Submitter : Mr. Rolando Rangel **Date:** 01/14/2007

Organization : self

Category : Congressional

Issue Areas/Comments

GENERAL

GENERAL

CURRENTLY IN THE STATE OF FLORIDA MEDICAID BENEFITS HAVE BEEN CUT DRASTICLY. I AM CONCERNED THAT THE PROPOSED CHANGES WILL FURTHER CRIPPLE FLORIDA'S MEDICAID PROGRAM. AS A VOTER I ASSURE YOU THAT SUPPORT OF THESE CHANGES WILL AFFECT MY FUTURE VOTES. SUPPORT FOR THESE CHANGES HURT LOWER INCOME PEOPLE AND PUNISH THE INNOCENT. PLEASE TAKE THESE PEOPLE INTO CONSIDERATION BEFORE SUPPORTING SUCH CHANGES.

I ASK THAT YOU FIND DIFFERENT OPTIONS TO ACHIEVE THE SAME RESULTS. THANK YOU.

Submitter : **Dr. gary wainer** **Date: 01/25/2007**

Organization : **MacNeal Hospital**

Category : **Physician**

Issue Areas/Comments

Background

Background

Medicare Graduate Medical Education (GME) payments to teaching hospitals. The proposal is included in a proposed rule titled Medicare Program; Prospective Payment System for Long Term Care Hospitals RY 2008

GENERAL

GENERAL

I belive that your requirement for hospitals to pay "volunteer" physicians has created significant burdens on the hospital and the teaching program: 1. the hospital must inquire of each voluntary physician what their financial arrangemnets within their practice is. While you have identified only two arrangemnst (straight salary without relation to patient productivity or pure productivity salary), in fact a plethora of compensation formulas exist running the gamut between these two extremes. Each phsyician signing an agreemnt with a hopsital to be a teacher would then need to disclose their financial arrangements within their practices and the hospital would be forced to deduce if they met compliance (what if you have a draw of salary, but year end total compensation is based on profit available to owners?) Most physicians would be unwilling to disclose this information and the exact strategy of pushing medical education into the community would fall flat on its face just based on this. 2. You also describe scenarios within which residents rotate full time at non-hospital entities. It is far more common for portions of training to occur at these sites; after we struggled over the interpretation hurdles described above, the facility would then need to include in its budget payment for the phsyicians; at a routine rate of $100 per hour, this will have significant negative financial impact on the facilities since they will more than likely not be able to absorb this additional cost. As a result they would minimize their exposure to voluntary physicians; 3.the voluntary medical staff who teach do this as a passion for teaching. While no one would trun away a fee for teaching residents, the honor and obligation to teach that many physicians feel would be abrogated in a mandatory paymnet mechanism.

Submitter : Ms. Emily Graham **Date:** 01/26/2007

Organization : Alliance of Specialty Medicine

Category : Health Care Professional or Association

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-6032-P-3-Attach-1.PDF

Alliance of Specialty Medicine
Sound Policy. Quality Care.

200,000 Physicians Strong

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202.863.2510

January 26, 2007

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-6032-P
P.O. Box 8020
Baltimore, MD 21244-8032

Re: Medicare Program; Use of Repayment Plans

Dear Ms. Norwalk:

Founded in 2001, the Alliance of Specialty Medicine (the Alliance) represents over 200,000 physicians in 11 medical specialty organizations and serves as a strong voice for specialty medicine. The Alliance is composed of a diverse mixture of organizations that represent non-surgical and surgical specialties, as well as hospital and office-based physicians.

The Alliance welcomes the opportunity to comment on the Centers for Medicare and Medicaid's proposed rule on Use of Repayment Plans (CMS-6032-P, Federal Register, Vol. 71, No. 227, November 27, 2006).

This proposed rule would modify Medicare regulations to implement a provision of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 pertaining to the use of repayment plans. We applaud CMS's willingness to grant a provider or a supplier an extended repayment schedule under specific circumstances and the effort to fairly define the concepts of "hardship" and "extreme hardship." Under the Tax Relief and Health Care Act of 2006, and the potential for the expansion of the Recovery Audit Contractor Demonstration project nationwide, as well as the expansion of other CMS Program Integrity programs, this proposed rule takes on even greater importance as providers and suppliers may become more subject to repayment of overpayments in the future. Of all providers that Medicare reimburses, however, we don't believe that physicians are a significant source of overpayments.

Overall, the Alliance supports to the proposed rule but has a few suggestions for improvements in the area of financial hardship. CMS is proposing that providers can get a minimum of six months to repay if the total amount of all outstanding overpayments equals 10 percent or greater of the total Medicare payments made for the period of the most recently submitted cost report or the previous calendar year. Although the 10% requirement for hardship is specified in the statute (MMA section 935), we believe that CMS should exercise some flexibility to allow use of a sliding-scale percentage so that the qualifying amount represents

a graduated burden based on the proportion of that physician's income represented by Medicare. This seems more equitable since 10% of total Medicare reimbursement for a specialist whose fee-for-service revenue is fifty percent Medicare is a much more significant amount than for a practice whose fee-for-service revenue from Medicare is only five percent of the total.

We are also concerned about the proposal to immediately collect on the entire overpayment under the automatic 6-month schedule if the provider misses one installment. This may actually encourage providers under an existing 6-month payment schedule to preemptively request an extended payment schedule if they are in fear of missing one payment. Such actions represent additional costs for both the provider and CMS in processing additional applications. It would be more consistent and easier to administer if CMS instead defined a default as missing two consecutive payments, as in the existing extended repayment arrangements.

Again, we appreciate the opportunity to comment on this proposed rule. Should you have any questions on our comments, please contact Emily L. Graham, RHIT, CCS-P, CPC, ASCRS Manager of Regulatory Affairs at egraham@ascrs.org or 703-591-2220, or Robin Hudson, MPA, AUA Senior Manager of Quality Improvement & Health Policy, at rhudson@auanet.org or 410-689-3762.

Sincerely,

American Academy of Dermatology Association
American Academy of Orthopaedic Surgeons
American Association of Neurological Surgeons
American Gastroenterological Association
American Society of Cataract and Refractive Surgeons
American Urological Association
American College of Emergency Medicine
American College of Obstetricians and Gynecologists
American Society for Therapeutic Radiology and Oncology
Congress of Neurological Surgeons
National Association of Spine Specialists