

REPORT NUMBER SIXTY

to the

Secretary

U.S. Department of Health and Human Services

(Re: Durable Medical Equipment Final Rule, Contracting Reform, Post Acute Care Project, Physician Quality Reporting Initiative, National Provider Identifiers, Personal Health Records, Physicians Regulatory Issues Team Update, and other matters)

From the

Practicing Physicians Advisory Council

(PPAC)

Hubert H. Humphrey Building

Centers for Medicare and Medicaid Services

Washington, DC

May 21, 2007

SUMMARY OF THE MAY 21, 2007, MEETING

Agenda Item A — Introduction

The Practicing Physicians Advisory Council (PPAC) met at the Hubert H. Humphrey building in Washington, DC, on Monday, May 21, 2007 (see Appendix A). The chair, Anthony Senagore, M.D., welcomed the Council members, particularly the new members who began their terms this meeting.

Agenda Item B — Welcome

Herb Kuhn, Acting Deputy Administrator of the Centers for Medicare and Medicaid Services (CMS), thanked all the Council members for their time and commitment and identified some of the programs that have benefitted from the Council's input. As Medicare moves from being a passive payer to an active purchaser of health care, he said, the perspective of practicing physicians is very important. Elizabeth Richter, Acting Director of the Center for Medicare Management, welcomed the Council members and recognized the new members.

OLD BUSINESS

Ken Simon, M.D., M.B.A., Executive Director of PPAC, presented the responses from CMS to PPAC recommendations made at the March 5, 2007, meeting (Report Number 59).

59-C-1: PPAC recommends that CMS provide the Council with a semiannual update of Medicare beneficiaries' access to physician care in America.

CMS Response: CMS currently can respond on an annual basis. Several of the prongs of our multi-prong approach to monitor access to care involves surveys and analysis of claims data that are reported annually. Surveys such as the Medicare Current Beneficiary Survey (MCBS) and Medicare Consumer Assessment of Health Plans Survey (CAHPS) have 12-month data collection and reporting cycles. Although claims data can be accessed more often, the Office of Research, Development, and Information obtains a research data file every July on an annual basis which is the standardized analytic file used for computing measures of physician density, dollar volume per physician and beneficiary, and the number of distinct beneficiaries per billing physician. Only the 1-800-MEDICARE monthly summaries of access problem calls are reported on a cycle less than 12 months. However, the numbers reported on a monthly basis are too small to be interpreted. We have found that at least a full year of data from the 1-800 system is necessary.

A change in the data collection cycles for the MCBS and CAHPS surveys is not feasible due to the significant additional resources that would be required. A change in the reporting on claims data would entail using a different process than is currently employed. MCBS and CAHPS surveys employ a 12-month data

collection cycle. A change to a 6-month cycle for access-to-care questions would require modifying the instruments as well as significant and costly alterations for the survey process. Further, the claims-based reports use a standard analytic data file constructed on an annual basis for multiple research and reporting purposes. Moreover, it typically takes several years to observe a meaningful change in a measure. If we reduce the period of observation with a measure that has significant variation in the short run we can arrive at incorrect conclusions, i.e., we can interpret a random fluctuation as real change.

59-D-1: PPAC recommends that CMS require fiscal intermediaries to transmit claims to the National Claims History file within one business day of receipt, so that any claim received by a fiscal intermediary by February 28, 2008, is transmitted to the National Claims History file by February 29, 2008, and therefore is eligible for inclusion in the calculation of the bonus payment.

CMS Response: To be included in the basis for the Physician Quality Reporting Initiative (PQRI) bonus calculation, claims must be submitted by professionals who are participating in the 2007 PQRI no later than February 29, 2008. It is possible that not all of the claims submitted by that date will have been transmitted to the National Claims History file in time to be included in the bonus calculation. The Tax Relief and Health Care Act, Division B, Title I, Section 101, allows CMS to estimate the charges upon which the potential 1.5-percent bonus for quality reporting will be based. We are reviewing our authority to add a nationally-applicable completion amount to each participant's charges before calculating potential bonuses.

59-D-2: PPAC recommends that CMS review future models of aggregation of Part A and Part B into a global system of care.

CMS Response: CMS has a number of demonstration projects underway that are evaluating, among other things, options for future integration of Medicare Part A and Part B services. These demonstrations include the Physician Group Practice Demonstration, the Physician-Hospital Collaboration Demonstration (Medicare Modernization Act [MMA] 646), the Gainsharing Demonstration (Deficit Reduction Act 5007), and the Medicare Health Care Quality Demonstration (MMA 646).

59-D-3: PPAC recommends that CMS consider the implications of simultaneous implementation of the new 1500 form in conjunction with reporting Current Procedural Terminology (CPT) category-II codes and, more importantly, the issue of potential edits related to those submissions, to ensure accurate and timely payment of medical services.

CMS Response: After due consideration, CMS does not anticipate that the use of CPT category-II codes for quality reporting or any other aspects of claims-based

quality reporting will cause adverse impact on the accuracy or timeliness of payments for professional services.

59-D-4: PPAC requests that CMS staff explain at the next PPAC meeting the source of funds that will be used to pay for bonuses for 2008 and beyond.

CMS Response: CMS' statutory authority to pay bonuses for quality reporting for 2008 and beyond is not clear. We will further discuss how we will address the payment for bonuses for physicians who participate in the PQRI and meet the thresholds for the quality reporting measures when the Notice for Proposed Rulemaking for the Medicare Physician Fee Schedule is published later this year.

59-D-5: PPAC requests that CMS define the methodology used for data analysis related to performance measure submission under the new PQRI.

CMS Response: CMS has defined the methodology that will be used to determine satisfactory reporting under the 2007 PQRI:

- A participating professional selects a measure by submitting, at least once during the reporting period, a quality code that represents the numerator for that measure.
- That professional's claims from the entire reporting period will then be analyzed to determine whether the 80-percent reporting threshold was met for that measure.
- In the analysis, the number of opportunities for reporting, as defined by the presence of the measure denominator's International Statistical Classification of Diseases, 9th edition (ICD9) and CPT category-I codes on the claims, is compared with the number of times that the numerator quality codes for that measure were actually reported on the corresponding claims.
- The analysis is repeated for every measure that a professional selects.
- The participating professional must meet the 80-percent threshold for reporting on one, two, or three measures, depending on the number of measures that are applicable to the patients who were treated during the reporting period.
- If three measures are reported satisfactorily, then the bonus payment will be calculated.

If only one or two measures are reported satisfactorily, then a validation will be performed on the claims from the reporting period to determine whether another measure could have been reported. If no other measure should have been reported, then the bonus payment will be calculated. If another measure should have been reported, then no bonus will be paid.

59-E-1: PPAC recommends that CMS provide assurance to providers that private information will be secure and that access to National Provider Identifiers (NPIs) restricted (including sale of NPIs) to only those physicians and other entities with legitimate health care administration needs.

CMS Response: A Privacy Act statement is part of the NPI application. The statement indicates that health care provider data collected by the Department of Health and Human Services (HHS) from the NPI application are protected under various laws and that data may be disclosed under specific circumstances to certain entities. HHS will be publishing a notice that will describe the policy by which HHS will disseminate health care provider data from the National Provider and Plan Enumeration System (NPES). The notice is expected to be published soon.

59-E-2: PPAC recommends that CMS publish the NPI data dissemination notice as soon as possible and allow time for public comment following publication.

CMS Response: We appreciate PPAC's interest in this important matter and for sharing your comments and concerns with us. HHS expects to publish a notice in the *Federal Register* that will describe our policy with respect to the availability of information from the NPES. We expect this notice will be published soon.

59-E-3: PPAC recommends that CMS establish a minimum 1-year contingency plan for implementing NPI numbers.

CMS Response: CMS announced that it is implementing a contingency plan for covered entities (other than small health plans) who will not meet the May 23, 2007, deadline for compliance with the NPI regulations under the Health Insurance Portability and Accountability Act (HIPAA) of 1996. Details are contained in a CMS document entitled, "Guidance on Compliance with the HIPAA National Provider Identifier (NPI) Rule." To view this guidance, visit http://www.cms.hhs.gov/NationalProvIdentStand/Downloads/NPI_Contingency.pdf on the CMS website. A press release on this topic is also available at http://www.cms.hhs.gov/apps/media/press_releases.asp on the web.

CMS encourages health plans to assess the readiness of their provider communities to determine the need to implement contingency plans to maintain the flow of payments while continuing to work toward compliance. Likewise, we encourage health care providers that have not yet obtained NPIs to do so immediately and to use their NPIs in HIPAA transactions as soon as possible. Applying for an NPI is fast, easy and free. Visit the NPES website at <https://npes.cms.hhs.gov/>.

59-G-1: PPAC recommends that CMS promote the same level of transparency for health plans as for physicians and other providers. Specifically, PPAC asks that

health plans become more transparent about pricing information, physician fees, insurance claims processing and payment practices, the practice of re-underwriting, and identification of intermediaries that offer health plans unauthorized discounts and reductions in physicians' payments.

CMS Response: CMS agrees that greater transparency across the entire health care industry is important. CMS sets a positive example by making quality information available on a variety of providers, including hospitals and nursing homes, as well as on the health plans that provide benefits to Medicare beneficiaries. CMS also makes payment information available for hospitals, physicians, and ambulatory surgical centers via its website. Beneficiaries are also able to access benefit and cost structure information, including premiums and cost-sharing obligations, about Part C and Part D plans to enable them to make more informed choices, using the CMS website.

59-G-2: PPAC recommends that, to be effective and fair, CMS apply transparency initiatives to all sectors of the health care market.

CMS Response: CMS agrees that transparency is important for all stakeholders. The most effective steps to achieving lasting improvements in health care require a critical mass of support from all stakeholders—including health care providers, consumers, payers, and purchasers—investing their time and resources toward shared, meaningful, actionable goals. The system will benefit substantially if public and private stakeholders actively collaborate to establish and support uniform standards for health information technology interoperability and measuring and reporting quality and cost or price information. Considerable efforts to develop more extensive, uniform standards are already underway and need to be reinforced. This information is necessary for all stakeholders to make effective decisions and to work towards improved literacy for better care.

59-G-3: PPAC recommends that CMS dissuade health plans from implementing policies or quality initiatives that focus on cost without regard to quality.

CMS Response: We agree that, where possible, price or cost information should be made available with relevant quality information. To this end, HHS materials and speeches consistently promote the importance of this concept. As well, CMS activities will increasingly link these concepts through demonstration projects and release of information.

59-H-1: PPAC recommends that, due to the demonstrated insignificant amount of overpayments recovered from physicians, recovery audit contractor (RAC) audits of physician practices be discontinued.

CMS Response: Section 302 of the Tax Relief and Health Care Act of 2006 specifically requires CMS to utilize RACs to identify underpayments and

overpayments and recoup overpayments for all services for which payment is made under Part A or B. The use of recovery auditors will allow CMS to determine where policies need to be corrected to prevent improper payments in the future. Paying claims correctly remains CMS' goal in the recovery audit program.

59-H-2: PPAC recommends that if a RAC audit is appealed and the provider prevails, RAC reimburse the provider 25 percent of the originally requested overpayment amount to offset the cost of the appeals process to the provider.

CMS Response: CMS has implemented the recovery audit program to mirror the process utilized by fiscal intermediaries and carriers. This allows providers to maintain all of the advantages of the administrative appeal process as well as the ability to have claims repaid by offset of future payments. An appeal for an overpayment follows the same process as an appeal for a denied claim. CMS has not implemented a different appeal process for RAC-identified overpayments, and paying a portion of the provider's appeal expenses is currently not a process utilized by CMS.

59-J-1: PPAC recommends that CMS hold a briefing within the next 10 days on the formula described in the proposed rule published in the *Federal Register* on February 1, 2007, about graduate medical education volunteer preceptors and transmit the information to the Accreditation Council for Graduate Medical Education and all residency review committees.

CMS Response: CMS has outlined the data proxies and the guidelines pertaining to graduate medical education volunteer preceptors in the nonhospital setting in the Long Term Care Final Rule. To view this guidance, visit <http://www.cms.hhs.gov/LongTermCareHospitalPPS/downloads/cms-1529-f.pdf> This information will also be posted on the website of the Physicians Regulatory Issues Team (PRIT), located on the CMS website, and transmitted to the Accreditation Council for Graduate Medical Education and all medical specialty societies using our usual channels of communication.

59-K-1: PPAC recommends that CMS evaluate the implications of additional documentation requirements proposed by local carriers that supersede the base recommendations by CMS. In particular, PPAC recommends that CMS evaluate recent determinations that require specific documentation of negative findings as part of the review of systems.

CMS Response: CMS will review its current documentation requirements with the Medicare contractors and relevant CMS parties to better understand the potential issues surrounding additional requirements, if any, the carriers have put in place.

59-M-1: PPAC appreciates the legislation passed to avert the 5-percent cut to Medicare physician payment rates planned for 2007 but remains concerned about planned cuts totaling almost 40 percent over 8 years. To avert the steep cuts and avoid the looming crisis in health care access for seniors, PPAC recommends the Secretary of HHS and CMS leadership work with Congress to repeal the Sustainable Growth Rate (SGR) methodology this year and replace it with a system that adequately keeps pace with medical practice cost increases. If repeal of the SGR is not possible this year, PPAC recommends that CMS use its statutory authority to remove Medicare-covered drugs from the SGR calculation.

CMS Response: The formula for the SGR and the physician update are defined by statute. We are working closely and collaboratively with medical professionals and Congress on the most effective Medicare payment methodologies to compensate physicians for providing services to Medicare beneficiaries. We are committed to developing systems to enable us to encourage quality and to improve care without increasing overall Medicare costs.

The Council thanked Dr. Simon for his report. Dr. Simon said the Agency would try to provide the Council with annual updates on its assessments of beneficiaries' access to care. He also agreed to provide an update at the next PPAC meeting on CMS' progress on revising its calculations regarding professional liability insurance.

Recommendations

60-C-1: PPAC requests that CMS present timely reports that include assessments of the quality and outcomes of its various demonstration projects (e.g., the Gainsharing Demonstration, the Medicare Health Care Quality Demonstration, the Physician Hospital Collaborative Demonstration, and the Physician Group Practice Demonstration), specifically as they relate to gainsharing across Medicare Parts A and B.

60-C-2: PPAC recommends that the Secretary of HHS and CMS leadership make it a priority this year to work with Congress to enact legislation that would repeal the SGR, replace it with a system that adequately keeps pace with increases in medical practice costs, and establish a 1.7-percent update for physicians in 2008, as recommended by the Medicare Payment Advisory Commission.

60-C-3: PPAC recommends that drugs be removed from the SGR calculation prospectively.

NEW BUSINESS

Agenda Item D — Physicians Regulatory Issues Team Update

William Rogers, M.D., Director of PRIT, gave an update on a number of issues recently addressed by PRIT (Presentation 1). He said all the RACs will have medical directors, which should be very helpful in resolving physician concerns early in the process of recovery audits. Among other progress, Dr. Rogers noted that an interim final rule would allow hospitals to provide some continuing medical education within reason. Also, PRIT resolved the problem some specialists who treat patients with human immunodeficiency virus (HIV) had in getting antiretroviral drugs under some Part D prescription drug plans.

Recommendation

60-D-1: PPAC recommends that all carrier advisory committees allow alternate delegates as well as delegates to attend meetings to facilitate mentoring of alternate delegates so they can effectively substitute for delegates who are unable to attend meetings.

Agenda Item E — Durable Medical Equipment (DME) Final Rule

Joel Kaiser, Deputy Director of the Division of DMEPOS (durable medical equipment, prosthetics, orthotics, and supplies) Policy, described the Agency's effort to institute competitive bidding procedures for DMEPOS (Presentation 2). He said CMS spends about \$12 billion on DMEPOS annually, with about \$9 billion going to DME alone. The Agency projects saving about \$1 billion through the competitive bidding process, and it is hoped that beneficiaries will pay less for DMEPOS. Winning bids will be announced at the end of 2007, and contracts will go into effect April 1, 2008. Suppliers must be accredited by a CMS-approved accrediting organization. The program is being phased in gradually across the country.

Recommendations

60-E-1: PPAC recommends that CMS expand to physicians the exemption from the competitive bidding process for dispensing orthotics that has been proposed for physical and occupational therapists.

60-E-2: PPAC recommends that where the Final Rule exempts health care providers from competitive bidding requirements for DMEPOS that CMS also consider including physicians among those providers who are exempt.

60-E-3: PPAC recommends that CMS acknowledge that physicians are qualified to supply DMEPOS by virtue of their education, training, and experience and therefore should be deemed accredited for this process.

Agenda Item F — Contracting Reform Update

Karen Jackson, Director of the Medicare Contractor Management Group, gave an update on the status of contract reform for Medicare's fee-for-service program, which was mandated by the MMA (Presentation 3). Regional Medicare administrative contractors (MACs) will integrate the roles of various contractors into a single authority responsible for Medicare Parts A and B. The first MACs have already proposed innovative approaches and collaborative business arrangements, and CMS projects the MACs will have lower administrative costs as a result. The Agency will evaluate the performance of the MACs annually; the Provider Satisfaction Survey is a key component of evaluation. Dr. Senagore invited Ms. Jackson to present the results of MAC performance evaluation to the Council when they are available.

60-F-1: PPAC strongly recommends that CMS allow national physician participation in the critical phase of the MAC communication and development meetings.

60-F-2: PPAC recommends that CMS require a performance rating of 90 percent or better on the Provider Satisfaction Survey as the standard of performance for MAC contractors.

Agenda Item G — Swearing in of New Members

Leslie V. Norwalk, Esq., Acting Administrator of CMS, swore in the new members of the Council: John E. Arradondo, M.D., a family physician from Hermitage, Tennessee; Roger L. Jordan, O.D., an optometrist from Gillette, Wyoming; Jonathan E. Siff, M.D., an emergency physician from Cleveland, Ohio; Helena Wachslight Rodbard, M.D., an endocrinologist from Rockville, Maryland; and Arthur D. Snow, M.D., a family physician from Shawnee Mission, Kansas. Ms. Norwalk said she frequently asks key staff members for the PPAC perspective to inform her decision-making process.

Agenda Item I — Post Acute Care Project

Michael Rapp, M.D., J.D., Director of Quality Measurement and Health Assessment Group in the Office of Clinical Standards and Quality, described a new tool to allow assessment of care provided to patients by home health providers, nursing homes, and inpatient rehabilitation facilities after hospital discharge (Presentation 4). He said there has been great interest for nearly 20 years in developing a single instrument to evaluate and compare care across these settings. Dr. Rapp emphasized that CMS has funding from Congress to develop this tool as a demonstration project but does not have funding to implement the tool. Joanne Lynn, M.D., medical officer in the Quality Measurement and Health Assessment Group, described specifics of the development. She said the goal was to create a clinically relevant, useful tool that would assist in ensuring continuity of care. The Council debated whether such a tool should provide more or less detail and suggested CMS look to existing initiatives for guidance.

Agenda Item J — 2007 Physician Quality Reporting Initiative

Tom Valuck, M.D., J.D., Director of the Special Office for Value-Based Purchasing, described the PQRI, which was mandated by the Tax Relief and Health Care Act of 2006 to replace the Physician Voluntary Reporting Program (Presentation 5). He said the program will look at 74 evidence-based quality measures that have been developed through the American Medical Association's Physician Consortium for Performance Improvement, the National Quality Forum, and other consensus-based bodies.

Susan Nedza, M.D., M.B.A., Chief Medical Officer of the Chicago Regional Office, offered advice on how physicians could make the most of their participation in the PQRI. She suggested physicians consider their practices' quality improvement goals for 2007 and choose quality measures from the PQRI list that align with those goals. The American Medical Association and others are developing assessment worksheets specifically for the PQRI. Drs. Nedza and Valuck confirmed that the 1.5-percent bonus incentive for reporting quality measures would be calculated on the basis of the total amount of allowed charges during the reporting period (July 1 to December 31, 2007), but a cap may be applied.

Dr. Rapp provided details about the quality measures, noting that the 74 measures apply to 35 of the 39 specialties that Medicare recognizes. Council members noted that the 1.5-percent bonus incentive does not seem commensurate with the investment of time and technology required on the physicians' part for a program that will last only 6 months. Council members also pointed out that the evidence-based measures developed by the National Quality Forum and others do not always reflect either the best available evidence or the consensus of the relevant specialty.

Recommendation

60-J-1: PPAC recommends that CMS annually review the appropriateness of continued use of individual quality measures through a Notice of Proposed Rulemaking and comment period in which specialty societies and others can provide additional analyses of peer-reviewed published data (or the absence of such data) that may refute the applicability of individual measures in specific circumstances.

Agenda Item K — Personal Health Records (PHRs)

Tony Trenkle, Director of the Office of E-Health Standards and Services, said CMS has been considering what role it should play in the growing use of PHRs (Presentation 6). This year, CMS initiated two programs, the Medication History and Registration Summary, in which beneficiaries enroll to get summaries of all their current medications, and a demonstration project among fee-for-service plans that will test adoption and use of PHRs by beneficiaries. Mr. Trenkle said a number of issues, from infrastructure to policy to security, need to be addressed. The Council noted that interoperability with existing electronic health records, electronic prescribing methods, and databases is key to the

success of PHRs. The integrity, validity, accuracy, timeliness, and utility of the information were also concerns raised by Council members.

Agenda Item M — National Provider Identifier

Cathy Carter, Director of the Business Applications Management Group in the Office of Information Services, and her colleague Marlene Biggs gave an update on the status of NPI enrollment (Presentation 7). Ms. Carter said 2.1 million NPIs have been issued, which represents about 91 percent of the total number of providers CMS estimates will need an NPI. She described the Agency's contingency plan for use of legacy numbers during the transition to NPIs. Outreach is underway to encourage providers to obtain and begin using their NPIs and to educate vendors about the use of the NPI. Providers are encouraged to test the validity of their NPIs by submitting a small number of claims with only the NPI (and not the legacy number) on the claim.

Recommendation

60-M-1: PPAC recommends that CMS allow physicians (e.g., residents) who are relocating to a new area to apply for an NPI and be enrolled as a Medicare provider at least 6 months in advance of anticipated service to Medicare beneficiaries and other patient groups that require an NPI for physician registration for payment.

Agenda Item N — Testimony

No written or oral testimony was offered.

Agenda Item O — Wrap Up and Recommendations

Dr. Senagore asked for additional recommendations from the Council. He then adjourned the meeting. Recommendations of the Council are listed in Appendix B.

60-O-1: PPAC recommends that CMS partner with the National Medical Association (and similar groups serving underserved populations) to conduct pilots/demonstrations among underserved patients (involving providers who traditionally serve the underserved) to collect information that would enable CMS to adjust value-based purchasing and PQRI rules/practices that affect underserved populations.

Report prepared and submitted by
Dana Trevas, Rapporteur
Magnificent Publications, Inc.

PPAC Members at the May 21, 2007, Meeting

Anthony Senagore, M.D., Chair
Vice President of Medical Education
Spectrum Health
Grand Rapids, Michigan

John E. Arradondo, M.D.
Family Physician
Hermitage, Tennessee

Jose Azocar, M.D.
Internal Medicine
Springfield, Massachusetts

Vincent J. Bufalino, M.D.
Cardiologist
Naperville, Illinois

Peter Grimm, D.O.
Radiation Oncologist
Seattle, Washington

Roger L. Jordan, O.D.
Optometrist
Gillette, Wyoming

Geraldine O'Shea, D.O.
Internal Medicine
Jackson, California

Tye J. Ouzounian, M.D.
Orthopedic Surgeon
Tarzana, California

Gregory J. Przybylski, M.D.
Neurosurgeon
Edison, New Jersey

Helena Wachslicht Rodbard, M.D.
Endocrinologist
Rockville, Maryland

Jeffrey A. Ross, D.P.M., M.D.
Podiatrist
Houston, Texas

Jonathan E. Siff, M.D.
Emergency Physician
Cleveland, Ohio

Arthur D. Snow, M.D.
Family Physician
Shawnee Mission, Kansas

M. LeRoy Sprang, M.D.
Obstetrics/Gynecology
Evanston, Illinois

Karen S. Williams, M.D.
Anesthesiologist
Washington, DC

CMS Staff Present

Leslie V. Norwalk, Esq., Acting Administrator
Centers for Medicare and Medicaid Services

Herb Kuhn, Acting Deputy Administrator
Centers for Medicare and Medicaid Services

Marlene Biggs
Business Applications Management Group
Office of Information Services

Cathy Carter, Director
Business Applications Management Group
Office of Information Services

David C. Clark, RPH, Director
Office of Professional Relations
Center for Medicare Management

Karen Jackson, Director
Medicare Contractor Management Group
Center for Medicare Management

Joel Kaiser, Deputy Director
Division of DMEPOS Policy, Center for
Medicare Management

Herb Kuhn, Acting Deputy Administrator
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Joanne Lynn, M.D., Medical Officer
Quality Measurement and Health Assessment
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Susan Nedza, M.D., M.B.A., Medical Officer
Chicago Regional Office and Office of Clinical
Standards and Quality

Michael Rapp, M.D., J.D., Director
Quality Measurement and Health Assessment
Group
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Elizabeth Richter, Acting Director
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William Rogers, M.D., Director
Physicians Regulatory Issues Team
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Ken Simon, M.D., Executive Director, PPAC
Center for Medicare Management

Tony Trenkle, Director
Office of E-Health Standards and Services
Centers for Medicare and Medicaid Services

Thomas Valuck, M.D., J.D., Director
Special Program Office for Value-Based
Purchasing
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Dana Trevas, Rapporteur
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APPENDICES

Appendix A: Meeting agenda

Appendix B: Recommendations from the May 21, 2007, meeting

The following documents were presented at the PPAC meeting on May 21, 2007, and are appended here for the record:

- Presentation 1: PRIT Update
- Presentation 2: DME Final Rule
- Presentation 3: Contracting Reform Update
- Presentation 4: Post Acute Care Project
- Presentation 5: Physician Quality Reporting Initiative
- Presentation 6: Personal Health Records
- Presentation 7: National Provider Identifier (NPI)

Appendix A

**Practicing Physicians Advisory Council
Hubert H. Humphrey Building
Room 705A
Centers for Medicare & Medicaid Services
200 Independence Avenue, SW
Washington, DC 20201
May 21, 2007**

08:30-08:40	A. Open Meeting	Anthony Senagore, M.D., M.B.A., Chairman, Practicing Physicians Advisory Council
08:40-08:50	B. Welcome	Herb Kuhn, Acting Deputy Administrator, Centers for Medicare & Medicaid Services Elizabeth Richter, M.S. Acting Director, Center for Medicare Management Centers for Medicare and and Medicaid Services
08:50-09:10	C. PPAC Update	Kenneth Simon, M.D., M.B.A., Executive Director, Practicing Physicians Advisory Council
09:10-09:30	D. PRIT Update	William Rogers, M.D., Director, Physicians Regulatory Issues Team, Office of External Centers for Medicare and Medicaid Services
09:30-10:15	E. DME Final Rule	Joel Kaiser, Deputy Director, Division of DMEPOS Policy, Center for Medicare Management
10:15-11:00	F. Contracting Reform Update	Karen Jackson, Director Medicare Contractor Management Group,

		Center for Medicare Management
11:00-11:45	G. Swearing in of new members	Leslie V. Norwalk, Esq. Acting Administrator Centers for Medicare and Medicaid Services
11:45-1:00	H. Lunch	
1:00-1:45	I. Post Acute Care Project	Michael Rapp, M.D., J.D., Director, Quality Measurement and Health Assessment Group, Office of Clinical Standards and Quality
1:45-2:30	J. PQRI	Thomas Valuck, M.D., J.D. Director, Special Program Office for Value-Based Purchasing, Centers for Medicare and Medicaid Services
		Michael Rapp, M.D., J.D., Director, Quality Measurement and Health Assessment Group, Office of Clinical Standards and Quality
		Susan Nedza, M.D., MBA, Medical Officer, Chicago Regional Office and Office of Clinical Standards and Quality
2:30-3:15	K. Personal Health Records	Tony Trenkle, Director, Office of E-Health Standards and Services Centers for Medicare and Medicaid Services
3:15-3:30	L. Break (Chair Discretion)	

3:30-4:00	M. NPI	Cathy Carter, Director Business Applications Management Group, Office of Information Services, Centers for Medicare and Medicaid Services
4:00-4:15	N. Testimony	
4:15-4:45	O. Wrap Up/Recommendations	

Appendix B

PRACTICING PHYSICIANS ADVISORY COUNCIL (PPAC) RECOMMENDATIONS

May 21, 2007

Agenda Item C — PPAC Update

60-C-1: PPAC requests that CMS present timely reports that include assessments of the quality and outcomes of its various demonstration projects (e.g., the Gainsharing Demonstration, the Medicare Healthcare Quality Demonstration, the Physician Hospital Collaborative Demonstration, and the Physician Group Practice Demonstration), specifically as they relate to gainsharing across Medicare Parts A and B.

60-C-2: PPAC recommends that the Secretary of the Department of Health and Human Services and CMS leadership make it a priority this year to work with Congress to enact legislation that would repeal the Sustainable Growth Rate (SGR), replace it with a system that adequately keeps pace with the increase in medical practice costs, and establish a 1.7-percent update for physicians in 2008, as recommended by the Medicare Payment Advisory Commission.

60-C-3: PPAC recommends that drugs be removed from the SGR calculation prospectively.

Agenda Item D — Physicians Regulatory Issues Team (PRIT) Update

60-D-1: PPAC recommends that all carrier advisory committees allow alternate delegates as well as delegates to attend meetings to facilitate mentoring of alternate delegates so they can effectively substitute for delegates who are unable to attend meetings.

Agenda Item E — Durable Medical Equipment (DME) Final Rule

60-E-1: PPAC recommends that CMS expand to physicians the exemption from the competitive bidding process for dispensing orthotics that has been proposed for physical and occupational therapists.

60-E-2: PPAC recommends that where the Final Rule exempts health care providers from competitive bidding requirements for durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) that CMS also consider including physicians among those providers who are exempt.

60-E-3: PPAC recommends that CMS acknowledge that physicians are qualified to supply DMEPOS by virtue of their education, training, and experience and therefore should be deemed accredited for this process.

Agenda Item F — Contracting Reform Update

60-F-1: PPAC strongly recommends that CMS allow national physician participation in the critical phase of the Medicare administrative contractor (MAC) communication and development meetings.

60-F-2: PPAC recommends that CMS require a performance rating of 90 percent or better on the Provider Satisfaction Survey as the standard of performance for MAC contractors.

Agenda Item J — Physician Quality Reporting Initiative (PQRI)

60-J-1: PPAC recommends that CMS annually review the appropriateness of continued use of individual quality measures through a Notice of Proposed Rulemaking and comment period in which specialty societies and others can provide additional analyses of peer-reviewed published data (or the absence of such data) that may refute the applicability of individual measures in specific circumstances.

Agenda Item M — National Provider Identifier (NPI)

60-M-1: PPAC recommends that CMS allow physicians (e.g., residents) who are relocating to a new area to apply for an NPI and be enrolled as a Medicare provider at least 6 months in advance of anticipated service to Medicare beneficiaries and other patient groups that require an NPI for physician registration for payment.

Agenda Item O — Wrap Up/Recommendations

60-O-1: PPAC recommends that CMS partner with the National Medical Association (and similar groups serving underserved populations) to conduct pilots/demonstrations among underserved patients (involving providers who traditionally serve the underserved) to collect information that would enable CMS to adjust value-based purchasing and PQRI rules/practices that affect underserved populations.