy and dare I say the patients in the Phoenix area will also lose a center that they have come to rely on. I struggle with the logic behind such a drop in reimbursement to the audiologist for services they provide each day. If this is a cost savings effort I can offer several other suggestions that would provide more sense, but can honestly say that such reductions in reimbursement is only going to lead to an exodus of clinical audiologists and what the patient will be left with is a technician doing testing and an MD, DO, DC, or other "physician" reading the results, who have little or no background in the area of clinical audiology. This would be as ridiculous as asking me to determine if a patient had a stroke based on their CT Scan. I would never do this of course because it is outside my expertise, but CMS is encouraging just that with their current fee schedule to physicians and their proposed reduction in reimbursement to me and my colleagues in my profession. Please take a moment and ask yourself if you or one of your family members woke up one day with a sudden hearing loss and debilitating dizzy who would you want to be able to see? Someone who is going to tell you there is nothing they can do, go home and live with it. Or someone who is going to take the time to do a complete and thorough evaluation, explain the anatomy and physiology in a way you and your love ones can understand, and work with you to make sure something is done so that you or your loved one can return to work, travel, hobbies, life? I can guarentee if you drop reimbursement to the audiologist of 21% your choice will be made for you and living with dizziness and hearing loss increases the risk of falls and other injuries that could have been avoided. I urge you to reconsidered your decision to decrease reimbursement and I also welcome the opportunity to sit down with CMS in and open and professional diaglog to discuss the Practice of Audiology.

Dana L. Day, AuD, CCC-A, MBA
dana@azbalance.com
222 West Thomas Road, Suite 110
Phoenix, Arizona 85013
602-406-3605

Submitter : Dr. Louis A. VanderMolen

Date: 09/28/2005

Organization : Orange Coast Oncology Hematology Med. Assc., Inc.

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

"See attachment"

CMS-1502-P-2006-Attach-1.DOC

CMS-1502-P-2006-Attach-2.DOC

OCOH ORANGE COAST ONCOLOGY HEMATOLOGY
MEDICAL ASSOCIATES, INC.

LOUIS A. VANDERMOLEN, M.D.
DAVID J. KLEIN, M.D.
GEORGE B. SEMENIUK, III., M.D.

September 26, 2005

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1502-P, Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

To Whom It May Concern:

The proposed MMA changes commencing on January 1, 2006, have severe ramifications for community oncology.

Our practice treats hundreds of Medicare patients each month. We will not be able to provide this service with the intended reimbursement cuts in 2006.

We are already experiencing severe reimbursement issues with so many of the chemotherapy drugs that are vital to the patients care. The ASP+6% reimbursement for several of these drugs is less than our cost from the vendors. If not for the Demonstration Project, we would be fiscally unable to provide much care and treatment to Medicare patients.

We ask that CMD continue the Demonstration Project throughout 2006 and that the ASP+6% reimbursement be reviewed and revised before any drastic curtailment to services and treatment are necessary.

If the 2006 reimbursement is not adjusted it will certainly limit access to senior patients. In addition, it will cause staff reductions, resulting in less efficient care.

Sincerely,

Louis A. VanderMolen, MD
David J. Klein, MD
George B. Semeniuk, III, MD
And staff

OCOH ORANGE COAST ONCOLOGY HEMATOLOGY
MEDICAL ASSOCIATES, INC.

LOUIS A. VANDERMOLEN, M.D.
DAVID J. KLEIN, M.D.
GEORGE B. SEMENIUK, III., M.D.

September 26, 2005

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1502-P, Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

To Whom It May Concern:

The proposed MMA changes commencing on January 1, 2006, have severe ramifications for community oncology.

Our practice treats hundreds of Medicare patients each month. We will not be able to provide this service with the intended reimbursement cuts in 2006.

We are already experiencing severe reimbursement issues with so many of the chemotherapy drugs that are vital to the patients care. The ASP+6% reimbursement for several of these drugs is less than our cost from the vendors. If not for the Demonstration Project, we would be fiscally unable to provide much care and treatment to Medicare patients.

We ask that CMD continue the Demonstration Project throughout 2006 and that the ASP+6% reimbursement be reviewed and revised before any drastic curtailment to services and treatment are necessary.

If the 2006 reimbursement is not adjusted it will certainly limit access to senior patients. In addition, it will cause staff reductions, resulting in less efficient care.

Sincerely,

Louis A. VanderMolen, MD
David J. Klein, MD
George B. Semeniuk, III, MD
And staff

Submitter : Dr. Terrance Posluszny **Date:** 09/28/2005

Organization : Terrance L Posluszny M.D.

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

As a practicing cardiologist in south Texas I have strong concerns regarding the reduction of the RVU and conversion factor in the 2006 Proposed Medicare Physician Fee schedule posted on the Federal Register. Comparing my practice expenses this past year with the prior year (s) all parameters have increased, some dramatically: staff salaries, rent, equipment costs, disposables cost, furniture and fixture taxation rate for Hidalgo county, malpractice expense (not reduced as predicted,) transcription costs, postage, utilities, accounting and all my other work expenses too numerous to list have risen over the previous year(s). For one test, I actually currently get reimbursed less than what the test stips cost to purchase at the local hospital-negotiated price which is the lowest I can find anywhere. I run a very lean office with a very low overhead so I can honestly say these reductions are probably going to result in some type of cutbacks everywhere,in my office,and most of the other physicians I know and work with here in south Texas. Thank you for your time and kind attention.

Submitter : Dr. Hui Yuan

Date: 09/28/2005

Organization : Saint Louis Univesity School of medicine

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

Mark McClellan, M.D., Ph.D.
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attn: CMS-1502-P/TEACHING ANESTHESIOLOGISTS
P.O. Box 8017
Baltimore, MD 21244-8017
Dear Dr. McClellan:
I am writing as an anesthesiologist at Saint Louis University School of Medicine at Saint Louis, 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.
Sincerely
Name: Hui Yuan, MD
Address: Department of Anesthesia and Critical Care
Saint Louis University School of Medicine
3635 Vista at Grand Blvd
Saint Louis, MO 63110

Submitter : Dr. Joe Rater

Organization : Dr. Joe Rater

Category : Physician

Date: 09/28/2005

Issue Areas/Comments

GENERAL

GENERAL

I feel it is grossly unfair to short-change reimbursement to academic Anesthesiology departments/residency programs. Society entrusts them to provide a continuous supply of quality health care providers.

Teaching programs are inherently less efficient than private community health care facilities with experienced personnel. Furthermore, many Anesthesiology residencies are already serving populations in demographic areas with poor payer mixes, and have no opportunity to cost-shift or find other sources of revenue. They deserve more society/government support than 50% reimbursement per resident.

Sincerely,
Joe Rater, M.D.

Submitter : Mr. Ben Golden

Organization : Mr. Ben Golden

Category : Pharmacist

Date: 09/28/2005

Issue Areas/Comments

GENERAL

GENERAL

To whom it may concern:
It is beyond comprehension that in present day USA a teaching anasthesiologist,who frequently works 2 rooms or more in order to teach and keep up with the busy scheduels of the hospitals, should only recieve 50% pay on each patient.
The teaching hospitals are understaffed on the anasthesiologist level because they can make much more in a private hospital, where no teaching or room splitting is done.
What are your priorities? As it is the US is becoming a second rate country in the teaching of specialities because of the pay scheduele.
Please take a step to reward those who are putting themselves out for the sake of teaching!
Sincerely,
Ben Golden (Chicago)

Submitter : **Kenneth Schlesinger** **Date: 09/28/2005**

Organization : **Kenneth Schlesinger**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

Submitter : Dr. Alan Israel

Date: 09/28/2005

Organization : Dr. Alan Israel

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

The proposed reductions in reimbursement for medical oncology, specifically for the administration of cancer chemotherapy in the physician's office will necessitate the admission of Medicare patients to the hospital for treatment. It is unlikely that this will result in a net savings for CMS. If the demonstration project for chemotherapy instituted in 2005 is not extended at its present level this will require that almost all Medicare patients receive cancer chemotherapy in the hospital or equivalent facility. This will not only be more costly but will also be destructive of the patient's quality of life.

Reductions for IVIG in 2005 have already led me to admit patients for this simple infusion. Similarly, I now admit all patient's with poor coinsurance for hospital based treatment. CMS should prepare itself for greater number of hospital admissions for chemotherapy should the proposed changes be enacted.

Dr. Alan Israel oncologist, NJ

Submitter : paul gratz

Organization : paul gratz

Category : Individual

Date: 09/28/2005

Issue Areas/Comments

GENERAL

GENERAL

It took us over three years to find a primary care physian in Santa Cruz County who would accept my 87-year old mother as a new Medicare patient. Physicians continue to opt out of Medicare and new physicians are not moving here.

Thus, I support the removal of Santa Cruz County from Medicare Locality 99. This 40-year old designation has nothing to do with cost of living reality in our urbanized area. The current situation is very harmful to those least able to afford medical care. Please increase the Medicare reimbursement rate Santa Cruz County physicians. Thanks. Paul Gratz

Submitter : Mrs. Shelby Schewe

Date: 09/28/2005

Organization : Centers for Medicare

Category : Federal Government

Issue Areas/Comments

GENERAL

GENERAL

Dear CMS Sfaff:
I am a resident of Santa Crua County, CA. I am writing to support your proposed rule that would remove Santa Cruz and Sonoma Counties from Locality 99 and place them into unique payment locations that accurately reflect the high cost of practice in those counties. I receive my medical care from an excellent physician in our community. I am NOT currently a Medicare beneficiary, but I am very concerned that my physician be reimbursed for services in an equitable fashion so that the practice can be maintained and so that new physicians can be recruited into the community when needed. The current under-reimbursement by Medicare makes that very difficult.

I applaud you efforts to rectify a long-standing problem and wholeheaartedly support your proposed changes!
Sincerely,
Shelby Schewe
455 Deer Run Road
Felton, CA 95018

Submitter : Dr. Syed Razvi

Date: 09/28/2005

Organization : Private

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 Elliot Hospital in Manchester, NH, 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: Syed A Razvi, M.D.
Address: Elliot Hospital
One Elliot Way
Manchester, NH 03103

Submitter : Dr. Charles Crowder **Date: 09/28/2005**

Organization : Washington University School of Medicine

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

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

I am writing as a teaching anesthesiologist at Washington University School of Medicine and a member of the Association of University Anesthesiologists (AUA) and head of the AUA's scientific advisory board to urge the Centers for Medicare and Medicaid Services (CMS) to change the Medicare anesthesiology teaching payment policy. I watch with great concern as many of our best trainees opt for private practice over a teaching position at our hospital. The primary reason in most cases is the much lower salary, typically half, than that of a private practioner. Many factors contribute to lower salaries but one major factor is the CMS rule for reimbursement of resident supervision.

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

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

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

Please end the anesthesiology teaching payment penalty.

Sincerely,
C. Michael Crowder, M.D., Ph.D.
Associate Professor of Anesthesiology and Molecular Biology/Pharmacology
Washington University School of Medicine
660 S. Euclid Ave
St. Louis, MO 63110
email: crowderm@morpheus.wustl.edu

Submitter : Ms. Sarika Rane **Date:** 09/28/2005

Organization : The Endocrine Society

Category : Health Care Professional or Association

Issue Areas/Comments

GENERAL

GENERAL

See Attachment.

CMS-1502-P-2018-Attach-1.DOC

THE ENDOCRINE SOCIETY

8401 CONNECTICUT AVENUE, SUITE 900 + CHEVY CHASE, MARYLAND + 20815-5817 + TELEPHONE 301.941.0200 + FAX 301.941.0259 + www.endo-society.org

September 28, 2005

The Honorable Mark McClellan, MD
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Hubert H. Humphrey Building, Room 445-G
200 Independence Avenue, SW
Washington, D.C. 20201

Re: CMS-1502-P, Revisions to Payment Policies Under the Physician Fee Schedule (PFS) for Calendar Year 2006

Dear Dr. McClellan:

On behalf of The Endocrine Society (TES), representing more than 11,000 physicians and scientists in the field of endocrinology, we appreciate the opportunity to provide comments on the Centers for Medicare & Medicaid Services' (CMS) proposed revisions to the payment policies under the physician fee schedule for calendar year 2006. The Society looks forward to working closely with the Agency as this proposed rule moves toward implementation.

Founded in 1916, our Society comprises physicians and scientists, representing the full range of professionals engaged in research and treatment of endocrine disorders, such as diabetes, infertility, osteoporosis, thyroid disease, and obesity.

The Society's comments address the following areas:

1) Sustainable Growth Rate (SGR); and
2) Coding: Telehealth List of Covered Services and Providers.

I. Sustainable Growth Rate - Repeal the Current Formula

In the proposed rule (CMS-1502-P), CMS notes its interest in moving toward a pay-for-performance (P4P) system and examining other alternative payment systems.

COMMENTS

Although this may provide some relief, it would be difficult to enhance the Medicare program without a repeal of the current SGR formula. The SGR and P4P are inconsistent methodologies from both a conceptual as well as practical standpoint. The Endocrine Society and most medical subspecialty organizations believe the SGR formula must be repealed for any alternative payment systems to be implemented successfully.

The Endocrine Society is concerned that the Medicare program is at a critical crossroads. The existing payment update formula, the sustainable growth rate (SGR) spending target, threatens the future long-term sustainability of the programs and services that so many Americans rely on for their health care needs. Now is clearly the time to modernize the way that Medicare pays physicians to help support quality care.

As you know, the Medicare Trustees project that physician payments will be cut by 26 percent over the next six years. Such cuts will begin this year with a negative 4.3 percent update for 2006. The economic impact on Endocrinology from the proposed rule is a negative 4.6 percent update for 2006. The Endocrine Society is concerned about the negative effects of such a reduction on crucial resources and on access to health care for patients.

The Society appreciates CMS' examination of alternative methodologies to establish a new payment update formula and encourages the Agency to explore all options.

II. Coding: Telehealth List of Covered Services and Providers

CMS proposes not to include Diabetes Self Management Training (as described by HCPCS codes G0108 and G0109) to the list of Medicare telehealth services because of concerns regarding the merits of providing beneficiary training to administer insulin injections via telehealth. The Agency further proposes not to add group medical nutrition therapy (MNT) to the list of Medicare telehealth services. The proposed rule would add individual MNT as a Medicare Telehealth Service and seeks to expand the provider list to include a registered dietitian and nutrition professionals.

COMMENTS

The Endocrine Society supports CMS' updates and proposals for Medicare telehealth coverages. While our members are supportive of the emerging technology of telehealth medicine and the benefits it can bring to patients, we share CMS' concerns for more conclusive data regarding the efficacy of certain expanded services.

In conclusion, The Endocrine Society appreciates the opportunity to forward these brief comments regarding CMS' proposed rule and revisions to payment policies under the physician fee schedule for calendar year 2006. As always, the Society is grateful to CMS staff for all the hard work that went into drafting this proposed rule. Please do not hesitate to contact Janet Kreizman, Director of Government & Professional Affairs for The Endocrine Society at jkreizman@endo-society.org if we may provide any additional information or assistance as you move forward in developing this rule.

Sincerely,

Andrea Dunaif, M.D.
President
The Endocrine Society

Submitter : Ms. Celeste Connor

Organization : Ms. Celeste Connor

Category : Nurse

Date: 09/28/2005

Issue Areas/Comments

GENERAL

GENERAL

I am a new Medicare beneficiary, living in Sonoma County California. I have watched the decline in available health care resources in this county as cost of living, especially housing, soared while health insurance reimbursement, lead by Medicare stayed an unacceptably low levels. Something must be done!
Celeste T Connor RN

Submitter : Lois Miller **Date:** 09/28/2005

Organization : Lois Miller

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

I am a Medicare recipient and live in Sonoma County, CA. The median home price here is over $600,000 and over $700,000 in some communities. This deters many young doctors from coming here to practice, resulting in a shortage. My own general practice physician and her 2 partners closed their practice to new patients about 5 years ago. The Sonoma County Medical Association states that "As of July 2005, 60% of Sonoma Co. primary care physicians in private practice were NOT accepting new Medicare patients".
What benefit does Medicare provide to seniors who cannot find a doctor?
I support increasing the fee schedule for Sonoma County doctors, CMS-1502-P.
Lois Miller

Submitter : Dr. Lee Micken **Date:** 09/28/2005

Organization : Micken Hearing Services

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 and to respectfully request that CMS impose a moratorium on audiologists? reimbursement reductions in its most recent proposed physician fee schedule. The proposed reductions would result in a four times greater reduction for audiologists? reimbursement than any other profession, and are being made without any objective data regarding the cost of running a practice or providing services to the hearing impaired. Such drastic reductions will, without a doubt, affect my ability to provide quality services to the many hearing-impaired citizens who request and require the services of an audiologist. This proposed massive change in reimbursement rates will effect an ever increasing aging population. I respectfully request that CMS impose a moratorium on audiologists? reimbursement reductions in its most recent proposed physician fee schedule until such data can be obtained justifying any change.

Sincerely,
Lee E. Micken, Au.D.
Doctor of Audiology
1008 N. 7th Avenue
Bozeman, MT 59715

Submitter : Dr. Cynthia Earle

Organization : Asheville Audiology Services

Category : Other Health Care Provider

Date: 09/28/2005

Issue Areas/Comments

GENERAL

GENERAL

Re:CMS-1502-P
The proposed reduction in the reimbursement rates for audiologists is terrible. I spend approximately 1 hour with each patient conducting an audiological evaluation, explaining the results, and making recommendations. This elimination of "non-physician zero work pool" codes without consideration of my time and expertise is ridiculous. CMS need to collect data on audiological practices before proceeding any further.

The proposal results in a four times greater reduction for audiologists' reimbursement than any other profession. Obviously, CMS needs to study and understand the role of audiologists in the assessment and rehabilition of hearing and balance problems in the elderly population.

I would request a moratorium on audiologists' reimbursement reductions in the most recent proposed physician fee schedule. I would invite a panel to survey and spend a day with a private practice audiologist to better understand our role in the hearing health care of the elderely.

Sincerely yours,
Cynthia Earle, Au.D
Doctor of Audiology

Submitter : Dr. Peter Kosek

Date: 09/28/2005

Organization : Pain Consultants of Oregon

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

This is to comment on payment for 62367 and 62368, codes for programming spinal pumps. The programmers for these devices are NOT provided by Medtronic, and are a practice expense. I have invoices for the seven programmers that my practice purchased for use, and these devices are $1050/each. This practice expence needs to be included in pahyment for these codes.

For programming in hospital settings, the programmers belong to the hospital, and therefore no practice expence for the physician is necessary in that setting.

CMS-1502-P-2023-Attach-1.PDF

Medtronic
When Life Depends on Medical Technology

I N V O I C E
Standard

INVOICE: 3585456	Page 1
Invoice Date: Feb 10, 2003	
P.O. No: PETER KOSEK	
Ordered by: PETER HERBST 5415017467	

REMIT TO:
MEDTRONIC USA INC
4642 COLLECTIONS CENTER DR
CHICAGO , IL 60693

Due Date: Mar 12, 2003
Terms: Net 30

Bill To: 118782

PAIN CONSULTANTS
1125 DARLENE LN STE 200
EUGENE OR 97401-1601

Ship To: 713308

PAIN CONSULTANTS
1125 DARLENE LN STE 200
EUGENE OR 97401-1601

Order Nbr	Request Date	Carrier	Currency: USD
7821415 SO	02/06/03	FXP1	U.S. Dollar

Qty Order	Qty Ship	Product ID	Description	UM	Prices Unit	Prices Extended
	1	CAT: 8840PAK2	KIT - N'VISION PROGR	EA	1,050.0000	1,050.00
	1	CAT: 8840	PHYSICIAN PROGRAMMER	EA		
		Lot/Sn # - NHF012675N				
	1	CAT: 8870AAA02	APPL CARD, SW. VERSI	EA		
		Lot/Sn # - NHH014733N				
	1	CAT: 8529	MAGNET-PHYSICIAN PRO	EA		
		Lot/Sn # - B9S0003489				
	1	CAT: 8840PAK2	KIT - N'VISION PROGR	EA	1,050.0000	1,050.00
	1	CAT: 8840	PHYSICIAN PROGRAMMER	EA		
		Lot/Sn # - NHF012708N				
	1	CAT: 8870AAA02	APPL CARD, SW. VERSI	EA		
		Lot/Sn # - NHH014735N				

CONTINUED ON NEXT PAGE

SALES TO UNRELATED PARTIES - FOB SHIPPING POINT: The price on this invoice is net of discounts provided at the time of purchase. Some of the products listed on this invoice may be subject to additional discounts. You may have an obligation to report discounts and credits to Medicare, Medicaid or other state health programs.
INTERCOMPANY SALES: The ownership of and the legal and beneficial title to, the risk of loss, and the right to possession and control over the goods shall remain with the seller until the shipment reaches the port of entry in the country of destination or U.S. possession and all documents related to the goods have been transferred to purchaser, not withstanding any other pricing or shipping terms. ACCEPTANCE OF THE GOODS CONSTITUTES ACCEPTANCE OF THE INVOICE.

COUNTRY OF ORIGIN: U.S.A.

CERTIFIED TRUE AND CORRECT PER

Medtronic
When Life Depends on Medical Technology

I N V O I C E
Standard

INVOICE: 3585456 | Page 2

Invoice Date: Feb 10, 2003

P.O. No: PETER KOSEK

Ordered by: PETER HERBST 5415017467

REMIT TO:
MEDTRONIC USA INC
4642 COLLECTIONS CENTER DR
CHICAGO , IL 60693

Due Date: Mar 12, 2003

Terms: Net 30

Bill To: 118782

PAIN CONSULTANTS
1125 DARLENE LN STE 200
EUGENE OR 97401-1601

Ship To: 713308

PAIN CONSULTANTS
1125 DARLENE LN STE 200
EUGENE OR 97401-1601

Order Nbr	Request Date	Carrier	Currency: USD U.S. Dollar
7821415 SO	02/06/03	FXP1	

Qty Order	Qty Ship	Product ID	Description	UM	Unit Price	Extended Price
1		CAT: 8529	MAGNET-PHYSICIAN PRO	EA		
		Lot/Sn # - B9S0003491				
1		CAT: 8840PAK2	KIT - N'VISION PROGR	EA	1,050.0000	1,050.00
1		CAT: 8840	PHYSICIAN PROGRAMMER	EA		
		Lot/Sn # - NHF012715N				
1		CAT: 8870AAA02	APPL CARD, SW. VERSI	EA		
		Lot/Sn # - NHH014736N				
1		CAT: 8529	MAGNET-PHYSICIAN PRO	EA		
		Lot/Sn # - B9S0003268				
		622267942383	Waybill			

Total	3,150.00
Sales Tax	.00
Shipping	.00
Total Order	3,150.00

#1685

SALES TO UNRELATED PARTIES - FOB SHIPPING POINT: The price on this invoice is net of discounts provided at the time of purchase. Some of the products listed on this invoice may be subject to additional discounts. You may have an obligation to report discounts and credits to Medicare, Medicaid or other state health programs.
INTERCOMPANY SALES: The ownership of and the legal and beneficial title to, the risk of loss, and the right to possession and control over the goods shall remain with the seller until the shipment reaches the port of entry in the country of destination or U.S. possession and all documents related to the goods have been transferred to purchaser, not withstanding any other pricing or shipping terms. ACCEPTANCE OF THE GOODS CONSTITUTES ACCEPTANCE OF THE INVOICE.

COUNTRY OF ORIGIN: U.S.A.

CERTIFIED TRUE AND CORRECT BY

Medtronic
When Life Depends on Medical Technology

INVOICE
Standard

FEB

INVOICE: 3595156		Page 1
Invoice Date: Feb 12, 2003		
REMIT TO: MEDTRONIC USA INC 4642 COLLECTIONS CENTER DR CHICAGO , IL 60693	Due Date: Mar 14, 2003 Terms: Net 30	P.O. No: PETER KOSEK
		Ordered by: PETER HERBST 5415017467

Bill To: 118782

PAIN CONSULTANTS
1125 DARLENE LN STE 200
EUGENE OR 97401-1601

Ship To: 713308

PAIN CONSULTANTS
1125 DARLENE LN STE 200
EUGENE OR 97401-1601

Order Nbr	Request Date	Carrier	Currency: USD
7828775 SO	02/06/03	FXP1	U.S. Dollar

Qty Order	Qty Ship	Product ID	Description	UM	Prices Unit	Prices Extended
	1	CAT: 8840PAK2	KIT - N'VISION PROGR	EA	1,050.0000	1,050.00
	1	CAT: 8840	PHYSICIAN PROGRAMMER	EA		
		Lot/Sn # - NHF012606N				
	1	CAT: 8870AAA02	APPL CARD, SW. VERSI	EA		
		Lot/Sn # - NHH014921N				
	1	CAT: 8529	MAGNET-PHYSICIAN PRO	EA		
		Lot/Sn # - B9S0003484				
	1	CAT: 8840PAK2	KIT - N'VISION PROGR	EA	1,050.0000	1,050.00
	1	CAT: 8840	PHYSICIAN PROGRAMMER	EA		
		Lot/Sn # - NHF012650N				
	1	CAT: 8870AAA02	APPL CARD, SW. VERSI	EA		
		Lot/Sn # - NHH014922N				

CONTINUED ON NEXT PAGE

SALES TO UNRELATED PARTIES - FOB SHIPPING POINT: The price on this invoice is net of discounts provided at the time of purchase. Some of the products listed on this invoice may be subject to additional discounts. You may have an obligation to report discounts and credits to Medicare, Medicaid or other state health programs.
INTERCOMPANY SALES: The ownership of and the legal and beneficial title to, the risk of loss, and the right to possession and control over the goods shall remain with the seller until the shipment reaches the port of entry in the country of destination or U.S. possession and all documents related to the goods have been transferred to purchaser, not withstanding any other pricing or shipping terms. ACCEPTANCE OF THE GOODS CONSTITUTES ACCEPTANCE OF THE INVOICE.

COUNTRY OF ORIGIN: U.S.A.

CERTIFIED TRUE AND CORRECT PER

Medtronic
When Life Depends on Medical Technology

I N V O I C E
Standard

INVOICE: 3595156	Page 2
Invoice Date: Feb 12, 2003	
P.O. No: PETER KOSEK	
Ordered by: PETER HERBST 5415017467	

REMIT TO:
MEDTRONIC USA INC
4642 COLLECTIONS CENTER DR
CHICAGO , IL 60693

Due Date: Mar 14, 2003
Terms: Net 30

Bill To: 118782

PAIN CONSULTANTS
1125 DARLENE LN STE 200
EUGENE OR 97401-1601

Ship To: 713308

PAIN CONSULTANTS
1125 DARLENE LN STE 200
EUGENE OR 97401-1601

Order Nbr	Request Date	Carrier	Currency: USD
7828775 SO	02/06/03	FXP1	U.S. Dollar

Qty Order	Qty Ship	Product ID	Description	UM	Prices Unit	Prices Extended
	1	CAT: 8529	MAGNET-PHYSICIAN PRO	EA		
		Lot/Sn # - B9S0003271				
	1	CAT: 8840PAK2	KIT - N'VISION PROGR	EA	1,050.0000	1,050.00
	1	CAT: 8840	PHYSICIAN PROGRAMMER	EA		
		Lot/Sn # - NHF012662N				
	1	CAT: 8870AAA02	APPL CARD, SW. VERSI	EA		
		Lot/Sn # - NHH014924N				
	1	CAT: 8529	MAGNET-PHYSICIAN PRO	EA		
		Lot/Sn # - B9S0003496				
	1	CAT: 8840PAK2	KIT - N'VISION PROGR	EA	1,050.0000	1,050.00
	1	CAT: 8840	PHYSICIAN PROGRAMMER	EA		
		Lot/Sn # - NHF012695N				

CONTINUED ON NEXT PAGE

SALES TO UNRELATED PARTIES - FOB SHIPPING POINT: The price on this invoice is net of discounts provided at the time of purchase. Some of the products listed on this invoice may be subject to additional discounts. You may have an obligation to report discounts and credits to Medicare, Medicaid or other state health programs.
INTERCOMPANY SALES: The ownership of and the legal and beneficial title to, the risk of loss, and the right to possession and control over the goods shall remain with the seller until the shipment reaches the port of entry in the country of destination or U.S. possession and all documents related to the goods have been transferred to purchaser, not withstanding any other pricing or shipping terms. ACCEPTANCE OF THE GOODS CONSTITUTES ACCEPTANCE OF THE INVOICE.

COUNTRY OF ORIGIN: U.S.A.

CERTIFIED TRUE AND CORRECT PER

Medtronic
When Life Depends on Medical Technology

INVOICE
Standard

INVOICE: 3595156	Page 3
Invoice Date: Feb 12, 2003	
P.O. No: PETER KOSEK	
Ordered by: PETER HERBST 5415017467	

REMIT TO:
MEDTRONIC USA INC
4642 COLLECTIONS CENTER DR
CHICAGO , IL 60693

Due Date: Mar 14, 2003
Terms: Net 30

Bill To: 118782

PAIN CONSULTANTS
1125 DARLENE LN STE 200
EUGENE OR 97401-1601

Ship To: 713308

PAIN CONSULTANTS
1125 DARLENE LN STE 200
EUGENE OR 97401-1601

Order Nbr	Request Date	Carrier	Currency: USD
7828775 SO	02/06/03	FXP1	U.S. Dollar

Qty Order	Qty Ship	Product ID	Description	UM	Prices Unit	Prices Extended
	1	CAT: 8870AAA02	APPL CARD, SW. VERSI	EA		
		Lot/Sn # - NHH014926N				
	1	CAT: 8529	MAGNET-PHYSICIAN PRO	EA		
		Lot/Sn # - B9S0003495				
	1	CAT: 8840PAK2	KIT - N'VISION PROGR	EA	1,050.0000	1,050.00
	1	CAT: 8840	PHYSICIAN PROGRAMMER	EA		
		Lot/Sn # - NHF012716N				
	1	CAT: 8870AAA02	APPL CARD, SW. VERSI	EA		
		Lot/Sn # - NHH014976N				
	1	CAT: 8529	MAGNET-PHYSICIAN PRO	EA		
		Lot/Sn # - B9S0003500				
		622267992734	Waybill			

Total	5,250.00
Sales Tax	.00
Shipping	.00
Total Order	5,250.00

#207 - 5 programmer units

SALES TO UNRELATED PARTIES - FOB SHIPPING POINT: The price on this invoice is net of discounts provided at the time of purchase. Some of the products listed on this invoice may be subject to additional discounts. You may have an obligation to report discounts and credits to Medicare, Medicaid or other state health programs.
INTERCOMPANY SALES: The ownership of and the legal and beneficial title to, the risk of loss, and the right to possession and control over the goods shall remain with the seller until the shipment reaches the port of entry in the country of destination or U.S. possession and all documents related to the goods have been transferred to purchaser, not withstanding any other pricing or shipping terms. ACCEPTANCE OF THE GOODS CONSTITUTES ACCEPTANCE OF THE INVOICE.

COUNTRY OF ORIGIN: U.S.A.

CERTIFIED TRUE AND CORRECT PER

Submitter : Dr. ramprasad sripada **Date:** 09/28/2005

Organization : saint louis university

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

Mark McClellan, M.D., Ph.D.
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attn: CMS-1502-P/TEACHING ANESTHESIOLOGISTS
P.O. Box 8017
Baltimore, MD 21244-8017
Dear Dr. McClellan:
I am writing as an anesthesiologist at St. Louis University Hospital, St. Louis, 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.
Yours truly,
Ramprasad Sripada, MD
Department of Anesthesiology and Critical Care
St. Louis University Hospital,
3635, Vista Ave at Grand Blvd,
St. Louis, MO 63110

Submitter : Mrs. Kimberly Koyanagi

Date: 09/28/2005

Organization : Cardiology Associates, Inc

Category : Nurse Practitioner

Issue Areas/Comments

GENERAL

GENERAL

I am a nurse practitioner in a 3 physician cardiology practice. I firmly believe that having office-based imaging allows myself and our physicians to provide good patient care. It promotes continuity of care and better patient outcomes. For example, if a patient has a history of coronary artery disease, and best practice medicine is to get subsequent imaging, cardiologist/radiologist will be able to compare current and previous studies. I oppose legistlative efforts that would limit our ability to diagnose Medicare patients using office based medical imaging. Allowing patients to have office based imaging not only allows for continuity of care, but also helps with early detection and better patient outcomes. Thank you for your time.

Submitter : Keith Knolles

Date: 09/29/2005

Organization : Keith Knolles

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

Sonoma County is a major part of the Bay Area that is being discriminated against in regard to reimbursements for doctors. This must stop. We are losing doctors because of this unfair practice. Update the schedule now.

Submitter : Dr. Rona Giffard
Organization : Stanford University
Category : Physician
Date: 09/29/2005

Issue Areas/Comments

GENERAL

GENERAL

see attachment

CMS-1502-P-2028-Attach-1.DOC

CMS-1502-P-2028-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 Stanford University Medical School to urge the Centers for Medicare and Medicaid Services (CMS) to change the Medicare anesthesiology teaching payment policy.

Medicare's discriminatory payment arrangement, which applies only to anesthesiology teaching programs, has had a serious detrimental impact on the ability of programs to retain skilled faculty and train new anesthesiologists. In California we have a very high cost of living, and recruiting and retaining faculty is a major challenge. To alleviate the shortage of anesthesia providers -- a shortage that will be exacerbated by the aging of the baby boom generation, we need to maintain strong teaching programs. Anesthesia training programs are the ones that are most penalized by the current rules.

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. Although teaching anesthesiologists are permitted to work with residents on overlapping cases, so long as they are present for critical or key portions of the procedure, they cannot receive full pay for these services. This is in striking contrast to reimbursement rules for teaching surgeons and internists. Since 1995 teaching anesthesiologists working with residents on overlapping cases face a discriminatory reduction on Medicare payment for each case to 50%. This penalty is unfair, and unreasonable.

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_____Rona Giffard, Ph.D., M.D._____

Address __Dept of Anesthesia, Stanford University School of Medicine____

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

Dear Dr. McClellan:

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

Medicare's discriminatory payment arrangement, which applies only to anesthesiology teaching programs, has had a serious detrimental impact on the ability of programs to retain skilled faculty and train new anesthesiologists. In California we have a very high cost of living, and recruiting and retaining faculty is a major challenge. To alleviate the shortage of anesthesia providers -- a shortage that will be exacerbated by the aging of the baby boom generation, we need to maintain strong teaching programs. Anesthesia training programs are the ones that are most penalized by the current rules.

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. Although teaching anesthesiologists are permitted to work with residents on overlapping cases, so long as they are present for critical or key portions of the procedure, they cannot receive full pay for these services. This is in striking contrast to reimbursement rules for teaching surgeons and internists. Since 1995 teaching anesthesiologists working with residents on overlapping cases face a discriminatory reduction on Medicare payment for each case to 50%. This penalty is unfair, and unreasonable.

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_____Rona Giffard, Ph.D., M.D._____

Address __Dept of Anesthesia, Stanford University School of Medicine____

Submitter : S. E.

Organization : S. E.

Category : Individual

Date: 09/29/2005

Issue Areas/Comments

GENERAL

GENERAL

Hopefully Medicare will have the common sense and compassion to take another look at the too-low reimbursement rate for doctor visits in Sonoma County, Calif., and put into effect an appropriate increase. Many seniors (including my sister) seem to have had a lot of difficulty finding the physicians and specialists they need to see because doctors in that county are saying they no longer want to accept Medicare's low rate of reimbursement for that county. As a consequence, those doctors aren't taking on new patients. It's my understanding that the Medicare program is ALREADY AWARE that it MISTAKENLY classified Sonoma County as a 'rural area' for reimbursement rate purposes, so why not do the right thing and correct this error? For many other purposes -- tourism, local commerce and economic issues, transportation, housing, employment, etc. -- Sonoma County is certainly considered by almost every segment of the population as part of the larger San Francisco Bay area. Because of its proximity to San Francisco, the cost of living in Sonoma County is comparable to elsewhere in the Bay area. Do the right thing and change the Medicare designation of Sonoma so that seniors (and those who are about to become seniors) will not have to hunt down doctors outside of Sonoma County and/or receive short shrift in medical care or even forego the care they need because they are either unable to find or travel to local physicians who can provide the services they need.

Submitter : **Dr. David Friedman** **Date: 09/29/2005**

Organization : **Dr. David Friedman**

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

Submitter : Dr. Joseph Fulfs

Date: 09/29/2005

Organization : Dr. Joseph Fulfs

Category : Other Health Care Provider

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 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's 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 magnitude 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,
Joseph M. Fulfs, Au.D.
Doctor of Audiology

Submitter : Dr. Thomas Johans

Organization : Western Anesthesiology Associates Inc

Category : Physician Assistant

Date: 09/29/2005

Issue Areas/Comments

GENERAL

GENERAL

September 28, 2005

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

Dear Dr McClellan:

I am writing as a VERY concerned anesthesiologist at St Johns Mercy Medical Center in St Louis, MO about the Centers for Medicare and Medicaid Services (CMS) change in the way Medicare anesthesiologists are paid while teaching residents in anesthesiology.

Currently, anesthesiologists are penalized by Medicare for supervising more than one overlapping anesthesiology resident to 50% reduction in fees.

This is not fair. Our surgical colleagues can supervise surgical residents in two overlapping surgeries and receive full payment. Internal medicine physicians can bill and collect full payment when they supervise up to FOUR residents in an office setting. Why are teaching anesthesiologists penalized?

In addition, this decrease in payment has quite a domino effect. Without that ability to collect on these fees, salaries for teaching and research anesthesiologists will no longer be competitive to retain them in academic institutions. This will severely compromise the number of graduating residents as well as significantly impair future developments in anesthesiology due to the loss of research.

We desperately need well trained anesthesiologists! There is a huge shortage!

We are not asking for something over and above other specialties; just want to be reimbursed on par with the other teaching physicians.

Sincerely,

Thomas G Johans, MD

CMS-1502-P-2032-Attach-1.DOC

September 28, 2005

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

Dear Dr McClellan:

I am writing as a VERY concerned anesthesiologist at St Johns Mercy Medical Center in St Louis, MO about the Centers for Medicare and Medicaid Services (CMS) c hange in t he w ay M edicare anesthesiologists a re p aid w hile teaching residents in anesthesiology.

Currently, anesthesiologists are penalized by Medicare for supervising more than one overlapping anesthesiology resident to 50% reduction in fees.

This is not fair. Our surgical colleagues can supervise surgical residents in two overlapping surgeries and receive full payment. Internal medicine physicians can bill and collect full payment when they supervise up to FOUR residents in an office setting. Why are teaching anesthesiologists penalized?

In addition, this decrease in payment has quite a domino effect. Without that ability to collect on these fees, salaries for teaching and research anesthesiologists will no longer be competitive to retain them in academic institutions. This will severely compromise the number of graduating residents as well as significantly impair future developments in anesthesiology due to the loss of research.

We desperately need well trained anesthesiologists! There is a huge shortage!

We are not asking for something over and above other specialties; just want to be reimbursed on par with the other teaching physicians.

Sincerely,

Thomas G Johans, MD

Submitter : Miss. Elizabeth McManus
Organization : Miss. Elizabeth McManus
Category : Other Practitioner
Date: 09/29/2005

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. 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,

Elizabeth McManus, M.S., CCC-A
10333 N. Oracle Rd. #19102
Oro Valley, AZ 85737
lizmcmanus@cox.net

Submitter : Dr. Stephen Smith

Date: 09/29/2005

Organization : Western Anesthesiology Associates, Inc.

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

September 28, 2005

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

I am an anesthesiologist at St. Johns Mercy Medical Center in Creve Coeur, Missouri, writing to urge the Centers for Medicare and Medicaid Services (CMS) to change the Medicare anesthesiology teaching payment policy. As a private practice physician, this change has no personal economic impact, but rather affects the future supply of anesthesiologists and thus, the very future of the specialty.

Medicare?s payment arrangement specifically discriminates against anesthesiology teaching programs, eroding faculty retention, and seriously impairing the ability of programs to train new anesthesiologists. Our specialty is currently experiencing a 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 internists may 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.

Similarly, teaching anesthesiologists also may 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, it is not reasonable and it must be corrected.

Our specialty has earned recognition by the Institute of Medicine as the leader among medical specialties in patient safety advances. High quality residency training programs producing highly trained anesthesiologists has led to the lowest morbidity and mortality in history, but now this achievement is in jeopardy.

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. Help us preserve the future of our teaching programs; please end the anesthesiology teaching payment penalty.

Sincerely,

Stephen R. Smith MD
339 Consort Drive
Ballwin, MO 63011
ssmith@waai.net

CMS-1502-P-2034-Attach-1.DOC

September 28, 2005

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

Dear Dr. McClellan:

I am an anesthesiologist at St. Johns Mercy Medical Center in Creve Coeur, Missouri, writing to urge the Centers for Medicare and Medicaid Services (CMS) to change the Medicare anesthesiology teaching payment policy. As a private practice physician, this change has no personal economic impact, but rather affects the future supply of anesthesiologists and thus, the very future of the specialty.

Medicare's payment arrangement specifically discriminates against anesthesiology teaching programs, eroding faculty retention, and seriously impairing the ability of programs to train new anesthesiologists. Our specialty is currently experiencing a 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 internists may 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.

Similarly, teaching anesthesiologists also may 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, it is not reasonable and it must be corrected.

Our specialty has earned recognition by the Institute of Medicine as the leader among medical specialties in patient safety advances. High quality residency training programs producing highly trained anesthesiologists has led to the lowest morbidity and mortality in history, but now this achievement is in jeopardy.

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. Help us preserve the future of our teaching programs; please end the anesthesiology teaching payment penalty.

Sincerely,

Stephen R. Smith MD
339 Consort Drive
Ballwin, MO 63011
ssmith@waai.net

Submitter : **Dr. Christopher Creighton** **Date: 09/29/2005**

Organization : **Advanced Pain Specialists, Inc.**

Category : **Health Care Professional or Association**

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 Des Peres Hospital to urge the Centers for Medicare and Medicaid Services (CMS) to change the Medicare anesthesiology teaching payment policy.
Medicare?s discriminatory payment arrangement, which applies only to anesthesiology teaching programs, has had a serious detrimental impact on the ability of programs to retain skilled faculty and to train the new anesthesiologists necessary to help alleviate the widely-acknowledged shortage of anesthesia providers -- a shortage that will be exacerbated in coming years by the aging of the baby boom generation and their need for surgical services.
Under current Medicare regulations, teaching surgeons and even internists are permitted to work with residents on overlapping cases and receive full payment so long as the teacher is present for critical or key portions of the procedure. Teaching surgeons may bill Medicare for full reimbursement for each of the two procedures in which he or she is involved. An internist may supervise residents in four overlapping office visits and collect 100% of the fee when certain requirements are met. Teaching anesthesiologists are also permitted to work with residents on overlapping cases so long as they are present for critical or key portions of the procedure. However, unlike teaching surgeons and internists, since 1995 the teaching anesthesiologists who work with residents on overlapping cases face a discriminatory payment penalty for each case. The Medicare payment for each case is reduced 50%. This penalty is not fair, and it is not reasonable. If your goal is to eliminate quality care for surgical patients, and you want YOUR OWN critical medical care to be delivered by a nurse rather than a doctor, this may be the best way to accomplish this. Personally, though I like nurses, I want a doctor providing care in such critical areas as anesthesia!
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.
Christopher P. Creighton, MD
2345 Dougherty Ferry Rd
Des Peres, MO 63122
(314) 966-9162

Submitter : Dr. Dennis Carter

Organization : Dr. Dennis Carter

Category : Physician

Date: 09/29/2005

Issue Areas/Comments

GENERAL

GENERAL

I am in opposition to changing the rates for CPT 93701. Currently Oklahoma does not even allow the national CMS reimbursement of $44.34. Oklahoma reimbursement is at $38.86.
My exoense of operating my office has not gone down. The cost of disposable sensors has not reduced over time. Current price is $7.50/pack. My staff salaries have not reduced over time, if anything, they have gone up with cost of living increases. The time for interpretation has not changed. My malpractice has doubled in the last 1 year. This is despite being claims-free for 5 years. The cost of shipping is increased due to higher fuel costs. The cost of electricity/natural gas has maintained itself and we have not seen a reduction in operating costs.
A reduction in reimbursement in my opinion is going to cause a reduction in services and thus a reduction in care of the patient.
Who thought this up? Do they have any sense of what it takes to maintain a rural practice that is geriatric based?
I would be glad to talk to whoever it is and offer insight as to the practicalities of running a business. This knowledge appears lacking as to this proposal

Submitter : Dr. David Berkey **Date:** 09/29/2005

Organization : The Hearing Center of Asheville, Inc.

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?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 A. Berkey, Au.D.
Doctor of Audiology

The Hearing Center of Asheville, Inc.
1 Vanderbilt Park Dr., Suite 110
Asheville, NC 28803
email: dberkey@thehearingcenter.com

Submitter : Dr. Jeffrey Steele

Organization : Dr. Jeffrey Steele

Category : Physician

Date: 09/29/2005

Issue Areas/Comments

GENERAL

GENERAL

See Attachment.

CMS-1502-P-2038-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 St. Francis Medical Center in Cape Girardeau, Missouri to urge the Centers for Medicare and Medicaid Services (CMS) to change the Medicare anesthesiology teaching payment policy.

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

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

Teaching anesthesiologists are also permitted to work with residents on overlapping cases so long as they are present for critical or key portions of the procedure. Unlike teaching surgeons and internists, however, teaching anesthesiologists 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 to sustain the service, teaching, and research missions of academic anesthesia training programs.

Please end the anesthesiology teaching payment penalty.

Sincerely,

Jeffrey S. Steele, M.D.
2709 Plymouth Dr.
Cape Girardeau, Missouri 63701

Submitter : Ms. Elizabeth McNeil

Date: 09/29/2005

Organization : California Medical Association

Category : Health Care Professional or Association

Issue Areas/Comments

GENERAL

GENERAL

Please see attachment. Thank you.

CMS-1502-P-2039-Attach-1.PDF

California Medical Association
Physicians dedicated to the health of Californians

September 27, 2005

Mark McClellan, MD, Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Room 445-G
Hubert Humphrey Building
200 Independence Avenue, SW
Washington, D.C. 20201

RE: GPCI

File Code: CMS-1502-P

Dear Dr. McClellan:

On behalf of the California Medical Association, we are writing to comment on the Proposed Rule governing the Physician Fee Schedule for Calendar Year 2006, specifically the Medicare physician payment localities (70FR45783) as published in the *Federal Register* dated August 8, 2005.

The CMA greatly appreciates the Centers for Medicare and Medicaid Services' (CMS) recognition of the Medicare geographic payment locality inequities in California and your willingness to take action to resolve the problem. However, the CMA has decided to pursue federal legislation with Chairman Bill Thomas to reform all Medicare geographic payment localities on a national basis without imposing payment reductions on other physicians. We are focusing all of our efforts on this approach.

Background

As you are aware, the intent of the Geographic Practice Cost Index (GPCI) is to appropriately reimburse physicians for geographical differences in the cost of providing medical care. Since payments within localities are meant to be uniform, the costs within localities should be uniform as well. In 1997, HCFA overhauled the Medicare geographic payment localities across the nation. HCFA applied a 5% Geographic Adjustment Factor (GAF) threshold to localities (not counties) that existed at the time and consolidated them into comparable localities. Unfortunately, this restructuring did not take into account costs to practice in individual counties and therefore, the 1997 rule established an inappropriate locality structure. Since 1997 the problem has compounded as dramatic demographic changes have occurred within California's payment localities, particularly Locality 99, with rural counties becoming more urbanized.

In the 1997 rule, CMS stated "...we will review the areas in multiple locality States if the newer GPCI data indicates dramatic relative cost changes among areas." Despite these dramatic disparities, it has taken CMS nine years to perform such a review and propose reform. Ten counties in California -- Santa Cruz, Sonoma, Monterey, San Diego, Sacramento, El Dorado, Placer, Santa Barbara, San Luis Obispo in Locality 99 and Marin in Locality 3 – have geographic cost factors 5% greater than their locality costs. Santa Cruz's Geographic Adjustment Factor (GAF) exceeds the Locality 99 GAF by 10%. Sonoma County exceeds its Locality GAF by 8%. Santa Cruz's border differentials with San Mateo and Santa Clara are 24%. Moreover, 175 counties across the nation have geographic adjustment factors that exceed their locality factors by 5%.

The Current CMS-Proposed Rule

The current CMS-proposed reform would move Santa Cruz and Sonoma counties out of Locality 99 into their own individual payment localities. And pursuant to federal Medicare laws, such Medicare payment changes must be made on a budget neutral basis. Therefore, the rule reflects the law by not providing the 2006 scheduled 0.4% increase to physicians practicing in counties remaining in Locality 99. Payments to physicians in these counties would essentially remain at current 2005 reimbursement rate levels.

While we appreciate that CMS is willing to fix the enormous discrepancies in Santa Cruz and Sonoma Counties, the rule will simultaneously take away a payment increase from the physicians in the rural and central valley regions of California. Moreover, the rule would not provide the needed increases in the more urbanized Locality 99 counties who also qualify under the 5% threshold rule to be removed from Locality 99. All of these regions are experiencing an exodus of physicians without an influx of new physicians to take their place. These counties have the highest Medicare participation opt-out rates in the state. And access problems in these areas have been well documented. The proposed rule places the CMA in an extremely difficult position because we have physician members and their patients who will either benefit or be harmed by the proposed rule.

As you know, the CMA has dedicated a great deal of time developing solutions to this problem. We are extremely concerned about future access to care for California's seniors. The GPCI payment differentials are equivalent to the projected SGR reductions for physicians in certain counties. Therefore, we cannot emphasize enough our profound disappointment that CMS did not enact the CMA statewide proposal as a demonstration project last year. Because of the SGR and the GPCI increases, CMS could have provided relief to the ten qualifying counties with a minor 0.4% payment adjustment in 2005 and a 0.8% adjustment in 2006 to all physicians statewide without imposing an actual reimbursement rate reduction. Such opportunities to resolve issues are rare and CMS was unfortunately unable to take the bold action necessary to correct eight years of inequity.

Legislative Solution

Since CMS rejected the CMA demonstration project in March, Congressman Bill Thomas has expressed his strong interest in enacting national GPCI reform legislation that would update the geographic payment localities based on current costs without imposing payment reductions. The CMA leadership met with Chairman Thomas last week in Washington, D.C. and despite the latest budget constraints placed on the federal government by the hurricane relief efforts, he was emphatically committed to passing a GPCI reform bill with new money this year.

As you know, CMA physicians have modeled the CMA 5% threshold rule proposal on a national basis and it would reform eighty counties in multiple locality states for a cost of $114 million or 175 counties in both multiple and single locality states at a cost of $300 million. In the federal budget perspective, the cost to correct eight years of national inequity is extremely minor. We have given this proposal to Chairman Thomas and the entire California Congressional delegation. The delegation is extremely supportive of our proposal.

CMA is strongly supporting a legislative solution that appropriately reimburses physicians based on their geographic costs without imposing budget neutrality payment reductions on other physicians. It is the optimal approach to resolving this issue. Such an approach allows Congress to waive the budget neutrality laws and provide additional funding to keep payments whole for physicians in the "losing" counties. It is the most equitable approach because it helps physicians and patients in all affected counties across the entire country. It would also establish a regulatory mechanism that gives CMS the authority to respond to the dynamic demographic and geographic changes that occur over time. And it would allow single locality states to reexamine their status.

Because of its overwhelming merit and the great potential for enactment, this is the only GPCI solution that we are supporting at this time. We urge CMS to support Mr. Thomas' legislative solution as well. We urge CMS to apply its resources to helping Mr. Thomas craft a national solution. We must not lose another precious opportunity to reform the GPCI system this year.

Thank you for the opportunity to comment. We sincerely appreciate the time you, Herb Kuhn, and your staff have dedicated to this problem in California. We look forward to working with you to solve the Medicare geographic payment locality issues in the most equitable way.

Sincerely,

Michael Sexton, MD
President

Jack Lewin, MD
CEO

Submitter : Dr. Jason Campagna

Date: 09/29/2005

Organization : Anesthesia Medical Group of Santa Barbara

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 with both an M.D. and a Ph.D. degree who has recently left academic medicine. During my time at Massachusetts General Hospital, I was considered a rising star; I was well funded, I had won numerous teaching awards, and I was a respected clinician, all within 5 years of finishing residency. Academic Medicine is however badly broken, and part of the problem rests with how we earned our money for practicing anesthesia. To this end, I urge the Centers for Medicare and Medicaid Services (CMS) to change the Medicare anesthesiology teaching payment policy. In large cities such as Boston, the proportion of patients who are Medicare is quite high, and given the very poor reimbursement policy of CMS, maintaining quality medical standards and earning a living is increasingly approaching impossible.
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: Jason A. Campagna M.D., Ph.D.
Address: Santa Barbara, CA

Submitter : Dr. Randy Fatheree

Organization : Dr. Randy Fatheree

Category : Physician

Date: 09/29/2005

Issue Areas/Comments

GENERAL

GENERAL

I am writing as an anesthesiologist at Barnes-St.Peters Hospital to urge the Centers for Medicare and Medicaid Services to change the Medicare anesthesiology teaching payment policy. Our Medicare population is becoming increasingly elderly and demands that the United States have a stable and growing pool of physicians trained in anesthesiology. That pool may dry up as the current Medicare teaching anesthiologist payment rule is unwise, unfair and unsustainable.

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

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

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

Please end the anesthesiology teaching payment penalty.

Sincerely,

Randy S. Fatheree, D.O.

Submitter : Ms. Lisa Getson

Date: 09/29/2005

Organization : Apria Healthcare

Category : Other Health Care Provider

Issue Areas/Comments

GENERAL

GENERAL

Apria Healthcare is submitting comments related specifically to pages 254-263 of CMS-1502-P. Please see two attachments.

Submitter : lynn trost **Date:** 09/29/2005

Organization : scmf

Category : Other Health Care Professional

Issue Areas/Comments

GENERAL

GENERAL

GPC1s I am writing this letter in support of removing Santa Cruz from Locality 99. I have worked with senior citizens for almost 30 years and I find it shameful that they are about to have to find a way to get to Dr. apts. over the hill in San Jose and that surrounding area in order to be accepted as medicare patients. They already have a hard time getting to the doctor locally. Most of these people have grown up here and need to see physicians that have cared for them their whole life. It is equally important that they have equal opportunity to see qualified and experienced doctors with the coverage they have worked for for years. The way the law stands now, it is very difficult to keep a doctor in this area due to the severe loss they encounter with reduced medicare coverage. Please vote to protect the people who have created the heritage as we know it in this area by allowing them the same benefits as those that live in other areas. Sonoma also would need these very important considerations. I have three children in college and would like them to see that what they are working very hard for will support the senior citizens and well as other people receiving medicare benefits. Please consider making the decison to improve the quality of life in this area by removing Santa Cruz and Sonoma from Area/Locality 99. Sincerely, Lynn Trost

Submitter : Leslie Cucuel **Date:** 09/29/2005

Organization : Santa Cruz Medical Foundation

Category : Other Health Care Professional

Issue Areas/Comments

GENERAL

GENERAL

GPCIs

I support the proposed change in Medicare payments for doctors in Santa Cruz and Somona counties. Our physicians should not be paid less than other counties when accceptiong medicare. Medicare patients will have a harder time finding doctors if accepting providers aren't compensated enough to continue seeing them. This proposal is also important to attracting and retaining physicians in our community. Thank you.