CENTERS FOR MEDICARE AND MEDICAID SERVICES

PRACTICING PHYSICIANS ADVISORY COUNCIL

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Room 705A
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Public Witnesses

AMA
[via written document]

MS. DANA TREVAS, Rapporteur
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A G E N D A

Morning

Open Meeting

Dr. Bufalino: Good morning and welcome. My name is Vince Bufalino, and I welcome you to the Practicing Physicians Advisory Council. This is the 68th Meeting of this august group, and we're glad to have all of you here in Washington. And I'd like to extend a warm welcome to my colleagues from around the country, and thank you for taking the time out of your schedules to join us in Washington. We look forward to the conversations today and also look forward to your input and opportunity to have your thoughtful contributions to today's agenda. As you know, the agenda is again, extensive. We have an opportunity to relook at Value-based Purchasing and the Physician Resource Use report, which we'll hear today, and a chance to begin providing some commentary around that. We are covering the Inpatient Prospective Payment System, Medicare Parts C and D, and Dr. Ross's favorite topic, the DME POS will be here as a discussion. Of course, we have Dr. Rogers here to talk about the PRIT as usual. And so we're looking forward to all those areas and hope to have all of you provide some comments today.

Let me begin by welcoming Jonathan Blum. Mr. Blum is the Director of the Center for Medicare Management, and we are thrilled to have him join us today. He is the beginning of the new era of folks that come to the table. We are still awaiting a number of positions to be filled, and so Mr. Blum has a number of jobs responsible for both, he's here's for CMM, but also the Acting Director of the Drug & Health Planned Choices, and that's an important area. Mr. Blum comes to us from his background at the Senate Finance Committee, advising Senator Bachus, and has been involved also with the OMB as an analyst for the White House, looking at Medicare related issues. His most recent job was with Avalere. Is that right? The health firm, overseeing Medicaid and long-term care policies. So we're thrilled to have you with us today and we know you have some prepared remarks, but we'd also love to ask you to extend into your small crystal ball of what do you think is coming since 2009 looks like a very exciting year in healthcare here in Washington. We'd love to have your insight as to where you think the world is going. Thank you.

Remarks: New Director of Center for Medicare Management

Mr. Blum: Thank you for having me here today. I want to thank the Council for coming into Washington, and I want to thank all the folks in the audience also as well. We have a very full agenda that I think is very timely with the overall health reform agenda that the President has laid out. The Congress right now is working on. And I said several times to the CMS staff and other forums, that health reform

really will happen if we can think about ways to reform the CMS payment systems to reform the CMS programs. The President's budget starts by thinking about cost containment and there's a very aggressive agenda to think about new payment system reforms for the Medicare program, thinking about new ways to pay for health plans in a more competitive environment, thinking about ways to bundle payment services, the hospital side, the post-acute care side, thinking about ways to promote more integrated care, more care coordination. Within the Medicare program, thinking about hospital readmissions policies, and to provide much more direct incentives on hospitals that think about ways to think about how to improve care, how to improve care management. The President has put out eight principles for how to think about health reform. I'm sure you're aware of; one) to protect financial health, to help folks avoid bankruptcy, a guaranteed choice of doctors and hospitals, thinking about ways to promote more prevention, wellness, and care, to improve patient safety, to assure affordable quality healthcare coverage for all Americans, and to end barriers to coverage for people that have pre-existing conditions. But these are just kind of health system changes. They start with CMS, they start with the Medicare program. And I really want to thank everybody for coming in today to help us think about ways to improve the programs. The President's budget, again, a very set agenda, very aggressive agenda that I think will be set this year by the Congress, but then take several years for CMS to implement, but really health reform is part and parcel to the programs here.

I also want to talk about some other priorities here at CMS that I think will be very active discussions for today's agenda, but I think for the next meetings. One is fraud and abuse. Secretary Sebelius and the Attorney General put out a statement a couple weeks ago, really trying to think about new ways for the two departments to work together to think about how to control fraud and abuse in the Medicare program. A lot of concerns about the budget, a lot of concerns about just the trust fund solvency, and both the Secretary, both the Attorney General made a new commitment to work together to think about fraud and abuse, and here at CMS, we're also thinking about way to promote better payment accuracy, to ensure benefits are paid correctly, to ensure that beneficiaries pay the right amount. For example, we're putting into place competitive bidding for durable medical equipment. CMS is required to take bids again, 2009, but really want to see it as a way to both improve quality, to improve payment accuracy, in a way that's right for beneficiaries, right for taxpayers, and right for the overall system. So beyond just a health reform debate happening in Congress, I expect CMS to have a very active agenda to think about payment

reform, to think about ways to improve the programs. We are very interested to set a new demonstration policy agenda, to think about new ways to test payment design changes that are happening, that are being discussed in the Congress. But that's going to start again here in CMS, so I see this agency having a very active agenda. So I'll stop there. Would love to go around the table just to hear folks' background, where you're from, and just to give a chance to kind of talk in person. So we'll start over the right side if you would mind just saying who you are, where you're from, and I'd love to get a chance just to interact in person.

Dr. Williams: My name is Karen Williams. I'm an anesthesiologist here in Washington at George Washington University. I've been in practice for more than 20 years. I'm very involved with the American Society of Anesthesiologists, and have been also a representative liaison with The American College of Surgeons. Because I work in an academic medical center, I'm very concerned about continuing training of medical students and residents and I guess I'm concerned about how the competitive process that may come out of all of this planning may result in potential decreased payments, since we're obviously looking at cost containment.

Dr. Standaert: Hi, I'm Chris Standaert. I am physiatrist, a specialist in physical medicine and rehabilitation in Seattle, Washington. I work for the University of Washington at Harbor View Medical Center, which is our Level One Trauma Center for the four-state region. Particularly, I do outpatient spine and musculoskeletal work. Strong clinical interest in spine care, advancing spine care on nonoperative musculoskeletal work again, I work with North American Spine Society a lot. And I'm on the Washington State Health Technology Clinical Committee looking at issues of technology assessment and coverage for the state, as well.

Dr. Sprang: Leroy Sprang. I'm a practicing obstetrician and gynecologist, and I'm a professor at Northwestern, but actually in private practice, and president of a group of 39 private practice obstetrician gynecologist, and very involved in organized medicine at every level, and I'll say my main interest is really kind of preserving the patient-physician relationship, and find that practice quality medicine with physicians and in patients have the most to say, but also in a value setting. And with our group, we do a lot of our procedures in the office, rather than in the hospital, which saves significant healthcare dollars and kind of just trying to perform the procedures in I'll say the setting that's safe, convenient, appropriate, and

the most cost-effective. So recognizing the importance of the dollars, but also wanting to emphasize the quality in the patient care.

Dr. Snow: I'm Art Snow. I'm a family physician, Kansas side of the Kansas City area. Family medicine trained. I'm doing primarily geriatrics at this point. I'm a solo practitioner. It's me, myself, and I in my practice and when you look at our state of Kansas, the majority of physicians practice in two- to four-physician groups in the rural areas. When you get into the metropolitan areas, obviously, there are large groups. And I think the cost containment efforts that we're looking for in this new health reform plan could very adversely affect small groups such as myself, and those providing most of the rural care across our country. So I'm very interested in how that impact is going to be alleviated through this so that we can continue to provide services.

Dr. Smith: I'm Frederica Smith. I'm a rheumatologist and internist in Los Alamos, New Mexico, and I've been in practice for coming up on 34 years now. And I'm in a small community. I serve the entire northern part of the State of New Mexico, as a rheumatologist, and no very well the shortage of primary care physicians and the difficulty that people are having economically with the limited resources available if we continue to put pressure on people with more reporting, more burdens, more time consumed. That means fewer hours for patient care, and so how that interplays with some of the proposals for cost containment in healthcare reform is a very big issue, I think, for all physicians in rural practice, as Dr. Snow was saying.

Dr. Siff: I'm Jon Siff. I'm an emergency medicine physician from Cleveland, Ohio. I work at Metro's Medical Center, which is the county hospital for northeastern Ohio, level one trauma center, which serves Cleveland and surrounding area. I serve a number of information technology and coding and billing groups for the American College of Emergency Physicians. I share many of the concerns my colleagues have already voiced, but particularly regarding maintaining the safety net, which emergency departments provide for patients, and ensuring fair payment for those physicians providing EMTALA-related mandated services, not just the emergency physicians, but the consultants whom we rely on help us with these patients.

Dr. Ross: I'm Jeff Ross, from Houston, Texas. I'm a practicing, solo practitioner in podiatric medicine and surgery. I also am an associate professor at the Bayla College of Medicine, where I'm Chief

of the Diabetic Foot Clinic at our county hospital. My specialty of both surgery, as well sports medicine and diabetic wound care. I'm also the Vice Chair of our state Department of Health Services Council, and the co-chair of our governor's Fitness Council. So my areas of interest are prevention, particularly with childhood obesity, the epidemic of type 2 diabetes, in our kids and how that's going to affect the healthcare system in the future, but particularly for the solo practitioner in podiatric medicine. I would say probably 80, 85% are in private solo practice. And my concerns are how those reimbursements are going to affect the private practitioner in the future, and the access to healthcare for the beneficiary.

Dr. Bufalino: Hi, I'm Vince Bufalino. I'm an interventional cardiologist. I run a 50-physician practice in suburban Chicago. Been very active with the American Heart Association nationally, and the Chair of the Efficacy Group for the American College of Cardiology. Our area of concern and I think I'd like to have an opportunity to participate in that discussion is the world of imaging and the fact that we have been very successful over my career in reducing the mortality from cardiovascular disease by almost 30% over that period of time, and it has because, it's partially because our ability to screen and detect early heart disease and get to these folks early. And so we'd like to make sure that in the next world, that wholesale cuts of imaging are not done indiscriminately, that opportunity for us to continue to screen and find early heart disease is at the forefront, since we can fix 95 out of 100 folks in this day and age, we just need a chance to get at these people, so that's my areas.

Dr. Ouzounian: I'm Tye Ouzounian. I'm an orthopedist. I'm in a solo private practice in Los Angeles. My expertise coming to this table has to do with physician work at the RUC, and more importantly Practice Expense at the RUC, which I worked on for about 10 years. I guess my interest here, selfishly, would be to preserve solo private practice, but I think I sit here representing 20,000 orthopedists in the interest to preserve orthopedic care, and make sure it's available for the population.

Dr. Kirsch: I'm Janice Kirsch. I'm a general internist [from Wisconsin? 14:59] City Iowa. I'm a hospital-employed physician. I'm very involved with the AMA, and also with our medical society. And as far as our medical society, one of our major concerns is geographic disparity in payment. We're very concerned about practice expense GPCIs that we feel inappropriately use apartment rentals to determine what our practice expenses are, strong concerns that there's geographic variation on things with fixed costs, such as ePrescribing, reimbursement, and such, and that's what you're going to see me advocating for.

Dr. Jordan: Roger Jordan from Gillette, Wyoming. I'm an optometrist. We have a group practice, four of us. I have been on the American Optometrist's Association's Federal Relation's committee for almost ten years and very involved politically for 25 years. And I think being a non MD, my concern is, representation wise, is to keep the access, I think of non MD care to patients across the country.

Dr. Howard: I'm Pam Howard. I am general surgery trained, and then I went into the military and trained in bone surgery at Brookline Medical Center. I just recently moved to Arkansas. I'm the only bone surgeon in the state right now, taking over 500 patients a year, including patients from other states. Some of the big concerns I have are a hospital-based employee. I'm not truly hospital employed; I'm actually through the university. But my patients are all within the hospital system. Some of the hospital-acquired incidents that we've talked about here in this meeting in the past and some of those things that I think, there are some concerns for those of us who practice in the hospital system that there are now pushes for some hospitals to get [liaison? 16:52] people when they come through the door, because of the response to some of these issues that have come to the table. So I think you'll hear me talk a little bit more about the hospitals that we see as far as reimbursements. And that's it.

Dr. Giaimo: My name is Joe Giaimo. I'm a pulmonologist from West Palm Beach, Florida. I'm in solo practice. I'm here representing the AOA, American Osteopathic Association. My concerns are mostly regarding access to care and certainly the ability of how that's going to affect solo practitioners and to be able to pay for graduate medical education programs, health information technology and those things. So a lot of the information that's out on the table is very germane to what I'm concerned about.

Dr. Arradondo: I'm John Arradondo from Nashville, Tennessee. Welcome to the CMS. I'm a Behavioral and Prevention-based Family Physician. I serve as a Medical Director for a small group practice. I'm past President of the Society of Teachers of Family Medicine, and past President of U.S. Conference of Local Health Officials, now the National Association of City and County Health Officers. I'm a past President and Chair of the Family Practice Section of the National Medical Association, and I currently serve on its Education Council. And I am interested in the role that an $800 billion entity can do in the healthcare system. I think it could be quite dynamic.

Dr. Bufalino: Thank you, John, thank you. Good chance to hear from everyone. Thank you for that opportunity. We'd also like to welcome Liz Richter. As you know, Liz is the Deputy Director of the Center

for Medicare and Medicaid Management. And we're thrilled to have her. She's that consistent player that is here every quarter and helps provide guidance for us. So thank you, Liz, for joining us.

So let's move on with the agenda. And we'll open up with Dr. Ken Simon, who's the Executive Director of PPAC, and Medical Officer here at the Center for Medicare Management. And an opportunity to Dr. Simon to present the responses from last time's PPAC recommendations.

PPAC Update

Dr. Simon: Good morning to the Council members, and thank you, Dr. Bufalino. I'll read the recommendations, as well as the CMS response from the March 9th meeting.

Agenda Item E, Value-based Purchasing Final Rule, Agenda Item 67E-1: PPAC recommends that in CMS's future planning for Value-based Purchasing programs, the following be included: one, measurement of physician participation and quality enhancement processes; two, recognition that a patient population socio-economic factors have an impact on achieving ideal patient outcome goals; three, recognition that a patient population's co-morbidity has an impact on achieving ideal patient outcome goals; four, continuation of the use of recognized reasonable consensus guidelines. The best source at present is the AMA Physician Consortium for Performance Improvement, commonly called the PCPI, and finally, an initiation of a discussion on enhancing patient education, activation, and motivation for participation and care. The CMS response: CMS appreciates PPAC's recommended principles for Medicare Value-based Purchasing programs. We believe that these principles are consistent with the goals, objectives, assumptions, and design principles presented for stakeholder comment in the physician and other professional Value-based Purchasing plan issues paper, which is also located on the CMS website. We plan to continue to base the development of the physician Value-based Purchasing plan on those principles.

Agenda Item 67E-2: PPAC recommends that in CMS's Value-based Purchasing programs, PCPI be recognized as the leading developer of physician level measures of quality. The CMS response: CMS has recognized that the Physician Consortium for Performance Improvement commonly called PCPI, as a leading developer of physician quality measures in our Value-based Purchasing programs to date. In fact, a majority of the measures that CMS has selected for the Physician Quality Reporting Initiative, commonly called the PQRI, have been developed by the PCPI.

Agenda Item 67E-3. PPAC recommends that in CMS's Value-based Purchasing programs, incentive payments be funded with new money, and that payments not be made on a budget neutral basis within the Medicare physician payment system. The CMS response: CMS is in the early stages of developing the physician Value-based Purchasing plan. No options have been precluded at this time. For example, the physician Value-based Purchasing plan issues paper presents the possibility of funding professional incentives out of savings for more efficient use of institutional care.

Agenda Item 67E-4. PPAC recommends to CMS that physicians and other providers involved in the treatment of a patient must have an opportunity for prior review and comment and the right to appeal with regard to any data that are part of public review process. Any such comments should also be included with any publicly reported data. The response: CMS is in the early stages of developing the Physician Value-based Purchasing plan, which will address both financial incentives and the nonfinancial incentive of public reporting. More specifically, the plan is expected to address the possibility of review, comment, and appeal of performance results, prior to use for payment or public reporting.

Agenda Item H, the Recovery Audit Program. 67H-1. Whenever a particular procedure or service has been questioned as unnecessary by a RAC after service has been delivered, all downstream services, including consultant services have been called into question. Request for repayment during the period of investigation has been made of consulting physicians, such as pathologists, radiologists, and anesthesiologists. These hospital-based specialists [winded? 23:32] their services in good faith in response to a request from another physician, and have no way of determining that the time that they are asked to participate in the care of a patient, whether the underlying procedure or service may be questioned or determined to be medically unnecessary by a RAC at some time in the future. Therefore, PPAC recommends that the RAC process be modified to exclude extenuating demands for repayment to subsequent consulting physicians for an index case for a particular surgery, procedure, or consultation. The CMS response: CMS appreciates the Council's concern that downstream practitioners not be held liable when an underlying precipitating service has been deemed not medically necessary or otherwise ineligible for payment. CMS staff are researching applicable statutes, regulations, policy statements, and precedents pertaining to this issue.

67H-2. PPAC recommends that the RACs only be allowed to request and review three records per physicians, per 45 days, regardless of whether the physician is a solo practitioner or part of a group of any size. The response: CMS has received a number of comments on the medical record request limits, which were set in an effort to minimize clinical burden while ensuring that the RACs have access to sufficient claims to carry out their CMS ordained mission. The requested limit of three records per clinician would potentially reduce the burden on solo practitioners and small group. We appreciate and share the desire to protect small practices from undue burden. We are committed to reviewing the medical record request limits annually and are considering several potential revisions for the fiscal year, starting in October 2009. The RACs have only recently begun receiving claims data and the first medical record request letters are unlikely to be sent out for several more weeks. To ensure that the RACs respect the request limits, CMS has developed a number of internal compliance reports. This information, as well as overall request volumes, will be included in our annual public report. We will closely monitor RAC activity, and will take the Council's recommendation under careful advisement.

67H-3. PPAC recommends that the RACs be required to reimburse providers for the cost of copies of requested medical records prior to commencement of a RAC audit. The CMS response: CMS will take this recommendation under advisement.

67H-4. PPAC recommends that CMS clarify for the RACs in writing that the 30-day deadline for filing an appeal should be flexible if there are extenuating circumstances, and that such information should be included in the RAC's letter to the provider. The CMS response: Physicians have the same appeal rights for a RAC initiated claim adjustment, as for any other Medicare adjustment. A request for redetermination must be filed within 120 days after the date of receipt of a notice of the initial determination. And the notice of initial determination is presumed to be received five days from the date of notice, unless there is evidence to the contrary. Following completion of RAC reviews, including a results letter of subsequent discussion period for complex reviews, the RAC will issue a demand letter concurrent with the remittance advice, issued by the clinician's claim processing contractor. The demand letter will include the amount due, along with a complete description and timeline of the physician's appeal rights.

Agenda Item O: Wrap up and Recommendations. Item Number 67O-1: PPAC recommends to CMS that physicians and licensed healthcare providers not be subject to costly and burdensome durable

medical equipment, prosthetics, orthotics, and supplies under the DME POS accreditation requirements, as they are already licensed and trained to provide durable medical equipment supplies to patients. The CMS response: The Medicare Improvements for Patients and Providers Act, commonly called MIPPA, Section 154(b) states that eligible professionals are exempt from meeting the October 1, 2009 accreditation deadline unless CMS determines that the quality standards are specifically designed to apply to such professionals and persons. The eligible professionals as defined in Section 1848 K(3)b of the Social Security Act, include the following practitioners and other persons: physicians as defined by Section 1861® of the Social Security Act, physical therapists, occupational therapists, qualified speech language pathologists, physician assistants, nurse practitioners, [unintelligible 28:33] nurse specialists, certified registered nurse anesthetists, certified nurse midwives, clinical social workers, clinical psychologists, registered dieticians and nutritional professionals. CMS did exempt these licensed professionals. Other persons that MIPPA gave the Secretary to exempt, included orthotics and prosthetics. CMS exempted opticians and audiologists, as these providers furnish only one-time items that have no fraud or abuse history. CMS announced these exemptions at a special Open Door Forum on September 3rd, 2008. Was also posted on the CMS list serve September 25, 2008, and posted a fact sheet with Frequently Asked Questions on September 16, 2008 on the CMS website. The National Supplier Clearinghouse announced these exemptions via list serve messages on September 22nd and December 18, 2008, and in their October 10th, March 20th, and March 27th newsletters.

67O-2, the final agenda item. PPAC recommends that CMS provide data to determine whether there's a decrease in care of the Medicare beneficiaries, as a result of a brown out, in essence, providers seeing fewer beneficiaries as opposed to opting out of Medicare. The response: CMS is sensitive to the implications of the potential negative updates and access to care. CMS periodically monitors beneficiary reported experiences on their ability to access needed care. Using longitudinal data from the Consumer Assessment of Health plan Providers and Systems, commonly called the CAPS survey for Medicare health plans, we will be able to examine and monitor at the state level, whether beneficiaries are reporting changes in their access to care. In addition, we would note that the Medicare Payment Advisory Commission, commonly called MEDPAC examines patient access to physician care in their annual March report to the Congress. In its recent March 2009 report, MEDPAC indicated that results from its 2008 survey indicate

that most beneficiaries have reliable access to physician services, with most beneficiaries reporting few or no access problems. MEDPAC also indicated that other national surveys show results comparable to MEDPAC's surveys. That concludes the agenda items from the March 9, 2009 PPAC meeting, Mr. Chairperson.

Dr. Bufalino: Thank you, Dr. Simon. Questions of Dr. Simon? Comments? Any areas that you think require revisiting? Okay. Hearing none—oh, I'm sorry. Dr. Ross.

Dr. Ross: Dr. Simon, on the DME POS item that was responded to, it's come across via a number of practitioners in various specialties that there still seems to be confusion as to the accreditation "process" that those practitioners that are reapplying for DME "accreditation" are being asked if they are accredited or not. And the CMS website is still asking for them to become accredited. So we're hearing calls from various specialties that there's a great deal of confusion out there as to whether or not these individual practitioners, professionals, licensed professionals need to be accredited. So later on, I will probably make another recommendation to determine why there is still this confusion going on and what we need to do to try to clarify this under the existing law, that, as you've just described, says that those professionals, licensed professionals, do not need to be accredited to dispense durable medical equipment.

Dr. Simon: I guess one question I have, since there are several notations on the CMS website pertaining to this issue, if there appears to be from your discussions with your constituents, a particular locale where that confusion tends to occur, then I think we'd probably be able to have, either the local people from Medicare in that area address those issues. Or if you can identify the areas of the country where there appears to be confusion, we can have our DME POS people address those areas specifically.

Dr. Ross: I think we'll determine whether or not it's the accrediting people who are creating this confusion, or if they're not, explaining or getting the message out correctly, or if they're leading to the confusion or not. But I'll try to get that information for you by the end of this meeting today. Thank you very much.

Dr. Bufalino: Roger?

Dr. Jordan: Going off of what Dr. Ross was talking about, I believe in the area of enrollment and/or re-enrollment, there's an issue that arises with the accreditation, where if I were to re-enroll for whatever reason, I'm asked, am I accredited, or not accredited? That as far as me answering not accredited,

I'm going to be kicked out of the system, not being allowed to do as far as the ME issues. But also, if I am accredited, then I'm going to have to go through the whole process of which I'm not required to do. And so we were looking at where there should be a box, where there should be exemption of, from being accredited, what's missing in the enrollment process.

Dr. Bufalino: Any other clarification there? Other issues? Seeing none, we'll move on and invite Dr. Bill Rogers to the table. Dr. Rogers, as you know, is here to provide our regulatory issues report, and we welcome you and look forward to your cartoons.

PRIT Update

Dr. Rogers: Notice it's been expunged from your presentation. No, thank you very much. I guess I've been doing this for about six or seven years now, speaking at the PPAC, and I have fewer issues than I've ever had, and I think it's because the great work that you all have done, and the great work that CMS has done in addressing some of the regulatory burdens that we have imposed on physicians. We are not perfect yet, but I think we're moving in the right direction in many areas.

A couple of the issues that have been important recently, as you know, in April, we changed our policy for retroactive billing. We used to allow physicians to bill up to 27 months prior to enrollment, for services that they delivered, up to 27 months prior to enrollment. And we changed the policy on April 1 of this year. And the new policy is pretty stringent. It says that physicians can only bill for services delivered up to 30 days prior to the date of submission of a successful enrollment package. There was a lot of misunderstanding when the policy was rolled out that the policy perhaps was banning all retroactive billing. So we just helped get the message out that that was not the case. Because obviously, particularly in California, that would have been a huge problem because of the time we were still dealing with the end of the enrollment problem that we had there with the transition to the new RAC.

This is a new issue that's been brought to us by the Healthcare Billing Management Association, and the Medical Group Management Association, having to do with Medicaid crossover. As you know, doctors who take care of dual eligibles are to be commended. It's tough work and often not very profitable. And we need to do everything that we can do to make it as easy as possible. It's very important, therefore, that Medicare claims automatically crossover to the Medicaid programs and the Medicaid programs process and pay those claims as simply as possible. And we had received a report from MGMA and HBMA that

there were a number of states in which that crossover process was not working efficiently. So we've looked into that. There's definitely a problem with South Carolina. New York, it seems, is now working much more smoothly, and we're actually polling individual members of MGMA and HBMA to figure out just how, where the situation is with the other states. CMS actually has a Medicaid crossover working group, which consists of CMS subject matter experts, and representatives from the Medicaid programs in most of the states, South Carolina excluded, and so it has been an issue that CMS has been trying to optimize for a long time, and they're very committed to get it fixed if it turns out that some of these other states really are having problems. It's a hard issue to get your arms around because it requires contacting individual practitioners and some of them are not all that comfortable initially with a phone call from CMS about their billing practices. But we're making progress on that.

This has to do with electronic funds transfer. As you know, there was a proposal to require that electronic funds transfers be made only to banks in the state in which the practice was located, and we've withdrawn that proposal because it was a challenging requirement for many practices, and it was unclear to the physicians what the value was in the new policy.

I'm still doing a lot of traveling. Summer's a relatively quiet time, but I do have a bunch of meetings scheduled for the next few months and just accepted a meeting in California at the Annenberg Center, which isn't on the list there. Couple of the other things that we've been working on, there's an organization called the Healthcare Administrative Simplification Coalition, which consists of a bunch of medical specialty groups and is sort of led by the MGMA and the American Academy of Family Physicians, which has been very effective in being thoughtful about how to simplify the process of medical billing and claims adjudication. And Charlene was very kind to accept an invitation to attend the meeting on November 13th of the HASC. There was a lot of enthusiasm at the HASC for allowing for the importation of physician data from a database, which is used by other insurance companies for credentialing and enrollment into PECOS. And Charlene attended the meeting and heard the issue out and has been supportive in maintaining that dialog between CAQH and our enrollment staff. They also have a number of other initiatives, such as machine readable cards, which would obviously decrease the administrative cost for physicians of doing that sort of front office process, and a number of other issues

that have more to do with the private insurance payers than Medicare, and a very effective group, and I'm pleased to represent CMS on the HASC.

We've also continued to have a number of enrollment issues, although California is much better. PECOS online I think, has been quite successful and I commend the CMS staff that developed that and rolled that out, because that's going to I think fix a lot of the problems that we've had for so long with the paper 855 forms.

Our website. It's working fine. And has been for the last few months, which is great. I look forward to hearing the issues as they come up at the meeting and anything that I can do to support the work of the PPAC, I look forward to doing. Thank you.

Dr. Bufalino: Thank you, Dr. Rogers. Dr. Snow?

Dr. Snow: I think Dr. Rogers is much too modest in his attributing CMS with a lot of things to do at this point, because I've been at several meetings where he's gone out and appealed to the populace, and he's brave enough on that last slide, as you'll notice—that's his cell phone number. He puts it out there for all of us to call and raise a stink with him, so I think he has done an exceptionally good job in reducing those, and Bill, thank you for all you've done for us.

Dr. Bufalino: Any other questions? Having none, thank you for joining us. Moving right along, Dr. Valuck joined us, and we'd ask you to join us since you have the hot topic of the day, we'll give you that extra time to have this conversation. As you know, Dr. Valuck is a frequent participant here at PPAC, and he and Lisa Grabert have been here discussing Value-based Purchasing and we're thrilled to have it. Dr. Valuck is a Medical Officer and Senior Advisor in the Center for Medicare Management and clearly the resident expert on this topic. So we're glad to have you with us, Tom and Lisa, thank you for joining us.

<u>Value-based Purchasing</u>

Dr. Valuck: Thank you, Mr. Chairman. It seems like we always have the hot topic under the Value-based Purchasing agenda item. But I'm pleased to be back to talk about our progress. In some of the previous updates that we've had for you all, we've kind of talked about philosophy and approach, generally, or about the process that we're using to get to the real deliverables. Well, we have a real deliverable for you today. It's one that we consider interim in many respects and you'll hear how it fits into the overall process and vision for where we're headed. But we're getting to the point where we're really

looking for your input. We've been seeking it from the physician community and other stakeholders more broadly and we're pleased to bring it to you today. Because I want to get down to the actual product, I'm not going to spend a lot of time on background, but I do see a couple of new faces around the table, so I need to give a little bit of the Value-based Purchasing overview and tie it into what we're talking about here. So the issue is of course, using our incentives, our financial and nonfinancial incentives of the Medicare program to make sure that we're encouraging the highest quality and most efficient care. And to do that, we have various tools, like measurement, like payment incentives, like public reporting to accomplish that. And whenever we talk about Value-based Purchasing, you'll recall we talk about the equation being composed not just of the kinds of quality measures that we would typically think of first as clinicians, like clinical effectiveness, but also about the cost of care. Cost of care represented by overuse, or misuse or waste, certainly are an important part of the quality equation. So when we talk about measurement of physician resource use we're really getting to measurement that will advise and encourage the use of the resources in the most effective way. And seeing this as important, Congress gave us statutory authority under the latest Medicare Act, I guess you could consider the Stimulus Act to be the latest, but the Medicare Improvements for Patients and Providers Act from last year gave us the authority to do several things related to confidential reporting for physician resource use. That was to use our Medicare data for measurements based on both episodes of care, and per capita to select physician specialties that treat high volume or high cost conditions for our beneficiaries, and to do a peer comparison identifying high and lost cost outliers. And then we were also given the option to consider including quality measurement, one that we will be pursuing, given that we really need that context for interpreting resource use measurement, and then also the option to look at measuring beyond the individual level, looking at groups or looking at more aggregate measures for cost of care. So in terms of our program implementation, we're pursuing a phased approach, and you'll be seeing the results from some of our earlier phases here today and as I mentioned, we've been collaborating with numerous public and private sector entities in our formative phases, of the development of the prototype that you'll see. We've contracted with Mathematic Policy Research to assist in this effort. And they're looking at issues like the design of the report but also very important issues like how to address attribution, risk adjustment, benchmarking, small numbers issues, things that we've talked about around this table, previously. In our first phase, we went out to specific cities to just test a very early

version of the prototype and got great feedback from the physicians who were contacted in in-depth, one on one, 60-minute interviews. And they gave us a lot of information about refining the report, which has been included in the report that you'll see today. After that kind of very initial testing, we've gone out with a greater number of reports to certain regions of the country called Community Tracking Survey Sites. We've now distributed reports in six of those sites, in South Carolina, Indiana, New Jersey, California, Washington, and New York, and then we're in the process of adding six more sites in Massachusetts, Ohio, Michigan, Arkansas, Florida, and Arizona. Again, we're asking for feedback from those who receive the reports, to still be in the formative phase, even though more advanced at this point. And we got good feedback from the first round of this expanded dissemination. I just wanted to remind you of the conditions that were focused on and you'll see them in the prototype report. But we wanted a mix of medical and surgical conditions including, colisystitis, COPD, community acquired pneumonia, congestive heart failure, coronary artery disease, and acute MI, hip fracture, prostate cancer, and UTI. And then of course, the specialties, who are the specialists in the specialties who are going to be receiving the reports, follow from the conditions that we've selected. We've presented this to the AMA staff, the medical specialty societies, who represent you all in Washington, D.C. a couple weeks ago, and that was very helpful in getting feedback and we're also going to be looking for feedback at this point, where I guess in a couple of months, where through the Physician Fee Schedule rulemaking, so you're going to have lots of opportunities, including this session, to have input. So with that background, I'm going to ask Lisa Grabert to walk through the prototype and we're going to take a very deliberate approach, because there is a lot of information here and if you want to ask questions along the way, please do so and we'd be happy to clarify.

Ms. Grabert: The first page of the report was distributed to participants on April 8 of 2009, but in advance of receiving the large report that you have in front of you, they received an advance notice letter, a couple weeks before the report, letting them know that they were selected in our sample, to receive a report and that they would be receiving a report in a couple weeks. So the front page of the report references that letter that was previously sent out and also at the bottom asked a couple of questions that we're specifically interested in getting feedback from for physicians in this prototype resource use report.

Then on the second page of what you have in your packet, is contact information for physicians who receive reports, to provide feedback to us based on this report. We provided a couple of different

mechanisms. Physicians were able to call in or email through feedback on their own. We also randomly selected a sample of physicians that receive report to extract some feedback from them through an interview phone call as well. The copy of the report you received went out to a real physician who was identified as a general internal medicine physician. I'm going to be walking through the profile for that physician.

This page covers the report highlights, and really what's included in the 40-page document that we sent out to the physicians. It reiterates that the goal of the program is to provide confidential feedback reporting on resource use, using peer comparison. It also highlights, there are several terms throughout the report that are in bold and underlined. Those terms are defined in the back end appendix so we define how we did the risk adjustment, how we did the cost standardization of prices across all of our different payment systems. So on and so forth in the appendix if you like additional information on that.

Then at the bottom of the page, we included some report highlights, which highlight a couple of different things that were relevant for this individual physician, from both methodologies that we used. The first methodology that we used was the per capita approach, where we look at the total expenditures across A&B for any given beneficiary. So that was the more holistic covering all conditions approach. And when we also used a per episode approach, where we focused on the eight conditions, specifically that Tom had mentioned. For this particular physician, he was an outlier for Medicare patients in 2007. His average cost was $20,170, and that was higher than 95% of his peers in the state of Indiana. Also we included information on specific cost of service categories, and for the hospice benefit. This physician was 14.7 times higher than the median cost of peers in Indiana. Then the bottom of the report highlights focuses on the episode of care approach. For urinary tract infections, specifically, this physician was 99% higher than all of his peers for UTI.

Dr. Valuck: So the highlights page has been somewhat controversial in our discussions, because it requires us to actually draw conclusions about the information that may or may not be meaningful in the context of that particular physician's practice. So one of the things we're considering is either developing protocols for selecting highlighted materials with, for example, a specialty society, or just not putting conclusions on the front of it that might not be relevant and just allowing the information to stand on its own. So that's one of the first comments that we've gotten from folks. Go ahead.

Dr. Kirsch: Looking at this, my eye looks at this and I go, what kind of practice does this guy have? And I'm sitting here going, does he geriatrician? Does he specialize in hospice? Is he a straight nursing home practice? So when I looked at this, my first concern is what are you planning to do with this? I think it's helpful feedback, I'd kind of like to know where I sit with everybody, but I sure would hate to see someone with an appropriate practice with these high numbers being told he's inappropriate.

Dr. Valuck: Well, we started a pool to figure out who could get the closest to what this physician actually does. I say that only partially facetiously because the first question everybody has is, who is doctor unidentified? And what does he do in order for you all to understand whether this would make sense from that perspective? My first thought was maybe she or he is a hospitalist because of the intensity of the services that are being provided. That apparently was not true. We are also blinded from who people are in this process. But Mathematica was able to give us a hot or cold. That was cold. So we started making other guesses. And this physician is an internal medicine, primary care physician, in a small group practice. I believe in Indiana, and so we wanted them to look more broadly at the practice and look at the rest of this physician's episodes and so on, just to kind of figure out that context for more meaningful understanding, but that's important I think for discussion in this exercise, but if you were doctor unidentified X, you would know what your practice is about, so you wouldn't necessarily need to think through that. But assuming that the information is a correct reflection, then I think you should think of it in that context, as if that were your practice.

Dr. Przyblski: I think having a report highlights or summary page with sort of outliers is a useful thing. I know that you might have gotten criticism for it, there was data published out of Denver, Colorado and orthopedic spine practices that found when physicians were told about their outlier status, they diverted to the mean over time, so it does influence behavior. I think it would be helpful for example, in the UTI section that there would be references for evidence-based medicine guidelines on UTI management as an education tool that says, okay, I'm an outlier, what's the data? Do I practice the way the guidelines suggest? And therefore you can influence behavior.

Dr. Valuck: Very helpful comments. The Government Accountability Office has issued a report about the importance of focusing on outlier and so I hear what you're saying and I agree that that, especially when the data may not be as precise as we would ultimately like for it to be. When you start

looking at second standard deviation, you still know directionally there's a problem there, even if it's not exactly accurate information, so that's very helpful.

Dr. Standaert: There's going to be a lot of comments about this topic, I have a feeling. I'm not sure how far he wants to go initially. When you presented last time, I had a lot of concern about the way the statistics were going to be used, and what was going to be presented as a number. And it stuns me that this is presented to the significance of a single dollar. And again, there's no talk in this whole thing of how these statistics came to be, for somebody trying to figure out how this happened, there's no way for them to look at this. If this were being submitted for publication, it would be rejected summarily because there's no description of the statistical methods. There's no error bars. There's no range of error. There's no other sort of ways of looking at the data to see if this is reliable, yet it's put to the value of a single number and you're given 95th, 94th, 93rd, and I'm willing to bet this number is nowhere near that reliable. And that strikes me as wrong. Because people are going to do with it exactly what people have already done with it. Oh, I'm 95th. Well, if I drop this by $300, I go down to 92nd. If I drop, people will assume that this is accurate and it strikes people as accurate, and so when you present it this way, you're presenting it inaccurately. This is, unless you have the reliability to get to that very number that you came to, which you don't statistically, it an inaccurate statement to say that, because you're not accounting for all the other variability. And I think that sets up a very bad dynamic in terms of what happens with this number. This gets published, patients think he's more expensive, insurance thinks this guy's more expensive, but there really isn't, they're pinning it on an immense degree of reliability, because that's the way the number's presented. And I don't know if I'm making my statistical argument clear enough, but that's a major, major problem. And I don't know that, I mean it's stunning that somebody comes down to a single dollar number, it doesn't make any sense.

Dr. Valuck: Yes. No, Your point is very clear and that's one of the reasons why we have taken the phased approach, to try to add in more precision over time. There certainly are those who would say that we should already be well beyond where we are in terms of doing a national dissemination for this information, because the question arises, with Medicare holding a huge amount of information about resource use, why aren't we sharing what we have in the way that we can, and then use it for what it's appropriate for? We're talking about confidential feedback reports here. We're not at this point, talking

about sharing this publicly. We're not at this point talking about connecting this to payment beyond planning for a time when we can be more precise. So you hear others saying it would be good to get this information, maybe some more caveats about don't take this literally at the dollar level, or the specific percentile, but use this to basically for what it's worth.

Dr. Standaert: I mean I guess my issue though is that that's going to happen. And you put this out there, it's going to happen. You say it's confidential, but it's not going to be. PQRI started as this is an individual thing, but then it goes on a Compare website when people didn't know that that was going to happen to the data they submitted. So this will go somewhere, I have no doubt whatsoever. And you can make an argument, you should present the data that Medicare has, but if you don't know the significance, the validity, the reliability, the applicability of the data you have, you shouldn't just present it willy nilly, because people don't have the understanding of the data nearly well enough down to be able to actually interpret it reliably. And you wind up with false conclusions. That's my concerns.

Dr. Smith: I share a lot of Chris's concerns, but I have a couple of additional things. One is your question of whether that summary page is needed, and if the data are accurate, about which I have a lot of question, I think it is, because otherwise the physician receiving it has absolutely no idea what Medicare is thinking, and nobody can sit down and spend an hour sorting through all of the data on every one of these diagnoses and see whether it's accurate and try and interpret how Medicare is thinking without some kind of summary. But having said that, I think it's incredibly important that it be accurate, and I wonder about the data collection system, and I guess what I'll call tangles with some of the other things we have to do. You see a patient for congestive heart failure, but the reason heart failure's worse is because the patient's running a fever and has a urinary tract infection was that a congestive heart failure diagnosis? Or is it a UTI diagnosis? If it's a UTI diagnosis and you didn't list the congestive heart failure, then it screws up your PQRI reporting. So you shift the diagnoses around. So how do you know what the principle diagnosis is, and whether it was influenced by some other reporting that was needed, PQRI begin the big example, if you're doing sequential things as opposed to the isolated 30-case system or whatever it is. How does CMS decide what is the principle diagnosis and what are co-morbidities, because if you take congestive heart failure, which is common in COPD patients, who then get a UTI, where does it fit? If you pick it for all of

those, it greatly raises the price for any one of them, because you're dealing with three different things. And I'm not sure from the information you have here, that you've been able to separate those out.

The other thing and this is back on one of my continuing concerns, is I'll call it the cost of the physician, and ultimately the healthcare system of yet another unfunded mandate in a broad sense, because you're sending this report to a physician who then has to sit down and figure out if it's accurate by your own comment, may spend an hour with you on the phone, for which I presume he is not paid his usual insurance rates, or even Medicare rates for the time he's investing, and during that time, he can't see patients, the time that he's spending doing this. So if you're asking people to try and use this information, there needs to be some way to be sure that it's incredibly accurate, rather than waste everybody's time in the process. We have too few physicians available to see patients as it is, and it's going to get worse, particularly in primary care, and so consuming more time sorting through data that aren't thoroughly accurate is going to create even more difficulties.

Dr. Valuck: So the accuracy does depend on at least two things; the coding, so it depends on how accurate your coding is, and then it also depends on the tools that we use to sort through the massive amount of data, and we've talked about the episode grouper as a tool that we're using and we've talked about the fact that the episode grouper is not perfect and so we have those limitations, and we're working on the level of precision from that standpoint.

In terms of the point that you're raising about our contacts with physicians, we have done that to try to get engagement with the physician community. So we asked them to voluntarily spend a little bit of time commenting on this report. If they didn't want to volunteer, they didn't. So we didn't get of course 100% people participating, but not asking them would be just like not asking you to come here to Washington, D.C. to talk about these issues.

Dr. Smith: Right, I understand that.

Dr. Valuck: So we really wanted to pursue the engagement. I think it was worthwhile investment.

Dr. Smith: I still don't know how you figure out when a person has COPD, congestive heart failure and a urinary tract infection is three diagnoses on the claim. To which one are you attributing it?

Dr. Valuck: Depending on how the claims are treated by the episode grouper, it can be multiple, well, there are lots of different permutations.

Dr. Smith: I understand that. That's what I'm asking.

Dr. Valuck: Yes.

Dr. Standaert: That's the whole problem.

Dr. Valuck: And so the grouper as we've said is not a perfect tool. It's one that's being refined and one of the things that we've been asking the medical specialty societies to weigh in on is issues related to the grouper. One of the vendors, for example, has put their product on line, at the algorithm methodology level for people to comment on. So I'd encourage you to take a look at that.

Dr. Sprang: And similar to what Chris says, too, we're [inaudible 07:02] insurance companies, we actually [inaudible] information. They also look at the reliability [inaudible] concerns about this. You have really a small number. There's a [inaudible] significance over, significance, I'll say misleading information probably worse than no information. So what kind of basis are you using? For instance how many patients they have to have to make it meaningful? You want credible, reproducible information. And I know that's not easy, and I know people think organized medicine is just always using it for a cop out for why we're saying you can't look at this, but we're trying to realistic. Is it good data? If it's not good data, then we're doing more harm than good. That's what I'm saying.

Dr. Valuck: Yes. So I think we hear that there are issues and we are trying to work through those in this phased approach and not use the data for things that it's not suitable for. So your comments about how to get there rather than the problems that we're all aware of would be really, really helpful.

Dr. Bufalino: Everybody has said exactly what you finally came up with, and that is if you look at the initial report that you've outlined, that's like a report card. It's like a letter B, and A, where you've given a percentile. The question is how did you dissect to get to that percentile? What were the criteria? Was it the E&M? Was it the level of care? And I think Frederica raised a very good point when she said, What about all those co-morbidities? And when we looked first, Dr. Valuck, months and months ago, we talked about Pay for Performance, when we looked at co-morbidities. If let's say Dr. Ouzounian is seeing a patient for a simple fracture, but that same patient may be a diabetic, with all these co-morbidities, I'm spending much more time with that patient, so maybe my level is greater, so my reimbursement may be greater for a similar diagnosis but I'm treating a much more high risk patient. So what I'm saying is I think you can dissect the criteria where the percentage is coming from, and that will give you a better analysis of

your percentage when you then give this report to the individual practitioner, instead of just saying, here's your percentage, and your 15, 20%, 95% above your peers in your median, in your area.

Dr. Valuck: So, Mr. Chairman, you're going to have to help us balance the sort of high level questions with a review of the rest of the report that we'd really like to share with the committee today. And if we want to stop here, with the report, and continue to take general questions, and comments, we can do that for the rest of our time, and then come back with this.

Dr. Bufalino: Sure.

Dr. Valuck: I just want to think about that.

Dr. Bufalino: Let's have a little more discussion and then we'll try to jump back and finish up. Why don't we start with Karen and come back around.

Dr. Williams: Two comments I have. When you say it's a risk adjustment, is that taking into account some of the issues that people are talking about? Maybe that's a further explanation that you need to put in your report. Second of all, when you report out Dr. X's statistical data, is this particular person, do you separate out people in teaching institutions, that also teach residents, medical students, therefore have the complex patients, but also take longer to do a procedure, which also will increase your cost of rendering care, and is that reported out separately from private practice, ambulatory care center? There are different patient populations in each one of those institutions and how do you take that into account?

Dr. Valuck: So, regarding risk adjustment, that is one of the major considerations. There are different methodologies that are being considered. We've talked a little bit about them in the past. We could talk more about them as Lisa gets into the methodology, which is appended to the material. In terms of this idea of segmenting out various practice settings, for example, an academic institution, it really raises the question of whether you would want to adjust out for that variation or whether you would want to recognize that there are variations in those settings, and present them, and take them for what they're worth. So when you do risk adjustment, other kinds of adjustment, you need to make sure that you're not adjusting away, all of the variation that may or may not be warranted. So what you're saying is that there's likely warranted variation.

Dr. Williams: It's going to cost more to go to an academic medical center to get your hip fixed, in general.

Dr. Valuck: So, you would raise the question then, and this is why we want to put the quality information in, if we're going to pay more for a service, we ought to be seeing a higher level of quality. So I would think we wouldn't want to risk adjust away, not risk adjust, but adjust away the cost difference, because we wouldn't want to adjust away the quality difference and we still want to look at the overall value to the program.

Dr. Williams: But if you're paying more because you're training people. I mean, the resident who's putting in a central line, for instance, might miss your complications, blah blah blah, if you're training a resident, and it's going to take you longer to put in this central line, therefore you're charging your money, I don't know if that's a risk adjustment or if it's training adjustment or an educational adjustment, I don't know what the term should be.

Dr. Valuck: Thank you, good point. I would like to think that supervised residents provide as good a quality of care as others. But I hear what you're saying.

Dr. Kirsch: Just a straight forward question. How will you assign patients? I mean patients hop around to doctors. How do you figure how many patients are in your pool and this is your cost per year?

Dr. Valuck: Well, there are literally maybe infinite is too dramatic a term to use, but there are several different attribution methods that have been tested and then the reason that I say more than just several, is because in between all of those options, there are other hybrids that could be developed. So there are a couple that are listed in your report on page 26. So this particular, each report of course only uses one attribution method, because [unintelligible 13:54] or subsequent attribution methods would require the generation of a second or subsequent report. So this is the attribution method that's used for this particular report. It's called multiple proportional, and you can see how it would work. Every attribution method has its pros and cons, so some are more focused on the care team, but when you focus on the care team, that means that what ultimately gets attributed to an individual isn't just what that individual has performed. Now, if you move away from the team and closer to the individual to be more precise about the direct cost that that individual may have caused, then you lose the idea of the team concept that everybody should be working together to manage the cost. So we're looking at different attribution methods. In the end, the right answer may be that you would use different attribution methods for different conditions. Maybe even in

different settings, depending on how the whole set up is playing. We're not there yet, but we're still in the testing phase for different attribution methods.

Dr. Howard: You wanted some helpful hints. I think what's coming up for us at least is that we're seeing the grade, but we're not seeing what brought us to this point; the 95% percentile. I think it would be helpful to have the statistics, because then we can go back and look at them ourselves. There's a lot of concern with that, and I think if it was more transparent to us how you got this data, and how you did it statistically, I think at least for a lot of us, we would have less concern, or maybe we'd be able to help you with where we think the inaccuracies are. For instance, a lot of the clinical risk factors that you have here are risk adjusted factors on this page. I know a lot of my patients don't know they have clinical risk factors. They're 80 years old and they're healthy because they've never been to a doctor. So a lot of these things that you're attributing and coming up with stage disease staging, I think at the initial onset, I don't even know they have these problems, so I think it's really potentially an issue to somehow go back and find out okay, they have diabetes, and they didn't know they had it. There's a lot of those things I see with the risk adjustment. So I think it would be helpful to have a little more of the transparency in how you came up with those numbers.

Dr. Valuck: And so we hear that and we also hear the report is already too complex. There's way too much information. I don't want to spend more than a few minutes looking at it, but then others want to see a drilldown all the way to how every one of their individual claims would map up to the ultimate data. So at some point, we have to think about how to find the balance. My thought is that as we move forward with levels of sophistication, we develop an online drilldown capable tool that would ideally, I don't know if this is ever going to be possible, certainly isn't now, could go from a summary page, all the way down to the specific claims that fed up into that. That would be ideal, because someone who wanted to spend the rest of their career, really drilling down into that, and figuring out whether they were coding right and so on and so forth, would then have that ability. But at this point, we're not there. We have to figure out how to do what Congress has asked us to do with the claims data that we have and we'll keep pushing forward with more sophistication.

Dr. Bufalino: Let me take the chairman's prerogative here, and just, could we just get you to do 15 minutes?

Dr. Valuck: You can get me to do whatever you want, Mr. Chairman.

Dr. Bufalino: Thank you. Maybe just a 15-minute kind of take us through the bigger pieces here and then we'll wrap it up with last 10 minutes of conversation. But I think we may be ahead of you, in giving you a chance to get through a little bit more depth—

Dr. Valuck: No doubt, you'll want to invite us back to the next meeting.

Dr. Bufalino: Most definitely, you have a permanent spot.

Dr. Valuck: Thank you for that. Keep going, Lisa.

Ms. Grabert: So if you want to, for the screen go back to page two. [chat] This first display is focused on the per capita cost. But the way that this is laid out is the same for the per episode, so really, we're explaining both methodologies as we go through an example for this one. This provides for the physician, their distribution curve for their benchmark. The benchmark is defined as the geographic area for this, is the state of Indiana. It's also defined by the methodology for this particular curve. It's per capita, so it's total cost, across all the beneficiaries. And it's just specifically for the specialty of internists. Those three factors make up what's in this peer comparison, or the benchmark, for the distribution curve. On this graphic we provide the 10^{th}, 50^{th}, and 90^{th} percentile as a perspective on the curve, and we show the physician where they lay in comparison to all of their peers on this curve. As we mentioned before, this physician is in the 95^{th} percentile, and their costs show up there on the curve at $20,170.

Dr. Valuck: So that the specialists have told us that they could care less about per capita. They really need to see the information broken down into specific episodes because their patient populations really aren't going to be comparable at the per capita level, but the primary care physicians have told us that even though they see a relatively homogenous set of patients, that they really like the idea of a per capita measure as a starting place, to see how their patient population that they're managing compares with the folks in their local region, at the state level, and then at the national level. So again, lots of different perspectives on what's more and less useful.

Ms. Grabert: So then on the next slide, exhibit 2, shows a couple of different benchmarks for the physician to look at. The very first box is for the local service area, which is defined as the area in which the physician typically refers to, and if you look along the column, the number of other internal general medicine physicians are quite low in terms of the numbers, 40, 43, 41, physicians only make up that small

local benchmark. Then, as you move down to the state of Indiana, in the second box, you get a little bit of a bigger benchmark, the number of general internists goes up, and then if you look at the national benchmark, which is a hybrid across all 12 of the states, you're sites that we're looking at, you're covering approximately 9,000 different physicians. So there are a lot of implications here for small numbers, depending on which benchmark we use, for each of these benchmarks we establish a different minimum criteria in order for the physician to qualify to see their data in these different formats. But you can see how we lose or gain statistical power as we change the benchmark moving through.

Then on page four of the per capita approach, we drill down a little bit further and we cover a high level graphic of cost of service categories. So across all the care that the patients receive that was attributed to this physician, we show the physician where they are in comparison to their peers. So even though the physician may only be seeing patients in their office setting, we still show them the full spectrum of services that their patients have. So we on this graphic show them, both the E&M services they provided, the E&M services other physicians provided for their patients, the inpatient services, the outpatient services, and all sorts of post-acute care services as well, to sort of give them a more holistic picture of what their patients are experiencing.

Dr. Valuck: This is the level of information at which we started to really get folks interested because they can see here they start to get a glimpse of information that could help them actually respond to this kind of report. It's not just sort of you're good, you're bad. It really says these are some things if you would draw conclusions from this, that you might think about addressing. And/or they might have meaning and this should be this way, this should be the picture for your particular practice. But regardless, it gives some real potentially actionable information. And then there's more of that on the next slide that Lisa's going to be talking about.

Ms. Grabert: So this drills down even further into the different cost of service categories and provides some benchmarks and comparative scores for the physician compared to his peers. So here again, we see for services provided by the individual physician for outpatient and patient consultations, then by other physicians, giving them a little bit broader perspective. Also looking at specific procedures, imaging, laboratory tests, and then further towards the bottom, by other physicians, and it shows them by primary

care, by medical specialty surgeons and emergency physicians as well. So this graphic is much more detailed information than may be useful for practice improvements.

Then on to page six is another further drill down, really focusing on care that's delivered from the outpatient setting, moving into the inpatient setting. We capture in this graphic, emergency room visits, for the patients assigned to the physician, hospital admissions, ambulatory care sensitive measures, and the average length of stay. And this particular graphic was something that we got a lot of positive feedback from many physicians, because many physicians treat their patients in an outpatient setting and they're not always aware of what else happens after they leave their office. So understanding the number of hospital admissions on average that their patients see was a very useful piece of information in terms of the feedback we received from physicians.

Then moving on to the next slide is moving into the per episode approach. We focused on eight episodes. This physician did not receive information for prostate cancer, colecistitis and acute myocardial infarction, because this physician did not have enough episodes to meet our minimum threshold for statistically reliable information so we suppressed that information, and did not show that type of information on here. As I mentioned before, the minimum threshold is defined differently for each condition, for each geographic area, and for each specialty.

Dr. Valuck: The threshold varies based on the distribution of the physicians that are in that particular sample. So a widely dispersed distribution requires higher numbers in order to get statistically reliable information from one period to the next. More narrow distribution requires a lower threshold.

Ms. Grabert: So that's pretty much a quick overview. The rest of the graphics are for specifically the per episode approach, and we do that same sort of breakdown for each episode, and then I'll also touch on Appendix A, which is a diagram that explains the attribution approach that we use. When we distributed these reports, we used two different attribution methodologies.

Dr. Valuck: It's page 26.

Ms. Grabert: This methodology covers the multiple proportional, where it looks at the number of E&M services, provided by physicians, and divides them proportionally, and assigns cost to physicians based on the number of E&M services provided. So for example, across all the services for a particular patient, there's a total of $10,000 for this patient. Physician one provided three E&M services, and is

therefore assigned 30% of the cost. Physician two, two E&M services, $2,000 or 20% of the cost and so on and so forth, so evenly divides based on the E&M services. The other attribution rule that we also used in distributing these reports assigns the full cost of the patient or the episode to the physician that has the highest number of E&M services, so it's a different attribution rule that is meant to show a different policy option

Dr. Bufalino: Questions? Go ahead, Chris.

Dr. Standaert: I'm just going back to your first page of the presentation of the data on the initial page. As I said, I have a big problem with you giving a number, because I don't believe it. Statistically it doesn't make any sense to me. Have you thought about 1) either giving a range and saying our data indicated you're between the 93rd and 75th percentiles and just giving, don't give them the number, don't give the median, don't give whatever number you came out with, but give the statistical range in which you think that physician lies, so basically you're giving the error bars, because that's truthfully where they would, from a statistical sense, that's where they should be, somewhere within those error bars, assuming your assumptions are correct. And you just said you used two different attribution models and did you think about presenting or comparing the data, well if we use one attribution model you're here, if we use another one, you're there, and giving people both? And one issue of both of these attribution models is you're going by E&M codes when this is a whole separate issue. So that's one.

Separate issue, when you do the attribution model, there may be one provider who's responsible for, or who infers most of the cost, so in my world, I see a lot of back pain. So a primary physician has somebody wants for back pain, they send them to me, they have a horrible spine, they need surgery, I see them once and say they need surgery, and the surgery the needs $80,000. And the spine surgeon bills $80,000, no offense. They're more expensive than the rest of us. But then the primary care doc gets hit with one-third of $80,000, so it doesn't really. You know? Attributing it that way doesn't divide up where the cost is going. I see where you're going that may be if that primary care doc used a surgeon who didn't operate as much or operated more cheaply than their costs would be lower, so they're incentivized to not use people who do a lot of stuff to jack up the cost, because it affects them. I see where you're coming with that.

Dr. Valuck: So thank you for making that point. But the real point isn't the absolute dollar amount, because remember the other PM&R physicians, who you're going to be compared with, are faced with a similar kind of situation. So it's not necessarily about driving down the surgery costs of this, it's about the appropriate application of surgery and that's something that the whole team, preparing for that patient, really should be conferring about, and not just within your world, but the guy down the street who you're being compared to, and the people in your state and also across the country. So think of it as comparative information and not as a specific dollar amount. The specific dollar amounts are just to give you and idea of where you fall in the range.

Dr. Standaert: Right, but that goes back to my not liking the specific dollar amounts—

Dr. Valuck: Right, you make an excellent point there—

Dr. Standaert: Had you thought of presenting a range?

Dr. Valuck: We have thought about that, yes. I think it's a very good idea.

Dr. Bufalino: Let's go to this side, Tye? Janis and then we'll back to Leroy and Art.

Dr. Ouzounian: I'd like to make a comment that's not been made around the table and might not be the most popular comment, because I haven't heard it. But you got this data and I want to see the data you have on me, and I want to be given the opportunity to respond. So if I'm right in the middle, that's fine, there's probably not much to say. But suppose I am this doctor at the 90% percentile. Couple of things are possible, number one, I need to change my behavior. You give me the data, fine. I'm an outlier, I'm doing this incorrectly, gives me the opportunity to change my behavior. If you have the data, and you don't share it with me, I don't have that opportunity. The other is that maybe there's a good reason why I'm that outlier, and I want the opportunity to explain it to you. So when comments are that don't give me the data and don't make me respond to you. I don't agree with that. If I'm this doctor, and I'm at the 90% percentile, and I have a good reason for being there, I want to be able to tell you, this is my patient population. This is why I'm here, and this is why it's acceptable. And I think the provider needs that opportunity.

Dr. Kirsch: Actually I wanted to compliment you. On the per capita cost per selected services, with these bars, now that I've taken a closer look at this, I think this is very helpful. I look at this and I'm not thinking this guy's a geriatrician, I'm thinking this is a guy who doesn't get his patients into his office,

and isn't taking care of them on the front end, that too much is getting done on the back end. And I think if you're using this for feedback, I think that looking at trends like this I think is very helpful. Another thing is on the episodes of care, like the number of hip fractures, I think it would have been helpful for this physician to have had an idea of the expected number of hip fractures for that population base to get a sense of maybe I need to be getting people in, getting bone densities, checking Vitamin D levels and being more proactive on the front end. But looking at this now I see this guy does have a problem.

Dr. Valuck: One of the things we think a lot about around the benchmarking is how to set that standard. You can do peer comparison, which is what we're looking at here, but that's assuming that the average that comes out of all of that is the right place to be, as opposed to wow, the whole practice is probably too weighted toward this or maybe not using something enough that is something that could contribute to quality of care that hasn't yet been incorporated into practice, so we need to think about the evolution of the benchmarks over time.

Dr. Kirsch: Also on this bar graph, they list the ancillary services. Are those the ancillary services ordered by this particular physician or are those all the ancillary services—this is all the ancillary services.

Dr. Valuck: Yes. All of the episode information is everything that was done for the patient that got pulled into that episode, regardless of whether that specific physician was the one who was ordering the service.

Dr. Sprang: As I said before, I'm an OB/GYN, I do have a lot of Medicare patients and so take post-menopausal bleeding, which is common, we'll do a D&C. It would make a significant difference if I actually do the procedure in the office, so my cost for treating that diagnosis is going to be much lower than somebody who takes the patient into the hospital. Is the hospital cost part of what the overall cost here is? My point there is then on vaginal deliveries, which are not very many Medicare patients, but on those, there are a couple of insurance carriers in Illinois that do this now, and compare, and stuff I do in the office, I compare very well. With stuff I do in the hospital, I compare with poorly with, because the hospital I practice in is a very high-cost hospital. The NUOR is $10,000 if you do any of your labs and stuff in the hospital, they're much more expensive. Yet, you say I chose to practice at that hospital. But if you're going to compare—[chat] but okay, I try my office is where my patients want to go. So I guess what everybody's saying is how do we take that part into account and then compare it to another obstetrician who maybe

practices in a hospital that tells half the cost, and is it really my fault that I kept in practice there? Or how do we take into account the hospital cost, which really do vary a lot?

Dr. Valuck: So, I wouldn't want to suggest that every physician in the country needs to rush to the one hospital in the region that—I mean we'd end up with access problems and so on. What I would like to think is that this information along with similar information that over time will be provided to hospitals, would cause the physicians in the hospitals to get together and figure out how to take their costs out of the system, versus the hospital and their medical staff down the street. So I think you do have some responsibility for working with the hospital as a part of their formal structure through the medical staff organization to and you might not see it now, but it's coming, there's this concept of accountable care entities or organizations where physicians and hospitals are likely to be paid together for services, and so Congress is considering those kinds of options. We're doing a demonstration within the Medicare program. So I'd encourage you to start thinking about how to work more closely as a unit, not only with the other members of the physician care team, but with the other institutions and not just limited to hospitals, but also post acute care.

Dr. Sprang: I agree but right now, the costs, obviously dealing with the CEOs, they have their budgets, and right now, they're not going to in any way listen to us. Maybe it will eventually change—

Dr. Valuck: I think that's going to be changing and maybe sooner than later.

Dr. Sprang: Depends who's stronger, the hospital or the doctors.

Dr. Bufalino: They incentivize you to change hospitals.

Dr. Snow: I still have a problem with the attribution of cost. In my particular situation, I'm family medicine. That's probably who I'm going to be compared to, but I practice only geriatrics. So under your attribution model here, since I'm doing work primarily in a nursing home, I may see a patient six times, I may get the whole cost of all these costly procedures because of the care I do in a nursing home, over a month or so, under the other attribution method, I may get 60% of it, say, which seems totally inappropriate. So it's not necessarily leveled out by the peer comparison, because your peer comparison doesn't have an accurate baseline. Family physicians who practice primarily geriatrics, ER, hospital work, whatever they do, they're not listed generally in those subspecialty areas they practice in.

Dr. Valuck: That is a real difficulty getting down to that level because we don't have good information through our enrollment data or on our claims about who's actually in what type of practice. So I hear what you're saying. Of course, ideally, we would want to be comparing geriatricians who have primarily nursing home practices, with other geriatricians who have primarily nursing home practice, and you're exactly right. We don't have the information to support making that comparison at this point.

Dr. Ross: Well, we're reading each other beautifully. I wanted to give you two scenarios which complement what Dr. Ouzounian said just a few minutes ago about the complicated case and the physician who's at maybe the 95th percentile. One would be for instance, a wound care patient, that has a severe, severe wound, osteomyolitis, hospitalization, surgery, wound care, hypobaric oxygen vacs, you're talking about a lot of ancillatory treatment, which drives the cost up, but that's just to save the limb. The other case scenario might be a surgical case, where it's an older patient and the patient has osteoporosis, and I send the patient to Dr. Sprang because the patient needs a dexoscan because of the osteoporosis. So complications of non union, needs a bone stimulator, the costs keep driving up. So if we've got these complicated co-morbidities and these patients that need all this attention and all this ancillatory, ssshhhht, there goes the percentile. So now we're not just treating the simple patient with no problems, no complications, we're dealing with other issues. So that's what I was trying to say earlier. And I think just try to explain those particular scenarios.

Dr. Siff: I have a shorter question. How will you treat hospital based specialists like emergency physicians, for attribution purposes? I think Art kind of touched on it briefly.

Dr. Valuck: So your particular specialty society has been very vocal and we'd like to thank them for their input. The truth is that we have that issue for a lot of different specialties. So how do you fit in the radiologist and the pathologist and the anesthesiologist and the emergency doc and the hospitalist and those who are practicing in nursing homes or other post acute settings, which is why of course, that we've chosen to start with the specific conditions and the specific specialties that we've chosen. They would probably be the ones that you would choose, too. There are some questions as to whether this particular kind of approach would ever work for those specialties or whether it's a good idea to sort of keep them in the mix because they are part of that team, and we want to encourage them to work with the people who are getting these reports, so that we can get to that more team-patient-centered concept. But there are other ways of

looking at the efficiency of the services that are provided by different kinds of specialties. In fact, the NCQA in collaboration with the AMA's Physician Consortium for Performance Improvement is going to be having a meeting in the next couple of weeks, where we're going to get together with them and talk about this concept of appropriateness measurement. So moving, if you think of resource use measurement on a continuum, starting with per capita, sort of this very aggregate way of measuring, all the way down to looking at the appropriate utilization of a specific procedure or service, or item, there are all kinds of options in between on that continuum, and the episode of care option falls somewhere in the middle, where you're just looking at all of the resources to care for a specific condition. But for an emergency doc, or a pathologist or a radiologist, for example, you might want to look at the appropriateness of the use of an item or a service, for example, the one that tends to come up, is an imaging. Imaging services like CT and MRI and reporting those numbers to the team so that the ordering physician and the interpreting physician, are encouraged to work more closely in order to be using those services, only where they meet the appropriateness guidelines. So that's another way to look at how to pull everyone in here. But the episode of care and the per capita isn't going to be as meaningful or as useful to everyone on the team.

Dr. Giaimo: Because most of this is really related to cost, and certainly that is a major factor in our economy and all these things that are going on, and we want to maintain access to care. People are going to adjust their habits to try to get closer to the mean, but there's no outcome based out of here. So are we fearful that we're going to start to—a very complex case, I do a lot of critical care medicine, and you have a case and you start to say, are you going to find people leaning, or is there a concern that we're going to go in the other direction? Instead of trying to salvage of limb, they're going to talk about an amputation instead? Is there any thought with that kind of a process?

Dr. Valuck: One of the things that I led with early on is that what we're ultimately talking about here, remember this is one little piece of our bigger, Value-based Purchasing activities, and we are exactly as you're saying, focusing just on cost and in some respect only on a piece of that picture, but as everyone has been pointing out, but the idea would be then to put this information together with the quality of care information that we're developing on other tracks, to get at that overall assessment of the value for the Medicare dollar, very broadly, the value for the services that are being provided for the person who's receiving that report, and see where the efficiency picture really fits in with what's happening within that

practice. So you're exactly right. And you will be seeing in a subsequent version of this, while we're still calling this the formative phases, how we would see putting the cost and quality information together in a meaningful way. So it becomes even more complex when you try to do that, because you're taking two sort of bodies of information that already have issues, like the ones that have been raised around here, and then putting them together, which of course, as we know, will only compound the issues of comprehending it and interpreting the information. But I think it would be very useful to see for example, a four quadrant diagram that says you're ideally a low-cost, high-quality provider. That's definitely the goal, but there are various combinations. The moderate cost in high quality would definitely be acceptable. Even high cost and very high quality, I think we were talking about the various settings of care. We'd like to think that in more costly settings that we're actually getting more quality out of that, so I think it's going to be useful to see that, and we're in the process of developing that right now.

Dr. Arradondo: I wanted to comment. I wasn't sure if I should raise this, but I wanted to comment on something that Dr. Standaert said earlier on, and Dr. Snow kind of picked up on on a different angle. The whole business, and at one point, Dr. Valuck, you said you well this is a problem, so I'm not sure I should raise it. But the whole business of definition of peer, that's clearly a problem. And it's not just, peers cannot be, I do not think that peers should be determined by their specialty, since virtually every specialty practices a whole array of services within that specialty. And I'm not just speaking of the primary level specialties, or the secondary level specialties. The tertiary level specialties do the same thing, and but for a variety of reasons they do that. So definition of peers seems to me a big deal here. And part of that might mean if you're using the numbers; you referenced the codes and you said we couldn't get down to it because of the way things are coded often. An example, you used chronic heart failure, I presume is the OCHF, at least that's what I call it, chronic heart failure. Suppose a family physician is taking care of people with chronic heart failure level one, and that's it. If he or she ever diagnoses a level two, send them off to somebody. On the other hand, let's suppose that another family physician takes care of not only the level ones, I mean that's a piece of cake, but level twos, and quite a few level threes. Sends off all of the level fours, maybe a few level twos, maybe some shared care in there somewhere if they have such an opportunity. Well those are not peers, if you use your coding data. So if the coding data is inadequate, then how does that get bolstered? So the definition of peer is one piece.

The definition of complexity of decision making seems to me might be important here, too, since that gets used in a rather general way, but also, it could be used in quite a specific way and I'm not just talking about the effect of co-morbidities, or the challenge of co-morbidities, although that's a very common piece of complexity of decision making. I kind of bring that because if you flip to an episode of care, or a problem that's attended to, kind of you alluded to this in your very last statement, and then start discussing appropriateness, some other factors come to play. For instance, if you select a batch of peers, say who treat congestive heart failure, chronic heart failure, level two, or level ones, lots, virtually all level twos, and a fair number of level three, stage threes, whatever the current term is. And that's quite, the people who've been making drugs for this have been trying to move that to the realm of the primary care provider. But they've not had a great deal of success, but they try to do that. And one batch of patients can pick whomever they want, so the peer group to some extent, gets determined by the patient, because they can pick different people, different primary care providers, for the same episode of say, illness. Medicare permits that, for instance, more than many insurances. That then will help not only skew the definition of peer, but it also will somewhat skew the definition of complexity of decision making, or for that matter, appropriateness of care, if you start looking at the number of visits, the outcome for each visit, the cost of each visit, you're looking mostly at cost right now, but if you look at other outcomes, then the patient's ability to choose skews it. I raise that because there are some patients that are in a system that permits them to go wherever they want, pretty much, and that gets thrown into this diagram on page 26 that's been discussed. On the other hand, some patients are in a system where they can't go any place that they want, at least not right away. They might need to get collaboration or an approval for somebody to go, whether that's their primary care physician, or a secondary care physician, or whether that's the insurance company manager case manager, other kind of manager, have to get some kind of approval to get some other care. Whether it's imaging care, whether it's surgical care, whether it's some other specialty care. That, again, affects definition of peer, certainly definition of complexity, and definition at least the attributes, the characteristics of appropriateness of care that you take out and measure with the codes that you have. So I can see that that complexity there, that you're having to deal with, the various balls in the air, so to speak. The very last thing that you mentioned, which is most intriguing to me, in a sense, is that the appropriateness argument, and that this, all of what we are talking about, mostly is a small piece, that's

what you said. Well, I'm kind of wondering, this is separate from all of what I've just said, but it's on the same dollar table. I mean there's a dollar over here, a dollar over here. Who, and I won't say when, but I'm assuming somebody is, so who in CMS is raising the question of how all of this can be approached differently? I mean you are putting some rules here, CMS putting some rules here that assumes that we're going to collaborate with each other, we, physicians. We providers, even broadly. Well, I could say, as one who's been around for a minute, if we were going to do that, you might be out of a job. We've already fixed it if we were going to collaborate. We have our own goals and obligations and opportunities, so collaboration isn't going to be our number one issue. To wit, the number of people we have around here just to represent physician. That's not a negative, that's just a description of what I see. And my glasses are still pretty good. On the other hand, I applaud—you have to start with what you have—so you have this mish mash of a system that we call the best around, and others say is not so good, depending on how you define health, and some rules are being put in. But on the other hand, with $800 billion, maybe a few billion could be used to put in place what you might think or you might think, or some future person is going to lead here, the administrator, advisors, maybe a bureaucrat's already figured this out. That would be my guess. Because we have some pretty good bureaucrats in CMS, put in place an "ideal system," whatever that is, from my perspective, an ideal system would be one that has more family physicians than any other specialty. I wasn't the first person to posit that as an ideal system. Maybe in my ideal system, it'd have more public health professionals than family physicians, prevent as much as you can, and then diagnose the rest of it as soon as you can. And then treat the hell out of it before the person gets sick, or dies, I mean kind of shades of an ideal system, so to speak, where health really is health, not just the absence of disease or considered to be medical care. So why not spend some money to put a little system in place? Somebody could organize it for you. It might not be too different from some of the traditional HMOs. I know they've long since passed. Managed care is the thing, and managed care is kind of like a broker, kind of like a bookie. No matter what happens, the organization makes dollars. Wall Street, not too different in that sense, broker, bookie. Some of the managed peer organizations seem to act that way and having served as medical advisor on three or four or five of them, six or seven by now, that is my observation. On the other hand, there have been a few HMOs, now kind of in the distant past, very small market share, that really do try to promote the health of the member, prevent as much as they can, care for

as much as they need to care for, and as high quality and as low a cost. If that's an ideal, and I'm just saying if it is, that might not be your version of ideal, why not incentivize some little system be put together, two or three pilots, and figure out what you can do from that perspective. That's different from pushing on what you have, which is all of us. That's putting into place something that might just work and if it does, then you can decide how do you relate to what you see our representing around this table. That's just a notion. It kind of follows your very last thing. Is that this is a very small piece. And I know we spent a lot of time speaking about very small pieces, very important to us, by the way, because many of them affect our pay, but in the overall scheme of health, seems to me an $800 billion organization might have just some other options, small options. I don't mean to take all that money and start doing something else with it, that's not been proven, but on the other hand, systems that promote health, help to maintain health, using medical model people who can use the health model. There's a lot of opportunity there.

Dr. Valuck: A very, very, very thoughtful comment. You started by reviewing all of my work for the past year in about five minutes, which is incredible. I saw my career passing before my eyes in a very thoughtful way, how the benchmarks are related to the risk adjustment, related to the attribution, and then how we fit all of that together with quality. And then how we build that into the bigger system. So I'm going to use one of your quotes, probably more than once, you said it publicly—spend a little time to put a little system in place. It's happening right now. It's called health reform. It's happening on the Hill, it's happening out of the Administration, President's budget proposals, it's happening within the Medicare program. What we're talking about here is a building block and you've correctly identified that. In terms of what the Medicare program can specifically do, some of the ideas I heard you raising around your ideal design are some of the things that we're looking at in our demonstration projects, and perhaps that's a good topic for a subsequent PPAC meeting, the accountable care episodes, demonstration, for example, which looks at paying hospitals and physicians in a way that would encourage them to collaborate. We're talking about the physician group practice demonstration project, which rewards those who are able to improve the quality of care and maintain the costs relative to a cohort and share in some of the savings from that, so we are taking these ideas and building them into the reform process, but thanks for your comment. I think you're right on target.

Dr. Bufalino: We're about 15 minutes behind, so maybe we could wrap this up and I'm sure for those of you that have individual questions. Dr. Valuck would be glad to stay around a minute or two, at my count we've spent 75 minutes badgering you over this topic. So thank you for your kind words and thank you for the opportunity to comment.

Dr. Valuck: If you wouldn't mind indulging me in a final comment, this has been an extremely productive discussion, and I knew from the previous discussions that we've had, which were sort of at a high level, I got a preview into the fact when we were able to actually start bringing you some of our products and deliverables, that we would get this level of engagement. The kind of counsel that we've received this group is invaluable; in some places, validating, in some places, challenging and that's exactly why, and in some places inspiring, and that's exactly why we want to have these discussions, so thank you very much.

Dr. Bufalino: Thank you. Glad to have you come back. Let's just take a 10 minute break and try to get back on task.

Break

Dr. Bufalino: Next, we invite Mr. Marc Hartstein to the table, to talk about the Inpatient Prospective Payment System. Marc is the Deputy Director of the Hospital and Ambulatory Policy Group here at Medicare. He's worked on Physician Fee Schedule since the 1990s. He's been here a long time and has had a storied career through work on drugs, drug administration, and a number of areas. He was also Deputy Director of the Acute Care, where he led the major reforms around Inpatient Prospective Payment, and since 2008, he has been the Deputy Director of the Hospital and Ambulatory Group, managing four divisions that pay approximately $200 billion out, so here's the man in charge of a lot of money, and we're glad to have you join us today and hear from you. Thank you for joining us.

Inpatient Prospective Payment System Update

Mr. Hartstein: You're welcome. It's certainly a pleasure to be here, and I wouldn't like to describe myself as the man in charge of a lot of money, particularly with my boss sitting right up there. There's a lot of decision makers at CMS and I don't think there's any single person who can say that they are the key decision maker. Some have more power than others but certainly the federal government, as many of you are aware, are large, large organization, a bureaucracy so to speak, with lots of decision makers and lots of

points of contact. I always appreciate these nice introductions. And one of these days, I'm going to video tape it and play it for my wife and children, because somehow it seems like, I feel like I'm lot more important when I get introduced here at one of these things than sometimes when I get home late for dinner.

So I'm going to talk about the Inpatient Hospital Prospective Payment System and actually I'd like to say I'm grateful to be back and talking to the Practicing Physicians Advisory Council. I have two different assignments where I worked on Physician Fee Schedule issues over the years, early on, in the early 1990s, when the fee schedule was adopted, and then from 1999 to 2004 when the MMA was enacted, and did a lot of work on drugs, and drug administration, SGR Resource-based Practice Expense, RVUs, and a variety of other things, it looks like the committee has pretty much turned over since the last time I spoke, but I do have some fond memories of making presentations to committee on a great variety of issues in my previous career.

So moving on to the inpatient rule, just this is a significant rule that we're now two years out from, well, I guess really one year out from Inpatient Hospital Payment Reform, which began in fiscal year 2008, so now we're doing some of the work that would follow the initial payment reforms. So some key dates; the Inpatient Rule was displayed on May 1, 2009. It was published in the *Federal Register* on May 22, 2009. We're in the midst of a 60-day public comment period. Public comments are due on June 30th, and the Final Rule, continuing with past practice, will be on display by August 1, 2009, and I think in our history we have never missed that statutory deadline of getting the Final Rule done on time, so I'm confident that we will make that Final Rule deadline as well this year.

Just a couple of key statistics, fiscal year 2010, Medicare projects Inpatient Prospective Payment System payments will be about $117.4 billion. Long-term care hospitals, which are now included as part of the IPPS Rule, projected to be 4.9 billion, and the proposed rule continues our efforts to enhance payment accuracy that began probably about four years ago in 2005, with a MEDPAC report. Moving on to the next slide, just a couple of more key data points, just about how the Inpatient Prospective Payment System affects acute care hospitals, and long-term care hospitals; 3500 acute care hospitals, 400 long-term care hospitals, slightly different market baskets, or measures of inflation, specific to different types of hospitals. Inpatient acute care hospitals 2.1%, long-term care hospitals, 2.4%, outlier thresholds—this is the threshold

above which if the hospital's cost per case exceed its payment by these amounts, they get some additional payments. The reason the outlier threshold is lower for long-term care hospitals is because we set the outlier threshold to pay a higher percentage of total payments as outliers. And then the payment amounts are there at the bottom of the slide.

Proposed policy changes. I'm going to just go over some of the, probably some of the bigger changes that were in the rule. There are a lot of smaller changes that probably got less attention and I certainly can answer as many questions, I'll try to answer as many questions as you may have about any issues that are in the rule. I'll do my best. Some of these I have less expertise on than others. The most I think the most significant proposal in the Inpatient Rule that has gotten the most attention is our documentation and coding adjustment that I'll speak about in more detail in just a couple of minutes. There has been, we've been, as Tom Valuck, my predecessor, who's been working on the Value-based Purchasing initiatives for CMS, one of the significant elements of that, that got us started on this is reporting hospital quality data for the annual payment update. I'll talk about that just briefly, preventable hospital-acquired conditions. This provision of the Deficit Reduction Act, back in 2006, that we implemented, beginning in 2008, has also gotten a lot of media attention and has really I think created even though the payment provision itself may not come into, may not apply very often, it seems like it's actually had a great effect on hospital behavior, in that hospitals are really focusing very much on how to prevent the types of preventable infections, or other conditions, after the patient's been admitted to the hospital. And finally, I'm going to talk about the wage index, for just a couple of minutes, because we have made some changes in the past couple of years, also in response to some statutory provisions. And there's probably some parallel issues on the hospital side that may be of interest to the physician community as well.

So the documentation and coding background, on the documentation and coding adjustment. So what Medicare did in 2008 is we adopted the Medicare Severity or MSDRGs. The goal was to improve the ability of our payment systems to recognize severity of illness and resource usage. We expanded the number of DRGs from 538 in fiscal year 2007, to 746 in fiscal year 2009, and there are three severity levels; with major complication and co-morbidity, without a major, I guess with a complication and co-morbidity, without a major complication and co-morbidity and then without either a major complication

and co-morbidity or complication and co-morbidity. Previously what we did is we had breaks by age; pediatric and nonpediatric. We collapsed those pediatric and nonpediatric DRGs, which I actually think is a good thing, because we don't have many pediatric patients in the Medicare population, and those DRGs were subject to some instability in the values because of the limited amount of data we have on children, and then otherwise, we generally broke it into two categories; with a complication and without a complication. And what our medical officers did, and I have to say this was really quite an impressive task. Dr. Simon participated in this effort as well, was they went through the 13,000 diagnosis codes, categorized them as major complications, complications, or not a complication. There were probably five or six physicians who were involved in this effort, with some staff support, and I have to say if you really want to see an interesting debate, have five physicians together debating whether something is serious or not serious. It was almost like a Talmudic discussion. It was very interesting.

Moving on, this then of course, led to our adopting this entire process. Essentially what we did is we went through as I said, all those 13,000 diagnosis codes to classify them, then we looked at the cases. We collapsed all of the existing DRGs, then we rebroke them up according to these three categories and then, because we have a lot more diagnosis related groups, or a lot more payment categories, what you have is the ability for hospitals to code conditions more comprehensively to get higher payment that previously may not have been coded, and that's what we call "documentation and coding." So improving documentation and coding, which could have an effect on increasing case mix, without a corresponding increase in severity of illness. Which of course, then, would increase inpatient hospital payments without really any change in the patient's condition.

So this leads us to the statutory requirements. Our statutory requirements are that the aggregate payments cannot increase or decrease as a result of DRG changes. That's one of the statutory requirements, which we commonly refer to as a budget neutrality requirement. So adopting a new DRG system, or new data or new weights, using a single year, we applied budget neutrality, making sure that it doesn't increase or decrease payments with one single year of utilization, but what we don't know is what'll happen once the utilization changes. So as I've just described, a feeling that case mix in payments could increase without an actual increase in severity of illness, and so, under the statutory obligation, we felt we had to take that into account. And then there is a second documentation and coding provision in the statute. It says if DRG

changes, did or likely to result in a change in aggregate payments that are a result of changes in the coding or classification of discharges that do not reflect real changes in the case mix, then the Secretary can adjust payments to eliminate the affect. And then the CMS Office of the Actuary, working with the Center for Medicare Management, we did a lot of analysis of the DRG system, the APR DRG system that was adopted in Maryland in the beginning of 2005, and for some hospitals earlier. We did some analysis of that and looking at other data as well, and estimated that the total documentation and coding affect would be 4.8%, and we had proposed to reduce prospectively rates by 4.8% in the IPPS Proposed Rule in 2008.

And then so we originally proposed to adjust rates by 4.8%, anticipating that that adjustment would then, the new DRG system would then produce the documentation and coding response that would essentially offset that adjustment and that we would be budget neutral, as required by the statute. In the IPPS Final Rule, what we decided was to transition the DRG system over a 2-year period in fifty percent-increments. The Actuary actually felt that it would take some time for some of this documentation and coding affect to occur, so what we did was we indicated that we would do the documentation and coding adjustment over three years in 1.2% the first year, 1.8% the second two years.

Then it was a provision of law that changed the documentation and coding adjustments in 2007, late in 2007, really just prior to the new MSDRG going into effect. What it did was it changed the documentation and coding adjustment that we had adopted for fiscal year 2008 from 1.2% to 0.6% and 1.8% for 2009, to 0.9% for 2009. And it left the 1.8% adjustment for fiscal year 2010 unchanged. The law also made that change budget neutral. If the change in the documentation and coding was different than that established by law, future rates would be adjusted to ensure that higher spending is not carried forward, so this is the prospective part of our adjustment. We make sure that the documentation and coding effect is not incorporated into future years. Congress have the adjustments. We would have the take the documentation and coding was different from what we estimated, or different than what we applied, then we would have to ensure that that documentation and coding effect is not carried forward into future rates. And then, in addition to that, the statute was clear that over fiscal years 2010, 11, and 12, we'd have to reduce rates to recoup the high past spending. And what we would do is we would reduce rates prospectively, one time only, to get the money back that we would have spent extra or the opposite, adjust rates prospectively higher, if the adjustments were less than what we anticipated, to either recoup or refund prior past

spending. In this case, we're really only talking about recouping past spending, because in the first year, the documentation and coding effect was higher than what we had anticipated.

So this next slide really just summarizes what happened. We proposed 1.2 for fiscal year 2008, Congress changed it to minus 0.6% and then we'd have to make adjustments for the difference between what we applied and what actually occurred. Same for fiscal year 2009, 1.8 was what had adopted. Congress changed it to 0.9 with a requirement that we go back and revisit it after the fact and make adjustments going forward to ensure that we did not increase or decrease spending relative to what otherwise would have occurred, had we not adopted these systems. And then, in fiscal year 2010, they made no change and that's really where we are now.

Here are all the numbers. Essentially what we found, the one number that we do know for sure, that kind of initiates all of this analysis is in fiscal year 2008, we know it's now fiscal year 2009, fiscal year 2008 is over. We know what the documentation and coding effect was. It was 2.5%. We removed 0.6% from the rates, as Congress required us to do, leaving 1.9% left over. We're currently estimating that the remainder of the documentation and coding effect 2.3% will occur in fiscal year 2009, and that we've already applied an offset of minus 0.9%. So what the next set of, the next part of this table tells you is what we have to go. So for fiscal year 2008, we would have to remove the 1.9% from the rates, that would be the additional 1.9% that was incorporated into the rates, and is being carried forward into the rates, and then in addition to that, we would have to get back the one-time only 1.9% extra that we spent in 2008 that was not budget neutralized. And then based on the estimates for 2009, we would have an additional 1.4% that's permanently incorporated into future rates that we have to get back, plus 3.3% which is 1.9% plus 1.4%. The 1.9 from 2008 that's then carried forward into 2009, which makes 2009 too high, plus the additional 1.4% that's in 2009 that we need to get back.

What we're proposing for fiscal year 2010, is a 1.9% adjustment. That's really just to remove the affect of the forward adjustment, the prospective adjustment so it's not carried forward into future rates, and then what you see is the remaining effect that we have to get back. So we have another 1.4% to remove from the rates going forward, a permanent 1.4% plus a 5.2 one-time effect that we would remove from the rates and then put back into the rates, so that's not a permanent adjustment.

Obviously that's a lot of information and a lot of detail, and we did our best to try to explain it in the rule so people could understand it. It's certainly subject to public comment, and we're very interested in public comments as to what we should do in the Final Rule.

And then on the next slide, we just show what the adjustments are for different type categories of hospitals. The reason they're somewhat different for different categories of hospitals is because just of some historical artifacts. So inpatient acute care hospitals, 1.9%, that's really the largest category of hospitals where this has been an issue, and I just explained how we got to the 1.9%. Hospitals receiving a hospital-specific rate, these would be sole community hospitals and Medicare dependent hospitals, on the hospital-specific rate portion of their payments, they actually did not receive any previous adjustment, so the 0.6% was not applied previously, so they get the 1.9% plus the previous adjustment that was not applied of 0.6%. The documentation and coding effect for Puerto Rico hospitals was actually a little bit lower. The Puerto Rico rate is only 25% of their rate, so they get a slightly lower documentation and coding adjustment on their entire rate and then we looked at the experience of long-term care hospitals independently of other hospitals to come up with the 1.8%. And that covers the documentation and coding adjustment. I'm sure when we get to the Q&A period, there won't be any concerns or questions about that issue. So I'm going to talk about the real stuff now.

Reporting hospital quality data for the annual payment update. Again, this is really the initiation of our interest in collecting quality data and Value-based Purchasing. Voluntary public reporting with a financial incentive. So what happens here is hospitals can report quality data to CMS on a variety of different metrics and then based on that, if they report the data to us, at least initially, they would get the full market basket update, and then we applied some standards to make sure that they were reporting accurate data to us, once we got this program up and running. So to get the full update, they would have had to pass some statistical test to make sure that the data that they were reporting to us matched what data was in the medical record. If they don't report the data, or it doesn't meet these quality standards, to make sure that it's accurately reported, the participants would receive an update of market basket less 2.0 percentage points. This program's been very successful. Over 90% of hospitals are reporting and receiving full update. Quite a bit more than 90%, I believe. And it's become the basis for providing us with lots of information for developing Value-based Purchasing and comparing hospitals on different quality measures.

Some of you may be familiar with Hospital Compare, which is information on the Medicare website, where patients can look at different information about hospitals and see how they reported on their quality measures. And then here are some of the things that they report: 25 chart abstracted measures, heart attack, heart failure, and pneumonia, surgical care improvement, claims-based measures as indicated here, surveys-based measure, and a structural measure. That is the hospital quality update. That's actually comes out of a different group than mine. It comes out of the office of Clinical Standards and Quality, so I have some limited ability to answer questions on that, but if you do have any questions on it, I'll certainly try my best.

The next issue is preventable hospital-acquired conditions. These are conditions that are high cost, high volume or both. They're assigned to a higher paying MSDRG when present as a secondary diagnosis, and they could have been reasonably prevented through the application of evidence-based guidelines. So the idea here is that the patient comes into the hospital and they acquire, let's say, an infection after admission, so the condition was not present on admission. We now have an indicator for present on admission for all diagnosis codes. It's essentially a yes or a no, or it's a not applicable. There might be some different details about depending on the code, but generally the idea is that for conditions where it's applicable, you would say whether or not the condition is a yes or a no, acquired, present on admission, or not present on admission. If it's not present on admission, it's acquired on admission, or after admission, and it's one of the conditions that leads the patient to be assigned to a higher paying DRG, DRG with a major complication or a complication, then that condition would not be counted as a major complication or a complication, if it's one of the selected conditions, which means that it's reasonably preventable through the application of evidence-based guidelines. My predecessor who sat in this chair, Tom Valuck and I, worked together closely on the reasonably preventable idea, and what's reasonably preventable is certainly subject to some judgment and some discussion, and we certainly got a lot of comments on that. This provision has now been out there for over a year. I think it started in fiscal year, we announced the first set of conditions in fiscal year 2008, we started applying the provision in fiscal year 2009, we did select some new conditions for 2009 beyond the original ones that we had proposed in fiscal year 2008. We are not proposing any new conditions for fiscal year 2010. I think we'd like to do some analysis of the provision and the present on admission data to see what information we can find. And then the next slide shows you

all of the conditions that we have determined based on judgment of our medical officers in consultation with the Centers for Disease Control, using the public comment process and so forth, the types of conditions that we think are reasonably preventable, and should not be acquired after admission with following evidence-based guidelines. That doesn't mean they're always preventable, it means that they're usually preventable.

And then the final topic I want to talk about is just adjusting for area cost differences, the Medicare Wage Index. The Inpatient Prospective Payment System like most of Medicare's payment system, it'll adjust for area differences in cost. In the case of the Inpatient Prospective Payment System, it's going to adjust for areas differences in the cost of labor, between metropolitan statistical areas. It's actually based on hospital reported data. Hospitals report their wages on a cost report. Hospitals are on different cost reporting periods. Once the last hospital cost reporting period that's included in a fiscal year ends, then we have all of the reported wage data, but then we have to go through an editing and auditing process and there's essentially a four-year lag between the data year, essentially two years in between. The fiscal year ends then there's two fiscal years when we're going through the reporting, then the auditing, and appeals process, and then it goes into effect in the fourth year, after the data year that the data's reported for. 67.1 or 62% of the rate is adjusted for area wage differences. The 67.1 is actually in this year's IPPS proposed rule. It's currently 69.3. We just made a re-estimate, just rebased the hospital market basket and found that hospital wages, as their percentage of total cost are somewhat lower than we have previously been using, so the labor share dropped from 69.3 to 67.1 and there's a provision in the statute that says if a hospital would get higher payments if we had used a 62% labor share, that's what we should use.

Geographic reclassification. What this does is it allows hospitals to be based on another area, nearby area's wage index, if the hospital's reported wages are different from their own and more similar to a nearby area. The idea here is that we use the Metropolitan statistical areas as proxies for labor market areas, but we recognized, and the statute recognizes, that they may not be completely precise boundaries for how labor market areas are drawn. So hospitals have the data themselves and we through this auditing process, can allow hospitals to apply to be reclassified, and again, the idea is if they feel they're not correctly located in the right labor market area and they can demonstrate that they're actually more similar to nearby area and dissimilar from their own area, then they can go to that area. And another topic that has

gotten some, been of some interest is the rural floor. This is a provisional statute that says that no urban hospital can have a wage index that's lower than the rural area of its state. From 1998 to 2007, we were applying budget neutrality through 2008, we were applying budget neutrality through a nationwide adjustment, so essentially the urban hospitals in a few states, their wage index was going up to match the rural area of the state, and then that additional money that we were paying to those urban hospitals we adjusted for by applying an adjustment, nationally, that affected all hospitals. But after some further thought on it and some requirements to study reform of the wage index, we decided that we would apply that adjustment within each state, rather than nationwide, and we're currently in a three-year transition to moving to that state wide adjustments.

And then finally, wage index reform. The Medicare Payment Advisory Commission, probably about two years ago, had recommended that we use Bureau of Labor Statistics instead of hospital reported data to determine the wage index. The Tax Relief and Healthcare Reform Act required us to study changes to the hospital wage index, including taking into consideration MEDPAC's study, and specifically study using Bureau of Labor statistic data, limiting geographic reclassification and about seven other areas as well. We have a contract with Acumen to assist us with this project. The first phase of the Acumen report is currently on the CMS website. Some of the preliminary conclusions from Acumen were that the Bureau of Labor Statistic is a preferred source of data for the Medicare wage index to hospital reported data on the hospital cost report. They said it avoids problems with circularity. In other words, hospitals reporting wages that then become used in its wage index, which then allow it to pay higher wages, or not pay higher wages, depending on what its wage index is. They also said there was less year to year variation and year to year volatility with the Bureau of Labor statistics data, compared to the hospital reported cost reported data. One of its main liabilities is that it doesn't have benefits data, and benefits is actually a fairly significant portion of hospital labor costs, although they did work with the Bureau of Labor statistics and did suggest that benefits data could potentially be available through the Bureau of Labor statistics if they were to augment their surveys in some ways. And then just some more information for your benefit. Here are some key websites, where you can get information about all of the issues that I discussed and some contact information for me. And with that, I'll be happy to answer as many questions as I can.

Dr. Bufalino: Thank you. Questions for Mr. Hartstein? I guess we're letting you off the hook. Thank you for being here. We appreciate it. We'll shift directions, and ask our Panel of RAC Update folks to join us. As you know, Commander Marie Casey and Lieutenant Terry Lew have been with us before and we ask, and today they're joined by Dr. Jesse Polansky to present for us today's update on the RAC. They have done an excellent job to date at giving us a perspective on where this program is going. So we're looking forward to hearing from all of you today as to the latest phase of where the RAC is going in the country. Thank you for joining us.

RAC Update

Cmdr. Casey: You're welcome, and thank you for allowing us once again to be here, today. We are pleased again to provide additional information on the RAC program and just to give you all some background information. Again, I'll go over the legislative background regarding the RAC program. In the first piece of legislation, that CMS received in implementing a demonstration program came through the Medicare Modernization Act, Section 306. This did allow us to have the three-state demonstration. The three states that were originally selected were California, New York, and Florida. We then expanded to the states of South Carolina and Massachusetts, prior to the end of the demonstration, which the end of the demonstration was March of 2008. We have not since had a RAC program at all, and I'll explain some of the details, why we have not established the RAC program until 2009. The other piece of legislation that allowed us to enact the national program came through the Tax Relief and Healthcare Act, was Section 302. This did allow us to establish the RAC program nationwide; however, we had been mandated by Congress to have this program up and running by January 1 of 2010. Both of the legislation that we received allowed CMS to pay all contractors on the contingency fee basis for recoveries, and again, they're both recoveries for underpayments as well as overpayments.

Now to talk a little bit more about the permanent program. Again, August of '07 the pre-solicitation for Recovery Audit Contractors was posted at Fed Biz Ops.gov, and then in October of '08, CMS actually announced four winning bidders. They were Region A, Diversified Collection Service, Region B, CGI, Region C, Conway Consulting Associates, and Region D, Health Data Insights, and I'll provide you with a map that shows you exactly where those jurisdictions are in the country. However, in November of '08, a protest was filed by two unsuccessful bidders and this delayed the implementation of

the RAC program until February of ’09. In February of ’09, the protest was actually settled, and we now have two additional subcontractors that will be working with our RACs. Those two subcontractors are PRG Schultz, and they are subcontractor to Region A, Diversified Collection Service, Region B, CGI, and Region D, Health Data Insights. And Viant will be a subcontractor to Region C, Conley Consulting.

As you can see, we’ve divided up again the country into four RAC regions. Those four RAC regions are identical to the DME MAC regions and I’ve listed for you all the contractors that will be working in those jurisdictions. Also the map has colors on it, and usually we say the color looks green on your particular slide, but normally it’s yellow. The yellow and green states are the states that we currently are conducting outreach. The blue states we will be conducting provider outreach, beginning in August. Also, claims are now available for RACs to review in both the yellow and green states. Originally, we had wanted to start the program with the yellow states and then gradually add the green states, but due to the protest, we’ve had to combine the yellow and green states together. So currently, again, we are looking at claims data for the yellow and green states. Providers may start to see if you’re in a yellow and green state, and outreach has occurred, you may start to see demand letters. However, the blue states should not have demand letters until after outreach is conducted, which should start late this summer and go into August and into September.

Again, I already mentioned about the outreach that we’re conducting. These are joint CMS and/or RAC contractor presentations. CMS provides background information on the RAC program. We talk about what the statement of work requirements are. And we also talk about some of the processes. Then the RAC provides background information on their unique processes for their jurisdiction, and we’ve done these presentations to the hospital associations, medical societies, as well as industry groups. Currently in the states that are to go live, we’ve conducted almost all the outreach for those yellow and green states; however we are planning on scheduling some additional trips this summer. We have some additional association meetings that our staff will be attending and providing RAC information just to get the word out regarding the program. If you would like more detailed information about our outreach schedule, it is available on the website that’s listed for you and the dates and times of those events are scheduled at that website.

Some more information on next steps in the program. CMS now has the claims data, or RACs rather have the claims data. The claims data that we have provided to them began with October ’07 data and has gone through February of ’09. Some March and April ’09 transmissions to the RACs are still pending, however, once again, RACs are able to look at any Medicare Fee-for-Service claim during the time period that we’ve authorized them to do reviews. RACs may not conduct widespread reviews without CMS permission or CMS approval, rather. This has been a change from the RAC demonstration. So again, if a RAC has an audit idea, they just can’t go out and ask for 500,000 charts and collect a lot of money. They must first have that issue approved through CMS. Approvals will initially be limited to automated reviews of administrative and coding requirements. We are not planning on doing medical necessity reviews probably until some time in 2010. So again, the reviews are going to be, at least in the beginning, limited to automated reviews. Eventually, we’ll move into some Part A coding type complex reviews, but for right now, we’re primarily focusing on automated reviews.

CMS, as part of the national program for expansion, has retained the services of Provider Resources, Inc. This is the RAC validation contractor. This contractor will provide an accuracy score for each RAC. They also will assist CMS in our new issue review process, in that they will look at a sample of claims for the agency to help us make a determination whether we believe this to be a good audit idea for the RAC to proceed in their particular jurisdiction. And lastly, again, PRI is going to on a yearly basis, I mentioned that they will be doing the accuracy study for us.

Some additional next steps. Initial automated reviews are expected to begin in June and probably demand letters will probably go out in the July time frame. Again, those are the yellow states. We’ll start with the yellow states on the expansion map and then move into the green states. And we hope to, we won’t be looking at any claims in those blue states that I mentioned until August or after August. Again, RACs are not permitted to conduct reviews three months before or three months after a MAC transition. The exception to that is if the FI or carrier, happened to be the winning MAC, so for instance, we had First Coast Service Options, which was a legacy contractor in the State of Florida. They actually won the MAC contract for the State of Florida, so there was no blackout period for the State of Florida. So again, if the legacy contractor now is the MAC contractor, there will not be a blackout period as there will be for other MAC transitions.

And with that, I would like to turn it over to Terrence Lew to provide information on the post-payment review process and he will also provide some updates on what providers can do to get ready.

Lt. Lew: Good morning. I'd like to thank the Council again for having us back. We appreciate every opportunity we have to come here and speak before you. Hopefully we will be able to provide some good information and answer any questions that you have as they arise. We will take questions at the end. A lot of the information that I'm going to be covering in the balance of the presentation is not necessarily new. This is information that we've been putting out there in other forums, and some of it quite possibly in this forum as well. But it's information that we feel is important. And it does bear repeating. One thing that's not actually on the slides, but it is important to note is that the RACs are obligated to follow the same review processes and policies as any other reviews conducted by Medicare contractors. They follow national local coverage determinations, national coverage determinations, local coverage determinations, and they follow the program integrity manual, and they follow all the same requirements that other contractors are subject to. Regardless of how a review is conducted, whether it's automated or complex, where they've requested the medical records, if they've identified an improper payment, they're going to forward it on to the claims processor to be adjusted. The RACs will send out the demand letters and they'll have detailed information on provider rights from that point, and one thing that is new is the Remittance Advice Remark code. N432, adjustment based on a recovery audit, that will appear on both paper and electronic remittances advices that are generated as a result of a RAC adjustment.

So again, there are two types of review; automated and complex. For an automated review, that's where the RACs have done the data mining, and there's been no interaction with the provider, prior to the demand letter. We are not allowing them to do automated review in cases where there's really any kind of wiggle room, on whether a policy applies or not or whether a coding instruction should be applied this way or that way, if a RAC is doing an automated review, our intent is that it be a crystal clear issue; that there not be any gray area in that. If there is any gray area, that's going to throw the issue into complex review.

One of the things we heard loud and clear from the RAC demonstration is that providers wanted a clean, transparent process. We didn't want to be doing behind-the-curtain reviews, automated reviews, on issues that had those kinds of gray areas. Anything like that, we wanted to make sure that a human being, not a computer, was conducting those reviews. And that you, as a provider, could subsequently reach that

human being and discuss your concerns if you disagreed with their finding. That gets again, to complex review. Any time a complex review is conducted, medical records are requested, you're going to receive a letter with the results of that review, whether there are improper payments that have been identified or not, you'll get that letter and you'll be able to get that sense of closure. You know that review is complete. It's not just hanging out there and six months or six years down the road, you're going to get a letter that says, oh, by the way, provider, you owe us X dollars.

Also the recovery process is the same for improper payments that have been identified by carriers, FIs or MACs. One thing that came out of the last meeting here; providers have 120 days to appeal a RAC determination. I believe that 30 days was put out there at one point, but it actually is 120 days. It is the same appeal rights for a RAC decision as for any other claim adjustment. All the normal provider appeal rights and policies regarding limitations on recoupment do apply.

How can providers prepare for RAC reviews? These recommendations are the same that we've presented previously, and those are basically to do your homework. Know where previous improper payments have been found. Look at OIG reports, CERT reports, the RAC demonstration report. The RACs are probably going to be looking at a lot of the same things that other program integrity organizations have looked at and identified. We're also encouraging providers to carefully review their own operations. Make sure that you're in compliance with all the applicable Medicare policies, coverage determinations, coding directives, requirements for documentation, the best way to protect yourself against finding some improper payments is to keep a clean shop. Maintain a compliance officer, maintain a rigorous compliance program, and do the best you can to ensure that you are incompliance with all applicable requirements.

RAC specifics. Develop processes for tracking and responding to RAC record requests or other correspondence. There are timelines. There are deadlines attached to RAC requests for medical records. There are timelines attached to demand letters. You're going to want to have a system for tracking those timelines and knowing that if you have x days to come up with a record for such and such claim, or Y days to file an appeal if that's your decision on a RAC determination.

Also every RAC has a process for identifying key contacts at your organization. You're going to want to avail yourself of that. Especially large organizations, large medical groups—if you have correspondence going to six different offices for six different things, it's very easy for things to get lost in

the shuffle, and we would encourage you to identify a RAC point of contact to whichever RAC is operating in your region.

Next one, appeal when necessary. The RAC program offers a discussion period. If you disagree with the outcome of a complex review, and we would certainly encourage you to avail yourself of that discussion period. But at the same time, if you feel strongly, or perhaps not so strongly even, if you make a business decision that an appeal is warranted, we would certainly encourage you to appeal. Nothing in the RAC parameter is intended to discourage providers from taking advantage of any of their rights under any other claim review program. Another way you can prepare for a RAC review is to learn from colleagues in past experiences. The associations, all of them, I'm sure are having all sorts of information on preparing for RAC reviews. There's a considerable consulting industry that's sprung up around preparing for RAC reviews. Learn from others' experiences. We would certainly encourage you to take advantage of others' experiences and apply those to your own practices to get as prepared as you possibly can be.

Where are we going in the future? The RACs must currently accept imaged medical records. Right now, we're working on a system to allow uploads to a central repository rather than mailing in paper, mailing in CDs or DVDs. Perhaps some day we'll be able to have full data interchange, where your EMR can talk to our system. Don't know when that will happen but that is something that we would like to work toward. RACs must post approved review topics and vulnerabilities on their websites. That is something that has to be in place, I believe it's January. Anything that a RAC has been approved to review has to be on that RAC website, so you'll be able to go to that website and see what the RACs will be looking at. Vulnerabilities, the same thing. If RACs are seeing common problems, and they've reached a certain threshold, then we'll direct them to post them on their websites. Again, getting back to keeping a clean house, being prepared, knowing what the RACs are finding in other providers, and looking at your own operations to see if perhaps you're needing to be concerned. RACs also must have claims status websites; an opportunity for you to go on line and see the status of a review. Again, going to transparency and predictability. We don't want you to get medical record request letters, send off those records, and then just be sitting there, wondering what's happening with them. The RACs are required to have websites where you can go and see the record has been received, the record has gone to reviewer x, y, and z, and to basically follow the process of that review, to see where you are and what you might be expecting.

Future directions, part two or three. Medical record request limits. This is something that we know the Council is acutely interested in and we do want to assure you that we have heard your recommendations and we have taken them under advisement. We can't say right now that the medical record limits for FY '10 are going to be X, Y, or Z. We are still considering various options. We are still considering very carefully the recommendations that you all have put forth. Again, I want to emphasize that we do take your concerns and your comments very seriously and we do consider them in determining what directions we're going to go. We're looking at the possibility of using Tax ID numbers for next year. We haven't settled on anything yet. I do want to make that very clear. We have not settled on any changes for FY '10, but we are considering a number of different options, getting back to our goals of predictability, no ability and fairness. Because that is something that we are trying to get to. We want to have as fair a process as possible, a predictable and knowable a process as possible. And again, any changes would be in FY 2010, starting October, 2009.

So some questions for you. Commander Casey mentioned that we are doing outreach. We are continuing to do outreach through the summer. We are reaching out to hospital associations, provider groups, provider societies, as many possible outreach venues as we can, we're trying to get to, but we know we can't reach everybody. We would encourage you to look at the outreach schedule that we have posted on our website, and if there's anybody else that you think would be a good outreach partner, someone to work with to reach a provider group that we haven't spoken with yet, please let us know. One of the later slides has our contact email address and we would be happy to take your input. Also, the next meeting, I believe, is in Baltimore. And if you're interested, we'd be happy to have the RAC medical directors come in and speak. In our March presentation, we had a slide with their names and their specialties. If you'd like to put faces to the names, if you'd like to speak with them, we could certainly invite them to the next meeting and you could put faces to the names and go from there.

Our program website, you can also register for email updates. CMS.HHS.GOV/RAC. There's a lot of information there. We post things fairly regularly, and you can request email updates. You'll get a flash whenever something has been posted and you can go in and check it out. And I believe this is our final slide. Our contact information, our email address. There are about 20 people in the division. We have a variety of experts in a variety of different things. Feel free to send your questions to that address, and that

goes for everyone in the broader provider community. Feel free to send in your questions and we'll do our best to get back to you as quickly as possible. The four regional project officers are listed there as well; Ebony Brandon, Scott Wakefield, Amy Reese, and Commander Kathy Walsh, who's also a Commission Corps Officer. That's pretty much all we have for today. At this point, we'd like to take your questions.

Dr. Bufalino: I'm sorry, I just was going to ask Dr. Polansky, did you want an opportunity to say something? No? Thank you. Let me begin, and then we'll go around. A question that we raised the last time we were together was for you to give us several examples of areas that would be concerns for the physician community in terms of specific areas that will be investigated by the RAC contractors aimed at physician practices. A lot of what we've talked about up to now have been aimed at the hospital community, and we talked a little bit last time and that was an area that wasn't as clear, and wondered if you had any further delineation on some examples of things that the physician community be looking for that will be looked at by the contractors?

Cmdr. Casey: Well, we don't have much data. We only have what was available to us at the demonstration, and because Evaluation & Management codes number one, were not something that the RACs were allowed to review, we don't have a lot of E&M data. The things we primarily saw during the RAC demonstration that were problems with part B services in general, one was, I think the drug Nulasta, we did have an issue with some duplicate claims, but they were very simple things. They weren't things that really related to medical necessity. I do believe there was a fascia joint issue, down in Florida, that we actually made a decision at CMS that we would actually rule in favor of the provider and actually we required that the contractor down there actually overturn the initial decision made by the RAC contractor, due to some confusion over a local coverage determination. But there really weren't a lot of information that we can bring to the table to you from our demonstration. That being said, we have not received to date any new issues that are physician services issues that have come in to the agency as part of this new issue review process that we can share with you. So the only information that we have in terms of what things a RAC might consider is actually what's all available to you. Things that were identified as errors by the CERT contractor, things that have been identified by the OIG or GAO in their reports, or anything actually that's out there in the medical literature as a potential problem with abuse or improper billings. But again—

Dr. Bufalino: So there haven't been specific areas that the RACs have said to you would you approve one, two, and three for us to be aimed at physician practices?

Cmdr. Casey: No.

Dr. Bufalino: Thank you. Let's begin. Jeff?

Dr. Ross: Back in August, in Baltimore both Amy Reese and Melanie Combs Dyer reported to us on some overbilling. There was a question in regards to 1% durable medical equipment, about $6.3 million in over charges for physician versus commercial suppliers. I had asked the question specifically if we could differentiate between the over charges or over billing that took place between the physicians and the medical suppliers. We even passed a recommendation that said that PPAC recommended that the RAC provide data for over payments collected of DME and differentiate between the physicians and the commercial suppliers. My logic, at the time, for asking this question was was this over billing taking place from the medical suppliers versus the physicians. The implications are very strong, because we're dealing with DME today and with this accreditation process, we're trying to show that it's not the physicians that have committed the over billing, but rather the onus of responsibility really should be on the suppliers and that the physicians are just doing what they should be doing and we're being lumped in. So at the time when that recommendation was passed, we had asked for a differentiation and report. So here we are almost coming to a year later, we still haven't seen that data or that information. Like to know if you can furnish us with that information, either today, probably not, or at our next meeting.

Lt. Lew: Sure. That actually is an example where we did hear you loud and clear. Going forward, we are tracking DME provided by physicians, versus DME provided by suppliers, so going forward, that is something that we will be able to report out $50 here, $50 million there, however the breakout winds up being. I don't know if we're going to be able to go back and review the demonstration data. It's sort of hard to reconstruct from our archive things that aren't there now. I'm not sure if that is something that we would be able to do, but I can tell you that with certainty, going forward we'll be able to tell you DME by physicians, DME by suppliers.

Cmdr Casey: Actually my understanding is that we can't go back and get that information from the RAC demonstration data that you were using in your example. But going forward, it is something that we'll be able to report out in our yearly reports.

Dr. Ross: And when will that take place?

Lt. Lew: I don't know if we have a schedule for producing yearly reports—

Cmdr. Casey: We're actually at a little bit of a disadvantage because we don't have a full year's time frame, so in the past it was usually in January that we would issue our report. Since we have not started to actually collect anything yet, and probably won't start until July, it's going to be a very short time frame, so I'm not sure whether we'll report out just from July through December, and provide a report in January, or we'll take a whole year July to July and report in July.

Dr. Ross: So if I'm reading you correctly, the 1% can't be differentiated between medical suppliers and physicians from that demonstration that was reported back then, a year ago. So here we are a year later and we still don't have that information, nor that data can't be used from the previous demonstration. Is that correct?

Cmdr. Casey: The data can't be used for what I think you're looking for. We just can't go back—

Dr. Ross: And so we're starting all over again.

Cmdr. Casey: We didn't have the process in place at the time to get the data reports to you as you suggested, but we utilized the information that you had provided as that was something you needed in the future, we have added that to hopefully fix and provide that information to you in the future.

Dr. Bufalino: Great. Others? Frederica?

Dr. Smith: Thank you first of all, for hearing us on the question of the burden of medical records, both in terms of numbers and [unintelligible 57:25] and so I'm glad you're at least looking at that question. I hope that you'll reach the same conclusion that we did, but we appreciate that. In terms of your outreach programs, I think I honestly haven't paid any attention to what your schedule is or whom you've tried to reach. I only know that it certainly hasn't gotten to me and I think it would have been something I would notice, just because I'm aware of the issue. I suspect that it has not reached a lot of physicians in rural areas and so on. I mean giving a talk in a city 100 miles away at 9:00 on a weekday morning just isn't something that people are going to cancel an office day to do. I wondered if you'd gone through, I guess I'd call them venues, like articles in medical society newsletters, and specialty society newsletters, things like that that might be one way to reach people. People tend to read one or the other, or perhaps both on occasion.

I have a couple of recommendations, if it's appropriate to raise them? One is based on my continuing concern of costs associated with complying with various things like this, and I'll expand that a bit to say it's very nice to know that you can look up on the website and see what the progress is of your review and so on, but that's a time issue, again. Somebody in the office has to do it. It's not likely to be the physician in that case. And so I would like to offer that PPAC recommends that CMS assess the time for physicians or other medical providers, the resources, such as staff time, and hence the cost per physician of complying with existing regulatory burden of such things as PQRI, ePrescribing, and RAC requests.

Dr. Bufalino: Thank you. Second?

[second]

Dr. Bufalino: Discussion? Did you get that?

[off mike discussion]

Dr. Bufalino: So can we vote on that? Can you read that again, I'm sorry.

Dr. Smith: PPAC recommends that CMS the time for a physician or other provider, the resources, such as staff time, and hence the cost per physician of complying with existing regulatory burdens, such as PQRI, ePrescribing and RAC requests.

[off mike discussion]

Dr. Ouzounian: There's a whole bunch of things that are regulatory. So I think you need to say not for example, you need to say specifically what you want them to look at, because we could say that other things should be included and where does that end?

Dr. Smith: I'm okay with that.

Dr. Bufalino: Would you like to modify it?

Dr. Smith: I want them to assess it, calculate it, figure it out.

Dr. Standaert: The costs.

Dr. Ouzounian: The costs for complying with those three things.

Dr. Smith: Right, the cost for complying with those.

Dr. Ouzounian: With those three things.

Dr. Smith: Right.

Ms. Trevas: I'm not sure how you want to reword what I have.

Dr. Ouzounian: Well you take you "for example."

Dr. Smith: I'll take out "for example."

Ms. Trevas: Okay.

Dr. Bufalino: Can I ask you to vote on that one? All in favor?

[ays]

Dr. Bufalino: Thank you. Others?

Dr. Smith: Yes. Companion one to that. That PPAC recommends that CMS be required to assess the time for physician or other provider, resources, such as staff costs, and hence the cost per physician before being allowed to implement new regulations.

Dr. Bufalino: Second?

[second]

Dr. Bufalino: Discussion? All in favor?

[ays]

Dr. Bufalino: Thank you.

Lt. Lew: If I could add a comment, Dr. Smith, on your initial comment about outreach. We'll certainly consider the medical society and specialty newsletters. I think that is a good point. We're also exploring web conferencing technology. One of my colleagues was recently trained in I don't know if Webinars is a trademark, but was recently trained in web conferencing software. That is something that we'll be looking at going forward, because we do realize that it is hard to take a day off and head down to the nearest big city or whatnot for an in-person presentation. But we do want to get the information out there and so that's something we'll consider.

Dr. Snow: Couple of quick questions. In fact, regarding that, apparently there have been some open door calls about the RACs. Are these available for playback now someplace on the website, because we've had several people looking for them, can't find them.

Lt. Lew: There are time limitations and I don't know the specifics on that but they do make the recordings and the transcripts available for certain periods, I'm not sure if there's anybody here who's more conversant with those, but at least for a little while, the information is available.

Dr. Snow: Okay and is that on the CMS website, the RAC website, where?

Lt. Lew: Through the CMS website.

Cmdr. Casey: Right. I believe it's under Open Door Calls. If you were to…

Dr. Snow: Okay. Secondly, I understand hospitals can charge and be paid for providing medical records for RAC audits. Is that correct?

Cmdr. Casey: That's correct.

Dr. Snow: Physicians cannot?

Cmdr. Casey: That's correct.

Dr. Snow: There seems to be a slight difference there. What's the rationale for that?

Cmdr. Casey: I had to answer this question to a group of physicians actually in Oklahoma and they didn't really care for my response. But my understanding is that the agency has taken that policy because they believe that the cost associated with photocopying medical records are included in the Physician Fee Schedule, and similar to the other types of contractors that we do have, that happen to be medical review, they also do not pay for medical records from physicians. However, the QIOs for year have paid for medical records, because that was supposedly not included in the payment amounts that the hospitals received. So that's currently the position the agency's taking on whether to pay or not to pay.

Dr. Snow: So hospitals' costs are not included in their DRG payment, somehow.

Cmdr. Casey: Supposedly, the costs of the photocopying and submitting those medical records is not supposed to be one of the things that slipped out and added into the payment that they receive.

Dr. Snow: So, but it's an agency decision, then is what you're saying. It's not statutory. It's just the agency. Can I make a recommendation?

Dr. Bufalino: I knew it was coming!

Dr. Snow: PPAC recommends strongly that CMS reconsider its decision on nonpayment for physician copying costs for RAC audits.

[second]

Dr. Bufalino: Any discussion? All in favor?

[ays]

Dr. Bufalino: Thank you.

Dr. Snow: One third, quick last question. What do RAC letters look like? I mean, for instance, the reason I ask that and this came from one of our health people in our state. First Coast a contractor for reconsideration for second level appeal has a sailboat on it, so you know you get a sailboat letter in your office and boy that's going to be damned important. You're going to put it at the top of the list.

Lt. Lew: My understanding is that the letters will be posted to the websites. This is slightly old information but the last time I saw them, the CMS logo was at the upper left corner, the RAC's logo was perhaps at the upper right corner, but it was fairly, to me, fairly clear that it was an official letter from, or under the umbrella of CMS.

Dr. Snow: Okay, and it's going to be addressed to the provider?

Lt. Lew: Yes.

Dr. Snow: Okay. Thank you.

Dr. Sprang: We talked before [inaudible 65:51] E&M coding for physicians. Where is that in the process? Are they doing it? Are they not doing it, or is it still up for review or…

Cmdr. Casey: Well, we haven't had them, under their statement of work, they are allowed to reviewed E&M codes now, during the national program. They weren't allowed to review those during the demonstration. However, to date, we have not received any requests from the RACs that came in through the new issue review process to look at physician services, E&M claims.

Dr. Sprang: So we are [unintelligible 66:20] the reason I bring it up is I just had recently one of our business consultants, and he said that he had heard from people in New York that doctors were getting reviews for looking at E&M coding from the RAC.

Cmdr. Casey: Not from the RACs. RACs haven't, there hasn't been one letter sent out yet, requesting a review or demanding payment from the RAC program. Must be another Medicare contractor.

Dr. Sprang: But they are able to do it.

Cmdr. Casey: They are able to do it and that's certainly something that they could, in the future, do, but to date, we haven't received any requests for E&M codes to be reviewed, and it's certainly something I don't think we're going to be looking at in the next few months here.

Lt. Lew: I believe at a previous meeting and I can't remember who it was, but one of the Council members mentioned receiving a RAC letter in fairly recent history. That should not have been the case.

There should not have been any RAC letters going out in the last few months. Nor should there be any going out in this very instant. The letter may have come from another contractor, Dr. Smith. Was it you that received the letter?

Dr. Smith: I got a letter from somebody, I thought it was RAC, saying that I needed to submit documentation about having ordered blood test on a patient, for the magnificent sum of $2.96 which I thought was a little extreme.

Lt. Lew: There are a number of contractors that do send out request letters under the umbrella of CMS. It may have been one of those. It probably should not have been a RAC letter.

Dr. Standaert: Couple questions. One, look for the, he said RACs may not conduct widespread reviews without CMS approval. Is there a difference between a widespread review and some other kind of review?

Cmdr. Casey: Well, actually there is. But in general, the type of audits that the RACs review is mostly widespread. Our other Medicare contractors, a lot of times what they do is they do really targeted reviews, just because they have such limited resources. And what they'll do is they'll do a 20-claim probe sample and they'll drill down to the couple groups or couple people who they think are truly the problem providers and they'll send out education letters to the provider, to help them better understand why they're doing what they're doing, and then a few months later, they'll put them maybe back on reviews to see if they've changed their billing behavior. That's typically the way our MACs review. The way that the RACs reviewed on the demonstration and the current plan for RAC review is that they will look at a particular vulnerable code, and they will look across their entire jurisdiction, and they will look in every state at as many providers as they have the resources to review and they will collect overpayments or underpayments.

Dr. Standaert: Is there a formal definition of that, though, or can a RAC say, well, I don't want to get authority to go through this one so I'm just going to look at just one hospital for this one code, and then it's targeted, it's not widespread, and then, is there a—

Lt. Lew: Let me speak to this one. I think I put this slide together. One of the things that we're trying to get at here, we didn't want the RACs going out and sending out hundreds of medical record request letters without CMS having a chance to look at it first, to see what it is they wanted to review. That's why we established the new issue review process. Now they are allowed to go out and request 10

medical records for a pilot study to determine if it's worth coming to us in the first place. So if a RAC decides that they want to review issue X, but they're not sure if it's a really big problem nationwide, or if it's just limited to the small locality or what the scope of the problem is, they can request up to 10 medical records, review those letters, they're not allowed to send out demand letters, they're not allowed to recover on those but those are their pilot study, those ten reviews, where they can see is this a real problem? Is this something that we want to go to CMS on and request permission for widespread review? At that point, if we approve it for widespread review, it has to go on the website. Our intent behind this bullet is really saying 99.9% of the time, you are not going to receive a medical record request letter for something that's not on the website. You might request one if you happen to fall within their initial pilot sample. If you get a request for 100 different records for something that's not on the website, that we want to hear about.

Cmdr. Casey: I just want to make a point of clarification. A demand letter may eventually be sent on that initial 10, but it won't be sent until after CMS approves it.

Dr. Standaert: Just wondering if there's some other kind of, if everything has to be approved by CMS so they can get recovery without a CMS approval.

Lt. Lew: No. In order to recover, they have to receive CMS approval.

Dr. Standaert: Okay, so my second question. Just to your question about outreach, I'm in Washington and I've never heard a thing. I mean I come here to and I got on your listserve, so I do, but I guarantee I'm about the only person I know on your listserve. So there's nothing. And I think from a suggestion standpoint, I don't know about the rest of you, but in my world, I mean physicians get information from their hospitals grand rounds. I don't think most of us are trolling the CMS website looking for what's coming next. And so you need to get people where they are. And a web conference sometimes takes more time out of your day to schedule some conference. I'm on the West Coast, the hours are, so you need to sort of get it into their schedule. So maybe if you provided hospitals with information or a slide set or some presentation they could give to their providers, or some other way to directly get at people in their workday, you might get—again, I don't know if you've made it to Washington, but I've never heard a thing. So—

Cmdr. Casey: We actually have put the slide presentation on the website that we give on these outreach sessions, but we have had considerable difficulty in scheduling the physician outreach. We're able

to schedule the hospital association, the outreach with the hospital associations, but trying to get the physicians together at the same time.

Dr. Standaert: You got to get at them where they are, that's my point.

Cmdr. Casey: It's been really difficult. We'll have to do like lunch. I've done a couple late night meetings from like six to eight, because the physicians are busy. They have patients all day long, so it has been very, very difficult for us to schedule the onsite presentations so that's why we are exploring other forms. Now I'm not sure exactly with Washington. I don't believe has been done yet for that state.

Dr. Standaert: Yes, I saw that. It looks like it hasn't.

Cmdr. Casey: Right. I think we've done most of, I know in New York, we didn't actually do an onsite presentation with the physicians. We did a web kind of presentation and they felt like that was sufficient.

Dr. Standaert: The people who saw the web presentation?

Cmdr. Casey: Well, actually we had a group of people that called in and we went through our slide set and the people we talked to from the medical association felt that was sufficient because they had been a demonstration state. So they felt that was sufficient so CMS had considered that to be the physician outreach for that state. Now we haven't heard anything negative that New York providers wanted more education.

Dr. Standaert: You probably will when they start getting letters for their money.

Dr. Ross: I appreciate your clarification about the demonstration, but I'd like to make this recommendation for the future data and for the future report. That PPAC recommends that the RAC provide data of overpayments collected for DME and differentiate between the physician overpayment versus the commercial suppliers. PPAC recommends that the RAC provide this new collected data in January of 2010 and at the subsequent PPAC meeting.

[second]

Dr. Bufalino: Second, thank you. Discussion? All in favor?

[ays]

Dr. Bufalino: Thank you.

Dr. Giamio: [inaudible 4:47] process when people go into that, is that a transparent process for anyone or just the individual group has charts reviewed? In other words, is that a findable thing? If that's on your website can anyone search that data? So for instance would you be able to go and look on Dr. Smith's review.

Lt. Lew: Certainly, not.

Dr. Kirsch: Just very quick, it's been brought to my attention that when you go to the website, it's difficult to find the names of the Regional Medical Directors. Could you make that just a little clearer on the website?

Cmdr. Casey: The RAC medical directors' names.

Dr. Kirsch: Right.

Cmdr. Casey: Okay.

Dr. Sprang: [inaudible 05:30] confusion as to sometimes when there's RAC or any organization something, asking for more records, and maybe it's not really clear to the doctor and they end up setting it, and maybe they're kind of being misled a little bit. So I'm going to say, PPAC recommends that CMS prohibit MA organizations and RAC organizations from explicitly stating or implying in their communications and correspondence with physicians that they are obligated to submitted to large scale medical chart review as part of a CMS regulatory oversight and payment requirement when that is not in fact, the case. I think the doctors seem to be getting letters that they think they have to do this, because the way that it's implied in the letter, and it really isn't something that CMS has already approved and said that they have to do. That's at least what we're hearing.

Dr. Smith: For the pilot project, you're talking about.

Dr. Sprang: Is that clear—

[chat]

Dr. Sprang: It seems that physicians are getting letters asking for a lot of charts and the way it's kind of implied in the letter, they think they have to because CMS is behind it. But in fact, CMS is not behind it.

Lt. Lew: Letters should not be going out requesting large numbers of records.

Dr. Sprang: But they seem to be that they are.

Lt. Lew: Letters from RACs shouldn't have gone out at all since last January-ish, since early 2008.

[chat]

Lt. Lew: I would hesitate to put anything out there saying that you do not have to comply with a record request—

Dr. Sprang: Unless it's really from, unless CMS approved it. And that's what I thought I heard you just say, that CMS has to approve—

Cmdr. Casey: But that's only on a RAC review. So it sounds like other reviews that may be occurring. Those things do not have to be—a MAC, one of the MAC contractors or OIG, or one of our PSEs, those don't have to be approved by CMS. This was a process developed specifically for the RAC program, because of the potential for the RACs to quickly add resources as collections occur, they can quickly staff up and it could potentially have a large financial burden on a provider type, so CMS wanted to ensure that we were having good oversight of the process and we wanted to make sure we didn't have a RAC go out and collect $10 million and then have to refund that money because it was an error they made in review and interpretation of the policy.

Dr. Sprang: But are organizations, specifically like the Medicare Advantage can just ask for hundreds of charts?

Lt. Lew: Medicare Advantage is completely outside of our area of expertise.

Dr. Sprang: Just because we're talking about letters going out—

Cmdr. Casey: But my understanding is with other entities though, that they do not have the same new issue review process, in which the issue was approved before a provider reviews it. It's only for the RAC?

Dr. Sprang: They can do whatever they want, ask for 100 or a 1000 charts and the doctors just have to do it?

Cmdr. Casey: I don't want to speak on behalf of other operational units, but I don't believe there's—Dr. Jesse, I don't know if you can answer this.

Dr. Polansky: What we're saying here is there's a variety of contractors. There's a CERT contractor, there's routine operations of the MACs, there are letters that go out to physicians other than the RACs. And sometimes to the provider community, they may be indistinguishable if they don't look

carefully. What they're saying with great clarity is since the demonstration ended March of '08, the RACs have not been authorized to send letters. It's very unlikely that they've done that. So we're not going to comment on what the Medical Advantage plans are doing, the CERT plans, the MACs. There's a variety of people under the Medicare umbrella, doing outreach to get medical records. We don't believe in the RAC program that letters are going out at this point. It would be very highly unlikely and as people are describing, there's a highly regulated process to make sure before reviews begin, that it's been synthesized through the new issue review process, which I will tell you, is staffed by a very enriched clinical team. It'll have commentary from the policy components and it'll be a very deliberate process.

Dr. Sprang: So then clearly what you're saying is that [it would not happen? 10:14] in the RAC program?

Dr. Polansky: Yes, I'm not sure that's a concern you should be focused on.

Cmdr. Casey: And even with the new issue review process, where there's ten test claim samples, those letters are supposed to clearly indicate that it's part of our test, pilot test, to see if this is an issue that the RAC wants to pursue for widespread audit.

Dr. Sprang: Good enough.

Dr. Bufalino: Okay, we'll remove that recommendation, then?

Dr. Sprang: Yes.

Dr. Bufalino: Anyone else? Thank you for joining us. And I guess there is one last question. Is there interest on the part of the Council to meet the RAC Medical Directors next time?

[Yeses]

Dr. Bufalino: Oh, they'd love to meet them.

Lt. Lew: We will invite them.

Cmdr. Casey: And if you have anything specific that you would like us to have them address, so that we can properly prepare them that would be great.

[?]: I think focused around the physician issues would be fabulous for us to just learn—

Cmdr. Casey: And hear what their thoughts might be as to what they might want to pursue, okay.

Dr. Polansky: Let me just sort of communicate to the group that building a coherent clinical culture in the RAC program is essential. And to that end, I've been traveling around the country which has

been different than the outreach program, to the providers but really conducting clinical review judgment training sessions with all the RACs and ensuring that they understand we're going to hold them to task, and understanding our policies, following our policies, and avoiding policies that may be antiquated, unclear, ambiguous. So we would hope to have pretty good clinical clarity as the program begins. And to that end, they're actually coming to Baltimore in a week where we're going to hold some more sessions, including integrating them into the fabric of our greater community of medical directors. So we look forward to bringing the RAC medical directors to you to have an interactive dialog, as part of our real approach to make sure this is a coherent clinical program.

Dr. Bufalino: We're not going to be in Baltimore, we're going to be in Washington next time. So just so you know. We'll be here in August. Thank you. Why don't we take a break for lunch. We'll be back here at promptly one to begin.

Lunch Break

Dr. Bufalino: So, we're beginning the afternoon phase, and one more time, just to take a moment to, well we can't recognize Leroy because he's gone. So when he comes back, we'll recognize him. Greg's here. We got half. But we'll do it later. So it's my pleasure to introduce Dr. Jeffrey Kelman, who's here to talk about Medicare Parts C & D. Dr. Kelman is the Chief Medical Officer of the Center for Drug & Health Plan Choice and glad to have you here this afternoon. Welcome.

Medicare Parts C & D Update

Dr. Kelman: Thank you. Great opportunity. For those of you who were here last time, I spoke four years ago, we have changed the name of the center from CBC to CPC. I haven't gone anywhere. I'd like to actually talk about updates on Part D and Part C. Part C, specifically, if we have time, on the Special Needs Plans which have actually changed since last time I was here. Now Part D, if you remember, we launched on January 2006. This was actually just after my last presentation and by the way, my assumption that that would be no problems in January, may have been overly optimistic. In retrospect, the difficulty of combining huge data bases, federal databases in terms of Medicare and Social Security, 50-state databases and three territories were much more involved, and the reason, and it took about a month to get these databases sort of compatible, was that this program has real time adjudication, as opposed to a Part B claim, which is adjudicated post hoc. And I know that they talk to you about the RACs just before I arrived. I

always like to follow the RACs, because no matter what I say, everybody thinks I'm doing a good job. These claims are adjudicated in real time. Somebody goes into a pharmacy with a card, with a prescription, without a card, they have to be identified, the correct formula has to be identified, the correct copay has to be identified, the accumulation of all out-of-pocket costs on an ongoing plan year has to be done instantaneously. And so any database inconsistency caused problems. And in fact, this would have been impossible, with the development in the last 10 years of the pharmacy switches, which can do this in real time.

I didn't think of all of this unfortunately, and it's a story that those of you who are practicing and on call will appreciate. I made the mistake of giving people my cell phone number to call me if there were any problems. And my wife will never forget, or let me forget, the 12:05 a.m., I was at a New Year's Eve party, and it started going off and the battery actually blew three days later. And there's a moral there somewhere, which I won't pursue. So, in general, the benefit of Part D, cut me off when I'm over my time, is there's a standard design, $295 deductible, $295 to $2700 is the coverage period, there's then a gap, which some people call "the doughnut hole," and a $6,154 of retail price for the drugs, reinsurance. Basically the beneficiary has to accumulate $4,350 this year of out-of-pocket costs to get the reinsurance. During the coverage period, the beneficiary has an average, and this is in the law, 25% cost share. In the doughnut hole, there's no coverage, and in the reinsurance, in the gap, there's a 5% beneficiary cost share. We allow certain changes, that is the actuarial equivalent where there isn't a standard 25% cost share, there are tiers—there we're joined by Liz Richter, I feel better—there's the basic alternative, where there are tiers but no deductible and then if you work it out, it's a 32% cost share and there's an enhanced benefit, where a premium is charged that goes to things like lower copays, coverage in the gap, increasing coverage period. But they're all actuarially identical, and that also, is in the law.

The copays don't hold true for people of low income. Full benefit dual eligibles pay $1.10 for generics and $3.20 for brands, and low-income subsidy individuals 100, 150%, pay different amounts, but in general, for most of them, $2.40 for generic and $6 for a brand. For the full benefit duals by the way, that $320 is per dispensed about. So for a three-months supply, it's $3.20. this is actually a very good benefit, particularly for the lower income. We did some interesting analysis. This program is made for analysis. Every time a drug changes hands, a 37-element PDE, prescription drug event report is transmitted and

saved. We get about 37 billion data elements a year, all of which are kept and can be linked with various other data bases, but at least to analysis.

Now, in terms of generic drugs, we went from about 60% in 2006, to I think 67.8% the last quarter we looked at it. This is actually very good. That's about as high as almost anybody can achieve. I think the VA is at 75% with mandatory generic exchange. However, if you look at cost, it's 20% generics and 80% brands, which does explain a lot of the drug market. The top 100 drugs account for 66% of all costs. And the top 10 drugs by fill, and there's a top 10 drug by cost. And this also is very interesting from a physician point of view. I'm going to read the drugs. When I give the chemical name, it's of course a brand drug: It's furosemide, lycinapro, Lipitor, hydrocodone and acetaminophen, attetal, thyroid, Plavix, Nexium, Novax, hydrochlorthyazide, metoperal, and medforman. Those are by number of fills. In terms of cost, it's Lipitor, Plavix, Nexium, Seroquel, Norvasc, Zyprexa, Prevacid, Aricept, Advair, and Zocor. Note the very strong presence of mental health drugs and metabolic syndrome drugs in both groups, particularly in the cost. And there's also a very strong potential for therapeutic interchange, if not generic exchange. If you look deeply into the list I gave you, there are only two drugs on the list which don't have in the same class, a generic potential. This also tells you a lot about the drug world in the US at this point.

We have a specialty tier which has gotten a lot of interest, so I think it's worth talking about. Drugs over $600 a month are allowed to be put on a specialty tier plan, although not required. They're general oral anti-cancer, immuno suppressants, immuno logics, antiritrovalves, and the biologics. This was put there originally to try to make sure that no plan could overcharge people with high cost drugs, because we limited the cost share to the standard design. In the standard design in the original Bill by Congress, all drugs are at 25%. So we limited the specialty tier to 25% or an actuarial equivalent, if there's no deductible, it's 33%. In general, of course, people on specialty drugs, have a much lower out of pocket at the end of the year because they reach reinsurance. They all accumulate enough to go into reinsurance, at which point they have 5% OS exposure. Some drugs, such as alpha [wana? 08:55] ditripsin, of course they'll reach reinsurance after the first day.

If you analyze the experience in Medicare, point five, that's 0.5% of all fills were specialty drugs which accumulated more than 10% of all costs. It was tremendously, like Medicare itself, right sided, skewed. If you look into FDA phase 3 drugs, or even phase 2 drugs, they're very heavily represented on

biologics and if you look at the MEDPAC last meeting, their discussion of follow-on biologics got a lot of interest. And looking at the statistics in Part D gives some idea as to why that's so.

Satisfaction. We went through a bunch of satisfaction surveys. They were done with independent agencies. Actually, it was very high and what was even more surprising is that the total cost of the program was actually 40% under the actuarial projection in 2005. Part of it was to the high generic dispensing rate. It looks like and you can talk to my friends, the economists, the demand elasticity actually did work and we've gotten increased adherence because of low cost and increased access. When you talk to the pharmacist, and we spend a lot of time talking to pharmacists, they do admit that they're getting to see people come in regularly who couldn't afford drugs previously, particularly people at low income and with very high drug costs, because this is basically a progressive benefit.

The cost share goes up depending on level of income and cost. The dual eligible, to be LIS, very low or no deductible, very minor copays and they pay nothing in reinsurance, and because of the reinsurance as a catastrophic benefit, which by the way, would have existed on its own, the story which probably everybody in this room, when I was seeing patients, I certainly did, will no longer see Medicare beneficiaries bankrupting themselves, even at the $120,000 a year drug bill, the beneficiary's cost is about $6,000. And so low income, high drug use, get the best part of the benefit.

There's a question in 2005, it may have actually come up in this group, as to whether a plan could efficiently manage dual eligibles, because there were no price signals, if there were no significant copays. It's hard to know for sure. It looks like they can in fine analysis, with risk adjustment, but in gross analysis, the generic dispensing rate in 2006 was 59.4% for [Alias? 12:03] and 60.9% for non Alias, and it pretty much stayed the same in 2007 although both went up. There's a 2% difference, and that doesn't suggest that this benefit can't be managed, and it's curious. It suggests it can be managed almost as well without that kind of copay price signal.

Quality and performance measurements. This is something that I wasn't quite sure, last time I spoke here, how it was going to work out and it had to do with Plan Finder. Because there are so many choices in Part D, some multiple plans, we had to use a tool. I mean drugs, themselves, are a commodity, not like physician services, but the plan benefits changed. Formularies change, cost of individual drugs change, they have to be the same actuarially, but it doesn't mean that every drug costs the same amount,

obviously. Plan Finder, which is open to anybody, was created, started as a tool to help people choose drugs. It turns out to actually have many more features, and it's grown over time, but basically, it lets anybody figure out what the actual retail price of a drug is at any pharmacy in the region, and I can't do that. Unless I open up Redbook, and even Redbook only gives me AWP and I have to make a projection of cost. Well, you go and put in your zip code, and put in the name of a drug, it'll list every plan that has that drug and what it costs at preferred pharmacies, no preferred pharmacies, mail order, both with what the copay is and what the price is in the gap. This was a tool that gave transparency to the legal drug business that never existed before, and there was a certain amount of push back. Generic exchange is the default. If somebody really wants brand, they can check a box and get their prescriptions in brand alone. We default to generic exchange. We also have and it was new, I think we started it last year, therapeutic interchange option. After someone picks his plan or set of plans, there's one more button for save more money or some such language that gives a set of suggestions that they can take to their physician for therapeutic interchange among classes. This took a lot of working through with processors and it's an Ask Your Doctor. And basically, it does it for proton pump inhibitors, statons, nonsedating antihistamines, nonsedating antihistamines decongestions, ACs, ARBs, ARBs and diuretic combinations, calcium channel blockers, and non heart light lowering, beta blockers, either select beta I beta II, and H2 antagonists. And I mean I'd be interested in feedback as to how you would feel, or practicing physicians would feel, if someone in the beginning of a plan year were to come in with a list of cost saving alternatives in the class, with the amounts that were saved. Some of them are trivial because it is the algorithm, like most algorithms, gives a gross answer. However, if in general, this is a tremendous cost saving, and you can see by the costs of that original list I gave you, if you believe in therapeutic interchange within class for most people, not for everybody, this gives the doctor an automatic insight and the actual price saved. But I'd like, I haven't gotten as much feedback from the physician community as I'd hoped on that. So I would be interested whether you think this is a valuable tool, whether it'll never be used, or whether somewhere in the middle.

Ratings. How do we rate the plans? And this is always an issue with contracted plans. For the Part C plans, the Medicare Advantage Plans, we use things like [heatus? 16:17] measures, CAHPS measures, health outcome survey measures. For D Plans, we had to sort of create everything ourselves. There weren't

really measures for drug plans, because it just wasn't done. They were felt to be pass through. And we have four things that we rate them on which we increase every year. We have customer service; things like call waiting times, appeals timelines, overturn of appeals, customer service [withstandability? 16:45], call center accuracy. Number two is member complaints in this enrollment. We looked at the complaint tracking module, complaints about enrollment and disenrollment, and corrective action plans that we insert on the plans. General member satisfaction. We developed a Part D CAHPS, Consumer Assessment and Health Plan Survey, just for the drug benefit, and drug pricing and safety. The accuracy for copays for LIS, any mid-year pricing changes, Beers List drugs. This year we had for the first time, it's not really Beers List, we call it inappropriate drugs in the elderly. It's a measure we worked out with the NCQA and things like belladonna, Meprobomate, Cascara, I mean, the obvious drugs, which probably in general, shouldn't be used in the elderly, we have a tool of that. We end up consolidating these into actually star rating, which goes up on Plan Finder at time of enrollment. And in certain ways, putting quality ratings in the enrollment tool, really is Pay for Performance, because enrolling members is the most clear direct payment for these plans.

Drug Utilization Management, another interesting topic that I've heard a lot from practicing physicians, and basically, it's prior authorization quantity limits, and step therapy. They exist in all formularies. Commercial formularies, Medicaid formularies, Medicare formularies, retiree drug subsidy formularies. We decided in the beginning that it was important to try to make these more of a quality process than a cost process and so we've done certain things to align them with a label. We only allow quantity limits that exceed the upper limit of the FDA label. A plan can't restrict it any less than that, and in fact, you can argue that restricting it above that picks up a lot of mistaken prescriptions and error rates. We require prior authorization, if it exists, to incorporate every single FDA approved label for the drug. So for an ACE, if it has a label for hypertension and heart failure, the plan can PA it, but it has to include hypertension and heart failure. They can't limit it less than the label itself. And we stuck there. We require that only those indications that are in the label and the compendia be stepped to another indication in the label and the compendia. And there are statutory compendia in the law that we use to look at. This has produced, and again, I didn't really expect this, a sort of unique, personal health record for medications within the Part D history. It's a medication history, where the step edits are safety algorithms. And I figured

this out early, when I got a call, a complaint from the regional office, that a plan had been disapproving a mental health drug for a patient, which was on formulary. And they shouldn't have been. Our rules don't allow that. And I looked into it and I called the son, actually, and the patient had been on Respiridone, Obellafia, Zyprexa and Seraquil all at the same time, from four different doctors, being filled a different formulary by pharmacies. And the fact that there's no way that the son of the beneficiary, who at this time was in a coma by the way, would have known. I mean the names don't incorporate that they're mental health drugs, the doctors didn't know they were being given the same drugs, and it turned out the pharmacies weren't in the same chains necessarily, and so didn't pick it up in the pharmacy system. But the plan knew and the doctors were called, and I adjudicated, and the beneficiary woke up, but it became more obvious to me—laugh if you want, but if you take those four nobody in this room will be awake in a week. Nobody. And you end up with, and we never had it in this country, that this has become a sort of medication list with various data in it that protects the Medicare beneficiaries, and certain ways, and many ways, it becomes the positive outcomes the benefit that I never expected. We do, by the way, allow exceptions and appeals for not only off formulary exceptions, but for prior authorization step therapy and quantity limits. And since it's a federal program, and we can set the rules, we insist that an expedited appeal go to independent review entity in four days and the administrative law judge in seven days, and we grade the plans on their ability to reach those goals. And the independent review entity really is an independent review entity. They're our contractor, and they are very good about being appropriate.

There was an interesting article, because again, we didn't know what was going to happen last time I was here, with the benefit. But Will Shrank from the Brigham, wrote an article in *Journal of American Geriatric Society* in 2008. He used a series of PBMs and looked for the conversion from 2005 to 2006 of Medicaid beneficiaries to Medicaid to Part D. And this is the group to use because there is much less chance of them paying for it out of pocket. I mean they just don't have the funds. And this is the group that's the most vulnerable, that we're worried about the most. And in the end of the day, he found that there was no affect in terms of use of all the study drugs he examined. In other words, there was no [fall offing? 22:49] use, but there was actually a cumulative reduction in copays, seen by the beneficiaries between going from Medicaid to Medicare. I was surprised at that but my presumption, or he found, his presumption

was some states have much higher copays than the guarantee copays in Part D, especially if the 3-month supply is done.

EPrescribing. Part of Part D plans is the requirement of plans accept and support the foundation standards for ePrescribing. [unintelligible 23:24] and the initial standards, which are formulary and benefits, medication history, and fill status, doesn't mean doctors have to use it. It just means if they use it will be connected into the plan system. And I'm sure you've been talking about ePrescribing here, but remember the ePrescribing part is the easiest. Sending an electronic transmission between a doctor, the doctor's system, the hub, and the pharmacy system is simple, it's just electronics. And in terms of the beneficiary and the doctor, it's no harder, in fact it's not much easier than sending an electronic fax. All this other infrastructure though is very important. If a physician can tap into the formularies, while he's writing the prescription, it may make a big difference. Now the one, and this is a little bit of an aside, but it's come up enough times, I like to get into it, is fill status. One of the initial standards that we have approved that is now going to be built in or has been built in to all the vendor systems that are certified systems, which they all basically have to be, is notification on the physician when the prescription he sent was filled by the patient, or notification if it hasn't been filled. Mostly, the first, because it's presumed. And I actually initially thought this was a wonderful idea in terms of compliance. I've heard feedback from certain physicians, certain groups, that it's a terrible idea because of the risk of being overwhelmed with signals and the potential for liability the physician's in. In other words, what's the responsibility of a physician, of a provider, if he or she knows that a drug isn't filled? And I don't know the answer to that. But it was a turn that I didn't expect.

That's enough for these things in Part D.

Part C, Medicare Advantage, as you know, used to be a federally qualified HMO's Medicare Plus Choice. The big new change is the growth, since I was here last time, in special needs plans. These are Medicare Advantage, capitated plans, they get paid exactly the same way as Medicare Advantage plans, but they can focus on unique individuals up to about 1.2 or more beneficiaries this year, which is a huge growth. And there are three kinds. There are dual eligible, which have to have state contracts. There are institutional plans, which have to have nursing home contracts, and chronic diseases, which have to focus on specific medical needs of patient populations with a chronic disease. They also obviously, all three have

to fulfill and cover the basic AB benefits. Based on MIPPA, the recent law, we invoked or convened a chronic disease panel. It's a very good panel. I have to admit. We had Carolyn Clancy from ARC, Mary Barton from ARC, George Mensa from the CDC, and we defined those chronic diseases that we felt were most appropriate for this kind of plan. And they're worth going over and hearing your input. The chronic alcohol and drug dependence, autoimmune disorders, we define them further down of course. These are the basic titles. Cardiovascular disorders, chronic heart failure, dementia, diabetes meladous, end stage liver disease, end stage renal disease on dialysis, severe hematologic disorders, HIV AIDS, chronic lung disorders, chronic & disabling mental health conditions, neurologic disorders, and stroke. We'll also allow certain combinations; diabetes with heart failure, diabetes with cardiovascular disease, chronic heart failure with cardiovascular disease, all three and stroke and cardiovascular disease. Basically, these are metabolic syndrome diseases. And the plans have to have a focused plan benefit package with assessment, disease management, [tare? 27:56] management, coordination of care, transition care, and cost sharing, hopefully specific to that chronic disease. And it's more or less obvious once you lay it out. In other words, diabetic supplies, eye exams, for example, for diabetes; rehab services and orthotics for CDA, respiratory therapy for COPD, IV chemo therapy for cancer. The networks should be broader, and the cost share should be better and there should be better communication tools. In other words, you can have enhanced nursing care in the institutional setting.

Before I joined the government, I spent a lot of time in long-term care with the founding medical director for Lifecare Center, and we spent a lot of effort preventing hospital discharge. We'd take people in the community, we'd move them to the nursing home, we'd use everything, IVs, we even once had a ventilator in the nursing home because we didn't like to move people out of the community. And at the end of the day, and we were pretty successful with this. It struck me that we gained, as a community, the beneficiary gained, by not being moved out, but financially, the only one who gained, was Medicare. Because all these were spent on our nickel. There is no money for extra, this kind of extra high intensity services at home. And institutional SNF can do that. They can bring in extra nurses, they can have round the clock care, they can bring in physicians every day, and their savings at the other end are aligned with the savings to reduction in hospitalization. Everybody has interests aligned in this. And the real interest is whether these kind of coordinated efforts, in other words, this sort of disease management, care

management, you can call it value-based reduction in cost share insurance design, if you want to get technical, can you have meaningful outcome improvements as part of an integrated delivery system? There's been an argument as to whether a freestanding disease management, and you all heard it, works and part of the reason is it may be free standing. In the special needs plan world, it's only integrated into the delivery system. We're spending a lot of time with the NCQA at the GMAP, Geriatric Measurement Assessment Panel in the committee on performance measurements, to develop specific quality measures for SNFs which is very hard, because you could argue that general quality measures can be applied broadly across plans in the population, because they have the same mix of people. Special needs plans, by definition, don't have the same mix of people. Can you have, and take the easiest example, is the new [heatus? 30:49] measure of Hemoglobin A1C less than 7. Now whether or not you believe in that measure, it is a measure. If you have a very, very good special needs plan diabetic SNF that only recruits high-risk diabetics, who are obese on multiple drugs, can they reach, even with the best care in the world, Hemoglobin A1C's less than 7 in the majority of their patients? And I don't think they—it's very hard to do so. On the other hand, nobody has ever figured out how to risk adjust, case mix adjust, quality measurements. It's easy for process measurements. You can always measure someone testing hemoglobin A1C every six months, I mean they should be able to do that no matter what the population is. But to achieve goals and get outcomes, rise and falls on risk adjustment, because you could end up disadvantaging plans that have the sickest people, or the lowest income people, or the greatest number of minorities. And it's a very tricky issue which we're involved in right now, but we're hoping to get information from the SNF process that will use us to inform the entire MA world and possibly beyond. I think that's about it. I was going to leave time for questions, which you may or may not have.

Dr. Bufalino: Thank you. Appreciate that, and obviously you threw out a number of things there that you're looking for input from, so Panel, questions, comments, concerns.

Dr. Kirsch: I want to start with your two top 10 lists, of the utilization and the cost. I go through this with our Blue Cross Blue Shield provider in that I'm not sure that you're capturing all the generic drugs that are being prescribed. I think a lot of people are paying cash. So I think your generic numbers might be higher. I think it's very hard to measure when you have $4 prescriptions at Wal-mart.

Dr. Kelman: Well, what we try to do by the way, is most of these contracts have UNC clauses in it. Or lower. So they pay the negotiated copay or whatever is available. In theory, going to Wal-mart, they still can charge it to their plan and get even a better deal. There was a study somebody did, which I think it was released, or at least should have been released, looking at Plan Finder prices, versus pharmacy prices. And it was curious. There was a significant dislocation, but 93% of it was cheaper at the pharmacy than it was in Plan Finder. I would have understood the other going in, because the cost of drugs, I'm sorry to say, goes up throughout the year, and there's a lag on Plan Finder of one to two months, so you expect some of that and that was the 7%. The 93% looks like capturing reductions at a local pharmacy for a given deal that we want to capture for our beneficiaries as well. So we were capturing a lot of that.

Dr. Kirsch: Okay. And as far as on your list of top 10 medicines as far as expense, I think there are a couple PPIs on there; there was Nexxium and Previcid, I think?

Dr. Kelman: Yep. Absolutely.

Dr. Kirsch: And I would say that a lot of my patients are pushing toward Prilosec OTC, they're not using those drugs unless those are the drugs that they need to be on. And that's hard to measure because you're comparing to a drug that's available over the counter and trying to capture how much people are using that as opposed to using those prescription items.

Dr. Kelman: Well, we do allow and this came up the second year, which is why I was curious that they were still on it. We allow a regular plan and a lot of them do this, to offer a zero copay over-the-counter benefit for this kind of drug, in other words, to go from Nexium to Prilosec, they can allow the beneficiary to get it, and it's free. They can't charge anything. So we started picking up those at that end. That's what I wonder, I figure everybody wants Nexium—

Dr. Kirsch: How many patients know that, that they have a zero copay for that—

Dr. Kelman: The plan tells them because it's to their advantage.

Dr. Kirsch: Just because the plan tells them doesn't mean the patient knows.

Dr. Kelman: It's true

Dr. Kirsch: Because I didn't know it.

Dr. Kelman: There may be Nexium, maybe we should make more outreach if you didn't know that. There may be people getting Nexium who should be on, or who failed on Prilosec.

Dr. Kirsch: Well, I guess what I'm saying is that there are a lot of people who need PPIs and you're kind of pointing to those numbers kind of suggesting hey, this Prevacid and Nexium use is inappropriate, but I think there's a lot of pushback from the patients to keep that cost down and we're sitting there trying to fight that doughnut hole right and left, and I'm saying that probably a lot of those people that are on those drugs, probably those are the drugs that they need.

Dr. Kelman: I didn't actually say they're inappropriate. Having worked in this field, I'm very careful!

Dr. Kirsch: You're looking at cost utilization though.

Dr. Kelman: But I did sort of think it.

Dr. Standaert: I was going to say you asked about [inaudible 36:21] and I'm not the primary care provider who gets hit with it, but actually it seems like a reasonable idea, because I definitely see people who have switched providers, and have multiple providers and if somebody needs to be on Nexium, and then they come in and say can I take something else, you say, no, I'm not a primary care provider, but you can say no, we've been through that. You do better on Nexium, or you could say, you know what, Prilosec is free if you go get it and you haven't tried that before and we didn't give you Prilosec because you didn't want to pay for it, so—

Dr. Kirsch: Do you mind if I comment on that?

Dr. Standaert: No, that's what I said, I'm not the primary care—

Dr. Kirsch: This is what happens. Because Medicare will be late in the field on this. Other insurance companies already do this, and I guess within my practice, I have so much pressure on the patients to keep those costs down that I find those little reports highly intrusive. They come one at a time and we're spending a lot of time getting those charts pulled out, reviewing this and half the time it's not pertinent. It's a good idea in theory. Maybe if they just did it once a year, all as one block, it wouldn't be so bad, but if they're throwing report after report after report at me and I'm having to pull the chart and look and it and look at it and look at it and I'm not being paid for my time or my time or my staff time, I find the way it's being done with a lot of insurance companies highly intrusive. It's well meaning, and maybe not everybody is as on the ball as I like to think I am as far as costs, and keeping the costs down, but it sounds wonderful, but in practice, it can be a royal pain in the butt.

Dr. Bufalino: Other comments?

Dr. Kelman: One last question for the group if we have a minute. Going back to the electronic prescribing. What percentage of this group actually does that? Is that, anybody? Five, six, that's not bad, actually. And would you use the formulary component if it were available?

Dr. Bufalino: It's available on ours, it's a green face, yellow face, red face, green in the plan, yellow borderline, red not in the plan. So it's pretty obvious.

Dr. Kelman: And it works?

Dr. Bufalino: I mean it's there, and you can pick it based on—

Dr. Kelman: And it saves time?

Dr. Bufalino: Saves time. Yes. I would say the one thing that you asked earlier, which I don't want to know who filled those prescriptions. That'd be a nightmare of additional data, in our face, calling people back, chasing people.

Dr. Standaert: Like you said, the liability issue.

Dr. Kelman: Well that's what I heard, and first time I heard it was a couple of months ago, so I thought it might be worth pursuing. So the fill status isn't considered…

Dr. Bufalino: So let me go back, something you raised earlier, just ask a question. So at least what I'm reading now is between 60 and 70% of the country is in generics, and depending on where you're at and I just got a survey from our big integrated provider in town and we were at 68% or something in that range. Are we going to be happy with that? Is it that we've got to move it to 90%? If you'd asked me 5 years ago and said if we got to 70% of the country on generics, wouldn't we be celebrating? I would have said, wow, yes that would be pretty impressive if we got 70%.

Dr. Kelman: It's an interesting thing, following the flow here. About 60% nationwide, is generics. Maybe 62. It's higher in plans who make an effort to it. The VA is at 75% and that's about the max right now, and the reason is about 15% are drugs that could be generic that aren't used and certain of those are multi-source brands that are very much like generics. But of the remainder, about 10% of the brands are going to have a generic alternative by the end of the 2010, so it may, and we're getting about 15 to 20 new drugs coming down the pike approved by the FDA, and so part of this is the inflow in the pipeline is such that we may reach 80, possibly more percent generic prescribing, just by the nature of new drug

development. The problem is that it hasn't necessarily cut average cost because the drugs coming in at the other end are more and more expensive and so I don't know what to make of this entirely, but yet it's getting higher generic efficiency is a very good idea, but it's a smaller and smaller proportion of total drug cost. In part D, it was 20% was generics, even though we'd achieved what I thought was a very successful rate of generic dispensing.

Dr. Smith: I'll just make a comment. I'm a rheumatologist, so I use those biologics and they've made a world of difference for my patients and it's just incredible. And I think from a rheumatologist's point of view, the concept of a generic biologic is very scary because we read articles about the other generics where they can have I think it's between 75 and 125% of biovailability to be considered equivalent.

Dr. Kelman: 85.

Dr. Smith: 85% to 120.

Dr. Kelman: For the A end of the curve and C max.

Dr. Smith: Yes. And when you're talking about a drug with potential for affecting infection rates and things like that, if something turns out not to behave the way you expect it to, that's very scary. I actually extend that to things like Warforin and Oxin and so on, it's not just the biologics. It's a concern how those would be handled. Would they have to have a much narrower bioavailability, therapeutic equivalency, whatever the correct terminology is, in order to be considered equivalent? Can that be narrowed so they're safer? And in that case, the cost probably won't be much less, because they'll be as expensive to make and test.

Dr. Kelman: The problem is, that's exactly a good question. Is there any endocrinologist here? No. Does anybody ever use growth hormone, somatatropin? There are five different somatatropins, But for historic reason in the FDA, they're all called somatatropin, and that's the only example I can really find of having a multi-source biologic that has the same name. However, so in theory, a somatatropin prescription could be filled at a pharmacy and the pharmacist could pick which of the five he or she wanted. In reality, if you go down to the pharmacy chains and independents, they almost never do. They almost always call the physician and ask which one you want? And it brings this question to the fore. Because this doesn't even take a biogeneric. This [unintelligible 43:39] in the field. Nobody has yet—and those are the questions that

haven't been even worked out. And the concerns you raised, are the concerns people raise is are they the same drug?

Dr. Smith: There are data showing that that's not the case, in some other drugs. A very recent big article on it—

Dr. Kelman: It's all the therapeutic [crosstalk] is how broad do you need, how tight a therapeutic index you need for the drugs. And the advantage of Cumadin is if you, you get it monitored, and if you're on the same drug everyday, you get the same dose. If you change it with different therapeutic index, therein are issues, or could be issues.

Dr. Ross: I want to take it just a step further and look at some of these generics that may be made in various countries and their bases are made in certain countries and then they're compounded, maybe here in the United Stated and looking at their safety record, or looking at what's in the bases. I bring up an example of a patient who was on Norvasc and went to generic Norvasc, and the patient developed a reaction, or an accumulation of arsenic as a result of this medication base. The patient was hospitalized for this many weeks. So the question was how do we really test some of these generics? Where are they made? What process does the FDA go through to test these various generics abroad, that are made abroad and are brought to this country?

Dr. Kelman: That's a good question. As you know the FDA just opened an office in China, because everybody's sensitive and they work very hard. We spend a lot of time with the FDA and they're very sensitive to the fact that a drug is only as good as the ingredients that go in.

Dr. Ross: Right. And the efficacy issue is another one. Particularly with our antibiotics, and when we look at some of the drug resistance to MRSA and other microbials, I mean that's an issue that we're seeing at the hospital, with our diabetic patients, particularly with our community-acquired MRSA leading back into the hospital and how good some of these antibiotics are? We're seeing Vancamycin resistant MRSA.

Dr. Kirsch: I think you had asked for comment about utilization reports, about sending those out. I think that would be very positive. I would just try to consolidate mailings and reports as much as you can. And so if you would like to send something about utilization like do you want your patient on Lipitor, or do

you want him on [unintelligible 46:16] Zocor or whatnot, you try to consolidate your reporting, and such as much as you can, but I think a utilization report would be very helpful.

Dr. Arradondo: When do we get a copy of your written presentation?

Dr. Kelman: Never. Having been in the federal government and lived in Washington for 25 years, I believe in [plausible? 46:46] deniability. I'm not even actually here. You're getting raw data, I mean things that have just come up for the purpose of this. This is the summary, so I don't even have slides.

Dr. Arradondo: There are half a dozen people around this table who can chew on your raw data, swallow it, digest it, and do a couple other things with it.

Dr. Kelman: Which is another reason by the way.

Dr. Arradondo: This is not an acceptable response, Mr. Chair. This is not an acceptable response to this Council. Thank you, sir. I have another question I was going to ask, but I won't even ask it. I decided not to actually, not because of his reply. The other part was there used to be a time when the bioavailability of generics had to be, was over 90% of the brand. This was before AUC became a matter of consideration. It was hardly a research procedure at the time, so for those of you who remember that, that was a while ago, because AUC has been around for a minute. It seems to me it would be useful if generics were going to be pushed by an insurance plan, for the bioavailability to be back up to something reasonable. I happen to think reasonable is between 3 and 5%, and that's being generous. And that's something—FDA has a role there, but it's also something that the payer can require. I know that much about the rules on depending payment by Medicare, searched the clause. But that's something that a payer can require, and that would be an interesting step because some of the generic do take license, and I'm not speaking of arsenic, I'm not even speaking of Melamine and as long as FDA cannot inspect the thousands of sources of food and drugs in China, and those are growing monthly, the PR trip, what can I say? I shed a tear for Andy when he met up with the Secretary, Andy…

Dr. Kelman: Von Eschenbach.

Dr. Arradondo: Von Eschenbach, when he went over with the Secretary to do this, it was like his arm was twisted to go, so to speak. I'm sure the Secretary had to go, and felt the same way. But opening up an office in China when you couldn't even put your finger on the drug and taste it like the cops do on the street, what does that do? So in lieu of FDA having that kind of restriction, funding, the House Member

from Michigan, Dingle, had to drag it out of von Eschenbach—I hope that was a preplanned episode—to say, no, we don't have enough money to inspect the ones in the United States of America, not to mention those abroad. So that's a big limitation that we cannot take the responsibility for. CMS can't, we can't. But the payer can require some things. I [don't know? 49:59] make a recommendation on that because this whole presentation is kind of over here. Any presentation we have every four years, is obviously not mainstream stuff for us, but it's very important to me, because it has a lot of possibility, despite what the presenter says about his present report, and living in Washington, D.C.

Dr. Bufalino: Thank you. Any other comments? Questions?

Dr. Arradondo: And by the way I say all that because it is recorded.

Dr. Bufalino: Last comment?

Dr. Sprang: [inaudible 50:35] …and the actual liability is too. I just came back from a PIA meeting, Physicians Insurance Association of America, and Vince had said he really didn't think it would be a good idea if we had the information where the patients had it filled or not. There's a whole new industry now in suing healthcare, and plaintiffs' attorneys are hiring information technology experts, and in cases, looking at all the data in the computer and every possibility of thing of information that can map access to and if you didn't respond to that, that just adds to the case, that's now a malpractice plus because they can find a lot more things because they are in electronic healthcare records, so it's just another aspect of it that we do need to consider as to what is in there and it's upside and it's downside, and the name of the presentation was an hour and a half on electronic healthcare records, The Good, the Bad, and the Ugly. So it's actually a whole new realm of liability cases against us.

Dr. Bufalino: Thank you for joining us. Have a good afternoon. We'll move on to the next speaker. We asked Mr. Frank Whelan to join us. He is here to talk about the DMEPOS Surety Bond Policy. Mr. Whelan is the Health Insurance Specialist in the Division of Provider and Supplier Enrollment at the Office of Financial Management and there are a number of people anxious to hear this presentation, Mr. Whelan, so welcome.

DMEPOS Surety Bond Policy & Implementation

Mr. Whelan: Thank you very much. Again, my name is Frank Whelan. I work in the Division of Provider, Supplier Enrollment in CMS and I'm here today to talk about the new Surety Bond requirement.

We had a Final Rule that was published in the *Federal Register* on January 2, and this Final Rule basically required $50,000 bond for each national provider identifier. Before we go any further, let me just say this only applies to DMEPOS suppliers. It does not apply to non DMEPOS suppliers, so there's only a specific category of suppliers that this provision applies to. Basically some DMEPOS suppliers have to obtain an NPI by practice location, except for sole proprietorships. If you had an organizational DMEPOS supplier that had 20 locations, they would have to acquire a $1 million surety bond. Now it's not necessary that 20 separate bonds be required, one for each location. They can all be aggregated onto a single surety bond, but it must be $50,000 per location. Now there are going to be a couple of instances where an amount greater than $50,000 will be required and that's if the supplier poses a higher than average risk to the Medicare trust fund, and by that, what we mean is if they have had imposed against them, an adverse legal action, and by that we mean, and this is spelled out in the regulation, but it means some sort of felony conviction, within the last 10 years, Medicare revocation, a licensure suspension, things along those lines. But again, other than those situations, it'll be a $50,000 surety bond.

Now the exemptions from the bond requirement are as follows: The first exemption is for government-owned suppliers. The second exemption is for state licensed orthotic and prosthetic personnel in private practice. They have to be making custom-made orthotics and prosthetics, and the business has to be solely owned and operated by the orthotist and prosthetist and the business must only be billing for orthotics, prosthetics, and supplies. The third exception I think will be of great interest to most of the people at this table. Physicians and nonphysician practitioners are exempt if the DMEPOS items are furnished only to his or her patients as part of his or her professional service and let me just add that we're also talking physician groups as well. They are also exempt from the bond requirement. It's not just a physician who is in private practice by himself or herself. If you're a group of physicians, you are also exempt from the bond requirement. And the last exemption is physical and occupational therapists are exempt is the business is solely owned and operated by the therapist and if the DMEPOS item is furnished only to his or her patients as part of the professional services. Those are the only four exemptions to the surety bond requirement. Supplier does not qualify. They have to obtain surety bond.

The implementation date was actually a couple of weeks ago for certain suppliers. It was May 4, 2009, and this was for newly enrolling suppliers, including those that are adding a practice location. When

that deadline hit, and a couple of weeks thereafter, there were some suppliers who had applications pending with the national supplier clearing house and the NSE is the provider enrollment contractor for the DMEPOS side. They did have their applications rejected, because they did not have a bond at that time. We're not talking a lot of suppliers. I think there were maybe about 100 or so. So the bond requirement is really already in effect. For those that are currently enrolled in the program. They have until October 2, 2009 to get a surety bond. And that's really the deadline that I think most people are primarily concerning themselves with. The May 4th deadline really did not apply to all that many suppliers. The October 2nd deadline is really going to be the key. And in conjunction with this, one thing we did was we revised a CMS A55S, which is the Provider Enrollment Form, the Provider Enrollment Application and we've revised that to incorporate the surety bond data elements onto the form.

All of the information on the surety bond requirement will be on the MSC's website. What we wanted to do was we wanted to have one specific place where all of the surety bond policies are going to be, and it will be on this website. We have a series of FAQs. I think at last count we're up to about 47 or so. We just keep adding them as more and more issues come in. So basically that's where we are right now.

Just a couple of side notes. And I can only speak for myself on this. I personally have been a little bit surprised. We really have not gotten that much negative feedback from the supplier community on this. In fact, it's actually been pretty minimal. Obviously, as you know, there are a fair number of exceptions to the bond requirement, and obviously if you're exempted, you may not necessarily have a problem with the bond requirement. But even with groups, such as regular DMEPOS suppliers, there certainly has been some grumbling so to speak, but we have not really gotten the backlash that I think some of us expected, which I suppose is pretty good news. But again, everything seems to be moving pretty well. We're not getting a lot of questions or new issues brought to us. Most of the policies had been in place. One other thing I wanted to mention is the Surety & Fidelity Association of America has a standard bond form that CMS has looked at and given the thumbs up to. The form basically outlines all of the requirements that the bond has to have, and it seems like many suppliers are taking advantage of the use of that form, and that's the form that they are submitting. So that's pretty much where we are with the surety bond requirement. Does anybody have any questions or concerns?

Dr. Ouzounian: What's the bond cost?

Mr. Whelan: The cost of the bond? The cost of the bond usually would be maybe about 1500 or so, it's usually about 3% of the bond amount. But again it's going to depend obviously on the surety, and it's also going to depend on the supplier's background as well and how much of a risk.

Dr. Standaert: Is this because people have been defaulting, and overpayment sort of things?

Mr. Whelan: Basically, it's a fraud prevention measure to be in conjunction with accreditation one of the [unintelligible 59:34] things along those lines. As you know, fraud within the NSC community has, our DMEPOS supplier community has been a bit of a problem. The OIG has expressed their concerns to us on this, so one of the things we decided to do was to implement this requirement and basically it's an effort to stem the ongoing problem. We have made some progress in that area over the years, but still more work is to be done, and this is really part and parcel of that.

Dr. Bufalino: About how many total DME providers are in the country and about what does Medicare pay on an annual basis for DME?

Mr. Whelan: Right now, we have about 112,000. It's anticipated that about 65,000 will be subject to this bond requirement. So we're probably looking at a little more than half.

Dr. Bufalino: And about what does Medicare pay in durable medical equipment requests on an annual basis?

Mr. Whelan: To be quite honest with you, that's a little bit out of my subject area. I'm not really sure I'm qualified to comment on that. But I will say this, the amount is obviously great enough to be of some concern that we're trying to stem the problem before the DMEPOS community, so it's certainly not inconsequential.

Dr. Bufalino: Other questions?

Dr. Jordan: I'm an optometrist and I've got a couple of comments I want to, because I am a DME provider, but on page one of your form, we are listed optometrist and physicians, but according to Social Security Act, Section 1861, we are a physician, so there is a redundancy there that I'd like to see removed. And second, which I will unfortunately be going through the process. I'm going to have to be reenrolling here in the next couple months, and the way it is listed currently, when I get to a point of am I accredited or not accredited, which we are exempt from, I have no choices to pick. If I mark accredited, then I'm going to have to go through the process and the cost. If I'm not accredited then marking it, I may not be able to

even provide for my patients. So I'd like to do a recommendation right now? PPAC recommends that the new DMEPOS supplier enrollment form 855S, include an option to check Exempt from Accreditation in addition to the current accreditation and non accredited boxes in section 2G on page 12, just as the exemption from surety bonds is recognizes in section 12A on page 36.

[second]

Dr. Bufalino: Comments? All in favor?

[ays]

Dr. Bufalino: Thank you. Other concerns, questions?

Dr. Ross: Taking the accreditation process a little bit further, we've banged this dead horse quite a bit, but I think it's worth repeating. We're at a sort of junction stage here with the last Congressional action with the Bill that did away with accreditation for physicians and healthcare providers, but despite this Congressional authority, that permits CMS to exempt physicians and office-based healthcare professionals who are DME suppliers from accreditation, unless the Secretary decides to create specific accreditation requirements just for them, unfortunately at this time, CMS has yet to decide whether they plan on permanently excluding office-based suppliers from costly accreditation requirements. Furthermore, it remains entirely unclear whether or not these requiring physicians and licensed healthcare professionals will have to pursue costly accreditation process. It's not been stipulated. We have not exempted permanently. It's right now in a transition stage. It's still unclear. These providers are educated, they're trained, they're licensed to dispense DME to their patients, and furthermore, these requirements now to the providers to become accredited, despite the fact that they're already enrolled in Medicare to treat patients for non DMEPOS, as well as separately having to enroll them now in providing DMEPOS could provide and create an additional expense to both the provider and to Medicare. So now you've got a double whammy taking place. At this time, we can least afford to create more of an expense to both the doctor, the professional, as well as to Medicare. So having said that, I'd like to make a recommendation, Mr. Chairman. That PPAC recommends that CMS adapt language that would put in place a permanent exemption from DMEPOS accreditation and surety bonds for physicians and licensed healthcare providers.

[Second]

Dr. Ross: A permanent.

Dr. Bufalino: Discussion?

Dr. Giamio: Would you be willing to have an amendment to that where it would be just for practices within their practice? For their patients? Not for so that would be the other caveat to that.

Dr. Ross: Yes. Because he did explain very well that the DMEPOS providers who are physicians are office-based and they're providing that care and those supplies to their patients, and I could go along with that friendly amendment.

Ms. Trevas: Can I have a—

Dr. Ross: She wants an amended language to that and I think the language would be, if I can help him out with that, that the language should probably read for physicians who are providing—

??: It's the second one. Physicians and nonphysician practitioners.

Dr. Ross: That's right, physicians and healthcare providers, if the DMEPOS items are furnished only to his or her patients as part of his or her professional service. That's fine.

Dr. Bufalino: You have it Dana?

Ms. Trevas: Yes. Thank you.

Dr. Bufalino: All in favor?

[Ays]

Dr. Bufalino: Thank you. Other comments for Mr. Whelan. Hearing none, thank you for being here.

Mr. Whelan: Thank you very much.

Dr. Bufalino: So the hour's ahead and we will move ourselves forward. This is of course for all of you the testimony of the AMA is not being read today but it is available for your review and comment, and in addition then, I thought we'd spend 20 minutes here and go through some RAC wrap up recommendations. Take a break, let Dana finish them off, and then review them before we leave. Most of you probably have 3:00 flights, so we have the time to take the necessary time to kind of plod through this so if you'd like to write them down, begin presenting them. Let's start around the room. Art, let's begin.

Dr. Snow: I really appreciate Mr. Blum's discussion a little bit of healthcare reform. I think that's something that's going to come clearly. And he made a comment in there about the fraud and abuse problem, and I've not seen information, that's why I make this recommendation. PPAC recommend that

CMS provide the statistics at our next meeting regarding the fraud and abuse problem by physicians in the Medicare program. We hear a lot about fraud and abuse and I'd like to know what the specifics are, for physicians, not the other providers out there.

[second]

Dr. Bufalino: Second. Discussion? All in favor?

[Ays]

Dr. Bufalino: Thank you. Chris?

Dr. Standaert: This goes back to the resource utilization reports again. PPAC recommends that CMS consider presenting information indicating the statistical accuracy of data supplied in physician resource utilization reports.

Dr. Bufalino: Thank you. Second?

[second]

Dr. Bufalino: Discussion? All in favor?

[ays]

Dr. Bufalino: Thank you.

Ms. Trevas: I just want to make sure you went to that very quickly, and I just wanted to say, you wanted to say they consider presenting information on the statistical accuracy?

Dr. Standaert: Yes.

Ms. Trevas: Okay.

Dr. Williams: Two recommendations. Also, one on the utilization report. PPAC recommends that the CMS/RAC program develop a special logo to be used on its correspondence letters to differentiate it from other CMS derived requests for information for other programs. I thought that might get at what he was trying to get at. It's an important letter. It's not any of these other things and maybe that helps to clarify that part.

[second]

Dr. Williams: Second one is—oh sorry.

Dr. Bufalino: Second to that, okay, thank you. Any discussion on that? We're hoping not to spend hundreds of thousands of dollars developing the logo. All in favor?

[ays]

Dr. Bufalino: Thank you.

Dr. Williams: The second one is PPAC recommends that CMS consider including risk adjusted medical resource use data for attending physicians and academic medical centers to include recognizing the risks, benefits, and expense of training residents and medical students.

Dr. Bufalino: Got that? Second?

[second]

Dr. Bufalino: Discussion? Anybody have an issue with that? All in favor?

[ays]

Dr. Bufalino: Thank you. Next, Art?

Dr. Snow: PPAC recommends CMS present an update on its RUR to physicians, especially with respect to any planned public release, any plans to correct the attribution methods to more accurately reflect the physician's peer group for comparison purposes, and the physician's actual contribution the cost of the care attributed to him or her.

Dr. Bufalino: Start it again?

Dr. Snow: PPAC recommends CMS present an update on its RUR, the Resource Utilization Report to physicians, especially with respect to, which is divided into several things; 1, any planned public release of this information, 2, its plans to correct the attribution methods to more accurately reflect the physician's peer group used for comparison purposes, and 3, the physician's actual contribution to the cost of the care attributed to him or her.

Dr. Standaert: What do you mean by the second one?

Dr. Howard: I was going to make a recommendation along those line that they inform all the physicians, healthcare providers, and associations a minimum of two years prior to public release of information, so I don't know if you want to—you want to do it separately?

Dr. Snow: The second one has to do with this peer group that you're being compared to. I think you asked a question—

Dr. Standaert: …compared to your peer group. The wording is [inaudible].

Dr. Snow: Well this is actually what one of those charts is doing. They would define me as a family physician and I'm doing things that other family physicians don't, and very small piece of it, so they need to determine who the peer group is and find a better method of attributing that—

Dr. Standaert: Clarify the identification of the peer group and the subsequent attribution of, subsequent comparison of cost, it's the language that had me confused.

Dr. Snow: Well, the third one has to do with the actual contribution to care, because the attribution methods cause two separate errors; one, the peer group they're using for comparison purposes globally, and then the assumption is that the cost attributed to you go by this attribution method, which is faulty.

Dr. Standaert: Right. I get that.

Dr. Snow: So I'm saying, basically, correct both of those.

Dr. Standaert: Right. It's purely the language in the second one, I didn't understand the wording, that's all. I don't know if you—I just can't understand the wording.

Dr. Bufalino: All in favor?

[ays]

Dr. Bufalino: Thank you. Jeff?

Dr. Ross: I also want to concur that Mr. Blum we really appreciate some of the items that you brought out and I think one of them that I've brought up since the first day I stepped on this Council has been on prevention before intervention, and when I look at some of the work that we do back in Texas on our children, prevention on obesity, and trying to prevent some of our type 2 diabetic youngsters in their teenage years from developing some of the costs that later on translate into millions and billions of dollars in CMS cost, I would like to just throw out a possible recommendation, see if my colleagues agree with this and if we can get CMS to help us out with just some type of data or information. What I'd like to see is if PPAC can recommend to CMS a report on how prevention costs and those reimbursements, can be compared to later interventional treatments. And the example, for instance, would be childhood—let me just give you an example. Looking at childhood obesity, exercise counseling, early intervention for those issues, versus how bariatric surgery or other treatment interventions may come about and how would the cost differential be, and if we could get some type of information about that?

Dr. Simon: For what date?

Dr. Ross: I think one of our speakers said it could be years from now.

Dr. Bufalino: Anyone care to entertain that?

Dr. Standaert: It's rather an overarching recommendation. It's useful but boy, asking CMS to, that's an enormous undertaking. Could you narrow it down to something that would be more manageable they could actually comment upon in two months.

Dr. Ross: I would like a comment on how some of these prevention interventions can be beneficial in cost savings, compared to some of the later interventional treatments that are being—

Dr. Standaert: That's something like how they're factoring prevention into Value-based Purchasing, because they don't talk about that much. I would agree. They don't mention prevention as part of the Value-based Purchasing models.

Dr. Ross: That's very correct. That's one of the things that I'm talking about.

Dr. Standaert: That'd be a question that Tom Valuck could answer probably, that's fairly concise.

Dr. Sprang: It's a very complex question, does it say studies that actually saves money, or actually studies that say it doesn't even save that much money. I mean just way too complex an issue and I don't think there's any way Ken or anybody else could do it in any timely fashion.

Dr. Ross: Well maybe it is a question for Tom Valuck and maybe we can save that for his next testimony and just ask him at the time.

Dr. Standaert: You could say something like PPAC recommends the Value-based Purchasing group provide some information on how they're factoring prevention methods into cost utilization studies. Something like that. Gets your foot in the door anyway.

Dr. Ross: Could you restate it? I like the way you stated it.

Dr. Standaert: I don't know if I could say it again, did you get it?

Ms. Trevas: PPAC recommends that the Value-based Purchasing program, the staff from the Value-based Purchasing program provide information on how the program factors prevention—preventative services into cost utilization studies.

Dr. Ross: Okay, beautiful.

Dr. Bufalino: Second?

[second]

Dr. Bufalino: Any discussion? All in favor?

[ays]

Dr. Bufalino: Thank you. Made some good use of that.

Dr. Ross: I appreciate my colleague from Seattle.

[chat]

Dr. Przyblski: Something that's been brought up at the RUC has been a potential physician payment problem. Hospitals have been using data bases to determine whether a patient should be better classified as an inpatient versus an outpatient. Physician admits them, assuming that it's an inpatient, and lo and behold, later they find out that the hospital reclassified it as an outpatient. So as discussed in the AMA testimony, as well, so there are two recommendations I'd like to put forth: One, PPAC recommends that CMS require hospitals to notify treating physicians and patients, whose status as an inpatient is reclassified by the hospital, as an outpatient.

[second]

Dr. Bufalino: Discussion?

Dr. Ouzounian: The discussion is just to bring everybody's attention. The point, I think to the average practicing physician, the implication of that transition is not understand. You and I understand the implications of what happens with that database and how it gets misused, but to my I think physicians on staff, there's a Ok! Because they don't understand what happens with the data in the end.

Dr. Standaert: [inaudible] be billing the wrong code because it's an inpatient, it's not an outpatient procedure, it's an inpatient procedure?

Dr. Przyblski: It's a couple fold. One is billing the wrong code. Second is when one calculates physician payment for a 90-day global service, how that total RVU is calculated depends on whether the patient was an inpatient or an outpatient, so the numbers now start to change.

Dr. Standaert: Right, gotcha.

Dr. Bufalino: Other comments?

Dr. Sprang: [inaudible] from the patient perspective. It's changed from an inpatient to an out patient, it may change their insurance coverage, there may be more out of pocket expense to them because

it's outpatient, rather than inpatient. So there are significant affects to both doctor and patients. Clearly they should know it's being changed.

Dr. Bufalino: All right. All in favor?

[ays]

Dr. Bufalino: Thank you.

Dr. Sprang: But did you say both patients and physicians?

Dr. Przyblski: Yes, I did say—the corollary to that is PPAC also recommends that the RACs should be precluded from recouping payments to physicians from coding errors resulting from reclassification by the hospital of a patient status from inpatient to outpatient.

[second]

Dr. Bufalino: Got that? Discussion? All in favor—I'm sorry, Art?

Dr. Snow: You know that also, that hits a little bit on a similar question we had this time, having to do with those downstream providers for things that were deemed to not be appropriate. I'll just mention that I'd like to make another recommendation, based on that, when you get—

Dr. Przyblski: If you notice, I made a distinction from what the AMA had been thinking about, which was the admitting physician, because the downstream is all the other physicians. They left off admitting.

Dr. Bufalino: All in favor?

[ays]

Dr. Bufalino: Thank you. Art did you have—

Dr. Snow: Well, the response that we got from Ken on that previous question about downstream providers being perhaps penalized was that they were going to do a lot of research on the applicable statutes, regulations, policy statements and so on. I like to see if we can't bring that up to see if CMS staff has completed that so we can get a full answer to the question. I have a feeling we may have the same answer to this last recommendation. So I'd state that PPAC recommends that CMS provide PPAC its staff results of researching the applicable statutes, regulations, policy statements, and precedents, regarding not holding downstream practitioners liable when an underlying or precipitating service is denied or deemed

not medically necessary, or otherwise ineligible for payment. And that's actually in 67H-1, pretty much the wording is, I'm just asking for that to be provided to us, okay?

Dr. Bufalino: Second?

[second]

Dr. Bufalino: Discussion? All in favor?

[ays]

Dr. Bufalino: Thank you. Others? Recommendations?

Dr. Smith: I have a question. Can we get CMS to give us an update out of the 2008 PQRI by the next meeting? Because we're now almost through 2009, so if we're not doing 2008 right, how do we know whether we're doing 2009 right?

[chat]

Dr. Bufalino: You might want to just append to that a discussion on the ePrescribing, I think would be excellent, since they're obviously pertinent and in our lives, very actively, so I think.

Dr. Smith: That was my next question, was about the ePrescribing.

Dr. Howard: PPAC recommends that CMS inform all physicians, healthcare providers, participating in Medicare, and their associations, a minimum of two years prior to public release of Medicare physician-specific resource use reports.

Dr. Bufalino: Again?

Dr. Howard: PPAC recommends that CMS inform all physicians, healthcare providers, participating in Medicare, and their associations, a minimum of two years prior to release of Medicare physician-specific resource use reports to the public.

[second]

Dr. Howard: Is that better?

Dr. Bufalino: Discussion?

Dr. Ouzounian: Maybe just a little amendment, but they be made available to the physician and that they be notified, because they can, the way you worded it, they can simply say we're going to release your data in two years, but you might not have the data.

Dr. Howard: So I should make that—

Dr. Ross: I'm on the same track, and to respond, to be able to respond or to answer to that information. Because that information may not be accurate. It may be erroneous and then it's being publicly released.

Dr. Howard: Okay, so when I say inform, you think it better to say—

Dr. Ouzounian: It should be released to the physician and the physician should be advised at least two years in advance.

Dr. Howard: Okay, so I'll say at the end of that, use reports, this information should be released to the physicians at least two years before—

Dr. Smith: And the physician should be given an opportunity to correct any misinformation.

Dr. Ross: To respond at least, before it's published.

Dr. Smith: It's not just a response. You want to be able to correct, or ask them to correct incorrect information.

Dr. Przyblski: Almost like the national practitioner databank, where there's an opportunity for a physician to give a commentary to potentially explain something, there should be that same opportunity to say, I treat an unusual group of patients, or I do this or that and that explains why this data may be that way. Because it may not be inaccurate. It may be accurate but for good reason.

Dr. Smith: That's a good point.

Dr. Bufalino: Okay, God knows what we're recommending. Let's tweak it again. Dana you want to read what you have, and then we'll play with it?

Ms. Trevas: I would actually like to make my own little recommendation. The resource utilization reports only apply to people participating in Medicare. So it would be a lot easier if we just, so to whom are you recommending what, if you simplify it.

Dr. Bufalino: That CMS provide a two-year window prior to the release of information about RUR. In addition, that the physician is notified and has an appropriate opportunity to provide feedback about his or her report.

Dr. Howard: I like it.

Dr. Bufalino: Second?

[second]

Dr. Bufalino: Any other discussion?

Dr. Przyblski: Just question. Feedback could be you write a letter to CMS but nobody ever sees it when it's publicly reported, as opposed to the feedback is in the same publicly viewable information as the data.

Dr. Giaimo: So there would be a comment section, a rebuttal that would be included in that same text?

Dr. Przyblski: Correct. Is that okay with you?

Dr. Howard: Yes, that's fine.

Dr. Bufalino: Comment, rebuttal? Anyone else?

Dr. Giaimo: I said something for clarification, I wasn't sure about the RAC. When you do get audited from the RAC and then there is a level of discrepancy, how is that recorded, will that process, when that letter comes out to the practitioner have the mechanism instructive in there for them to go back and then question that audit? If that is not already in that letter is there a way that we can ask for them to put that in that letter, so say you have been audited for this and I—

Dr. Bufalino: Maybe I misunderstood it but I thought it was in the letter. [crosstalk] 120-day appeal process.

Dr. Standaert: You could have the appeals process written out. You could request that they give us a copy, show us a prototype of a letter so we'll know what they're talking about.

Dr. Bufalino: So could we finish this—I'm sorry, would you mind if we finish Pam's. We had a first, second, we just didn't vote on it. All in favor?

[ays]

Dr. Bufalino: Thank you, sorry.

Dr. Snow: With respect to Joe's question, I think they talked about two different kinds of audit and that first one, that automated, it almost sounded like that was a no-brainer, you screwed up, you don't have any chance for rebuttal. But the medically complex one where they review the record—

Dr. Giaimo: That one you have a five-step audit process. That's where I need some clarification of that, because if it's

[chat]

Ms. Richter: It's just the ordinary process for appeals.

Dr. Giaimo: Is that included in that letter that is sent to the practitioner?

Ms. Richter: The presentation, the response that Ken read in the morning, said that the appeals information was included in the letter.

Dr. Standaert: Do we want to see the letter?

Dr. Simon: We can get another [inaudible 23:35] actually this panel has received a copy. Melanie Combs showed a copy when she gave her last presentation, of a letter, and it was included in the package, but we'd be happy to get you another, but you have received one.

Dr. Kirsch: I guess I recommend, somebody needs to comment about Medicare Part D. PPAC recommends that potential reports on drug utilization be generated concisely, and avoid multiple communications. And this comes from insurance companies and how they communicate to us right now, because on one patient, I may get a report saying, well all your diabetics should be on [unintelligible 24:18] why isn't your patient on [Estantin? 24:21]. Next you get a report, oh, Previcid's very expensive. Haven't you put your patient on Prilosec OTC and these things get generated again and again and the charts get pulled and so I think Medicare really needs to keep an eye on conciseness of communications, because pulling charts, and reading through them is expensive.

Dr. Bufalino: Okay, got that recommendation?

[second]

Dr. Bufalino: Thank you. Any discussion? All in favor?

[ays]

Dr. Bufalino: Thank you. Other recommendations? Art?

Dr. Snow: PPAC recommends CMS provide PPAC the specific data regarding the periodic monitoring CMS does indicating what percent of Medicare beneficiaries have reliable access to physician services. I think one of our responses today indicates that they do the responses and they indicate there is no access problem, but I think it would be helpful to see the specific information about that.

Dr. Simon: [inaudible 25:34] so we can pull that information—

Dr. Snow: You indicated two different portions. One from MEDPAC, which agreed with the periodic monitoring that CMS does and I was wondering specifically about that periodic monitoring.

Dr. Simon: There's two. The agency uses the CAP survey and then in 2008, MEDPAC did an independent survey, where they indicated there was no access problems.

Dr. Snow: But can we get more specifics on that. It may be just a matter of presenting those reports to the group.

Dr. Bufalino: Okay, other recommendations?

Ms. Trevas: I'm sorry—was that a recommendation?

Dr. Bufalino: I'm sorry, we have to vote on that. Any discussion? Second we have. Any discussion? All in favor?

[ays]

Dr. Bufalino: Thank you. Okay. Other recommendations? Okay, seeing none, one order of business is to say goodbye and thank Greg and Leroy for your service to the committee. Four years of commitment has been exemplary. We thank both of you for being here and we're thinking you may have replacements next time, otherwise you may be here again, but if so—[applause]. So we were going to take a break and let Dana wrap up the recommendations and then let us take a look at them. Before we do that, just in an effort to let people move on to their other parts of their lives, I'd ask Mr. Blum, or Ms. Richter if they've got any wrap up comments for the day?

Mr. Blum: I will chime in as well. I just want to thank everybody for coming here today. It's been a very helpful meeting for me, just to understand the concerns and the comments from the physician community. I'm still struggling to learn everything in A, B, and C and D, and having kind of real time feedback and perspective, for me at least, is very helpful. We'll take all these recommendations very seriously. Staff will spend a lot of time going through them. We'll have responses back to the next meeting, but this is very helpful for me, for the staff, for the agency, for the public to understand how the programs affect day to day practices and most important day to day beneficiary interactions, so thank you very much.

Ms. Richter: Just repeat the thank you. I always enjoy these sessions. We learn a lot from them and thank you for taking the time.

Dr. Bufalino: Pleasure. So let's take a break and we'll work on the recommendations, have a quick review and then we'll end the meeting.

Break

Wrap-up and Recommendations

Dr. Bufalino: Thank you.

Dr. Smith: There was actually one thing that I think—I don't know what I said, but it didn't come out right in the second recommendation, under item H, the prosper physician or provider before implementing new regulations. In other words, for the new regulation, not the cost of complying with the existing ones, but the cost that would be incurred by implementing new ones. Additional costs incurred for new regulations.

Dr. Ouzounian: Additional costs before implementing new regulations.

Dr. Smith: Yes. The cost per physician or provider.

Dr. Snow: Just take out the word, "existing."

Dr. Smith: But it's not to comply, not in that second one, it's not to comply with the existing ones, it's the cost of new ones.

Ms. Trevas: Just take out the existing?

Dr. Smith: Right. Cost per physician or provider to maybe the way to rephrase it would be say to comply with a new regulation before implementing it.

Dr. Przyblski: How about proposed regulatory purpose so that we could potentially—

Dr. Smith: Avert it, thank you, right.

Dr. Bufalino: We're happy with that, okay. Any others?

Dr. Snow: I wonder on Item N, the second, the consider, PPAC recommends CMS consider presenting information. I would take out that word "consider," that CMS present information on the statistical accuracy of the data. Isn't that what we really want on that?

Dr. Bufalino: Take consider and presenting, and change it to present information. Okay?

Dr. Snow: And similarly the top of the second page.

Dr. Smith: No. No the first one is correct. The first one's correct. It's the second one that didn't quite capture what I was after. The first one is correct. I don't know if you care about grammatical things, but in the agenda item K, the accreditation requirements of surety bonds for physicians and licensed healthcare providers who provide DMEPOS to their patients, as part of their professional services, because you've got a plural subject.

Dr. Przyblski: The first two recommendations on the first page, I assume that CMS attributes those to the appropriate party, because they're not necessarily RAC recommendations. Meaning PQRI's—

Dr. Smith: No, they're different, they're different—

Dr. Przyblski: It's listed under H, so I don't know if you take care of—

Dr. Simon: Yes, we do, we do. We routinely do that.

Dr. Snow: On the second page on this [inaudible 03:59] use reports, with that three-pronged thing I had. I remember one I put numbers in there, one, two, and three. And I would add to the third one, because I don't think that reads well. Initially, I sort of had two and three together because the first part of two, any plans to correct the attribution method to reflect, should precede number three. So number three should read, "plans to correct the attribution method to reflect the physician's actual contribution to the cost of care attributed to him or her." Okay, number three should have half of that first line of two, in other words, plans to correct, any plans to correct the attribution method to reflect, then the physician's actual contribution to the cost of care. So insert "any plans to correct the attribution method to reflect."

Dr. Bufalino: Any others?

Dr. Williams: [inaudible] say in the first one on page two, you take out that—

Dr. Smith: No, no, the first one is correct. It's the second one.

Dr. Williams: No, I was asking Art if he's [crosstalk] on page two.

Dr. Snow: Yes, I think.

Dr. Williams: You said take out the consider and just include—you just want them to include it, don't consider it, just include it. [chat] So Dana can you take out in the very first recommendation on page two, strike consider, and take off the "ing" at the end of including and put include risk adjusted. E-d.

Dr. Bufalino: Anybody else? So can I have a summary recommendation to accept all the changes that we have mentioned here.

[so moved]

[second]

Dr. Bufalino: Any discussion? All in favor?

[ays]

Dr. Bufalino: Thank you. Have a good day. Thank you everybody, thank you Dana and John and everybody, and thank you Robin. Thank you for everything. Pleasure.

Adjournment