

CENTERS FOR MEDICARE AND MEDICAID SERVICES

**PRACTICING PHYSICIANS ADVISORY COUNCIL**

Hubert H. Humphrey Building  
Room 705A  
Centers for Medicare & Medicaid Services  
200 Independence Avenue  
Washington, D.C. 20201

Monday, March 5, 2007  
8:30 a.m.

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DR. PETER GRIMM  
DR. CARLOS HAMILTON  
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## **PPAC Meeting Transcription – March 2007**

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### Public Witnesses

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STEPHEN R. PERMUT, M.D., J.D.  
American Medical Association

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MS. DANA TREVAS, Rapporteur  
Magnificent Publications, Inc.

# PPAC Meeting Transcription – March 2007

## A G E N D A

### Morning

	<u>Page</u>
<b>Open Meeting</b> .....	4
Dr. Anthony Senagore	
<b>Welcome</b> .....	4
Mr. Herb Kuhn	
<b>PPAC Update</b> .....	7
Dr. Kenneth Simon	
<b>2007 Physician Quality Reporting Initiative</b> .....	24
Dr. Tom Valuck	
<b>NPI Update</b> .....	37
Ms. Cathy Carter and Ms. Nicole Cooney	
<b>Transparency Initiative</b> .....	48
Mr. Andrew Croshaw	
<b>Recovery Audit Contractor Update</b> .....	66
Ms. Melanie Combs and Ms. Connie Leonard	
<b>Farewell to Departing Members</b> .....	81
Dr. Tom Gustafson	
<b>PRIT Update</b> .....	83
Dr. Bill Rogers	
<b>Hospital Conditions of Participation</b> .....	87
Ms. Jeannie Miller	
<b>Public Testimony: Academy of Otolaryngology</b> .....	98
Dr. Charles Koopman	
<b>Public Testimony: American Medical Association</b> .....	100
Dr. Stephen Permut	
<b>Recommendations</b> .....	104
<b>Adjourn Meeting</b> .....	112

## PPAC Meeting Transcription – March 2007

### 1 Open Meeting

2 Dr. Senagore: Good morning. In the interest of attempting to stay on some kind of schedule, we'll  
3 go ahead and get started. I'm Dr. Anthony Senagore, I'm the Chairperson of the Practicing Physicians  
4 Advisory Council and it's my pleasure to welcome you to Washington, D.C. on this occasion of the 59<sup>th</sup>  
5 meeting of the Council. I'd like to extend a cordial welcome to all my colleagues and fellow Council  
6 members and we'll take a little break, probably after lunch because we will have five members who this  
7 will be their final point of service and so we'll let them be able to wax philosophical for a little bit after  
8 lunch. So first as many of you know, I've mentioned who will be going off, it will be Dr. Carlos Hamilton,  
9 Dr. Dennis Iglar, Dr. Joe Johnson, Dr. Laura Powers, and Dr. Robert Urata, and I'll let you decide your  
10 order of seniority to make your comments. And we will be welcoming 5 new members at the next meeting  
11 and I believe that announcement goes out today Dr. Simon?

12 Dr. Simon: Yes.

13 Dr. Senagore: So we'll have the information in a bit. Well I appreciate as usual your willingness to  
14 come help serve today and help debate these issues we have in front of us. CMS staff will present here  
15 today a number of new issues regarding regulations and instructions, which directly affect our colleagues  
16 and I welcome your considered input for these documents. As we look at today's agenda, you can see there  
17 are a number of exciting topics, as usual. And these include the 2007 Physician Quality Report Initiative,  
18 an Update on the NPI, the Transparency Initiative, and Update on Recovery Audit Contracts. And then  
19 there'll be a discussion that's included in a variety of topics in the Hospital Conditions of Participation  
20 Update. We'll also have our regular PRIT Update and I think I saw Dr. Rogers earlier, so we'll welcome  
21 him in just a bit. As always, I'm confident you'll give representatives their due attention and the full benefit  
22 of your expertise. So at this point, I would like to welcome Mr. Herb Kuhn. In the fall 2006, Mr. Kuhn  
23 assumed the position Acting Deputy Administrator for the Centers for Medicare and Medicaid Services and  
24 he is joined as usual, by Dr. Tom Gustafson in his new role as Acting Director, Center for Medicare  
25 Management. Mr. Kuhn would like to share a few opening remarks.

### 26 Welcome

27 Mr. Kuhn: Thank you so much, and it's a pleasure to be here with you all again this morning and a  
28 couple of quick things. One, thank you once again all of you for your service to this committee. You meet

**PPAC Meeting Transcription – March 2007**

1 four times a year. I know that's a lot of time when you think about the travel back and forth, and I always  
2 think of Dr. Urata, who travels all the way from Alaska so thank you for the trips that you make here. We  
3 find this to be invaluable to us because it again, it is the Practicing Physicians Advisory Committee and to  
4 get the information that you all share with us is very helpful. Also it's nice to be here to say thank you to  
5 the five that will be rotating off and thank you for your service and the time that you've given to this  
6 committee. I think it's made a significant difference to help us hopefully get better policy as we drive  
7 forward. And I can't think of any better time now than for this committee to be meeting, not only today but  
8 as we go forward because I think we know physician payment system is at a crossroads right now. If you  
9 look at the information that MedPAC put out last week in terms of their report to Congress, in terms of  
10 recommendations on the SGR. If you look at the information that we put out last week when we did our  
11 annual report to MedPAC in terms of the SGR, we noted that we're looking at a 9.9% cut. Not a reduction  
12 in the rate of growth, but an actual cut in terms of physician payment in '08 and then for nearly the next  
13 decade, cuts as far as the eye can see as we go forward. I don't think there's anybody here at CMS, I don't  
14 think there's anybody in the physician community, I don't think there's anybody on Capitol Hill that can  
15 say that this kind of program's sustainable. What we do know is that we need for the Medicare program to  
16 be successful. And how we guarantee a successful program is active participation by physicians and the  
17 best way I know to guarantee active participation by physicians is to have predictability, stability, and of  
18 course adequate payments in the system. And that's where we have to go forward. But how we pay also  
19 matters. And I think everybody knows from these meetings and information that we've shared in the past,  
20 we have incredible growth in the program in all parts of the program, but particularly in the physician side,  
21 particularly with volume and intensity of services. And so what you see and what you've all been helping  
22 us think about the last couple years is as we begin to transform the Medicare program from basically a  
23 passive payer of services to an active purchaser of healthcare as we go forward, and as you look at the  
24 program, and as you heard earlier, in terms of the program that's going to be out there today that you're  
25 going to look at, Dr. Tom Valuck is going to be spending a lot of time with you this morning talking about  
26 a continuation of that transition, particularly with the new initiatives and the tax technical bill last year, and  
27 what we hope to be able to do this year as we move forward in making some of those changes. So, again,  
28 thank you for your active participation. I look at this agenda not only with the information that we talked

## PPAC Meeting Transcription – March 2007

1 about in terms of Value-based Purchasing, which talks about as we move forward and what we're going to  
2 be thinking about not only later this year but the next few years as we begin to transform this program, but  
3 also a lot in this particular meeting, looking at kind of the here and now, particularly with discussions about  
4 the NPR, the Recovery Audit Contractor, issues like that. So again, thank you for your help on that.

5 One final thing I'd note before I turn it back to our chairman is we do have a bit of another change  
6 in terms of staffing at CMS that I want to kind of mention to all of you. As was introduced and mentioned a  
7 moment ago, Tom Gustafson has been an active participant in this meeting for years. And as noted when I  
8 moved up to become the Acting Deputy Administrator, Tom moved up to become the Acting Director of  
9 the Center for Medicare Management. But we had an announcement last week about Tom, and Tom is now  
10 going to be retiring from the federal government and this will be his last PPAC meeting as well, so he'll  
11 join the other five of you, so after lunch if you want people to opine on things, I don't want to put Gus on  
12 the spot but he might want to opine on stuff and tell us what he think about what's going on out there  
13 [laughter]. But let me brag on Tom in just a moment, but back filling for Tom, I'm also pleased to  
14 introduce Liz Richter. Liz, I don't know has ever been to a PPAC meeting before. A few years ago? Many  
15 of the people that work for Liz have been here in the past, but Liz is currently the director of the Hospital  
16 and Ambulatory Payment Group within the Center for Medicare Management. And that's the group that  
17 does hospital payment, ambulance, physician, and many other different payment systems and the fee for  
18 service side, and Leslie Norwalk, our Acting Administrator, has asked Liz to step up and assume the role  
19 that Tom now has and that is being the Acting Director of the Center for Medicare Management. She has  
20 gladly accepted and we are thrilled to have her stepping up to serve that role. So I'm glad Liz is here today  
21 and will be joining you in the future. But I'd be remiss if I didn't say that we at CMS and I think everybody  
22 in healthcare are mighty lucky to have had someone like Tom, Tom Gustafson in the role that he served, in  
23 the many different roles that he served at CMS and it's predecessor agency, the Health Care Financing  
24 Administration, also known as HCFA for the work he's done. And I would just say one quick point about  
25 that is that every meeting I've ever attended and I think this one is no exception, has been a better meeting  
26 as result of Tom's participation. I think his intellect, his humor, his experience, all the things he brings to  
27 the table have made all our meetings better, and I think we've made a better agency and a better policy for

## PPAC Meeting Transcription – March 2007

1 it. So we wish Tom all the best in his future endeavors, and look forward to your active participation in this  
2 meeting as well, Tom, so thank you very much. [applause] So that's it, so back to you.

3 Dr. Senagore: Thank you, when the music starts, then that's the time you have to terminate your  
4 discussion. [laughter] We're going to move on to the PPAC Update. I invite Dr. Ken Simon, the Executive  
5 Director, Practicing Physicians Advisory Council and the Medical Officer in the Center for Medicare  
6 Management to present the responses prepared by the Centers for Medicare and Medicaid Services to our  
7 December 4<sup>th</sup> PPAC recommendations. Dr. Simon.

### PPAC Update

9 Dr. Simon: Good morning to the Council members and to the public.

10 Agenda Item 58C-1. PPAC recommends that CMS consider updating annually the proportion of  
11 physician reimbursement that reflects the cost of professional liability insurance. The response, CMS  
12 agrees with the Council regarding the importance of updating the Physician Fee Schedule to reflect the cost  
13 of professional liability insurance. However, operational requirements make it difficult to update the data  
14 more often than once every 3 years. In order to update the PLI, CMS must conduct a multi-step process.  
15 CMS first received bids from vendors to obtain a contract, the contractor obtains data from the various state  
16 departments of insurance. When a states DOI does not have data or fails to provide data, the contractor  
17 must work with the private insurance industry to obtain data on at least 51% market share from that state.  
18 The collection of data takes a minimum of 6 months. Once the data's collected, it's standardized, analyzed,  
19 and transformed into PLI RVUs. This data collection process takes a minimum of a year to complete. The  
20 information is then integrated into the CMS Notice of Proposed Rulemaking in an effort to allow specialty  
21 societies and the public the opportunity to comment. That takes another year. The new rates are  
22 implemented the following year. The Physician Fee Schedule methodology requires these changes be done  
23 in a budget-neutral manner. If the PLI form, if the PLI from many or all specialty groups increased, the  
24 increase in everyone's rates increases the national average, so that the individual specialty society increases  
25 typically marginal. CMS however does welcome suggestions on alternative data sources, or methods to  
26 update the fee schedule for the practice liability insurance.

27 58C-2. PPAC recommends that CMS provide the Council at its next meeting a detailed  
28 explanation of how CMS monitors access to care for Medicare beneficiaries. National statistics suggest that

**PPAC Meeting Transcription – March 2007**

1 the Medicare beneficiaries have access to needed care. Nationally, only 4% of Medicare beneficiaries  
2 reported trouble getting care in 2005. The proportion reporting trouble getting care has not changed since  
3 2000, which was the last time we examined the statistic. However, with the potential reduction in physician  
4 payments in the future, there is reason to be concerned about whether access to care will be negatively  
5 affected. As a result of similar concerns in the past, CMS instituted several monitoring activities that  
6 continue to be available. Given a difficulty in accurately documenting access problems, a multi-pronged  
7 approach is required. A multi-pronged approach includes claims data at the national and county levels,  
8 beneficiary surveys, and reports to the Medicare 1800 number of access problems. CMS will use these data  
9 sources to detect potential access problems. Using claims data, we are able to track at the state level  
10 physician participation by examining how many distinct billing physicians appear in the Fee for Service  
11 claims data. In addition, we're able to track physician caseloads by examining the number of distinct  
12 beneficiaries per billing physician and their Fee for Service claims data. We are able to track physician  
13 density by examining the number of billing physicians per thousand Fee for Service Medicare beneficiaries.  
14 Finally, we're able to track dollar volume by examining Medicare payments per billing physician and per  
15 Fee for Service beneficiary. The state level participation in caseload file is not available until the claims  
16 data are complete, about 12 months after the close of a calendar year. In the interest of having more timely  
17 statistics, we developed national data on a quarterly basis for many specific types of physician services.  
18 While this data system only provides information at the national level, it can be used as a warning system  
19 to capture real time changes in utilization patterns that might suggest declining access. In addition to this  
20 national real time data system, we have developed a real time county level tracking system that continues  
21 utilization statistics that contains utilization statistics for a subset of key services. This system provides real  
22 time county-level data that can be used as a warning system. We can examine whether there are shifts in  
23 the proportion of total visits that are for new versus established patients, coupled with an increase in the  
24 proportion of visits to the emergency room. The data systems mentioned to this point are based on services  
25 that have already been rendered and captured through claims. As such, they do not directly address  
26 beneficiaries experiences with the health care system, or physicians' perspectives about their willingness to  
27 treat Medicare patients. To address the beneficiary perspective, two beneficiary surveys are available. The  
28 first the Medicare Beneficiary Survey, and the Consumer Assessment of Health Plans Survey. These



## PPAC Meeting Transcription – March 2007

1 surveys provide information on whether respondents are experiencing difficulty obtaining needed services.  
2 The MSBS is a national survey that has been continuously available since 1991. The Consumer Assessment  
3 Health Plan Survey, which has been available since 2000, is also a national survey but the largest sample  
4 size allow for the generation of statistics at a more local level. To address the physicians' perspective on  
5 their willingness to treat Medicare beneficiaries, CMS has relied on the periodic physician survey  
6 administered by the Center for Studying Health System Change.

7       Agenda Item F. Durable Medical Equipment 58-f-1. PPAC recommends that CMS determine the  
8 optimal means for physician documentation that complies for durable medical equipment; prosthetics,  
9 orthotics and supplies, claims submission to decrease the administrative burden for practicing physicians.  
10 CMS thanks the Council for their recommendation on this topic. Over the past few years, CMS has  
11 considered ways to streamline the process in a manner that maintains effective medical necessity  
12 documentation while reducing administrative burden on practicing physicians. CMS successfully  
13 eliminated the use of the manual wheelchair, motorized wheelchair and power-operated vehicle certificate  
14 of medical necessity. Thus, to minimize the documentational requirements for providers while assuring that  
15 documentation is adequate, physicians and treating practitioners will now prepare written prescriptions as  
16 required by MMA, Section 302, and submit copies of relevant existing documentation from the  
17 beneficiary's medical record, rather than having to transcribe medical record information onto a separate  
18 form, such as a Certificate for Medical Necessity. Further information about conditions of payment of  
19 power mobility devices including power wheelchairs and power operated vehicles Final Rule can be  
20 accessed on our website.

21       58-f-2. PPAC recommends that lower cost DME items, for example, orthotics, crutches, canes and  
22 cast braces be exempt from the Competitive Bidding Process when healthcare providers are capable of  
23 prescribing the DME post act as the supplier for those items. The response: This issue was addressed in the  
24 Notice of Proposed Rulemaking for the DME post Competitive Bidding Program. We will further address  
25 the issue in the Final Rule where we will respond to public comments in the near future. We thank the  
26 Council for their recommendation and input on this topic.

27       53-f-3. The Council recommends that CMS consider implementing a Competitive Bidding Process  
28 for other medical supplies, such as disposable equipment, using the operating room, and implantable

## PPAC Meeting Transcription – March 2007

1 devices such as cardiac stints to save healthcare dollars. CMS will take this suggestion under advisement as  
2 we consider legislation that might be recommended as part of the President's program. Statutory authority  
3 would be necessary to implement this recommendation.

4       Agenda Item G, Physician Fee Schedule Final Rule, 58-g-1. To avoid the looming crisis in  
5 beneficiaries' access to providers, PPAC recommends that the Secretary of the Department of Health and  
6 Human Services and CMS leadership work with Congress to avert the reimbursement cuts planned for  
7 2007 and beyond. Implement of positive payment update that covers increases in physicians' practice costs,  
8 and repeals the sustainable growth rate methodology and replace it with a system that adequately keeps  
9 pace with health care costs. We are fully cognizant of the potential implications of more than 9 years of  
10 negative physician updates. We remain concerned regarding those trends and are closely monitoring  
11 physicians' participation in the Medicare program. As well as beneficiaries' access to care. The formula for  
12 the SGR and the physician update are defined by statute. We are working closely and collaboratively with  
13 medical professionals and the Congress on the most effective Medicare payment methodologies to  
14 compensate physicians for providing services to Medicare beneficiaries. We are committed to developing  
15 systems that enable us to encourage quality and to improve care without increasing overall Medicare costs.

16       Agenda Item H. Outpatient Prospective Payment System. Ambulatory Surgical Center Final Rule.  
17 58-h-1. PPAC recommends that CMS establish a process to consult with national medical specialty  
18 societies and the Ambulatory Surgical Care community to develop and adopt a systematic and adaptable  
19 means of fairly reimbursing ASCs for all safe and appropriate services, allowing for changes in technology  
20 and current day practices. The response: The calendar year 2008 Proposed Rule for the revised ASC  
21 payment system was published on August 23, 2006 and provided for a 90-day comment period on the  
22 proposal. The proposal included a significant expansion of the list of surgical procedures for payment in  
23 ASCs and a proposed approach to updating ASC payment system annually through Notice and Comment  
24 Rulemaking in coordination with the Outpatient Prospective Payment System proposed and final rules.  
25 We've received thousands of public comments to the 2008 ASC Proposed Rule, including many comments  
26 from the ASC community and national medical specialty societies. We are currently considering all public  
27 comments in a development of the Final Rule for the 2008 Revised ASC payment system. We believe the  
28 process of annual Notice and Comment Rulemaking provides meaningful opportunity for broad input into

## PPAC Meeting Transcription – March 2007

1 the ASC update each year and permits us to adapt the payment policies of the ASC payment system to  
2 changes in technology and contemporary surgical practice on a regular basis. CMS uses a well established  
3 rule out process to ensure that the affected parties are informed of the updates and activities of the agency.  
4 CMS is committed to a transparent interactive process with the public in developing rules, and is guided by  
5 the administrative procedure act to obtain input to assist us in developing policies that improve the quality  
6 of care for Medicare beneficiaries, provided by clinicians participating in the program.

7 58-h-2. PPAC recommends that CMS apply any payment policies uniformly to both ASCs and  
8 Hospital Outpatient departments as appropriate. The response: The 2008 Proposed Rule for the revised  
9 ASC payment system was published on August 23, 2006 and provided for a 90-day comment period on the  
10 proposal. We are currently considering all public comments in the development of the Final Rule for the  
11 2008 revised ASC payment system and as part of the development of the Final Rule, we're also considering  
12 a recommendations of organizations on the structure and payment policies of the revised payment system,  
13 including PPAC, the GAO, the Medicare Payment Advisory Commission and others. We appreciate the  
14 Council's recommendation regarding consistent payment policies for ASCs and hospital outpatient  
15 departments and will take the recommendation into account as we finalize the policies of the revised ASC  
16 payment system.

17 Agenda Item J. Medicare Contractor Provider Satisfaction Survey Update. 58-j-1. The Council  
18 recommends that CMS identify actionable items based on best practices identified by the survey process to  
19 improve the provider contractor relationship. CMS acknowledges the recommendation and the agency  
20 recognizes the potential value of actionable item information to our contractors. In our continued effort to  
21 improve the provider contractor relationship, CMS intends to use the survey scores for monitoring  
22 contractor performance on an ongoing operation basis, as outlined in the Medicare Modernization Act,  
23 Section 911B3b. We will develop contractor performance requirements and standards for measuring  
24 provider satisfaction levels. CMS also plans to use the survey as a metric in the Medicare Administrative  
25 Contractor Award Fee plans for future Award Fee determinations. CMS encourages the sharing of best  
26 practices, however, given the competitive MAC environment, this act is voluntary and not a contractor  
27 requirement. At the same time, the competitive environment provides incentives for contractors to  
28 implement process improvements based on provider feedback so that they can gain the best competitive

## PPAC Meeting Transcription – March 2007

1 position possible. All contractors receive reports that provide disaggregate data for each of the 7 business  
2 functions and provider groups. Contractors can compare their business scores to the average aggregate  
3 scores, and develop process improvement initiatives. CMS will continue to work closely with and get input  
4 from contractors to enhance, to make enhancements to the on-line reporting tool so that it is able to support  
5 process improvements. CMS will continue to enhance the analytical tools so our Fee for Service  
6 contractors can identify specific areas where they should concentrate or reduce their efforts, based on the  
7 significant value or importance to the provider community. This mechanism will significantly enhance our  
8 contractors' ability to improve the services they provide to our Medicare physician and provider  
9 community.

10       Agenda Item K: Physician Quality and Cost Measures Update. 58K-1. PPAC recommends that  
11 CMS determine the relative benefits of pursuing the G-Code submission process in light of the considerable  
12 benefits associated with the episode grouper methodology. The response: CMS is evaluating the potential  
13 benefits of episode group technology for capturing and measuring resource use at the individual physician  
14 level. Our evaluation of the Ingenics and Medstat groupers, the two predominate grouper software products  
15 on the market, includes consideration of Medicare specific data issues, clinical logic, risk adjustment, and  
16 relevance to physician profiling reports. After our evaluation's complete in mid-2007, we will better  
17 understand the potential uses of episode grouper technology. In the meantime, CMS is coordinating with a  
18 number of entities including MedPAC, AQA, and NQF on our episode grouper evaluation and resource use  
19 measurement activities.

20       58K-2. PPAC recommends that CMS support development of outcome databases as an alternative  
21 to performance measures in the agency's quality and cost measures initiative. CMS is using G-Codes and  
22 CPT category 2 codes for the collection of physician self-reported quality information. This claims-based  
23 quality reporting system is expected to be a temporary approach to data collection for physician quality  
24 measures. We have been exploring the use of clinical databases, also called outcomes data bases, or  
25 registries. To facilitate the collection of a more robust set of data elements to populate quality measures,  
26 we will be accelerating our consideration of clinical databases for data collection in response to the  
27 statutory mandate in the Tax Relief and Health Care Act of 2006, Section 101, B4, which requires CMS to  
28 address a mechanism for registry-based quality reporting. One approach under consideration is that CMS

## PPAC Meeting Transcription – March 2007

1 would specify standardized reporting requirements for data elements and then any registry that could meet  
2 the specifications could report the physician quality data directly to the agency. This approach to data  
3 collection would raise the value of clinical databases and thereby encourage their development.

4       Agenda Item O: Wrap-up and Recommendations. 58O-1. PPAC recommends that CMS change  
5 calculations to use the unadjusted work RVUs in calculating indirect practice expense for the 2007  
6 Physician Fee Schedule. In the 2007 Physician Fee Schedule Final Rule, CMS stated it did not believe it  
7 would be appropriate to allow the increases in work RVUs for certain services as a result of the 5-year  
8 review to reduce aggregate payments for practice expense and professional liability under the Medicare  
9 Physician Fee Schedule. We believe it was most appropriate to use the budget neutralized work RVUs in  
10 the calculation of indirect practice expense, because this methodology appropriately maintains the current  
11 relationships between the work practice expense, and professional liability components of the Physician  
12 Fee Schedule. We also believe it is important to apply the revised budget neutrality work RVUs  
13 consistently with the Physician Fee Schedule framework. It would not be consistent to apply one set of  
14 work RVUs for work payments, but a different set for purposes of calculating indirect practice expense.  
15 Therefore, we based the calculation of both the work payments and the indirect practice expense on the  
16 revised budget neutralized work RVUs in the Final Rule.

17       58O-2. PPAC recommends that CMS use its statutory authority to remove Medicare covered  
18 drugs from the SGR calculation. CMS has carefully reviewed our authority to make administrative changes  
19 in the SGR, most notably the feasibility of removing part B drugs for the SGR. We believe it would be  
20 statutorily difficult to make such a change and even if we were to do so, it would not provide a reprieve to  
21 the negative updates projected for the coming years.

22       58O-3. PPAC recommends that CMS adjust the SGR calculation to account for increased  
23 spending due to national coverage decisions, just as it does for Medicare Advantage payments. CMS  
24 adjusts a factor of the SGR to reflect the change in the number of Fee for Service enrollees. When a number  
25 of beneficiaries enrolled in Medicare Advantage, changes and consequently the amount Medicare pays to  
26 Medicare Advantage plans changed, the SGR is adjusted accordingly. National coverage decisions do not  
27 affect the number of enrollees in Fee for Service system, and therefore CMS cannot adjust the SGR to  
28 reflect national coverage determinations in the same manner. While CMS may establish a national coverage

**PPAC Meeting Transcription – March 2007**

1 determination for a new item or service, the NCD does not necessarily increase Medicare spending to the  
2 extent that the service has, or would have been covered at local care or discretion in the absence of an  
3 NCD. Because Medicare might cover these services without an NCD, it is unclear whether there are any  
4 additional costs associated with the national coverage determinations.

5 Mr. Chairman that concludes the robust report from the last meeting. [laughter]

6 Dr. Senagore: Thank you for your brief comments. Are there any questions or comments for Dr.  
7 Simon at this point?

8 Dr. Przyblski: Ken, relative to the item 58C1, as you know sitting at the RUC, PLI work group  
9 had tried to work with CMS to develop alternative data sources, which were mentioned at the end of the  
10 CMS response, and looking back through RCU minutes, which I have dating back for a number of years, it  
11 was back in November of '04 that communications went back and forth to start to do that and given that  
12 that's now over 2 years ago, I was wondering what the status of that is.

13 Dr. Simon: The status of?

14 Dr. Przyblski: The status of the pilot project that was supposed to look at 5 different states, I  
15 believe if my memory serves correct, with PIAA data and see whether it's feasible to use them as a data  
16 source.

17 Dr. Simon: I have to report back to the Council at the next meeting. I'm now aware of the  
18 [laughter] current status of that pilot study.

19 Dr. Przyblski: And I'm sorry to bring it up here. We have not have a PLI work group meeting in  
20 the last couple of RUCs, so I haven't heard an update at the RUC and this seemed like an appropriate place  
21 to ask.

22 Dr. Senagore: Well, I guess in follow up to that is your searching the data banks. One other  
23 methodology would be to use a rolling average approach, with regular data fees rather than to have to do  
24 the current process of waiting for intermittent sampling to come back, so that's probably what Greg is  
25 alluding to, that that practice would allow for ongoing data accumulation.

26 Dr. Bufalino: Dr. Simon, can I ask the discussion which I think was elaborate in terms of access to  
27 care for Medicare beneficiaries, you outlined a number of ways you're going to be or are measuring and  
28 new ways to measure whether or not there's access to care in the country. So will we be getting an update

**PPAC Meeting Transcription – March 2007**

1 on a regular basis to understand this? Because I think, anecdotally, a lot of us have a growing concern that  
2 there's a progressive decline in patients' access to physicians for medical care in the Medicare beneficiary  
3 group. Will we have an opportunity to be able to have this data shared with us so that we can further  
4 comment on that as it goes forward?

5 Dr. Simon: Yes, I think the agency is clearly interested in tracking the services that are provided to  
6 beneficiaries by clinicians, and it hasn't been determined at what interval this data will be tracked and  
7 reviewed but we certainly will be working with our Office of Research and Development to obtain the data  
8 so that when we do collect it, we will bring it forth and share it with the Council.

9 Dr. Bufalino: Thank you.

10 Dr. Grimm: Ken, one issue I'd like to address is when you're answering questions, like for  
11 example, F2, that if there is an answer to the question that we not be referred to some other sort of  
12 legislation, that you just answer the question. Because then, now we have to go track it down for example,  
13 that one, F2, it says the issue is addressed in the Notice of Proposed Rulemaking. Just go ahead and answer  
14 what was the answer to the question, if you do that for us in the future, I'd appreciate that. Because now I  
15 have to go track down what actually happened in the Competitive Bidding Program or some way to get that  
16 I'd appreciate that.

17 Dr. Gustafson: Dr. Grimm, I think the, part of the reason for the answer on that one in particular is  
18 we have not yet issued the Final Rule. The entire DMEPOS industry is on tenterhooks waiting to hear what  
19 we will have to say. So we are not in a position to share that information with you yet.

20 Dr. Grimm: OK, well that's fine, if that is it, just go ahead and tell us that.

21 [chat]

22 Dr. Gustafson: That's the point of that sort of shall we say oblique answer, we admit it's oblique,  
23 but that's deliberate.

24 Dr. Ouzounian: That issue will be addressed or is being addressed? It says "was" which implies  
25 past tense. It should be available to us.

26 Dr. Gustafson: Let's, perhaps I need to be clearer. It was discussed in the Notice of Proposed  
27 Rulemaking. The point is, that's just a proposal and we will be coming back very shortly as I say, it's quite  
28 soon, that we will have more definite information on what's actually going to happen or what is actually in

**PPAC Meeting Transcription – March 2007**

1 the Final Rule. And we would be happy to provide a briefing for at the next meeting, to lay out all the  
2 details of that.

3 Dr. Senagore: It passed the grammatical test. Dr. Sprang?

4 Dr. Sprang: Ken, again going back to 58C1, Malpractice and Liability issues, I understand the  
5 answer but it seems that it, by taking 6 months for this and a year for the next portion and a year for the  
6 next portion, with that time frame obviously it would be impossible to do it in a more timely fashion. But  
7 I'll go back to the state of Illinois when through actually 35% increases going on annually by being three  
8 years behind, there was no connection between what we were getting, what they thought we were paying  
9 and what we were actually paying. So it seems there should be some way of shortening those time frames.  
10 Six months to collect the data, year to review it, another year for comments is just too long a period of time,  
11 and it's just not what's actually being given credit for and it's not consistent with what we're actually  
12 paying, and so it just somehow to be more realistic it should be shortened. And I'm not sure how that can  
13 be done, but those are very long time frames. To say it takes a year to review the data and another year to  
14 get more information.

15 Dr. Simon: I think the agency agrees with you and acknowledges that the process should be  
16 shorter than what it is. I think for that reason, we look forward in the proposed rule, since we do have folks  
17 like Dr. Przyblski who has been working with the RCU on PLI to provide us with suggestions for  
18 alternative means of updating the PLI in an accurate way in a more timely fashion.

19 Dr. Sprang: Thank you. And the other comment on access, which I think we'll all very concerned  
20 about. Access to care for Medicare patients. In some of the data, looking at the numbers again anecdotally  
21 that doesn't seem to be what we're seeing in practice, and I brought up at the last meeting, not only just the  
22 numbers, you can say there are so many physicians taking new Medicare patients, or taking Medicare  
23 patients, if the most qualified, most senior physicians are the ones who have the biggest practices, and they  
24 stop taking Medicare patients, and somebody else straight out of residency comes in and does take  
25 Medicare patients, you're going to have the same number of doctors seeing Medicare patients, but the  
26 access to I'll say the people who do the best hip replacements, the best knee replacements is not taking  
27 place. So Medicare are having access to not the same quality of people, even though the numbers would  
28 look the same, because the doctor right out of residency is now taking Medicare patients. It's hard, how do



**PPAC Meeting Transcription – March 2007**

1 you come by that data? And I don't have the answer, but I know that's what's going on, because in my  
2 locale, the people with the best and most extensive hip replacement data or records are just not going to  
3 take Medicare patients and they're big enough that they'll stay busy because other patients will still see  
4 them, so it's not just the absolute numbers. But actually the access to the people with the most experience.

5 Dr. Simon: And I'm not sure how we can—

6 Dr. Sprang: And I'm just pointing that out as a fact of what's actually happening in the practicing  
7 physician world.

8 Dr. Ross: Maybe just to take it a step further, just on the same vein, we discussed this issue the last  
9 time and I think Dr. Bufalino mentioned how many doctors are now starting to cut back the number of  
10 patients that they see per day, per week, and per calendar year. I think I brought that up in the last meeting  
11 and the question was how do we look at those statistics, or how do we look at their practices to see if those  
12 well established practices are now starting to cut back and if they are seeing patients at all, even though  
13 they haven't "delisted."

14 Dr. Simon: I think we're open to suggestions on how you think that data's achievable. How we  
15 can—I'm not sure we have the ability.

16 Dr. Ross: We're doing surveys, and maybe with the surveys, I'm not sure if people are going to  
17 volunteer that information or not—

18 Dr. Gustafson: If I could just jump in on this. You're pointing at a very difficult problem from an  
19 acquisition of knowledge standpoint, which is as an economist we like to look at what we call revealed  
20 behavior. It may be a very different thing what people will answer on a survey about what they do or intend  
21 to do, or will do if you cut us yet again, as opposed to what they're actually doing. And what they're  
22 actually doing may depend on vagaries of their particular market and their particular practice as much as it  
23 is an intention about gee, I'm going to take fewer or more Medicare patients. So it's, I'm not saying we  
24 can't sort that out, but it's an intellectual difficulty to try to grasp that.

25 Dr. Ross: The reason I bring it up and the reason I bring it to this panel is because I think the  
26 discussion, at least in my locale and I'm sure around the country is that with Medical economics, doctors  
27 are looking at their practices and asking how much does it cost per week per two weeks per month to keep  
28 their, as you would say, keep the lights on. And so the question is, how do we keep the lights on and still

**PPAC Meeting Transcription – March 2007**

1 provide access to the beneficiaries and yet pay for our bills, or keep the lights on? That's going to be the  
2 dilemma that I see in the next few years as more and more providers start to look at their overhead and say,  
3 how much can we afford and how many beneficiaries per week per month can we see and still turn "a  
4 profit" in our practice.

5 Dr. Williams: While probably not complete, there are a number of medical specialty societies that  
6 collect information from its members about when they plan to retire, how they're practicing, who they're  
7 practicing with etc. I don't know how many of your societies might have that type of information but it  
8 might be one source of information where you can gather that information.

9 Dr. Przyblski: In your response, you do describe being able to track number of dollars per  
10 physician billed to Medicare and I assume that you could probably figure out number of E&M services and  
11 divide it up into established and new so you should be able to follow groups of physicians, individual  
12 physicians, aggregate county level, however you want to do it, and the hypothesis might be that if  
13 physicians are seeing fewer Medicare beneficiaries, then high volume E&M billers in the past are not  
14 billing as many new or consultations and perhaps maintaining the same established or everything's going  
15 down as a way to track it internally. Because I gather there may be some concern about society developed  
16 data sources of what the members are saying, because I know AMA has put that out, I know AANS has put  
17 that out, but until you see it in your own numbers, I'm not sure what that means.

18 Dr. Ross: Dr. Williams raised a good way of maybe tracking this, and that is not just looking at the  
19 counties or looking at the state societies, but looking at how many individuals are leaving individual  
20 practice and now going into group practice and multi-discipline practice and seeing how their identification  
21 numbers have changed from being a solo practitioner and now going into a multi-discipline group. Those  
22 access individuals that were seeing doctors who were individual solo practitioners now may no longer be  
23 solo practitioners. And that may have occurred due to financial reasons or whatever reasons, so we could  
24 track that in terms of how many have now left individual practice and have now gone into group practices  
25 with a greater number.

26 Dr. Gustafson: Curious about your thinking about the implications of that for access of Medicare  
27 beneficiaries?

**PPAC Meeting Transcription – March 2007**

1 Dr. Ross: Well the question is, does the major group take less beneficiaries, the same number, or  
2 more? So if you're joining a major group, maybe that's improving your ability to have better access, maybe  
3 it's staying neutral, maybe it's improved. We don't know. But what I'm getting at is the individual who no  
4 longer can "keep the lights on" are now joining other groups because they just can't survive on their own.  
5 That's the premise. That's what I'm getting at.

6 Dr. Bufalino: Just to go back to Tom's comment about whether or not the perspective of the intent,  
7 the famous intent to treat here, are these folks intending to continuing to service Medicare beneficiaries or  
8 not? I think part of our interest here is providing an education for the Hill. From our perspective, we see  
9 this trend happening nationwide, and what we'd like to do is at least begin to bring out some data, and even  
10 if it says 30% of the folks are not seeing new Medicare patients, I think that might begin to get some  
11 attention here in DC to say that there is a growing access problem. No, they haven't ripped up their  
12 participation contracts, but as this next Baby Boomer generation, as this 70 some million hits 65 in the next  
13 few years, we're worried if we're not handling what we have today, how do we handle this next big wave?  
14 And from our perspective is trying to get some information to Congress to be able to begin to get them to  
15 understand that there's a problem, because at least my sense is that I'm not sure they see that there's a  
16 problem yet. Maybe you have a different perspective, but it seems to me that they don't think there's going  
17 to be an access issue.

18 Dr. Gustafson: I think my sense of the matter based on seeing reactions by Congress to testimony  
19 last week at Senate Finance and one the House Committees, I forget which one, Energy & Commerce? Was  
20 that the Congress is well acquainted with the issues here. Would additional documentation about the exact  
21 nature of the problem help policy makers in Washington? Absolutely. I don't think there's any question  
22 with that, about that. The picture on access of beneficiaries to Medicare providers is actually a fairly  
23 ambiguous one, and although there are results being presented that suggest as many of you have suggested,  
24 that folks are cutting back or leaving the program, retiring early, abandoning particular practice forms for  
25 other practice forms, whether that translates into Medicare beneficiaries being unable to find someone to  
26 treat them—maybe not their first choice, but finding someone, is a different question. That's coming at the  
27 problem from the other side, if you see. And if you think for instance about how we react to the closure of  
28 hospitals, which has been a byproduct or concomitant of the changes in hospital payment over the last 20 or

**PPAC Meeting Transcription – March 2007**

1 25 years, we're very interested in insuring, we the Medicare Program are very interested in insuring that  
2 our beneficiaries have access to hospital services. Not necessarily the services of hospital X or hospital Y.  
3 So are we interested in the questions you're posing, the problems you're pointing to, absolutely. There's no  
4 question. We all need to be very cognizant that we don't want the access problem to get worse. Clearly it is  
5 trembling in a situation where that may very well happen. The picture on the SGR over a number of years  
6 is at crisis proportion. Something must be done. Exactly how the Administration and Congress proceeds to  
7 wrestle with that sort of remains a question.

8 Dr. Sprang: Just kind of follow up. And it is obvious and we talked about it last time, too. I mean  
9 if there's a 40% decrease, there'll be a phenomenal decrease in access to care. I mean doctors will just not  
10 be able to see those patients and keep their offices open. What I was trying to make us see is just even a  
11 more, a more subtle and obviously much more difficult to demonstrate and prove, but I see it in my  
12 institution, which is a very first-call high class institution and I'll say to make the analogy: The master  
13 craftsman, the people who can do 3 and 4 hips in an afternoon, in a day and have excellent rehab and  
14 actually overall cut costs and get that patient back into the work force and back into a normal life, more  
15 quickly, those are the ones that are stopping seeing Medicare patients because they can see enough other  
16 patients because everybody wants to see them. The junior apprentice, straight out of residency, who is not  
17 going to have those skills and not going to be able to provide the same care and rehab and get them back  
18 into the work force as quickly, they're going to take Medicare patients because they have no other practice,  
19 they're just starting. So I'm really saying those are subtle changes, they're not as easy to demonstrate, but  
20 that have a negative impact on Medicare patients.

21 Dr. Gustafson: And don't dispute what you're describing, but I would ask you to reflect on the  
22 difficulty of a government program understanding that kind of effect. I mean as it is, we're in a, if you will,  
23 a legal and philosophic mode of not distinguishing between specialties, providing the same service, we pay  
24 the same regardless. We don't have sort of a quality index at present about a new versus experienced  
25 physician or much less one in different specialties. It would be very difficult for us to track the exact kind  
26 of problem you're speaking about without endeavoring somehow to label physicians in terms of their  
27 capability in ways that I think the profession might have some difficulty with our proceeding on.

**PPAC Meeting Transcription – March 2007**

1 Dr. Sprang: I understand it's very difficult. Just as the Practicing Physicians Advisory Council, I  
2 just kind of want you guys to know that is what is really what is going on and just kind of understanding it.  
3 Proving it's something else, but knowing that's what's going on and trying to obviously, again, correct the  
4 current flawed SGR and replace it with a system that we all hope will be better.

5 Dr. Grimm: You mentioned in your response to this issue about a couple ways in order to track  
6 this access to care issue. One is based on patient surveys, and the other one is based on physician surveys.  
7 And this periodic physician survey, which I have never seen before, could you comment on that? And one  
8 of the comments here was physicians' impressions about access to care. Could you comment on that what  
9 the periodicity is of that? And what is involved? I have not seen that before. This was the Center for  
10 Studying Health System Change. CMS has relied on a periodic physician survey administered by the  
11 Center for Studying Health System Change. I don't know if anybody else has heard of that before, but I  
12 haven't. So I wondered in terms of these surveys, are you going to use this information to, page 4...

13 Dr. Gustafson: If you're speaking about the survey mentioned here at the bottom of that response,  
14 of the Centers for Studying Health System Change, Centers for Studying Health System Change is a not for  
15 profit research and health policy organization, here in Washington. It is not a government agency. So that's  
16 why I think you're seeing us looking a little blank over here, saying Did you do that? Did I do that?  
17 [laughs]

18 Dr. Grimm: ...mechanism for really serving physicians' attitudes towards access to care, that's  
19 what we're saying here, is that correct? The government has no real mechanism for assessing physician  
20 perception of access to care, is that correct?

21 Dr. Gustafson: I do not believe we have been surveying on that subject, although the government  
22 covers a broad area, and there has been MedPAC research on this recently and I'm dimly aware of GAO,  
23 perhaps as well, I mean this has been a subject of interest. You're not the only crowd bringing this to the  
24 attention of Washington. And various other agencies have been pursuing that, so I wouldn't want to say  
25 whether some part of the government may have been looking at that question. We could perhaps look into  
26 that further and see if there's anything to report back to you on it.

27 Dr. Przyblski: Just to change gears for a second. I'm hoping for some clarification on 5802. Back  
28 in the December 5, 2005 PPAC Meeting, this is relative to removing drugs from the SGR, which you know

**PPAC Meeting Transcription – March 2007**

1 has been the advice and request of this Council, the AMA and multiple specialty groups. Back in December  
2 5, 2005, a comment was made that you did not have authority to do this retrospectively, but prospectively, you  
3 probably could. Then the following meeting in March 6 or 2006, the comment was made well we can't  
4 even do it going forward, and now the comment is it is statutorily difficult, which is not quite the same as I  
5 interpreted "you can't do it." And then the comment that even if we were to do so, which implies that the  
6 possibility exists, so it's kind of a mixed message over the past year and a half and I was hoping for some  
7 clarification.

8 Dr. Gustafson: I don't know what I can say here that won't get us in trouble. [laughter] I think that  
9 insofar as I've been following this, we certainly did look at the retrospective issue and concluded there is  
10 no way to proceed on that, and my recollection was actually that we thought we could do this on a  
11 prospective basis. The SGR includes physician services, labs, and incident to drugs, at present, and that is  
12 at the time we were doing it, was understood to be items we could attribute to the prescribing behavior of  
13 physicians and so it was appropriate to include them. Drugs have grown more rapidly than physician  
14 services. Labs less rapidly over the last decade. Curiously enough, no one's been pressing us to take labs  
15 out of the SGR, [laughs] and so I think there would be a possibility actually. Please don't make we walk the  
16 plank for this, but I believe there would be a possibility of taking that out on a prospective basis. I think the  
17 point that we have tried to stress on this, is even if we were to do that administratively, or if Congress were  
18 to do just that little change, let me emphasize the little part of it, statutorily, the affect it would have by our  
19 estimates, over the 40% cut interval is not, this isn't the rescue here. This might make a little difference  
20 around the edges, but it's not, as in fact the other issue that Ken pointed toward about national coverage  
21 decisions, that we think is even less important. It's just these are factors that might move things at the  
22 margin, but we're talking about a major problem.

23 Dr. Przyblski: But given that this has been asked and asked again, over the past several years, each  
24 year that we lose not doing it prospectively, is further reducing the overall impact that it could have had,  
25 had we done this 3 years ago.

26 Dr. Gustafson: I appreciate the point.

27 Dr. Ross: I don't want to keep belaboring, but I was just thinking of one possibility of looking at  
28 specialists, for instance, and looking at the number of cases that they performed on beneficiaries per year,

**PPAC Meeting Transcription – March 2007**

1 whether it's hips, knees, foot and ankle, OB/GYN, cardiovascular, and then tracking those individual  
2 providers the next year and the next year and seeing if their numbers have reduced; if there's been a  
3 significant reduction in the number of procedures on beneficiaries that they've performed. And if that's a  
4 trend or are they slowing down their practices? And rather than just looking at the survey and looking for  
5 an answer from them from the survey, whether that's correct or not, just looking at strictly statistics, and  
6 looking at the number of cases that they're performing.

7 Dr. Gustafson: This would point toward what I was describing earlier, as revealed behavior. What  
8 are folks actually doing, as opposed to what they will say when someone surveys them and say are things  
9 bad? Of course they're bad, because you want a change.

10 Dr. Ross: One's subjective, one's objective.

11 Dr. Gustafson: But not try to avoid this question at all but to note that one problem we have in  
12 looking through our claims data for such an analysis is we do not actually have the clear ability to track the  
13 behavior of individual physicians over time. This is where we refer to sort of an attribution problem. Or  
14 granularity problem, I guess it would be a safe way to say it. And Tom Valuck, who will be here, or is here,  
15 and will be around later, can perhaps go into that in greater depth if anyone's interested, or you can  
16 buttonhole him later. But basically, we pay on the basis of tax IDs at present. Now the NPI, the National  
17 Provider Identifier will provide hopefully a rescue to this, but what this means is you have a problem on  
18 both sides. In the one case, for a solo practitioner, off by themselves, obviously straight forward. Other  
19 individuals may be practicing in as many as 4 or 5 different practice venues over the course of a week and  
20 maybe billing under different numbers in each of those places. Alternatively, a group practice may bill all  
21 of its folks under the same and we don't know who's doing the service. So we can figure out some stuff,  
22 I'm not say it's, but it is a little cloudy and opaque as a result of that granularity problem. So would this be  
23 something to look at in the future? Yes. How much we want to employ in terms of research resources on it  
24 right now is a question.

25 Dr. Ross: Thank you.

26 Dr. Urata: It occurs to me that one thing you could do is just look at how many new Medicare  
27 patients each Tax ID number is taken on each year, and that would be a simple thing, and then follow that  
28 along. But part of the problem with that is that there's going to be increasing number of Medicare patients,

**PPAC Meeting Transcription – March 2007**

1 so while a practice might try to keep their number of Medicare patients less than 15% of their practice in  
2 order to pay bills, or could be less than that, they still have new Medicare patients coming on as those die  
3 off, that kind of thing. So it is a difficult problem.

4 Dr. Gustafson: Thank you for your suggestion. Thank you all for your suggestions.

5 Dr. Senagore: OK, well why don't we change discussions and invite Dr. Tom Valuck to join us.  
6 Dr. Valuck has addressed the Council many times in the past regarding the Pay for Performance issues. He  
7 is here today as the newly appointed Special Program Office for value-based purchasing, established under  
8 the direction of the Acting Administrator, Leslie Norwalk. Dr. Valuck leads the agency on this important  
9 program and is here to bring us up to date. Welcome, Dr. Valuck.

10 2007 Physician Quality Reporting Initiative

11 Dr. Valuck: Thank you Mr. Chairman and good morning to everyone. I'm here this morning to  
12 talk to you about the 2007 Physician Quality Reporting Initiative. This is our implementation of the Tax  
13 Relief and Health Care Act, Division B, Title I, Section 101. The reason why you didn't have any materials  
14 and why you're getting a handout this morning is because several of the policy decisions that are reflected  
15 in this particular document were decided last Friday and so since we're under a very urgent timeline for  
16 development, we wanted to get something out to you in written form to you today, but we weren't able to  
17 do that until this morning.

18 In order to put the statutorily authorized program in place, you'll see on slide 2, that there are a  
19 number of functions, if you will, that need to be addressed in order to make that happen. First of all, you  
20 have to understand who are the eligible professionals who are going to be participating; you have to have  
21 quality measures, for the participants. You've got to determine your form and manner of reporting as well  
22 as how you're going to analyze for successful reporting. How you're going to pay the bonus for reporting,  
23 and then a simple validation appeals is required along with feedback so that the participants can understand  
24 how they've performed, and how their payment was calculated and then we'll end by looking forward to  
25 2008 and talking about how we're actually going to roll this program out to the eligible professionals. As  
26 you can see on slides 3, 4, and 5, eligible professional is broadly defined. In fact, it's pretty much every  
27 member of the health care team. Obviously doctors of medicine and osteopathy, but also the others that are  
28 in the Social Security Act 1861R definition of physician, which include podiatrists, optometrists, oral



**PPAC Meeting Transcription – March 2007**

1 surgeons, dentists and chiropractors and then on slide 4, you see the professionals who are other than  
2 physicians listed there in 9 categories, and on slide 5, 3 categories of therapists. And the reason I wanted to  
3 emphasize this this morning is as we look at rolling out this program, and all that it entails, including the  
4 development of measure sets. One of the things that we've asked those who have been participating in  
5 measure development with us, like the Physician Consortium for Performance Improvement, the AQA  
6 Alliance and others, is to bring attention patient centered measures that take account of the various roles of  
7 every member of the health care team. We've been talking about payment systems this morning that were  
8 developed in silos and that's created problems for us in the delivery system. One example is just he  
9 problem of if a physician or another kind of practitioner listed here helps to avoid a re-hospitalization, how  
10 do we get the savings from the Part A program over into the Part B program to reward the performance of  
11 that Part B professional. So those kinds of silos have been a problem on the payment side and we're going  
12 to try to take this opportunity under this statute to address those silos that could create similar problems in  
13 terms of the provision of quality of care. So the point is that we'd like to see all of the professionals around  
14 the same table, developing patient centered, as opposed to profession centered quality measures. Another  
15 point about the eligible professionals that I'd like to make on slide 5 is we're getting some questions about  
16 whether or not the professional has to be a participating Medicare professional accepting assignment on all  
17 claims. The answer is no, that the initiative will be open to all Medicare enrolled professionals. So moving  
18 on from those who are eligible to a discussion of the quality measures, the statute is very specific about  
19 which measures we can use for 2007. The reason being that there wasn't time for an open rulemaking that  
20 would build in more flexibility potentially for the agency and those who would be responding through the  
21 rulemaking process. Congress had to point to something, and they pointed to what existed on, after  
22 December 5, 2006, as they were putting together the statute, which was the 66 measures, that were at that  
23 time to be the 2007 PVRP quality measures. And I put 2007 PVRP in quotes because PVRP ended on  
24 December 31, 2006 because the statute was passed in December. We no longer needed to continue our  
25 Voluntary Reporting Program and that's why we're transitioning to the Quality Reporting Initiative that  
26 will have a payment incentive associated with it. Unlike the 2006 PVRP. But anyway, those 66 measures  
27 were developed with an eye toward a 2007 PVRP. They will be the base for our 2007 PQRI measure set.  
28 Also under statute, we were allowed to add measures that went through some consensus process, which

**PPAC Meeting Transcription – March 2007**

1 was the AQA Alliance consensus process in January on the 22<sup>nd</sup>, I believe and we added 8 additional  
2 measures as a result of that process, which will bring several, many more providers will have access to  
3 participate because of those 8 additional measures. And so when you add the 66 and 8 additional, our final  
4 list is 74 quality measures that's now posted on our website as a download on the Measures and Codes  
5 page, on the PQRI website, and I'll be referring to the PQRI website several time here because that's the  
6 primary way that we're going to be getting information out to the participants and their office staff, their  
7 representatives in Washington, etc. The one point I would make that's still outstanding is that the actual  
8 measure specifications, which, in the end, give the detailed instructions and the codes etc. for how to report  
9 these measures that will be required for successful reporting. We're given under the statute until July 1 to  
10 make those kinds of changes. Now of course we want to give as much notice as possible for the specs  
11 because folks will need to begin to understand the instructions. We'll need to react to that well in advance  
12 of July 1, so we do plan to have those specifications posted. We expect during the month of March to give  
13 plenty of notice, with the recognition that we could still make changes. We get the core posted. If there  
14 were changes that needed to be made, we could do that through July 1, but we need to get those  
15 specifications out there for everyone to begin to understand how it's going to, how they can do successful  
16 reporting. In terms of the form and manner reporting, we will continue the claims based reporting that was  
17 established for the Voluntary Reporting Program. As you will recall, that claims based reporting uses the  
18 CPT Category 2 Codes, which are Quality Measure Codes. Or in the situation where CPT Category 2  
19 Codes are not yet available, we will be using temporary G-Codes, but where possible, we have replaced the  
20 temporary G-Codes with the CPT Category 2 Codes as they're developed by the PMAG at the AMA.  
21 Those quality codes are simply reported on the claims along with the codes for payment. The quality codes  
22 supply the numerator, and the rest of the information on the claim supplies the denominator. In other  
23 words, the payment information, the ICD9 Code, the CPT Category 1 Codes for services and procedures  
24 define the opportunity for reporting and then the quality code, or the CPT Category 2 Code is reported to  
25 supply the numerator, and that's how the claims based reporting works. Importantly, we've been getting a  
26 lot of questions about it, importantly, there is no registration or enrollment required to participate. Simply a  
27 reporting on the claims and then the reported information is captured along with the payment information.  
28 The determination of successful reporting now on slide 8 is laid out in the statute. If there are no more than

**PPAC Meeting Transcription – March 2007**

1 3 measures that apply to a participant's practice during the full 6-month reporting period, then each  
2 measure must be reported for at least 80% of the cases in which a measure was reportable. So that would be  
3 situations in which there are 1, 2, or 3 measures that apply to the total of the patients that the participant  
4 sees during the reporting period. If 4 or more apply, then at least 3 must be reported for 80% of the cases in  
5 which the measure was reported. Mr. Chairman, should we take questions now?

6 Dr. Senagore: Why don't we let the presentation go through—

7 Dr. Grimm: I'd just like him to give a real life example for what this means, because this is kind of  
8 confusing, Tom, in terms of what this is. Can you give an example of what it would mean for an individual  
9 physician, individual patient right at this point?

10 Dr. Valuck: In terms of the reporting threshold?

11 Dr. Grimm: What this means, what's the reporting threshold, yes. Walk through me with a patient.

12 Dr. Valuck: Yes. So a patient presents that you treat and when you go to bill for that, you have  
13 certain ICD9 and CPT-Codes that are going to apply to that patient. Those codes would define under the  
14 measure specifications whether or not that patient represents an opportunity for reporting. In other words—

15 Dr. Senagore: If I could get closer to what I think he wants to know. I may be wrong on the  
16 measures. But for diabetes, you have to report Hemoglobin A1C, lipid management, and I think it's blood  
17 pressure control. I forget what the third one is.

18 Dr. Valuck: Yes, those three.

19 Dr. Senagore: So those would be the 3 things that you would report on a patient with ICD9 of  
20 Diabetes Malidous. I think that was the question.

21 Dr. Valuck: Is that the answer to your question?

22 Dr. Grimm: ...in terms of what these three measures are.

23 Dr. Valuck: In order to not be overly speci—in order to not be misleading, the physician or the  
24 eligible professional has the opportunity to pick which measures they want to report. So, they might pick,  
25 because the 3 covers their whole patient population for the 6 month period if 3 or more apply. They might  
26 pick one diabetic measure. They might pick another one for their patients with heart failure. They might  
27 pick another one of a different condition. They don't have to pick all the diabetes measures or etc. So I  
28 don't want to leave that impression either. OK. So another important point there about the determination of

**PPAC Meeting Transcription – March 2007**

1 successful reporting, and this goes back to an issue that Gus was talking about earlier about Dr. Gustafson,  
2 I'm sorry, that

3 Dr. Gustafson: Yes, sir. [laughter]

4 Dr. Valuck: He was talking earlier about how we get at levels of information around individual  
5 physicians or practices etc. This analysis will be performed at the individual level, using the individual  
6 national provider identifier, and we've had a number of organizations, entities weigh in as to whether or not  
7 they would rather have the successful reporting calculated at the individual level so that they could get  
8 individual feedback and make changes that way or whether they would rather have it calculated at the  
9 practice level, based on tax ID. Our conclusion was that as we move in the direction of the NPI, the  
10 individual NPIs we move in the direction of having individual information available, potentially publicly  
11 under the Value Driven Health Care or Transparency Initiative, we feel like the NPI is the right direction  
12 and with the knowledge that individual information can always be rolled up at higher levels; a practice  
13 level, a system level, a community level, but the opposite is not necessarily true.

14 Moving to slide 9, this is regarding the bonus payment. The statute outlines that a participating  
15 eligible professional who successful reports may earn a 1.5% bonus subject to cap. That 1.5% bonus  
16 calculation is based on the total allowed charges during the reporting period. They have to be charges for  
17 professional service billed under the Physician Fee Schedule. They are not just the charges associated with  
18 claims that have quality codes reported on them. They are all charges. But the claims must reach the  
19 National Claims History by February 29, 2008. The reason being that we have to at some point cut off the  
20 intake of claims so that we can begin the calculations that would allow for the payment. The bonus  
21 payment will be made as a lump sum in mid-2008. And the bonus payments will be made to the holder of  
22 the taxpayer identification number as required by the statute for 2007. There will be no beneficiary co-  
23 payment or notice to the beneficiary related to the Quality Reporting Initiative.

24 Now one of the things that's been confusing to the industry has been how the cap calculation will  
25 happen, given that the 1.5% bonus is potentially subject to cap. So in slide 10, I've attempted to lay out  
26 both the purpose and the calculation for the cap. The cap is intended to apply when relatively few instances  
27 of quality measures are reported. And then it's calculated based on the number of instances of an  
28 individual's reporting, is one factor. The second factor is 300% or a constant of three, and then the final

## PPAC Meeting Transcription – March 2007

1 factor is this national average per measure payment amount. It's like an adjustment factor. And the way  
2 that's calculated is by looking at all the charges that have come in from the program over the whole  
3 reporting period for every participating professional, so it's the national charges associated with quality  
4 measures, so this time as opposed to the individual bonus that's all charges, this is just the charges  
5 associated with quality measures, divided by the number of national instances of reporting. So you get an  
6 average per measure charge amount, that then becomes the third factor in this calculation. That'll be the  
7 same for everyone. It's one nationwide number for all measures. So you have that adjustment factor, the  
8 constant, so the only thing that's changing here in calculating the cap is the individual's instances of  
9 reporting. So what we have then is a relative judgement of where the individual's instances rank as related  
10 to the reporting opportunities. If it's relatively high, then it's likely that the individual be over the cap and  
11 get the full 1.5%. If it's relatively low, then that individual may be subject to the cap. Without knowing  
12 these national numbers, there's no way to actually calculate how the cap might play out. So I can't answer  
13 any questions about will the cap kick in in this certain situation without knowing the national average per  
14 measure payment amount.

15 On slide 11, the statute does require a simple validation by sampling, or other means. Our  
16 validation plan is under development. And also appeals are restricted under the statute. The determinations  
17 that need to be made by the agency are excluded from formal administrative and judicial review. But we  
18 will have a simple, informal, inquiry process to satisfy our due process requirements. In terms of the  
19 confidential feedback on slide 12, as I mentioned, there will not be for 2007 any public reporting. But there  
20 will be reporting back to the individuals. We're designing that report now. We would hope that it would  
21 contain both the reporting performance, I'm sorry, the reporting rate and the performance rate that you can  
22 get out of these measures. Probably be similar to the report that I showed you before on the Voluntary  
23 Reporting Program that has columns that represent the reporting rate, the performance rate and the national  
24 comparisons. We do not have the capacity to do interim reporting during 2008. But that would be a future  
25 enhancement. In terms of 2008, the measures process will be somewhat different in that we will have, we  
26 are required under the statute to do rulemaking for the 2008 measure set. The problem is that the timing of  
27 the rulemaking will, again, restrict us to not potentially be as broad I the measure set as we would like to be  
28 because we must have the measures proposed by August 15<sup>th</sup>, which means we need clearance time through

**PPAC Meeting Transcription – March 2007**

1 the agency, and the department and the White House. And so we're actually looking at more like an April  
2 date, which just about a month from now to need to know about at least the strategy that we're going to be  
3 taking on putting together the 2008 measure set. So we're going to be relatively time limited again. In  
4 terms of the statutory requirements for the measures, you see them there. They have to have been adopted  
5 or endorsed by a consensus organization, they have to include measures that have been submitted by a  
6 physician specialty, they have to use a consensus based process for development, and they must include  
7 structural measures, such as the use of electronic health records, or electronic prescribing technology.

8 Other 2008 considerations. We are looking forward to registry based and electronic record based  
9 reporting. With our short lead time for 2007, it won't be possible to put that in place, but we're hoping to  
10 open up those channels for 2008 reporting. And we do believe that registry based reporting, using  
11 standardized specifications and centralization could dramatically reduce the burden of reporting for  
12 participants and CMS as well as make the information more useful, both to CMS as well as to private  
13 payers, states, other entities to which participants would need to report. In terms of getting the word out on  
14 our program, outreach and education, on slide 15, we do have the website up that I mentioned. That is  
15 going to be our primary mechanism for putting out all of the information that we'll have about the program,  
16 whether it's program instructions or educational materials or tools to support successful reporting. Those  
17 would all be disseminated through the website. The carriers will have a simple inquiry management  
18 through their call centers and so we're going to be educating them on how to handle inquiries and then we  
19 will have various education programs that will be offered, as well as tools to support successful reporting.  
20 So that I'd be happy to take your questions and comments.

21 Dr. Senagore: I've got a couple of questions to start with. Assuming that 100% of the Medicare  
22 providers participate, the bonus of 1.5% will come from what source?

23 Dr. Valuck: From the Part B trust fund.

24 Dr. Senagore: OK. Number 2, has there been any sort of calculation of the cost of data input,  
25 particularly if we're looking at maybe a temporary means of responding that data the CPT 2 level codes, if  
26 that isn't the end game, would people invest in that transition? And if the current legislation mandates a  
27 transition to electronic medical records, what his the cost implication for the vast majority of practices  
28 today that can simply not afford to buy that product and quite honestly, most of those products don't really

## PPAC Meeting Transcription – March 2007

1 exist, in a robust format to accommodate this process. And then finally, rather than a rush to judgment at  
2 the individual level, in all deference to all of my colleagues, I'm not sure that we know that any of these  
3 individual process measures will truly lead to measurable quality improvement and/or cost control  
4 measures in the end game. So why not take what would essentially be a very good research project, with a  
5 very highly powered study and analyze the results of these measures to say did anything really improve? At  
6 least in the short run. You won't be able to do long-term outcomes, but you'll certainly be able to figure out  
7 short term changes that maybe prove cost effectiveness.

8 Dr. Grimm: In a follow up on your question about the funding of this, the trust as I understand it is  
9 just for 2007, is that correct?

10 Dr. Valuck: That's correct.

11 Dr. Grimm: In 2008, it has not been determined yet where the funding is coming for that, correct?

12 Dr. Valuck: That's our current understanding.

13 Dr. Grimm: OK, and then the other question I had was could you explain to us what this, what the  
14 rationale around the cap is? I'm really not clear on what started this whole concept and how it works. It was  
15 just a bit confusing to me.

16 Dr. Valuck: Sure. Let me give you an example. A certain physician, let's say we have 2 physicians  
17 with the same patient population, hypothetically, or at least when they go to do their claims for payment,  
18 they end up with patient populations that have identical ICD9-Codes, and identical codes for services and  
19 procedures, CPT Category 1 Codes, so they basically have the same patient population. Physician A  
20 chooses 3 measures to report on for which his patient population or her patient population doesn't have  
21 very many instances of reporting. They happen to pick things that don't correlate well with the patient  
22 population and so they may be reported twice on each measure during the whole reporting period. So they  
23 had 6 instances of reporting and it was 100%, but it was only 6 instances. Whereas, another physician with  
24 the same patient population picks 3 different measures and instead of just 2 instances on each of the 3  
25 measures, they had 2,000 instances on each of the 3 measures. So they had 6,000 instances of reporting,  
26 whereas the other one only had 6. So when you plug that into the cap calculation, one physician's  
27 calculation is 6 times the constant of 3, which would be 18, times whatever that national number turns out  
28 to be. Let's say it's 100. So if their calculation would then be 6 time 3 times 100, their cap would be 1800.

**PPAC Meeting Transcription – March 2007**

1 Whereas, the physician who reported 6,000 would be 6,000 times 3 times 100 and that number would likely  
2 be much higher than 1.5%. They would get their 1.5%. The other would likely be capped. Does that help?

3 Dr. Grimm: When you say “capped” does that mean he would not get—

4 Dr. Valuck: He would get whatever the cap was rather than the full 1.5%.

5 Dr. Powers: I see the point in doing that, but I just was analyzing this view from for instance if  
6 measures for stroke, if I had a practice that had very few stroke patients for whatever reason, compared to a  
7 practice that had a large number, if I had a fewer number, I could calculate ahead of time, just roughly that  
8 it wouldn't be worth the time and effort to report those measures and therefore you're discouraging  
9 practices with small numbers of patients to perform these quality measures.

10 Dr.Valuck: Well, I'm not going to try to defend Congress's determination that they should put this  
11 cap in place, however I would say, that in the situation where you're only reporting a small number of  
12 measures, your burden, i.e., your cost, is also going to be relatively low, compared to the person who's  
13 reporting a lot of them.

14 Dr. Powers: Not if you had to pay your software vendor to open up the data ports on your billing  
15 and so forth, that's a one-time charge.

16 Dr. Valuck: Got it.

17 Dr. Senagore: Which was my question before, about the cost of implementation. If we're talking  
18 about a temporary process and a methodology to enter. I don't know what latitude you have in your  
19 mandate, but it would be much better to collect a lot of data points on diabetics and worry less about the  
20 individual physician reporting those and get a much broader brush stroke of what's going on with diabetic  
21 care, and do any of these 3 measures actually impact hospitalization for hyperosmolar coma, or amputation  
22 rates, or something in the short run data that you have. I think that what you'll end up with is a bunch of  
23 data that will be unevaluable in terms of actually addressing any process improvement downstream.

24 Dr. Azocar: Yes, I can concern also in the same area that Dr. Senagore mentioned. When you talk  
25 about form and manner of reporting, many of the small clinics, or single practices or small groups, which  
26 don't have the resources for electronic medical records, I understand that they have to provide the person or  
27 the staff who's going to do the recollection, and so that brings an additional expense, that many small  
28 practices can't afford. And I can tell you because I have seen that in action. And that may be, that may



1 favor that you don't get the whole picture. You may select for some clinic which has the possibility or the  
2 financial resources to pay an employee, or have the electronic medical records, where other clinics will be,  
3 you won't get data from those clinics. On the one hand, I think that the instruction to get the electronic  
4 medical record, one way or the other, that's the only thing that is outside the conversation, but that's a key  
5 component of your success in this thing here. And I did mention before in a few other meetings that the  
6 outcomes are going to change regardless of the physician according to the population that you have with  
7 the rate of compliance in that population, the complications. So that's the only thing that must be taken into  
8 consideration when you look into that, the results.

9 Dr. Valuck: So this is a pay for reporting program, currently I would say unfortunately, but in this  
10 narrow situation, I guess fortunately none of these are outcome measures that would need to be risk  
11 adjusted. They're all processes that the profession has determined should be provided to the patients in  
12 order to get good care for these specific conditions. So as we look forward to having outcome measures in  
13 the future, we'll definitely need to address that issue.

14 Dr. Senagore: But again that's the question. I'm not sure this is the way I would have chosen to go  
15 forward, based on my experience with process improvement, but be that as it may, if this is the way you go,  
16 then to not be able to take this data and develop the OE ratios is a problem, because you're collecting a lot  
17 of data and it's going to be in a format that you're not going to be able to determine those odds ratios  
18 downstream. And I'll take an example with heart failure, and I don't recall the name of the medication. But  
19 it has differential impact in African Americans versus Caucasians. That could have been something that  
20 would be sorted out by having a large population data base to say that the readmission rate for heart failure  
21 in patients with this drug was very different. What's going on? In this Pay for Reporting format, you would  
22 never capture that. And so I have concerns about how robust this data is going to be collected and in what  
23 evaluable form it will be used to actually drive quality improvement.

24 Dr. O'Shea: Dr. Valuck I have a question on intent on slides 5 and 7. All Medicare enrolled  
25 eligible professionals may participate regardless of whether they have signed a Medicare Participation  
26 agreement to accept assigned on all claims. And again repeated there, they wouldn't have to be enrolled. I  
27 question why, I can see if you just wanted to have open all comers, all who wanted to participate in this  
28 value reporting, but if this is only going to be a short time, why are you actually asking people that don't,

## PPAC Meeting Transcription – March 2007

1 are not enrolled to take Medicare patients to see them for this short time and then they won't be seeing that  
2 patient again. I think it's kind of a disservice to the patient. And that's how I'm interpreting it. Again,  
3 you're getting more data, but if they don't have to be an assigned to Medicare, as in, I'm a provider, but I  
4 don't usually take Medicare, but I want to be part of this survey, and so I'll see the patient for this, and then  
5 I won't see them again.

6 Dr. Valuck: No, I'm sorry. I had hoped that by, we did actually a rewrite on this statement on page  
7 5. The participants must be enrolled to provide services to Medicare patients. It's just that they don't have  
8 to have assigned a participation agreement to accept assignment on the claims. In other words, there's this  
9 part op, non part op, they don't have to be a participation physician, but they have to be enrolled to provide  
10 services in the program.

11 Dr. Gustafson: I think there's an additional confusion introduced by the last line on slide 7 and I  
12 think what we're attempting to articulate there is that no additional enrollment is necessary, so you do have  
13 to be enrolled to provide Medicare services to beneficiaries, but you don't have to sign up for this special  
14 program.

15 Dr. O'Shea: OK.

16 Dr. Valuck: Thank you.

17 Dr. Ouzounian: I have a question, looking at slide 9. You indicate that the codes for reporting are  
18 not going to be published until July 1 and then they need to be to your claims history, filed by February 29,  
19 2008. Is that the same as getting the bill and the codes submitted to CMS or is there then a transition from  
20 CMS to that file, and if so, how long is that delay?

21 Dr. Valuck: There are several steps in claims processing. And I don't profess to be an expert in  
22 that area. But here are some of the steps that are relevant to this process. First of all, the information that  
23 appears on the claim has to get from the eligible professional onto the claims form somehow, either through  
24 direct entry, the office staff does it, or however it's handled within the office. Then, that claim has to get  
25 through and sometime an internal billing process. Some have electronic systems. It'd have to get through  
26 that system. Then some use a clearing house, so it'd have to get through a clearing house, and then it comes  
27 into the carriers. The Part B carriers. So it has to make it through that system and then it comes into our  
28 systems at CMS into the national claims history. So there are points along the way that may take more or

**PPAC Meeting Transcription – March 2007**

1 less time depending on the physician office's own systems, depending on whether or not they use a clearing  
2 house, depending on their specific carrier, and then also depending on whether or not there were any  
3 problems with the payment part of the claims. There are certain edits that can kick it out.

4 Dr. Ouzounian: So my issue and question really has to do with the stuff that's outside the  
5 physician's control, and that is from when the bill hits the carrier, the local carrier director, and then that  
6 information is transmitted to you, how long does that take?

7 Dr. Valuck: It can, I think your question is getting at the point that it can be variable.

8 Dr. Ouzounian: That's correct, and that's a problem.

9 Dr. Valuck: Yes.

10 Dr. Ouzounian: Because that physician might get that information, theoretically to the carrier  
11 director by October 1 and if the carrier director doesn't get it to you by February 28<sup>th</sup>, that physician is  
12 going to be penalized.

13 Dr. Valuck: And this deadline is one that is in the statute.

14 Dr. Ouzounian: OK, that's a problem.

15 Dr. Valuck: So the statute does potentially create a problem.

16 Dr. Ouzounian: That's outside the physician's control.

17 Dr. Senagore: But is the deadline defined by time of claim submission, time of payment of clean  
18 claim, because those could be very different issues particularly if it has to be resubmitted. And then the  
19 follow up is have we guaranteed that on the CMS and fiscal intermediary side that none of these things are  
20 subject to any edits, that they won't get kicked out because of an error on the CPT 2 Code that has nothing  
21 to do with the original claims submission and that would result in a denial of, or a rejection of that claim.  
22 Has that been determined on CMS's side?

23 Dr. Valuck: For the claim to have reached the national claims history, it has to have gone through  
24 all of those various processing pieces that I mentioned.

25 Dr. Senagore: Right, but I guess my caution would be has the word migrated out to the folks that  
26 process the claims that none of these things are subject to any edit protocols. That the edits remain as they  
27 are currently. There's no new edits that would kick these things out for claims submission.

28 Dr. Valuck: I'm not aware of any new edits associated with this particular program.

**PPAC Meeting Transcription – March 2007**

1 Dr. Senagore: OK, as long as we're comfortable if that's the case, I think that would be a concern  
2 on the practicing physician's side.

3 Dr. Grimm: One other question about this cap, because every time you talk about a cap, people  
4 always understand it to be a limited amount of money available.

5 Dr. Valuck: That's correct.

6 Dr. Grimm: That's what a cap means. OK. [laughter] I'm trying to get my grasp around this thing.  
7 Is there a limit on how much money, everybody participates in this, everybody does everything absolutely  
8 correct, what happens?

9 Dr. Valuck: No, because the individual's bonus amount could be subject to a cap. But if  
10 everybody earns the full 1.5% then everyone will receive the full 1.5%.

11 Dr. Grimm: OK, so there's not a cap on that side.

12 Dr. Valuck: Exactly. There's not an aggregate cap.

13 Dr. Bufalino: Question. Dr. Valuck, you talked earlier about the silos of part A and part B. Could  
14 you speak to what may be coming next in terms of looking at how physicians are going to be reimbursed?  
15 Are we going to participate in let's just use my world of heart failure and disease management and we all  
16 know that the savings to CMS are really surrounding decreased hospitalizations and although the hospital  
17 or the DM demonstration project is participating in that, many of us practice in a world where we have the  
18 ability to try to control the advent of those people coming back in the hospital again. Do you see that as  
19 next line or next project or next world?

20 Dr. Valuck: I would like to believe that we're heading in that direction. Certainly from the  
21 perspective of the agency. We are interested in seeing Pay for Performance value based purchasing type  
22 payment reforms happening in all of our payment systems. And in order to maximize that, then you would  
23 want to see coordination among all of those various programs. We are already looking at, for example,  
24 aligning measure sets. Then it would seem that it would be a logical outgrowth of that kind of work to be  
25 able to look at the kind of system that you're describing that has a much better coordination between and  
26 among the various components of the program. So yes, we would like to see movement in that direction.

27 Dr. Przyblski: When and if this bonus payment is paid in 2008, will that extra physician payment  
28 be considered part of the calculation of the SGR targets for 2007 as well?

**PPAC Meeting Transcription – March 2007**

1 Dr. Valuck: I have asked that question to our legal counsel. Here's the way it was explained to me  
2 and this is the only way I know how to explain it because this is the way they explained it to me. It's part of  
3 the calculation but there's an offset that's also a part of the calculation. So it's not that it's, there are various  
4 things that are excluded from being in the calculation, and my understanding is and Liz and Gus may know  
5 this better, that it is a part of the calculation, but in another part of the calculation, it gets offset. In other  
6 words, it doesn't penalize the part B providers as a whole, moving forward because it is a statutory or  
7 considered a statutory or regulatory change under the law.

8 Dr. Przyblski: So I can assume that it's a 100% offset, meaning as part of the calculation statutory  
9 requirements supposed to be calculated into increase the spending target, so I assume it's 100% offset.

10 Dr. Valuck: That is my understanding. And if either of you want to comment. [laughter]

11 Dr. Senagore: So in accounting lingo, is it above the line or below the line, that's what really  
12 matters. So I'm hoping it's above the line. Any other comments or questions for Dr. Valuck? Thank you.

13 Dr. Valuck: OK. Thank you all.

14 Dr. Senagore: Let's move on. I think we've still got a little bit of time, and I've got some  
15 discretion for a break so unless someone is major needs, we'll try to get through the NPI update. We're  
16 well aware of the rapidly approaching deadline of May 2007 for the NPI implementation. Today, CMS will  
17 address two distinct aspects of NPI. One is the implementation strategy, as well as provide a community  
18 outreach. And today with have with us Ms. Cathy Carter and Ms. Nicole Cooney. Ms. Carter has 30 years  
19 of experience at CMS working with information technology, and bulk [inaudible] for service. She is the  
20 Director of the Business Application of Management Group in the Office of Information Services, and she  
21 manages the systems used to process Medicare claims, as well as a system that houses Medicare  
22 beneficiaries. We can as you about the edit question. And Nicole Cooney has worked in the provider  
23 Communications Group in the Division of Provider Information, Planning & Development for the past 3  
24 years, focusing on provider partnerships and national educational campaigns, including prescription drug  
25 coverage and the NPI. Nicole has private industry experience, working as a writer for IBM and computer  
26 sciences corporations. Please welcome both Ms. Carter and Ms. Cooney.

27 NPI Update

**PPAC Meeting Transcription – March 2007**

1 Ms. Carter: Thank you very much. I've heard NPIs mentioned a couple of times this morning. So  
2 this is all about just the sheer implementation of it. I was going to cover the issuance of NPIs, what  
3 Medicare's implementation strategy has been, which some of you might be aware of. Some NPI claims  
4 statistics, a contingency plan that Medicare has underway which really involves the way we're doing  
5 testing, and our NPI crosswalk matches. So on slide 3, CMS first began accepting applications to issue  
6 NPIs on May 23, 2005, so that's almost 2 years ago now and we endorsed, for purposes of implementation,  
7 we endorsed at that time and still ongoing the WIDI implementation strategy of dual use of NPI and  
8 Legacy identifiers. What that suggested was that health plans should be capable of receiving both an NPI  
9 and a Legacy prior to the deadline; that we couldn't all wait, both providers as well as health plans couldn't  
10 wait til the very last moment to do the implementation. So it was really a way of staging things. Initially  
11 though, we were continuing to rely on the Legacy identifier to actually identify the provider. For slide 4,  
12 what we decided to do for Medicare was implement NPI in 4 stages. Stage one was effective over a year  
13 ago in January of 2006 and at that point in time, we were able to accept NPIs on electronic transactions,  
14 both claims, claim status inquiries, and eligibility transactions. However, we needed the Legacy number  
15 there as well, because at that point in time, NPIs were only edited just to make sure they looked like and  
16 met the format of the NPI. We were not using the NPI in order to do our processing. During that period,  
17 obviously then for all of last year, we were continuing to accept claims with Legacy only as well as other  
18 transactions. And we were accepting Legacy on paper claims until the new versions of those claim forms  
19 were implemented. And both of those are now in effect, October of last year for the new 1500 as well as  
20 March of this year for the new UB04. We're continuing to send out both the Legacy number as well as the  
21 NPI, if it's available, on the remittance advice during that stage.

22 Stage two became effective in October of last year and at that point, we began using a crosswalk  
23 to identify the Medicare Legacy identifier if the NPI came in on the claim. That crosswalk was providing a  
24 means for our claims processing systems to convert the NPI to a Legacy number. The crosswalk is able to  
25 search both ways; from the Legacy number to an NPI, and from an NPI to a Legacy number. The electronic  
26 transactions can be submitted with the NPI only, although at this point, we are still encouraging in all the  
27 outreach which you'll hear about next, for providers to continue to submit their Legacy numbers. And at  
28 this point, we are still submitting the outgoing transactions with the NPI as well as the Legacy number.

## PPAC Meeting Transcription – March 2007

1           Stage three should be effective on May 23<sup>rd</sup>, at that point, according to the law and the regulations,  
2 we would transition to the full and exclusive use of the NPI, both on incoming transactions as well as  
3 outgoing transactions, with the exception of the COB transaction, because small health plans have an  
4 additional year and because we do not have a way of determining which are the small health plans, our plan  
5 was to send out the COB transaction with the Legacy number as well, so that means everybody would get  
6 the Legacy on the outbound COB.

7           Stage four then was simply to eliminate that last piece, which was for purposes of COB. We  
8 would then not send out those Legacy numbers on the coordination of benefit transactions. Slide 7 talks  
9 about control testing of the Medicare NPI crosswalk process. Any claim that comes in with an NPI only  
10 and we do have a significant number of claims coming in with an NPI only, we are actually using the  
11 crosswalk fully to translate to the Legacy number for our internal processing. Claims that come in with an  
12 NPI and a Legacy, what we're doing is testing in stages, moving over fully to that crosswalk process. The  
13 goal here being that we want to make sure we're not rejecting or denying or suspending a significant  
14 volume of claims. So we're doing this in a staged fashion. Claims with Legacy only are still coming in, are  
15 still allowed to come in during this period of time, and those are bypassing the crosswalk logic altogether at  
16 this point.

17          Slide 8. CMS is currently working with a few contractors and a growing number of contracts to  
18 fully test that crosswalk process. You can see the ones listed there. Sigma in Tennessee and Idaho, on the  
19 Part B side, National Government Services in Indiana and Kentucky, and on the A side in Wisconsin. And  
20 we are working with these contractors, looking very carefully at statistics, at claims that are rejecting or  
21 suspending and what the reasons for those rejections and suspensions are. And our intent is to continue to  
22 add other contractors to the list as we move on. The provider outreach message, I was only going to cover  
23 one piece of this, because the outreach piece of this is next, but we are encouraging everyone to make sure  
24 that claims that are submitted contain a valid NPI, and if in fact, one of the things that a provider can do  
25 that's critically important is to look into the provider enumeration system to make sure that your Legacy  
26 number is actually entered in that system. At the point in time when NPIs first started being distributed, I  
27 do not believe there was an edit there, and there are some providers that did not include their Legacy  
28 number or did not note that it was Medicare. And that will definitely help us out for purposes of the

1 crosswalk. So that is one of our newer outreach messages, is to make sure that and it's a sort of cost-free  
2 way of making sure that we have the data that we need, looking on the NPI website and making sure your  
3 data is correct. If information in the NPI data base is correct, but you still encounter problems with your  
4 claims, what we're suggesting is that in that case, you may have to submit an additional or an updated 855,  
5 Provider Enrollment Application, but you should check with your contractor before you do that.

6 On slide 10 there are some statistics for everyone to see. You can see the volume. Probably the  
7 most important column on there is the one on the far right, which is the overall percent of claims that are  
8 coming in with an NPI. Now that includes both claims that have a Legacy and an NPI as well as those with  
9 NPI only and you can see the percentage there for the most recent data on the slide is 11.89%. We have  
10 been increasing about half to a percent each week. I have new statistics that we received on Friday and we  
11 are now up to 13.44%. So the percentage does keep increasing.

12 The next slide is some information that talks about our crosswalk. I wanted to make sure that  
13 everybody understood what this means because there's 2 statistics that we've been using. Really one is the  
14 number of claims that come in with an NPI on them, so we know how many providers are actually using  
15 that NPI on their claim. The other one is how successful we've been in matching the Legacy to the NPI.  
16 And what the slide is explaining is that we are looking at all of our Legacy numbers and trying to match  
17 them to an NPI. It does not relate to claims information. It's totally separate from claims information.  
18 One could deduce that based on your crosswalk percentage you'd be able to find either a greater or a  
19 smaller number of claims through your crosswalk, but they're not directly related.

20 And the next slide actually has those numbers of matched and unmatched provider numbers. You  
21 can see that our Legacy provider number total is 5.3 million. That includes all of the PINs, the UPINs, the  
22 OSCRs, and the DME numbers, all the various numbers added together. We've been able to match 3.8  
23 million of those with a direct one to one match, which is about 72% and we still have 28% that are actually  
24 unmatched. And the new statistic there, it went up a little bit. We're at 72.5% for unique matches. At this  
25 point, we do not know of that 27. something percent of the numbers that are unmatched, we do not know  
26 how many of those are because the provider does not have an NPI, versus how many of them we have not  
27 been able to match in our system. We're using a series of we call them "recipes" of matching the Legacy to  
28 the NPI and looking at various ways of combining the data and looking at some of this as addresses and



**PPAC Meeting Transcription – March 2007**

1 names. It's alpha characters and we're trying to figure out which is the best way to do the matches. Some of  
2 it, we're certain that the data bases are not matching up exactly.

3 The next page is a graph that just shows the crosswalk statistics that I mentioned, and you see a  
4 couple of dips in that line. One of the reasons is because the volume of Legacy numbers we have been  
5 trying to make sure that inactive numbers are purged out of our Legacy files, so some of that we're  
6 jockeying the numbers around a little as we change our universe somewhat, but you can see for the last few  
7 weeks, we have a slightly increasing percentage. This past weekend, as well as next weekend, we have a  
8 couple of processes that are changing in the crosswalk matching process and we're hoping to have an  
9 increased number of matches as a result of that. Can't forecast at this point what the percent would be.  
10 Hopefully, we'll see a pretty sharp upward slope in that line after these changes.

11 Dr. Senagore: Will there a plan eventually to communicate with the physician if there for some  
12 reason, they're not matching on your crosswalk?

13 Ms. Carter: Yes, in fact, that will be part of the plan when we get to that point. We're trying to  
14 limit that to the extent possible because we do not want to see large volumes of queries, of letters, or phone  
15 calls having to be done by the Medicare contractors, but in fact there will be some of that I'm sure at some  
16 point that will be necessary. But we want to keep that to a minimum.

17 Dr. Bufalino: Could I ask a question. How, are we prepared for 80 days from now when only 13%  
18 of the folks are using NPI that this other 87%, how's that all going to happen in the next 80 days?

19 Ms. Carter: Well, there was a hearing back in January that the NCBHS conducted about the NPI  
20 and readiness all across the industry, and there has been a recommendation made by the NCBHS to the  
21 Secretary, and the Secretary's currently considering that recommendation. There are variety of options that  
22 are being talked about. There are significant concerns I think with the percentage, with two things, really.  
23 The percentage of claims that are coming in with an NPI, as well as some other information that was  
24 related to hearing about readiness of vendors, of providers, of even some health plans. Although most  
25 health plans are saying that they're ready, as is Medicare, where we can certainly accept NPIs as well as the  
26 Legacy number and have been for quite some time.

27 Dr Grimm: Just a follow up that. In my understanding, about 80% of the providers have NPIs right  
28 now, is that correct? About?

**PPAC Meeting Transcription – March 2007**

1 Ms. Carter: I'm not sure that we know a specific percentage, because for purposes of Medicare, as  
2 I said, there are some matches, which we call one to many or many to one, because you do not have to get  
3 an NPI for every one of your Legacy numbers. And so we don't know the absolute universe at this point,  
4 but we've been able to match 72.5% of our Legacy numbers to an NPI. And some of those are where a  
5 situation that remaining percentage, where we just can't find a match on our file, and somewhere the  
6 provider doesn't have an NPI, and at this point we don't have a specific number of how many for Medicare  
7 purposes have not gotten their NPIs.

8 Dr. Grimm: To follow up on Vince's question, you must expect some sort of rush here in the next  
9 30 to 80 days in terms of people now providing the NPI on their claims, correct?

10 Ms. Carter: That would be the hope, yes, that we would expect two things. One is additional  
11 providers getting their NPI, applying for their NPI, and then also for them using it on the claim.

12 Dr. Senagore: Hold for a second, we'll have Ms. Cooney weigh in, I think, she has a few things to  
13 discuss.

14 Ms. Cooney: In terms of NPI Outreach, the first thing I'll talk about is our strategy. Our key  
15 message is some highlights of what we've been up to recently, outreach data, future plans and just a little  
16 bit of information about our website. In terms of our content strategy for NPI, we knew from the start that  
17 the main goal of our outreach to begin with at least, had to be to motivate providers to enumerate and to  
18 help them understand why proactive enumeration is so important to their business practices. Adding into  
19 that, NPI is a cross-component initiative within CMS. We've maintained tight control of our outreach  
20 messages to keep the information consistent so that it's not coming from several points in the agency. So  
21 how we formulate our messages. Each month, we work with all NPI [inaudible] to gather content. The  
22 content can be new information, it could be reminders, or helpful hints. The content will also include a  
23 separate section on NPI information specific to Medicare providers. Once we obtain necessary clearance,  
24 the message is released around the 23<sup>rd</sup> of the month. So once we have our message, how do we get into the  
25 hands of Medicare providers and private industry? First, we meet the WIDI NPI outreach chairs on a  
26 monthly basis. We discuss industry outreach needs. We review content for upcoming messages, and once a  
27 message is distributed, WIDI circulates it to their membership as well. We all use our established  
28 relationships with Medicare Fee for Service contractors including instructing them to post information to

## PPAC Meeting Transcription – March 2007

1 their websites, place message on the automated IVR that callers listen to while their on hold with the  
2 provider call center, and we also provide training materials for provider education events that the  
3 contractors conduct. We've also established the agency wide NPI outreach subgroup. It contains at least  
4 one representative from each CMS component as well as every regional office. We hold monthly meetings.  
5 We distribute the monthly outreach message to members of this subgroup. The members then distribute this  
6 via their list serves. And through this mechanism, we reach Medicaid Agencies, QIOs, Medicare  
7 Advantage Plans, and more. These entities agree then to take our message and further distribute it to their  
8 membership. Our message also goes to our provider partners, more than 100 national associations and 1600  
9 local and regional medical associations and these groups have also agreed to send our messages to their  
10 membership. As Cathy mentioned, we have several key messages that we've identified through the content  
11 creation process, through questions we've received, and feedback from our provider partners. We identified  
12 this information and then we try to repeat it. And the frequency with which we can repeat depends on the  
13 other information we have to distribute in a given month. I've included some of these key messages here  
14 for your review, though I won't go through them now. Similarly these are some of the key messages we've  
15 used specifically for Medicare providers as well on slide 7. Moving to slide 8. In addition to creating  
16 outreach messages, we've also been busy with events in education. September's roundtable had 5,000 lines  
17 participate, and thousands more accessing the encore presentation. We've created 4 training modules for  
18 use by contractors and all providers on topics including general information about NPI, subparts, electronic  
19 file interchange, as well as Medicare implementation. We've also recently published NPI journal ads in the  
20 journal of the *American Medical Association*, which was published on February 28<sup>th</sup>. *The New England*  
21 *Journal of Medicine* on February 22<sup>nd</sup>, and *The American Academy of Family Physicians* on February 15<sup>th</sup>.  
22 To keep track of our progress, we also collect outreach data. Each member of our subgroup submits a  
23 monthly outreach report. These monthly reports are rolled up into quarterly analysis reports. This slide  
24 shows the outreach data for the last quarter. This particular quarter did not see as much activity as we've  
25 seen in the past or will see in the future. It represents a time period where little new information was  
26 available, but still there were 94 external outreach events during this quarter. In terms of what's coming up  
27 next for NPI outreach, we've heard from various industry sources that we need to do more to reach small  
28 providers and we're looking into that. We're currently working on a letter that contractors will issue to

1 reach small providers. We're hopeful that WIDI will encourage industry health plans to use this letter as a  
2 model and do the same. We anticipate more roundtables are important information is released, such as the  
3 data dissemination notice. Our 5<sup>th</sup> training module on data dissemination will also be released once the  
4 notice is published, and of course we'll continue our monthly messages, most likely with a stronger  
5 emphasis on Medicare implementation.

6 And I'd just like to talk a little bit about our NPI website, which is really our warehouse of  
7 information on the NPI. As you can see on the left hand side of the page, we've organized it into separate  
8 sections including CMS communications, which is an archive of all of our monthly outreach messages, a  
9 section on how to apply, educational resources houses all of our NPI MLM Matters articles, our fact sheets,  
10 tip sheets, and a link to NPI FAQs. Enumeration reports will show you the latest information on how many  
11 providers have received an NPI by state. Medicare NPI implementation is specific information and tools for  
12 Medicare providers. There's also a section of information on electronic file interchange and how to  
13 participate. And finally, NPI question resources provides access to a document that will help providers  
14 navigate the website to find answers to common questions. And finally, as I've said, we've heard from  
15 industry that we need to improve our reach to small providers, as well as minority providers. Does the  
16 Council have any suggestions on effective ways to do this?

17 Dr. Senagore: Comments or questions? Thank you for the report. I think aside from what you've  
18 outlined, I'm not sure we have any additional suggestions for you. I guess you have a question.

19 Dr. Przybski: No, a comment. If a claim gets rejected because there was no NPI number, that'll  
20 get somebody's attention pretty quick. Although not a desirable way to get it.

21 Dr. Sprang: I think you're probably said you already do this, but state medical society, county  
22 medical societies, obviously they will especially at the county level, they will get to the smallest practices  
23 and the smallest counties. That would be the most direct way to get to them.

24 Dr. Powers: I think that the smaller practices, the practices out in rural areas are very reliant on the  
25 programs that their local Medicare carriers put on, and if they're giving the message, they're probably  
26 getting it.

27 Dr. Grimm: This gets back to my question I asked earlier, but it looks like the answers right here.  
28 How many been enumerated means people who have the number? Is that right? Just making sure I know

1 what enumerated means. 1.8 out of 2.2 is about 80% or more. So is that, I'm accurate in reporting to my  
2 colleagues that about 80% have been enumerated?

3 Ms. Carter: If you, and I guess I was assuming you were talking about Medicare purposes, and so  
4 that's the piece that we don't know absolutely for sure. If you assume that Medicare providers are being  
5 enumerated at the same percentage, and if those estimates were correct in the first place, about how many  
6 providers there were, then that would be about the right percentage. The problem is that there are some  
7 inactive providers, some providers who just aren't going to get enumerated, so we don't know the absolute  
8 figure.

9 Dr. Ross: Will CMS be sounding out a notice to those in the next 80 days who have not signed up  
10 as NPIs? And if so, are we educating them at this point? Or trying to let them know that they're not going  
11 to be reimbursed if they don't have that NPI number when they submit their claim? That might be one of  
12 the ways—might be a wake up call.

13 Ms. Carter: I'm not sure about sending a letter to every provider that's not be—the cost involved  
14 in that—

15 Dr. Ross: Electronically? If they're filing electronically, that's probably easy enough to send.

16 Ms. Carter: Well, the message is like Nicole said, we have messages everywhere, on the website  
17 and a variety of ways that we're telling people that they have—

18 Dr. Ross: Through their associations? Maybe?

19 Ms. Cooney: Yes, we are trying to make sure that everyone understands that not having an NPI,  
20 not only not getting the NPI but not getting it with enough time to implement it in your business will have a  
21 major impact on your cash flow, so that's one of our messages that we are trying to get across.

22 Dr. Bufalino: But it seems still pretty unrealistic whether they have the numbers or not, only 13%  
23 of the claims have NPIs on them that we're really going to, in this next 80 days, turn the switch and have  
24 everybody convert to NPIs. So they may have their numbers, but there must be some internal issues in each  
25 of those locations that they're unable to deliver. Because I'm sure if they had the number and they had it on  
26 their claims, they'd be doing it already, I would think.

27 Ms. Carter: Well, I think one of the points is, that even though, because obviously more than 13%  
28 have their numbers. I think it appears obvious that more than 13% have their numbers. The question is what

1 do they have to do to put that on the claim? Is it a vendor issue? A clearing house issue? Whoever their  
2 billing service is, are they changing software? And what are they doing? Those are the steps that the  
3 providers need to take. And I suspect as we move closer to May 23<sup>rd</sup>, you'll see additional notices,  
4 additional warnings, additional information coming out but the goal is to have, to not lose the momentum  
5 here and to have providers go ahead and get the number and start using it, even if they're using it with their  
6 Legacy number at this point. That's the critical question is can a provider actually not just get the number  
7 but use it in their claims process successfully and then can Medicare and other payers process that number  
8 as well. So getting the number and using it on the claim is the very first piece, even before you get to the  
9 issue of editing and rejecting every claim that does not contain an NPI.

10 Dr. Senagore: Which is a huge question. If we're having troubles implementing this for something  
11 that actually translates into a payment for what we typically do, how are we going to get CPT 2 level codes  
12 into a position to report on the measures by July 1? But different department. Did Dr. Powers have a  
13 comment?

14 Dr. Powers: Have you been hearing from people who, I mean I understand there may be some  
15 problems with the vendors not being ready for the NPI numbers. Is that something that you all hear about?

16 Ms. Carter: What I've heard is, at the hearing that was held, that was one of the points that was  
17 made by some of the health plans in terms of not their own availability, but in terms of vendors and it was a  
18 survey that was done. It was sort of anecdotal evidence. But some vendors obviously are successfully using  
19 NPIs on claims, because for Medicare's volume, 13% does sound low, but that's several million claims  
20 every week that are coming in with an NPI.

21 Dr. Williams: Is it clear when the data dissemination notice will come out? And what safeguards  
22 will be put into place to guard the security of the NPI numbers and the information that's contained therein  
23 while at the same time allowing my colleagues to find out, a practitioner's NPI number in order to  
24 appropriately process a claim from a consultation, for instance?

25 Ms. Carter: Actually neither one of us come from the area that's dealing with data dissemination,  
26 and I don't really think we can address specifically when it's going to come out. It's in the clearance  
27 process and hopefully it will be soon. One of the things that I think, the major issue that's been wrestled  
28 with is exactly how to do what you suggested, and that is how to safeguard the data, but how to make it

**PPAC Meeting Transcription – March 2007**

1 available for those that need it for the claims process. For example, for prescriptions that need to have the  
2 prescribing physician's NPI on them, and how is that going to be looked up or for labs and things like that.  
3 So those are the very issues that have been looked at and I can't really say what the date.

4 Dr. Williams: Can we assume that it has to be out by May 23<sup>rd</sup>, since that's when all this other  
5 stuff will happen?

6 Ms. Carter: I would hope that it will be out by May 23<sup>rd</sup>.

7 Dr. Simon: We're hopeful that the dissemination notice will be out before May 23<sup>rd</sup>. We were  
8 actually anticipating having that discussion at this meeting. But in light of the fact that it has not become  
9 public we wanted to inform the Council on other aspects of NPI, which we felt were equally important and  
10 I think that if the data dissemination notice is made public prior to our next meeting, then we will plan to  
11 have that as part of our discussion for the May meeting.

12 Dr. Senagore: Not being a urologist, I've been insensitive to the break times. So [laughter] we'll  
13 have to put that break in sometime soon.

14 Dr. Sprang: Just relative to what we're talking about, I was going to make a recommendation:  
15 PPAC recommends that CMS publish the NPI Data Dissemination Notice as soon as possible, and allow  
16 time for comments following publication.

17 Dr. Senagore: Well, why don't we save that we're going to take all our time for comments in just a  
18 bit, so.

19 Dr. Ouzounian: I just have a comment. I'm a small provider, and I'm sure there are some others in  
20 this room, and I find it hard to believe that most people that need an NPI don't have it. I mean that  
21 information's been out there for a long time. I've had my NPI number for a long time. My vendor's  
22 updated my software. But I have not access to stuff that I can report it to you and I'm also concerned about  
23 the other carriers which actually a large part of my business. And the two things that I don't have are the  
24 NPI from all my referring sources, because I got to pay somebody to call all my referring sources and then  
25 enter that I the computer because you don't have access on line and number two is I'm a small practice. I'm  
26 allowed to bill on paper, we bill on paper, and the form to bill it on paper with the NPI numbers, according  
27 to your thing just released on March 1, our vendor said is not yet available. Can I buy it from my vendor  
28 now? To bill it to you on paper?

## PPAC Meeting Transcription – March 2007

1 Ms. Carter: My understanding is the form actually is available, although what I heard just last  
2 week, and I don't have any further information from Friday is that there appears to be some problems with  
3 the actual scanned form. So it is out there, although subject to some concerns I heard the other day, there  
4 may be concerns about implementing it right at this very moment, but it is available.

5 Dr. Senagore: Well, with that, we'll thank folks for the presentation. We'll take a ten-minute  
6 break, and then return.

### Break

8 Dr. Senagore: Thank you. We're going to continue on along a similar line of discussion and that's  
9 the Transparency Initiative. Our next presenter comes to us from the Department of HHS. Andrew Croshaw  
10 is a senior executive advisor to HHS Secretary Michael O. Leavitt and is the project leader for the Value  
11 Driven Healthcare Initiative. In his role as project leader, Mr. Croshaw manages the overall implementation  
12 of the initiative, which aims to improve the connectivity of America's Health Information Systems and  
13 encourage the measurement availability of quality and price information and enhance incentives for all  
14 healthcare stakeholders to seek high quality competitively priced health care. Working closely with the  
15 Operating Division leadership within the Department at External Business Partners, including medical  
16 health plan and consumer communities, he is responsible for coordinating the advancement of HHS toward  
17 this goal. Mr. Croshaw comes to HHS most recently from the pharmaceutical industry, where he worked  
18 with Novartis Pharmaceuticals. Mr. Andrew Croshaw, you can describe your small task to us this morning.  
19 Welcome.

### Transparency Initiative

21 Mr. Croshaw: Thank you. I'm very pleased to be here with you. I don't know where one who  
22 receives healthcare and one who is a consumer of our health care sector in this country, expresses gratitude  
23 to the health care providers, but I suppose this is as good a forum as a person ever gets and as a father of  
24 young children who need the care of practitioners, I am deeply grateful for the services that you provide  
25 and having just taken our 3-year-old in for some analysis of some sleeping behaviors that he was  
26 exhibiting, I am deeply grateful for the work that you do. And every time we use our health care system, I  
27 think we're reminded of how important it is to us. So I just say that because I don't know where else to say  
28 it and that's what I have been feeling the last couple of days.



**PPAC Meeting Transcription – March 2007**

1 Dr. Senagore: Thank you.

2 Mr. Croshaw: Let me just invite you as we spend the next few minutes together to comment and  
3 engage in discussion while we move through as opposed to waiting to the end. I think that makes for a  
4 better discussion and so I'd be happy to be interrupted as we go through this. So my goal as I understand it  
5 is to walk through the Secretary's initiative, transparency as it's sometimes called, in health care certainly  
6 wasn't invented by the Secretary. But we believe and are starting to see I think some influence that he is  
7 making in this movement in health care to begin to try and understand quality and price information in a  
8 way that we haven't before systemically and to be able to use that information for the benefit of quality  
9 care delivery and also consumer awareness and participation. So to begin, I think it's clear to everyone that  
10 we recognize there's a growing anxiety in our health care system today. And it's felt by many of the  
11 stakeholders as kind of articulated on the slide here. One thing that we often here from large purchasers of  
12 health care, both from the federal government perspective, but also in the private business is that their  
13 health care costs far out pace inflation, far out pace wage increases for their employees, and therefore puts a  
14 pressure on them. This is increasingly the case in a global economy where the employers in this country are  
15 competing with employers in developing countries, but also in industrialized countries and where health  
16 care costs are being a significant factor in investment decisions. From the consumer perspective of course,  
17 we hear a lot about this, especially from those consumers who have a co-pay of 100% because they don't  
18 have any kind of health care coverage. But even those who have health care coverage increasingly feel the  
19 stress of paying for their costs and the threat of losing it as their employers opt out of offering that. Insurers  
20 are often caught in the middle between their employer customers and the providers that they contract  
21 directly with, attempt things to placate their employer customers and to work with their provider customers,  
22 but they are definitely affected by this anxiety and then of course with the reimbursement challenges that  
23 exist in the provider community and the administrative challenges that are often thrown upon the providers  
24 to begin to try and collect quality information or to make that available, the anxiety certainly reaches out  
25 and touches that community. So this really in the Secretary's perspective, provides an opportunity because  
26 change in health care does not come easy and he believes that the convergence of this anxiety is a necessary  
27 component of making meaningful change. And one of the fundamental areas of change that he envisions is  
28 to begin to build a system out of what we today have, which is a health care sector, a large rapidly growing,

1 robust health care sector and we're surrounded by systems in many aspects of our lives. We probably all  
2 carry a cell phone in our pocket or purse, probably comes from a different manufacturer, likely have many  
3 different service providers represented in this room that work with those manufacturers, and yet there is a  
4 common set of communication standards and systems that are in place so that using my Sprint phone, it's  
5 actually an LG phone, but it's a Sprint service provider, I can call my mom who uses a different provider  
6 and uses a different manufacturer for her cell phone. And that's a seamless communication platform based  
7 on a common set of standards. The banking system is another example of a system that has migrated over  
8 time towards a common set of standards that allow for secure, private information to be transmitted quickly  
9 and at a very low cost, not only in the United States, but all around the world. We know that we can take  
10 our bank card with us, no matter what color it is and put it in any ATM around the world, not any ATM,  
11 most ATMs, and be able to get currency in the denomination that we choose. The picture of the ATM that I  
12 selected for this slide actually comes from the Philippines. But it looks just like an ATM that you'd find on  
13 the corner, here in the District.

14 We know that we don't enjoy that kind of system in health care today. The best picture I could  
15 find for a system is represented by the nurse here who's in on a Saturday morning and is going through  
16 charts to determine if the diabetic population got their HBA1C check or what time an antibiotic was  
17 administered. And that is largely across our sector of health care, because it's paper based, the way that we  
18 try to begin to collect information to do some of the mission of the Secretary, and there are a lot of reasons  
19 for that, that I think need to be overcome before we can see the widespread adoption that we need to. May I  
20 move along.

21 So I alluded to costs a little ago and many of you probably saw, or may have seen the CMS  
22 Actuary Report that came out a couple of weeks ago but we as a percentage of our gross domestic product  
23 today, spend about 16 cents of every dollar on all goods and services that we buy in this country, 16 cents  
24 of it goes toward the purchase of health care, and that is something that has consistently doubled over the  
25 last 2 generations. About the time that my dad was born, it was 4%, and about the time I was born, it was  
26 8%. And now, as my children are being born, we're at 16%. That's not growth in dollars, that's growth in  
27 percentage of GDP, meaning it is beginning to crowd out investments in our education, in our safety, in our  
28 transportation infrastructure, and the other things that we as an economy, as a society choose are important

1 for us. And it is headed in a way that is likely going to threaten our economic sustainability as a country,  
2 because we compete in a global market place, and because we compete against other industrialized nations,  
3 that don't seem to spend what we spend on healthcare.

4 Dr. Przyblski: Sorry to interrupt. Your OECD medium that you used as a comparison a tap, what's  
5 that stand for?

6 Mr. Croshaw: It is the Organization of Economic

7 Dr. Gustafson: Cooperation and Development.

8 Mr. Croshaw: Thank you. And there are—

9 Dr. Gustafson: It's basically the European, Western European countries, plus Japan. If I recall  
10 correctly.

11 Dr. Przyblski: OK, so socio-economically equivalent.

12 Dr. Gustafson: Yes, exactly. Sort of our peer group, if you will.

13 Mr. Croshaw: And according to that peer group, we seem to spend about double what they do on  
14 health care. You can argue for a lot longer than we have today about why that's the case. And I don't think  
15 that we want to model our system after the system of health care that they have. But when companies, and  
16 I've spoken to several that are international companies, make investment decisions about where to build a  
17 factor or a retail outlet, these are costs that they take into account. And so it's an issue. Moving along, the  
18 information that we have today on our system of care is relative to some of the other systems where quality  
19 and price information is more available is relatively scant. Without much trouble, I can go to the health  
20 plan website that serves my family and I can get a list of providers and hospitals that are in their network,  
21 and I can easily find out how far away those providers are from home. I can often find out when somebody  
22 graduated from medical school, what specialties they have, in some cases, I'm beginning to be able to see  
23 customer survey information on what their perception of that care episode, how that went. But even that is  
24 quite scant and so the opportunity for consumers to have meaningful information on a specific service or a  
25 specific episode of care, is largely unavailable. It's the same for inpatient or outpatient. I show here on the  
26 slide just a representative sample of some cost information that may be available. Sometimes you can get  
27 average costs in an area if you're considering a hip replacement or something and some type of elective  
28 procedure. But that may not be very useful to you if you don't know what your co-pay is going to be when

1 you go, or how that cost may differ from institution to institution. I wouldn't share this publicly if the  
2 Secretary hadn't shared it publicly, but he recently was investigating colonoscopies, because he's reached  
3 that age where it's part of the normal course, and in calling around and trying to understand how much that  
4 would cost, he learned that there was a thousand dollar difference between 2 of his choices, both  
5 performing the procedure at the same location and it's just demonstrative of the fact that our system today  
6 really isn't set up to deliver an answer on how much things cost, and there isn't an awareness of that along  
7 the chain.

8         So when we talk about incentives, our system today doesn't align incentives as well as they could  
9 be. You have consumers that have health coverage and largely are shielded from the actual cost of their  
10 health care. They know how much their co-pay is when they go to the doctor, they just pay what they're  
11 asked to pay at the pharmacy counter without a lot of understanding of what's going behind that and  
12 providers themselves are reimbursed today based on the quantity of care that's delivered. CMS will pay the  
13 same for a procedure of a surgeon of a high infection rate as they do for a surgeon with a low infection rate.  
14 It is not a system of reimbursement that really emphasizes for consumers to seek value. Or for providers to  
15 seek value. That's not the system that has evolved in this country. Political interests are listed there as well  
16 under misaligned incentives. Every time it seems we try to make substantive change to health care through  
17 our legislative means, we have 16% of the economy that's interested in that decision and as a result, you  
18 have a lot of political will that gets unholstered and aimed at each other and as a result of that, legislative  
19 solutions to enhancing the effectiveness and the value of our health care system often fail. Either die a quiet  
20 death in committee or get essentially watered down to something that's more palatable to this and closer to  
21 the status quo. So the Secretary, I think is taking as I said, not a philosophy that he invented necessarily, but  
22 I think he's begun to put this together in a way and begun to put the efforts of the federal government  
23 behind this in a way that really has a good chance of taking us towards what most agree is a health care  
24 system, a health care market place that really delivers value for our citizens. This is just essentially a  
25 summary of what we've talked about.

26         So the essentially the foundation that underlies the Secretary's efforts are what he calls 4 corner  
27 stones of a system, a system that's based on value. The first one is health information technology. The  
28 second is the availability of information on quality that's used for improving care and for consumer

1 awareness, the availability of the same information on cost, and then lastly, aligning incentives, incentives  
2 for providers, payers, and consumers that drive us more toward seeking value. So to begin with, HIT as you  
3 know, has been a priority for a couple of years. The Office of the National Coordinator was created back in  
4 2004 by Executive Order of the President, and since that time, that office has been working with a lot of  
5 stakeholders and players in the community that builds and buys HIT systems to begin to come up with a set  
6 of standards. One of the problems that we faced with adoption on HIT standards in the medical community  
7 is that there are just so many standards to choose from, and as a result of that, it's a strong disincentive  
8 when an ambulatory practice wants to purchase and HIT system, they don't want to buy the wrong one.  
9 They want to buy one that as it is upgraded and updated, will be consistent with their ability to  
10 communicate with hospitals, but with other care settings. And that hasn't really existed very much in the  
11 past, but the American Health Information Community or AHIC, as it's called, is now making quite steady  
12 and impressive progress toward a common set of standards of interoperability that will be available for  
13 manufacturers of software, on the network level, on the software level and even on the data level that can  
14 be built into products so that as organizations go out to purchases these systems, they can look for that  
15 Goodhousekeeping Seal of Approval if you will, that it'll be a CHIT certification, a certification  
16 commissioned for HIT will be able to stamp these products, and so the next step is really, well, does that  
17 stamp mean anything? Well if purchasers of health care and the buyers of those products begin to look for  
18 that seal when they buy, it will begin to mean a whole lot. And that is really part of what the Secretary is  
19 doing, is going out there and creating awareness among the payers of health care, that when they set up  
20 their contracts with health plans, and by corollary with providers, that that is something that they emphasize  
21 in the RFP. Something that they begin to look for. So that the market can begin to align to delivery on that  
22 corner stone.

23 Understanding quality. Not too dissimilar from the type of collaborative work that's going on with  
24 AHIC, with HIT, there are efforts underway I'm sure that you're aware of, that are really feeding our  
25 understanding of how we go about measuring quality. It's something that I think we can admit is very hard  
26 to do, and especially when we begin to use that information for decision-making. And use it broadly. The  
27 ambulatory quality alliance and the hospital quality alliance have been leading out in this regard and really  
28 using a lot of the great work of the AMA convened consortium or a lot of specialty organizations are

**PPAC Meeting Transcription – March 2007**

1 coming together to develop and test measures. The National Quality Forum is working together. They're  
2 both members of the AQA and HQA, but they're also involved in endorsing measures that are coming  
3 forward. What the Secretary really believes the role of government is in value driven health care is to  
4 encourage and convene efforts to create quality measures by the medical family. And then to try and align  
5 payers to use those measures as opposed to going out and working with their employee consulting firms or  
6 their health plans to come up with measures that they think are useful and helpful to them and if all  
7 employers go out and do that, then you have this trickle down effect, where providers are being asked to try  
8 and collect and provide quality information that only affects a small percentage of the patients they serve,  
9 have difficulty getting the numbers of procedures to actually come up with credible data analysis and you  
10 have a whole bunch of different definitions of what quality actually means. And so the effort underway on  
11 quality measurement is not for the government to create measures, but to really draw attention and try and  
12 bring widespread use of what would be adopted consensus based measures in merging from the AQA and  
13 the HQA and the many provider organizations that are working together with them. Again, good progress  
14 being made there. This is a kind of a long and a difficult road, but there are already measure sets emerging  
15 out of these groups, which are going to be, which will continue over time, to be available. Now when we  
16 get to price, price is very sensitive and very easily misunderstood. When we talk about price, I think we can  
17 narrow it down in terms of the Secretary's vision on what kind of price information is useful to the market.  
18 And it would be a few simple things; it would be first of all pricing that takes an episode of care and  
19 bundles it together. If you are going for a colonoscopy or something like a hip replacement, there are  
20 several different providers involved, and charges that in aggregate would represent the cost of that  
21 procedure, but it's not an easy task to pull that together and it's frankly an impossible task to do for a  
22 consumer, and so being able to begin to bundle costs of care together into some kind of system that could  
23 be compared is a key element of price transparency. Another key element is really focusing on what the  
24 consumer pays. It's not our intent to try to promote the disclosure of proprietary negotiated contracts that  
25 health plans have with hospitals, and in fact, in some cases, there are legal requirements of those contracts  
26 that prevent that disclosure. But focusing on what the consumer pays becomes very useful information, not  
27 only for the consumer, but the employer who has an interest in what health care is being consumed so that  
28 they can create benefit designs that support the pursuit of value. So that's really what we focus on when we

**PPAC Meeting Transcription – March 2007**

1 talk about information on price. I know you'd be raising your hand if you had comments or questions, but  
2 keep moving.

3 Back in August of last year, the President really began putting the market muscle of the federal  
4 government, not as a regulator but as a purchaser of health care behind these reforms, and in August, he put  
5 out an Executive Order that affected many federal agencies that either subsidized health care or provide it  
6 directly, the VA, the DOD, Indian Health Services, OPM, which basically is federal employees, and CMS,  
7 of course, which are all affected by this then. And in that Executive Order, he challenged these agencies to  
8 begin to align themselves behind the same 4 cornerstones that we've talked about over the last few minutes.  
9 So that if you want to do business with the federal government going forward, then you'll be to need to  
10 align your use of interoperable HIT systems, not requirements to go purchase systems, but as you upgrade  
11 your systems, or as you buy new systems, that you do it in accordance with this developing set of measures,  
12 that you begin to look in your quality measurement efforts toward the work of the AQA and AQA, and you  
13 use that information in your local community or with your employees to help them understand measures of  
14 quality, and the same with price information. And that you look to structure incentives for your employees  
15 to really use that information. There are many studies out there that suggest that even if you provide a  
16 consumer with information on price and quality, but you give them no incentive to use that, it will largely  
17 sit there unvisited on a website somewhere in cyber space, so the incentives piece is critical, though the  
18 manner of incentives is not something that HHS or the Secretary is really trying to be prescriptive on. It has  
19 a tendency to take this effort, which has so much promise and drag it into a little bit of the partisan world,  
20 when you begin to become too prescriptive on the nature of incentives. So we recognize the principle needs  
21 to be present, but we leave it up to the purchases and payers who are signing on to these principles to really  
22 decide how they would like to structure that for their populations that they serve.

23 Dr. Przyblski: When seeking price information, what specifically are you looking for? Is it the  
24 price being charged? Is it the cost combination?

25 Mr. Croshaw: It's a couple of things. It's the cost to the consumer; what they pay. We think that's  
26 the information that will be relevant for consumers to be able to act rationally, and then the total cost of the  
27 episode is helpful as well, not the charge, not the hospital's cost in that example, but the cost that the health  
28 plan would pay and that can actually be derived anyway if you tell a consumer that they're paying 15% and

1 their cost is X, well, they can figure out what the total cost anyway is in that regard. So to emphasize, it's  
2 not the intent to try and expose the proprietary negotiation that goes on provider by provider, or internally in  
3 terms of the actual cost of providing the care, but it's what is ultimately charged to the consumer that we  
4 want to be available, and we want it to be available for buckets of care. So to take an episode of care and be  
5 able to price that out, that becomes helpful if you're considering an elective procedure that involves just  
6 more than one provider, if, in the case of a hip replacement, it's helpful if you were to make a decision as to  
7 where to go for you to understand, well, what will the surgeon's costs be, and what will the therapy, the  
8 anesthesiologist cost, and when I go to the physical therapist—to begin to have that information bundled  
9 allows people to choose. And frankly it helps providers of health care to be able to be price competitive.  
10 That's not easy to do because that's really not the way our system is designed today. I mean there are some  
11 integrated systems that could maybe start delivering that kind of information, but those buckets of care are  
12 the type of thing that...

13 Dr. Senagore: To follow up on that question, I mean there already is potential to look at that,  
14 because there's a number of DRGs that are matched with and without complications. So an incremental  
15 cost could be whoever was admitted at the lower DRG, and became the more complicated DRG, because  
16 the one that comes in, whatever the diagnoses are, if they're already in with complication DRG, there's no  
17 difference in cost to Medicare under the current program. But there is a big cost for the folks that migrate  
18 from one to the other, that should have come in without and left without complications. So is that the cost  
19 structure you envision reporting, or is that the number of with complications that we have no control over  
20 because they came in that way.

21 Mr. Croshaw: Well you almost have to segregate what Medicare's going to put out there on price  
22 information. And what may be available otherwise. You may be aware that Medicare's already putting  
23 pricing information out there about what they pay for certain elective procedures and I don't know with  
24 detail—I'm assuming those are non complication DRG postings that they're putting out there.

25 Dr. Senagore: I honestly haven't seen the data reported in that fashion, because that's the only  
26 measurable difference that could be altered by a system, by making all the system investments, the only  
27 thing you could do is say I can keep as many folks in the without complication DRG as possible. From  
28 making that transition. I can't do anything about this group. I'm stuck treating those folks. All I have is



1 added costs to manage those complications. But the group that goes in between in the group I could  
2 perform better and so if Greg beats me on the migration number, then he's economically more efficient  
3 than I am.

4 Mr. Croshaw: And I think our vision is that this is not just a government kind of program, but that  
5 this is adopted by the majority of the market, which is not Medicare beneficiaries, but would still be able to  
6 aggregate cost information in a way that it is useful to consumers—

7 Dr. Senagore: Well, to put in economic terms, if Greg was 20% better than me in that system, he  
8 could charge 10% more and still be a bargain. And so his price would look higher than mine, but the net  
9 expenditure for that episode of care, would be far less doing business with him than doing business with  
10 me. And so I think as we look at this, the only way that it will make an inappropriate system to invest in the  
11 technologies to get to the things that you're articulating, there has to be enough in play to invest to become  
12 better. To be able to do the systems that make a difference. If all you're going to do is get the same dollars  
13 anyway, it's very hard to make those business decisions to invest in those technologies, and I think that's  
14 the challenge you're seeing in the current system.

15 Mr. Croshaw: Agreed. It is a little bit of a chicken and egg. But we're doing some things I think  
16 that will help stimulate or provide incentives through demonstration projects that will emerge I think over  
17 the coming, in the remaining administration, that really will provide opportunities for those hospitals or  
18 providers that can demonstrate that they can bundle care together and price it competitively that they can be  
19 rewarded with volume, just to demonstrate that these principles will work in the health care marketplace.

20 Dr. Sprang: When you're talking about cost and price to consumer, I think that is my major  
21 concern in kind of looking at it. The reality is the cost and price varies so much already and you're saying  
22 you don't want to give the actual information that insurance companies have, but the reality is each contract  
23 that they have with the hospital, the hospital charges \$10,000 to do this cardiac cath and put in 2 stints, but  
24 for the blues they pay \$5,000 and United may pay \$6,000 but if you as an individual consumer didn't have  
25 insurance, you pay the \$10,000. So I mean there's so many different prices, even just to the consumer, I'm  
26 not sure how you take all that into account. And is that type of information supposed to be available, so if a  
27 person knows if they're paying cash, it costs them this much, but if you have insurance it costs them half of  
28 that?

1 Mr. Croshaw: I agree, it's incredibly complex. It's one of the reasons that I think we'll need to  
2 make it relevant for the customer, so the customer can say if I have a choice to make about where to get  
3 care, and I know that I'm a Blues plan member and I would like to be able to see how that price might vary,  
4 because that Blues plan might have a different negotiated rate with many different providers and as a result,  
5 I would have a different co-pay to make.

6 Dr. Sprang: Yes, but I guess my point is just that for each individual person, their cost is actually  
7 going to be different, depending on their circumstances. That's so very complex amount of information.

8 Mr. Croshaw: It is and we don't think the government ought to provide that information, but we  
9 think the payer, the employer, working through their health plan is interested in people making value based  
10 decisions and could make that information available through their health plan. There are other websites or  
11 other companies that are emerging today who want to be in this space. Web MD has products emerging  
12 now that they sell to health plans and directly to consumers, and Revolution Health and companies like that  
13 that into this space, and it will probably become available in many different forms. It's not our desire to try  
14 and capture that complexity in a master, kind of government one source, but we think there's enough  
15 motivation and value in making it available through employers and their health plans that that'll probably  
16 be the primary source for it.

17 Dr. Sprang: I just want to commend you for it, because I agree 100% if that kind of information  
18 was out there, it would decrease cost, and it would even make the hospitals, the physicians even more  
19 competitive. If somebody's charging twice as much but nobody knows it, they feel quite comfortable in  
20 charging twice as much. If that information was much more widely available you may actually get  
21 competition.

22 Mr. Croshaw: And I'll just mention, since you brought that up, that price transparency by itself, in  
23 the absence of information on quality, can actually increase prices because people find out that hey, I could  
24 be charging heck of a lot more and what we I think often do, I'm guilty of it myself, that in the absence of  
25 quality information, price becomes a surrogate of quality. So if it costs more, it must be better right? No, I  
26 don't want to go get that \$3,000 colonoscopy because there must be something wrong with that when  
27 everyone else is charging \$5,000. We make those kinds of mistakes in our minds in the absence of quality  
28 information and that has been communicated to us by a lot of stakeholders that have done experiments with

1 this in the marketplace, that just putting out price information can actually make things worse. So we want  
2 to pair that with some quality indicator that can be useful.

3 Dr. Senagore: I think doing it in isolation without looking at the episode of care could be very  
4 misleading, I mean, just to take, in my specialty, if my superficial wound infection rate is twice as high,  
5 which costs about \$300 additional to treat, but my tumor failure rate is 50% less that costs about \$650,000  
6 to treat, what's my value proposition, you know? I should be able to command a much better space in the  
7 marketplace, regardless of what my wound infection rate is. And so that's why I think to take things in  
8 isolation, not understand the total expenditure related to a treatment episode can really get some unusual  
9 behaviors to propagate.

10 Mr. Croshaw: And our price, there's a committee of the, let me just mention. Many of you  
11 probably know this, but the leadership of the AQA and the HQA are working together in what's called the  
12 Quality Alliance Steering Committee and there is a subgroup working on that committee that is really  
13 tackling this price issue. They're, as far as basically laying out principles of what price transparency should  
14 address and have the difficult job still ahead of them of beginning to use some of the quality measures  
15 emerging and begin to match those up with buckets of care. We have to have the help of the provider  
16 community in doing this because there's too much complexity and we want it to be right, so there's a really  
17 good merger right now going on. There's also a tension though with the pace at which this is all happening.  
18 The payers out there really want this done now and largely are less concerned if it's done right. The  
19 provider community feels the pressure of getting this right because of the direct impact that it can have on  
20 them, and so that tension, the Secretary recognizes, can be constructive. It can help us move at an  
21 appropriate pace to get this done.

22 Dr. Ross: Mr. Croshaw, you mentioned a couple things in the beginning and one of the areas we  
23 talked about was bundling costs to increase volume. Those were the terms that you used, and I expect that  
24 you're looking at the questioning of incentivizing. When I look at, or as Dr. Senagore mentioned, because  
25 I've talked to him about this as well, and many of the specialists who perform procedures, when you look at  
26 the per hour cost of performing those procedures, and the out of cost expenses that are involved by not  
27 being in the office, the question is is it more profitable for the specialist to be performing procedures or to  
28 be in the office? So the question is, if you're looking at decreased reimbursement by providers, the question

1 is, will that specialist be incentivized to perform those procedures or will they be better off being in the  
2 office and doing primary care? So they may be a little more conservative in not performing those  
3 procedures, because as you heard a moment ago, if there's an increased risk of complications, now that  
4 specialist is going to be seeing really cases that are much more complicated, and now involving much more  
5 time, maybe more hospital time, less office time, the question is "how profitable or how decreased  
6 profitability" will occur? That was one area that I wanted to talk about. But basically I'm looking at how  
7 much does it cost the practitioner to perform those procedures, particularly complicated procedures, versus  
8 being in the office? And when you're talking about bundling costs, versus volume, that volume may not  
9 actually be that much of an incentive, if it's a decreased reimbursement, performing more procedures may  
10 not be that helpful.

11 Mr. Croshaw: I think the demonstrations on this will be highly enlightening in that regard, and we  
12 may find that there isn't a way to do this, but we're very optimistic that it can be done, because there's a lot  
13 of coordination that can yet happen in terms of bundling the costs and putting together relationships that  
14 could delivery a higher quality lower cost system than what we have today. Your first question I'm not sure  
15 I can address. I'm not sure I understood it. I would imagine that today when a provider performs a  
16 procedure, the time involved in doing that procedure is probably related to the complexity of the case today  
17 and that's probably you know if you can only use your equipment or your time in the operating room or  
18 whatever, you probably want that to be as efficient as you can today as well, right?

19 Dr. Ross: Correct, but you also have to look at what the reinforcement figures will be for that  
20 procedure, versus if you saw X number of patients in the office, would it cost you less to be in the office,  
21 and be able to carry your overhead a lot better?

22 Mr. Croshaw: In an economically efficient market, the market would begin to set those prices,  
23 because if more providers migrated to the office, then the number available to do the procedure in the  
24 surgery would go down and the price would go up and it would regulate itself. We're far from that today  
25 and I don't sit here to say that I think we can achieve that level of efficiency any time soon, especially in  
26 the absence of electronic medical records. But we can certainly begin moving that direction in terms of  
27 having bonuses and rewards for those physicians that can offer higher quality measures at a competitive or  
28 a lower cost.

**PPAC Meeting Transcription – March 2007**

1 Dr. Senagore: But your last comment was exactly crystallizes the problem. What we have is a fee  
2 schedule that rewards us for time, irrespective of quality, one in actually and shh anybody that's on the  
3 RCU, time by itself may actually be a negative, that more time to perform a certain task, is actually a  
4 marker for a poor performer, so what we've done is we've created this very obtuse system that has really  
5 taken away the value proposition that any of us brings from our specialty to the table, and so we have a  
6 very economically inefficient system, because you're not rewarded for what you really want, which is  
7 better performance. You're rewarded in cap 5 minutes.

8 Dr. Grimm: One question I have, and seems to be rather critical is who is your consumer? The  
9 consumer that we're talking about here is not the patient. The consumer that we're talking about here is  
10 Medicare, the consumer we're talking about is Blue Cross Blue Shield, the other payers here, that's our real  
11 consumer. Who may dictate all of this, and that's exactly your point, was that that's where the pressure's  
12 coming from. It's really not coming from the patients. And so it really changes the nature of how you  
13 approach all of this if you're approaching your consumer from that point, and whether you're approaching  
14 from the patient perspective. And I'd like to get the Secretary's and your ideas in terms of who you  
15 perceive your consumer to be. Is it Medicare and the carriers? Or is it the patients? It's a whole different  
16 approach in how you approach it.

17 Mr. Croshaw: We actually believe that there's a strong role for the patient, the individual  
18 consumer in all of this. We believe that if a consumer has a benefit design, that causes them to have an  
19 interest in the cost of care, there's an inherent interest that people have in the quality of care anyway. We  
20 want to get the best quality care. If we are motivated to make those decisions as consumers, then quality  
21 information and price information is very meaningful to us. And I think the Secretary believes that we  
22 don't achieve this vision if we don't get that far with this. If this is only about using these measures for  
23 health plans and employers to structure their benefit design, we don't think we get ultimately the quality.

24 Dr. Grimm: You understand that the point that several people have made here is that the  
25 perception of quality demands a very, very well informed person to be able to really understand what that  
26 means and actually, there's only those that are really going to analyze this very carefully, are really going  
27 to understand what quality means, and it's rarely going to be the consumer who understands it. They're  
28 going to know it what quality is in a much different way and as you said, price can be one of those

1 determinants, which, so it's an enormous task what you're talking about in terms of getting it down to the  
2 consumer level.

3 Mr. Croshaw: Yes, and I think I understand the point you're making and I whole-heartedly agree  
4 with you. It's a very complex measurement process that we can not expect end consumers to engage in. We  
5 have to find a way to use not an enormous body of measures to measure the quality, but to begin to use  
6 surrogate measures and take that complex information and boil it down for consumers in a way that they  
7 can begin to respond to it. And it's something that's got to resemble more of a Travelocity or a Zagget  
8 survey that helps them to understand basically, OK, I can understand 4 stars and 2 stars, and when I click  
9 on that, I can see some basic information about that may mean infection rates, or readmission, or there's  
10 some basic information behind that perhaps with the consumer, but the bottom line is it's got to be  
11 translated for them simply. I think consumers will always have a big stake in wanting to be or increasingly  
12 being involved in the health care decisions. You know, what medicine is being prescribed for them, or their  
13 access to a certain hospital and so we don't propose to allow that to be denied the consumer by having this  
14 information only available to the health plans and employers. But we want to have the consumer be a part  
15 of this and so that they say I can have any drug that I want, and frankly I can go to any hospital I want, or  
16 any provider. But the amount I pay is going to vary based on the information that we have on quality, and  
17 so I can still go to my brother-in-law and have him provide the procedure, but it may cost me more out of  
18 pocket than it would if I went to the institution that had ranked more highly. So that's—

19 Dr. Grimm: That takes you back to these bodies that are going to make those decisions, and again,  
20 your consumer now is your, you know these large bodies making these decisions are, what is the Zagget  
21 rating? And who gives the Zagget rating on this? So that is really what your consumer's going to be for all  
22 of us who focus on this issue. It's going to have to Blue Cross and how are they going to measure us? And  
23 to get to Tony's point, are these things actually meaningful? That's the key issue to me.

24 Dr. Senagore: It's intriguing to say that payers have no data, because I sit here and say how could I  
25 not know in Chicago of all of the gazillion stints that are placed what percentage of patients from which  
26 practices ended up going to cardiac surgery for dissection? Those have 3 distinct CPT-Codes, they have  
27 two different DRGs. I could easily should be able to from my system, be able to say if they go to hospital  
28 X, it's this, if they go to hospital Y it's this, and that gives me a value proposition right off the top, so I

1 wonder again, and it was in earlier discussion from this morning, the onus is on us to report more and more  
2 stuff. We already have stuff out there that should be able to be analyzed in some fashion, at least give us a  
3 benchmark to say, where are we starting from? Because if we do these things, how do we know we didn't  
4 make it worse? We won't really know that unless we know where we are right now. And that's a concern  
5 for me just as an individual and how I have to transfer those to small group practices, to say what is the  
6 benefit of reporting these things? We don't really know what it is, and we don't know if we're making it  
7 better.

8 Mr. Croshaw: This brings me to I think an important part of the discussion that we have not yet  
9 arrived to, that I know we're getting to the end of our time here, but I really like to—

10 Dr. Senagore: We have more minutes, Dr. Simon gave me license.

11 Mr. Croshaw: If I may, let me head that direction, and it cause us to kind of move through a  
12 couple of slides here, quickly. There are a few slides here on what we call the Statement of Support. And I  
13 will only say that although the federal government is the largest purchaser of health care, we don't believe  
14 that a government initiative by itself ever changes the market, but if you can get enough of the marketplace  
15 to buy in to participate and support these changes, then at some point, you hit a tipping point, and you begin  
16 to have the business operations and the products that are offered, begin to cater towards these principles.  
17 And that is what we are trying to do. We are going out to the health plan community, to the provider  
18 community, to invite them to participate in local collaborations that I'm going to talk about in a minute and  
19 to the payer community in inviting them to use in their purchase decisions of health care, these 4 corner  
20 stones and we're making progress in that regard. We have gained the commitment from a large number of  
21 the largest companies in this country to begin to buy their healthcare according to these principles. And  
22 states of course are very large purchasers as well, so we're up to about 70 now of the largest corporations  
23 making this commitment. We have several hundred medium and smaller corporations that are doing this.  
24 The health plans are signing up to participate through the AQA and the HQA. We need this to be a  
25 collaborative effort nationally to set the measures and standards, but we also need it to be collaborative  
26 locally and that's what I kind of wanted to talk about briefly.

27 Here we go. We, right now, CMS is funding 6 pilot communities that are doing the difficult work  
28 of trying to take local data from health plans and employers there, and to be able to merge that with

1 Medicare claims data. It's a combination of claims and some clinical data to begin to look at what the  
2 measures look like in their community. And those pilot sites have the participation of all the stakeholders at  
3 the table; the providers, the health plans, the employers and in some cases, the patients themselves  
4 participating. We think that's critical for 2 reasons; number one, data collection in the next couple of years  
5 will remain to some degree a manual process. We can use claims data to measure adherence to procedures  
6 and protocols, but a lot of information will still need to be collected on a local level where the care is  
7 delivered. That is one reason that it's important to have providers involved locally. The second reason is  
8 really trust. We believe that unless providers are involved in a locality to understand what information's  
9 being collected, and helping to interpret that information, then you really can't ever improve quality  
10 without the participation of the providers locally. And so we are promoting the development of local  
11 collaborations around the country.

12 I mentioned the 6 pilot sites that we have. They're doing the heavy lifting of learning how to  
13 aggregate this data in a meaningful way using the national measures. But we are promoting what we call  
14 value exchanges, which are implementation sites, that can use the learning of these pilots and begin to run  
15 data reports, have the right stakeholders at the table, begin measuring quality in their neighborhood, I say  
16 neighborhood, but in their region and make that information available for quality improvement and for  
17 consumer reporting. And that's a critical piece of this movement of value driven health care is the  
18 emergence of these communities.

19 Dr. Senagore: If I can go to the last slide, or if you want to go through—

20 Mr. Croshaw: The last slight is just a depiction of what the future could look like for a consumer.

21 Dr. Senagore: I have questions from it, that's why. And so I'm a reasonably educated consumer. If  
22 I look at the chart, I say well the highest volume provider is the lowest cost provider and so when I see  
23 quality in there for the lowest volume producer, are they just cherry picking the healthy folks? That don't  
24 have any risk of complications? And more importantly, what is quality? I want to know what my rate of  
25 DVT is, my operative mortality rate, my risk of blood transfusion, my risk of hip dislocation downstream,  
26 because of poor fitting of the prosthesis. And what's my return of range of motion? That's how I would  
27 ask, if I'm in the office, that's what I would want to know from my orthopedic surgeon.

28 Mr. Croshaw: You would be a very unusual patient. [laughter]



**PPAC Meeting Transcription – March 2007**

1 Dr. Senagore: But this is my problem. See this is out there now and those things that I know really  
2 do matter, I'm sure are part of none of this evaluation and I would tell you at first blush, I'd go to the  
3 highest volume place because if they're not touchy feely, that isn't really my major concern. I can buy a  
4 dog, I'll have a friend. [laughter] But I want to know that they are going to do high volume, high outcome  
5 surgery, and all things being equal, they're probably pretty good at what they do. They probably done any  
6 of these folks, they're probably a machine. You come in, you get done, you get operated, and you're out the  
7 door. And so I really wonder, the devil's always in the details here and when I see stars applied, I need to  
8 know what those stars are, because I could just say I'm only operating on healthy, skinny people with stage  
9 one colon cancer, no other diseases. I wouldn't be very busy, but I would have very good outcomes in that  
10 scenario.

11 Dr. Grimm: The other factor is timing. If you do things and everybody gives you a nice latte as  
12 you come to the door, and somebody shakes your hand and everybody's really nice, as you walk out the  
13 door, you feel real warm and fuzzy going out and you give them a high star. But 2 months later, they all  
14 might merge and have the same result. So patient assessment of care and professional assessment of care,  
15 just to as your point. There are several levels of the—

16 Mr. Croshaw: Absolutely. And what I hear you saying is some of this information is more useful  
17 to you than others. You've got people who really say, hey, the number of patients per year, I'm going to  
18 really anchor on that. And you've got other people who say touchy feely really matters to me, bedside  
19 manner's important to me, so this is why we need your help in measuring quality. And in understanding  
20 what the complications are and how to do that. In the beginning, this has really got to be simple. We've got  
21 to demonstrate that this can work elementary. And then as we get more sophistication and more capability  
22 with HIT, we can begin to measure with more sophistication.

23 Dr. Senagore: You're off the hook. I've been warned by Dr. Simon, we have to move on to the  
24 next presentation. So hopefully we can get you back at some point for another discussion on this very  
25 interesting topic. I appreciate your time. Thank you.

26 Mr. Croshaw: I appreciate your time. Thank you.

27 Dr. Senagore: I think we ought to move on to the RAC Update. Melanie Combs is here today and  
28 Ms. Connie Leonard returns. Which is amazing, you came back. The December 4<sup>th</sup> meeting, you recall,

## PPAC Meeting Transcription – March 2007

1 they presented some RAC pilot data for us, they announced the expansion of the project and will give us a  
2 further update at this time. Welcome.

### RAC Update

3  
4 Ms. Combs: Thank you.

5 Ms. Leonard: Yes, thank you for having us back. We were just here last quarter. But things have  
6 changed, so we always appreciate your feedback. Today we—

7 Dr. Senagore: I'm sorry, Ms. Leonard if we moved a microphone between you folks, it'll work  
8 better.

9 Ms. Leonard: I do have a tendency to talk softly. I'll try to increase my voice. Today, we have 2  
10 main purposes. We want to update on our analysis of the data, what we found, and how we can then  
11 disseminate that back out to the provider community so that we can hopefully pay that claim right the first  
12 time, which was always our goal as we set forth with the demonstration and we want to keep that goal,  
13 going forward. And then the next, we want to talk about how CMS is going to expand the demonstration  
14 from the 3 states that we are currently in to a nation wide program. This slide is basically, you guys have  
15 seen it a couple times, the biggest issue on here is bullet number 2. Since the last time we have met,  
16 Congress passed the Tax Relief and Health Care Act of 2006. In Section 302, it did make the RAC Program  
17 permanent and nationwide by no later than 2010. I will talk more about that near the end of the  
18 presentation. But that's the major point on this slide. The rest, you guys have seen before. What the RACs  
19 do, they identify the underpayments and overpayments, recover the overpayments and we do have two  
20 types right now; the claim review and the Medicare second day payer and then the bottom of the slide lists  
21 the applicable RACs in each state.

22 You guys have seen this information before, too. The RACs are paid on contingency fees for any  
23 overpayment collected, and for the underpayments identified and returned to the providers. The  
24 demonstrations started in '05. We're almost a year away from the end of the demonstration. We'll talk  
25 more about that a little later, too. And the RACs had 4 years of claims. It's a rolling year, so if you thought  
26 about it now, they're basically looking from March 2003 and they don't have current year claims, so  
27 they're looking through September 30, 2006. And we worked really really hard to try to exclude any claim  
28 that was already reviewed. We've hit a couple bumps in the road, but for the most part, we have been able

**PPAC Meeting Transcription – March 2007**

1 to, if the FI carrier, QIO, OIG, anyone else has reviewed that claim for any reason, we don't want the RAC  
2 coming behind and looking at that claim again. And we've been somewhat successful with that.

3 Ms. Combs: The next slide talks again, this is information that you've already seen but just  
4 reminder. In fiscal year '06 when we came out with the report in November, we showed that \$68 million  
5 were collected by the Recovery Audit Contracting Program. \$2.9 million were paid back to providers and  
6 there was \$232 million in the cue. Somewhere to be collected or to be paid back, but it had not yet occurred  
7 for a total of \$303 million identified in improper payments by the RAC Program. If you take the collected  
8 dollars of \$68 million and you subtract the cost of \$14 million, that's where you get the \$54 million that  
9 went back to the trust fund. The next slide shows you just very briefly, a pie chart showing that most of the  
10 dollars collected came from the claim RACs, not from the Medicare Secondary payer RACs. The next pie  
11 chart shows the improper payments broken down by overpayments and underpayments. And the vast  
12 majority that they are finding are overpayments. The next slide breaks down the improper payments  
13 identified by type of provider, with the biggest piece of the pie coming from inpatient hospital. And if you  
14 look at the next slide, actually there's been one slide that's added. I'm not sure if it's in your handouts or  
15 not, but it's called the RAC mission, and I'll just read it to you briefly. The RAC Program's mission is to  
16 reduce Medicare improper payments through the efficient detection and collection of overpayments, the  
17 identification of underpayments, and the implementations of actions that will prevent future improper  
18 payments. And it's those actions to prevent improper future payments that the next couple of slides are  
19 about. This is a new piece. This is stuff that you guys have not heard before. And this is the first slide. This  
20 is all about inpatient hospital. These are the 3 largest problem areas that the RACs found in fiscal year '06,  
21 and I know that you guys are short on time, but I'm going to go through at least a couple of these. The first  
22 one is debridement. This is a problem where the hospital is picking the wrong procedure code to put on  
23 their bill, to put on their claim. And what's on the claim form is not matching what's on the medical record.  
24 The medical record shows that they performed a non excisional debridement. But on the claim form that  
25 they're sending in, they're putting down that they did an excisional debridement and of course it's  
26 complicated if you look at the coding rules about when you use one versus when you use the other, but the  
27 RACs are finding that often times a hospital is not getting it right on debridement and so the corrective  
28 actions, the tools that we have in our toolbox to prevent future improper payments really fall into 3

1 categories. Provider education, edits that can either deny the claim or return to provider, that's what RTP  
2 stands for, return the claim to the provider. And then thirdly, prepayment review. For this particular one,  
3 for debridement, we think that provider education is probably where we need to work. We think that by  
4 issuing a MedLearn Matters article, by encouraging the QIOs to educate hospitals about the coding rules,  
5 that's really where we need to expend our efforts on this one. We don't think that an auto deny edit is  
6 possible because when a claim comes in and it has excisional debridement or non excisional debridement  
7 on it without the medical record, you don't know which one is the right one to pay and which isn't the right  
8 one to pay. There's just no way to set up an auto deny edit or even a return to provider edit on that one.  
9 And prepayment review is not something that we rely on in the inpatient world, because we don't have a  
10 contractor that has been tasked with performing prepayment review. The QIOs do post payment review, the  
11 fiscal intermediaries don't look at inpatient hospital claims on a prepayment basis, so we really can't use  
12 that particular tool to fix this problem. The next one is respiratory failure. This is a problem where the  
13 provider is listing the correct procedure codes and they're listing the correct diagnosis codes, but they're  
14 picking the wrong diagnosis code to be principle. And it's the principle diagnosis that really drives that way  
15 the grouper picks the DRG. And so because they're picking the wrong principle diagnosis here, question,  
16 go ahead.

17 Dr. Ouzounian: I'm sorry to interrupt, but you keep using the term provider. And what you're  
18 talking about inpatient hospital. That has nothing to do with me as the provider who admits the patients,  
19 takes care of the patient, does stuff to the patient. When that gets coded by the "provider" it's done by the  
20 hospital personnel, not me.

21 Ms. Combs: I apologize. I will try to use hospital personnel. [laughter] I use the term provider type  
22 to really define who's doing the billing, the hospital the skilled nursing facility, the physician or DME, and  
23 I will try to use hospital personnel.

24 Dr. Ouzounian: OK, but that's what you're talking about here.

25 Ms. Combs: Yes in this particular, it says under the column hospital type, where it says inpatient  
26 hospital, inpatient hospital, inpatient hospital, that is the provider type that's coming in. The claim is  
27 coming from an inpatient hospital, and it is the hospital personnel that has hired people to do the coding  
28 and fill out the claim forms and send in the claim forms, and it is somewhere in the system between

**PPAC Meeting Transcription – March 2007**

1 documenting what's happening in the medical record and filling out those claims that something has gone  
2 wrong. Or, as you'll see on a future slide, it may be that the hospital or the skilled nursing facility or the  
3 physician is filling out everything correctly and there's a problem at the carrier end or the FI end not paying  
4 things correctly. But you don't see that on this particular slide. These are issues where the personnel at the  
5 inpatient hospital is listing the codes incorrectly on the claim. Thank you for helping me get my  
6 terminology correct here.

7         So for respiratory failure, again, having the wrong principle diagnosis listed on the claim, by the  
8 inpatient hospital personnel, we believe that an edit is not possible and prepayment review is not possible.  
9 So again, we're going to be relying on provider education to try to fix that problem, to educate the hospital  
10 personnel about the way to pick the correct principle diagnosis particularly in respiratory issues and to  
11 hopefully prevent future improper payments from occurring at least to the degree that they occurred in this  
12 time period. The third problem that the RACs found in the inpatient hospital claims was when the hospital  
13 personnel listed "discharge to home," when they should not have. And in fact, the patient was not  
14 discharged to home. They were discharged to another hospital, and when that other hospital submitted their  
15 claim, it looked like it was a completely unrelated claim, and the right payment rule about taking one DRG  
16 and splitting it between 2 different facilities did not get applied properly because the first hospital didn't list  
17 the discharge status correctly. So again, we believe that educating the hospital personnel is what we need to  
18 do to prevent those kind of improper payments going forward.

19         Dr. Senagore: Just to follow up on the previous discussion, a couple of these issues are very  
20 clearly where medical terminology that we use daily is just not transferred because of relatively arcane  
21 rules to fill in the coding piece. So for example, if you're in a small hospital and you have a patient with an  
22 astomodic leak, the diagnosis of colon cancer may not have made it. But the diagnosis on discharge was an  
23 astomodic leak, the receiving hospital's treating an astomodic leak. They're no longer treating colon  
24 cancer, so what's lost in that transfer of data is the medical terminology that we all use to be able to feed  
25 the systems on the outside. So if we could make any plea the interoperability is where the deficiency really  
26 is. Because I don't think any of this is really outright issues in terms of trying to do incorrect coding. It's  
27 the fact that the terminology doesn't transfer easily to the information that you folks get.

**PPAC Meeting Transcription – March 2007**

1 Ms. Combs: Thank you. The next slide is talking about outpatient hospital, rehab hospitals, and  
2 skilled nursing facilities and the biggest problem area here was with inpatient rehab claims. This is a  
3 medical necessity issue and this is a problem where the services that were provided, the patient did need to  
4 receive. They were medically necessary services. They just didn't need to be provided in the inpatient side.  
5 These were primarily people that had had single joint replacements and had finished with their inpatient  
6 stay and now they needed some rehab. And they didn't have a medically complex case. They did not need  
7 to be treated in an inpatient setting. They could have been treated in a SNF or they could have been treating  
8 in a home health setting and so it was the level of service that was not medically necessary in this case.  
9 This is something that we believe we can do provider education. Auto-deny edits will not work in this case.  
10 And there could be some pre-payment review that the fiscal intermediary could do as part of their error rate  
11 reduction plan. That's the acronym that you see in the far right column. Question.

12 Dr. Senagore: Again, following up on our most immediate discussion. So is the Florida hip  
13 hospital the one that just says you don't qualify for the inpatient treatment, you're fine, go home. But the  
14 other one, that does 86, says oh absolutely. Go to the SNF. You're fine. They get a much higher satisfaction  
15 score, but then they get dinged on this. This is where again, we're at cross-purposes here. If we're going to  
16 truly do value, then let's define the total value of the entire encounter the same way. Don't take with one  
17 hand giveth and the other hand taketh away, because you're going to have all kinds of again, unusual  
18 behaviors that you're not going to drive the overall outcome that you want.

19 Ms. Combs: Thank you. The next row is a drug called Nulasta, and this is a situation where the  
20 personnel at the outpatient hospital facility were billing for 6 units of Nulasta but because of a definitional  
21 change in the code, they were actually billing for 6 vials of Nulasta, when they were really only trying to  
22 bill for 6 ccs of Nulasta, and the carrier, or the FI didn't catch it, and paid the claim and this is a situation  
23 where we do believe that some provider education would be helpful, but we also think that it might be  
24 possible to put into place an auto-deny edit. Particularly if there are rare circumstances where a patient  
25 would really need some vials of Nulasta given at one time, and if that's the case, we may be able to set up  
26 an auto-deny edit, or at least a return to provider edit, to say are you sure you really meant to bill 6 vials of  
27 this stuff.

28 Dr. Urata: Aren't they like pretty expensive?

**PPAC Meeting Transcription – March 2007**

1 Ms. Combs: Yes. The last column is talking about pre-payment review and we believe that there  
2 could be fiscal intermediaries who could analyze their data and see if there are individual hospitals who  
3 tend to bill this more frequently than others and perhaps consider doing some pre-payment review if it's not  
4 possible to put in place an auto-deny edit in these situations. The last row is talking about speech therapy.  
5 This again is an issue where the code says you get to bill one of these for an entire session and the therapist  
6 or whoever's filling out the claim form thinks that they are to be billing per fifteen minutes. And so they  
7 bill 3 of these if they see the patient for 45 minutes, but they really should have only billed one. Again, this  
8 is something that we think that provider education and possible pre-pay review would be helpful for,  
9 probably not something that we could do an auto-deny edit on. This is the slide that talks about some of the  
10 physician services, where the Recovery Audit Contractors found problem areas. The first one is vestibular  
11 function tests. And this is a situation where the local coverage determination says that these services should  
12 not be billed more than once a day, and yet the provider billed for many of these a day. I actually think this  
13 comes down to sort of understanding again the definition in the code, is the code for sort of session of  
14 vestibular function tests, or per little individual thing that you're doing along the way. We believe that  
15 provider education is going to be best at handling this and carriers can determine if a pre-payment review is  
16 appropriate. The second row here is a typo, you can scratch that out. Nulasta is really an issue on the  
17 outpatient hospital side, not really something that the RACs found on the physician side, at least not yet.  
18 And the last row is multiple surgeries. This is a situation where the billing rules that if the physician is  
19 doing 3 different surgeries during one operative session, he gets 100% payment for the first one, and a  
20 smaller percentage for the additional ones that come after that. But in these cases, the physician got 100%,  
21 100%, 100%, 100% and so it looks like either the carrier accidentally turned off the edit, or we're not  
22 exactly sure what was happening. At least 75% of the cases here, the surgeries were coming in on different  
23 claims and we're not exactly sure why that was happening. Why a physician would send in one claim for  
24 the first thing and a second claim for the second surgery and a third claim for the third surgery, but that was  
25 what was happening and so we need to dig a little deeper and try to figure out what we need to do with our  
26 systems to make sure that we pay correctly the first time and that we prevent improper payments.

27 Dr. Senagore: A lot of folks are wondering where that FI is. [laughter]

**PPAC Meeting Transcription – March 2007**

1 Dr. Powers: On the first one, are you saying that that was billed for one patient several times in  
2 one day, or—

3 Ms. Combs: Yes.

4 Dr. Powers: Oh, OK.

5 Ms. Combs: Same patient getting—

6 Dr. Powers: Because it might be a neurologist who is doing some interventions in between those  
7 testings, there might be some exceptions to the rule.

8 Ms. Combs: I would love to talk to you afterwards, so that I can get a better understanding of what  
9 some of those exceptions might be. I appreciate that, thank you.

10 Ms. Leonard: As you can see our Improper Payment Prevention Plan is still a work in progress but  
11 we think it's something very important and where you guys are going to be able to help us. How do we get  
12 out to those providers? The next question you want is when are we coming to your state, right? [laughter]  
13 The first step that CMS is exploring right now, we're in 3 states. And it's a big task to go to 50 states, as  
14 you can imagine, and you know we think we were at least on the right track the first time around and we  
15 did a lot of provider outreach, and we really worked with the associations. We still work with them, on a  
16 monthly basis, and we want to keep that going forward. So we are exploring, we have our existing RAC  
17 contracts which go until March 2008, so we have about a year left, and giving them an additional state or  
18 two, that kind of lets us get our feet wet and some more working with other associations. We're working  
19 with our contract staff to determine where that might be. Which states they may go into. When we do that,  
20 we would have to do a contract modification to add those states in. We're also going to make a couple other  
21 clarifications to the RAC process and the biggest thing, is we're going to require each RAC to have a  
22 medical director. We think as they go forward, dealing with more associations, dealing with more complex  
23 issues, possibly getting into medical necessity, there's a need for a medical director so each RAC will be  
24 required to have one. I'm saying that probably April 1<sup>st</sup> or sometime in the month of April this year will be  
25 required to have a medical director. We will have the information public just as it is for FIs and carriers and  
26 even invite them to our medical director calls, so that physicians can talk to them if they need to, so that  
27 should be in the very, very near future.



**PPAC Meeting Transcription – March 2007**

1 Dr. Senagore: Do you have any kind of information in terms of learning curve issues or standard  
2 operating procedures that have lead to best practice so that if you bring new groups into a region, that they  
3 don't have to go to school again, they can already learn those hard lessons?

4 Ms. Leonard: Exactly right, and I agree with you. We've learned a lot in the demonstration and  
5 actually if you go to the next slide, we talk about how we're going to do this nationally. And that is one of  
6 the most important things is taking what we've learned in the demonstration and we've actually already  
7 made some changes and I'm going to get into those in just one second. These four regions that we have up  
8 here are the same as the DME MAC jurisdictions. You all are probably familiar with them to some extent,  
9 same regions, A, B, C, and D. And this is what we plan to have, one RAC in each jurisdiction. They'll be  
10 responsible for all claim types in patient, outpatient physician supplier, home health claims, all across the  
11 board. What we have, or sometime probably this week, we're going to release a request for information.  
12 This basically is going out to the industry to see who is interested in doing this type of work. With that  
13 request for information is also a draft statement of work, and in that draft statement of work, we already  
14 have made some changes, based on what we've learned in the demonstration. We also think and what is not  
15 in the request for information is our evaluation criteria, but early on and even in demonstration we knew  
16 that provider outreach was going to be on one of our key success factors. We still feel the same way. That  
17 the getting answers to providers' questions, talking to the associations, being out there in the forefront, you  
18 know, attending meetings, you know, working with the FIs, carriers, the MACs, all of that's very, very  
19 important, so that we don't have the same mistakes that were created the first time around. And a lot of  
20 those you know, small mistakes that we had we were able to, they were data issues, and we were able to fix  
21 them with new data so once we kind of did that once, we certainly don't want to repeat that again. But  
22 some of our mistakes that we have had with incorrect identifications, for example. We're trying to work on  
23 ways that we can review a sample claims before they even hit the street, go out to providers, so that we  
24 don't are not wasting a provider's time more than we need to. We certainly know that it is a burden for any  
25 provider, be it a small physician or a hospital, to copy medical records to send them into the RAC. We want  
26 to make sure that whatever they're reviewing, an accurate finding is the final product, be it a finding, or no  
27 finding at all. We want to make sure that provider that is accurate, we don't want to waste a provider's time  
28 making them having to appeal or anything else.

**PPAC Meeting Transcription – March 2007**

1           This kind of gives you our expansion time frame. I said that we are getting ready to release the  
2 RFI; that draft statement of work will be out there. It's available for anyone to comment on. What we  
3 would like to have, even though the legislation gave us until 2010 is we see a need for continuity, because  
4 everyone knows about the RAC program a little bit. We have learned those lessons. We want to be able to  
5 incorporate them into the nationwide project, and we want to keep going with our provider outreach, so we  
6 hope to have the 4 RACs in each region this time next year, basically, so that they would be able to start.  
7 Now with any new RAC, or new region, there is a time period that it takes them to get up to speed, so  
8 you're really looking at probably 9 to 12 months for them to get the data, analyze it, and go forward. We've  
9 made a couple of big changes based on what we learned in the demonstration. One will obviously be the  
10 required [inaudible]. That's going to go forward. That's going to be official, and some other ones are right  
11 now the demonstration, evaluation, and management codes are not available to the RACs. That will stay, at  
12 least for the beginning of the nationwide transition, so to speak. We want to make sure that CMS used to  
13 come full out and have a very concrete definition of how we're going to evaluate those codes and we don't  
14 feel that the RACs are, that that is a code we want to allow the RACs to review right now. So they will still  
15 be off the table. We are thinking about having a staggered timeframe for the transition, meaning we may  
16 go, we're really thinking about going into inpatient and then outpatient, and then physician claims. That  
17 allows us as CMS and the RACs to focus on the hospital associations, the AHA first, to then move forward  
18 and getting into the physicians so that we can reach all the necessary provider groups so that we're not in,  
19 in region A they're looking at physicians, and region B, they're looking at hospitals. We want to know  
20 what everyone is doing, and we kind of had that the first go around. Down in Florida, they were really  
21 looking at physicians and then in New York and California, it was hospitals and we think maybe we should  
22 have it staggered and be everyone looking at the same thing first. We're also working with the MAC  
23 transitions to make sure we're not impacting the beneficiaries and the providers in those jurisdictions, as  
24 they're getting ready to change who's going to pay their claim and who's going to answer their questions.  
25 So we are working with the transition teams and CMS to maybe have a what we're calling a black out  
26 period, or times where the RAC is not actively contacting providers when there's an impending, or a  
27 transition from a MAC just occurred. And we're also, some of you may be aware of the details of the  
28 demonstration—what happens right now with an appeal, if a provider would chose to appeal the claim and

**PPAC Meeting Transcription – March 2007**

1 at the first level, which is the retermination level, it would be in the agency's favor. Then the RAC no  
2 longer had any financial responsibility for that debt. If the provider went on to the reconsideration or the  
3 ALJ level, it didn't matter what the decision was, the RAC, if they collected any money up front, still  
4 received that contingency payment. As we go forward we've decided that the amount of appeals at the  
5 reconsideration or the ALJ level is manageable and we are going to have the RACs assume full financial  
6 responsibility, no matter what level appeal. So if the provider chooses to take it to the ALJ level, and they  
7 win at the ALJ, and the RAC has collected any contingency fee, they will have to repay Medicare. So that  
8 is a big change. Again, we had to be able to analyze the data, see how big an impact appeals was going to  
9 be in the demonstration. We want these Recovery Audit Contractors making accurate decisions. And if they  
10 have to take that decision all the way forward, maybe they'll think twice if it's a grey area or if it's a little  
11 on the line. So you know those are just a couple of the changes that we think impact providers on the front  
12 end, that we want to let you guys know of where we made those changes. That RFI is public. We certainly  
13 welcome you know, anyone's comment. You guys are certainly busy enough, but if anyone has a comment  
14 on it, and we want to hear from you guys, again, how we can get the word out to physicians and providers  
15 about any corrective actions that we may have from these identifications, as well as you know, any ideas  
16 you might have. Wait a minute, you forgot about this issue. We think we've done a good job in keeping  
17 track of the lessons learned from the demonstration and moving those forward, we know there'll be more.  
18 There always is more. And hopefully we can fix them and keep them small.

19 Dr. Senagore: Do you notify software vendors as well? Because of these areas are probably  
20 embedded in the software that were missed edits internally, pre-submission, inability to put in the wrong  
21 data. They might be someone included in your discussions.

22 Ms. Combs: That's a very good point and we will certainly consider that. We've struggled a little  
23 bit in terms of trying to figure out how public to make this information and whether to post it on the  
24 website and in how much detail, and maybe we should just sort of lay it all out there so that the software  
25 vendors and everybody that's involved in this can make sure that they're fixing their little piece of it.

26 Dr. Senagore: I think that allows us to make value based decisions on what software vendors we  
27 [laughter]

**PPAC Meeting Transcription – March 2007**

1 Dr. Urata: I just have a question. Where does the money come from for the contingency fees paid  
2 to RACs for discovering under payments to providers.

3 Ms. Leonard: That's a great question. What happens is when the amount is recovered from the  
4 overpayment, and it goes back into the trust fund, anything for the underpayment will come out of the trust  
5 fund, too. So if there is a \$100 underpayment, that would come out of the trust fund, but more than likely,  
6 it'll come out of what they found from overpayments. Obviously, the hope is we're going to putting more  
7 back into the trust fund than what we're paying out or obviously we have a major issue, and again, we want  
8 to pay that claim right first time, being underpayment or an overpayment, but that money is coming, really  
9 is out of trust fund, but we usually term it as saying it's out of the collected fees.

10 Dr. Urata: OK. So there's still plenty of incentive for them to find underpayments as well as  
11 overpayment.

12 Ms. Leonard: Certainly, certainly.

13 Dr. Ouzounian: I have two comments. One is when I look at your presentation, your data is  
14 painfully obviously to me that physicians are doing an outstanding job of reporting their services. [laughter]  
15 And it would seem to me that you ought to leave them alone and go where the money is, and the money's  
16 with the facilities. Because it probably costs you an equal amount of money to chase a physician, and  
17 you're getting less than 6% of your paybacks from physicians. So that would seem to me to be a very  
18 reasonable thing to do.

19 Ms. Comb: I think that the RACs, at least some of them, were pretty aware of that as they were  
20 trying to choose which claims they wanted to go after. Remember CMS paid them 0 dollars. The only way  
21 they make money is by finding improper payments and making it right, and so some of them decided real  
22 quick that it was in the inpatient hospital side that they needed to target their work.

23 Dr. Ouzounian: Well, maybe we just ought to take the physicians off the radar, just go one step  
24 further, but anyways, the other is the comment that you made that the RAC identifies an "overpayment"  
25 and the provider then appeals that and prevails. That's a very expensive process for the provider, it takes a  
26 lot of resources, lot of time, and expense, so here's a RAC kind of shot gunning things to get money. Many  
27 providers will simply pay it because it's a simpler thing to do and how is a RAC penalized or punished.  
28 Because I can see where to them, taking a shotgun, well you know, it might be, might not be, let's just send

**PPAC Meeting Transcription – March 2007**

1     them a ding notice and they'll pay us, and worse thing they're going to appeal it and so we lose. We don't  
2     lose anything. And the RACs ought to be punished if the provider appeals something and wins. They  
3     should be punished for that.

4             Ms. Combs: Are you going to talk about elevation?

5             Ms. Leonard: Well, I was getting ready to talk about, you know you're exactly correct. And we  
6     were worried early on about a quantity versus quality type of scenario where they would just go out and  
7     identify all of these overpayments and who cares what the appeal process ended up being? And what, we  
8     want to have basically a 2-steps, we want to have what we are calling a validation contractor. Basically that  
9     is where a sample of overpayments are sent to a, for each issues, a sample, certain percentage of claims are  
10    sent to an independent validation contractor to actually review first to make sure this is an accurate  
11    interpretation of the LCD or the NCD, the regulations, to make sure they're just not doing the some sort of  
12    shotgun effort. What we also have on the flip side is one of the evaluation criteria for the RACs is going to  
13    be their appeal rate. It's not just about how much did you identify or how much did you collect. Your  
14    provider outreach is into that as well as your appeal. And it's not just going to be a flat out you know 5 year  
15    contract. What CMS normally does—CMS will always have that option at the end of the year to say, you  
16    haven't met our standards. You know, we, you have a deficiency in one of our major criteria, so we're  
17    going to go in another direction. And we wanted to make sure that that door was always open in the event  
18    that they were falling deficient on the appeals. We're also working with the FIs, the carries, the MACs,  
19    even the [inaudible] to some extent, to go back to these are the individuals hearing the appeals. And to go  
20    back to the RAC, have the conversations about why that particular claim or that overpayment case was over  
21    turned at the appeal, so the RAC can learn. It's a constant learning process for the RAC.

22            Dr. Ouzounian: I would suggest an even more stringent punishment, such as financial  
23    disincentive.

24            Ms. Combs: To me, the loss of the contract is about the biggest financial disincentive that we can  
25    come up with. Just if they can't perform up to our standards, they can't play in our game.

26            Dr. Senagore: Do the lessons that you learned and the errors that you articulated, do they go to the  
27    white states as well? Or just to the current RAC states?

**PPAC Meeting Transcription – March 2007**

1 Ms. Combs: We have started that process now and we are going to be informing all of the  
2 contractors, whether there's a RAC in their state or not, because we believe there are actions that they can  
3 take now to start looking for these kinds of problems. Put in place these kinds of edits, make sure that their  
4 systems are set up to prevent these payment—

5 Dr. Senagore: But to hospitals as well? That these are, is there an educational piece that says these,  
6 based on the RAC audits, here's the issues we find, you might want to look at your own processes to see if  
7 this is happening.

8 Ms. Combs: We will be working through the QIOs and the QIOs are networked into all the  
9 hospitals, and so where they think it's appropriate, they will disseminate that information to the hospitals.

10 Dr. Senagore: I guess what I'm saying is rather than go after it with some governmental agency  
11 that has other authorities, wouldn't it be nice to educate the people, say, hey, you may have these errors  
12 already in your systems. Why don't you see if you can fix them on your own now, so when the RAC audits  
13 show up, they're already fixed?

14 Ms. Combs: What do you think would be the best educational vehicle to use to reach those  
15 hospitals?

16 Dr. Senagore: Probably something through HHA, or some other educational issue there, how they  
17 do their Medicare billing, I think would be a much more attractive way to transmit the lessons learned.

18 Ms. Combs: Thank you. Any other suggestions for how to—

19 Dr. Grimm: I think what the states and everybody else will feel is that this is the Roman Army  
20 coming in. They'll clear out all their women and children. [laughter] Because they'll want to know exactly  
21 what are the problem errors and they'll want to clear them out fast, and so if I'm looking at it purely as a  
22 business, if I was a RAC business, I'd realize my income is going to head out the door even before I get  
23 there. So the education, I think they're going to be highly motivated to find out what these things are,  
24 because they don't want to go through this process. One of the questions I had is how far are you going  
25 back and is the cost, what the RAC is receiving based on collected or is it on what this was in a cue—is it  
26 based on a \$303 million dollars or was it based on the \$68 that was collected.

27 Ms. Combs: We go back 4 years, and they get their contingency fee based on what gets collected  
28 in overpayments and what gets paid back in underpayments.

**PPAC Meeting Transcription – March 2007**

1 Ms. Leonard: I will state that in the draft statement of work, we are right now limited to only  
2 going back for 3 years, so we have heard from the physicians, from the providers about how difficult it is to  
3 find the medical record that is 4 years old. Maybe it's off site, it's in the, it's microfiched or it's  
4 microfilmed or it's somewhere else and it hard for them to get to, so right now in the draft statement of  
5 work, we currently have it only for 3 years.

6 Dr. Azocar: Do you have numbers on the average that you obtained each RAC for hospital or for  
7 physician?

8 Ms. Combs: Are you asking what is contingency fee that we're paying the RACs?

9 Dr. Azocar: No, what's the—

10 Dr. Senagore: Claim, the reclaimed per provider type, individual physician.

11 Ms. Combs: Oh, I think we might have had that in the status report, but I don't have that with me.  
12 The actual collections back from the hospital?

13 Dr. Azocar: An average. Per hospital and per physician.

14 Ms. Leonard: I know it varied by state. Now for the physicians, it was really low. For example, in  
15 Florida, I think it was around \$175 and in California, it was about \$244. We don't have information for  
16 New York yet, because they have not yet released physician data, or any physician claims in New York.  
17 From the hospital perspective, I think it really varied. I want to say New York's was around \$5,000, but if  
18 you went to California, it increased up to about \$17,000, just different types of claims they were viewing.

19 Dr. Powers: I think the MedLearn Matters would be a good way to disseminate information. But  
20 are you going to standardize the letters? I know that with the original, people were getting letters that were  
21 somewhat ambiguous, or threatening, or—

22 Ms. Combs: The medical record request letters or the you owe us money letters?

23 Dr. Powers: Either one.

24 Ms. Leonard: You know, we are looking into standardizing the actual demand letter. We call it the  
25 demand letter, or the letter that says you owe us this amount of money and we are actually working with  
26 some of the associations on getting their input about how we could standardize that letter and make it more  
27 provider friendly. Not only from the perspective of what the RACs are using, but also, what the MACs use

**PPAC Meeting Transcription – March 2007**

1 or the FIs, carriers. We think it would be nice if there was one standardized letter that everyone sent, that  
2 basically said the same thing. So that's what we're kind of working towards.

3 Dr. Powers: And will it have the CMS logo on it so that people will understand where it's coming  
4 from?

5 Ms. Leonard: Yes, and all RAC letters right now should have the CMS logo on it.

6 Dr. Azocar: Can I ask you a question? What will the difference be between this system now, RAC,  
7 and what used to be audits before? Is there any difference in the procedure in the criteria for...

8 Ms. Combs: Between what the RACs and what who is doing?

9 Dr. Azocar: What used to be audits, is that right?

10 Ms. Combs: Are you talking about the medical review audits that were done by the carriers and  
11 fiscal intermediaries?

12 Dr. Azocar: That's right.

13 Ms. Combs: It's a very, very similar review that occurs. It's a request for medical record, review  
14 of the medical record against the claim, and it's happening in addition to what's happening at the carriers  
15 and the FIs, and the QIOs. The only difference from CMS's perspective is that when we go to hire a QIO,  
16 or a carrier or a fiscal intermediary, to do those audits, we have to pay them money to do it, and there's a  
17 limited budget that Congress gives us, and so they can only do so many of those audits. In the Recovery  
18 Audit Contracting world, we don't have to pay them any money. They get to get paid through the  
19 contingency fee, and so they can do as many as they can find overpayments and underpayments for. That's  
20 the big difference.

21 Dr. Azocar: It looks like what will the regulation be, or how does CMS get involved to avoid any  
22 kind of over review or abuse of the carrier in terms of review like that. Is that something you control? You  
23 have a regulation mechanism there?

24 Dr. Senagore: They screen for multiple reviews.

25 Ms. Combs: We make sure that, I think your question is how do we make sure that the Recovery  
26 Audit Contractors are not reviewing medical records that have already been reviewed by a carrier—

27 Dr. Azocar: Not really. I mean if the review is something that is motivated and started by the  
28 carrier, how is CMS involved there in regulating, avoiding over, an excess of review of this kind of thing.



**PPAC Meeting Transcription – March 2007**

1 Ms. Leonard: I think that—

2 Dr. Azocar: Is that something that depends on your department, or maybe I shouldn't—

3 Ms. Comb: No, I think it's us and I think that the philosophy perhaps is beginning to change a  
4 little bit in CMS, where in the past we looked to our carriers and our fiscal intermediaries to do 2 things; to  
5 go back and collect old payments that were made improperly, and do stuff to prevent future improper  
6 payments. Do pre-payment review, and do things that would prevent future improper payments. Now that  
7 we have the Recovery Audit Contractors who can look back and sort of fix the old problem claims that got  
8 paid incorrectly, we're exploring the possibility of having our carriers and our fiscal intermediaries spend  
9 less time cleaning up the old mistakes, and spending more of their time and resources preventing future  
10 improper payments. Does that help answer your question? Great.

11 Dr. Azocar: Thank you.

12 Dr. Senagore: Another other questions? Thank you very much, we will recess now and reconvene  
13 at 1:45. Thank you.

14 Break

15 Dr. Senagore: Before we get started with the exciting PRIT Review, we have a few housekeeping  
16 items to take care of. And I'd like to invite Dr. Gustafson to say a few words to our outgoing members, and  
17 should he so choose, he can have the liberty of saying some of his own outgoing messages as well. Dr.  
18 Gustafson

19 Farewell to Departing Members

20 Dr. Gustafson: Thank you very much. And I want to express the Department's appreciation to the  
21 five departing members of the committee. It seems like a lot of folks to lose all at once and we're going to  
22 miss you and your wise counsel. It's worth emphasizing yet again things that have been said many times  
23 about the advantages to the government and to the nation of having really outstanding professionals willing  
24 to give their time, take time away from their practices. This is a Practicing Physicians Advisory group. All  
25 of you have lots of other things you could be doing with your time to perhaps its greater profit at a personal  
26 level than coming here. And we can't get the kind of input that you give us in any other way. It's very  
27 important for us and helps us run the programs that we all rely on better. I'll just say just a word or two  
28 about my own situation. I'm retiring now after 30 years with the government. That happened kind of by

**PPAC Meeting Transcription – March 2007**

1 accident. I came here intending to stay for something less than 2 years on a temporary appointment and  
2 about 8 years into that, I realized that I was no longer in a temporary appointment at that point, but realized  
3 that the work that I was doing here was what mattered, and the colleagues I was doing it with, such as  
4 yourselves, were first-rate professionals with a very strong motivation for public spirit, public service, and  
5 that has spelled the, a very nice career for me, given me the opportunity to serve the public and as corny as  
6 it sounds, that's what gets me up in the morning and gets me to put on my pants and come to work. And it  
7 has been a much longer run at doing this particular kind of thing than I expected, but one which I have  
8 found personally of great profit and great interest. But with that, I think there were some certificates that  
9 I'm supposed to deliver. These are to commemorate the service of the individuals who will be leaving  
10 today. And these are very pretty in the Department's colors, you see. [laughter] These are also colors of the  
11 Cub Scouts. I don't know if that [laughter] indicates anything or not. And signed by our Acting  
12 Administrator, Leslie Norwalk, in recognition of the valuable contributions and service to the Practicing  
13 Physicians Advisory Council. The first is to Joe Johnson of Florida. [applause] And then we have Laura  
14 Powers, who I understand is actually retiring retiring. [laughter, applause] And Dr. Urata [applause]. Our  
15 practically off the continent representative. [laughter] Dr. Iglar.

16 Dr. Simon: He's not here today.

17 Dr. Gustafson: He's not here today. I thought I hadn't seen his smiling face.

18 Dr. Simon: Exactly.

19 Dr. Gustafson: So we'll hold this in commemoration for him.

20 Dr. Simon: Dr. Hamilton left.

21 Dr. Gustafson: Oh, and Dr. Hamilton left us just immediately before lunch, so we'll salute him as  
22 well. There you go.

23 Dr. Senagore: Thank you.

24 Dr. Simon: I'd just like to say beginning in May, at May meeting, the five new members will be  
25 sworn in, Dr. Jordan, an optometrist from Gillette, Wyoming, Dr. Siph, Emergency Medicine physician  
26 from Cleveland, Ohio, Dr. Snow, a family physician from Kansas, Dr. Arradando, a family physician from  
27 Nashville, Tennessee, and Dr. Robar, an endocrinologist from Rockville, Maryland.

**PPAC Meeting Transcription – March 2007**

1 Dr. Senagore: Impressive memory of a medical man. [laughter] We'll go ahead and start with the  
2 PRIT Update. And you all know Dr. Rogers, the Director of the PRIT in the Office of External Affairs, and  
3 he addresses us on a regular basis. Dr. Rogers.

4 PRIT Update

5 Dr. Rogers: Mr. Chairman, when would you like the next speaker to start, just so I can...

6 Dr. Senagore: We'd like to spend a little bit of time, we're going to follow right on with yours.

7 Dr. Rogers: So you think 10 minutes?

8 Dr. Senagore: Yes, sir.

9 Dr. Rogers: OK, great. Well, thanks it's a pleasure to be here. I have to say Ken that theatrical  
10 suspense while you thought of that last name, I couldn't have come up with one much less five. So that was  
11 very impressive [laughter]. I'm glad to be here. I should announce that Robert Bennett, who has been the  
12 other half of the PRIT for a long time, has now gone to the private sector as well. He was a little bit ahead  
13 of Dr. Gustafson. And we actually have stolen somebody from the Office of Legislation named Matt  
14 Brown. He's not here right now because he's at the Health Care Administrative Simplification Coalition  
15 meeting, which is going on right now. I was going to lead off with a cartoon, we were so clever, the  
16 handout doesn't have the cartoons in it, so this is the one thing that'll keep your attention. OK.

17 I'll just go through these issues quickly. Deeming was an issue that sort of bubbled up about 3  
18 months ago. Initially, the calls that we were getting asking about deeming were not clear exactly what the  
19 concern was and then I was speaking to the American Academy of Dermatology a couple of weeks ago and  
20 it became clear that this had to do with the expansion of the private Fee for Service plans. And the was, the  
21 fact that if one sees a private Fee for Service patient, and basically cashes the check, then they're deemed to  
22 be participating with that plan at whatever fee schedule that plan has determined. As it turns out there are a  
23 lot of protections in the regulations for physicians in this and it is not nearly as onerous a thing as it  
24 appeared to be at first glance, but because this has expanded so rapidly recently, we've had to get some  
25 information out to physicians about precisely what this is all about and so we're working to do that.

26 The next two issues were really just corrections to the Physician Fee Schedule that physicians  
27 brought to our attention that we were able to get corrected. This prior authorization for anti-retroviral  
28 medications, we've actually had a number of prior authorization issues. We have been sort of designated by

1 a number of specialty societies as being the go to group for physicians and the societies are having  
2 problems with particular plans and prior authorizations, and this just happened to be an issue with one of  
3 the anti-retrovirals that should not have had a prior authorization on it. We got it fixed.

4 This also was a correction. One of the care and medical directors actually brought it to our  
5 attention, and it had to do with the description of the national coverage decision wording for thyroids  
6 staging. And Humera and FDA warnings, I thought this was going to be an issue of interest to physicians.  
7 One physician said every time he prescribes Humera, he has to sign a letter which says that he's aware that  
8 there are certain contra-indications to the drug and it seemed reasonable that if this was a burden, that the  
9 plans might just have a doctor do one Humera letter a year. Because presumably that should fulfill the  
10 plan's responsibly to make sure these drugs aren't being prescribed inappropriately. So we sort of tried to  
11 find a physician who was angry about the number of letters they were having to sign, and we actually  
12 haven't really found anybody who seems to be all that upset about it. So [laughter] for the moment, unless  
13 we hear from somebody, we're going to sort of leave it as it is.

14 I don't know if you can see the cartoons. Physician saying to the patient, I have no idea what's  
15 wrong with you at all, so I'm going to prescribe a cure-all. This is, these are 2 issues here; one having to do  
16 with the PQRI the Physicians Quality Reporting Initiative. There was, of course, the statute requires that  
17 the payment be made based on tax ID number. And the original plan was to report out the quality measures  
18 at the tax ID level, too, which for larger groups, would really make it difficult to know which physicians  
19 were performing well and which weren't, and so the current plan is actually to report out the quality  
20 information at the NPI level, which will make it easy for groups that want to, to know which of their  
21 physicians or other providers are scoring well and which are not. If they want to ignore that and just base,  
22 whatever the payment or whatever at the tax ID level, the group level, that's their option, but it does give  
23 them the detailed information if they want it. The other issue had to do with the Physicians Voluntary  
24 Reporting Program description of one of the quality measures and the information that we got from the  
25 doctor's office about that was helpful because we were able to use it to make sure that we clarified the  
26 description with PQRI, which, as you know, has a lot more measures.

27 This was particularly an issue of interest to optometrists. Many of the plans were requiring DEA  
28 numbers for all prescriptions. And they were using them sort of as a way of identifying the prescriber. This

**PPAC Meeting Transcription – March 2007**

1 was something that the DEA really didn't encourage—the use of DEA numbers on prescriptions that  
2 weren't for controlled substances. But because it was interfering with optometrists' ability to get  
3 prescriptions filled many optometrists don't have DEA numbers, it was something that CBC felt needed to  
4 be corrected. So a letter was sent out to all of the plans saying that they should not continue to rely on DEA  
5 numbers, when prescriptions were being written for noncontrolled substances. We've gotten a few isolated  
6 reports where there were still problems, and those have all been pharmacy problems, not plan problems. So  
7 as far as we're aware, all the plans have complied with this and are now using license numbers, when they  
8 require a number. Now once the NPIs come out, everybody will have NPIs, and they'll be able to use NPIs  
9 as the identifier and that's really going to work much better.

10 Two issues here. One has to do with the ability of groups that employ active duty physicians for  
11 moonlighting to bill government payers, Medicare and Tricare, particularly. This was sort of a surprise to  
12 me that this came up as an issue, and frankly we have attorneys looking at it to clarify exactly what the  
13 correct answer is to this and I don't have a final answer for you yet. They've been working on it for a  
14 couple of months. But it requires the DOD and our attorneys to work together to get through this, so  
15 perhaps by the next PPAC meeting, I'll have an answer.

16 Simplifying the work of enrollment, we now have an 855 form which you can fill out on line.  
17 Unfortunately, unless you own the full Adobe Suite, you can't save it. So you have to finish the 855 form in  
18 one sitting, which is not always easy to do. So we are working with Adobe to have the capacity, even if you  
19 don't own the full Adobe Suite to save a partially completed 855 form. And I expect that we're going to  
20 have this available by April, at the latest. It's taken longer than I expected, but we are moving in the right  
21 direction.

22 Definition of consultation. This has been an issue since Transmittal 788. Unfortunately, we're  
23 hoping the CPT Editorial Panel could help clarify what the best wording was for the description of  
24 consultation, and in their meeting last month. They weren't actually able to come up with the language,  
25 which could help us with this, so we are still working on trying to make sure that physicians and people  
26 who bill understand precisely what we mean when we say a consultation

## PPAC Meeting Transcription – March 2007

1           Next slide was just a correction. This has been fixed. We had a mistake in the manual, which said,  
2           appeared to say that nurse practitioners couldn't bill for services they'd provided in the hospital. And it just  
3           required a correction of the manual.

4           The MGMA health care billing management association. A lot of organizations have made it very  
5           clear to us how important it is that they have the ability, that physicians and people who bill, have the  
6           ability to look up NPI numbers on line and of course we have to have a policy if we're going to do that, and  
7           that's called the NPI Dissemination Policy. And that's been under active work for quite a while now. It's a  
8           complicated issue because there are concerns about privacy, but there are also concerns about the efficient  
9           operation of offices, and so attempting to develop a policy which addresses the issues of both of those  
10          groups has been a challenge, but it really needs to happen soon and we recognize, and the Administrator  
11          recognizes that that's a priority.

12          This has been an ongoing issue for a long time. The exact amount of CME that a hospital can  
13          provide to members of the medical staff. And we are now writing a Final Rule, which is going to replace  
14          the interim Final Rule that we've been operating under since 2004 and that Final Rule must be released by  
15          March 24, 2007. So expect us to be resolved pretty soon, I hope.

16          GME Rule. This has been a challenging thing to resolve. The volunteer physicians, well-  
17          represented by the AMA, AFP, AOA, and others AAMC, have concerns about excessively burdensome  
18          requirements that we might impose as we fulfill our responsibility to ensure that all or substantially all of  
19          the costs of graduate education being paid by the teaching hospitals. And so we've been working very hard  
20          to come up with a nonburdensome policy which does fulfill those responsibilities, and I can't say that we  
21          have accomplished it yet, but we are working on it. This is an opportunity for comment because we have  
22          made a proposal in the long term care proposed rule and you can comment on that rule until March 25, of  
23          2007. So I'd encourage you to read the proposal and respond to it and I can give you language for the  
24          correct way to respond if you want me to, off line. [laughter] Just kidding about that. Somebody was dosing  
25          off in the back so I thought I'd throw that in.

26          Recovery Audit Contracts. I don't need to talk about that. You got a very good presentation on  
27          that. I was certainly pleased with a lot of the information we got, particularly, the plan to get medical  
28          directors for all of the Recovery Audit Contractors. I think that's going to be great.

## PPAC Meeting Transcription – March 2007

OK, my wife made me put this cartoon in. All right, and last slide. That's my phone number, email address and look forward to hearing from you.

Dr. Senagore: Any comments or questions for Dr. Rogers?

Dr. O'Shea: Yes, Dr. Rogers, I do think that the NPI listing is going to be really important. It was already brought up and I think you actually can, before, that we have kind of a closing window and as that closes down, not only the NPIs for each individual or group going to be in but the billing. It's going to be real important for us. So if you have any inroads to making that happen faster for us.

Dr. Przybalski: I just want to thank Dr. Rogers for encouraging commentary in issues that we've brought before and in the future. He's been very responsive and quickly trying to get to the bottom line of things and it's appreciated.

Dr. Senagore: Agreed. Dismissed. [laughter] Let's move on to hospital Conditions of Participation update. And as we continue here, let me introduce Ms. Jeannie Miller. Ms. Miller's the Director of the Division of Institutional Quality Standards in the Office of Clinical Standards and Quality Clinical Standards Groups. That must be fun to get on your business card. [laughter] The Clinical Standards Group is responsible for development of the health care and quality standards for approximately 22 different providers and suppliers. Her responsibilities include oversight of regulation development, and policy interpretation for hospitals, critical access hospitals, organ procurement organizations, and long-term care facilities. Prior to her employment at CMS, Ms. Miller was employed at the West Virginia State Survey Agency for 8 years as a surveyor and program administrator. And she's had a 20-year career as a hospital nurse, prior to government service. Welcome.

### Hospital Conditions of Participation

Ms. Miller: Mr. Chairman and Committee, Dr. Simon invited me here to provide you all with some information regarding the latest revisions to the hospital conditions. OK? So I'm going to be very happy to do that. There are two revisions that were published. One in November and one in January. And I'm going to give you a brief summary about what both of those revisions require of the hospitals. One's on what we call the carve-out, which is four distinct parts. Our particular pieces of the regulation, I'll be more clear about that in my presentation. The others on patient rights. When I'm finished, I hope that you have a little bit of an understanding of what exactly the requirements are. OK?

**PPAC Meeting Transcription – March 2007**

1           The November revision was published on November 27<sup>th</sup>. It revised the history and physical  
2 requirement, the verbal orders requirement, requirements for drugs and biological storage and post-  
3 anesthesia evaluations. I want to give you a little bit of background information so you'll have an  
4 understanding. There was a complete revision to all of the hospital requirements back in 1997. At that time,  
5 we received 63,000 comments on that proposed revision. That total revised package was never completed  
6 or finalized. There were a lot of guild issues, a lot of controversial issues that kept CMS, HCFA at that  
7 time, from finalizing the entire package. Since then, there have been select Conditions of Participation that  
8 were finalized based on public comment or Congressional interest or concerns. Some of those were like the  
9 organ procurement requirement, quality assessment performance improvement, life safety code, the CRNA  
10 issue, so these four areas that are in this regulation were identified to us by a number of different sources;  
11 through the PRIT, Congressional interest, AMA repeatedly for years, so we were asked by the  
12 Administration and CMS to address these 4 pieces of the entire package of Conditions of Participation.

13           I want to stress that the requirements in this carve-out are particular requirements, not an entire  
14 Conditions of Participation, so the history and physical requirement is under the medical staff Conditions of  
15 Participation, under the medical staff bylaws. So it now requires that H&Ps can be completed 30 days  
16 before admission or 24 hours after admission. What this rule did is it increased the number of people that  
17 can do an H&P, from what was currently in the books. It also extended the time for history and physicals to  
18 completed before a patient is admitted. The old requirement was 7 days before, 48 hours after. OK? Joint  
19 commission had been required 30 days before for a number of years. CMS caught up on this one. It did  
20 decrease the amount of time for an H&P to be completed after a patient is admitted from 48 hours to 24.  
21 The logic behind that was to try and get the information available to all the care providers as quickly as  
22 possible for the patients. H&Ps done before admission must have an updated exam and note within 24  
23 hours of admission. We had a lot of questions regarding that requirement. The update note is not expected  
24 to be extensive. We can look at an H&P that was placed on the chart for a patient having surgery where the  
25 surgeon has written, I concur, status the same, no change, that's dated and timed and signed by the  
26 physician as a note just on the H&P. That is one way that you can do that update note. So it's something to  
27 take into consideration. The hospital needs to define by their policies how they want that to be



**PPAC Meeting Transcription – March 2007**

1 accomplished. The key issue when a surveyor comes is, is one, that you're meeting the requirement, two,  
2 that you're following the hospital policies. OK? Keep that in mind.

3 Dr. Senagore: Just a clarification on that one question. In a teaching institution, would any  
4 member of the admitting team be eligible to perform that task if it as approved by the bylaws of the  
5 institution?

6 Ms. Miller: Perform the task of doing the update? If they are, have authority through state law and  
7 hospital policy to do an H&P, then yes.

8 Orders must be documented, signed by the practitioner, authorized by state law. We expanded this  
9 requirement, saying that anyone that's responsible for the care of the patient. What we mean by that is the  
10 practice where everyone covers for each other. The regulations that were in effect prior to this rule said the  
11 orders could only be signed off, a verbal or telephone order could only be signed off by the prescribing  
12 practitioner. This expanded that. OK, to allow much more flexibility. OK, so if your partner's willing to  
13 assume the responsibility for that or they can sign it for you, that helps with the medical records  
14 requirement of completing discharge records, and so forth. OK?

15 Verbal orders used infrequently and accepted only by authorized people. This actually is in the  
16 nursing COP, Conditions of Participation. It hasn't really changed. What we were stressing with this is that  
17 the orders in a hospital should only be accepted by authorized person by state law and hospital policy to do  
18 that. So we've run into issues with the physician, telling a pharmacist that doesn't have a porter authority  
19 that they don't, they want to change a particular order or whatever. So that's what we were trying to capture  
20 here. Also with IT there's an expectation that there will be a decrease in verbal and telephone orders  
21 anyway.

22 Again we're discussing the orders and this is under the medical records Conditions of  
23 Participation. Like I said, these are how the Conditions of Participation are arranged are the Conditions of  
24 Participation with the lead in statement, under that is standards, and under the standards are elements. So  
25 these are either standards or elements within a particular Conditions of Participation. The newest in this  
26 order is that the orders need to be timed. And we've had a lot of questions about that and a lot of concern. If  
27 you think about the continuity of care, quality assessments, performance improvement, tracking services  
28 provided to the patient, timing is actually crucial. So we do expect timing—not just for orders. Orders

**PPAC Meeting Transcription – March 2007**

1 specifically, but also any entry in a medical record to track whether or not the service is provided timely in  
2 the correct order, etc. There is a nuance in this particular regulation that allows for other practitioners to  
3 sign off on their partner or someone else's order for 5 years from the effective date of this rule. With the  
4 expectation that in 5 years, hospitals will have electronic medical records, or CPOE, something in place to  
5 where signing their own orders, telephone or verbal orders, will be easy, so actually in 5 years, physicians  
6 will not, or licensed independent practitioners, will not be able to sign off their partner's orders. This is  
7 another way that the Department of Health and Human Services is trying to promote or encourage  
8 electronic health records, electronic services within hospitals. So if hospitals in the United States are not up  
9 to speed, and able to do all of their ordering through their practitioners electronically we will write another  
10 rule to continue this, if that's what the administration at CMS wants us to do, continue allowing you to sign  
11 for each other, or that will go into effect and that will go away. So it's whatever direction the administration  
12 at that time chooses to go.

13         If there's no state law imposing a timeframe for authentication, there's always been an issue with  
14 authentication of verbal or telephone orders. If there is a state law present, the way the regulation is written  
15 right now, if there is a state law, regardless of the time frame, the state law supersedes the federal law. If  
16 there is no state law on when orders have to be authenticated, we require 48 hours. There's a little bit of a  
17 nuance. In the verbal orders is in the nursing COPs, Conditions of Participation, obviously when these were  
18 written, they were expecting nurses to take the majority of the orders. In medical records, there's a  
19 requirement that all entries, including verbal and telephone orders be signed promptly. Well promptly is not  
20 defined by CMS, but promptly does not, 30 days doesn't seem prompt. So there are some states out that  
21 have requirements for 30 days. Stay tuned. But the regulation very clearly and concretely says if there is a  
22 state law, it supersedes the 48 hours.

23         Drug storage. There were some issues with current practice in a lot of OB suites now, a lot of  
24 patients are self-medicating. There's many different issues that requiring all drugs and biologicals to be  
25 locked at all times in a hospital is not appropriate with current practice. It wasn't when this order was  
26 written. Nitroglycerin at the bedside, inhalers, all those things. If even lotions, if you look at the FDA law,  
27 their regulations as to what is considered a drug or biological would be required to be locked at all times.

1 We changed that and now it says “secure.” Which matches more with current practice and allows much  
2 more flexibility. And of course controlled substances are always locked. Nothing has changed with that.

3 The post anesthesia evaluation. I don’t know why the rules were written the way they were in ’86,  
4 the original rules, but the pre-anesthesia evaluation said that anyone that could administer anesthesia could  
5 do the pre-anesthesia evaluation. But the post-anesthesia requirement said it had to be the person that had  
6 administered that particular anesthesia. Well that makes the logical sense, but it doesn’t meet with the  
7 current practice now, with people that travel from place to place, providing anesthesia services and so forth.  
8 So now the post-anesthesia evaluation can be done by anyone that is qualified to administer anesthesia.

9 So what we tried to with these 4 pieces was allow more flexibility, meet current practice and  
10 relieve some of the burden on people trying to provide services to patients in hospitals.

11 I’m going to now talk a little bit about the patient rights requirement. The patient rights rule has  
12 become known as the Seclusion and Restraint Rule. It was actually published in the *Federal Register* on  
13 December 8<sup>th</sup> and was effective one month later. It finalizes the patient rights Conditions of Participation,  
14 and it is applicable to all patients. I will stress that. All the requirements in the hospital are applicable to all  
15 patients regardless of payer source. Regardless of your payer source, the Medicare Conditions of  
16 Participation are applicable for all patients. Like I said, this rule has become known as the Seclusion and  
17 Restraint Rule, it was also originally published in the ’97 proposed rule and pulled out. It was actually  
18 published as an interim final rule with comment in 1999. And the reason it was published that way was  
19 because 2 additional requirements were added, and that was the Restraints and Seclusion standards. And  
20 that was based on public interest and Congressional concerns. If you remember the *Hartford Current*  
21 articles that came out about all the deaths, had the Restraints and Seclusion. And that’s what prompted this.  
22 But the whole rule actually addressed notices of rights, patients exercising their rights, privacy and safety  
23 and confidentiality. We received over 400 comments on the 2 new additions, standards E and standards F,  
24 and that’s what the Final Rule was based on.

25 In the IFC that was published in 1999, we had 2 separate standards. One, they were trying to  
26 articulate use of restraints and seclusion in a med-cert setting, and in a behavioral health setting. In, based  
27 on all of those comments, and with extensive, and I mean extensive collaboration with different HHS  
28 agencies, we combined standards E & F and increased the requirements for training and reporting. So

**PPAC Meeting Transcription – March 2007**

1 there's no longer separate sections for acute med surge and behavior health, and there, but there are still  
2 specific requirements in there that identifies when you are providing or doing restrains or seclusion for  
3 behavioral management purposes. But I believe, we all believe, the department believes that it's much more  
4 clear now and believe it or not, we've actually had many many more calls and questions related to the 4  
5 carve-out pieces that I just discussed than we have to this restraint rule, which kind of surprised us.

6 Dr. William: Jeannie, can I ask you a question? So with the acute restraint order and the med surge  
7 now being equal to the behavior management. If I have an unconscious patient in the operating room,  
8 who's arms I'm restraining on an arm board, so that the patient's arms don't accidentally fall off the bed  
9 while they're unconscious, do I actually, since I'm the actually the physician doing the restraining, do I  
10 actually have to write an order in the chart saying that I'm doing that?

11 Ms. Miller: No, it's not, that's what's much more clear in this rule. If it's medically related, to  
12 provide medical care and medical services, then no it's not considered a restraint.

13 Dr. Williams: Got it, thank you.

14 Ms. Miller: I want to go through some of the general requirements that really have changed since  
15 the original '97 proposed and the '99 version just to make sure everyone understands. They have a right to  
16 be free from unnecessary restraints, not used for convenience or discipline or retaliation; that patients  
17 always need to be treated with respect and dignity, you're only to use them to ensure immediate physical  
18 safety of the patient, and to the staff and others and it's to be discontinued at the earliest possible time,  
19 regardless of the order length.

20 We've had some questions about only used when least restrictive interventions have been  
21 determined ineffective. Of course we get the calls about there's not always time, particularly in the  
22 behavioral health setting, to determine what would be least restrictive, and we understand that. That's not  
23 always possible, emergency situations in particular. You have to do what you have to do. I was a psych  
24 nurse for 10 years, so I understand very much, and I had the adolescent psych unit that I managed, so I  
25 understand you didn't have an opportunity to try a lot of interventions at times. I want to stress at this point  
26 that documentation is the key issue for hospitals. We really have a lot of debate with the department that  
27 there was a belief among some people that there's absolutely no reason ever ever to use a restraint. And we  
28 didn't feel that way. There are times that that has to occur whether you like it or not, there are times. So we

1 can't stress how important it is that you document the rationale for any kind of restraints that you're using.  
2 Type or techniques must be the least restrictive possible. In accordance with written modifications to the  
3 patient's plan of care, one of my favorite examples is a lot of times people have protocols for an intubated  
4 patient and they'll use wrist restraints. The protocols are OK, but because restraints are restraints, and  
5 people are vulnerable, there still have to be an order for that restraint. But you can put in the patient's plan  
6 of care that you're doing that, that you're using the restraints at that time because the patient's not safe to  
7 himself, he could try to extubate himself. So there are reasons that you would put it in the plan of care.  
8 Never complete the PRN or as needed.

9 Another question that we've had, implemented in accordance with safe and appropriate techniques  
10 as per hospital policy and accordance with state law. There are some states that actually have very specific  
11 laws governing restraint use. And we do expect the hospitals, if any law that is more stringent than ours,  
12 then you're automatically going to meet ours. So if state law's more stringent, we would expect you to be  
13 meeting your state laws. And I wanted to throw in here, we've had a lot of questions on the seclusion use  
14 regulation where it says "secluded alone and prohibited from leaving a room or an area." We've had a lot  
15 of focus on the "alone" because we added that language, that one word, so people thought we now were  
16 focusing on the alone. If someone is secluded, the majority of the time, they are going to be alone. Our  
17 focus at CMS is still that they are prohibited from leaving their area. Whether it's a staff person standing in  
18 the doorway for a job or the door's locked, so the alone is not the issue for us.

19 Orders for seclusion and restraint. We now are saying that they can be written by a licensed  
20 independent practitioner, anyone that in accordance with state law and hospital policy has the right to write  
21 orders. In some states, that's a nurse practitioner, advanced practice nurse has that authority. It is based on  
22 state law, and hospitals are free to say we may have that state law, but we choose not to honor it in this  
23 facility. So that's why we say hospital policy and state law. Again, it can never be written as a standing  
24 order or on PRN basis. And if someone other than the attending physician has the reason to order restraints  
25 and seclusion for a particular patient, then it's an expectation that that attending physician will be notified  
26 immediately. And again, it's to be discontinued at the earliest possible time regardless of the length of the  
27 order. The doctor may say a chest restraint for 2 hours or wrist restraints, 4 points, depending on the  
28 scenario. If you can remove them in 30 minutes, remove them, even if it says on for 2 hours.

**PPAC Meeting Transcription – March 2007**

1 For the management of violent or self-destructive behavior that jeopardizes the immediate  
2 physical safety of the patient, staff member or others, patient has to have a face to face evaluation by  
3 someone within an hour of that intervention being implemented. We have increased the number of people  
4 that are able to do that. Now it can be done by a trained nurse, physician's assistant, prior to this rule it had  
5 to be a physician that had to see and evaluate the patient within one hour of the implementation of this rule.  
6 And we never stopped hearing complaints about that requirement, since 1999. That physicians thought that  
7 was too burdensome. CMS's understanding is that if someone needs to be restrained or secluded, it's  
8 actually an emergency situation, particularly in a behavioral health situation. That was their approach. After  
9 24 hours before a new order can be written, a physician or licensed independent practitioner must see and  
10 assess the patient. Again the face to face evaluation can now be conducted by a physician or other licensed  
11 independent practitioner or trained RN or PA. The evaluations expected to look at the immediate situation,  
12 the patient's reaction, the medical or behavioral condition that may have precipitated that, the need to  
13 continue or terminate the use of restraints or seclusion. And again, I want to stress that even if you have an  
14 emergency situation, you put somebody in restraints, and in 30 minutes, they're calmed down, the  
15 intervention was effective and you can release the patient, the physician hasn't come in yet, they still need  
16 to come. There was an emergency situation that precipitated the event, and so the patient needs to be seen.  
17 That's CMS's approach. And again, if it's, the evaluation is conducted by an RN or a PA, they must consult  
18 with the attending physician or the other LIP that is responsible. As soon as possible after completion of the  
19 one-hour face to face evaluation. So whoever's covering if the attending is not available, needs to be talked  
20 to and informed that this situation has occurred. And the purpose is for coordination, collaboration,  
21 guidance, everyone's on the same page. Simultaneous use of restraint and seclusion is only permitted if the  
22 patient is continually monitored, and that means face to face by an assigned staff person, or by both video  
23 and audio equipment in close proximity. And the very vulnerable patient population, patients when they are  
24 restrained, period, and when they're restrained and secluded also, they're a danger to themselves. Scenario,  
25 and I will just share one little story of when I was working with adult psych unit. A patient was in 4 point  
26 restraints and someone forgot to lock the door in her room, and she was raped on the spot. And that's pretty  
27 scary, and I've thought about that, that was 15, 20 years ago for me. I've never forgotten that patient, or

1 anything about it. It's a very, very vulnerable population. And you have to be very careful with them and  
2 they have to be watched closely.

3 Documentation. Document, document, document, the nurses will think the hospital's crazy. There  
4 need to be policies and procedures governing exactly how you want restraint and seclusion situations  
5 handled in the med surge situations and in the psychiatric behavioral management. The description of the  
6 patient's behavior and interventions, alternatives or other interventions that you attempted that didn't work.  
7 The patient's conditions or symptoms. Most of it is automatically going to be charted anyway or  
8 documented anyway. And your note about the incident. It's important that all the different avenues are  
9 covered, particularly in a med surge situation where you're not using it, you're not putting on a restraint  
10 because it's a behavioral health issue or it's a safety measure for medical purposes and there is a fine line,  
11 so I would encourage everyone to read the preamble to the Patient Rights Regulation, because we discuss a  
12 lot of different scenarios and answers a lot of questions in the comments and response section that helps to  
13 clarify what we're talking about. The one hour face to face, the medical behavior evaluation. There needs  
14 to be documentation by that physician or other licensed independent practitioner that comes in and see the  
15 patient that they were there and that needs timed. Because they're going to look, did that doctor show up 4  
16 hours later or did he show up in an hour? And again it's prudent practice or standard practice for the  
17 documentation but a lot of times people will be in a hurry and they'll forget and then it's the hospitals need  
18 to be able to show that they are following these requirements the best they can.

19 Some of the policies that we would expect the hospitals to have, what are the restrain and  
20 seclusion techniques? And are they in accordance with your state law? Who's authorized to order restraints  
21 and seclusion? The renewal times, the intervals for monitoring a patient's condition when they're in  
22 restraint, how is the face to face visit evaluation going to be documented? The training requirements? For  
23 the staff, before they can participate in apply restraints or implementing seclusion, we're not expecting  
24 them to be trained and to demonstrate competency. We've identified in the regulation a number of different  
25 areas but the hospital's always free to go beyond that, so implementation of seclusion, monitoring  
26 assessment, providing care, the application of restraints, different types of restraints. We are expecting  
27 training for restraint and seclusion use in the facility as part of the orientation process and then periodically  
28 on a periodic basis consistent with hospital policy. And the hospital can define how often they want to do

1 that. And we do expect to see documentation on the staff that's been trained and that they've demonstrated  
2 competency. The training requirements, one of the things we've gotten a lot of questions about is does  
3 everyone in the hospital have to be trained? And if you have a psychiatric facility, does that mean, or  
4 psychiatric unit within your hospital, does that mean that everyone in the hospital has to be trained on all  
5 the restraints you might use in a psychiatric setting? And the answer to that is no. It says "appropriate staff  
6 based on your patient population needs." And that is for psychiatric staff, and anybody in the med surge  
7 setting that would come over and help, or if it's in ICU, the ones you would use in ICU or in a med surge  
8 setting, the ones that are appropriate for the med surge setting. So it relieves a little bit of the burden.  
9 People were thinking it is a little bit more extensive than it is. It's based on the population. OK? And again,  
10 we listed some of the things they definitely have to be trained in. Use of nonphysical interventions, choice  
11 of least restrictive interventions, there's a requirement for use of first aid and CPR certification. The last  
12 time I was in the hospital setting, all the clinical staff had to be CPR trained, that's nothing new. The first  
13 aid, that will be clarified more in the Interpretive Guidelines, actually, as to what we mean there. And the  
14 hospital always has the opportunity to go beyond what the requirements are.

15 And continue to just talk about more of the training requirements. The person providing the  
16 training. We've had a lot of calls about are there any particular programs that we endorse, and no, CMS  
17 doesn't endorse particular programs. But hospital staff themselves can be qualified to provide this type of  
18 training to develop a training program and actually be able to provide CEUs for attendants, given their  
19 qualifications they go through an association or an organization. But the hospital, it's up to them to either  
20 set up their own program, hire someone to come in, have people go to training and become trainers and  
21 come back. There's a lot of different opportunities for hospitals to give this training for their staff.

22 And the last requirement is the death reporting. The original 1990 rule, '99 rule, only required  
23 death reporting if it was behavioral health related. This regulation requires any restraint death that occurs  
24 while the patient is in seclusion or restraints, or within 24 hours of being removed, or within one week after  
25 seclusion or restraint if it's reasonable to think that that contributed to the patient's death on any patient, in  
26 any setting in the hospital. It's not restricted to just behavioral health. And a lot of questions on who to  
27 report to. It's to be reported by telephone no later than close of business the next business day, and the next  
28 business day means the next CMS business day, a lot of questions on that. And to whom, we will put



**PPAC Meeting Transcription – March 2007**

1 guidance out, but it's to the Regional Office. Some hospitals could report to the state agencies who would  
2 go to the Regional Office, but directions will come out that you need to call your Regional Office.

3         The surveyors in the state agencies use interpretive guidelines to go in and determine whether or  
4 not hospitals are in compliance with the requirements and the guidelines simply tell them what to look at,  
5 the kinds of things to look for, the questions to ask when they're determining compliance with a particular  
6 regulation. The interpretive guidelines for both of these revisions is in development right now and it would  
7 be wonderful if they'll be out within the year, by the end of this year. I can't guarantee that but they are in  
8 the works in development right now and I wanted to let you all know that we work continually with the  
9 Joint Commission and we have been in a number of conference calls with them and so forth to ensure the  
10 coordination of their standards with our requirements. The statute requires, although Joint Commission is in  
11 the statute as having deemed authority for hospitals, they also have to meet or exceed our requirements. So  
12 we work very closely. You cannot do a side by side comparison of the CMS requirements in the Joint  
13 Commission standards, but you should be able to find all of the Medicare requirements within the Joint  
14 Commission standards somewhere. And the last slide is the resources, although I was told someone tried  
15 them and I'm glad you don't have these to click on actually. Just need to go to the Access GPO website and  
16 you can find these documents. But don't, I'm understanding that the links didn't work when downloaded  
17 on there, or the *Federal Register* site and you can find these documents by date that they were published  
18 and they are under CMS and they under Hospital Conditions of Participation. So you go in *Federal*  
19 *Register* November 26, 2006 and look for CMS Conditions of Participation and you'll find the carve-out  
20 rule.

21         Dr. Senagore: OK. Thank you. Any comments or questions? I had one issue that was brought to  
22 my attention that wasn't part of your presentation, but was referring to the fact that several fiscal  
23 intermediaries had made a determination that recording of the review of systems rather than the current rule  
24 that says you can comment on two that are positive if the remainder are negative, you can say, all the  
25 remainder are negative. You have to put all of the negatives in documentation form. So I don't know if  
26 that's come to your attention, but that would seem to be somewhat more onerous than the current  
27 regulation.

**PPAC Meeting Transcription – March 2007**

1 Ms. Miller: Well, it is because CMS does not dictate medical practice, and to us that would be  
2 considered medical practice. How you decide to go through your history and physical, be it by systems or  
3 whatever. Plus the way hospitals choose to have that documented in their medical records is governed by  
4 hospital policy and their medical staff and governing body. So we in this Conditions of Participation do not  
5 specify how the H&P is to be completed.

6 Dr. Senagore: Why don't we have Dr. Charles come up and give some testimony on this issue, and  
7 if you don't mind staying there for just a minute, we can pick your brain as well after the testimony. Dr.  
8 Koopman is from the Academy of Otolaryngology, Head and Neck Surgery, to comment on this issue, I  
9 believe. Dr. Koopman?

10 Public Testimony

11 Dr. Koopman: Yes, thank you, Mr. Chairman and Council members. The Academy of  
12 Otolaryngology Head & Neck Surgery would like to extend their gratitude for this opportunity to comment  
13 on what we understand is a CMS ruling, that for an E&M service to be a candidate for a level 4 of 5  
14 evaluation, the review of systems must include specific documentation supporting negative findings, in  
15 addition to positive findings. Prior to this ruling, the provider could enumerate the positive findings and  
16 then state that the remainder of the review of systems was negative. It is our understanding that now this  
17 will no longer be accepted, especially for the level 4 and 5 visits. If we are correct, then the American  
18 Academy of Otolaryngology Head & Neck Surgery, object to the ruling for the following reasons.

- 19 1. This requirement to enumerate negative responses in the review of systems does not yield any  
20 documented added value for the patient. No evidence has been presented to show that  
21 documentation of individual review of system negatives provides any direct benefit to the  
22 patient, nor does it lead to any improvement in either the quality of care or patient outcomes.  
23 In fact in a busy practice, this could lead to less time being available to spend, discussing  
24 clinically important material or to counsel the patient more completely.
- 25 2. Secondly, in his March 1, 2007 presentation to the subcommittee on health committee on  
26 Ways & Means at the US House of Representatives, Dr. Glen Hackbarth, from MedPAC,  
27 emphasized that CMS should "encourage providers to reduce the quantity of inputs required  
28 to produce a unit of service," and also that Medicare should expect that healthcare providers

**PPAC Meeting Transcription – March 2007**

1 meet the competitive market demands by continual improvement in productivity. This  
2 unnecessary enumeration of negative review of systems will reduce productivity over time.

3 3. Thirdly, this requirement unnecessarily increases overhead costs, again countered to Dr.  
4 Hackbarth's recommendation to decrease inputs for given services.

5 4. Fourthly, any suggestion by CMS that the providers are not covering the review of systems  
6 completely, yet are acting as though they are, should require accurate documentation. This  
7 documentation requirement suggests that CMS believes the providers are trying to dry lab the  
8 data. We believe that failure to ask the question should not be assumed or implied. If the  
9 agency is concerned, then they should utilize either retrospective audits, or prospective trials,  
10 if they truly believe the providers are not doing the appropriate review of systems.

11  
12 In summary, the American Academy of Otolaryngology Head & Neck Surgery supports measures that  
13 would improve the quality or value of its members care for their patients. We do not believe that  
14 enumeration of negative review of systems adds value or improves quality. We would ask that PPAC  
15 formerly recommend that CMS state that provider are eligible for any level of payment when they  
16 document positive review of systems findings and summarize negative review of systems by stating that the  
17 remainder of the review of systems is negative, assuming all other areas of documentation are in  
18 accordance with accepted coding standards. Thank you very much.

19 Dr. Senagore: Thank you, Dr. Koopman. Sort of blindsided here with this discussion, so I'm not  
20 sure you're prepared to answer at this time, but...

21 Ms. Miller: I will do the best I can. I listened to testimony. The Conditions of Participation  
22 requirement for history and physical presents the expectation that a complete history and physical is going  
23 to be conducted. How that is documented to prove that that's occurred is not specific in the Conditions of  
24 Participation. So if you look at a history and physical, you're going to expect to see something related to  
25 systems, but the conditions do not dictate how that documentation is [put?]. The expectation is it's a  
26 complete physical.

27 Dr. Senagore: I'm sure we'll make some recommendations that may give clarification and allow  
28 you to respond after a little more considered thought, but I think there's a two-step issue here, is one, under

**PPAC Meeting Transcription – March 2007**

1 current CMS regulations does a fiscal intermediary have the authority to independently alter documentation  
2 rules for E&M or procedures? That's I think, one issue, because this is mandated by four FIs, as I  
3 understand it. And then the second corollary to that is, is there truly any advantage to documenting  
4 negatives that by definition don't have a role in the patient's overall outcome. So I guess we'll probably  
5 have those 2 recommendations to consider.

6 Ms. Miller: And the first comment that came to mind was I wouldn't consider them altering the  
7 requirements so much as clarifying it for their intent. Because we require a history and physical.

8 Dr. Senagore: Right, but you, but concurrent federal guidelines to say that the pertinent positives  
9 and then all remaining are negative's adequate documentation. They're asking for a higher level of  
10 documentation than currently exists generally with CMS guidelines.

11 Dr. Simon: I would only state that carriers do have the authority to provide local carrier discretion  
12 pertaining to the guidelines of the Medicare program. It is not uncommon for the agency to provide broad  
13 guidelines that must be met by participants in the program and the carriers may at their discretion choose to  
14 clarify or further elaborate the extent to which those guidelines must be met.

15 Dr. Senagore: OK, well thank you.

16 Ms. Miller: OK. I hope it was helpful. I enjoyed speaking with you all.

17 Dr. Senagore: Why don't we go ahead and take the last bit of testimony and I will allow the  
18 retiring members to say their peace while we're all thinking of our recommendations. So with that, I would  
19 invite, Dr. Permut from the AMA to give the AMA's perspective on several key issues.

20 **Public Testimony**

21 Dr. Permut: Good afternoon, Mr. Chair and members of the Council, my name is Steve Permut.  
22 And I'm a practicing family physician in Philadelphia, and chair of the AMA's Council on Legislation. The  
23 AMA appreciates that HR 6111, the Tax Relief and Health Care Act of 2006 prevented the 5% cut in  
24 Medicare physician payment rates scheduled for 2007. And that 5% cut would have been calculated due to  
25 the flawed SGR physician payment formula. In 2010, the leading edge of the baby boomer generation will  
26 start enrolling in Medicare, with enrollment growing from 43 million in 2010, to 49 million by 2015.  
27 Action to repeal the SGR this year is needed to preserve Medicare access for future generations. Yet,  
28 physician payments are expected to be cut by 10% in 2008, with almost 40% in total cuts scheduled over 8

**PPAC Meeting Transcription – March 2007**

1 years beginning in 2008. The AMA urges PPAC to recommend that CMS commit to working with  
2 Congress to repeal the SGR this year and replace it with a system that produces payment updates that  
3 accurately reflect increases in medical practices costs. Further, Congress allocated to the Secretary of HHS  
4 \$1.35 billion for physician services in 2008. We urge CMS to commit to using these funds to help repeal  
5 the SGR and avert the 2008 cut.

6 Now turning to the Medicare Physician Reporting Program established by HR 6111. We've heard  
7 from CMS today how this program will work. We emphasize that there are a number of questions still to be  
8 resolved prior to the July 1 implementation date. For example, physicians will receive a 1.5% bonus on  
9 certain claims submitted from July 1 to December 31, 2007. Yet this bonus is subject to a cap and questions  
10 remain about how this cap will be applied. The AMA appreciates CMS's responsiveness to working with  
11 the medical community to address questions about the reporting program. We will continue to work with  
12 CMS as we near the July 1 implementation date. Further, of the 74 measures that are now included in the  
13 Physician Quality Reporting Initiative, 60 were developed by the AMA Physician's Consortium for  
14 Performance Improvement. The Consortium which has already developed 155 measures will continue its  
15 extensive measure development efforts as well as its work with CMS on quality initiatives. In a related  
16 matter, the AMA has several concerns about the administration's health care quality and price transparency  
17 initiatives. The AMA has long supported transparency efforts, yet to be effective and fair, such initiatives  
18 must be developed correctly, and must apply to all sectors of the health care market, not just physicians.  
19 Thus we urge PPAC to recommend that when promoting transparency, CMS should insist that health plans  
20 also be more transparent about pricing information, physician fees, disclosure of insurance claims  
21 processing and payment policies and identification of intermediaries that offer health plans, unauthorized  
22 discounts, and reductions in physician's payments. Further, CMS should dissuade health plans from  
23 implementing policies or quality initiatives that focus on cost without regard to quality.

24 Next I'll turn to the National Provider Identifiers, or NPIs. As we near the May 23<sup>rd</sup>, 2007  
25 compliance deadline, it is urgent that CMS undertake several initiatives. First, CMS should issue  
26 requirements for disseminating NPI numbers and associated data. Second, CMS should collaborate with the  
27 AMA to explore methods for minimizing the administrative burden on accessing the NPI while ensuring  
28 appropriate security safeguards. Third, CMS should institute at least once a year, at least a one-year

**PPAC Meeting Transcription – March 2007**

1 contingency plan, under which Legacy numbers can be used on or after May 23<sup>rd</sup>, 2007, and fourth, CMS  
2 should conduct more NPI outreach activities to physicians. We urge PPAC to make these recommendations  
3 to CMS.

4 Finally I'd like to address the AMA's continuing concerns with the Recovery Audit Contractor, or  
5 RAC demonstration project. This program will apply to physicians nationwide, by January 1<sup>st</sup>, 2010. We  
6 urge PPAC to make the RAC recommendations detailed in our written testimony. An overview of these  
7 recommendations is as follows:

- 8 1. CMS should limit the number of times a physician can be audited under the RAC program;
- 9 2. CMS should require the RACs in consultation with the medical community to standardize  
10 communications to physicians and provide more information about who they are when  
11 contacting physicians;
- 12 3. CMS should provide physicians with information about the scope of the RAC audits and  
13 expand its outreach efforts to provide physicians with educational information about billing  
14 errors found by the RACs; and
- 15 4. CMS should continue the open dialog with the AMA about ongoing concerns as the RAC  
16 Program is expanded.

17  
18 We thank you for the opportunity to be here today. And I'm happy to answer any questions.

19 Dr. Senagore: Thank you, Dr. Permut. Any questions at all? Thank you very much. I guess I will  
20 around the table and give Dr. Johnson first crack if he has any parting wisdom for the Council, and then  
21 we'll go to Dr. Powers and then Dr. Urata.

22 Dr. Johnson: Having served on PPAC for 6 years, and prior to that 2 years with Medicare  
23 Governing Advisory Committee, Executive committee level, that's 8 years. I appreciate the opportunity of  
24 service, and it's been fun.

25 Dr. Senagore: Thank you for your service. Dr. Powers.

26 Dr. Powers: I had to prepare this and I have to read it. First of all I would like to than CMS for  
27 allowing me to be a part of this important process for the last 4 years. I truly believe that working from the  
28 inside is better than criticizing from the outside. I've come to understand that in general, the bureaucracy of

**PPAC Meeting Transcription – March 2007**

1 Medicare is dedicated to the health and well-being of its beneficiaries and in doing so also cares about the  
2 satisfaction of the providers. I've learned that many of the shortcomings of the system are due to  
3 legislation, although the agency is not without some leverage in Congress. I ask the remaining and new  
4 members of PPAC to continue to read and listen critically to help guide the agency wherever possible, and  
5 we need to work to be sure that this opportunity continues as it should in a government such as ours. I'm  
6 concerned about the future of healthcare in the United States. We need to eliminate the misalignment in  
7 payments that incentivizes procedures over basic care. The SGR has failed to control volume, but rather  
8 encourages increases in volume by reducing overall reimbursement. We need to be able to demonstrate the  
9 quality of care, but it isn't the only answer to the problems with the system. That said, quality reporting  
10 should not proceed to the extent that providers are spending so much time and money documenting  
11 compliance that we can no longer afford to keep our doors open or that incomes are reduced to the extent  
12 that few will enter the profession, because they will not be able to pay back the debt of education in a  
13 profession where we're faced with the constant threat of malpractice that other professions do not have.  
14 And in closing, I plan to continue to follow closely and try to help as best I can shape medical policy  
15 through my national organization and I thank CMS for being so [interruption] to us.

16 Dr. Senagore: Thank you, Dr. Powers.

17 Dr. Urata: I asked to come on to this Council, because I was disappointed in the direction  
18 Medicare was going. I was hoping to change the direction. But I discovered that it's hard to change the  
19 direction of something so big and huge. [laughter] It's like the Exxon Valdez, when they realized it was  
20 heading for the reef, they tried to change it, and they weren't able to change it in time. Well, same thing  
21 might happen with Medicare down the line. I hope it doesn't. I think that we are making changes that may  
22 help when we get up to Medicare age that it will be something of value in our lives, and I think the process  
23 that we're undergoing is a slow process, but it's a good process, and I think we'll come up with the correct  
24 answers. I want to thank staff that I've worked with through the years. I'm disappointed in seeing Tom  
25 retire, but after 30 years, I guess you deserve it [laughter] and you still seem—

26 Dr. Gustafson: I'm not apologizing. [laughter]

## PPAC Meeting Transcription – March 2007

1 Dr. Urata: You seem like you still have a lot of energy left, though, to continue the process. I want  
2 to thank Ken and Bill and David and Theresa for all the travel and stuff that was a lot of work to do, and  
3 best of luck to all of you as you continue in this work.

4 Dr. Senagore: Thank you very much. Well, let's go ahead and go through our list and see if we  
5 have recommendations. We'll just start from the beginning with the Quality Reporting Initiative. Anybody  
6 have recommendations out of that.

### 7 Recommendations

8 Dr. Ouzounian: I have a recommendation for the Quality Reporting Initiative. PPAC recommends  
9 that the fiscal intermediaries be required to transmit claims to the National Claims History within one  
10 business day of receipt. This would have the effect that any claim received by a fiscal intermediary by  
11 February 28, 2008, would be transmitted to the National Claims History File by the 29<sup>th</sup> for inclusion in the  
12 bonus.

13 Dr. Senagore: Is there a second?

14 Dr. Sprang: Second.

15 Dr. Senagore: Any comments, questions? Do we have it?

16 Ms. Trevas: PPAC recommends that fiscal intermediaries be required to transmit claims to the  
17 National Claims History file within one business day of receipt, so that any claim received by fiscal  
18 intermediary by February 28, 2008, would be transmitted to the National Claims History file by February  
19 29<sup>th</sup>, 2008 and therefore be eligible for the bonus. Yes?

20 Dr. Ouzounian: Yes.

21 Dr. Senagore: Anybody else? I have one otherwise. We'll call the question. All in favor?

22 [Ays]

23 Dr. Senagore: Anyone against? Vince have one?

24 Dr. Bufalino: I have one. PPAC recommends that CMS review the future models of the  
25 aggregation of parts A and parts B into a global system of care.

26 [seconds]

27 Dr. Senagore: Do we have it? All in favor?

28 [Ays]



**PPAC Meeting Transcription – March 2007**

1 Dr. Senagore: Anyone against? Motion carries. I have one. PPAC recommends that CMS consider  
2 the implications of simultaneous implementation of the new 1500 form in conjunction with reporting CPT  
3 2 level codes and more importantly the issues related to any potential edits related to those submissions to  
4 assure accurate and timely payment of medical services.

5 [seconds]

6 Dr. Senagore: Did I go slow enough?

7 Ms. Trevas: Yes.

8 Dr. Senagore: If you're good to go, we're OK. All in favor?

9 [Ays]

10 Dr. Senagore: Oh, do we have discussion? Is there discussion? No discussion. All in favor?

11 [Ays]

12 Dr. Senagore: OK, anyone against? Great. Any other issues related to this topic? Peter?

13 Dr. Grimm: PPAC recommends that CMS explain the source of bonus funds for 2008 and beyond  
14 at the next PPAC meeting.

15 Dr. Senagore: Second?

16 [Second]

17 Dr. Senagore: Any questions? All in favor?

18 [Ays]

19 Dr. Senagore: I've got one last one in this area. PPAC recommends that CMS define the  
20 methodology for data analysis related to performance measure submission under the new Voluntary  
21 Reporting Program, Pay for Performance, yeah. I'll take that friendly amendment. Second?

22 [second]

23 Dr. Senagore: Any comments, questions? All in favor?

24 [Ays]

25 Dr. Senagore: Anyone against? OK if we go down to the NPI, discussion?

26 Dr. Grimm: PPAC recommends that CMS provide assurance to providers that private information  
27 will be secure and restrict access to NPIs only to physicians and other entities with a legitimate need for  
28 health care administrative needs.

**PPAC Meeting Transcription – March 2007**

1 [second]

2 Dr. Senagore: Discussion?

3 Dr. Williams: Does that include the way he's worded it, the lack of sale of, is that wording  
4 restrictive enough?

5 Dr. Senagore: I think it can be implied, but we can strengthen it with—

6 Dr. Grimm: We can strengthen it with—

7 Dr. Williams: The lack of sale of information.

8 Dr. Senagore: Can you put it in somewhere, including—

9 Dr. Grimm: Assets or sale of NPIs.

10 Dr. Senagore: Just put in parenthesis including sale. With that friendly amendment, any further  
11 discussion? All in favor?

12 [Ays]

13 Dr. Senagore: Anyone against? Yes.

14 Dr. Sprang: PPAC recommends CMS publish the NPI data dissemination notice as soon as  
15 possible and allow for comments following publication.

16 [second]

17 Dr. Senagore: All in favor?

18 [ays]

19 Dr. Senagore: Any other issues related to NPI?

20 Dr. Sprang: One more. Just because we heard the numbers and some of the difficulties that only  
21 13% of doctors so far have used the NPI and obviously we don't know for sure how many doctors even  
22 have their NPI numbers, that PPAC urge CMS to establish a minimum one-year contingency plan for  
23 implementation of the NPI numbers. This is consistent with CMS's contingency plans for transition to the  
24 HIPAA transition and code sets. So it's just consistent with that.

25 Dr. Senagore: Support?

26 [second]

27 Dr. Senagore: Any comments?

**PPAC Meeting Transcription – March 2007**

1 Dr. Przyblski: I'm not sure that Contingency Plan is specific enough. I don't know what that  
2 necessarily means. Are we better off just saying allow for the Legacy numbers to still be used through the  
3 end of the year?

4 Dr. Senagore: I can phrase it that way, I'm not sure that anyone has that authority, but we can ask  
5 that question.

6 Dr. Sprang: I think it's covered, just more specific.

7 Dr. Senagore: OK, I think they understand what we're asking, so, call the question. All in favor?

8 [ays]

9 Dr. Senagore: Anyone against. Thank you. Any other NPI issues? OK. Transparency Initiative?  
10 Any issues related to that?

11 Dr. O'Shea: PPAC recommends that CMS promote the same level of transparency from health  
12 plans as CMS is promoting with regard to physicians and other providers. PPAC specifically asks that  
13 health plans become more transparent about pricing information, physician fees, disclosure of insurance  
14 claims, processing, and payment practices, and identification of intermediaries that offer health plans,  
15 unauthorized discounts, and reductions in physician payments.

16 Dr. Senagore: I'd like to add one more comment in there when she catches up. Then I would just  
17 add somewhere in the midst of those descriptions, if you can add, comma, re underwriting. Second for that?

18 [second]

19 Dr. Sprang: Could she read it again?

20 Dr. O'Shea: PPAC recommends that CMS promote the same level of transparency from health  
21 plans as CMS is promoting with regard to physicians and other providers. PPAC specifically asks that  
22 health plans become more transparent about pricing information, physician fees, disclosure of insurance  
23 claims processing, and payment practices, and identification of intermediaries that offer health plans,  
24 unauthorized discounts, and reductions in physician payments.

25 Dr. Senagore: And we put re underwriting in there somewhere. Any other discussion on this? All  
26 in favor?

27 [ays]

28 Dr. Senagore: Anyone against? Is there another one related to transparency?

**PPAC Meeting Transcription – March 2007**

1 Dr. Sprang: It's pretty consistent with what Gerry just said, but I'm just going to be say, to be  
2 effective and fair, transparency must apply equally to all sectors of the health care market.

3 Dr. Senagore: Support? Yes, PPAC recommends—any comments, other discussion? All in favor?  
4 [ays]

5 Dr. Senagore: Anyone against? OK.

6 Dr. O'Shea: PPAC recommends that CMS dissuade health plans from implementing policies or  
7 quality initiatives that focus on cost without regard to quality.

8 Dr. Senagore: Support?

9 [Second]

10 Dr. Senagore: Any discussion? All in favor?

11 [Ays]

12 Dr. Senagore: All against? Passes. Any other issues here in transparency. The RAC audits?  
13 Anyone have any recommendations?

14 Dr. Ouzounian: PPAC recommends that due to the demonstrated insignificant recovery from  
15 physicians that the RAC audits of physician practices be discontinued.

16 [second]

17 Dr. Senagore: Any discussion? All in favor?

18 [Ays]

19 Dr. Senagore: Anyone against?

20 Dr. Ouzounian: PPAC recommends that if a RAC audit is contested and if the provider prevails at  
21 the appeal, that the RAC reimburse the provider 25% of the requested recovery amount to offset the  
22 appeals cost.

23 [second]

24 Dr. Senagore: All in favor? That'll take a statute. All in favor?

25 [ays]

26 Dr. Przyblski: I would just comment why not make it the whole cost, the provider had to spend?  
27 Why should it be an arbitrary—

28 Dr. Ouzounian: How does the provider come up with the cost?

PPAC Meeting Transcription – March 2007

1 Dr. Sprang: Legal costs.

2 [chat]

3 Dr. O'Shea: That's more time to do that. By just doing 25% it cuts that process down.

4 Dr. Przyblski: I would include that time in the time it took.

5 Dr. Senagore: It's more than their contingency.

6 Dr. Przyblski: That's the point.

7 Dr. Senagore: All in favor?

8 [ays]

9 Dr. Senagore: Anyone against?

10 Dr. Ouzounian: Did somebody amend the 25? What's their contingency fee?

11 Dr. Senagore: I thought it was 15 was their contingency. [off mike discussions] And usually we  
12 don't have anything related to the PRIT Update, but if there are any things related to—oop, we do.

13 Dr. Urata: PPAC recommends that CMS hold a briefing in the next 10 days on the GME volunteer  
14 preceptor issue and that the formula described in the proposed rule that appeared in the *Federal Register*  
15 February 1<sup>st</sup>. The purpose of which is to have the stakeholders be able to question and understand this rule,  
16 because the rule just came out, they only have, and it's apparently not clear to all the stakeholders what's  
17 involved in this complicated formula and this would give some of the stakeholders that are trying to get  
18 together to discuss this with CMS and ask questions before making their final comments. The last half was  
19 discussion, but [repeating] the PPAC recommends that CMS hold a briefing in the next 10 days on the  
20 GME volunteer preceptor issue and the formula described in the proposed rule that appeared in the *Federal*  
21 *Register* February 1<sup>st</sup>.

22 Dr. Senagore: Can I add an additional sentence?

23 Dr. Urata: Sure.

24 Dr. Senagore: In addition, transmit that information to the ACGME and all residency review  
25 committees. With that amendment, any further discussion? All in favor?

26 [Ays]

27 Dr. Senagore: Anyone against? Any other issues related to the PRIT? Hospital conditions? We're  
28 working our way through them and if there's anything doesn't fit in, we'll grab them. The Hospital

**PPAC Meeting Transcription – March 2007**

1 Conditions of Participation? I have one. PPAC recommends that CMS evaluate the implications of  
2 additional documentation requirements proposed by local carriers which supersede base recommendations  
3 by CMS. In particular reference should be made to the recent determination regarding documentation of  
4 negative information as part of the review of systems. Any discussions?

5 Dr. Ouzounian: Tony why can't we be a little more direct with our request that they just put it  
6 back the way it used to be?

7 Dr. Senagore: Well, I'm not sure that I understand what the implication, what control they have  
8 over the local carriers, that would be the flavor of the discussion, so.

9 Dr. Ouzounian: The way I understood Ken's comment, was that CMS has changed the  
10 requirement.

11 Dr. Senagore: Well, no, the local carriers did, that's the problem.

12 Dr. Ouzounian: The local carriers changed it? Local carriers changed it.

13 Dr. Gustafson: Carriers typically have discretion over details of documentation requirements, and I  
14 think the controversy here arises in so far as we have as a matter of central policy said you can do thus and  
15 such, do you wish to see that limited to that or to continue to allow carriers to have discretion to build  
16 additional requirements over and above that. That appears to be where the area of controversy is.

17 Dr. Senagore: Right, and then particular attention to this one issue. Any other discussion? All in  
18 favor?

19 [Ays]

20 Dr. Senagore: Anyone against? Anything on the Hospital Conditions of Participation? No? And  
21 Open forum? Dr. Ross?

22 Dr. Ross: Mr. Chair, PPAC recommends to CMS that there be a review of those individual  
23 practitioners who have either left individual private practice as Medicare Medicaid providers, and are now  
24 practicing in group practices or multi-discipline practices and demonstrate if there is a correlation with  
25 decreased providership, as Medicare Medicaid beneficiaries. To Medicare Medicaid beneficiaries.

26 Dr. Senagore: Support?

27 [Second]

28 Dr. Senagore: Any discussion? All in favor?

**PPAC Meeting Transcription – March 2007**

1 [Ays]

2 Dr. Simon: I guess just one comment. I think it will be challenging for the agency to determine  
3 those physicians that choose to join groups of their own physicians for a variety of other reasons that are  
4 not related to the discussions held today, versus those that have joined forces with other groups or created  
5 groups as a result of some of the initiatives that are going forward. So it would be a suggestion to the  
6 Council to we may seek assistance in terms of how that information can be retrievable, because I don't  
7 think that we typically store that kind of information.

8 Dr. Ross: I'd like to amend it possibly and also find out how many of each, how many have left as  
9 providers.

10 Dr. Senagore: Left as providers—I guess I'm—

11 Dr. Bufalino: I was going to go there—I was just going to ask that PPAC recommend that CMS  
12 provide bi-annual updates of Medicare beneficiaries X as to physician care in America and I think it's  
13 surrounding the, not that this needs to be in there, but articulated the issues that Ken talked about this  
14 morning, that we need to hear those on a regular basis.

15 Dr. Senagore: Can I get a second for that.

16 [second]

17 Dr. Senagore: The possibility would be that we could retract Dr. Ross's and supplement or send  
18 both up. Does the committee have a preference one way or the other.

19 Dr. O'Shea: I think I heard the motion say that we wanted bi-annual, every two years?

20 Dr. Bufalino: I'm sorry, every 6 months.

21 Dr. O'Shea: Every six months.

22 Dr. Senagore: Semi-annually.

23 Dr. Bufalino: Semi-annually.

24 Dr. Senagore: So do we think these are complimentary or should both go up or I'll leave it to the  
25 Council's decision.

26 Dr. Urata: I'd recommend we go with Vince's because that encompasses everything, and that's  
27 actually the real question that we need to get to.

28 Dr. Senagore: All in favor of the current proposal?

**PPAC Meeting Transcription – March 2007**

1 Dr. Urata: Well, we have two proposals on the table. Can you withdraw?

2 Dr. Ross: Yes.

3 Dr. Urata: Now we have one.

4 Dr. Senagore: And so all in favor?

5 [Ays]

6 Dr. Senagore: Any other items? Yes, Dr. Sprang.

7 Dr. Sprang: PPAC appreciates the fact that legislation was passed to avert the 5% cut to the 2007

8 Medicare conversion factor, however PPAC is deeply concerned about the future drastic pay bit rate cuts

9 totaling about 40% over 8 years. To avert those steep cuts of almost 40% and to avoid the looming crisis in

10 health care access for our seniors, PPAC recommends that the Secretary of the Department of HHS and

11 CMS leadership work with Congress to repeal the Sustainable Growth Methodology, the SGR, this year

12 and to replace it with a system that adequately keeps pace with the medical practice cost increases.

13 Dr. Senagore: Second

14 Dr. Sprang: Can I add to, make it part of to? If repeal of the SGR is not possible this year, PPAC

15 recommends that CMS use its statutory authority to remove Medicare covered drugs from the SGR

16 calculation.

17 [Second]

18 Dr. Senagore: Discussion? All in favor.

19 [Ays]

20 Dr. Senagore: Any other issues? Dr. Gustafson, as your last official duty do you have any wrap up

21 comments for the Council?

22 Dr. Gustafson: Thank you all for coming. [laughter]

23 Dr. Senagore: Thank you very much. Next meetings in May, do we have a location?

24 Dr. Simon: May 21<sup>st</sup>—let me just check to make sure.

25 Adjourn