WESTCHESTER MEDICAL CENTER
ACADEMIC HEALTH CENTER
OF NEW YORK MEDICAL COLLEGE

DEPARTMENT OF
ANESTHESIOLOGY

NEW YORK MEDICAL COLLEGE

KATHRYN E. MCGOLDRICK, M.D., D.A.B.A.
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AUG - 9 2005

August 5, 2005

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

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

Dear Sir or Madame:

I write to urge CMS to correct the discriminatory policy of paying teaching anesthesiologists only 50% of the fee for each of two concurrent resident cases. This existing policy is completely "unworkable" for teaching anesthesiologists and immediate revisions are necessary.

A surgeon may supervise residents in two overlapping operations and collect 100% of the fee for each case from Medicare. An internist, furthermore, may supervise residents in four overlapping outpatient visits and collect 100% of the fee for each when specific requirements are met. A teaching anesthesiologist, however, will only collect 50% of the Medicare fee if he or she supervises residents in two overlapping cases.

The current discriminatory practice is both unfair and unreasonable and is contributing to a crisis in academic anesthesiology departments nationwide. 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 patient care, teaching, and research missions of academic anesthesia training programs.

As the Professor and Chair, as well as Director of Anesthesiology, at a 1,000 bed teaching hospital, I have found it increasingly difficult to recruit and retain high quality faculty to teach our 28 residents in Anesthesiology. Moreover, the budget shortfalls attributable to the current Medicare policy have also impeded our ability to conduct research. Currently, we have three vacant faculty positions in our department because I am unable to offer highly trained anesthesiologists a competitive salary.

If we are to avoid "The Perfect Storm," Medicare must pay teaching anesthesiologists on a par with their surgical colleagues.

Thank you for your attention to this critical issue.

Sincerely yours,

Kathryn E. McGoldrick

Kathryn E. McGoldrick, M.D.
Professor and Chair of Anesthesiology
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Susan L. Goelzer, MD, MS, CPE
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UNIVERSITY OF
WISCONSIN-MADISON
MEDICAL SCHOOL

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AUG 10 2005

August 9, 2005

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

RE: Teaching Anesthesiologists

Dear Dr. McClellan:

As the Chair of a premier academic anesthesiology department with a respected residency training program, I feel it is important to comment on the current Medicare teaching anesthesiologist payment rule (file code CMS-1502-P). The current payment rule reduces payment by 50% for teaching anesthesiologists medically directing concurrent cases with residents. In comparison, a teaching surgeon may supervise two residents in overlapping operations and will collect 100% of the fee for each case from Medicare.

This inequity between medical specialties in the application of the Medicare teaching rule is further compounded by the fact that the Medicare anesthesia conversion factor is less than 40% of prevailing commercial rates, significantly less than other medical specialties. In combination, these payment rules result in revenue that is grossly inadequate to sustain the service, teaching and research missions of academic anesthesia training programs. This is not fair and it is not reasonable. It is also important to recognize that academic health centers also care for a significant portion of the Medicare patient population.

The delivery of high quality safe medical care in the aging population demands that we have a stable and growing pool of physicians trained in anesthesiology to meet the increasing demand for services. In order to supply the necessary physicians, Medicare must recognize the unique delivery of anesthesia care and pay teaching anesthesiologists on par with their surgical colleagues. The CMS anesthesiology teaching rule must be changed to allow academic departments to cover their costs in caring for Medicare patients. Thank you for your attention to this matter.

Sincerely,

Susan L. Goelzer, MD, MS, CPE

AUG 11 2005

Department of Anesthesia
Indiana University School of Medicine
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Indianapolis, IN 46202

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

In reference to: TEACHING ANESTHESIOLOGISTS'

Dear Sirs:

Teaching anesthesiologists across the United States are giving up their practices, and teaching, to take more lucrative positions in private practice. Anesthesia programs are closing across the country, in spite of a growing need for anesthesiologists.

There are several issues that are at the root of the problem:

1. Teaching hospitals get a disproportionate share of MC and especially MK patients, relative to non-teaching hospitals.

2. Both MC and especially MK far underpay anesthesiologists relative to other physician groups.

3. MC inexplicitly pays anesthesiologists only for a single case when he or she directs two cases done by residents. Only anesthesia is singled out in this fashion.

The acuity of cases done in teaching programs exceeds that in private practice, plus the teaching anesthesiologist shoulders both the burden of patient care and the additional burden of teaching. In spite of this, anesthesiologists in teaching institutions make far, far less than their colleagues in private practice, so many of the best and brightest leave academic medicine to practice in institutions with less of a burden of uninsured patients and patients with MC and especially MK.

I have worked in a children's hospital, Riley Hospital for Children, for 26 years, and my income in REAL DOLLARS, not inflation corrected, has risen by about 75% over a quarter century. Needless to say, my inflation-adjusted income has shrunk to less than half of what it was. This in spite of long hours and little time off (after a quarter century of service, I get 4 weeks off).

I am a member of the Contracting Committee for Clarian, one of the largest hospital networks in the country. I know what insurance companies pay. It's interesting that the contracts for all physician specialties in our hospital network, ***except anesthesia***, are based on a percent of MC. For anesthesiologists, the insurance companies pay us a direct unit value for work done, since to be equitable, they'd have to pay us 300 to 400 percent of MC. Somehow, MC treats anesthesiologists differently from all other physicians, and teaching physicians take a double blow, since we cannot bill for the services of a second resident, even though we are physically within seconds of all patients all the time.

And the MK situation is even more abysmal. Consider that in Indiana, MK pays an anesthesiologist $52 per hour. I don't know about you, but I can't get a plumber for that rate. Our adult anesthesiologists do very poorly, financially, relative to the anesthesiologists in private practice, who work in the same hospital system, mainly because they can't bill for all the work they do or direct. Those of us in a Children's Hospital do even worse, since MK pays such a pittance relative to insurance or even relative to MC.

Nearly all of the anesthesiologists in Indiana are trained in our facility (Indiana University School of Medicine) and the great majority of anesthetics in Indiana are administered by anesthesiologists, not by nurses. We are the only teaching facility in Indiana, with about 80 residents and/or fellows in training at any given time. If our program fails, as is quite possible, this entire state will suffer from an even greater shortage of qualified providers, both for the elderly MC patients, and also for our MK babies and children.

Our program is beginning active discussions on limiting our MK involvement, except for emergent cases, with our Indiana State Society of Anesthesia. Chicago hospitals recently have begun refusing to accept Indiana MK patients from NW Indiana (the Gary area) due to low reimbursement. The MK train is already leaving the station.

We don't expect miracles, but we do expect that our specialty will be reimbursed at a level of payment that at least matches that of other specialties. No insurance company refuses to pay a teaching anesthesiologist for simultaneously directing two anesthetics with residents. If any did, we would instantly stop doing business with that company. And the MK rate of $13 per unit speaks for itself. A few years ago, only a few children qualified for MK, but now almost 40% of the pediatric population of Indiana can qualify for MK or CHIPS. We could do a small percentage of patients for nearly free, but now that our MK load at Riley Children's has risen to nearly 45%, we can no longer do that many cases without adequate pay. We can not longer recruit physicians, so those of us left work even harder – we are in danger of entering an irreversible downward spiral. We have to not only attract ENOUGH physicians to teach, but we have to be able to attract the BEST and BRIGHTEST to keep the specialty alive and growing, and the care continually improving. All teaching physicians should be board certified, and preferably with fellowship training, not merely graduates looking for a job because they are unable to find work in the private sector.

We need to work together to correct the errors that were introduced when the relative value system was established. Anesthesia services have been grossly undervalued from day one, and the gap was to a large degree covered by insurance. Now too large a proportion of the population are either MC or, even worse, MK, so insurance companies can no longer shoulder the burden. The government has to move away from the unfunded mandate for anesthesia services. Come around to my hospital and follow me around for a few days, then see if you are paying me an equitable amount, relative to my colleagues in private practice. There's a reason good physicians are shunning teaching jobs in anesthesia, and those of us left are leaving.

Most sincerely,

Thomas M. Wolfe, MD
Asst Professor of Pediatric Anesthesiology
Indiana University

THE WESTERN
PENNSYLVANIA HOSPITAL

WEST PENN ALLEGHENY HEALTH SYSTEM

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DEPARTMENT OF ANESTHESIOLOGY

JEFFREY A. GRASS, M.D., M.M.M.
Chairman

AUG 11 2005

August 6, 2005

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

RE: CMS-1502-P TEACHING ANESTHESIOLOGISTS

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

We currently have 24 residents, 4 pain fellows and 8 faculty openings in the Western Pennsylvania Hospital/Temple University Anesthesiology Program. This creates great inefficiencies in scheduling, personnel allocation, and case assignments. It is very difficult for us to recruit and retain faculty due to budget shortfalls and non-competitive salaries that can be directly attributed to the current Medicare teaching anesthesiologist policy. Our two integrated teaching hospitals subsidize the anesthesia program with payment of $3.9 million annually, which is non-sustainable for our hospitals! Anesthesiology teaching programs, caught in the snare of this trap, are suffering severe economic losses that cannot be absorbed elsewhere.

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

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

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

Sincerely,

Jeffrey A. Grass, MD, MMM

Jeffrey A. Grass, MD, MMM
Chairman and Program Director
The Western Pennsylvania Hospital/Temple University
Anesthesiology Residency Program

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JOHNS HOPKINS
MEDICINE

AUG 11 2005

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John A. Ulatowski, M.D., Ph.D., M.B.A.
Director
The Mark C. Rogers Professor

August 8, 2005

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

Re: Teaching Anesthesiologists, Reference File Code: CMS-1502-P

To Whom It May Concern:

I am writing to express my strongest urging that CMS once and for all correct the inequities posed in the current fee schedule regarding teaching anesthesiologists. These include the current rate of reimbursement for anesthesiology which is considerably lower than other medical practices. Medicare anesthesia conversion factors are less than 40% of prevailing commercial rates, this is in stark contrast to other medical specialties. Second, and of more recent concern, is the CMS' proposed changes to the Medicare fee schedule for 2006 which were released on August 1, 2005.. These changes do not include a correction of the discriminatory policy of reimbursing teaching anesthesiologists, only 50% of the fee for each of two concurrent resident cases. While I appreciate CMS' continued attention and desire for more discussion in this manner, I think the decision remains clear. The inequities regarding reimbursement for anesthesiology teaching cases must be corrected once and for all.

The current teaching anesthesiologist payment rule is unfair and is unsustainable if we wish to maintain the high level of teaching of future anesthesiologists and in fact, the maintenance of the number of resident positions and residency training programs. There is a nationwide shortage of anesthesiologists. Many programs have closed already. Others are contemplating similar action due to financial insolvency directly related to supervising residents. Despite the encouraging increase in enrollment at anesthesia training programs, we will remain far behind due to the down sizing of some programs and the increasing rate of retirement among the aging population of anesthesiologists in the very near future. As such, it is absolutely necessary that we insure the health and vitality of our current training programs. This will become an even greater concern for

CMS as the number of elderly continue to rise in our surgical population. Quality medical care and patient safety will depend upon a stable and growing pool of physicians trained in anesthesiology. This highlights the importance of anesthesiology training over and above other efforts to increase anesthesia care providers, specifically CRNAs and anesthesia technicians.

The current practice of reimbursement for teaching anesthesiologists is unreasonable and frankly unfair given the current precedence for other teaching specialties. Our teaching anesthesiologists can only collect 50% of the Medicare fee if he or she supervises residents on two overlapping cases. This includes even if that overlap is for "one minute." This in itself demonstrates the unreasonable nature of this rule for anesthesiology. Furthermore, to my knowledge we as a specialty are the only ones to exist under this impediment. A surgeon may supervise residents in two overlapping operations and collect 100% of the fee for each case from Medicare. Beyond this, an internist may supervise residents in four overlapping outpatient visits and collect 100% of the fee for each when certain requirements are met. Medicare must recognize the unique discrimination placed upon the delivery of anesthesia care in teaching institutions. Medicare must pay teaching anesthesiologists on par with their surgical colleagues.

Anesthesia teaching programs are being forced to make sacrifices and compromises between education and economic hardship. Many teaching programs including our own here at Hopkins have changed our scheduling of residents to avoid circumstances in which large numbers of Medicare patients are being cared for on a predictable basis. Alternative staffing which would mandate a one-on-one supervision of residents is used to insure their adequate training and maximize financial recovery from Medicare cases. However, this comes at a price as well. The cost of supervision of an anesthesiologist and a resident is inordinately high. The only resolution to this problem is for CMS to allow anesthesiology teaching programs to cover their costs by recouping 100% of the Medicare allowable fee when covering two operations.

I will give one other instance where the impact of this rule has dramatically affected anesthesiology for the future. In academic programs, any extra revenue beyond the cost of providing teaching and clinical care is usually diverted in the support of academic pursuits. These monies are vital to further research in anesthesiology. If we are to keep up with the growing demand of the elderly patient by demonstrating new techniques and medications which will insure their safety, anesthesiology will fall short of its mission to provide safe care over and above the number of practitioners in the field. Academic funds are diverted to cover existing losses.

I must wholeheartedly and emphatically protest the delay of a decision of the policy which continues to short change teaching anesthesiology programs in this country. As Director as one of the larger training programs in the country, I will continue to work to insure adequate training of our residents which is the life blood of safe care of the elderly in the future. However, this struggle will come at a significant cost, and I cannot guarantee that our program and the programs of my colleagues will be able to provide the high level of training and devotion to academic advancement. I am reminded of the most recent reports of the Institute of Medicine highlighting the large number of errors in medicine. In these articles, anesthesiology has stood out as a specialty which has made a dramatic impact on the safety in medicine in this country. I am very concerned that the continued policies of CMS will prevent us from maintaining that high standard, and in fact, there will be an erosion of our abilities to lead our country in the safe practice of medicine. Please do not allow this to occur to our profession and to the American people.

Sincerely,

John A. Ulatowski, M.D., Ph.D., M.B.A.

JAU:jt

cc: ASA email: mail@asawash.org

File:U/Letters/2005/CMS

STANFORD
SCHOOL OF MEDICINE
Stanford University Medical Center

AUG 11 2005

TIMOTHY ANGELOTTI, M.D., PH.D.
Assistant Professor
Department of Anesthesia
Associate Medical Director, LifeFlight

August 8, 2005

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

Re: CMS-1502-P "Teaching Anesthesiologists"

Dear CMS Administrators:

As an Assistant Professor in an academic anesthesiology department, I am writing to ask for your strong support for the revision of the Medicare Physician payment rule, as applied to academic anesthesiology programs. I chose a career in academic medicine and specifically academic anesthesiology, following extensive training. However the current payment schedule from Medicare is preventing me and others like me from pursuing our mission, namely service, resident training, and research. With the aging population, the proportion of Medicare patients for whom we provide anesthesia services will increase. With the current Medicare Physician payment rule for anesthesiologists, my department will continue to suffer financial hardships, preventing us from fulfilling our multiple missions.

A healthy academic anesthesia department is determined by economics, specifically reimbursements for clinical care. At present, the current Medicare teaching anesthesiologist payment rule is unwise, unfair and unsustainable. By withholding 50% of the funds for providing anesthesia services to concurrent surgical cases, my department suffers due to a loss of revenue. I find it interesting that my surgical colleagues can supervise two overlapping cases and my internist colleagues can supervise four concurrent outpatient visits and each receive 100% of the Medicare fee for each case. Such a discrepancy in payment schedules leaves the impression that Medicare does not recognize the challenges and skill sets associated with the specialty of anesthesiology, nor the unique challenges of taking care of the elderly.

In order to achieve my mission of furthering anesthesia research, I need to be part of a healthy academic anesthesia department. The Medicare anesthesia conversion factor of less than 40% of prevailing market rates has led to a loss of revenue that is inadequate to support the service, teaching and research missions of academic anesthesia training programs. The NIH has supported my training throughout medical and graduate school, for which I am sincerely grateful. I have received support from the NIGMS under the Pharmacological Sciences Training Program (PSTP), an NINDS training grant (NRSA),

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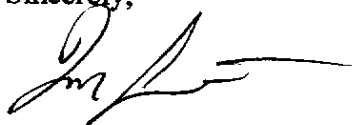
and the NIGMS Medical Scientist Training Program (MSTP). I chose the specialty of anesthesiology because I felt that I could best use my research and teaching skills to train and develop the future of anesthesiology.

Too much training, money, and time has been put into preparing me to be an academic anesthesiologist. It would be a waste of taxpayers' money, if I was not able to give back to this country. I implore you to modify the Medicare payment rule and bring us on par with our surgical and medical colleagues, namely allowing for 100% payment for concurrent delivery of anesthesia services. Doing so, will ensure that academic anesthesiology departments can continue to thrive and achieve the goals to which we are committed.

Sincerely,



Timothy Angelotti

PACIFIC IMAGING
AND TREATMENT CENTER

5395 Ruffin Road, Suite 202, San Diego, CA 92123
Phone: 858.569.7800 • Fax: 858.569.7899

August 4, 2005

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

Re: NUCLEAR MEDICINE SERVICES
Section P

Dear CMS:

I would like to take this opportunity to comment on the proposed CMS changes to include Nuclear Medicine under Stark regulations. I have been practicing Nuclear Medicine for more than 25 years, in both an academic and private setting. It is my hope that the implementation of this proposal can be coordinated with your stated purpose of minimizing the impact on physicians who are currently parties to arrangements that involve nuclear medicine services.

We currently perform diagnostic PET/CT as well as gamma camera studies, primarily for our oncology and cardiology colleagues. My recommendations are directed toward the cardiology services we offer. We perform PET myocardial perfusion exams, utilizing a rubidium generator. Each of these studies requires the administration of pharmacologic stressors (e.g., adenosine or dobutamine), cardiac monitoring during stress, image acquisition and processing, and takes approximately 45 minutes. For patient safety and quality, one of our referring cardiologists is always present (even though I am a board certified internist and ACLS certified). During the time frame of the test our cardiologist is essentially unavailable for other duties.

I feel that it would be most appropriate, and fair, to credit the cardiologist for time spent in our center monitoring these labor intensive studies. To add an additional 8 hour requirement seems burdensome and will present significant logistical problems for our center. Secondly, I feel that for busy cardiologists, reducing the time requirement from 8 hours to 4 hours is extremely important. Cardiology participation in my center is critical for patient care, especially for the performance of studies with limited availability (due to the cost of a PET/CT scanner and a rubidium generator). We are one of only three outpatient PET/CT centers in California performing PET myocardial perfusion studies. As such, we provide a unique service to our community. Our local hospitals have been unable to commit the substantial capital to bring these studies to our patients.

PACIFIC IMAGING
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Summarily, while all of us concur with the goals of competitiveness and appropriate referral, I feel these are attainable under less stringent guidelines. The ultimate beneficiaries will be our patients who will continue to have access to the latest technology, performed under the safest conditions.

Thank you for your consideration

Sincerely,

Michael S. Kipper

Michael S. Kipper, M.D.
Medical Director

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AUG 11 2005

College of Physicians & Surgeons of Columbia University | New York, N.Y. 10032

DEPARTMENT OF ANESTHESIOLOGY

Margaret Wood, M.D., F.R.C.A.
E.M. Papper Professor and Chairman

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August 8, 2005

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

Dear Sir/Madam:

I write as Chairman of a large academic anesthesia department to comment on the teaching rule for anesthesiologists. The policy of paying teaching anesthesiologists only 50% of the fee for each of two concurrent resident cases is discriminatory, unwise, unfair and in the long term will not allow academic departments to survive.

We have a faculty of more than 70 and anesthetize more than 35,000 patients per year. We find it extremely difficult to recruit and retain academic anesthesiologists because of the CMS change in the teaching rule – our budgets do not compare to private practice, and in the NY area we face a very competitive market place from the non-academic community.

Quality medical care, patient safety and an increasingly elderly medical population all require that the United States not only have a stable but growing pool of anesthesiologists. It is departments such as ours who provide quality training. At the present time, the Medicare CMS teaching rule short changes teaching programs, withholding 50% of their funds for concurrent cases. Our department is suffering severe economic losses, and we believe that the CMS teaching rule must be changed to allow us to cover our costs.

A surgeon may supervise residents in two overlapping operations and collect 100% of the fee for each case from Medicare. An internist may supervise residents in four overlapping outpatient visits and collect 100% of the fee for each, when certain requirements are met. However, a teaching anesthesiologist will only collect 50% of the Medicare fee if he supervises residents in two overlapping cases. This cannot be fair, nor is it reasonable. Medicare must recognize the importance of anesthesiology care, and pay Medicare teaching anesthesiologists on par with their surgical colleagues.

The Medicare coverage factor is less than 40% of prevailing commercial rates. Reducing this already inadequate payment by 50% for teaching anesthesiologists results in revenue grossly inadequate to sustain our service, teaching and research missions, and in the long term threatens the viability of academic anesthesia training programs.

Yours sincerely,

Margaret Wood

Margaret Wood, M.D.

MW:vm

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

Thomas W. Cutter, M.D., M.A.Ed.
Associate Professor, Associate Chairman
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Medical Director, Operating Rooms

Telephone: (773) 834-2464
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August 8, 2005

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

Re: File Code CMS-1502-P: "TEACHING ANESTHESIOLOGISTS"

Quality medical care, patient safety and an increasing Medicare population mandate that the United States citizenry have a sizable and well-qualified pool of physicians trained in anesthesiology. The current CMS rule for paying teaching anesthesiologists undermines this goal, is grossly negligent and shows a callous disregard for the health needs of the elderly. Fewer anesthesiologists are choosing academic anesthesiology because of the ill-conceived Medicare policy that shortchanges anesthesiology teaching programs by withholding 50% of their funds for concurrent cases. Caught in the snare of this economic trap, training institutions are suffering severe economic losses that cannot be absorbed.

While a surgeon may supervise residents in two overlapping operations and collect 100% of the fee for each case from Medicare and an internist may supervise residents in four overlapping outpatient visits and collect 100% of the fee for each when certain requirements are met, a teaching anesthesiologist may only collect 50% of the Medicare fee if he or she supervises residents in two overlapping cases. This is neither fair nor reasonable. If it continues, there will be too few anesthesiologists to staff two rooms, much less a single room, resulting in many patients not receiving any anesthesia care at all. Surgeries will be postponed or canceled altogether because of the absence of anesthesia services. This will begin in academics, but as these institutions go under, it will spread as the number of practicing anesthesiologists becomes smaller and smaller since fewer will be trained each year.

The University of Chicago is fortunate in having one of the more desirable training programs and has thus far maintained an acceptable quality and quantity of residents, but we have seen our faculty numbers decrease and are having increasing difficulty in recruiting new faculty because of out inability to compete with the non-academic sector. As we lose faculty, the remaining few are being required to fill in the gaps, reducing the time available to do research and to teach. This eliminates two of the most important and desirable aspects of being in academics, resulting in even more people leaving. This will result in a critical shortage of teachers and training programs, leaving the elderly without high quality anesthesia services.

Medicare must recognize the unique delivery of anesthesiology care and pay Medicare teaching anesthesiologists on a 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. The CMS anesthesiology teaching rule must be changed to allow academic departments to attract and retain high-quality clinicians, researchers and teachers.

Thomas W. Cutter, M.D., M.A.Ed.

TWC:smy
Enclosures (2)

cc: ASA (Washington, D.C.)
J.L. Apfelbaum, M.D.

10

AUG 15 2005

NEW YORK MEDICAL COLLEGE

DEPARTMENT OF ANESTHESIOLOGY
MACY PAVILION - ROOM 2389 VALHALLA, NEW YORK 10595 TEL 914-493-7692 FAX 914-493-7927

August 9, 2005

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

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

Dear Sir or Madame:

I write to urge CMS to correct the discriminatory policy of paying teaching anesthesiologists only 50% of the fee for each of two concurrent resident cases. This existing policy is completely "unworkable" for teaching anesthesiologists and immediate revisions are necessary.

A surgeon may supervise residents in two overlapping operations and collect 100% of the fee for each case from Medicare. An internist, furthermore, may supervise residents in four overlapping outpatient visits and collect 100% of the fee for each when specific requirements are met. A teaching anesthesiologist, however, will only collect 50% of the Medicare fee if he or she supervises residents in two overlapping cases.

The current discriminatory practice is both unfair and unreasonable and is contributing to a crisis in academic anesthesiology departments nationwide. 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 patient care, teaching, and research missions of academic anesthesia training programs.

As a faculty member at a 1,000 bed teaching hospital, I am aware that it is increasingly difficult to recruit and retain high quality faculty to teach our 28 residents in Anesthesiology. Moreover, the budget shortfalls attributable to the current Medicare policy have also impeded our ability to conduct research. Currently, we have three vacant faculty positions in our department because it is impossible to offer highly trained anesthesiologists a competitive salary.

Thank you for your attention to this critical issue.

Sincerely yours,

M. Bairamian M.D.

Mosses Bairamian, M.D.

STANFORD UNIVERSITY SCHOOL OF MEDICINE
DEPARTMENT OF ANESTHESIA
300 PASTEUR DRIVE • STANFORD, CALIFORNIA 94305-5640

Ronald G. Pearl, M.D., Ph.D.
Professor and Chairman

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August 4, 2005

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

Re: File code CMS-1502-P: TEACHING ANESTHESIOLOGISTS

To Whom It May Concern:

I was extremely disappointed to learn that the CMS proposed changes to the Medicare Fee Schedule for 2006 do not include a correction of the discriminatory policy of paying teaching anesthesiologists only 50% of the fee for each of two concurrent resident cases. As the chairman of a large academic anesthesia department (60 residents and 12 fellows) at Stanford University, I had hoped that CMS would have decided to correct the current policy. The current Medicare teaching anesthesiologist payment rule is unwise, unfair and unsustainable.

Quality medical care, patient safety and an increasingly elderly Medicare population demand that the United States have a stable and growing pool of physicians trained in anesthesiology. Right now, slots in anesthesiology residency programs are going unfilled because of ill-conceived Medicare policy that shortchanges teaching programs, withholding 50% of their funds for concurrent cases. As one of the leading programs in the United States, we have been able to fill our residency positions, but the quality of the candidates on a national level is decreased by the current policy and many other programs have unfilled positions due to the Medicare policy. As you are aware, there is a major national shortage of anesthesiologists, and a policy which decreases anesthesia trainees will eventually result in an inability to provide anesthesia coverage for Medicare patients. Despite extensive hospital and medical school support, our department currently loses over $1 million per year. This deficit can be attributed to the discriminatory policy whereby only anesthesiologists have money withheld due to concurrent coverage of more than one resident. This deficit results in decreased ability to pay competitive salaries and thereby decreases the quality of anesthesia teachers available for the residents. A shortage of faculty results in an inability to provide anesthesia for all patients who require it. Academic research in anesthesiology is also drying up as department budgets are broken by this arbitrary Medicare payment reduction.

A surgeon may supervise residents in two overlapping operations and collect 100% of the fee for each case from Medicare. An internist may supervise residents in four overlapping outpatient visits and collect 100% of the fee for each when certain requirements are met. A teaching anesthesiologist will only collect 50% of the Medicare fee if he or she supervises residents in two overlapping cases. Anesthesiology teaching programs, caught in the snare of this trap, are suffering severe economic losses that cannot be absorbed elsewhere. The CMS anesthesiology teaching rule must be changed to allow academic departments to cover their costs. Medicare must recognize the unique delivery of anesthesiology care and pay Medicare teaching anesthesiologists on par with their surgical colleagues.

The arbitrary reductions in Medicare payment are particularly problematic because 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. Academic anesthesia training programs already have an excess number of Medicare patients compared to private practice programs, and the additional 50% reduction in payment makes it economically impossible to continue to provide quality anesthesia coverage for these patients. Unless the rule is changed, academic anesthesia will not remain viable.

I urge you to change the rule so that anesthesiologists are treated similar to other specialties and receive the full payment for their services when providing coverage of two resident trainees.

Sincerely,

Ronald Pearl

Ronald G. Pearl, M.D.

RGP/km

AUG 15 2005

Department of Anesthesia
Indiana University School of Medicine
1120 South Drive, FH 204
Indianapolis, IN 46202

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

In reference to: Teaching Anesthesiologists

To Whom It May Concern:

I am an Associate Professor of Clinical Anesthesia at Indiana University School of Medicine providing pediatric anesthesia services at the Riley Hospital for Children in Indianapolis, IN. I train anesthesia resident physicians on a daily basis, frequently supervising two anesthesia residents at a time. We are the only anesthesia residency program in the state of Indiana and we probably have trained approximately 75% of the anesthesiologists in Indiana. Our department, and academic anesthesiology across the country, is facing a critical problem regarding reimbursement from Medicare and Medicaid. These programs reduce the fee paid to teaching anesthesiologists if they are covering more than one resident. Anesthesia is the only medical specialty treated this way and other insurance carriers reimburse us fully for this type of service.

I am serving my seventh year as an academic pediatric anesthesiologist, making 40-50% less than the private practice anesthesiologists that I train. Each year I have been on the faculty we have done more cases than the previous year, yet my salary last year was lower than my first year (not even considering inflation). This is primarily due to the continuing increase in the percentage of Medicaid patients that we provide services to, since many other hospitals in the area refuse to take care of children with Medicaid.

Anesthesiology programs are struggling across the country, despite a continuing national shortage of anesthesiologists. Teaching anesthesiologists are already taking a large financial hit to remain in academia. There is no reason for Medicare and Medicaid to add to our struggles. Please correct this problem such that we are treated the same way as other teaching physicians.

Sincerely,

Michael S. Mazurek, MD
Associate Professor of Clinical Anesthesia
Section of Pediatric Anesthesia
Indiana University School of Medicine

THE UNIVERSITY OF TENNESSEE
MEDICAL CENTER

• *University Memorial Hospital*
• *Graduate School of Medicine*

AUG 16 2005

1924 Alcoa Highway
Knoxville, TN 37920-6999
(865) 544-9000

August 8, 2005

In regards to: file code CMS-1502-P

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

Dear Sir or Madam:

SUBJECT: TEACHING ANESTHESIOLOGISTS MEDICARE RULE

The proposed changes by the Centers for Medicare and Medicaid Services to the Medicare Fee Schedule for 2006 were released on August 1, 2005, and did not include a correction of the discriminatory policy of paying **TEACHING ANESTHESIOLOGISTS** only 50% of the fee for each of two concurrent resident cases. As Chairman and Program Director of an anesthesiology training program, I am encouraged that CMS has invited comments to suggest how improvements to the current payment policy could be made "that would allow CMS to be more flexible for teaching anesthesia programs". The mere fact that CMS is seeking improvements to the current payment policy acknowledges that the existing policy is unwise, unfair and unsustainable.

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

For example, our Department of Anesthesiology at The University of Tennessee Medical Center at Knoxville currently performs over 26,000 anesthetics per year. Medicare recipients comprise about 35% of our patient population. At our institution, anesthesiology residents, certified nurse anesthetists and student nurse anesthetists may function as the anesthesia care provider whom my teaching staff supervise. Our personnel supervise at ratio of one faculty per two anesthetizing locations when anesthesia trainees are involved. If one of my faculty supervises one certified nurse anesthetists and an anesthesiology

• *University Memorial Hospital*
• *Graduate School of Medicine*

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resident, then no reduction in fees occurs. However, if my faculty supervises two residents in anesthesiology, two student nurse anesthetists or a combination of one resident and one student nurse anesthetist, then the 50% decrease in fee reduction occurs. The operating room schedule at tertiary care hospitals like The University of Tennessee Medical Center at Knoxville, which also functions as a Level One Trauma Center, may change dramatically over the normal course of the day. No degree of planning can prevent anesthesiologists from an overlap of two different Medicare patients occurring simultaneously.

As the aging of America's "Baby Boom" generation continues, the proportion of Medicare patients in our operating rooms will continue to increase. Anesthesiology teaching programs, caught in the snare of this trap, will continue to suffer worsening economic losses that cannot be absorbed elsewhere. The CMS anesthesiology teaching rule must be changed to allow academic departments to cover their costs. Already academic institutions have undergone dramatic changes as reimbursement continues to dwindle. Academic research in anesthesiology is "drying up" as department budgets are broken by this arbitrary Medicare payment reduction. Indeed, research in anesthesiology is now dominated by Europe and Japan. This decrease in research is evidenced by the relative lack of NIH funding in anesthesiology compared to other medical specialties.

Perhaps even more telling, anesthesiologists are dramatically underpaid relative to our surgical colleagues. In Tennessee, the Medicare anesthesia conversion factor is @ 30% of prevailing commercial rates. In contrast, surgeons at our teaching institutions are reimbursed by Medicare at about 60 to 70% of the prevailing commercial rates. A surgeon at The University of Tennessee Medical Center at Knoxville may supervise residents in two overlapping operations and collect 100% of the fee for each case from Medicare. An internist may supervise residents in four overlapping outpatient visits and collect 100% of the fee for each when certain requirements are met. However, a teaching anesthesiologist will only collect 50% of the Medicare fee if he or she supervises residents in two overlapping cases. Reducing a fee that is only 30% of commercial rates by another 50% for supervising two trainees simultaneously results in a revenue stream that is grossly inadequate to sustain the service, teaching and research missions of academic anesthesia training programs.

Two crucial changes must occur for academic anesthesiology programs to survive. First, the Medicare conversion rate must be increased to levels comparable to other specialties relative to the prevailing commercial rates. Next,

• *University Memorial Hospital*
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the Teaching Anesthesiology rule must be changed so that teaching anesthesiologists receive 100% of reimbursement for overlapping Medicare cases.

Sincerely,

J. L. Epps, M.D.
Chairman, Department of Anesthesiology

jle

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THE UNIVERSITY of TEXAS
HEALTH SCIENCE CENTER AT HOUSTON
MEDICAL SCHOOL

AUG 16 2005

DEPARTMENT of ANESTHESIOLOGY

6431 Fannin Street, MSB 5.020
P.O. Box 20708
Houston, Texas 77030

713 500 6200
713 500 6201 *fax*

August 5, 2005

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

RE: Teaching Anesthesiologists CMS-1502-P

To Whom It May Concern:

Academic anesthesia is in a crisis. Academic Health Science Centers are struggling. Academic anesthesia has been financially strapped because of the unfair policy of paying 50% of the fee for each of two concurrent resident cases. The RRC put in the rule of no more than two concurrent resident cases per faculty member for educational purposes, and yet our specialty finds itself penalized for adhering to educationally sound objectives.

I am currently Chair of Anesthesiology at U.T. Health Science Center at Houston. I was recruited to get the department financially viable so that a young dynamic chair may be brought in. Currently, this department faces an operating budget for the upcoming year of a $3 million deficit. I am in the process of cutting faculty. Medicare comprises about 20% of our cases. We have one CRNA and 70 residents. We have a very sound educational program and a non-viable financial one, largely because of this Medicare rule which is also being adopted by Managed Care companies who contribute zero to the educational enterprise.

Medicare patients are being steered to academic medical centers because surgeons in the private community choose not to do these patients at private ambulatory surgical centers. Although it is often said, Medicare rates for anesthesia services are 40% of commercial payors; in Houston, Texas, it is closer to 20%. A Medicare-only anesthesiology practice is not financially viable.

Obviously, this CMS rule is not the only problem facing academic anesthesiology, but without a correction of the rule, we will remain running deficit margins, and UT Houston has declared that no department can have a deficit budget.

Allow anesthesiologists the same equity that other specialists are granted. The Hsaio study severely damaged our specialty financially, and this rule makes the current situation untenable. In the past six months, I have consulted at the University of North Carolina and UT San Antonio, where severe economic hardship exists. Up until a year ago, I served as Chair of our Residency Review Committee for 3 years. In three years, over one-half of the anesthesiology training programs were reviewed. Many were borderline. When a root cause was done, inadequate financial resources were the predominant theme.

Our specialty needs your help. By a simple regulatory administrative decision, you can make our training program more financially secure and, in doing so, you will enhance their educational quality.

Sincerely yours,

James F. Arens

James F. Arens, M.D.

JFA/kf

Cc: ASA Washington Office
Alexander A. Hannenberg, M.D.
Eugene P. Sinclair, M.D.
Fred Guidry, M.D.
Mark Lema, M.D., Ph.D.

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AUG 16 2005

NEW YORK MEDICAL COLLEGE

DEPARTMENT OF ANESTHESIOLOGY
MACY PAVILION - ROOM 2389 VALHALLA, NEW YORK 10595 TEL 914-493-7692 FAX 914-493-7927

August 9, 2005

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

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

Dear Sir or Madame:

I write to urge CMS to correct the discriminatory policy of paying teaching anesthesiologists only 50% of the fee for each of two concurrent resident cases. This existing policy is completely "unworkable" for teaching anesthesiologists and immediate revisions are necessary.

A surgeon may supervise residents in two overlapping operations and collect 100% of the fee for each case from Medicare. An internist, furthermore, may supervise residents in four overlapping outpatient visits and collect 100% of the fee for each when specific requirements are met. A teaching anesthesiologist, however, will only collect 50% of the Medicare fee if he or she supervises residents in two overlapping cases.

The current discriminatory practice is both unfair and unreasonable and is contributing to a crisis in academic anesthesiology departments nationwide. 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 patient care, teaching, and research missions of academic anesthesia training programs.

As a faculty member at a 1,000 bed teaching hospital, I am aware that it is increasingly difficult to recruit and retain high quality faculty to teach our 28 residents in Anesthesiology. Moreover, the budget shortfalls attributable to the current Medicare policy have also impeded our ability to conduct research. Currently, we have three vacant faculty positions in our department because it is impossible to offer highly trained anesthesiologists a competitive salary.

Thank you for your attention to this critical issue.

Sincerely yours,

Jian Hou, M.D.

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AUG 16 2005

August 10, 2005

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

Dear Colleagues,

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

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

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

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

Sincerely,

Catherine DeVito CRNA CPT USAR

Signature

Print name: Catherine DeVito

Street address: 4927 Lansing ST NE

City/State/ Zip: St. Petersburg FL 33703

H.I.P.
Santa Cruz County

HEALTH IMPROVEMENT PARTNERSHIP
OF SANTA CRUZ COUNTY
375 Encinal, Suite A • Santa Cruz, CA 95060
(831) 466-4316 Telephone • (831) 466-4310 FAX

August 11, 2005

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

Re. File Code CMS1502-P

Issue Identifier: GPCI's / Payment Localities

Dear Sirs:

We are writing on behalf of the Health Improvement Partnership of Santa Cruz County to enthusiastically support the proposed revision to physician payment localities in California recently published in the reference rule. Our health leadership group represents our county's hospitals, physicians, public and private clinics, health department, Medicaid program and community foundations. We have written previously regarding our concern that the current payment locality of our county and the resultant fee schedule adversely affect not only the providers of medical care in our community, but has also been a major contributing factor to a crisis of stability on our health care system which affects all county residents.

We are encouraged by your proposed change to physician payment localities, and we are strongly supportive of the proposed rule. You have recognized that CMS is "ultimately responsible for establishing fee schedule areas", and we laud your efforts at rectifying a long-standing inequity. You have addressed the two most problematic counties in the state and have proposed an important change that will be instrumental in ensuring access to health care services for residents in our county.

We understand this to be a fundamental issue of fairness. Neighboring counties to Santa Cruz and Sonoma have some of the highest payment levels in the nation. Your proposed adjustment appropriately addresses the current inequitable payment problem and brings you closer to your goal of having physician payments reflect the cost of practice in the locality.

Sincerely,

Wells Shoemaker

Wells Shoemaker, M.D.
Chairperson, Health Improvement Partnership of Santa Cruz County

A Community Partnership to Assure Quality Healthcare For All

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THE UNIVERSITY OF UTAH

AUG 16 2005

August 10, 2005

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

RE: TEACHING ANESTHESIOLOGISTS

Dear Sir/Madam:

I am writing to you to express my deep disappointment regarding the continued implementation of your compensation policies for teaching anesthesiologists. I am the Department Chair at the University of Utah where we are currently training 36 anesthesiologists. Like other parts of the country, Utah has too few anesthesiologists. The outstanding trainees we graduate are vitally important for the safety of our Medicare, Medicaid, and other patients in our state. Your unfair compensation of teaching anesthesiologists has to a great extent been responsible for our growing reliance on our Hospital resources to cover the expenses of our clinical programs. It is vitally important that you change this unfair policy for teaching anesthesiologists so that our Hospital can utilize all of its very limited resources for the capital and other expenditures desperately needed. How is it fair that a surgeon may supervise residents during overlapping operations and internists in overlapping clinic visits and receive their full CMS compensation, while anesthesiologists are penalized 50% of our fee even if we overlap care by only 1 minute? Our Medicare conversion factor is already well below the prevailing commercial rates in Utah. Reducing compensation by 50% for teaching anesthesiologists is grossly inadequate compensation to support the

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multiple missions of an academic department. The health and welfare of Medicare, Medicaid, and all other patients depend on the continued progress of anesthesiology as our patient population ages and grows sicker. The outstanding accomplishments of anesthesiology in advancing patient safety cannot continue if your unfair compensation to us bankrupt our departments and the academic medical centers that support us.

I appreciate your attention to this matter.

Sincerely,

Michael K. Cahalan, M.D.
Professor and Chair

MKC:vl

Cc: ASA Washington Office mail@asawash.org
Dr. Kochenour
Gordon Crabtree
Utah Senators and Congressmen

AUG 16 2005

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

Re: GPCI

To Whom It May Concern:

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

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

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

CMS acknowledges that they have the responsibility to manage physician payment localities. We understand that there have been not been revisions to the localities since 1996. You have selected the most important area in our state to begin to correct this problem.

Sincerely,

Correia Care Centers
Residential Care

Maria Elena Gabriel
2000 Brommer St.
Santa Cruz, Ca. 95062

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AUG 16 2005

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

RE: GPCI

To Whom It May Concern:

I would like to present you with some information on why revising the physician reimbursement rates for both Medicare and Medi-Cal is so important to the people of the County of Santa Cruz. I have been involved in the community as both a citizen and as a professional social worker. Our poor and elderly are not able to access the care they need in this County due to the low reimbursement rates. In addition the agencies providing care to these populations are struggling to provide a high level of care on the low rates. Currently as a Hospice social worker I have witnessed the balance that an agency has to maintain to stay financially afloat on the very low Medicare reimbursement. It is very important to the most vulnerable people in our community and the agencies that support them that reimbursement rates for the County of Santa Cruz are in line with surrounding Counties.

Dave Resnikoff MSW
133 Redwood St.
Santa Cruz, CA. 95060

DAVE RESNIKOFF MSW

Beth Israel Deaconess Medical Center

A teaching hospital of Harvard Medical School

AUG 17 2005

Carol A. Warfield, M.D.
Chairman
Department of Anesthesia, Critical Care, and Pain Medicine

Edward Lowenstein Professor of Anaesthesia
Harvard Medical School

August 8, 2005

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

RE: Reference file code: CMS-1502-P
"Teaching Anesthesiologists"

Dear CMS:

I am writing in strong opposition to the teaching rule which reduces fees for anesthesia services by 50% for concurrent resident supervision. This ruling unfairly penalizes anesthesiologists in teaching hospitals who are already penalized by delays and long surgeries due to the training of surgical residents. In addition, this decrease in revenue will make it impossible to sustain a core faculty in teaching hospitals which need to compete with private practice institutions for the dwindling numbers of anesthesiologists available. Despite many measures, we are still experiencing a critical shortage in anesthesia personnel especially in teaching institutions and with the population aging the demand for anesthesiologists is likely to increase in the future. Without sustainable teaching programs, we will not be able to provide this country with the necessary physician numbers.

In our own institution at Harvard, we have lost many of our faculty to private practices where they are not subjected to this 50% rule. Therefore, if they are supervising nurse anesthetists and we are supervising residents we have a considerable shortfall in revenue which translates to substantially reduced salaries. Years ago, these reduced salaries were acceptable to many since the working hours for academic anesthesiologists were considerably shorter than those for private practitioners. However, the recent information we have collected indicates that our anesthesiologists at Harvard who on average provide more than 50 hours per week of direct patient care in addition to nights and weekends worked provides a similar lifestyles to that in private practice. In addition, years ago this decrease in revenue

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cwarfiel@caregroup.harvard.edu

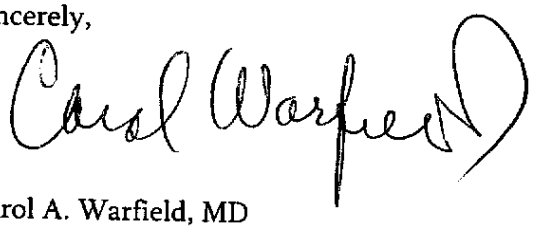
could be absorbed elsewhere in large teaching hospitals. Unfortunately this is no longer the case.

In short, as long as this rule is in existence we will not be able to provide training of residents to increase the workforce of anesthesiologists and we will not be able to support our clinical physicians let alone those who perform the important research which leads to improvement in care.

In addition, not only does this rule unfairly penalize us compared with private practice anesthesiologists but also penalizes us compared with academic surgeons. The surgeons may supervise residents in two overlapping operations and collect 100% of the fee for each. An internist may supervise residents in four overlapping outpatient visits and collect 100% of the fee.

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

Sincerely,



Carol A. Warfield, MD
Chairman
Department of Anesthesia, Critical Care & Pain Medicine
Beth Israel Deaconess Medical Center
Lowenstein Professor of Anaesthesiology
Harvard Medical School

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AUG 17 2005

STANLEY HAJDUK, M.D., F.A.C.E.P.
Managing Partner
EMERGENCY MEDICAL GROUP
200 Linda Vista Drive, La Selva Beach, Ca 95076
Phone/Fax: (831) 763-0535
E-Mail: docstan@cruzio.com

August 15, 2005

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

Re: File Code CMS1502-P
Issue Identifier: GPCI's/Payment Localities

Dear Sirs:

I am writing on behalf of Emergency Physicians of Watsonville, California, to strongly support your proposed revision to physician payment localities in California recently published in the reference rule. Our organization consists of nine physicians. We have been contracted to supply emergency services 24/7 to our community for the last thirty years. We have written previously to express our concern about the viability of the health care system that serves our residents. The great difference between the cost of medical practice in Santa Cruz County, as measured by GAF cost values, and the low rate of reimbursement due to being assigned to Locality 99 has made recruitment and retention of physicians willing to serve Medicare beneficiaries very difficult.

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

Sincerely,

Stanley Hajduk, M.D.
Chairman, Department of Emergency Medicine
Immediate Past Chief of Staff
Watsonville Community Hospital

SH:kg

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AUG 17 2005

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

Re: GPCIs

To Whom It May Concern,

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

There has been a problem for many years with the method by which you pay physicians in the SF Bay Area. Two of the ten counties in this metropolitan area are paid at rural California rates. We understand that this proposed rule corrects this inequity.

We applaud you for addressing this problem.

Sincerely,

8/15/05

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Monterey County Medical Society

AUG 17 2005

August 15, 2005

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

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

Dear Doctor McClellan:

On August 8, CMS unveiled its physician payment rules for 2006 and is proposing to move two California counties (Santa Cruz and Sonoma) out of payment Locality 99, "Rest of California" at the cost of reducing reimbursement to the remaining Area 99 counties, including those already adversely impacted by averaging with lower cost counties. The proposed rule would result in a 0.4% cut in physician reimbursement for Monterey County physicians in 2006 – this would be on top of the planned 4.7% cut due to the flawed sustainable growth rate formula.

The Monterey County Medical Society, representing over 350 physicians practicing in Monterey County and over 90 retired physicians (Medicare beneficiaries) residing here, objects to the proposed rule because it fails to correct proven inadequacies in physician reimbursement to all the counties in Area 99 that exceed a 5% threshold (the "105% rule") over the national 1.000 average. Specifically, by extracting Santa Cruz and Sonoma counties from Area 99, CMS is exacerbating reimbursement deficiencies for the California counties of Monterey, San Diego, Sacramento, Santa Barbara, and El Dorado.

The Monterey County Medical Society (MCMS) supported and continues to support the proposal drafted by the California Medical Association for and at the recommendation of the Centers of Medicare and Medicaid Services. The proposal included a formula to determine which counties qualified for their own payment regions. Unfortunately, we vigorously oppose the half-hearted attempt by CMS is put a tiny and inadequate band-aid on a problem recognized by all physicians in California as a mortal wound.

With respect to Proposed Rule CMS-1502-P, the leadership of MCMS is also concerned that the proposed rule does not speak to any continued corrections to payment locality discrepancies by CMS in the future.

In 1996, CMS began an attempt to decrease the number of payment localities for Medicare Part B providers. In determining which counties belonged where, CMS determined that a 5%-or-

Monterey County Medical Society
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greater differential in practice costs from other California counties, would secure a county's qualifying for its own payment region. When CMS determined that Monterey County did not qualify as a greater-than-5% county, MCMS was shocked – national publications had identified Monterey County as one of the counties in America that had the highest health care costs.

For the past several years, as practice costs in Monterey County have increased at the same rate as those in San Francisco County, physicians have become more and more disillusioned with the Medicare system.

Hopes were high when the California Medical Association House of Delegates was able to secure consensus on a formula that would allow, with CMS' regular updates, for counties demonstrating 5%-or-greater differential from the "Rest of California" to be moved into their own payment locality with the financial burden being spread throughout the entire state, including those counties that were already in their own payment localities.

Who would have thought that California physicians could reach consensus on a Medicare GPCI formula proposal in which most counties would have had to accept less reimbursement?

With all the angst, politicking, and frustration that went into obtaining a consensus among physicians, it was quite discouraging to find that the August 1, 2005 edition of the *Federal Register*, obliterated everything the CMA had tried so ardently to achieve. Again, California physicians find themselves butting heads with CMS! Why is it that CMS seems hell-bent on creating divisiveness among physicians in our state?!

No one disparages Santa Cruz and Sonoma County physicians – the squeaky wheels obviously got the oil – but the Monterey County Medical Society urges you to reconsider the well-thought-out and debated proposal of the California Medical Association. The CMA proposal established a formula for determining geographic disparities, recommended regularly scheduled Geographic Adjustment Factor updates, and recommended the implementation of regularly scheduled locality adjustments for qualifying counties in California.

The Monterey County Medical Society supports the California Medical Association's recommendation that Congressman Thomas and the Centers for Medicare and Medicaid Services work together to devise a nationwide fix to the GPCI problem. The proposed rule to extract Santa Cruz and Sonoma counties from California's Area 99 is *not*, in our collective opinion, a viable first step toward that goal.

Monterey County physicians cannot afford another cut in Medicare reimbursement.

Sincerely,

Scott H. Schneiderman, DO
President

Monterey County Medical Society
19065 Portola Drive, Suite M • Salinas, CA 93908 • (831) 455-1008 • Fax: (831) 455-1060 • www.montereymedicine.org

cc: Michael O. Leavitt, Secretary, U.S. Department of Health and Human Services, 200 Independence Avenue, SW, Washington, DC 20201
U.S. Congressman Sam Farr, 17th District of California, 100 W. Alisal St., Salinas, CA 93901
U.S. Senator Diane Feinstein, 1 Post St., Suite 2450, San Francisco, CA 94104
U.S. Senator Barbara Boxer, 1700 Montgomery St., Suite 240, San Francisco, CA 94111
U.S. Congressman William Thomas, Chair, Committee on Ways & Means, 2208 Rayburn, Washington, DC 20515
U.S. Senator William H. Frist, MD, U.S. Senate Majority Leader, 509 Hart Senate Office Building, Washington, CA 20510
U.S. Congressman J. Dennis Hastert, Speaker of the U.S. House of Representatives, 235 Cannon House Office Building, Washington, DC 20515
John Lewin, MD, EVP/CEO, California Medical Association, 1201 "J"Street, Suite 200, Sacramento, CA 95814-2906

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AUG 18 2005

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

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August 16, 2005

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

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

To Whom It May Concern:

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

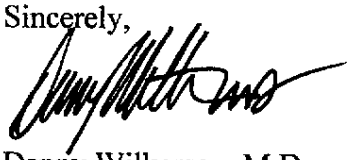
Currently, a teaching anesthesiologist will only collect 50% of the Medicare fee if he/she supervises residents in two overlapping cases. A surgeon can supervise residents in two overlapping operations and collect 100% of the fee for the case from Medicare. An internist may supervise residents in four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

The Medicare anesthesia conversion factor is less than 40% of prevailing commercial rates. By reducing that conversion factor 50% for teaching anesthesiologists, this results in revenues grossly inadequate to sustaining the service, teaching, and research missions of academic anesthesia training programs.

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

Thank you for your consideration in this matter.

Sincerely,



Danny Wilkerson, M.D.
Assistant Professor

DW/cp

26.

UAMS

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

AUG 18 2005

Carmelita S. Pablo, M.D.
Associate Professor and Chair

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August 15, 2005

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

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

To Whom It May Concern:

I am the present Chair in the Department of Anesthesiology at the University of Arkansas for Medical Sciences. As such, I make every effort to be aware of all Medicare policies affecting our program. The CMS' proposed changes to the Medicare Fee Schedule for 2006 has one glaring omission, that of correcting the discriminatory policy of paying teaching anesthesiologists only 50% of the fee for each of two concurrent resident cases. This current Medicare teaching anesthesiologist payment rule is unwise, unfair and unsustainable.

Our increasingly elderly Medicare population demands that we have a stable and growing pool of anesthesiology trained physicians to provide quality medical care and patient safety. Right now, programs such as ours are having slots unfulfilled because of the rule of withholding 50% of funds for concurrent cases. We currently seek two CAII residents and 2 faculty in our Department of Anesthesiology. The CMS anesthesiology teaching rule must be changed to allow academic departments to cover their costs. Because of this arbitrary Medicare payment reduction, academic research is also being squandered as department budgets are being broken up. Our program is suffering economic losses that cannot be absorbed elsewhere.

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

The Medicare anesthesia conversion factor is less than 40% of prevailing commercial rates. By reducing that conversion factor 50% for teaching anesthesiologists, this results in revenues grossly inadequate to sustaining the service, teaching, and research missions of academic anesthesia training programs.

I implore that this current Medicare rule be revised as soon as possible so that we can provide the quality of care that the patient deserves. We also deserve a fair and workable policy in par with our colleagues in surgery – 100% of the Medicare fee for each of two overlapping procedures involving resident physicians.

Thank you for your consideration in this matter.

Sincerely,

Carmelita S. Pablo, M.D.
Associate Professor and Chair

CSP/cp

27

AUG 18 2005

OHSU
Oregon Health & Science University

SCHOOL OF MEDICINE
DEPARTMENT OF ANESTHESIOLOGY AND PERI-OPERATIVE MEDICINE

Mail Code UHS-2 • 3181 S.W. Sam Jackson Park Rd. • Portland, Oregon 97239-3098
Tel: 503-494-4908 • Fax: 503-494-4588 • kirschje@ohsu.edu

Jeffrey R. Kirsch, M.D.
Professor and Chairman

August 12, 2005

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

Attention: Teaching Anesthesiologists CMS – 1502 – P

Thank you for the opportunity to respond to the proposed change in the anesthesia teaching rule regarding reduction of fees by 50% when an academic anesthesiologist supervises two resident trainees.

As CMS is well aware, this is an arbitrary ruling that penalizes the anesthesia specialty. It is not applied to Surgical or Medical specialties, although these academic practices also provide concurrent care under the Teaching Regulations. Under the Teaching Regulations, surgeons can medically direct two overlapping operations, internists can medically direct up to 4 overlapping patient visits, and anesthesiologists can medically direct two overlapping resident cases. Only anesthesia is required to report the concurrency, and only anesthesia is financially penalized with a 50% reduction in pay for medically directed concurrent cases. In addition to the basic unfairness, we also object for these reasons:

1. We do not think it is appropriate to consider a resident as a "qualified" provider of care under the definition for modifier "QK" which results in the 50% payment rule. In the care team model, this modifier is used for medically directing two or more "qualified providers", including CRNAs, AAs, or interns and residents. Only CRNAs and AAs are qualified providers who have completed their training and are fully licensed and credentialed as anesthesia providers. A resident is a trainee and is not a "qualified" provider of care yet. As a qualified provider, the CRNA portion of the case is billable to CMS under the modifier "QX", resulting in an additional 50% payment of the fee schedule. It does not make sense for a resident to be considered "qualified" under the "QK" definition but to not recognize their "qualified" contribution to the care team with a second billable modifier. This could be rectified by including residents as a "qualified provider" under "QX", or deleting them from the definition of "QK". Another option, if CMS wants to track the cases with resident involvement, would be to report all cases with a medically directed resident using modifier "GC", whether performed concurrently or under one to one medical direction.

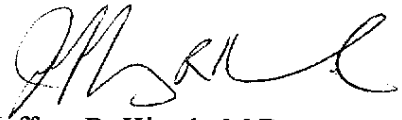
2. The Medicare anesthesia fee schedule is already significantly less, when compared to prevailing commercial rates, than other specialties. This means that anesthesia is already the poorest paid specialty under Medicare, receiving 40% of prevailing commercial rates compared to the 60% rate received by other specialties. When payment is reduced by 50% for cases done under concurrent care (2 residents under the supervision of one faculty anesthesiologist), it worsens the economic impact of Medicare revenue support for this undervalued field.

3. Anesthesia is in the midst of a critical manpower shortage. Recruitment and retention for academic anesthesia practices is especially difficult. This is because academic institutions can not compete with private practice compensation, due partially to the unfair payment treatment by Medicare. Academic institutions tend to be DSH facilities (Disproportionate Share Hospitals that serve more of the indigent population), so clinical revenue is less. Medicare adds to this problem by the practice of disallowing 50% payment for concurrent cases.

4. Academic institutions are training the providers of care for the future. Anesthesiology is a field that has contributed tremendously to patient care and safety over the past ten years, with impressive results that have been widely recognized in the business and insurance fields. In order to continue to make strides in this area through research and education programs, academic anesthesia practices need to have support from the government, not be treated unfairly.

Please act to correct this unfair Medicare guideline. We urge you to reconsider the definition of "qualified providers" under the modifier "QK" and clarify that this term relates only to CRNAs. All resident cases (whether medical direction is 1:1 or 1:2) should be billed under modifier "GC" and paid at 100%, as they are in all other specialties.

Sincerely,



Jeffrey R. Kirsch, M.D.
Professor and Chair
Department of Anesthesiology
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28

AUG 18 2005

DANIEL H. HWANG, M.D.

NEPHROLOGY AND INTERNAL MEDICINE
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August 15, 2005

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

Re: File Code CMS 1502-P

Issue Identifier: GPCI's/Payment Localities

Dear Madam or Sir:

I am writing to you in support of the proposal to change physician payment localities in California, namely, that of moving Santa Cruz and Sonoma counties from Locality 99. I know for a fact, that because of the low reimbursement rates in Santa Cruz County, this community has had difficulty in recruiting new physicians and retaining them in the long run. Santa Clara County, which is our direct neighbor to the east, has some 24% higher reimbursement rate for similar services than we do. And yet, the cost of living in Santa Cruz County is not significantly less. I have included a table below, indicating the similarity of housing costs between the two counties.

July 2005 Statistics
Price of a Single Family Home on the Market
(Source: Santa Cruz Association of Realtors, The Real Estate Reports)

	Santa Cruz County	**Santa Clara County**
Median	$759000	$750000
Average	$868068	$907889

The change you have proposed will help us to bring more physicians into our county, and over the long run, the health care services for all citizens of this county will improve. Thank you for your proposed recommendations.

Sincerely,

Daniel Hwang

MEDICAL COLLEGE OF WISCONSIN

AUG 19 2005

David C. Warltier, MD, PhD
Professor and Senior Vice Chairman

Departments of Anesthesiology,
Pharmacology and Toxicology, and
Medicine, Division of Cardiology

August 18, 2005

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

Re: CMS-1502-P "TEACHING ANESTHESIOLOGISTS"

Dear CMS Administrators:

I was recently very disappointed to learn that the proposed changes to the Medicare Fee Schedule for 2006 did not include a correction of the discriminatory policy of paying teaching anesthesiologists only 50% of the fee for each of two concurrent resident cases. This is an extraordinarily important issue for anesthesiology residency programs in this country. The current ruling seems to be arbitrary and capricious but most importantly, it is highly destructive and threatens manpower resources in an important subspecialty of medicine. The limited reimbursement from concurrent cases will ultimately be met with a reduction in the number of residents trained in this country. This occurs at a time when there is increasing demand for anesthesiologists outside of the operating room in each hospital. Anesthesiologists now regularly function in cardiology (electrophysiology) catheterization laboratories, radiology suites, pain clinics, intensive care units, and others. We have seen an explosive demand for anesthesiologists occur, while training programs in general have seen a reduction in numbers of trainees over the last several years. Reimbursement is a critical issue to already underpaid faculty (compared to their private practice counterparts).

The current Medicare Teaching Anesthesiologist payment is unfair. The cases done by teaching physicians/residents at academic medical centers are often very difficult, such complexities not willing to be dealt with in the private hospital sector and patients subsequently transferred to academic centers. It seems unreasonable that the compensation for these difficult cases should be less than that done at a private institution without residents.

The population of patients that receive Medicare is rapidly growing. With an increase in demand at the hospital for anesthesiologists in and outside of the operating room, and a growing elderly population, more anesthesiologists must be trained. Slots in training

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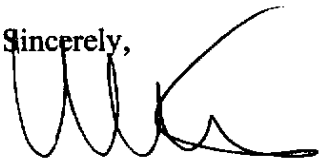
melhanke@mcw.edu

Re: CMS-1502-P "TEACHING ANESTHESIOLOGISTS"

programs are presently going unfilled because of the Medicare policy that discriminates against teaching programs, withholding 50% of the funds for concurrent cases. My program is presently filled, but I believe we will be unable to sustain this with the current levels of reimbursement. In essence, we are subsidizing the costs of healthcare for elderly patients by providing resident physician and faculty services that are not covered by Medicare. Of most significance, the incongruous and arbitrary nature of the ruling is readily evident when one considers that a surgeon may supervise residents in two overlapping rooms and collect 100% of the fee from Medicare. At a minimum, full coverage of two anesthesiology residents supervised by a physician should be allowed. Anything less threatens the existence of academic programs. I hope that you will support a change in the present ruling for the benefit of healthcare in the United States. Thank you for your consideration in this matter.

Sincerely,



David C. Warltier MD PhD
Professor and Chairman
Department of Anesthesiology

DCW:melh

AUG 2 2 2005 30

~~AUG 2 0 2005~~

COMMUNITY HEALTH PLAN OF WASHINGTON

Committed to your health.

Memorandum

To: Alma Hardy, David Worgo
From: David DiGiuseppe
Date: Aug 15, 2005
Re: FQHC wraparound mechanics under Medicare Advantage

Alma and David:

Despite numerous conversations with yourselves and others, I'm afraid I still don't have my analysis of the impact of Medicare Advantage on FQHC wraparound payments correct.

I'm hoping that you can help me fill in the holes in my understanding.

CMS's proposed approach sounds like it could work well for FQHCs with respect to providing care to non-dually eligible beneficiaries as Medicare Advantage enrollees. My concern though is that it seems like the FQHCs that govern our not-for-profit health plan may stand to lose revenue serving Washington's dual eligibles as members of our proposed MA-SNP, relative to fee-for-service.

My current understanding of the existing wraparound under fee-for-service is this:

Hypothetical example: dually eligible beneficiary fee-for-service visit in the state of Washington

- A beneficiary visits an FQHC.
- The FQHC submits a bill to UGS with a charge of $150.
- UGS pays $89.70 (80% of urban UPL = $109.88).
- Medicaid is balance billed. In Washington, I'm told that Medicaid will pay 20% of the ***charges*** which in this example equals $30.
- In total the FQHC receives $89.70 + $30 = **$119.70** for the visit.

However, under Medicare Advantage it seems like the following would happen:

Hypothetical example: dually eligible beneficiary MA visit

- A beneficiary visits an FQHC as a member of an MA-SNP with a $0 copay but a 20% coinsurance (ie, a cost-sharing structure that mirrors the current fee-for-service cost structure).
- The FQHC submits a bill to Acme Health Plan with a charge of $150. 150
- Acme pays the contracted $70/visit rate.
- The FQHC submits a bill to UGS with a charge of $150.

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phone 206-521-8833 fax 206-521-8834

COMMUNITY
HEALTH PLAN
OF WASHINGTON

Committed to your health.

- UGS pays $39.88 (100% of urban UPL = $109.88 minus the $70 payment received from Acme).
- In total the FQHC receives **$109.88** for the visit, $9.82 **less** than was received under the Medi-Medi fee-for-service environment.
- **It appears to me that the FQHC will not be able to balance bill Medicaid because UGS is now providing wraparound up to 100% of the UPL. Do I understand this correctly?**
- **Can the FQHC in Washington continue to bill Medicaid for the difference between what the FQHC would have received under fee-for-service in Washington and what it does receive under MA?**
- **If there is, in fact, a role for Medicaid to still cover beneficiary out-of-pocket responsibility, am I correct in thinking that the FQHC will have to send out 3 bills: 1 to the health plan, 1 to UGS and 1 to Medicaid?**
- **When the FQHC bills UGS, how will UGS know the amount that Acme Health Plan already paid? Is this accomplished based upon the estimate for the first rate year described on page 45853, such that the FQHC does not have to wait to bill UGS until after payment has been received from Acme Health Plan?**
- **If our organization does not enter Medicare Advantage until 2007, does that mean that 2007 would be considered the "first rate year" with respect to our MA plan?**

I have a few additional questions:

1. Regarding the proposed rules of August 8, 2005, in § 405.2469 (page 45871) what does (a)(iii) refer to? Are these charges made directly to the patient? If so, if the FQHC slides those charges, does that mean that the charges were "made"?

2. Regarding the proposed rule on page 45853, do the provider types listed at the bottom of the first column and the top of the second column differ in any way from the provider types covered under the Original Medicare FQHC wraparound? For example, does "clinical social workers" broaden the covered provider types?

3. Under the proposed rules, would the upper payment limit still apply?

4. Per § 422.527 (page 4738 from January 28, 2005), if we pay our FQHCs on a system that involves incentive pools, does this language mean that we would have to pay any non-FQHC contracted primary care providers in the same way that we pay our FQHCs?

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HEALTH PLAN
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5. Is it correct to say that currently under fee-for-service, if a beneficiary visits an FQHC and that beneficiary has not yet met his/her Part B deductible, that CMS pays the FQHC directly at 80%, essentially waving the deductible?

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phone 206-521-8833 fax 206-521-8834

Mark B. Feinberg, MD, PhD
Vice President
Policy, Public Health & Medical Affairs

AUG 2 2

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Tel 215 652 8664
Fax 215 652 8918

August 16, 2005

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

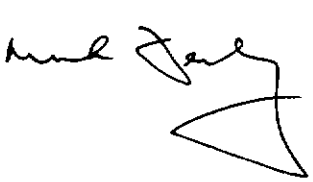
MERCK
Vaccine Division

RE: Revision to Payment Policies Under the Physician Fee Schedule for Calendar Year 2006; Oral/Intranasal Vaccination Administration Codes (90467-90468 and 90473-90474)

The Centers for Medicare & Medicaid Services (CMS) has taken numerous steps which recognize the importance of vaccination in helping to prevent morbidity and mortality. Most recently CMS' "Quality Improvement Roadmap" highlighted the need to pursue transformational breakthroughs, including vaccination in nursing homes. We believe that these actions are notable, and increasing vaccination rates in all settings will improve overall health.

We have reviewed the 2006 Physician Fee Schedule and were pleased to find that CMS had taken the step of providing valuations for the oral vaccine administration codes, namely CPT® codes 90467, 90468, 90473 and 90474. This publication of the Relative Value Update Committee's (RUC) recommendations will provide invaluable guidance to payors and reassurance to providers, which will ultimately lead to our shared goal of increasing immunization rates for all vaccines. The assurance of appropriate reimbursement for provider services is necessary to provide quality care, as was highlighted in the "Quality Improvement Roadmap." We applaud CMS for its commendable work in increasing the utilization of preventive services, including vaccination. It is our hope that CMS will continue to advocate for preventive medicine and help to assure that vaccinations are an integral part of its future planning.

Sincerely,



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Department of Anesthesiology

AUG 2 2 2005

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Hyperbaric Therapy
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August 19, 2005

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

Dear Sir or Madam:

I am writing to you as the Interim Chair of the Department of Anesthesiology at SUNY Upstate Medical University in Syracuse NY to express my dismay over the ***Proposed Rule for the 2006 Physician Fee Schedule***. I'm very concerned that it does not include a correction of the discriminatory policy of paying teaching anesthesiologists only 50% of the fee for each of two concurrent resident cases.

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

Although we anticipate seeing an increase in the number of elderly patients in our operating rooms, there is a currently a short fall nationally in the number of practicing anesthesiologists. Additionally, anesthesiology training programs are not able to train adequate numbers of physicians to meet the projected future need. Economic factors force salaries for teaching anesthesiologists to be less than those for anesthesiologists in the private sector, so attracting faculty to train the next generation is problematic. I currently have four open faculty positions. The Medicare anesthesia conversion factor is less than 40% of the prevailing commercial rates. Reducing that meager amount by a further 50% for providing medical direction concurrently to two residents results in revenue stream which is grossly inadequate to cover faculty salaries. In 2004, my Department provided excellent anesthesia care to over 2700 Medicare patients.

Residents were involved in the care of all patients. The residents gain the experience they need to practice state of the art anesthesia upon completion of their residency and our elders receive cutting edge care. In 68% of the cases, a faculty anesthesiologist provided concurrent care to a second case for a portion of time. My Department lost in excess of $293,000 in revenue as a result of the discriminatory concurrency policy. This is clearly not a sustainable situation for us.

My surgical colleagues are able to supervise residents performing two overlapping surgical procedures and collect 100% of their fee for each case from Medicare. My colleagues in internal medicine can supervise residents in four overlapping outpatient visits and collect 100% of the fee for each case. Reducing a teaching anesthesiologist's fee by 50% is neither fair nor reasonable. Failure to promptly correct this discriminatory policy will continue to adversely affect my ability to train residents in anesthesiology thereby reducing the availability of well trained anesthesiologists to care for tomorrows' senior citizens.

Sincerely,

Colleen E. O'Leary

Colleen E. O'Leary, MD
Associate Professor & Interim Chair
Department of Anesthesiology
SUNY Upstate Medical University
Syracuse, New York

Cc: Congressman James Walsh
Senator Charles Schumer
Senator Hillary Rodham Clinton
American Society of Anesthesiologists, Washington Office

AUG 2 2 2005

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

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

Gentlemen:

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

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

Thank you.

Harold McCann
Ellen McCann

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

Leonard J. Klay, M.D

Sutter Medical Foundation
of the North Bay
A Sutter Health Affiliate

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AUG 2 2 2005

August 17, 2005

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

Re: GPCI's

Dear Sir,

I am a physician practicing in Santa Rosa, Sonoma County, California. I strongly support your proposal to create a new payment locality for Sonoma County.

Medicare reimbursements have not kept pace with increasly expensive cost of living in Sonoma County. Without this cost adjustment it is more difficult to accept new Medicare patients and to meet practice expenses.

Thank you.

Leonard J Klay MD

35

AUG 2 2 2005

THOMAS O. HYLAND D.P.M.

PODIATRIC MEDICINE
525 CAPITOLA AVENUE, CAPITOLA, CA 95010
831-465-8213

August 16, 2005

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

Re: File Code CMS1502-P
Issue Identifier: GPCI's / Payment Locality / Support Proposed Rule Change

Dear Sirs:
I am writing to comment on the Proposed Rules governing the Physician Fee Schedule Calendar Year 2006 as printed in the Federal Register of August 8, 2005.
I applaud the proposed removal of Santa Cruz and Sonoma Counties from Locality 99. Doing this does address the GAP between Santa Cruz and its neighbors San Mateo and Santa Clara. It would also address the 10% loss that Santa Cruz would sustain if left within Locality 99. Because of new funds the remaining Locality 99 counties sustain a less than 0.1% decrease.
You have covered all the complex negatives and positives in the discussion. This action would finally address disparities that existed even before the last California Locality change. I think this is a good start to trying to figure out how to react as measured cost of providing care changes in different localities.

Sincerely,

Thomas O. Hyland, D.P.M.

36.

AUG 2 2 2005

BCM
Baylor College of Medicine

LYDIA A. CONLAY, M.D., Ph.D., M.B.A.
Professor and Chairman
Department of Anesthesiology
lconlay@bcm.edu

August 11, 2005

Center for Medicare and Medicaid Services
Department of Health and Human Services
ATT: CMS-1502-P
Mail Stop C4-26-05
7500 Security Blvd
Baltimore, MD 21244-1850

RE: **File Code CMS-1502-P**
TEACHING ANESTHESIOLOGISTS

To Whom It May Concern:

I write to express sincere concern for the proposed comments regarding the Teaching Rule for Anesthesiologists. This language does little to clarify a situation that is already unclear, unsustainable, and unfair. Anesthesiology is the only specialty which has been subjected to such billing regulations. In contrast, a surgeon may supervise residents in two overlapping operations, and collect 100% of the fee for each case from Medicare. An internist may supervise residents in four overlapping outpatient visits and collect 100% of the fee. A teaching anesthesiologist can only collect 50% of a Medicare fee if he or she supervises two cases which overlap by even one minute!

The reduction in fees paid for Medicare patients are important for academic anesthesiology programs for several reasons. First, academic institutions typically care for a disproportionate share of the aged and the indigent, and are less likely to receive payments at commercial private rates. Moreover, commercial payors are very rapidly adopting the extraordinarily restrictive Medicare rules.

Yet, there is a significant shortage of anesthesiologists, and academic practices must compete with our private-practice counterparts to recruit faculty. We simply cannot do so with current Medicare reimbursements, particularly when our fees are cut in half. Thus, almost all academic departments, and ours in particular, function in "the red", and with vacancies for physicians. This has serious consequences, and in some cases no doubt reduces our ability to provide care for the patients whom we serve.

Our training programs are also seriously imperiled as we remain challenged to recruit teachers for our residents and students. A major determinant of the need for anesthesiologists is the number of surgical procedures, and the number of surgical procedures increases as individuals (such as the "babyboomers") age. We worry that we shall simply not be able to produce enough anesthesiologists to provide care in the near future.

RE: File Code CMS-1502-P - TEACHING ANESTHESIOLOGISTS
August 11, 2005

Quality medical care, patient safety, and an increasing Medicare population demands that the United States have a stable and growing pool of physicians trained in anesthesiology. To treat teaching physicians in our specialty differently from all others is not fair and is not reasonable, particularly given the population of patients who are traditionally served by academic medical centers.

We ask that you seriously consider the potential consequences of the current rule patient care for the population in the years to come, and that teaching anesthesiologists be considered and reimbursed on par with their surgical and other medical colleagues.

Thank you for your consideration.

Cordially yours,

Lydia A. Conlay, M.D.
Professor and Chair
Department of Anesthesiology
Baylor College of Medicine

AUG 2 2 2005

5707 Plateau Drive
Felton, CA 95018
August 19, 2005

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

Dear Policy Makers,

I am writing to urge you to change the Medicare status of Santa Cruz County, California, from rural to urban. This is one of the most expensive areas in California, indeed, in the entire country, in which to live, with the median home price approaching $800,000.

Changing to an urban status is crucial for the recruitment and retention of doctors, and ensuring quality care in the county. As a health care consumer with a family, I urge you to now take this long-overdue step. Thank you.

Sincerely,

Michele Mosher

AUG 2 2 2005

Centers for Medicare and Medical Services
Department of Health and Human Services

Attention: CMS-1502-P

Medicare and Medicaid payments to doctors (and for medical services in general) should be adjusted based on the costs of "doing business" and cost of living for medical professionals.

In Santa Cruz county (California), the vast majority of medical doctors and health care facilities are located in urban areas where the cost of living and cost of doing business is extremely high. A large proportion of the county's population lives in unincorporated areas where costs of living are, in many cases, as high or higher than the incorporated cities of Santa Cruz, Watsonville, Capitola, and Scotts Valley.

It seems to be a matter of common sense to adjust Medicare and Medicaid payments based on the costs associated with the delivery of medical services to the recipients in the community. Designations such as "rural" and "urban" based on historic or geographic designations are inappropriate.

Sincerely,

William R. Finch
346 Los Altos Drive
Aptos, CA 95003

email: billfinch1@aol.com

39.

AUG 2 2 2005

OPPOSITION to File Code CMS-1502-P
Medicare Payment Localities – "Rest of California"

August/September, 2005

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

To Whom It May Concern:

I am a Medicare beneficiary who receives care from a knowledgeable and dedicated physician. I understand that the Proposed Rule CMS-1502-P will remove Santa Cruz and Sonoma counties from Medicare's payment Locality 99 in California, at the expense of the remaining Locality 99 counties, including my own county, Monterey.

My physician will be expected to take yet another cut in Medicare reimbursement, putting my continued care in jeopardy. I'm worried that my physician may decide to stop seeing Medicare patients altogether.

There is no doubt that the Medicare system needs to be fixed and that the physician payment formula needs to be improved, but you're not solving any problems by this piecemeal approach. In fact, you're jeopardizing the continued participation of your current Medicare providers in the remaining Locality 99 counties.

I appreciate your consideration of my opposition to CMS-1502-P.

Sincerely,

Jerry M Parker

AUG 2 2

Sutter Maternity & Surgery Center

A Sutter Health Affiliate

Community Based, Not For Profit

2900 Chanticleer Avenue
Santa Cruz, CA 95065-1816
(831) 477-2200
(831) 477-2211 Fax

August 17, 2005

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

Re: File Code CMS1502-P - Issue Identifier: GPCIs / Payment Localities

To whom it may concern:

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

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

Sincerely,

Richard Nichols

Richard Nichols
Administrator

41

AUG 2 2 2005

Albany Medical College

47 New Scotland Avenue, Mail Code 131, Albany, New York 12208-3479

(518) 262-4305
Fax: (518) 262-4736
E-mail: robertk@mail.amc.edu

Kevin W. Roberts, M.D.
Office of the Chairman
Department of Anesthesiology

August 17, 2005

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

To Whom It May Concern:

I am the chairman of an academic Anesthesiology Department that has an anesthesiology residency program and cares for many Medicare and Medicaid recipients. Our residency program currently trains 20 residents in anesthesiology and the medicare policy with-holding 50% of the funds for concurrent cases short changes our teaching program and ultimately medicare recipients. It causes inefficiency in scheduling, personnel allocation, case assignments and budget short falls. In the current environment where there is a shortage of both anesthesiologists and nurse anesthetists these monetary short falls lead to artificially low salaries which results in my own department having three anesthesiology positions that we are unable to fill.

Ultimately, academic anesthesia departments are responsible not only for the education of medical students and residents in anesthesiology, but also research and one of the first missions that suffers is academic research in anesthesiology since scarce resources are first directed to patient care services. It is unfair and unreasonable that a surgeon may supervise residents in two over lapping operations and collect 100% of the fee in each case from Medicare, and that an internist may supervise a resident in four overlapping out-patient visits and collect 100% of the fee for each when certain requirements are met, while an anesthesiologist will only collect 50% of the Medicare fee if she or he supervises in two overlapping cases.

While the medicare conversion factor reimburses surgeons and internists at approximately 80% of the currently prevailing commercial rates, the Medicare anesthesia conversion factor is only 40% of those commercial rates and reducing that by a further 50% for teaching anesthesiologist concurrence results in revenue grossly inadequate to

sustain the service, teaching and research missions of academic anesthesia training programs.

In my own department the cost of delivering a unit of anesthesia is approximately $36.00 and the medicare conversion factor in the state of New York is approximately $17.00 while the Medicaid conversion factor is $10.00 per unit. Thus our budget short falls are compounded every time we care for a recipient of Medicare or Medicaid and extremely exacerbated when we care for a Medicare or Medicaid patient in concurrent cases. As the elderly population grows the number of patients who are Medicare recipients also grows. Our anesthesia residents need training to care for this population. Patients with cerebral vascular disease, renal disease, coronary artery disease, and peripheral vascular disease are overwhelmingly Medicare recipients. The complex nature of these cases which involves specific expertise, complex and lengthy care compounds the financial loss incurred in caring for these patients. Many of the advancements in the care of the elderly surgical patients and the increased safety of the perioperative period has been the result of advances in anesthesiology care. Medicare must recognize that the future of the anesthesiology care of the elderly requires paying the teaching anesthesiologist on a par with their surgical colleagues.

Sincerely,

Kevin W. Roberts, MD
Professor & Chairman

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

AUG 2 2 2005

August 17, 2005

To Whom It May Concern:

I'm writing in regard to the low Medicare payments that are sent to physicians in Santa Cruz, California. Because Santa Cruz is classed as rural, few primary-care doctors accept new Medicare patients. My sister had terminal cancer and moved from the Bay Area to be near her children. We found an oncologist that accepted Medicare, but finding a primary-care physician that would accept a new Medicare patient was another story.

Having AARP as her supplemental insurance made no difference. Because we could not find a primary-care physician, the oncologist had to try and be the primary-care physician too. It was a heartrending time and not having a primary-care physician added to the pain.

I can't understand why your center thinks of Santa Cruz as rural. I can't understand why this hasn't been rectified. I can't understand why there's even debate about this issue. It's a discrepancy---fix it. If no one in your department has not heard of Santa Cruz, let me tell you--- it's not rural. Santa Cruz is congested, with house prices the third highest in the nation. During commute times, the cars are bumper to bumper on the freeway. A little beach city it is not. Santa Cruz is an extension of the Bay Area/Silicon Valley.

Being able to find a primary-care physician wouldn't have changed my sister's impending death, but being able to find a primary-care physician at the beginning of her illness would have caused less stress for everyone.

Please, please, take that rural rating off of Santa Cruz Co. It's a blemish to our senior citizens that need to find qualified doctors when they are ill. What good does it do to have Medicare if hardly any doctors accept it?

Linda Lillehaugen

Linda Lillehaugen
909 Aloha Lane
Santa Cruz, Calif 95062

AUG 2 2 2005

School of Medicine
Department of Anesthesiology
and Perioperative Medicine

C. Alvin Head, M.D.
Professor and Chairman

August 10, 2005

Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attn: CMS-1502-P
P.O. Box 8017
Baltimore, MD 21244-1850

RE: File Code CMS-1502
TEACHING ANESTHESIOLOGISTS

As the Chairman and Program Director of one of only two anesthesiology residency training program in the state of Georgia, I ask your support for changing the misguided, Clinton-era policy under which Medicare financially supports our vitally important faculty members who provide hands-on teaching of anesthesiology residents. Our patient population is one of the highest mixes of self-pay (no pay), Medicaid, and Medicare patients in the state. Due to the shortage of Anesthesiologists, we can not be competitive with the salaries of private practices in our area. If we lose any more Anesthesiologists at our hospital, we may be forced to shut down operating rooms in our hospital reducing access for Medicare and Medicaid patients. Where will the next generation of anesthesiologist come without training programs? Without proper support of these faculty members, they leave academic settings to enter private practice leaving academic practice with few educators in a specialty that is already short-handed.

We need anesthesiologists! Specifically, at the Medical College of Georgia (MCG), we have 6 vacant faculty positions as a result of lower salary compensation due specifically to the shortfall created by this ruling. We may possibly lose other physicians over this next year, as there are significant shortages of Anesthesiologists in our area with positions open in private practice.

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

Under current Medicare regulations, teaching surgeons and other teachers of "high risk" medical specialties are permitted to work with residents on overlapping cases so long as the teacher is present for critical or key portions of the procedure. The teaching surgeon may bill Medicare for full reimbursement for each of the two procedures, in which he or she was involved. I am asking for parity with surgeons in resident education reimbursement.

Anesthesiologists are also in a "high-risk" specialty. The Anesthesiology faculty members in our academic department work hard to teach residents and are also permitted to work with residents on overlapping cases so long as they are present for critical or key portions of the procedure and immediately available during the other portions of the procedure. However, unlike teaching surgeons, 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 has had a significant financial impact on our program. Our training program at MCG loses nearly one million a year as a result of the Clinton payment rule.

Your support for correcting this inequity will go a long way toward assuring the application of Medicare's teaching payment rules consistently across all complex or high-risk specialties and toward assuring that anesthesiology teaching is reimbursed on par with reimbursement for surgery and other high-risk specialty teaching.

Thank you for your consideration,

C. Alvin Head, MD
Professor and Chair of Anesthesiology & Perioperative Medicine
Medical College of Georgia

C: American Association of Anesthesiologists

August 20, 2005

44

AUG 2 2 2005

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

RE: GPCI's

Dear Sirs:

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

I fully support the CMS proposed to create a new locality for Sonoma County and to establish a new geographic adjustment factor that recognizes the cost of practice here. I want my Dr. to be fairly compensated so he can remain in practice here and be available when I need to see him.

Thorm Klay.
1927 E. Foothill Dr.
Santa Rosa, Ca
95404

Date 8/14/05

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

Re: File Code CMS 1502-P

Issue Identifier: GPCI's/Payment Localities

Dear Sirs,

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

Sincerely,

AUG 29 2005

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

Re: GPCIs

To Whom It May Concern,

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

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

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

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

Sincerely,

Kathleen Chamberlain
1860 Via Pacifica Gardens
apt. 1204
Aptos, CA 95003-5873

603 Miramar Dr.
Santa Cruz, CA

AUG 29 2005

Aug. 20, 2005

Department of Health and Social Services
Center for Medicare and Medical Services
CMS-1502-P
Washington,
Baltimore, Maryland

Dear Sir,

We are on Medicare. Santa Cruz and other communities Cities that you have as being Rural are no longer Rural. The Cost of Housing and Cost of living is greater in Santa Cru than in Urban City areas you ha e classified as Urban.

This means that doctors in Santa Cruz, get 25 percent less reimburse ent for Medicare patients than in your so called Urban areas. This iswrong.

Santa Cruz loses good doctors. Good do tors can not afford to come to Santa Cruz. Worse of all, doctors will ha e to stop accepting Medicare from patients or make it difficult to find doctors who will accept people on Medicare as patients.

Please do what is right .

Sincerely,

Kay Trebbien

49

AUG 29 2005

Please make
Capitola, Santa Cruz
an Urban district
instead of a
rural district.

Mary Emma John

50

AUG 29 2005

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

Re: GPCIs

To Whom It May Concern,

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

There has been a problem for many years with the method by which you pay physicians in the SF Bay Area. Two of the ten counties in this metropolitan area are paid at rural California rates. We understand that this proposed rule corrects this inequity.

We applaud you for addressing this problem.

Sincerely,

DPT

Jennifer Jaeger

AUG 29 2005

August 23, 2005

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

Re: File Code CMS1502-P - Issue Identifier: GPCIs / Payment Localities

To whom it may concern:

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

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

Thank you for your support.

Sincerely,

Isabella Gordon Hughes

Isabella Gordon Hughes
1672 Aptos Creek Road
Aptos CA 95003
831 688 7147

August 20, 2005

Center for Medicare & Medicaid Services -

I am an 84 yr old who has lived in Santa Cruz County since 1964. The county has grown to over 250,000 Residents - my Doctors deserve to have more medicare payments - the medium price of a home here is about $800,000.00. Doctors are leaving or not taking new patients - we are not a rural county -

Thank you

Margaret Ogle
270 Hames Rd. # 42
Watsonville, Ca. 95076

the Community Foundation *of* Santa Cruz County

2425 Porter Street, Suite 17, Soquel, CA 95073
(831) 477-0800 (831) 477-0991 *fax* www.cfscc.org

AUG 29 2005

August 23, 2005

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

Re: File Code CMS-1502-P

Issue Identifier: GPCI's/Payment Localities

To Whom It May Concern:

I am writing on behalf of the Board of Directors of the Community Foundation of Santa Cruz County. Our foundation serves the needs of the residents of Santa Cruz County. We have been an active participant in our county's Health Improvement Partnership, and are aware of the acute problem created by physician reimbursement under the Medicare program.

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

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

Sincerely,

Lance Linares
Executive Director

AUG 29 2005

Docket Management Comment Form

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

Review Comment Submissions

Submitter: Ms. Phyllis Swan

Organization: Ms. Phyllis Swan

Category: Individual

Issue Areas/Responses

General Modify

I strongly recommend the adoption that Santa Cruz County be changed to an urban designation because it obviously is an urban area When you drive around and check housing, gas and other expenses.

Attachments Thank you! We can't keep losing good doctors!!!!

No Attachments

It is so hard to find a Dr, no matter what your age is!!!

Phyllis Swan

You may attach an optional file with your comment. (No .exe or .zip files will be accepted). Select correct file type to ensure file will be accepted in correct format.

You must click the yellow "Attach File" button in order to complete attachment process.

Attachment: Browse...

File Type:

Attach File

REMINDER: Your submitted comments and name will become part of the public record and may be posted to the Agency web site.

Save Comments | Cancel/Exit

Modify - Make changes to a comment
Save Comments - Save the comment and proceed to View/Print
Cancel/Exit - Abandon the comment and leave the application

August 23, 2005

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

RE: File Code CMS 1502-P

Issue Identifier GPCI's/Payment Localities

Dear Sirs:

I strongly support your proposed change to the physician payment localities in California, which is stated on Page 92 in your recently published Revisions to Payment Policies Under the Physician Fee Schedule for Calendar Year 2006. This refers to your proposal to move Santa Cruz and Sonoma Counties from Locality 99 to their own unique localities. As you know, the cost of medical practice here in Santa Cruz County is more than 10% above the average cost of medical practice in Locality 99. Because of the relatively low rate of Medicare reimbursement, it is difficult to recruit new physicians and to retain established physicians in this area. Especially since our neighbor, Santa Clara County, has a 24% higher reimbursement rate for the same medical services, luring physicians to move to that area.

Your proposed change appropriately addresses this payment imbalance and will help develop an adequate physician base in our area. This will improve access to health care services for all people, especially the senior population, of which I am a member. In fact, some of my senior friends have had difficulty finding a physician in Santa Cruz who will take them on as Medicare patients.

I applaud your recommendation to correct this long-standing inequality.

Sincerely,

Shirley Thielk

Shirley Thielk
326 Gault Street, #E
Santa Cruz, CA 95062

AUG 29 2005 56

SURINDER KUMAR, M.D., F.A.C.P.
MARITINA S. RODRIGUEZ, M.D.
DIPLOMATES AMERICAN BOARD OF NEPHROLOGY AND INTERNAL MEDICINE

1595 SOQUEL DR., SUITE 210
SANTA CRUZ, CA 95065
(831) 476-1551
FAX (831) 476-3241

40 PENNY LANE
WATSONVILLE, CA 95076
(831) 724-6676

August 15, 2005

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

RE: File Code CMS-1502-P
Issue Identifier: GPCI's/ Payment localities

I am writing to comment on the proposed rules governing physician fee schedule for calendar year 2006 published in the Federal Register this summer. I **strongly support** the proposed rules changes regarding physician payment locality revisions in California involving Santa Cruz and Sonoma Counties because they correct inadequacies in reimbursement to these two counties, both of which currently remain in Locality 99 even though their GAF's have exceeded the 5% threshold(105% rule) over the national 1.000 average.

In particular, the County of Santa Cruz, when broken out from Locality 99, would otherwise reflect a 1.125% GAF. The boundary payment difference between Santa Cruz and its neighboring County of Santa Clara(Locality 9) is a whopping 25.1% for the same medical service. The status quo is unfair and discriminatory to the citizens of Santa Cruz.

Access to medical care suffers because Santa Cruz remains in Locality 99. The imbalance between physician reimbursement and geographic practice costs has many serious health consequences for us. Physicians are leaving the area, retiring early or moving away. It is difficult to recruit new physicians to replace those who die, retire, or relocate. Those new physicians who do come here usually stay only 1-2 years before moving to other parts of the state or country where they can afford to live and work. Medicare recipients then have immense difficulty finding new doctors because few primary care physicians can afford to take on new Medicare patients. When patients do not have primary care doctors, they have to use our overcrowded emergency rooms for primary care. Many more patients are admitted to the hospital for acute and severe medical diseases that might have been prevented or managed as outpatients. Furthermore, sometimes critically ill patients must be transported out of our county altogether because the hospitals do not have the necessary medical specialists on staff for emergencies.

During my working career, I have paid all required taxes, and as a citizen living in Santa Cruz County, I deserve the same access to quality health care as those residents of Santa Clara. I vigorously applaud CMS in taking action now to correct this unfair situation, which has existed far too long. Placing Santa Cruz in a separate Locality with physician reimbursements appropriate to the current geographic practice costs is the right thing to do.

Thank you for your efforts to create an equitable solution in 2006.

Sincerely yours,

MARITINA S. RODRIGUEZ, M.D.

AUG 29 2005

SURINDER KUMAR, M.D., F.A.C.P.
MARITINA S. RODRIGUEZ, M.D.
DIPLOMATES AMERICAN BOARD OF NEPHROLOGY AND INTERNAL MEDICINE

1595 SOQUEL DR., SUITE 210
SANTA CRUZ, CA 95065
(831) 476-1551
FAX (831) 476-3241

40 PENNY LANE
WATSONVILLE, CA 95076
(831) 724-6676

August 15, 2005

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

RE: File Code CMS-1502-P
Issue Identifier: GPCI's/ Payment localities

I am writing to comment on the proposed rules governing physician fee schedule for calendar year 2006 published in the Federal Register this summer. I **strongly support** the proposed rules changes regarding physician payment locality revisions in California involving Santa Cruz and Sonoma Counties because they correct inadequacies in reimbursement to these two counties, both of which currently remain in Locality 99 even though their GAF's have exceeded the 5% threshold(105% rule) over the national 1.000 average.

In particular, the County of Santa Cruz, when broken out from Locality 99, would otherwise reflect a 1.125% GAF. The boundary payment difference between Santa Cruz and its neighboring County of Santa Clara(Locality 9) is a whopping 25.1% for the same medical service. The status quo is unfair and discriminatory to the citizens of Santa Cruz.

Access to medical care suffers because Santa Cruz remains in Locality 99. The imbalance between physician reimbursement and geographic practice costs has many serious health consequences for us. Physicians are leaving the area, retiring early or moving away. It is difficult to recruit new physicians to replace those who die, retire, or relocate. Those new physicians who do come here usually stay only 1-2 years before moving to other parts of the state or country where they can afford to live and work. Medicare recipients then have immense difficulty finding new doctors because few primary care physicians can afford to take on new Medicare patients. When patients do not have primary care doctors, they have to use our overcrowded emergency rooms for primary care. Many more patients are admitted to the hospital for acute and severe medical diseases that might have been prevented or managed as outpatients. Furthermore, sometimes critically ill patients must be transported out of our county altogether because the hospitals do not have the necessary medical specialists on staff for emergencies.

During my working career, I have paid all required taxes, and as a citizen living in Santa Cruz County, I deserve the same access to quality health care as those residents of Santa Clara. I vigorously applaud CMS in taking action now to correct this unfair situation, which has existed far too long. Placing Santa Cruz in a separate Locality with physician reimbursements appropriate to the current geographic practice costs is the right thing to do.

Thank you for your efforts to create an equitable solution in 2006.

Sincerely yours,

SURINDER KUMAR, M.D.

58

August 23, 2005

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

Re: File Code CMS1502-P - Issue Identifier: GPCIs / Payment Localities

To whom it may concern:

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

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

Thank you for your support.

Sincerely,

Daphne Morrissey

Daphne Morrissey
560 30th Ave. #33
Santa Cruz, CA 95062

AUG 29 59

August 15, 2005

Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1502-P
P.O. Box 8017
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RE: File Code CMS-1502-P
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Thank you for your efforts to create an equitable solution in 2006.

Sincerely yours,

Dennis K. Krause

60

AUG 29

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

Re: GPCIs

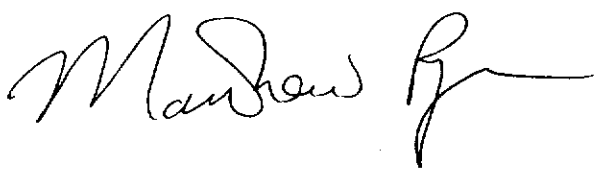
To Whom It May Concern,

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

There has been a problem for many years with the method by which you pay physicians in the SF Bay Area. Two of the ten counties in this metropolitan area are paid at rural California rates. We understand that this proposed rule corrects this inequity.

We applaud you for addressing this problem.

Sincerely,



AUG 29

August 15, 2005

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Department of Health and Human Services
Attention: CMS-1502-P
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Thank you for your efforts to create an equitable solution in 2006.

Sincerely yours, JULIE SKILTON

Julie Skilton

8 Dick Phelps Rd.
Watsonville, Ca.
95076

AUG 29

August 15, 2005

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Department of Health and Human Services
Attention: CMS-1502-P
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Thank you for your efforts to create an equitable solution in 2006.

Sincerely yours,

SHANNON M. SULLIVAN
8 DICK PHELPS ROAD
WATSONVILLE, CA 95076

AUG 2 9

August 15, 2005

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

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Thank you for your efforts to create an equitable solution in 2006.

Sincerely yours,

Michelle LeClair
710 Del Valle Dr.
Aptos, Ca. 95003

64

AUG 2 9

August 15, 2005

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

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Thank you for your efforts to create an equitable solution in 2006.

Sincerely yours,

Patricia McClain
710 Del Valle Dr.
Aptos, Ca. 95003

AUG 29 2005

August 15, 2005

Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1502-P
P.O. Box 8017
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RE: File Code CMS-1502-P
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Thank you for your efforts to create an equitable solution in 2006.

Sincerely yours,

Greg Scott

Greg Scott, D.C.
710 Del Valle Dr.
Aptos, Ca. 95003

AUG 29 2005

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

Re: GPCI

To Whom It May Concern:

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

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

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

CMS acknowledges that they have the responsibility to manage physician payment localities. We understand that there have been not been revisions to the localities since 1996. You have selected the most important area in our state to begin to correct this problem.

Sincerely,

Marguerite Tuchardt
1635 Tremont Dr. Apt 223
Santa Cruz, Ca 95062

AUG 29 2005

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

Re: GPCI

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Sincerely,

Bill Lewis
122 Robinson Ln.
Santa Cruz, CA 95060

Thomas Schmida, MD
200 Huntington Court
Aptos, CA 95003

August 19, 2005

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

Re: File Code CMS 1502-P

Issue Identifier: GPCI's/Payment Localities

Dear Sirs:

I am a retired physician, having practiced in Santa Cruz County for 40 years, so I have personally experienced the low reimbursement that we have had for Medicare and Medicaid.

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

Sincerely:

Thomas Schmida, MD

AUG 29 2005

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

Frank W. Rosten,
119 Oak Lane, #2,
Scotts Valley, CA 95066

August 19th '05

Re: GPCIs

To Whom It May Concern,

We are most grateful that revisions to the physician payment localities in California have been published in the reference rule, a move we most strongly support.

The two most problematic counties in the State of California, viz. Santa Cruz and Sonoma are surrounded by Bay Area counties with the highest level of Medicare payments to medical practitioners. While the cost of living in Santa Cruz county has skyrocketed in recent years, to the point where we are losing physicians to these adjacent counties, Santa Cruz has continued to be classified as a locality 99 county with consequent low reimbursement rates. We strongly support and encourage your efforts to rectify this situation in the interests of fairness and your proposed adjustments appropriately address the current inequitable payment problem.

As far as we are informed, CMS, while acknowledging its responsibility to manage Medicare reimbursement rates to medical practitioners' localities, has made no adjustments since 1996. This seems to be the case notwithstanding that Geographic Patient/Cost Indexes, (GPCI), have been determined from time to time but the GAFs have not been adjusted accordingly.

We endorse your efforts to rectify this imbalance by selecting the most important county in California, viz. Santa Cruz, to begin this effort.

Yours truly,

Frank Rosten,

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

Re: GPCI

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Sincerely,

JERROLD C. KARGER
416 SOQUEL AVE.
SANTA CRUZ, CALIF 95062

AUG 29

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

Docket: CMS-1502-P – Revisions to Payment Policies under the Physician Fee Schedule for Calendar Year 2006

I am a senior and read in the paper this morning that doctors in Santa Cruz area are paid 50% of their costs per patients by Medicare, where Santa Clara Valley doctors are paid 55%. It is important to realize that the cost of living here in Santa Cruz is the same or more (housing costs are higher) than Santa Clara Valley. I care about this since we lose young doctors from our system because they cannot afford to live in this area. As our older established doctors move on to retirement, we need good quality young doctors as replacements. Our older citizens (and there are many) need to have the same care available to them as those in other areas.

Sincerely

Gloria Lombardi Lester

555-16-6237

Help!

AUG 2 9 72

PAJARO VALLEY UNIFIED SCHOOL DISTRICT

OFFICE OF THE
SUPERINTENDENT

Mary Anne H. Mays, Ed. D.
Superintendent

August 22, 2005

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

To Whom It May Concern:

Santa Cruz California has had the greatest Physician cost/payment mismatch in the state for nine years. There is a 25% difference between Santa Cruz, CA and Santa Clara, CA counties. The result has been an exodus of physicians and increasing access problems for our seniors. We desperately need your help to support our Medicare patients and our medical community.

Please enact the proposed adjustment for Santa Cruz County.

Sincerely,

Dr. Mary Anne Mays

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

August 17, 2005

To Whom It May Concern:

I'm writing in regard to the low Medicare payments that are sent to physicians in Santa Cruz, California. Because Santa Cruz is classed as rural, few primary-care doctors accept new Medicare patients. My sister had terminal cancer and moved from the Bay Area to be near her children. We found an oncologist that accepted Medicare, but finding a primary-care physician that would accept a new Medicare patient was another story.

Having AARP as her supplemental insurance made no difference. Because we could not find a primary-care physician, the oncologist had to try and be the primary-care physician too. It was a heartrending time and not having a primary-care physician added to the pain.

I can't understand why your center thinks of Santa Cruz as rural. I can't understand why this hasn't been rectified. I can't understand why there's even debate about this issue. It's a discrepancy---fix it. If no one in your department has not heard of Santa Cruz, let me tell you--- it's not rural. Santa Cruz is congested, with house prices the third highest in the nation. During commute times, the cars are bumper to bumper on the freeway. A little beach city it is not. Santa Cruz is an extension of the Bay Area/Silicon Valley.

Being able to find a primary-care physician wouldn't have changed my sister's impending death, but being able to find a primary-care physician at the beginning of her illness would have caused less stress for everyone.

Please, please, take that rural rating off of Santa Cruz Co. It's a blemish to our senior citizens that need to find qualified doctors when they are ill. What good does it do to have Medicare if hardly any doctors accept it?

Linda Lillehaugen

Linda Lillehaugen
909 Aloha Lane
Santa Cruz, Calif 95062

August 15, 2005

14

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

AUG 29 2005

RE: File Code CMS-1502-P
Issue Identifier: GPCI's/ Payment localities

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Thank you for your efforts to create an equitable solution in 2006.

Sincerely yours,

Mrs. Catherine C. Lenox
210 Old Graham Hill Rd.
Santa Cruz, CA, 95060

(One of my neighbors sent this sheet of information to me. I am now 84 years old, and I have had excellent medical care in Santa Cruz. The concern is that young doctors can't afford current prices. I moved here years ago when Santa Cruz was affordable. Now I stay, by renting some of the rooms in my house.) Young people can't afford housing.

Date: August 23, 2005

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1502-P
P. O. Box 8017
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Re. File Code CMS1502-P

Issue Identifier: GPCI's / Payment Localities

Dear Sirs:

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

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

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

Sincerely,

Majel Jordan

August 24, 2005

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

Re: GCPI

Santa Cruz County must have a new rating for MediCare and MediCal patients. It is no longer sensible to have a rural rating with the growth and extremely high cost of living in this area. We need to have our doctors stay here to enable all of us to have the needed medical care. Young doctors often cannot afford to buy homes for their families and therefore must move to other areas.

I am a senior citizen and have lived in this area for 20 years, moving here from Los Angeles. When I came here the traffic, both on surface streets and the freeway, was a pleasant change from that in Los Angeles. Now it is very much like what we left in Los Angeles. And the house we bought here for $175,000 would now be listed for over $810,000!

It's time for a change in the rating!

Irene Farlee

Mrs. Irene Farlee
5090 Chiquita Way
Soquel, CA 95073
831-479-0345

August 15, 2005

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

RE: File Code CMS-1502-P
Issue Identifier: GPCI's/ Payment localities

I am writing to comment on the proposed rules governing physician fee schedule for calendar year 2006 published in the Federal Register this summer. I **strongly support** the proposed rules changes regarding physician payment locality revisions in California involving Santa Cruz and Sonoma Counties because they correct inadequacies in reimbursement to these two counties, both of which currently remain in Locality 99 even though their GAF's have exceeded the 5% threshold(105% rule) over the national 1.000 average.

In particular, the County of Santa Cruz, when broken out from Locality 99, would otherwise reflect a 1.125% GAF. The boundary payment difference between Santa Cruz and its neighboring County of Santa Clara(Locality 9) is a whopping 25.1% for the same medical service. The status quo is unfair and discriminatory to the citizens of Santa Cruz.

Access to medical care suffers because Santa Cruz remains in Locality 99. The imbalance between physician reimbursement and geographic practice costs has many serious health consequences for us. Physicians are leaving the area, retiring early or moving away. It is difficult to recruit new physicians to replace those who die, retire, or relocate. Those new physicians who do come here usually stay only 1-2 years before moving to other parts of the state or country where they can afford to live and work. Medicare recipients then have immense difficulty finding new doctors because few primary care physicians can afford to take on new Medicare patients. When patients do not have primary care doctors, they have to use our overcrowded emergency rooms for primary care. Many more patients are admitted to the hospital for acute and severe medical diseases that might have been prevented or managed as outpatients. Furthermore, sometimes critically ill patients must be transported out of our county altogether because the hospitals do not have the necessary medical specialists on staff for emergencies.

During my working career, I have paid all required taxes, and as a citizen living in Santa Cruz County, I deserve the same access to quality health care as those residents of Santa Clara. I vigorously applaud CMS in taking action now to correct this unfair situation, which has existed far too long. Placing Santa Cruz in a separate Locality with physician reimbursements appropriate to the current geographic practice costs is the right thing to do.

Thank you for your efforts to create an equitable solution in 2006.

Sincerely yours,

Myra J. Morris

Mrs Myra J Morris
200 Old Graham Hill Rd
Santa Cruz CA 95060-1427

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

Docket: CMS-1502-P – Revisions to Payment Policies under the Physician Fee Schedule for Calendar Year 2006

I am a senior and read in the paper this morning that doctors in Santa Cruz area are paid 50% of their costs per patients by Medicare, where Santa Clara Valley doctors are paid 55%. It is important to realize that the cost of living here in Santa Cruz is the same or more (housing costs are higher) than Santa Clara Valley. I care about this since we lose young doctors from our system because they cannot afford to live in this area. As our older established doctors move on to retirement, we need good quality young doctors as replacements. Our older citizens (and there are many) need to have the same care available to them as those in other areas.

Sincerely

8/24/05

Date: 9/23/2005

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

Re: GPCIs

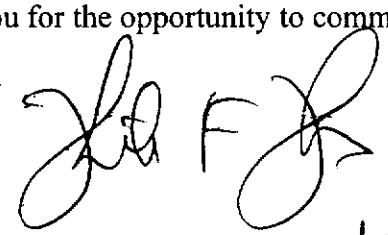
As a physician practicing medicine in Sonoma County, California, I strongly support your proposal to create a new payment locality for Sonoma County. The new locality would lessen the disparity between practice expenses and Medicare reimbursements.

This disparity has adversely affected our local health care system for several years. In many cases, Medicare reimbursements don't cover expenses, and a significant number of local physicians have stopped taking Medicare patients or have simply left the county. The disparity has also hampered efforts to recruit new physicians to Sonoma County.

By creating a new payment locality for Sonoma County, you will help ensure the viability of physician practices in the county and will improve access to care for local Medicare beneficiaries. Your proposal will correct existing payment inequities and will help you achieve your goal of reimbursing physicians based on the cost of practice in their locality.

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

Sincerely



Name: Keith Korwon, MD
Office Address: 3536 Mendocino Ave, #200
City, State, ZIP S. Rosa, CA 95403

cc: Two copies attached.

 80

August, 2005

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

Re: **File Code CMS-1502-P**

Issue: GPCIs / Payment Locality / Oppose Proposed Rule Change

To Whom It May Concern:

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

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

I am also concerned that no where in the proposed rule is it mentioned that this "two-county fix" is the beginning of a greater effort to move all counties in the state and nation into payment localities that truly reflect their respective costs of providing medical services.

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

Sincerely,

C. Krishna

Chandrika Krishna, M.D.
Monterey, CA

AUG 29

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

Re: GPCIs

To Whom It May Concern,

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

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

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

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

Sincerely, Suzanne, Reaption Desk, Santa Cruz medical Foundation,

82

AUG 2 9 2005

Santa Cruz Medical Foundation

A Sutter Health Affiliate

2025 Soquel Avenue
Santa Cruz, CA 95062

August 23, 2005

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

To Whom It May Concern:

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

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

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

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

I understand that CMS is interested in the opinion of the California Medical Association as it pertains to this proposed rule. I am a practicing Physician Assistant in Santa Cruz County. While the opinion of the state medical association is important, it does not represent many of the health professionals who care for Medicare beneficiaries. CMS should implement this rule because it is the right thing to do for all health care professionals and Medicare beneficiaries in California.

Sincerely,

Lucas Stang

Lucas Stang, PA-C

Date August 24, 2005

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

Re: File Code CMS 1502-P

Issue Identifier: GPCI's/Payment Localities

Dear Sirs,

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

Sincerely,

John J Houston

84

AUG 29

August 23, 2005

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

RE: File Code CMS 1502-P

Issue Identifier: GPCI's/Payment Localities

Dear Sirs:

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

Sincerely,

Sister Maureen Keeler, OP

3057 Salisbury Drive
Santa Cruz, CA 95065

AUG 29

Shelly Young
24694 Dolores St.
Carmel, CA 93923

August 22, 2005

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

Re: File Code CMS1502-P - Issue Identifier: GPCIs / Payment Localities

To whom it may concern:

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

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

Sincerely,

Shelly Young

August 23, 2005

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

Re. File Code CMS1502-P

Issue Identifier: GPCI's / Payment Localities

Dear Sirs:

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

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

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

Sincerely,

Francie Newfield

Francie Newfield
5341 Glen Haven Rd.
Soquel, CA 95073

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

Re: GPCIs

To Whom It May Concern,

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

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

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

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

Sincerely,

Julie M Connell

88

AUG 29 2005

Date: August 22, 2005

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

Re: GPCIs

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

This disparity has adversely affected our local health care system for several years. In many cases, Medicare reimbursements don't cover expenses, and a significant number of local physicians have stopped taking Medicare patients or have simply left the county. The disparity has also hampered efforts to recruit new physicians to Sonoma County.

By creating a new payment locality for Sonoma County, you will help ensure the viability of physician practices in the county and will improve access to care for local Medicare beneficiaries. Your proposal will correct existing payment inequities and will help you achieve your goal of reimbursing physicians based on the cost of practice in their locality.

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

Sincerely

Fred C. David MD

Fred C David, MD
121 Sotoyome St
Santa Rosa, CA 95405

cc: Two copies attached.

Date: August 22, 2005

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

Re: GPCIs

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

This disparity has adversely affected our local health care system for several years. In many cases, Medicare reimbursements don't cover expenses, and a significant number of local physicians have stopped taking Medicare patients or have simply left the county. The disparity has also hampered efforts to recruit new physicians to Sonoma County.

By creating a new payment locality for Sonoma County, you will help ensure the viability of physician practices in the county and will improve access to care for local Medicare beneficiaries. Your proposal will correct existing payment inequities and will help you achieve your goal of reimbursing physicians based on the cost of practice in their locality.

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

Sincerely

William P. Meseroll, M.D.

William P. Meseroll, M.D., F.A.C.R.
121 Sotoyome Street
Santa Rosa, California, 95405

AUG 29 2005

August, 2005

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

Re: **File Code CMS-1502-P**

Issue: GPCIs / Payment Locality / Oppose Proposed Rule Change

To Whom It May Concern:

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

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

I am also concerned that no where in the proposed rule is it mentioned that this "two-county fix" is the beginning of a greater effort to move all counties in the state and nation into payment localities that truly reflect their respective costs of providing medical services.

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

Sincerely,

Jerry Ginsburg, M.D.
Monterey County, CA

AUG 2 3

603 Miramar Dr.
Santa Cruz, CA 95060

Aug. 20, 2005

Center for Medicare & Medicaid
Dept of Health & Human Services

Attn CMS-1502-P
P.O. Box 8017
Baltimore, MD ~~8501~~ 21244-8017

Dear Sirs:

The cost of housing and living in our Santa Cruz, CA. town is one of the highest in the state. We have grown, and we are an urban area, not a rural area for determining medicare payments to our local doctors. We need our doctors; 15% of people here are on medicare.

Please declare Santa Cruz, CA an URBAN area.

Sincerely.

Jeanne M Trebbien

AUG 2 · 92

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

Re: GPCI

To Whom It May Concern:

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

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

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

CMS acknowledges that they have the responsibility to manage physician payment localities. We understand that there have been not been revisions to the localities since 1996. You have selected the most important area in our state to begin to correct this problem.

Sincerely, Jill Ginsburg

Jill Ginsburg
1864 16th Av
Santa Cruz CA 95062

Greg : Stephanie Mahoc
1800 Lotman Dr.
Santa Cruz, CA 95062

August 22, 2005

Center for Medicare/
Medicaid Services

Dept. of Health : Human
Services

When we moved to Santa Cruz in 1974 the population was 14,000. In 2005 the population is 60,000 : growing. We have seen home prices quadruple along with the exodus of families : blue collar workers unable to afford to own a home and live in Santa Cruz.

Physicians too are leaving at an alarming rate. This last year alone our family lost 4 doctors. They cannot afford to stay with the poor medicare reimbursements. Many have been refusing to take on medicare patients. With the influx of population, increase in building of homes, loss of open space our status should be changed from rural to urban. It costs more to live here than San Jose (classified as urban)

As Baby Boomers approach retirement it is imperative to receive medical care in our community, with our established physicians.

Sincerely,

Greg Mahon : Stephanie Mahone

August 10, 2005

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

Dear Colleagues,

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

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

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

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

Sincerely,

Ethan Berry
Signature

Print name: Ethan Berry

Street address: 13624 SE 97th Avenue

City/State/ Zip: Clackamas, OR 97015

AUG 29

Date 8-19-05

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

Re: File Code CMS 1502-P

Issue Identifier: GPCI's/Payment Localities

Dear Sirs,

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

Sincerely, Nicholas Niven

This is WAY overdue! Thanks

NICHOLAS NIVEN, M.D.
1595 Soquel Drive, Suite 350
Santa Cruz, CA 95065

AUG 29

Date: 8/22/05

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

Re: GPCIs

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

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

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

Sincerely,

Fred C. David

Name: FRED DAVID
Address: 2525 BRUSH CREEK RD
City, State, ZIP SANTA ROSA, CA. 95405

cc: Two copies attached

LOMAK
Property Group, Inc.

820 Bay Avenue, Suite 220

Capitola, California 95010

AUG 2 9

August 22, 2005

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

Re: Physician Payments Santa Cruz County, California
GPCIs

Center for Medicare and Medicaid Services:

I have enclosed a portion of yesterday's real estate section from our local paper. Note that the week's "Featured Property" is a 292 square foot "house" on a 400 square foot lot listed for $499,000. Other houses of average size and condition are listed at prices ranging from the mid $600,000's to well over $1,000,000. These housing prices are just one indication of how extraordinarily expensive it has become to live and work in the greater Silicon Valley.

Thank you for doing all that you can to adjust payments to local physicians to more accurately reflect the true cost of living in our community.

Sincerely,

Doug Kaplan
Lomak Property Group

DK/dh

Enclosure

Phone: 831.476.3627

Fax: 831.462.0333

Web: www.lomakpropertygroup.com

NORTH SONOMA COUNTY
HOSPITAL DISTRICT
Quality, Compassionate Care

AUG 2 3

August 24, 2004

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

Re: GPCIs

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

This disparity has affected our local healthcare system for many years. I have seen many physicians leave Sonoma County to relocate in others areas that have a higher Medicare reimbursement rate. We cannot recruit new doctors because of the high cost of living and low Medicare reimbursement rates. The Hospital has a Physician Referral Program for new residents looking for a doctor, and most local physicians will not accept any new Medicare patients because of the reimbursement rates.

By creating a new payment locality for Sonoma County, you will help ensure the viability of physician's practices in the County and will improve assess to care for local Medicare beneficiaries. Your proposal will correct existing payment inequities and will help us achieve your goal of reimbursing physicians based on the cost of practice in their locality.

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

Sincerely,

Dale Iversen
Chief Executive Officer

Enclosure - Two copies of letter

1375 University Avenue • Healdsburg, CA 95448 • Phone: 707.431.6500 • Facsimile: 707.431.6588

GPCIs

8/22/05

Dear Sirs,

My wife and I are moving to Santa Cruz County California in November and are concerned about the ability to find a doctor who will take us as new patients since we are both medicare patients.

We understand that Santa Cruz County has been designated as rural and physicians accepting Medicare patients are now paid considerably less than those with an urban designation. It would help us to get accepted as new patients if Santa Cruz County would get an urban designation so doctors would be paid more fairly.

Thank you very much

John Beisner
Charlene Beisner
315 Vinings Dr.
Bloomingdale, IL
60108

To the Dept of Health and Human Services

We feel it is past time Santa Cruz, County California be classified urban instead instead of rural.

As it is no Internal Medicine doctor will accept new medicare patents.

This needs to be changed Please see that it is.

Margaret Schuckraft
George Schuckraft
Aptos, S.C. County

August 23, 2005