

REPORT NUMBER FIFTY-FIVE

to the

Secretary

U.S. Department of Health and Human Services

(Re: Pay-for-Performance Initiatives, Part D Drug Program, Medicare Contractor Reform, Medicare Contractor Provider Satisfaction Survey, Multiple Procedure Reduction for Imaging Services, Recovery Audit Contracts, Medicare Health Support, and other matters)

From the

Practicing Physicians Advisory Council

(PPAC)

Hubert H. Humphrey Building

Washington, DC

March 6, 2006

SUMMARY OF THE MARCH 6, 2006, MEETING

Agenda Item A — Introduction

The Practicing Physicians Advisory Council (PPAC) met at the Department of Health and Human Services' Hubert H. Humphrey Building in Washington, D.C., on Monday, March 6, 2006 (see Appendix A). The chair, Ronald Castellanos, M.D., announced that this meeting marked the final term for him, Rebecca Gaughan, M.D., Christopher Leggett, M.D., and Barbara McAneny, M.D. He thanked Bernice Harper, M.S.W., M.Sc.P.H., L.L.D., who recently retired from CMS, for her excellent work in support of PPAC. Dr. Castellanos emphasized that the Council's input influences CMS regulations and guidance that affect the physician community.

Agenda Item B — Welcome

Herb Kuhn, Director of the Center for Medicare Management, welcomed the members and echoed Dr. Castellanos' praise of Dr. Harper. Mr. Kuhn said PPAC has been "enormously helpful" to CMS and added that the agency and other stakeholders benefit from PPAC's input. Four future members of PPAC joined the Council for this meeting as observers; they will be sworn in at the May 2006 PPAC meeting (page 11 of this report).

55-B-1: PPAC recognizes and sincerely appreciates the work of Mr. Kuhn and CMS staff for their efforts in implementing provisions to the Deficit Reduction Act in a timely and efficient manner.

OLD BUSINESS

Agenda Item C — Update

Ken Simon, M.D., M.B.A., Executive Director of PPAC, presented the responses from CMS to PPAC recommendations made at the December 5, 2005, meeting (Report Number 54).

54-C-1: PPAC recommends that CMS work with the National Institutes of Health (NIH) and other entities that do clinical trials to determine fair reimbursement rates for data collection, whether or not information technology is involved.

CMS Response: The administrative costs of a clinical trial includes the costs of data collection, which is derived from the clinical trials budget. The budget is determined by the NIH and the clinical trial centers that are participating in the trial. CMS does not have the statutory authority to provide separate reimbursement for the collection of data at this time irrespective of whether information technology is involved or not.

54-C-2: PPAC recommends that CMS and the Secretary of the Department of Health and Human Services actively support an increase in the Physician Fee Schedule conversion factor for 2006.

CMS Response: CMS worked with Congress to secure passage of the Deficit Reduction Act, which froze physician payments at the 2005 rates. CMS has worked to implement a process that isn't burdensome for physicians.

54-C-3: PPAC recommends that CMS encourage the Office of the Inspector General to continue counting patient assistance programs as part of patients' true out-of-pocket expenses.

CMS Response: Pharmaceutical company patient assistance programs can provide coverage for particular drugs that are included in the Medicare drug benefit. This assistance would remain independent of the Medicare drug coverage, as it was before 2006. Any assistance a pharmaceutical patient assistance program provides to a Part D enrollee for prescription drugs that would have been covered under his or her Part D plan would not count as an incurred cost that would be applied toward the enrollee's true-out-of-pocket costs balance or total drug expenditures.

54-C-4: PPAC recommends that CMS require Part D carriers to have a simplified, uniform form for appeals on behalf of beneficiaries who need drugs that are not on the approved formulary.

CMS Response: CMS is working to minimize the impact of Part D on practices in three ways: 1) We are developing a website which will aggregate all of the forms in one place simplifying the office staff task of finding and printing the form. 2) We are working with the American Medical Association (AMA) Workgroup on Part D to develop a standard form which can be used by plans in situations where they do not need detailed drug-specific information to process the exception request. 3) We are working to reduce the number of prior approvals required by the private prescription drug plans (PDPs) to an absolute minimum; for instance, we are asking the PDPs to drop the prior approval requirement for drugs that are also sometimes covered by Part B as long as the practitioner writes a Part D diagnosis and the words "Part D" on the prescription.

54-D-1 PPAC recommends that the CMS Administrator, Dr. Mark McClellan, provide a prompt and positive answer as to whether continuing medical education can be funded or provided by local hospitals for the medical community.

CMS Response: The agency is actively considering this issue but has yet to reach a final determination.

54-D-2: PPAC recommends that CMS allow electronic resubmission of claims denied as a result of minor mistakes. PPAC requests that representatives of the Physicians Regulatory Issues Team (PRIT) evaluate the issue and present their findings at the next PPAC meeting.

CMS Response: Medicare contractors have implemented the technical parts of this requirement (the computer code to do the denials) at all managed care support contractors but to date, have not activated these edits at any contractor site. The Program Integrity Group is currently working with the Appeals Division to pilot test the requirement that contractors deny resubmitted medical review denials. As part of the test, CMS will assess how we can allow providers to resubmit denials electronically. Please note that all denials that result from this requirement are medical review denials; few medical review denials are the result of clerical errors. Further, CMS will identify which educational efforts contractors need to implement to have providers comply with the requirements of the change request. CMS will publish a *MedLearn Matters* article, which is currently under development. In order to carry out the testing of the requirement, CMS has requested a new remark code that will inform the provider that the carrier has paid for the service but, in the future, will not. Use of this code will allow CMS to assess the impact of the requirement and provide context-specific education. The approval of the code is imminent. CMS will use the new code at a contractor site until we have determined that the providers understand and are able to comply with the requirements of the off-label.

54-F-1: PPAC recognizes that the Physician Voluntary Reporting Program will require additional physician office staff, training on the use of G codes, reconfiguration of computer programs, and increased costs to physician practices. Therefore, PPAC recommends that any effort to implement quality measures and reporting must come after physician payment reform is enacted and current regulatory and administrative demands are reduced. Otherwise, efforts to improve care will be impeded.

PPAC recommends that instead of implementing the current Physician Voluntary Reporting Program demonstration project, CMS work with each physician specialty group to determine appropriate, scientifically valid quality measures, adjusting for illness, severity of condition, socioeconomic factors, patient compliance, and comanagement of patients. Further, as with the Hospital Voluntary Reporting Initiative, PPAC recommends that CMS reimburse physicians for data collection.

CMS Response: The Physician Voluntary Reporting Program is one that is entirely voluntary. This program was designed to help us better understand how to develop a program that incorporates pay for reporting.

CMS has been working in a collaborative fashion with the AMA on the development of category II AMA Current Procedural Terminology (CPT) codes as a vehicle for reporting clinical activities relating to pay for reporting. If Congress moves to pay for performance, we will continue to work with each physician specialty organization to help develop and determine the appropriate clinical outcome measures. We identified a core starter set of 16 measures that has

been released. The number of measures (in the starter set) that apply to any given physician is now smaller. While we have received recommendations for coding specifications and other measures, we have not received feedback that questions the underlying scientific basis for the measures themselves.

54-F-2: PPAC recommends that CMS request input from appropriate specialty organizations with an interest in the issues already included in the proposed pilot program. In addition, as with the Hospital Voluntary Reporting Initiative, PPAC recommends that CMS reimburse physicians for data collection.

CMS Response: See the response to F-1.

54-F-3: PPAC recommends that CMS work in conjunction with developers and certifiers of electronic medical records to develop software that facilitates the collection of data that CMS would like to gather for quality assessment purposes.

CMS Response: CMS supports the use of electronic medical records including as a means to facilitate quality measurement. The adoption of electronic health records is an administrative priority. Through the efforts led by the Office of the National Coordinator on Health Information Technology, it is anticipated that the certification of electronic medical records will be addressed. In addition, CMS is specifically engaged with the physician community and software developers on designing a process that will make this collection of data less burdensome. It is anticipated that later this summer, we should have more specific information to report.

54-H-1: PPAC recommends that CMS change the methodology for measuring practice expenses to one based on measurable data rather than assumptions.

CMS Response: CMS uses measurable data to the maximum extent possible. Unfortunately, it is not feasible to assign practice expense relative values to over 7,000 physician services without making reasonable assumptions. For example, indirect expenses account for nearly two-thirds of the total practice expense payments. There is no one generally accepted methodology to allocate indirect expenses.

54-H-2: Given that the Physician Fee Schedule Final Rule indicates that the statute gives the Secretary the authority to specify the services in the Sustainable Growth Rate (SGR) calculation, PPAC recommends that the Secretary use all means available to avoid future decreases in the conversion factor, including but not limited to removing drugs from the SGR calculation, adding new money to the system for good measurements of practice expenses, identifying both the immediate and subsequent costs that result from adding new screening benefits, and working with Congress to create a system in which money for services provided under Part B be shifted from Part A to Part B when appropriate.

CMS Response: We believe that fully addressing this situation will require legislative action by the Congress. We look forward to working with Congress as it explores a legislative resolution to these challenges. As a growing number of stakeholders now agree, we must increase our emphasis on payment based on improving quality and avoiding unnecessary costs to solve the problems with the current physician payment system. CMS has already taken a number of important first steps in developing the standards, information, and systems needed to move us toward a payment system that encourages quality, supports physicians in their efforts to provide the most effective care, and avoids unnecessary costs. These steps will prepare us to quickly and efficiently implement a fully modified payment system should Congress make that possible.

54-H-3: PPAC recommends that CMS actuaries explain to PPAC their methodology for evaluating costs of all new services resulting from the addition of new screening benefits, including colonoscopy, the “Welcome to Medicare” physical, etc.

CMS Response: We will invite staff from the Office of the Actuary to discuss these issues at a future PPAC meeting.

54-H-4: PPAC recommends that CMS share with PPAC the methodology used to determine the update given to Medicare Advantage Plans to account for new benefits.

CMS Response: See response to 54-H-3.

54-H-5: Because the Average Sales Price (ASP) methodology was not intended to cover the handling and storage of drugs, because the suggestion was made to add 2 percent to cover inventory costs to hospitals, and because no codes exist for inventory pharmacy services for physician practices, PPAC recommends that CMS reevaluate the adequacy of the ASP-plus-6-percent methodology for reimbursement.

CMS Response: Section 1847A of the Social Security Act requires use of the ASP-plus-6-percent payment methodology for drugs and biologics furnished incident to a physician’s service except in limited instances. The costs of handling drugs are paid through the Physician Fee Schedule practice expense relative value units (RVUs) for the drug administration code. Studies by the Government Accountability Office (GAO) (GAO-05-142R), the Office of the Inspector General (OIG) (*Adequacy of Medicare Part B Drug Reimbursement to Physician Practices for the Treatment of Cancer Patients* [A-06-05-00024]), and the Medicare Payment Advisory Commission (MedPAC) (October 6, 2005, public meeting report on oncology site visits) found that physicians generally can obtain oncology drugs for prices below Medicare reimbursement. In addition, the OIG’s

studies of widely available market prices for Part B drugs will provide another opportunity to assess the adequacy of the ASP-plus-6-percent payment methodology. We will continue to monitor our claims data and other data on acquisition costs for hospitals and evaluate the adequacy of the payment level established in the 2006 Final Rule.

54-H-6: PPAC recommends that all physicians who have primary responsibility for treating a particular type of cancer be included in the Oncology Demonstration Project.

CMS Response: The oncology demonstration for 2006 applies only to the specialties for hematology or oncology. The demonstration is similar to last year's demonstration in terms of the specialists who were included, that is, oncologists and hematologists providing office-based cancer care. Expansion of the demonstration would require additional funding and approvals. CMS will consider the issue further if any future demonstrations are developed.

54-K-1: PPAC recommends that a representative of CMS and the corresponding Recovery Audit Contractor (RAC) meet with the carrier medical director (CMD) in each of the three states in the demonstration project.

CMS Response: We concur. CMS met with the CMDs in the states affected by the RAC demonstration on January 30, 2006. The CMDs thanked CMS for providing the briefing and indicated that they looked forward to future briefings on the RAC findings. We will have a presentation at the March 6, 2006, meeting. 54-K-2: PPAC thanks CMS for having the RACs recognize the issue of underpayment and recommends CMS find an incentive for RACs to identify underpayments. Further, CMS should reimburse physicians when underpayment is identified.

CMS Response: We concur. CMS plans to publicly announce the plan to financially compensate the RACs for identifying an underpayment in the near future. When a RAC identifies an underpayment, the RAC must first notify the appropriate fiscal intermediary/carrier who will validate the underpayment and adjust the claim, making the appropriate payment to the provider.

54-M-1: PPAC recommends that Dr. McAneny be reinstated for a second term on PPAC.

CMS Response: After careful review of the information submitted on behalf of all of the nominees including current Council members under consideration for PPAC, the Secretary has selected the following new members:

- Vincent Bufalino, M.D.
- Tye Ouzounian, M.D.

- Jeffrey Ross, D.P.M., M.D.
- Karen Williams, M.D.

PPAC members thanked Dr. Simon for his update but felt their concerns regarding the cost to physicians of collecting data (54-C-1) had not been adequately addressed by CMS.

55-C-1: PPAC recommends that CMS measure the costs of data collection incurred by physicians in the planned Coverage with Evidence Development program. Once data are gathered, the costs should be conveyed to Congress for inclusion in the Physician Fee Schedule. CMS should also ensure that trials conducted under the Coverage with Evidence Development program be subject to the same regulatory requirements as other clinical trials, such as Institutional Review Board participation and assurance that patients who decline to participate are not penalized.

PPAC asked CMS staff to report to the Council any information available on the current status and projected future of pharmaceutical manufacturers' drug assistance programs for those who cannot afford to buy prescription drugs, even under the Part D program.

NEW BUSINESS

Agenda Item D — PRIT Update

William Rogers, M.D., Director of PRIT, said his office is exploring the possibility of a directory of National Provider Identifiers for use by physicians but must address privacy issues raised by the AMA and others (Presentation 1). PRIT continues to investigate the availability of specific drugs identified by individual physicians as being unavailable for the published ASP. PRIT staff developed software that allows users to reconfigure remittance data for further analysis. CMS is targeting fraud by developing a list of "medically unbelievable" edits, for example, hysterectomy performed on a man. Dr. Rogers would like to distinguish a separate category for "medically unlikely" edits, such as a high number of biopsies of a single area, that would prompt investigation but not automatic denial.

55-D-1: PPAC recommends that CMS provide an online directory of National Provider Identifier numbers for use by physicians.

55-D-2: PPAC recommends that CMS publish in its proposed and final rules the RVUs forwarded by the AMA's Relative Value Update Committee (RUC) for new physician services for which CMS has made a noncoverage decision.

55-D-3: PPAC recommends that CMS withdraw the proposal to create a list of "medically unbelievable" edits and resubmit the proposal through the normal, formal rulemaking process, working closely with the medical community throughout.

Agenda Item F — Moving Toward Pay for Performance

Tom Valuck, M.D., J.D., Medical Officer for the Center for Medicare Management, outlined the various pay-for-performance initiatives underway at CMS (Presentation 2). The Medicare Modernization Act mandates that CMS implement such programs, and many entities support the concept. CMS will partner with Federal, State, nonprofit, and private entities to develop reporting strategies and criteria. The pay-for-performance programs will encourage adoption of electronic health records, promote innovation, and rely on evidence-based guidelines for effective use of technology.

55-F-1: PPAC recommends that CMS use a payment methodology that uses bonuses rather than differentials to avoid damaging practices that serve patients who are socioeconomically disadvantaged or noncompliant.

55-F-2: Given that many pay-for-performance measures will require more Part B services, which will 1) increase the future volume and intensity of services provided by outpatient providers, 2) lower future conversion factors as calculated under the Sustainable Growth Rate (SGR) formula, and 3) penalize providers for implementing the quality measures CMS requires, PPAC recommends that CMS delay implementation of pay-for-performance measures until the SGR is replaced with a more equitable system.

55-F-3: PPAC recommends that some of CMS' pay-for-performance pilots be directed toward small practices, especially those that cover socioeconomically and geographically diverse populations, and not just large, vertically integrated practices.

55-F-4: PPAC recommends that CMS initially focus on process measures rather than outcome measures.

55-F-5: PPAC supports efforts of CMS to explore the possibility of incentivizing beneficiaries to be compliant with processes being measured.

Agenda Item G — Update on Implementation of the Part D Drug Program

Jeffrey Kelman, M.D., Medical Officer of the Center for Beneficiary Choices, said CMS is successfully addressing the biggest complication affecting the new Part D drug benefit: the need for rapid, accurate, electronic communication among numerous databases. He noted that as CMS addresses the various technological issues, it is moving toward a unified list of drugs for each patient that would help providers identify potential drug interactions, overdoses, or duplications.

55-G-1: PPAC recommends that CMS monitor the amount of time physicians spend appealing Part D pharmacy coverage decisions and the amount of time involved with and the costs of care related to substituting medications.

55-G-2: PPAC recommends that CMS use the findings from evidence-based medicine and peer-reviewed journals to allow off-label use of medicines covered under Part D.

Agenda Item H— Medicare Contractor Reform

Tom Gustafson, Ph.D., Deputy Director for the Center for Medicare Management, explained that all fiscal intermediaries and carriers will be replaced by Medicare Administrative Contractors (MACs) over the next 5 years (Presentation 3). CMS hopes the MACs will improve coordination of administrative efforts for beneficiaries and providers by offering a single point of contact. Once established, all MACs will be required to take part in competitive bidding every 5 years; it is hoped that the competition for contracts will encourage better service. Each MAC must have at least one CMD for its jurisdiction and a plan for maintaining the same level of access to CMDs that providers currently have within that jurisdiction. MACs will be assisted by so-called functional contractors that provide specific services related to claims appeal, beneficiary information, and program safeguards.

Agenda Item J — Medicare Contractor Provider Satisfaction Survey (MCPSS)

David Clark, Director of the Division of Provider Relations and Evaluation, gave an overview of the MCPSS, which will be used by CMS to identify areas for MAC improvement (Presentation 4). CMS began collecting data in January 2006 and hopes to publish data in the summer of 2006. The survey will be conducted annually. Vasudha Narayanan of Westat, MCPSS Project Director, explained how CMS is following up with providers to encourage survey response.

Agenda Item K — Outpatient Prospective Payment System (OPPS) and Multiple Imaging

Jim Hart, Director of Outpatient Services, reminded the Council that CMS had proposed applying a payment reduction in certain cases in which multiple imaging procedures are performed on the same patient on the same day (Presentation 5). CMS delayed implementing the proposal when commenters suggested that efficiencies associated with performing multiple procedures were probably already captured in the cost-to-charge ratio that is reflected in the OPPS rates. CMS found that for the technical component of about 150 imaging codes (or 25 percent), the Physician Fee Schedule rate was higher than the OPPS rate. Beginning in 2007, for the technical component of imaging, when the OPPS rate is lower than the Physician Fee Schedule rate, CMS will pay the OPPS rate. However, as directed by statute, when the Physician Fee Schedule rate is lower than the OPPS rate, CMS will pay the Physician Fee Schedule rate.

Agenda Item M — Recovery Audit Contracts (RAC) — Update

Melanie Combs, Senior Technical Advisor in the Division of Analysis and Evaluation for CMS, said that CMS will pay RAC contractors the same contingency fee for identifying underpayments as it does for identifying overpayments (Presentation 6). She explained that the funds recovered through identifying overpayments are divided among the RAC contractor, CMS administration, and the Medicare trust fund. The contingency fees for identifying underpayments will come out of the funds allotted for CMS administration. Ms. Combs provided sample copies of a letter sent by a contractor to a physician requesting refund of an overpayment. CMS hopes to post online samples of letters from all the RAC contractors for all situations. She noted that once a contractor requests information or charts from a physician, the contractor must notify the physician within 60 days of the status of the investigation.

Agenda Item N — Medicare Health Support

Barbara Hoffman, Director of the Division of Chronic Care Improvement Programs, said CMS has established pilot programs to evaluate the effectiveness of disease management programs among beneficiaries with multiple chronic conditions, one of which is either diabetes or heart failure (Presentation 7). She detailed the parameters of the pilot projects, which include a variety of approaches, including nutrition education and linking patients to appropriate social services.

55-N-1: PPAC recommends that CMS establish a pilot program that gives resources for disease management, such as funds to pay for translation and social services and the costs of management fees, to primary care physicians and compare the costs of primary care physicians providing the same services with those of the disease management industry.

Agenda Item O — Testimony — American Medical Association

John H. Armstrong, M.D., of the AMA said that despite the efforts of Congress to mitigate the reduction of physician fees, in view of inflation, freezing current rates means physicians will continue to suffer from fee cuts under Medicare (Presentation 8). He said the current SGR formula is a barrier to the goal of pay for performance, because pay for performance requires substantial investment in technology. Dr. Armstrong said the AMA is working on a model form that physicians could use to request a formulary exemption on behalf of patients.

Agenda Item P — Wrap Up and Recommendations

Dr. Castellanos thanked the Council members, CMS staff, and CMS contractors for their hard work on behalf of PPAC. The Council reviewed the recommendations, and Dr. Castellanos adjourned the meeting. Recommendations of the Council are listed in Appendix B.

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

PPAC Members at the March 6, 2006, Meeting

Ronald Castellanos, M.D., *Chair*
Urologist
Cape Coral, Florida

Gregory Przybylski, M.D.
Neurosurgeon
Knoxville, Tennessee

Jose Azocar, M.D.
Internist
Springfield, Massachusetts

M. Leroy Sprang, M.D.
Obstetrician–Gynecologist
Evanston, Illinois

Carlos Hamilton, Jr., M.D.
Endocrinologist
Houston, Texas

Robert Urata, M.D.
Family Practitioner
Juneau, Alaska

Joe W. Johnson, D.C.
Chiropractor
Paxton, Florida

Members-Elect
Vincent J. Bufalino, M.D.
Cardiologist
Naperville, Illinois

Barbara L. McAneny, M.D.
Clinical Oncologist
Albuquerque, New Mexico

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

Geraldine O’Shea, D.O.
Internist
Jackson, California

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

Laura Powers, M.D.
Neurologist
Knoxville, Tennessee

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

CMS Staff Present:

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

Vasudha Narayanan, MCPSS Project Director
Westat

Melanie Combs, Senior Technical Advisor
Division of Analysis and Evaluation

William Rogers, M.D., Director
Physicians Regulatory Issues Team

Thomas Gustafson, Ph.D. Deputy Director
Center for Medicare Management

Ken Simon, M.D., Executive Director, PPAC
Center for Medicare Management

Jim Hart, Director
Outpatient Services
Center for Medicare Management

Tom Valuck, M.D., J.D., Medical Officer
Center for Medicare Management

Barbara Hoffman, Director
Division of Chronic Care Improvement Program

Public Witnesses:

John H. Armstrong, M.D., American Medical
Association

Jeffrey Kelman, M.D., Medical Officer
Center for Beneficiary Choices

Dana Trevas, Rapporteur
Magnificent Publications, Inc.

Mr. Herb Kuhn, Director
Center for Medicare Management

APPENDICES

Appendix A: Meeting agenda

Appendix B: Recommendations from the March 6, 2006, meeting

The following documents were presented at the PPAC meeting on March 6, 2006, and are appended here for the record:

Presentation 1: PRIT Report

Presentation 2: Moving Toward Pay for Performance

Presentation 3: Medicare Contractor Reform

Presentation 4: Medicare Contractor Provider Satisfaction Survey

Presentation 5: Payment for Imaging Procedures Under the Outpatient Prospective Payment System

Presentation 6: Recovery Audit Contract (RAC) Update

Presentation 7: Medicare Health Support

Presentation 8: Statement of the American Medical Association to the Practicing Physicians Advisory Council

Appendix A

**Practicing Physicians Advisory Council
Hubert H. Humphrey Building
Room 800
Centers for Medicare & Medicaid Services
200 Independence Avenue, SW
Washington, DC 20201
March 6, 2006**

08:30-08:40	A. Open Meeting	Ronald Castellanos, M.D. Chairman, Practicing Physicians Advisory Council
08:40-08:50	B. Welcome	Herb Kuhn, Director Tom Gustafson, Ph.D, Deputy Director, Center for Medicare Management, Centers for Medicare and Medicaid Services
08:50-09:15	C. PPAC Update	Kenneth Simon, M.D., M.B.A. Executive Director, Practicing Physicians Advisory Council
09:15-09:45	D. PRIT Update	William Rogers, M.D., Director, Physicians Regulatory Issues Team, Office of Public Affairs, Centers for Medicare and Medicaid Services
09:45-10:00	E. Break (Chair Discretion)	
10:00-10:45	F. Moving Toward Pay for Performance	Tom Valuck, M.D., J.D. Medical Officer Center for Medicare Management

10:45-11:15	G. Update on Implementation of the Part D Drug Program	Jeffrey Kelman, M.D. Medical Officer Center for Beneficiary Choices
11:15- 11:45	H. Medicare Contractor Reform	Tom Gustafson, Ph.D Deputy Director, Center for Medicare Management
11:45-1:00	I. Lunch	
1:00-1:40	J. Medicare Contractor Provider Satisfaction Survey (MCPSS): The 2006 Administration and Its Application to Contractor Oversight and Performance Evaluation	David Clark, Director Division of Provider Relations and Evaluations Alan Constantian, Deputy Director, Medicare Contractor Management Group and Vasudha Narayanan MCPSS Project Director, Westat
1:40-2:15	K. OPPS Multiple Imaging Update	Jim Hart, Director Outpatient Services Center for Medicare Management
2:15-2:30	L. Break (Chair Discretion)	
2:30-2:50	M. Recovery Audit Contracts (RAC)--Update	Melanie Combs, Senior Technical Advisor, Division of Analysis and Evaluation and Connie Leonard, Project Officer, RAC Division of Medicare Overpayments, Centers for Medicare and Medicaid Services

2:50-3:20	N. Medicare Health Support	Barbara Hoffman Director, Division of Chronic Care Improvement Programs
3:20-3:45	O. Testimony— American Medical Association	John H. Armstrong, M.D.
3:45-4:15	P. Wrap Up/ Recommendations	

Appendix B

PRACTICING PHYSICIANS ADVISORY COUNCIL (PPAC) RECOMMENDATIONS Report Number Fifty-Five March 6, 2006

Welcome

55-B-1: PPAC recognizes and sincerely appreciates the work of Mr. Herb Kuhn and CMS staff for their efforts in implementing provisions to the Deficit Reduction Act in a timely and efficient manner.

PPAC Update

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Moving Toward Pay for Performance

55-F-1: PPAC recommends that CMS use a payment methodology that uses bonuses rather than differentials to avoid damaging practices that serve patients who are socioeconomically disadvantaged or noncompliant.

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55-F-5: PPAC supports efforts of CMS to explore the possibility of incentivizing beneficiaries to be compliant with processes being measured.

Update on Implementation of the Part D Drug Program

55-G-1: PPAC recommends that CMS monitor the amount of time physicians spend appealing Part D pharmacy coverage decisions and the amount of time involved with and the costs of care related to substituting medications.

55-G-2: PPAC recommends that CMS use the findings from evidence-based medicine and peer-reviewed journals to allow off-label use of medicines covered under Part D.

Medicare Health Support

55-N-1: PPAC recommends that CMS establish a pilot program that gives resources for disease management, such as funds to pay for translation and social services and the costs of management fees, to primary care physicians and compare the costs of primary care physicians providing the same services with those of the disease management industry.