

CENTERS FOR MEDICARE AND MEDICAID SERVICES

PRACTICING PHYSICIANS ADVISORY COUNCIL

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Open Meeting

Dr. Rapp: I'd like to welcome the members of the public. I'd like to thank all of the Council members for attending. We have a number of new members on the Council, and so I would like to just briefly go around, introduce yourself, where you're from and what you do in real life.

Dr. Powers: I'm Laura Powers. I'm a neurologist in Knoxville, Tennessee.

Dr. Hamilton: I'm Carlos Hamilton, endocrinologist, from Houston, Texas.

Dr. Gaughan: I'm Becky Gaughan, ear, nose, and throat, Olathe, Kansas.

Dr. Johnson: Joe Johnson, chiropractic, Paxton, Florida.

Dr. Heyman: Joe Heyman, gynecologist, Amesbury, Massachusetts.

Mr. Grissom: I'm Tom Grissom, the director of the Center for Medicare Management here in D.C.

Dr. Rapp: I'm Michael Rapp. I'm an emergency physician from McLean, Virginia.

Dr. Rudolf: I'm Paul Rudolf. I'm an internist, endocrinologist. I'm a medical officer at CMS. I work with Tom Grissom.

Dr. Wood: I'm Doug Wood. I'm a cardiologist and vice-chair of the Department of Medicine at the Mayo Clinic in Rochester, Minnesota.

Dr. McAneny: I'm Barbara McAneny. I'm a medical oncologist in Albuquerque, New Mexico.

Dr. Castellanos: Ron Castellanos. I'm a urologist in Fort Myers, Florida.

Dr. Iglar: Denny Iglar, family practice in Oconomowoc, Wisconsin.

Dr. Urata: Bob Urata from Juneau, Alaska. I'm a family physician.

Mr. Clark: David Clark, CMS staff. I'm responsible for administrative support for the Council.

Dr. Rapp: Okay. It looks like we have to share a few microphones, so I guess we'll do the best we can on that.

I would announce that Dr. Bergeron, Dr. Rothhammer and Dr. Moultrie-Lizana are unable to come, and there's Dr. Leggett. Maybe you can introduce yourself quickly.

Dr. Leggett: I'm Chris Leggett from Atlanta, Georgia, a cardiologist.

Dr. Rapp: Thank you, Chris.

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1 All right. The first item of business is an oath of office and welcome by Tom Scully, who is here, arriving.

2 Mr. Scully: Well, thank you for coming out today, our new members in particular. I'm pleased to have the
3 opportunity. Normally, Secretary Thompson would also be up here to say hello to you today, but as you probably
4 saw, he's in Geneva. If you read the *Post* this morning, you're probably as happy as I am, as physicians, that he
5 actually managed to change the Administration's long-standing position to support for the international tobacco
6 treaty, which if you're interested in public health, is probably a very good thing. I know he still wanders outside the
7 building and yells at people who smoke. He's about as anti-smoking as you can get. Being the Secretary of Health,
8 that's admirable, I think. Knowing him, I'm sure he single-handedly changed the tune of the Administration on that,
9 which I think is much for the better.

10 But anyway, we appreciate you all coming to do this today. I think PPAC has developed a strong
11 relationship with CMS and the Department over the last couple of years, thanks to Mike and lots of other input. I
12 hope you have a stronger view. We have lots of advisory committees. I have a family full of doctors. I know you're
13 all very busy, and my view is if you come to these advisory committees, you don't fly all the way across the country
14 to be treated like a potted plant. You like to have input, I think you should have input, and I think I would
15 encourage you to do more. I get lots of input from RUC. I spent a morning with the RUC in Chicago a couple of
16 weeks ago, and that's even a bigger group, even more unwieldy. And to be honest with you, that's a group for the
17 specialty groups. I've been in politics a long time, and the reality is that the people on the RUC in the specialties are
18 on there for a reason. They have to represent their specialties, and one of the reasons we picked you for this group is
19 to have real, live physicians giving us advice about what to do, and there's no easy way out of the bind that we're in
20 with the physician fee schedule. We have lots of issues on EMTALA; we've got about 600 recommendations, and
21 hopefully about 60% of those we're on the way with. I think they were very, very helpful. I think you ought to be
22 more aggressive, especially between meetings, thinking about things that you could recommend to us, because I
23 think, for two reasons. One is so we can always use the recommendations. We had about 30 docs when I got here
24 and now we've got about 80, and I still don't think that's enough out of 5,000 employees; we're trying to hire more
25 doctors — Barbara Paul makes 4 or 5 on her own, I think. I think when you're running anything this big, you can't
26 have enough input from physicians, and I think we just need to get more, and also, I think the more that we get you

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1 involved — we make extremely bad decisions, so we feel strongly about what you do every day, and they're more
2 defensible if you're behind us. But seriously, the more input we have from physicians, the better. But there's no
3 easy way to run the system. As those of you who have been on it for a while know, I was one of the architects, I
4 guess, of RPRPS in 1989, so I do believe it's the right way to go. I've always defended it — fixing prices and all. If
5 I had my druthers, obviously, we'd have Blue Cross plans providing health care for 66-year-olds just like they do for
6 64-year-olds, whatever. But we had 17 percent physician inflation in the mid-'80s, and that's the reason for the
7 RPRPS: inflation and volume intensity were out of control, and that's the way the system is. It's not perfect, but it's
8 worked reasonably well.

9 We've had some glitches over the last couple of years. I know a lot of physicians said they were very
10 angry about the fact that we thought we'd get over the hump on our negative update last year. (I still don't know
11 how you can have a "negative update;" they should call it a "down-date" or something.) But we fixed it. I think
12 Secretary Thompson and I were probably as aggressive advocates as anybody in the country for fixing that last year.
13 We got from -5.4 to +4.6, which I don't think we've had without Secretary Thompson or me. However, I have had
14 much more mixed opinions about it this year, and I'm not sure that there's going to be a fix in Congress. I'm not
15 sure there should be a fix in Congress, and the reason is -- and this is all an actuarial set of guesstimates that will
16 change as the course of a year goes by, but unfortunately, the volume and intensity of services, which was expected
17 to go up 2 percent last year instead went up over 8 percent. So you look back and see why we had a -4.2 percent
18 update projected for next year — believe me, there's nobody in the world less delighted to be back in the soup than
19 me, because we thought we fixed it, but the reality is that in the year when we had the actual negative 5.4 percent
20 cut, we saw an 8 percent increase in volume. Now, I've had lots of friendly discussions with AMA and other groups
21 about whether it's accurate or fair, but I can tell you that the CMS actuaries are renowned for being THE fairest,
22 most accurate people out there — they are totally unbiased. In fact, in my case, unfortunately, they're also
23 uncoachable. But they do a great job. And they've been more right than anybody in the world about Medicare over
24 the years, which is not easy. And, unfortunately, you look and see that kind of volume, they have to estimate that
25 it's going to continue. Now, it may or may not. We'll have to track this year going on, if that kind of volume and
26 intensity of services do not continue to go up, it's possible that the update will be better. But we're in a box.

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1 Congress has decided long ago that the goal of spending should be growth of 7 to 9 percent a year, and when you
2 put together the facts on volume and intensity to get there, it's not easy. But I don't think there's anything that
3 causes more of a problem for the physician rule than that.

4 Now, the reality is, to really stir the pot a little bit, when you look at the numbers for 2003 so far, despite
5 the fact that we are very worried about access -- I think in some parts of the country, there is a concern about that --
6 the actual number of doctors participating in the Medicare program has gone up from 89.7 percent in 2002 to 91.5
7 percent. So despite the rhetoric, doctors are not dropping out of the program; in many cases doctors report that their
8 incomes are being squeezed, and sometimes that's good news. But the fact is that so far there isn't any evidence that
9 it's causing major access problems for seniors, which has been the ultimate goal, to make sure the seniors get
10 coverage.

11 We've also, in the Medicare program in the last year, increased the percentage of covered charges; in other
12 words, the services that we actually cover as covered services have gone up a tick from about 96 to almost 97
13 percent in the last year. So there is some good news on the consumer side and on the doctor side. The bad news,
14 we're back in this box. We've got -4.4 percent projected -- 4.2 percent, excuse me, projected update, and hopefully,
15 as the year goes on, our actuaries will look at it and say that the volume and intensity of services this year -- in other
16 words, if it was 8 percent in '92 if you go to the year '93, you get a positive update last year instead of negative. If
17 that kind of volume and intensity churning doesn't continue, then hopefully the numbers will start coming out next
18 year a little better. But, unfortunately, our physician update problem has not gone away.

19 Our overall spending problem is not going away either. Medicaid went up 13 percent last year; Medicare
20 went up 9 percent, so it's not like we're not spending enough money in this Department -- we're spending the money
21 in the wrong ways and creating a lot of incentives in the wrong places. And it's always great to wake up on Monday
22 morning and hear all this good news. But anyway, I didn't really come here to give my views. If we have lots of
23 good news and all of our issues were easy, we wouldn't need all of your advice. That's why you're all here and
24 that's why the Secretary chose you and why we asked you to be on here. Dr. Wood has been extremely aggressive
25 and extremely helpful to the Secretary and me in a number of roles over the past year and a half. I assume the
26 reason you all want to be on here is that you want to have a voice in national payment policy, and I would invite you

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1 to do that rather aggressively. I may not agree with you, but I think getting input from people who are actually out
2 there seeing patients is pretty critical.

3 So there's no question that doctors do a great job. I've had my mother in the hospital for a month, for five
4 and a half weeks now, and she's getting great care. Despite our miserable Medicare reimbursement -- she's 74 --
5 she got terrific care, and the healthcare system does work, and I think the Medicare system is a great social safety
6 net that provides terrific care for seniors, and obviously, making sure that we pay the physicians the right amount to
7 make sure that care continues is a critical goal of the program.

8 So anyway, with that, I'll say thank you for coming. I'm happy to talk after we swear in our new members,
9 to answer any questions or stir the pot more, cause more trouble. It's my specialty, by the way. I also want to thank
10 Mike Rapp for doing a terrific job chairing PPAC -- I guess it's been a year now, or a little over a year.

11 So the first order of duty is swearing in our new members.

12 Dr. Powers, Dr. Hamilton, Dr. Iglar, and Dr. Urata. All right. Just raise your right hand.

13 Dr. Powers: I, Laura Powers, do solemnly swear that I will support and defend the Constitution of the
14 United States against all enemies, foreign and domestic, that I will bear true faith and allegiance to the same; that I
15 take this obligation freely without any mental reservation or purpose of evasion; that I will faithfully discharge the
16 duties of the office which I'm about to enter, so help me God.

17 Mr. Scully: Thank you very much.

18 Dr. Hamilton: I, Carlos Hamilton, do solemnly swear that I will support and defend the Constitution of the
19 United States against all enemies, foreign and domestic; that I will bear true faith and allegiance to the same; that I
20 take this obligation freely without any mental reservation or purpose of evasion; that I will faithfully discharge the
21 duties of the office which I'm about to enter, so help me God.

22 Mr. Scully: Thank you very much.

23 Dr. Iglar: I, Dennis Iglar, do solemnly swear that I will support and defend the Constitution of the United
24 States against all enemies, foreign or domestic; that I will bear true faith and allegiance to the same; that I take this
25 obligation freely without any mental reservation or purpose of evasion; that I will faithfully discharge the duties of
26 the office which I'm about to enter, so help me God.

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1 Mr. Scully: Thank you very much.

2 Dr. Urata: I, Bob Urata, do solemnly swear that I will support and defend the Constitution of the United
3 States against all enemies, foreign or domestic; that I will bear true faith and allegiance to the same; that I take this
4 obligation freely without any mental reservation or purpose of evasion; and that I will faithfully discharge the duties
5 of the office upon which I'm about to enter, so help me God.

6 Mr. Scully: Thank you very much.

7 [Picture-taking session.]

8 Dr. Rapp: Apropos of the Physician Payment Update, one of the recommendations made at the last
9 meeting is that CMS should move drug expenditures from the definition of physician services in the calculation of
10 the sustainable growth rate. I wonder if you have ...

11 Mr. Scully: I think that's a perfect example of what I'm talking about. The obvious thing is just simply
12 take out the drug. There's a reasonably good argument for pulling drugs out. But if you just pull drugs out of the
13 existing formula, instead of it being a -4.2 over the next 10 years, the formula goes the other way and you get huge
14 updates that are also not justified. So we really should be coming up with a formula that potentially pulls drugs out
15 gradually, or has some limited impact on drugs, because the fact is drugs are under the physician's control. So I
16 don't know if you decide to pull them out or not, but I think some hybrid approach that pulls them out slowly ... The
17 other problem we get into is, when you look at other parts of the program, that physician services account for (Paul
18 probably knows) \$45 billion out of \$67 billion roughly, give or take half a billion or so.

19 The other parts of the program that are exposing outside of drugs are DME – you know, we had a 97%
20 increase in wheelchairs, for instance, in one of the four regions last year... there weren't 97% more seniors that were
21 disabled or disabled non-seniors coming into the program. The only way you can get a mobile wheelchair, for
22 instance, is to write a prescription from a doctor. So, there are a lot of strange things going on in the program that
23 we need to look at; it's like Whack-a-Mole. You see these things spike up, and you hit one and another one comes
24 up next to it. Those are in the pot of \$67 billion, along with other things like clinical labs. So, if you're going to
25 look at it, you should look at overall spending. The real purpose of putting the physician payment update in at all is
26 to control overall spending. Drugs went up 35% last year. It's not going to get any better if you take it out of the

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1 SGR. Physicians really have ... the only monitoring on prescription drug volume is from physicians. So there has
2 to be some way behaviorally to modify the system. Just taking ... I'm not sure it's fair to penalize the physician fees
3 for 35% drug growth. On the other hand, saying well let's just take it out and forget about it is not the answer either.
4 So I guess my point is I think it's overly simplistic to say let's pull drugs out of the system and just let it go on ...
5 instead of updates that are underpaying, you get updates that are vastly overpaying ... that's not the right answer.
6 So, I guess my point is to do a little more digging. I would love nothing more than to come up with something ...
7 Chairman Bill Thomas of Ways and Means and Chairman Grassley of Finance would love nothing more than to
8 come up with a long-term fix for this formula and have physicians behind them. But just pulling drugs out is not the
9 answer. It's got to be a little bit more complicated to fix this than pulling drugs out. That may be part of the answer.
10 I think it would be great if you could just forget them, but ...

11 Dr. Rapp: Well, the thing about the drugs is that physicians really control virtually everything so one could
12 make the same argument for drugs, for hospitalization, for wheelchairs ..

13 Mr. Scully: Even in hospitalization, they don't do it that way. In hospitalization, there's one capitated
14 amount, so you give it to the hospital. The patient goes in the hospital and gets a hip replacement, and we pay the
15 hospital \$18,000 and say, "You figure it out." That's a very effective way of keeping drug prices down because the
16 hospitals mark everything else from one big pile, and the hospital has every incentive to push back the drug price
17 and everything else because the more ... it's the whole idea of capitation. You give the hospital a capitated rate, and
18 they'll make absolutely certain that it works out in the end. I can tell you -- once again, I'll go back to the
19 laboratory last month with my mother, when they called up and said it's time to move her into the [inaudible] unit;
20 we think she's ready, but she really wasn't. I said, "What I think it means is your DRG's probably run out of gas.
21 That's just the way the system works. On the physician side, there's no incentive for any kind of behavioral change
22 or cost containment. Unfortunately, what happens is when there's a 35% increase in drugs, individual physicians
23 have very little ability to control that. It comes back out of your payment the next year, which is not good for the
24 physician, but the answer is not just to take all the structural constraints out of the program. The answer is on
25 [inaudible]. I'm not a doctor, I'm just a lawyer, but I've been in the healthcare business for a long time. I never,
26 ever, ever seen any my friends who are docs say, "My office visit went from \$42.00 to \$39.00. It's unfair. But you

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1 know what? I know it's the guy down the hall cranking out too many procedures, or the hospital just decided to do
2 two CAT scans which I know they don't need." This all comes out of one pile. There's got to be a better way to
3 design it. But just saying, "It doesn't work. It's unfair to docs. Let's take all the restraints off the system," is not
4 the answer.

5 Dr. Rapp: Dr. Heyman?

6 Dr. Heyman: Well, I guess my problem with all of this is that if you're concerned about incentives, I mean,
7 that incentive doesn't have any effect on the way physicians prescribe drugs. And I'm also concerned about, you
8 know, there are mandates to provide more services now than there used to be, and that makes a contribution to the
9 update. And if the incentive is for us not to provide those services, then it's just very contradictory to have a
10 program where you increase the number of services you want us to provide and at the same time because we are
11 providing those services you cut our pay. I just think it's paradoxical thinking.

12 Mr. Scully: Well, I don't disagree with you on that front, but the issue is the Medicare program against my
13 philosophy of where we'd like to be in 20 years. We love Medicare. It's a great program but it's a check-the-box
14 program where there's no incentive to do anything but provide more services. And that's been the whole problem
15 with it all along. As much as you may dislike your local Blue Cross plan, or you may dislike Oxford up in New
16 York, they have a much better feel for what doctors are doing, who's doing a better job, what the practice patterns
17 are, who's behaving in what way. There's no way in the world, you'd have -- for example, in the last quarter -- two
18 doctors in Houston did over 50% of the wheelchair scrips. That wouldn't happen. So I just think behaviorally we
19 have a large check-the-box system which has no incentives for anybody. And unfortunately Congress put a system
20 in place to try to control costs artificially. I agree ... I don't think it works. But I don't think we're going back to the
21 days, nor we shouldn't go back to the days of 17 – 18% annual physician payment inflation. I don't think that's
22 healthy either, so we've got to come up with a better system. All I'm saying is the answer is not just to take out all
23 the restrictions. The answer is to come up with a better one and that's one reason I hope we have PPAC and RUC
24 and other people around. I know you're all busy as practicing physicians but I also think you're one of the
25 representatives that go back to your specialty groups and says, you know, let's come up with some new ideas, we
26 need some new ideas. A new idea that I don't think the administration is going to support and I can guarantee

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1 nobody in Congress will support is just taking off all those restraints. That's just not going to happen, so we need to
2 come up with a better system or live with the system we have. Unfortunately the design of this system, which is a
3 very ugly macro system, I can tell you, it's hard to work. No doctor 2 years ago -- I've gotten into some fights,
4 pleasant ones most of the time, with some drug companies about the costs of some drugs that are excessive because
5 it all comes out of the same pot. As doctors start to understand that the drug cost funding comes out of the same pot
6 as their physician update, they're a little more willing to take on some of the drugs that we're paying for in the
7 Medicare program that are overpriced. That's the way it's intended. It's all one big pot. It's not a very good way to
8 do business, in my opinion, but it's better than just saying let's have 17% a year growth, which I know for a fact we
9 had at least one year when I was previously in government.

10 Dr. Rapp: Dr. McAneny and then Dr. Castellanos. Then Dr. Wood.

11 Dr. McAneny: I have two points I would like to make on that. The first is the "incident-to" drugs are the
12 ones that are in the SGR. And that puts us -- as an oncologist, that puts me in a situation when a patient comes in,
13 and needs a new drug, one of the wonderful drugs that can --say-treat elderly people with lymphomas, like Ritoxin,
14 and things like this that we can now use. I have absolutely no control over the cost of them. I have to purchase
15 these medications and administer them, but it would be unethical for me to deny them to Medicare patients. And as
16 we look at the attempts like Senator Grassley's amendment that he put on the tax bill to cut the AWP for drugs, this
17 for the first time affects my group in that I have asked now my CPA to run me a spreadsheet to look at what level of
18 Medicare patients I can afford to take care of in my group. In 20 years of practice I have never before had to say,
19 because of the cost of the drugs, because of the reimbursement levels of Medicare, because of the question now of
20 another fee decrease next year -- this is the first time in 20 years that I've ever had to say, I have to look at whether
21 or not I must limit the number of Medicare patients that I'm willing to take care of in the practice, in order to ensure
22 that the practice will continue to survive financially. That goes against my philosophy and the pride that I've had
23 over 20 years in being able to take care of everybody who comes through the door. It may be a little more
24 exacerbated because in New Mexico, Medicare and Medicaid and uninsured is 52% of our population. But it still is
25 going to be an access issue, even though I'm a participating physician. So, the drugs are completely *not* in our
26 control. I have no say-so over how much I have to pay for them. And when the reimbursement drops I can't afford

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1 to do them. And also when they go into the entire system when they come up with a new drug for us or for the
2 rheumatologists, to have everybody have a decrease in fee just basically makes no sense to most of the doctors in the
3 country. The other point was --

4 Mr. Scully: Let me jump in on the fee because I'm a zealot ... that makes ...

5 Dr. McAneny: I know.

6 Mr. Scully: That makes Senator Grassley look like a patsy. AWP is flat-out indefensible. It's the biggest
7 scam. I've been in Washington for 23 years, since I've been doing health care policy for 20, and there's never been
8 -- with possible, hospital outliers, it could be a toss-up with another big scam this year -- average wholesale price is
9 totally indefensible. Now we paid oncologists \$4 billion for drugs last year and \$1 billion for services. Any
10 government class in the country, if you try to explain the average wholesale price system, they would pass out.
11 They would be so shocked that our government is that stupid. Now, the answer for me is Senator Grassley cutting
12 AWP 5% of average wholesale price, which is a totally made up number, is to pay you right - correct with your
13 practice, expenses directly from the drugs. But the margins on drugs are laughable. It's not the drug companies'
14 fault. They follow the incentives they're provided. But AWP is shockingly outrageous as a government policy and
15 ought to be fixed. Now, Senator Grassley, because he was trying to pay for other things, cut AWP and took the
16 money and spent it on rural health. That's his option, his constituency, and that's what he'd like to do. The
17 administration would very clearly like to fix it, put some of the money back into oncology, rheumatology, and some
18 other things. It may not be one-for-one, but it would be significant to pay the right amount for drugs and the right
19 amount for practice expenses. It's the number one group. I'm sure you're aware it's been holding us up the last 5
20 years, and I watched it, because I helped it for a while -- I was in the hospital business. Because the hospital called
21 and said what's holding us up has been the oncologists. And I've been thrown, you know, I've been pleading with
22 them for 2 years to work with us to get this fixed or it could end up in a pretty ugly way, and their attitude is, to be
23 less than gentle about it, which I usually am... They stir up the patients, you know, the Democrats are calling on
24 everybody who wants to do this. This is a very bipartisan thing. They're trying to hurt cancer patients. Nobody is
25 trying to hurt cancer patients ... AWP is an outrageous government policy, and it is totally indefensible, and it should
26 be fixed. At the same time we ought to pay oncologists and rheumatologists and gastroenterologists and dialysis

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1 clinics and everyone else that's affected the right amount for their practice expenses. And so consciously we knew
2 that the margins were massive on drugs. A lot of those areas were so consciously with the agency. I think probably
3 someone - appropriately under the circumstances - it was a cross subsidy bill where we consciously underpaid in
4 certain areas because we knew what the drug transfer was. So, we ought to fix both. As a taxpayer, we're ought to
5 pay the right amount for your practice expenses, the right amount for your drugs. But, you know, Ritoxin is a great
6 drug. I went through a lot with those guys. They're a very good company. They're very honorable, and so when
7 they first came in with a drug, they said it was \$28,000 a dose. Why? Because they could. I don't blame them for
8 doing it. And I said, great, I'll give you a code sometime in the next 600 years at that price. And they sat down and
9 worked it out. They were very honorable, decent people. But it's a wacky system that doesn't work right. So I
10 think what Senator Grassley did the other day, was, in my opinion, terrific, for no other reason than the fact that he
11 hoped it would wake up the practice groups to the fact that this thing is going to be fixed. And the best way to fix it
12 is Senator Grassley would take the money and not put the money back in oncology, but we would put some back in.
13 And I think they're going to realize this is going to happen. It's a freight train; there's a lot of political support
14 behind it. When Secretary Shalala and Nancy DeParle, my predecessor, tried to fix this 5 years ago, they got
15 shellacked because nobody understood it, the cry was, "No you're hurting cancer patients." Now, there's a much
16 better understanding of the facts. It's not about cancer patients but totally bogus made-up drug prices. And it ought
17 to be fixed - at a bipartisan level there's support for it, and I think the oncologists need to understand this is going to
18 happen. And it could either happen with them getting fair payment for the practice expenses or not get fair payment
19 on practice expenses. I'm on the side of paying them fairly, because I think it's the right thing to do. But coming in
20 and just saying, "No, no, no, "-- I think they hopefully are going to realize now it's going to happen whether they
21 like it or not because it's completely indefensible. I mean, you know that.

22 Dr. McAneny: I know that and I think having the increase in practice expense is the way to go because
23 right now we use the markup in order to pay a practice expense plus - with a patient who's getting a drug, when I
24 purchase an expensive drug, what I'm getting from Medicare is currently the 95 percent of AWP, and I recognize
25 that AWP is fiction. We all know that it's a made up number. But what we end up getting is actually 80 percent of
26 that because the patient can never come up with their 20 percent. But the point of having this decrease without an

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1 increase in practice expense, on top of the projected 4.2 percent decrease in Medicare for next year is really going to
2 put us on the brink in terms of being able to treat Medicare patients. I think the other thing that worked --

3 Mr. Scully: One thing we can hopefully look at is the pot for next year is growing 8.5 percent and spending
4 is not going down. Projected spending is going up 8.5 percent. There's got to be a way with an 8.5 percent to make
5 the incentives work right. And in the long run, you know, we have to do something with drug prices. We can't
6 afford the 35 percent increase we had last year with drugs. At some point we have to do something about the drugs
7 and maybe if we take some of that pressure off -- it probably isn't fair in some degree that doctors in their update
8 have to eat that 35 percent—that comes under the line of intensity of services and that affects your update. But I
9 think -- instead of just looking at the oncologists, we certainly have a problem with practice expenses this year --
10 we've got a big problem with anesthesia as well, we're trying to fix their coverage. We're trying to figure out in the
11 whole context of the \$67 billion what the rate will be for the next 7 to 10 years. And not just for one group but for
12 everybody. It's obviously hard, it's not easy. If it was easy, we would have done it already.

13 Dr. Rapp: Dr. Castellanos?

14 Dr. Castellanos: Well, I think we're just really kind of beating around the bush. I think we all recognize
15 the real problem is the flawed formula. I think MedPac just came out with some recommendations that the formula
16 will be replaced. I know CMS has agreed that this is a flawed formula. And I know this group has made
17 recommendations. Is there any move in Congress at all at this time to replace that formula and get a more equitable
18 way ...?

19 Mr. Scully: No, the MedPac formula, unfortunately, also cost \$160 billion dollars, or something like that.

20 Dr. Heyman: \$1.6.

21 Mr. Scully: What?

22 Dr. Heyman: \$1.6 billion next year.

23 Mr. Scully: No, over the next 10 years. They usually look at 10 years. It's a big, big, number. It's over a
24 \$100 billion. And I think members of Congress, they're as stunned as I am that we're back in this box. They were
25 pushed to spend more money -- in budget terms, \$54 billion fixing the thing last year. And I think we should look
26 at shaving the SGR. However, I think people should remember this -- I was running a hospital association back in

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1 1997, and in 1997 the hospitals took a huge hit that ran them into their worst year in the history of the hospital
2 business in '98, '99, 2000. Home health took a massive hit and basically wiped out a third of the home health
3 industry in '97. Skilled nursing facilities – five of the top six went into bankruptcy because Congress saved so much
4 money in '97. And the one group in '97 that didn't take any hit at all, if you look at the biggest budget deal of all
5 times hitting Medicare, were the physicians. And the reason was their part of the deal was they tightened up the
6 SGR. It was done at the recommendation of the AMA in lieu of taking a big hit for the fees like the doctors, like the
7 hospitals, like the home health and skilled nursing facilities. I'm not saying that's right but I'm just saying if you
8 look at the huge budget savings back in '98, '99, 2000, none of it came out of physicians. It all came out of home
9 health and other areas of the health care system. Home health spending went from \$18 billion to \$11 billion in the
10 course of 2 years which is probably a little harsh. It also happened to go from \$3 billion in 1992 to \$18 billion to
11 \$11 billion in the course of 2 years — we probably should have called them on that spike in the middle ... and there
12 was a lot of wild stuff going on in the nursing home business that shouldn't have been going on. But my point is
13 that this didn't happen by accident -- I was involved in the first set of reforms in '89 and SGR was a tightening up
14 potential to avoid short-term cuts. Well, the tightening up of the structure made it much less flexible and made them
15 come back and ball up in the system. If you look at overall physician spending versus hospitals versus anything else
16 in the last 4 or 5 years, the physician spending is going up faster. So, there's more volume. There's more intensity.
17 There's less per physician ... when you look at the overall proportions of the program and where it's going, it's hard
18 to argue that the physician side has been shortchanged. It's the volume and intensity part of the overall program ...
19 as I said, I'm not a big fan of ... I love the Medicare program, I'm not a big fan of single-payer national healthcare
20 which is what we have here, for 65 year olds. We try to make it work the best we can. But if you look at the bulk
21 parts of the program where the spending has been going, it's hard to say that it is the Part B side or the physician
22 side, there's not enough spending. It's the internal dynamics of how it works that's caused the problems. So, I'm all
23 for fixing it, but fixing it by just cranking more money into the system, I don't think is going to happen. You have
24 to come with a way to make the behavior change and come up with a system that's more equitable and fair. Maybe
25 a little bit more money, but one of the things that MedPac did, and MedPac, to their credit, has been much tougher
26 this year... last year by all counts MedPac membership last year showed none of the spine that they've been known

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1 for in the past. And they basically ... their recommendations from last year, the ones you're talking about, were they
2 basically gave away money to everybody. This year they've been significantly more responsible.

3 Dr. Rapp: Dr. Wood?

4 Dr. Wood: I think your last comment actually begins to get to the crux of the matter, Tom, my concern
5 about having drugs in the sustainable growth rate actually is that it is difficult for physicians to exert any sort of
6 pressure on that kind of spending when it comes down to issues of price. Now, volume utilization may be a
7 different story. But the circumstances are that when you consider the number of Medicare beneficiaries with
8 chronic conditions who end up requiring more prescription drugs, then the expectation actually is that for no other
9 reason than the number of patients for the number of primary physicians is increasing, the overall utilization would
10 increase. So, from the perspective of figuring out, then, how we manage that total bill, the challenge for us -- I don't
11 think is going to be on the price fixing side, it's going to be on the process of care. I mean, there is a point at which
12 you can't do much anymore by fixing the price.

13 Mr. Scully: If I can use my mom as an example, as I was watching the bills last month ... but I've been in
14 the hospital business a long time, too ... and she was in two hospitals last month and had four different MRI's, two
15 CAT scans. She's had an innumerable number of doctors come to visit her. To be honest with you, if she'd been in
16 the general Blue Cross plan, at least somebody would have been called on to look at the overall management of care.
17 Medicare does none of that. It's just check the box and if it looks okay, the bills get paid. So, if you're in, by
18 definition, a system that has no utilization over you then you're going to get what you get, I'm not for that, but that's
19 the system we have. I mean, you don't have that kind of system if the patient is 64, you can hopefully in a
20 reasonably well-run insurance program, at least, some of them might not be overtly aggressive about pushing that,
21 but somebody would at least be looking at overall patient management which doesn't happen when you're 66. And
22 that's, to me, part of the problem. And that's a more systemic problem that's going to take 25 years to fix gradually.

23 Dr. Wood: Well, if you go back to some of the discussions we had at the Secretary's Advisory Committee
24 on Regulatory Reform, we recognized that difficulties that are encountered are exactly that. That is, there is no
25 ability to look back at a Part A study. There's no ability to look between providers on the Part B side, and there's no
26 ability to look from the Part B side to a skilled nursing facility, or a Part A side skilled nursing facility. We need a

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1 different way of managing the process of care. And if there's something that CMS could do that would give
2 physicians a tool to manage that longitudinal pattern of care...

3 Mr. Scully: Well, we talked about capitated practice.

4 Dr. Wood: Capitated practice wouldn't do it. I mean, the issue really is having access to information to
5 know exactly what has been done and the policies to support that. If I could look back at what had been done at a
6 previous point in a patient's care, then I might not need to repeat something or I could do something differently.

7 Mr. Scully: We're way, way beyond electronic health records. We're trying to come up with a patient data
8 set, which obviously would be extremely helpful.

9 Dr. Wood: Well, I think those are things that, if we're going to manage this we need to do faster than 20 or
10 25 years.

11 Mr. Scully: Well, that's only 10 years off.

12 Dr. Wood: We won't make it. So, if there's something then, in particular, that physicians could do
13 together with CMS to help that integration, then I think we ought to begin to have some of those discussions. And
14 hearkening back to your comments at the beginning of the meeting, if you would like us to become more active then
15 I think there are a number of opportunities for this council to become very active in terms of how we would like to
16 see that integration go and perhaps could give some direction to CMS.

17 Mr. Scully: You can help on the electronic health records thing which the Secretary is very big on and that
18 is a big deal; the American Academy of Physicians has a pretty good product, it's probably 2 years off there. We've
19 been trying to support a lot of the technology groups to try to push Congress to come up with a standardized
20 electronic health record. The VA has one that's very good. Excellent from the hospital point of view. Actually, this
21 will be used by other physicians. Obviously, their practice model is different, but it's a good boilerplate that's out
22 there but I think you're totally right, if every physician in 5 years, which is probably as quickly as it could possibly
23 happen, had a standardized set of patient records where they can pull up the patient history (within the privacy
24 rules), any place in the country and figure out what had been done. I mean, the Secretary always says that, you
25 know, he goes to Jiffy Lube in Baltimore one day and gets more information from going to Jiffy Lube in
26 Washington the next day than if he went to a hospital or a doctor's office. But the technology is there. The

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1 Government doesn't have the standardized, you know, set of rules, and we're pushing hard to get them to do that but
2 it's difficult. Having the backing of the physician groups to push that faster would be great. I think the Academy is
3 doing a great job of pushing that but you can clearly be very helpful in pushing the electronic health records issue.

4 Dr. Rapp: Dr. McAneny?

5 Dr. McAneny: One of the other issues that I wanted to bring up in terms of volume intensity was the shift
6 of procedures that can be very high tech from the hospital setting now into the office setting, yet the money doesn't
7 follow the patient. If the procedure has previously been done under Part A Medicare in the hospital, and we now
8 can do a lot of the things in our offices that are there, it will increase the amount of services that we're providing.
9 Both volume and intensity will go up. Yet the Part A money does not transfer over into Part B Medicare. And I
10 understand that those are two different trust funds. But it seems that as we look at this, we need to break out of the
11 cycles of looking at in the hospital service and out of the hospital service. I know that you've had interest in
12 equalizing costs among the different sites of services, but I think that's an important way that we can look at ways to
13 save the entire program money. If we're doing things in a less intensive setting in the outpatient arena, currently we
14 get penalized for it because it increases the volume intensity, the SGR drops down the pay rate, and that's something
15 that seems like it should be --

16 Mr. Scully: Well, that's something that could be looked at in the SGR if you can show that that's -- you
17 have to show you're actually saving costs. If we're spending less in Part A because you're moving services to Part
18 B, then as you said, part of the problem in all our struggles with this ... as an agency, we've done a great job of
19 getting started on this. That's driving me crazy and we had the same, you know, a colonoscopy done in the doctor's
20 office versus the emergency room or the hospital outpatient center.... you know, we drive behavior by incentivizing
21 where we pay them. That's what concerns me -- we don't always look at it that way because we've got three
22 different pots of money with three different sets of staff to do it. And if we are going to incentivize more service in
23 the physician office because it has lower overhead and the practice expenses are theoretically lower in a physician's
24 office than they are in a hospital outpatient center, that's something we can look at, but generally we see that the
25 volume and intensity in services goes up. We're just spending more in all settings.

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1 Dr. Wood: From a practical perspective, if you wanted to do that, would you do that by looking at a per-
2 beneficiary utilization pattern, say over a year's time, total utilization of service per beneficiary so you can actually
3 see that savings, because otherwise, it would seem to me, that if you did it on an aggregate fashion it would not be
4 possible to see the overall savings. It would be diluted.

5 Mr. Scully: Even if it has to be done statutorily, which it probably does, the issue is going to be ... John is
6 the guy who's the actuary; it's going to be the Office of the Actuary who's going to say, how do we actually judge.
7 I mean, the real issue is going to be to show if you actually start doing a higher volume of oncology procedures in
8 the office and a little less than the outpatient setting and even less in the hospital. Should there be a shift... is this a
9 legitimate change in practice patterns to say we should be taking less out of Part A and put more into Part B, since
10 we have more of a demand on the Part B pot. You're obviously driving down, you know, the volume and intensity
11 are going up ... you're driving down demand on Part A and driving up demand on Part B. And that's going to be the
12 judgment of the actuaries, so it's a question you've got to ask them.

13 Dr. Wood: Well, I think the real reason to ask the question ... If you look at total spending, it is hard to
14 escape the conclusion that even as aggressive as we might be in reducing utilization in the short term, total spending
15 will actually increase simply because of the demographics.

16 Mr. Scully: The demographics are not going up that much. The estimate is \$.4 billion. The growth, ... the
17 aging in the population is very small piece of the explosion we're seeing in costs – what is it, .4 percent this year?

18 Dr. Wood: Looking at the slide set that CMS publishes, there are slides that the Office of the Actuary has
19 that suggest that there is a large contribution of the number of patients who are aging ... the number of chronic
20 conditions, the utilization of chronic conditions, and the costs related to that. But --

21 Mr. Scully: You're right. The real issue is when you look at how you're going to move this money around
22 to change the pots.

23 Dr. Wood: Right.

24 Mr. Scully: And whether we're making the right judgments and can we assure Congress that the money is
25 going out for good reasons, that's as far as the judgment could actually go.

26 Dr. Rapp: If you've got time ... Dr. Johnson?

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1 Mr. Scully: I'll come back later this morning.

2 Dr. Rapp: Okay.

3 Mr. Scully: I have to do my job here.

4 Dr. Johnson: Okay. I wanted to come back to the electronic medical records. Concerning the new
5 processes that are being developed, IBM or a pilot project, how is that moving along in the impact of the electronic
6 medical record and also the electronic claims processing, moving toward the impact on providers?

7 Mr. Scully: Well, the electronic claims processing and all the different things we're going to see this fall
8 are going reasonably well. The real issue is that there's no set standard for patient data transfer, either on the billing
9 side or on the patient record side. And the billing side is coming along better because of the HIPAA, but on the
10 patient record side just doesn't really exist. There's multiple contractors that have a foot in the federal government,
11 we're not actually big regulators—the railroads have to have the same gauge track. You know, the government's
12 job is to set the same gauge of tracks but we haven't really done that in the technology sector for healthcare. It's
13 like HDTV for television: it didn't develop because the FCC didn't set a standard for it. We need to set a standard.
14 We're trying to work hard to do that. I think at some point ... the Secretary believes it's our job to crank out the base
15 standards to make sure everybody comes up with the same thing — you can use any set of standards you want but
16 they have to be able to talk to each other. We put out probably about a third so far this year of what's needed and
17 we're working on getting it all done as quickly as we can. But the more push we get from the medical community to
18 go faster -- because there's always somebody who's against it. There's always another study, another 15 committee
19 meetings – we do these things. The faster we can get out standardized data, you know, for people to basically come
20 up with software that works with the same data sets, the better off you're all going to be.

21 Dr. Johnson: Is there something that's fairly close toward standardizing from a government standpoint ...

22 Mr. Scully: Yes.

23 Dr. Johnson: ... that you've got on the medical records. And as far as the pilots, how long do you think
24 that would be before it's out there?

25 Mr. Scully: We'll have all the standardized data measurements out there within probably a year. Again,
26 there's always somebody against it. Some vendor or somebody else that wants to use a different standard and the

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1 faster the actual practitioners get it and the harder you push for it, the faster you're going to get it. But as long as
2 you're sitting around with all the different vendors arguing about what software to use, which standards to use, the
3 longer it's going to be before we get anything in place. So, I would encourage you to push hard.

4 Dr. Johnson: This certainly would be beneficial in also having Medicare move in to a situation where you
5 could do fast beneficiary determinations.

6 Mr. Scully: Well, I'm not big on that, as you know. There are a lot of great things about Medicare. We
7 operate on .4 percent administrative costs. When I was at Oxford, which I think is a reasonably well-run insurance
8 company, our administrative costs were about 10 percent. As a result of that, they understand utilization, they
9 understand what's going on in a patient relationship. And they talked to the hospitals, they talked to the doctors and
10 they paid differentially based on quality. Where I get in trouble for saying this – Medicare is a wonderful program
11 but we are a big price fixer and we pay flat fees to everybody for the exact same amount and that's why you get
12 what you pay for. We have a .4 percent administrative offset. We spend \$1.5 billion a month, \$1.6 billion dollars
13 running a \$275 billion dollar insurance program. And you get what you pay for. It's actually less than that; we
14 spend a billion on the contractor side. And we are very good at setting rates and after that we just write checks. So
15 you don't get the utilization management. You don't get any efficiency balance system. You get a very, you know,
16 flat fee, cost-setting, price-setting system. So when you talk about getting advanced beneficiary notices which is a
17 big push on the Hill, it sounds great for seniors, that's wonderful but unless somebody wants to give me about a
18 billion dollars a year to go out and hire staff, there's not a snowball's chance in hell we can do it. It's a great
19 concept. If someone will show up and give me a billion dollars a year to hire staff to answer all those phone calls,
20 great, but otherwise it's almost laughable to me. It just can't be done. It would be fine with me if you want to walk
21 over to your offices and disagree with me on that, but just relying on the current system is not reasonable.

22 Dr. Rapp: Dr. Leggett?

23 Dr. Leggett: Just one brief comment, Tom. I think this sort of one-pot reality is creating, you know, quite
24 a duplicitous state of thinking, because inherently what you're doing is creating this inherent competition between
25 practicing what you know to be quality medicine and deciding how is your choice going to negatively impact you.
26 And I think that as we move forward and try to practice evidence-based medicine, which is clearly making the best

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1 choice for your patient, you don't want to have this inherent competition between, if I choose choice A and choice A
2 is the best for this patient, yet I'm looking at this one pot and I know choice A in that one pot is going to use up my
3 resources, it's just going to negatively impact the resources that are available to me. How does that affect the choice
4 that is actually best for the patient? I think when we fundamentally create this torn state of mind as it relates to
5 choices of medications, choices of technology for the patients, the physician is often -- it's a negative thing for them
6 to be put in this position -- just aren't making choices that are desirable, personally or economically or in terms of
7 their viability as a practice. And I think once you start on that slope, not only are you going to have a negative
8 impact on the patient you're caring for, but you can create a brand of doctor that I think is not what we want in this
9 country.

10 Mr. Scully: Well, you're getting into my other favorite subject, but we have one brand of doctor in this
11 country in the Medicare program. They're all exactly the same because we pay them all exactly the same. And we
12 don't measure quality. We don't talk about quality. We have no idea who's doing a better or worse job. I happen
13 to know that you're a terrific doctor from Atlanta, which is why I asked you to do this. Believe me, I have a whole
14 family full of doctors and I think physicians -- the whole profession is wonderful. But I can tell you that I don't
15 think the legal profession, which I'm in, measures quality enough. But it measures it more than the medical
16 community does. You basically have a single-payer government-run health system -- Medicare -- and we have no
17 measurement of quality and it scares people. But we pay people exactly the same and you get what the system is
18 designed to do. You're incentivizing a generic level of medical care that's the same for everybody. I think in the
19 long run, this is one of the reasons that I started, as you know, in nursing homes and home health agencies and we're
20 trying to move to hospitals and physicians because there are so many physicians, and the measurements are so hard,
21 it's a long way out before we can think about measuring the quality of physicians. But at some point, having people
22 know who's the best heart surgeon in Atlanta -- where are you going to go for the best outcomes and is it worth it to
23 go to a doctor. I mean, I can afford it, fortunately. I have rheumatoid arthritis. I go to the best rheumatoid arthritis
24 rheumatologist in Washington because I can afford it and he's not in my network and I pay a lot more for it, but I
25 know who he is, and I found out by word of mouth. And it's only because I'm in the healthcare profession I found
26 that out. If I happened to be the average person in Washington and had rheumatoid arthritis, I'd have no clue. And

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1 every rheumatologist in Washington pays the same amount for office visits. So, I think no matter how you look at
2 it, the system is designed to generate unmeasured mediocrity, which is unfortunate but I think in the long run we're
3 all better off if we started measuring, fairly measuring outcomes, paying people differentially and incentivizing
4 quality on the markets, within the context of social insurance. The best -- the most wonderful thing about Medicare,
5 it's a social insurance program that covers everybody in a community rated plan. And you don't have cherry-
6 picking. We don't have 40 million uninsured. We have the under 65 system. It's a great social insurance model but
7 it is a social insurance model that doesn't differentiate anything on quality or payment and basically generates a lot
8 of mediocrity, which is not good. So, I agree to a large degree. The issue is how do you improve the current
9 system. Very few people in Atlanta with incentive to go see you if you're better than somebody else. You get paid
10 the same amount.

11 Dr. Leggett: Well, the payment is the same. I guess what I don't want to see happen is physicians start to
12 make choices about what's good for a patient because that choice costs too much. And since you have one pot to
13 pull that choice out of, economically, you don't possibly interpret that making that choice will lessen what it is that's
14 available for them. And I think that --

15 Mr. Scully: That's one of the problems in Medicare. For a 64-year-old patient, I assume, Blue Cross in
16 Georgia (which is now WellPoint, I guess) calls up and discusses with you the overall global context of all your
17 decisions. Nobody does in Medicare. You just keeping checking the boxes that you want. In the back of your mind
18 you know you're putting a squeeze on a \$67 million dollar pot, yes. But being an individual physician, rarely... the
19 data would show, I think, that doesn't really drive the decision making. I guess that's my point. In the long run, an
20 insurance company, at least a loosely run, not overly managed care local insurer understands your practice,
21 understands who the good doctors and good hospitals are, which is why the President is pushing this PPO model
22 which is roughly what that is. In the long run, the local community will work better, than having my staff -- brilliant
23 as they are -- set prices in Baltimore, set the same prices for everything without any behavioral change.

24 Dr. Leggett: Well, just one final comment. There is a lot of pressure in the cardiovascular marketplace for
25 what we can do with drug-coated stents in hospitals, where hospitals are making specific recommendations for
26 physicians that are not evidence-based. It's just cost-based, in terms of whether or not to use that device on a

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1 particular patient, because it negatively impacts the hospital because of what they get paid for Medicare. And it's
2 impacting some of the doctor's choices because they're now deciding, well, should I remain in the hospital's favor
3 by doing what's good for them, or should I do what's good for the patient irrespective of what's good for the
4 hospital, beyond costs that don't match up.

5 Mr. Scully: Believe me, nobody in the world worried about pressure more than me. That pressure was
6 designed intentionally and it's working out precisely as intended, which is the fact that the drug-coated stents –
7 traditionally CMS would not approve drug-coated stents for about a year and a half. J&J, the first ones that had a
8 stent on the market -- they charged \$3,200 for the stent, to insert. We looked at the pricing and obviously it's like
9 any other drug, they said, we'd like to charge \$3,200. Why not \$32,000? And I like J&J. They're great people.
10 But we called around Europe, and we found that there, they were charging \$1,200, or \$1,800 for the procedure. And
11 they said, nobody was going to pay for it. Well, the whole reason we give hospitals the option was to give the
12 hospitals, the average I believe was \$9,200. We raised it up to \$11,000. Should we raise the \$3,000 and give them
13 the whole delta for what they claimed? No. We wanted to give the hospitals what we thought was going to create
14 pricing pressure on the company. J&J has a monopoly for the next 7 or 8 months and some say Boston Scientific
15 and Guidant are going to be in the front of the market. I don't think it's good government policy for us to say a
16 company wants \$3,000, let's just pay \$3,000. They were charging a toll but in Europe they didn't get that much,
17 that was a fact. We called around and found out. So we gave them \$1,800, which is one and a half cents; now
18 they're coming in and saying five, six, seven cents per patient. But the whole point was we broke every rule in the
19 book . . . and we tried to create some pricing pressures so the hospital would push back on the companies to get
20 better prices. Now, in the short term J&J has the whole market for 6 months. But within the context of this year in
21 which we're paying for, that will change as competitors come on the market. There will be a lot of pricing pressure
22 downwards. One of the reasons we like Part A, as I said before, is we give the hospitals the money and let them go
23 fight with Guidant and Boston Scientific. We don't pay for stents. We pay for the entire process of inserting the
24 stent. We don't pay for the surgeon. We pay for the hospital and the entire hospital stay, which is usually, I think,
25 the average length of stay is four days or something. Is that right? Four to five days. So we pay for the four to five
26 day hospital stay, all the surgical care outside of the surgeon and the stent. And we let the hospital squeeze the

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1 company back for the price. We try to create the right pressure and the right incentives. So the hospital comes in
2 and says in the short term this is terrible because we only get paid \$1,800, which by the way is \$1,800 more than
3 anybody expected a year ago. And J&J is still charging \$3,000, well my bet is within 6 months that \$3,000 will be
4 \$1,800 or lower once they get two or three products on the market. Because the other alternative is to have the
5 government just go out and pay \$3,000 or \$3,500 more, which doesn't make any sense either. So I understand the
6 short-term pressure on the hospitals but that was done completely by design, and we may have missed this by a little
7 bit but I think we did the right thing. There's no question in my mind -- I've seen the hospitals coming to the
8 government screaming about not using drug-coated stents, but most of them are. I'm sure the hospitals are unhappy.
9 On the other hand the previous practice to give the hospitals the entire amount, \$3,000 -- we went out and basically
10 improved and changed the rules the way they change products and improved the new fairly large code, in 6 months
11 the FDA approved it, which has never happened before. So, I'm sorry -- you know, when you're in this national
12 global price-fixing model, you do the best you can to create the pressures. And the pressures are working out
13 exactly as I expect them to, which is the hospitals are screaming a little bit, which means that they're going to
14 scream at you, but the other thing they do is go back and yell at J&J. And say we'd like a two year contract for
15 stents, and guess what, in 6 months if Boston Scientific is selling them and you're not nice to us we may switch our
16 high volume hospital to somebody else, which I'm sure is what's going on.

17 Dr. Rapp: Dr. Iglar?

18 Dr. Iglar: The problem with that is that the hospitals then take it out on other insurances creating our health
19 insurance problems we're seeing in different parts of the country. So ...

20 Mr. Scully: That assumes that they pay the actual price instead, which is really \$3,000, which they have for
21 the next 6 months. I don't like setting prices at all, but I would set prices for a year. We did the best we could to
22 project where people were going to be. We obviously thought this stuff was going to be out last winter. It didn't get
23 approved. We actually created the code a month before the sale was actually approved by the FDA. So, we have to
24 do the best we can to guess. But I would much rather have you fight, as I said, with Blue Cross in Georgia than
25 have to deal with us. But we have to take a national guess. It's a \$100 billion dollar pot of money, so we guess
26 when the stents are going to come into line, and how much the line is going to be, and what the hospital margins are

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1 going to be. And for a smaller hospital that doesn't have a lot of leverage, they probably get squeezed more, but for
2 a bigger system my guess is that they're probably not paying \$3,000 for a drug-coated stent.

3 Dr. Iglar: Well, the stent is just one example but there's many other things too -- their raising prices to
4 commercial insurance companies and therefore in many parts of the country creating insurance crises ... I know in
5 southeastern Wisconsin

6 Mr. Scully: Well, Wisconsin has an unusually balkanized insurance system.

7 Dr. Iglar: Yes.

8 Dr. Rapp: Dr. McAneny?

9 Dr. McAneny: In the MedPAC report I noticed that Part A was set up so that the hospital margin was like 5
10 percent Medicare and about 10 percent on commercial insurance. For Part B, physicians in order to know what we
11 can do with our capital expenditures plan or to do a business by a long term, it would be helpful to know that we
12 also were going to be allowed a margin and that the structure was going to be set up so that we would have a
13 predictable margin. So my question is, do you think that physicians' private practice offices should be able to have
14 a predictable margin, and where do you think that should be?

15 Mr. Scully: I think the margin is a lot harder and more difficult to measure for the doctor than for the
16 hospital. It's hard to measure. I admit it that when I tried to track -- and I might get myself in trouble again, but
17 that's life -- I try to track physician incomes. I tried to watch them pretty closely, and one of the reasons -- I've said
18 this repeatedly publicly, I think probably Paul would acknowledge, the one place where we have the least idea of
19 what we're paying physicians correctly is probably anesthesia codes. And I've been concerned about that in the last
20 couple years. On the other hand, even though there is a cross subsidy from Medicare to private payers -- and clearly
21 private payers pay more -- anesthesiologists' incomes are rising. So I see family practice doctors' incomes going
22 down. I see insurance going down. I see a number of other areas where -- there are surveys that I usually follow out
23 there of physician income, and I see them going down, and I'm worried about anesthesiologists. But for whatever
24 reason, it may be, again a bizarre cross subsidy, their incomes are going up. I have a hard time -- I hope we fix the
25 anesthesia code this year. But taking more money out of the rest of the pot to fix anesthesiology when their incomes
26 are going up is a hard thing to fathom. I think it's what the RUC recommended last year. So, I think measuring

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1 margins at a hospital, a capital-intensive facility, is a lot different than measuring a physician's office. To me, the
2 real issue is net income at the end of the year and we try to watch that as much as we can. General surgery demand
3 clearly dropped the last couple of years. That's supply and demand probably. Overall, physician income has still
4 been rising modestly for the last 3 or 4 years. There've been a lot of payment problems. Now some of that may be a
5 bigger cost subsidy from private insurers and other things but overall physician income has not been dropping, at
6 least what I've watched.

7 Dr. Rapp: Thank you very much for taking the time...

8 Mr. Scully: I'll come back later... I really thank you – you all are very obviously leaders in your
9 professions and your time is valuable, and I don't think you're doing me any favors – or I'm doing you any favors –
10 by coming in and pussyfooting around. This year we had some complicated issues. Matter of fact, all your practices
11 and all your colleagues – to the extent that you've been telling us to fix it —that's extremely helpful to us. The
12 comments in the last year particularly have been helpful. Again, I think these some of these advisory committees are
13 very helpful, some have been less helpful. The tradition of this one has been kind of mixed, throughout the year.
14 There's nothing that's hotter or more difficult than a physician payment system and I think the more we get you
15 involved to understand and help us figure out the answers, the better off we'll be. I'll come back in about an hour.

16 Dr. Rapp: Thank you. Appreciate it. All right. Thanks again, Tom, for coming and talking with us. The
17 next item on the agenda is some opening remarks from Mr. Grissom.

18 Mr. Grissom: That's a tough act to follow. I didn't know he was going to be here that long, much less to
19 come back. I'm sure he's given all the reporters from Part B plenty of quotes. If you missed it, I love the one in
20 which he says we compensate for unmeasured mediocrity. All I wanted to do to get us started off is to call your
21 attention to a couple of things which we inserted into your workbook for this meeting, one of which Tom referred to.
22 There are two things: What our percent participation is and, David, where are these handouts in their book?

23 Mr. Clark: They're in the back, I think.

24 Mr. Grissom: Okay. What I wanted you to see is --

25 Dr. Rapp: Diana, could you bring us some copies of this handout. Is it in your --

26 Motsiopoulos: It's in the binder.

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1 Dr. Rapp: Oh, it is in the binder. Okay. It's C.

2 Mr. Grissom: Okay. And I will walk you through this. It's real simple, and if one of your questions
3 should be why you see a different number of claims processed versus claims received, is that there's always a tail,
4 and there's always a backlog of claims which while we have received, we have not processed. So, don't get too
5 concerned about the difference in those numbers. What we wanted to do was to compare, show you 3 years and
6 these are calendar years, and compare it through the first 3 months of '03. An assigned claim is a claim where the
7 doctor takes the rate, and if you take assignment, then you are a participating physician. You can be an enrolled
8 physician also but you bill differently and do not take assignment. An assignment -- a physician who accepts
9 assignment is kind of a surrogate measure, for better or worse -- I'll just take the rate. And I don't mean to imply
10 that it assumes 100 percent satisfaction with our rates. It happens to be easier on the physician offices and
11 frequently on their operating expenses, but it's a surrogate measure. And so if you look at the figures across the top,
12 what you see is that even though the number of claims is increasing dramatically, over 100,000 in 2 years and
13 probably will increase by even more in 2003, the assignment rate moves from 98.2 percent to 98.7 percent. And the
14 numbers of unassigned claims that are processed declines even though overall claim numbers are going up. So,
15 what it suggests is that doctors who are enrolled in the program disproportionately are accepting assignment or those
16 physicians who are enrolled in the program and are seeing Medicare beneficiaries are choosing to use assigned
17 claims. And there may be -- there are, in fact -- many doctors in the program who don't accept assignment, but
18 they're also not seeing many Medicare beneficiaries and therefore filing claims. If you drop to the second set of
19 numbers, just to show you the extent to which your colleagues are adopting the capability within their office
20 practices of sending electronic claims, that number continues to climb and we are now at over 85 percent of the
21 claims that are being filed with Medicare from physicians are coming in electronically. And what we did, all of
22 these numbers have stripped out durable medical equipment claims. And that constitutes a large number of Part B
23 claims. So this is just all physician or non-physician provider claims. At the bottom are the enrollment numbers and
24 for 2003 the only numbers that are there are for the first 2 months of this year, and if you will recall, that is the
25 period of time when there was a great deal of uncertainty about what the rates were going to be for '03, and we
26 continued to pay the rates in January and February at the '02 rates which were, in fact, higher than the rates would

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1 have been if Congress had not acted. When we get together again I'll give you final enrollment numbers and
2 assignment numbers for the calendar year '03 that we are in. But what we are seeing is continued high levels and
3 slight increases in our enrollments. And the number of participating doctors currently has increased from about
4 615,000 to 670,000 for the calendar year '03.

5 The other information in the back of your book that I wanted to call attention to is the operation of our
6 carrier call centers. There is again, a lot of concern among members of the Council that they can't reach carrier
7 medical directors, they can't get their questions answered when they call the carriers, and Ken Simon is here and
8 will talk, he will be available to talk more about carrier medical directors but I wanted to tell you what we're trying
9 to do to be more responsive to providers and also to physicians, and also show you the data. If you look at carrier
10 call center data, what you see is a really remarkable increase of ... a significant increase in the numbers of calls to
11 our carriers between '02 and '03. These data have not stripped out DMERC information so part of this increase in
12 numbers -- in fact, a substantial part -- is because DMERC providers are calling in to determine beneficiary
13 eligibility. But we move from a very -- two numbers moving around here that I want to call your attention to. One
14 is the increase in calls, and two is improved performance by the carriers to be responsive to those calls. So for
15 instance, if you look in March of '03, when you're up to 73 percent of completion, which means that we answer a
16 call in 60 seconds the first time that the call is made. And we have increased that number dramatically from the
17 previous year, and that number is going up from January to February to March even though the numbers of calls are
18 also going up. I won't belabor the point but what we are doing is working specifically with all of our carriers to
19 increase the numbers of 1-800 numbers, the number of call centers that they operate, hours of operation of those call
20 numbers. We currently are set up to have the capacity to answer 25 million provider calls a year. We're using 48
21 different toll-free numbers and our 20 carriers are operating 35 call centers. We're increasingly becoming more
22 knowledgeable and sophisticated about how long these calls take, what the subject matter is, what our costs are. We
23 see the demand increasing but we do not believe that it's coming from physician providers, although that number
24 does remain constant. And for fiscal year '04 we are putting in specific performance metrics for carriers to improve
25 the quality of responsiveness. And we have an 80 percent completion rate on the first call within 60 seconds for

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1 next year. I don't mean to say we've got it perfect but we are working at it. We're putting more resources there and
2 we're trying to improve upon our performance and I think we're going to accomplish that.

3 Since we last met the agency – as Tom Scully reported – we sent our estimates of update to the physician
4 fee schedule and it was, in fact, a range as we thought it would be in the area of -4.2 percent. So just to refresh your
5 memories about a subject that's not too pleasant, we had a 5.5 percent decrease scheduled for '03. It was suspended
6 for 2 months and fixed in the appropriation bill to result in a 1.6 percent increase. And within 60 days of that
7 Congressional action, or 30 days, we had our actuaries calculate the estimate for '04, and as Tom said, because of
8 the increase in the volume of physician services and the intensity of services, we predicted an estimate of a -4.2
9 percent to MedPAC the end of March. Additionally, as Tom reported, and not that we would want to talk about this,
10 for the long term there was a significant action in the Senate on Friday. An amendment was attached to the tax bill
11 that contains a number of fixes. People now have to go to conference, a tax bill conference, and what will happen to
12 those provisions is unclear. I think the feelings are pretty strong by members of the House Ways and Means
13 Committee, the Commerce committee that they would want to hold those changes for a Medicare reform bill and it
14 shouldn't be attached to a tax bill, and that their ideas of changes are different from those in the Grassley
15 amendment, so I don't know how that's going to work out. Of interest to you, however, is a reduction in the AWP
16 as a way to offset the cost of these changes, and as Tom indicated, that would mean that a savings on the drug side
17 would not be available for fixes on the physician fee side. Particularly the physician labor portion of the GPCIs that
18 control the regional variations in physician reimbursement, have been all moved up to one so that there is no penalty
19 or negative update for physicians who are practicing in rural areas. If you have an interest, I've got a quick version
20 of the provisions of that amendment, and we can talk about them. But we've got a full agenda and since the
21 Administrator is coming back, I think we should get to it. Paul, I know, is going to start with recommendations from
22 last month's meeting and he's also got an announcement to make about the DOQ initiative and what the agency is
23 trying to do to implement some of those changes.

24 Dr. Rapp: Thank you very much, Mr. Grissom, and now Paul Rudolf.

25 Dr. Rudolf: Thanks. Thanks, Tom. Well, I thought that in lieu of all the good news we've already had
26 today, and before I go to the recommendations, that you'd like a piece of true good news. That after about 2 years

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1 of trying and doing various, working in various groups, I think we're finally at the point where we're going to be
2 able to post the correct coding edits up on the CMS website. I don't know exactly when that's going to happen. It'll
3 probably happen over the summer. It's something that we've internally wanted to do for quite some time and there
4 have been several obstacles, some of them internal with the government and some not, but recently I believe that
5 we've reached an agreement with the AMA to allow the edits to be put on the website in the form that we publish
6 them. As you know, most physicians have to buy the edits through NTIS for about \$300 a year, so that will no
7 longer be the case once these are up on the website. The quarterly updates will be available as well. So, hopefully
8 that's at least some reduction in burden for at least the physicians who are affected by a lot of the edits.

9 Dr. Rapp: What's the website in the link, Paul?

10 Dr. Rudolf: I honestly don't know. What we will try and do -- as soon as that's available, we'll get that
11 out. As I said, I don't think this is going to happen for a couple of months, but we'll make sure that PPAC is
12 notified. We'll make sure that the website is available and for the next meeting in September we'll follow up. Now,
13 getting on to the recommendations, I guess you all have copies of the recommendations in front of you, right? And
14 since there are several pages, do you all want me to read the recommendation and the response, or do you want me
15 just to read the number of the recommendation and response ... what would be faster?

16 Dr. Rapp: The number.

17 Dr. Rudolf: Okay. Just the number. Okay, we're also going to get responses to the recommendations
18 made on the Doctor's Office Quality project from the December meeting. Do you all have those recommendations
19 as well in your books? Okay. So I'll read the recommendations from the last meeting first and then the Doctor's
20 Office Quality project, second. So, we'll start with recommendation D-1. And the response to D-1 is: Adopted.
21 PRIT intends to report to PPAC regarding this issue at this meeting. So, you'll be hearing from that in the near
22 future, in fact, in a few minutes. E-1: Adopt with change. CMS has advanced this recommendation internally for
23 consideration. The issue will be addressed in the 2004 physician fee schedule file rule although you've also heard
24 from Tom Scully this morning on that subject. So, we have remanded it internally for consideration. E-2 -- just give
25 everyone a second to remind themselves of what it is -- the CMS response is to not adopt. CMS already assesses the
26 impact of expenditures due to legislative actions as part of our efforts to calculate the medical payment rates each

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1 year. CMS carefully reviewed whether to adjust the sustainable growth rate for national coverage decisions in December 31st, 2002 final rule. Nevertheless, we expect to continue examining the effect of national coverage decisions and other sub-regulatory actions on the cost of services included in the SGR. E-3...

4 Mr. Grissom: Could I just ask a question about that answer.

5 Dr. Rudolf: At the chairman's discretion.

6 Dr. Rapp: Yeah, go ahead.

7 Mr. Grissom: Just one second. For the report of the meeting, although to expedite things he's just putting D-1, could you put the recommendation in the report so that somebody won't have to refer someplace else for it. Thank you.

10 Dr. Rapp: Go ahead, Joe.

11 Dr. Heyman: My only question because of the wording of the answer, I'm just not clear. When they do look at those costs, do they somehow find their way into the sustainable growth formula? I mean, you didn't actually say that. You just said they look at the costs.

14 Dr. Rudolf: Well, I think Terry Kay is here but my belief is the answer is no. We review whether we adjust the sustainable growth for national coverage decisions in the final rule -- when we assess the impact of expenditures due to legislative actions, which is different than a national coverage decision, as far as the national coverage decisions, no, they don't find themselves into the target.

18 Dr. Heyman: And how about the legislative things like colonoscopies? That's a new benefit.

19 Dr. Rudolf: Yes.

20 Dr. Heyman: And like the glaucoma screening...

21 Dr. Rudolf: Yes. If the actuaries for Congress budget "X" amount of dollars for that, assuming it would be so many services, that increases the target by whatever the expenditures are going to be.

23 Dr. Heyman: Okay.

24 Dr. Rudolf: So, the change in the colonoscopy screening, that would have increased the target by whatever the projected expenditure was going to be. E-3: Adopt. CMS currently works with physician groups regarding this issue and will continue to look for new ways to address concerns of outsider organizations in the future. E-4: Adopt.

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1 Comments were solicited in a December 31, 2002 rule, so CMS has accomplished this. E-5: Adopt. CMS welcomes
2 input from physician groups, works with the Practice Expense Advisory Committee, and conducts surveys to obtain
3 this information. CMS presently receives cost data from physician organizations and will continue to obtain input in
4 the future. E-6: Not adopt. CMS is currently evaluating this issue further to analyze whether adjusting the SGR for
5 the impact of national coverage decisions would have any impact on physician fee schedule rates. And that may be
6 confusing because we're not adopting it but we have internally decided to analyze the issue further. But analyzing
7 the issue is different from actually deciding to agree with the recommendations, so the answer to that is not adopt.

8 Dr. Heyman: Could I ask that at some future meeting once you've analyzed that, that we get a report on the
9 analysis?

10 Dr. Rudolf: I don't have any problem doing that. Once the analysis is complete, whenever that is, in a few
11 months, we would certainly be happy to share that. The question is will we actually publish it in the Federal
12 Register or, you know, how would we deal with it. But you can be assured that it will be made widely available.

13 F-1: Adopt. CMS is presently doing this annually. This was an agenda item at the CPT meeting in May 2003. F-2:
14 Adopt, with change. CMS will address decisions in payment in the proposed rule whenever possible, but will not
15 delay coding decisions that must be made in response to other programmatic requirements, for example, changes in
16 statute or national coverage decision which require us to create new codes immediately. F-3: Adopt. This is a
17 requirement by law. F-4: Adopt. CMS attempts to achieve coding standardization, accuracy and clarity and will
18 continue to do so. F-5: Adopt with change. CMS will not introduce new G codes without a significant
19 programmatic need. F-6: Adopt with change. CMS will not introduce new G codes that duplicate existing CPT
20 codes without significant problematic needs. G codes are often created in order to better define a particular service
21 within a CPT code. F-7: Adopt with change. CMS will continue and improve efforts to obtain appropriate provider
22 input when establishing G codes. F-8: Adopt. CMS will continue to study the utility appropriateness of the
23 anesthesia convergent factor in an attempt to determine proper reimbursement for anesthesia physician work. F-9:
24 Adopt with change. CMS understands that this is still an issue before CPT. CMS will wait for CPT to act and then
25 re-evaluate as appropriate based on CPT's decision. F-10: Adopt. The 2003 enrollment period was an anomaly due
26 to the late publication of the fee schedule and the change in update. CMS extended the enrollment period until April

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1 1st, 2003 in response to this unique situation. G-1: Adopt. CMS will review, explore and discuss alternative
2 mechanisms that may allow a finding of the methodology for professional liability coverage RV units for all
3 physicians. And CMS will publish this information in either the proposed rule or final rule at such time as different
4 mechanisms are formulated. G-2: Adopt with change. CMS will review and discuss any specific alternative
5 methodologies for professional liability RVUs as part of next year's rulemaking for the physician fee schedule. G-3:
6 Not adopt. We're looking at the feasibility of providing such data but CMS does not own the professional liability
7 premium data. There is a confidentiality issue with the insurance carriers from whom CMS obtains the data. G-4:
8 Not adopt. We considered this recommendation further. Unfortunately, it's not feasible to revisit the professional
9 liability RVUs for 2004. We plan to award a contract soon to support revision of these RVUs for 2005. It's not
10 possible to award this contract, analyze the data and produce revised RVUs in time for the 2004 regulatory cycle.
11 For 2004 payments, we are collecting more current professional liability premium data to be used to update the
12 professional liability geographic cost indices, the GPCIs. This revision will be discussed in this year's proposed rule
13 and will be based on our contractor collection of professional liability premium data for 2002-2003. The work and
14 practice expense GPCIs will not be updated until January 1st, 2005, because the major source of data for the work
15 and practice expense GPCIs is the 2000 Census, which is not yet available. So just to repeat – you don't have to
16 take this down -- the professional liability GPCIs will be updated this year but the work and practice expense GPCIs
17 will not be updated until next year because of the lack of availability of the Census data. Just to be clear. G-5: Not
18 adopt. Our research indicates this information would not be available in a timely manner and the format of
19 information needed is not available to be included in the MEI. For example, to include this data in the MEI, we
20 would need the percent change and professional liability insurance premiums for a given level of coverage between
21 the 2 years, and this information is not available from all carriers. We encourage PPAC and other physician groups
22 to help make available the appropriate information on a timely basis. G-6: Adopt with change. Regulatory change
23 is not required. A program memorandum addressing this issue is under development. It can be anticipated that this
24 requirement will be eliminated and guidelines put in place that will reduce the administrative burden on physicians
25 yet insure that outpatient therapy services for Medicare beneficiaries are both timely and appropriate. G-7: Not
26 adopt. We collect premium quotes from commercial carriers which are available directly from them. In addition,

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1 this information is available directly from the National Association of Insurance Commissioners, although not
2 available on a timely basis for our rulemaking process. G-8: Adopt with change. CMS is not proposing any
3 changes in the supervision requirements for radiology services at this time. However, CMS would welcome
4 comments from PPAC on this issue.

5 Now, with regard to the Doctor's Office Quality project.

6 Dr. Heyman: [Regarding G-5] I'm trying to understand because if we did get them to provide more
7 rapidly, would it then be included or why are we providing it more rapidly if you're going to ignore it anyway, is
8 what I'm trying to understand. Or, am I misunderstanding?

9 Dr. Rudolf: I wish this was an area of my expertise but it isn't. Terry, can you respond to that question
10 better than I could? You all, this is Terry Kay, who is the Director of the Physician and Ambulatory Care Division.

11 Mr. Kay: Unfortunately, I don't think I have a copy of exactly what you're looking at but...

12 Dr. Rapp: Let me read the recommendation ...

13 Dr. Rudolf: I'll read the recommendations and the response, Terry. PPAC recommends that CMS include
14 a statistically significant sample of all professional liability insurance carriers rather than only commercial carriers
15 on collecting liability premium data for the MEI. And part of the response was that we encourage PPAC and other
16 physician groups to help make available the appropriate information on a timely basis. The example we gave was
17 that we would need the percent change in liability premiums for a given level of coverage between 2 years and this
18 information is not available to all carriers.

19 Mr. Grissom: And I think Dr. Heyman's question is, are we asking the physician community to help us
20 obtain this information?

21 Dr. Heyman: ... and then if we do, will you include it?

22 Mr. Kay: Right. Ignoring the exact wording of this – clearly the intent is that we would like to work with
23 you all and anyone in the physician community to explore ways that we can more quickly obtain malpractice
24 professional liability premium data. Until the last year or so premium data has actually been quite stable. I think for
25 the previous 10 years there have been very few changes, so we've been kind of going along, updating the values
26 periodically as required. But it did not get a lot of attention because the numbers are very stable. In the last couple

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1 of years there's been significant changes in a number of states.. So, in the past our data was practically 2 years old
2 by the time we used it. Now, everyone is interested in having something more timely so we need to explore some
3 alternative sources and we'd love to work with you in working out options. We've already had a staff level
4 discussion with AMA staff on what could be some possibilities, and we would clearly use it, you know, we'd like to
5 explore new ways of doing this because the old ways, the data just gets to be too old by the time we get it.

6 [Discussion about where to find the next recommendation.]

7 Dr. Rudolf: 1) Adopt. The DOQ stands for Doctor's Office Quality. The DOQ project is committed to
8 developing measurement models that minimize or eliminate burden to physicians in their offices. The entire first
9 year of measuring the design to explore models that correlate well for the gold standard for measures, which is
10 sometimes in medical records, sometimes the administrative data or electronic data, and sometimes it's patient-
11 derived -- but to minimize or eliminate burden for offices. (2) Adopt. Currently a separate project called a
12 Physician Group Practice Demonstration will be using financial incentives to achieve quality improvement and
13 efficiency. In the DOQ project we're exploring incentives with financial invocations. For example, free CME
14 credit to physicians and linkage to malpractice premium reductions. Other demonstrations linking financial
15 incentives to performance are being discussed with CMS. (3) Adopt with change. CMS continues to work with the
16 consortium on the projects measure selection and project implementation, and expects the consortium will provide
17 insight into all aspects of the DOQ project. The DOQ three-state pilot project is not a public reporting pilot, and the
18 primary use of the measures will be for quality improvement. We do hope to be able to do some exploration in
19 modeling public recognition as an incentive for improvement. But there will be no public reporting of individual
20 physician results in the DOQ three-state pilot project.

21 Dr. Heyman: Are you agreeing that any resulting data would be used only for quality improvement
22 purposes? I'm not quite clear on that part of the answer.

23 Dr. Rudolf: Well, Dr. Barbara Paul is here. Barbara, maybe I'll go through all of them and you can answer
24 all the questions at once. Is that okay? We'll just note that you have a question on 3. Okay? (4) Adopt. CMS is
25 committed to work, continuing to work with AMA and the consortium to advance our common goals of enhancing
26 the quality of patient care, advancing the science of clinical performance measurement and improvement, and

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1 enhancing the practice of medicine. (5) Adopt with change. Data collected on the DOQ measures will be shared
2 widely, including sharing with the consortium. We plan to work closely with the consortium on an ongoing basis in
3 this endeavor. It is unlikely the data elements will be useful to the consortium or CMS. Is that right? It's unlikely
4 that the data elements?

5 Dr. Paul: Just let me read it.

6 Dr. Rudolf: ... unlikely the data elements will be useful to the consortium or CMS. (6) Adopt. CMS is
7 working with experts to evaluate all the issues surrounding the use of clinical systems and patient-derived measures
8 for quality improvement and for accountability, and is exploring a variety of data sources in order to understand and
9 advance the science of measurement. We plan to work closely with the consortium in this endeavor. In the three-
10 state pilot to the DOQ project there will be no public reporting of individual physician results. (7) Adopt. And this
11 says, See the response to 6. (8) Adopt with change. Manual data collection can be done retrospectively through
12 medical records or prospectively through flow sheets. We're very aware of issues around burden and are working to
13 minimize them, including exploring projects involving electronic medical records. We note for PPAC that in a
14 study funded by CMS to determine the accuracy of flow sheet data collection, that is prospective collection,
15 significant under-reporting of care occurred when flow sheets were used. Therefore, we're still exploring whether
16 data collection might be retrospective or prospective. (9) Adopt. This is an excellent idea and we appreciate the
17 suggestion. Most of the relevant specialty societies are our various core groups and panels. (10) Not adopt. In the
18 DOQ project, overall, we'll be exploring via focus groups of consumers and practicing physicians, and by field
19 testing a variety of options for public recognition of physician participation and quality improvement, for
20 improvement, and for achievement of excellent quality of care. In the three-state pilot to the DOQ project, the
21 participating physicians themselves will determine what level of public recognition they would like. We will
22 suggest this to them. (11) ...

23 Dr. Heyman: ... we will suggest that...

24 Mr. Kay: We will suggest, we will let them know what the recommendation is of PPAC. It's for them to
25 make.

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1 Dr. Rudolf: Okay. (11) Adopt with change. The Pacific Business Group on Health, funded by the AHRQ, is
2 developing and testing measures of efficiency. CMS will consider using those measures or any others that we
3 become aware of after careful review, most likely during the re-measurement year of the DOQ project. And lastly,
4 (12) Adopt with change. Specialist physicians have been included in the DOQ project as members of the technical
5 expert panel, and are certainly key to the development and implementation of measures as well as other aspects of
6 the project. DOQ is a primary care project, and as such, those practices included in the three-state pilot will be
7 primary care physicians. So, Barbara, if you don't mind coming up. There's a question about 3. I don't know –
8 were there any other questions?

9 Dr. Heyman: Yeah, I have a question about 10.

10 Dr. Rudolf: Okay. Do you have everything in front of you, Barbara?

11 Dr. Paul: Yeah, I have what you were just...

12 Dr. Rapp: For those new members, who may not know you, just introduce yourself and for all of us tell us
13 what you're doing now ...

14 Barbara Paul: I'm Barbara Paul and I'm the Director of the Quality Measurement and Health Assessment
15 Group here at the CMS. I formerly was the Director of the Physician's Regulatory Issues Team here, and I'm an
16 internist. And my group is involved with a whole variety of efforts to create performance measurement across the
17 entire healthcare spectrum -- in particular, the lead on the various quality initiatives under Tommy Thompson and
18 Tom Scully, such as the home health quality initiative that we just launched, the nursing home quality initiative last
19 year and the hospital work we're doing this year. So, on number 3, Joe, your question on that one was

20 Dr. Heyman: Well, my question was the part of the recommendation that says that any resulting data
21 would be used for quality improvement purposes only, is that going to be the case and if it's not the case, what else
22 are you going to use it for?

23 Dr. Paul: When you say any resulting data -- I mean, the results of the measures. You're not talking about
24 the underlying, for the things that go with, to construct the measures? The measures themselves, how are they going
25 to be...

26 Dr. Heyman: Well, my understanding is you're going to do a pilot project.

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1 Dr. Paul: Uh-huh.

2 Dr. Heyman: And the resulting data from that pilot project, are you going to be using that for quality
3 improvement purposes only, or are you going to be using it for something else?

4 Dr. Paul: Well...

5 Dr. Heyman: And if you are using it for something else, what is the something else?

6 Dr. Paul: We are asking the question in this project of whether you can measure quality at the level of the
7 individual physician office setting, that very small system, the individual physician office. And, so there will be
8 some modeling and other sort of research level work to see whether you can use these measures or create composite
9 measures, for example, something that would actually distinguish higher quality care from lower quality care. But it
10 won't be used for public reporting of that. It's really on a research level.

11 Dr. Heyman: So, we need not be concerned about some sort of punitive kind of result of this project?

12 Dr. Paul: This project is of 100 positions in each of three states. You have to keep that in mind. The
13 positions in those three states will be determining what level of public recognition occurs, and in the DOQ project
14 itself there won't be any public reporting.

15 Dr. Heyman: Well, that brings me to my other question which was on number 10. That is, you said that
16 the physicians within the project will be making that decision on their own. Can we assume that they'll be making
17 that decision before they know the results of the study? I mean, I would certainly hope so. Because otherwise there
18 will be some physicians who will feel strongly that they would like to have every last digit of their performance
19 displayed, and others who will not want their performance displayed at all, and it may be that this spread may not be
20 very wide. And I'm just concerned that that decision be made before they know the results.

21 Dr. Paul: That hadn't occurred to me. I don't know if we've thought about that. I would assume that we
22 would, you know, that this is a very open and kind of collegial and, you know, the two I/O's working with the
23 physicians very openly in each of those three states, and I would assume that there would be a decision that
24 everyone could be comfortable with. Now, when that decision is made, I don't know. I can check and find out, but
25 I just don't know.

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1 Dr. Heyman: Well, I would like to suggest that at some appropriate time during the meeting today,
2 whenever it is appropriate, that we have the opportunity to discuss the recommendation and suggest that that
3 decision be made prior to the results being released.

4 Dr. Paul: To the individual physicians working...

5 Mr. Grissom: Barbara, I think there may be some confusion here. It's certainly confusing to me. What
6 does the term "public recognition" mean and can we differentiate that for the members of the council from public
7 reporting?

8 Dr. Paul: Well, as I understand this issue, the wish of the PPAC, and certainly I have heard this from
9 others, was that public recognition in the DOQ project, simply the recognition that you are a participant in the
10 project, not that you scored A or B. And what we're saying is we're open to that if the docs in the DOQ project
11 want public recognition for being in the project. But we are going to let them decide that.

12 Mr. Grissom: Regardless of that, in other words, you're not going to report ...

13 Dr. Paul: Right.

14 Mr. Grissom: -- you mean by public recognition is either, that they're either going to be anonymous that
15 they participated, or you're going to have a list of participants.

16 Dr. Paul: Right.

17 Mr. Grissom: But the data for those participants, the outcome and how they measure ...

18 Dr. Paul: It's confidential.

19 Dr. Heyman: Oh, okay. Well, that's all I wanted to know.

20 Dr. Rapp: I think the concern was that they would get 25 gold stars for being the best doctors in California.

21 Dr. McAneny: Many of your recommendations should say that things are going to be published at a future
22 date in a Federal Register. For those of us who don't routinely read the Federal Register, could we have an e-mail or
23 some sort of a warning that says when they have to be published.

24 Mr. Grissom: Absolutely.

25 Dr. McAneny: With the URL to make it simple.

26 Mr. Grissom: We'll do that.

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1 Dr McAneny: You're wonderful.

2 Dr. Rudolf: Usually when we talk about publishing in the Federal Register, it's a code for it'll be
3 published. It'll be out in the open, but we will send it to you.

4 Dr. McAneny: Okay.

5 Dr. Rudolf: Well, just to be clear. All you have to do is go on the CMS homepage, and it'll say right up
6 there when the physician proposal was published, that that's where it is. You just click on it and you can download
7 it. You don't have to go anywhere. You just have to go to CMS.gov and you'll be right there. But we certainly will
8 let you know when it's available on the website. And the final rule is always published or usually published on
9 November 1st.

10 Dr. Rapp: Okay. Thank you. Let's take a five-minute break, but only five minutes.

11 (BREAK)

12 Dr. Rapp: Let's call the meeting back to order please. All right, the next item on the agenda is the
13 Physicians Regulatory Issues Team update. Dr. Simon and Dr. Lawlor. Could you do us a favor and, welcome,
14 introduce yourselves for us and tell us what your areas of responsibility are

15 Dr. Simon: Yes, good morning, Mr. Chairman and the Council. My name is Ken Simon and this is Rich
16 Lawlor. We presently compose the PRIT team. I've been acting in this capacity for the past 6 weeks or so. My
17 other responsibility includes working for Tom Grissom on policy issues for the Centers for Medicare Management.
18 For the new members of the PPAC, I'm a vascular surgeon by training.

19 Dr. Lawlor: Good morning, or almost good afternoon. My name is Richard Lawlor and I actually am a
20 practicing, not a practicing anymore, but trained as a chiropractor, and I'm board certified in sports medicine as
21 well. And I've been working in the PRIT capacities for about 4 ½ months now, and I also play a role in the open
22 door forums with Mr. Tom Barker here at the agency. Thank you.

23 Dr. Simon: This morning we will share with you the results from the Carrier Medical Director Access
24 Survey. We'd like to point out that CMS recognizes the importance of communication between itself, the carrier
25 medical directors and the medical community at large. And we do appreciate the Council's high level of interest on
26 this topic, and we recognize that it's both your responsibility and your commitment to ensure, on behalf of the

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1 medical community at large, to ensure the policy maintenance, that we continue to engage in dialog and consider the
2 concerns that you have and exchange thoughts and ideas as we try to streamline and improve the delivery of health
3 care to the Medicare beneficiaries. And, so it's really with this understanding that CMS undertook this survey in an
4 effort to establish baseline information of the carrier medical directors' perception of access and availability. To
5 that extent, we receive responses from 23 to 48 carrier medical directors. Each of the carrier medical directors
6 responded independently to several questions that were posed to them. The first question, do physicians have
7 adequate access to you? The majority of carrier medical directors felt that they provided adequate access to
8 physicians. In fact, over 90 percent of carrier medical directors indicated that they provided either a direct home
9 number, e-mail address, or both as the primary mechanisms of communication to the physicians in your local
10 communities. Other methods of access include communication which would provide a conduit for physicians to talk
11 with carrier medical directors include communicating through the customer service representative and their
12 administrative staff be it the medical review personnel or the physician education team. The second question is,
13 what is the predominant method by which physicians use to reach you? Over half of the carrier medical directors
14 indicated that direct phone line access or e-mail access was the primary mode of communication used by many
15 physicians in their communities. Roughly 20 percent indicated that there was no clear and well-defined method but
16 that it was either phone mail access, e-mail access, or using the customer service representatives or the
17 administrative staff. The next question was, what is a typical weekly vine when calls or contacts are received from
18 physicians? Over half of the carrier medical directors indicated that they communicate with physicians on the order
19 of 10 to 20 contacts or phone calls per week, and that through this they found themselves either fielding questions
20 directly from physicians as they called in, or they returned calls to physicians in response to questions that were
21 posed to them. On the average, there was a range of time spent by the carrier medical directors addressing physician
22 concerns, which ranged anywhere from 4 to 25 percent of their workload time. On the average, the average carrier
23 medical director spent about 13 percent of their time communicating with physicians. And it's roughly a 50/50 split
24 between carrier medical directors either answering an incoming call from physicians, or returning calls to
25 physicians. And again, 13 percent of the workload for the average carrier medical director was spent addressing
26 issues by telephone. Do you feel that you could accommodate a slow increase in the number of calls? Over 90

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1 percent of the carriers indicated that they could handle additional phone calls. And roughly 10 percent or so
2 indicated that they were at their threshold. The next question was, is your direct phone number listed, or a number
3 used that would ultimately allow you to be reached? And is it available to physicians and/or other proprietors and if
4 so, where is it listed? The majority of carriers reported that the direct phone number is publicly available, and it's
5 available in several different venues. The most commonly is listed on the carrier website, but they also indicated
6 that it was listed with the state and local medical societies. It's usually posted with the newsletters that would be
7 sent out indicating the updates as well as with direct physician correspondence, and with carrier mailings. 39
8 percent of the carriers did not indicate whether their direct phone number was listed. Do you make your e-mail
9 address publicly available to physicians? If so, where is it listed? Over three-quarters of the carriers responded that
10 their e-mail address was publicly available. Again, they used a host of venues to try to reach out to the community.
11 Their e-mail address is available on the carrier website, on their business cards. Again, it's listed in the state
12 medical society roster. It's on their professional letterhead. When they meet with hospital staff, in medical society
13 meetings, and at other medical meetings, they indicated that they make their e-mail address publicly available.
14 Well, the next question posed, what would you do to make yourself more accessible to the physician with an issue
15 requiring your attention? About 25 percent of them indicated that they would recommend increasing the contact
16 through physician group meetings. They felt that would be a venue where they would be able to engage in more
17 dialog and they would have this nurtured developed communication and relationships with physicians in the
18 community. 20 percent indicated that they would increase, try to find different venues where their phone number of
19 e-mail address could be posted to make it easier and more accessible to physicians. And roughly half of the group
20 did not know what other venues, other than what currently was in place, they'd be able to use to increase access in
21 accessibility. Would contractor staff make you aware that a physician is trying to call you? Well, the three primary
22 groups that they principally communicate with are the call center staff, the medical community staff and the
23 continuing education staff. They also used other members of the administrative staff, but those three components
24 seem to be primarily used as a conduit to transfer or communicate directly with the carrier medical director of issues
25 of importance to physicians. And, incoming customer survey representative calls can be routed to you or to one of
26 your administrative staff when the provider has a question that cannot be answered by the customer service

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1 representative or professional relations staff? Well over 90 percent of the carriers have processes established
2 whereby it allowed direct transfer of physician calls or information directly to the carrier medical directors. We see
3 that roughly 10 percent do not have established processes in place, and clearly that would be one area where there
4 would be room for improvement. Do you and the other medical review or physician education clinicians keep track
5 of how many calls you're getting on a particular subject and develop scripts for customer service representatives and
6 professional staff? Well, 35 percent of the carriers tracked their calls on certain issues and 13 percent of those
7 carriers develop scripts that they give to the administrative staff in order to enable them to communicate to
8 physicians on those issues when they're called. About 26 percent currently don't track their calls, and 39 percent
9 didn't indicate, so again this would offer another area for room of improvement where communications between
10 physicians and carriers could be enhanced. What proportion of your time is spent in education and outreach,
11 including phone calls to physicians and other providers/suppliers? Well, more than half of the carriers surveyed
12 spend around 15 to 30 percent of their time on outreach and education to physicians, other healthcare providers, and
13 to suppliers. A quarter of the carriers certainly spend less than 15 percent of their time, and the remaining quarter
14 spent more than 30 percent of their time on outreach and education. All of the carriers surveyed indicated that they
15 had not had any complaints regarding their access to physicians. And CMS certainly recognizes that this survey is
16 an imperfect one in that half of the carrier medical directors responded to the survey. And we believe that, though
17 there's been useful information that has been derived from the survey, that clearly more information should and
18 could be obtained to better inform us. And we think that it would be important for us to not only hear from the
19 remaining carriers who did not respond to this initial survey, but equally important to hear from participating
20 physicians in the Medicare program throughout the country to hear what their concerns are so that we would have a
21 better understanding of the extent that access and communication remains a problem. We would also recommend
22 that all carrier medical directors have their direct phone line published on their website as well as their e-mail
23 address. And that it should also be published in all the carrier newsletters. And we would encourage the carriers to
24 work together to develop a uniform response of customer service process so that it would hopefully help streamline
25 not only the calls that physicians make to carriers, but streamline a process that would lead to improved
26 administrative support for a physician, and decrease the burden for physicians in trying to obtain information from

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1 carriers. And those are the results that we have from the survey that were taken, Dr. Rapp, and we would field
2 questions at this point.

3 Dr. Rapp: How will the recommendations or thoughts that you just mentioned, in terms of improving
4 communication, be handled then? Do you have the ability to deal with that, or how will that be handled internally?

5 Dr. Simon. I think that once we speak with Mr. Grissom and others in CMM, then we will begin to
6 develop a framework where we can formalize the process and operationalize some of the areas where we perceive
7 weaknesses at this time.

8 Dr. Rapp: Dr. Heyman?

9 Dr. Heyman: How did you know I had a question.

10 Dr. Rapp: I just assumed you might, or a comment or whatever.

11 Dr. Heyman: Well, I think it's a very interesting survey, and I agree with you that it would be important to
12 talk with some of the physicians who actually deal with those carrier medical directors because obviously there's an
13 incentive for these folks to indicate that they're always available and that there are never any problems getting in
14 touch with them. I think that my impression has been, over the years coming here—and I have had, up until this
15 day, a wonderful carrier, NHIC which has always been terrific. Now, I don't know if that's because of Charlotte
16 Yeh or because of NHIC. And I'm very concerned now that Charlotte's working for you guys that it's not going to
17 be as good as it used to be. But I wonder about the carriers. There were some interesting statistics that, there was a
18 statistic that showed that a certain number of carriers could not handle any more increase in their phone
19 conversations, 11 percent, I presume. And there was another slide that showed that some carriers only spend 3
20 percent of their time on the phone. And I'm wondering whether there was any juxtaposition of which carriers
21 couldn't handle any more phone calls because of this 3 percent of the people who only spend the 3 percent of the
22 time on the phone, who can't handle any more phone calls. Then that might be an indication that those are a
23 particular group of carriers, medical directors who we hear from time to time here in PPAC about having problems
24 with. So, I'm just wondering about, you know, that particular – I mean, having sat here for many years I've heard
25 that in certain regions of the country they're not as lucky as I am. And, of course, I'm not there to experience the
26 frustration, but having heard the frustration, I wonder whether or not you were able to notice that the carriers that did

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1 90 percent or 88 percent who said they could handle more phone calls, were the same carriers who were already
2 handling a lot of phone calls, or were they the ones who were only doing 3 percent? Do you understand the point
3 I'm making?

4 Dr. Simon: I understand the question, yes. From some of the data that we looked at, it appeared that some
5 of the carriers that spent a lower percentage of time on the telephone and spent more time actually dealing with e-
6 mail and fax communications, as opposed to spending it on the phone.

7 Dr. Heyman: Okay.

8 Dr. Rapp: Just mechanically, the issue about making their telephone number accessible, or their e-mail
9 address and so forth, in terms of what the relationship of CMS is to the carriers, basically they're contracted, so how
10 would you mechanically just, could you all up and say, we'd like you to do this, or how would that work?

11 Mr. Grissom: It will be a performance requirement in the '04 budget. There won't be any cajoling to done.

12 Dr. Simon: Okay. All right. Who's next?

13 Dr. Rapp: Dr. McAneny and Dr. Wood?

14 Dr. McAneny: Yes, I appreciate your work on keeping all of this as open as possible, Ken, and thank you.
15 One of my concerns is that if the carrier medical directors feel that they're getting all these phone calls, yet they're
16 only getting about 20 per week, I think the number was, you don't know how many people are trying to call who
17 never got through because the carrier medical directors would have no way of knowing how many doctors gave up
18 before they got through to the carrier. One of my concerns also is that in our area, because we've lost a carrier
19 medical director, I've just been doing an informal survey asking people if they know that they can call, if they know
20 who the carrier medical director is, what kind of questions would be appropriate to ask that person. And,
21 particularly people who have been in practice for 5 years or under, have no idea what to use it for. So, this is an area
22 that we need to work on, is to tell people it's there. The other thing that I see is that things that used to be approved
23 without any difficulty, now because we've lost our local carrier medical director, and then the guy from Oklahoma
24 is doing a great job of trying to pick up and help us out, but a lot more questions come through. For example, we're
25 having to send in more information to justify the medical necessity including things like Guaiac, which we never
26 had to do before but we've seen that. Or we'll have just more denials or more requests for more information, and I

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1 think that that might be a way to track it particularly in those areas like ours where a change has occurred. If we
2 have any idea how many requests for information occurred before a change, and then look at the loss of the carrier
3 medical director to see if you're getting more requests, that might be a way to get a handle on are we generating
4 more administrative responsibility at a more administrative expense without improving the quality of healthcare.

5 Dr. Simon: In response to that, I think one of the, some of the responses that the carriers gave when
6 queried how they perceived they could improve dialog and communication with the medical community, was to
7 increase the direct outreach time that they spend with physicians. And I think that that probably would be a very
8 useful medium for them because it would give them the opportunity not only to acquaint themselves with the
9 doctors in the community but equally important for these issues such as Guaiac and all to be able to establish dialog
10 and educate one another on the medical necessity of perhaps asking that question, and the clinicians being able to
11 provide the medical reasoning why it's clinically warranted. So, I think that their response of increasing their direct
12 outreach time could be mutually beneficial for both groups.

13 Dr. Rapp: Dr. Wood?

14 Dr. Wood: Looking at the data that was referred to earlier this morning, as far as in terms of call
15 completion and then listening to this, I hearken back to the GAO report from February of 2002 which was on
16 Medicare communications with the physicians. We've not really discussed that very much here at PPAC, and I
17 don't know how much it had, how much work it has engendered at PRIT. But the report actually shows that there
18 were major problems with communications. And there were some serious recommendations that were made. From
19 your perspective, Ken, what's actually happening at PRIT to improve the likelihood that you would be able to access
20 a carrier medical director when someone else gives an inaccurate answer to a physician's question? I mean, the
21 issue of the quality. Call completion is one thing but there's still a 20 percent call abandonment rate which would, I
22 think, skew some of the information that is perceived by the carrier medical directors.

23 Dr. Simon: I guess I'm not sure of the question in regards to inaccurate information. I'm not sure exactly
24 what.

25 Dr. Wood: Well, from the perspective of the data that you show here where the calls come in to the carrier
26 medical directors, a lot of them come from other than a direct call. And if 20 percent of your calls are never

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1 completed at a call service center or a routing center, then the carrier medical directors are obviously not reporting
2 the number of problems they're encountering.

3 Dr. Simon: I think they just don't know about it.

4 Dr. Wood: So, the real question is, from my perspective, why do this survey and why look at call
5 completions when we have a GAO report that says there's a significant problem with communication with
6 physicians? Why are we not working on a plan to address those problems that were already identified and find ways
7 to solve those problems?

8 Dr. Simon: Well, I think that the first order is that this survey was undertaken as a direct response to a
9 request from PPAC, I think at the last meeting. The Council wanted to derive more information in regards to the
10 accountability and accessibility of the carrier medical directors. We tried to impart that this morning to you. I think
11 the next step is to obtain information from the physician community at large to find out what the magnitude of the
12 problem is and the extent, if any, of accessibility and communication between carriers and the local medical
13 community. So, I think those will be the next steps, investigating what has been in written in the GAO report.

14 Dr. Wood: Well, I guess my question is, then, you would interpret the GAO report as being either
15 inaccurate or unrevealing, and look for a better answer in the physicians communities? Your assessment is that
16 somehow the response from the physicians would be better than what the GAO got, and a sort of a secret shopper
17 approach? Although the GAO persons were actually identified themselves to the call centers when they made the
18 phone call. I mean, I look at, in my perspective, we don't need any more setting. We know what the problem is.
19 Let's just talk now about fixing it.

20 Dr. Rapp: Okay. Well, first of all I think you have had a number of recommendations that you were going
21 to suggest. Right? One is the – can you just review what your recommendations were after having done this? And
22 one had to do with today. Posting the telephone number and the e-mail address and so forth.

23 Dr. Simon: We're going to post the telephone number and I believe the e-mail address publicly, and also
24 discuss what the carrier medical directors, and from their own information supplied to us, that there's a need for
25 more direct physician outreach, and that we would encourage them to communicate more closely with the medical
26 community that they serve.

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1 Dr. Rapp: And Mr. Grissom has been forthcoming with the idea that that could be, I think those first two
2 items could be performance criteria. And then, I don't want to put you on the spot, but have you reviewed that GAO
3 report?

4 Dr. Simon: I've not personally reviewed the GAO report but I will discuss it with others that have. So, my
5 understanding that there were, that the GAO report also included BFI's and, excuse me, that was not a component of
6 what this survey comprised of. So we would need to look at it to be able to tease out exactly what the GAO report
7 referred to that would be relevant to the concerns here, carriers specifically.

8 Dr. Rapp: Well, I think that this came to you because we were sort of coming up with our own ideas, an
9 800 number and so forth, and that didn't meet approval, so the last time we asked Dr. Rogers if he would take on
10 this project to help look at it and in his absence it looks like you've, as far as I'm concerned, done a good job in
11 initially looking at it, but perhaps you would look at the, as Dr. Wood has suggested, the GAO report in coming up
12 with any further thoughts on it. Dr. McAneny?

13 Dr. McAneny: ... a significant percent, I believe around a fifth of that was inaccurate. So, I would hope
14 that one of the areas and maybe I'll make this as a recommendation that PPAC requests that the PRIT look at the
15 accuracy of CMV information, and figure out a tool by which we could a) upgrade it, and b) know that we're doing
16 so.

17 Dr. Simon: I think it would also be important to identify where the inaccurate information is coming from.
18 I think carrier specific, I mean.

19 Mr. Grissom: I feel like we have a little disconnect here. I do not want the members of the council to get
20 the impression that we have not read that report and we have not taken steps to respond to it. We may not have
21 fixed everything, I agree to that, but the difficulty in here is that we are not getting three million phone calls a month
22 from doctors. We are not getting three million phone calls a month from doctor's offices. There are hundreds of
23 thousands of DME providers who make these phone calls. There are hundreds of thousands of doctor's offices who
24 have their back room managers make these phone calls. Now, I don't think that most of those phone calls need to be
25 directed to a carrier medical director nor do I think that they are asking questions that a medical doctor sets policy or
26 enacts policy for a carrier he's charged with. And all of the provider phone calls that are going to FI's, I'm

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1 assuming, are not questions relating to the issues affecting physicians. So, of the entire universe that the GAO
2 measured in 2000 and 2001, and reported, is a universe much larger than having anything to do with carrier medical
3 directors. Since the report has come out, what we have attempted to do is, we have worked with both FI's and
4 carriers to increase the number of people that they have assigned to this responsibility. The numbers of 800 phone
5 lines that they have assigned to this responsibility. The number of call centers that they have set up. We have put
6 into place for both this year and next year call monitoring capabilities that will allow us, when somebody answers
7 the phone, to say that this call may be monitored for quality improvement purposes. What that means is that we are
8 making specific tie-ins for a number of calls to find out what the question is, who it's directed to, and whether the
9 answer is accurate or not, which is essentially what the GAO did, and got that information in their report. We have
10 spent more money, not less money, on provider education and we're trying to use the same kinds of technology and
11 tools for providers that we have already had in place for beneficiaries. But the size and the enormity of this problem
12 is not related to carrier medical directors. It's related to nearly one million providers who we have in the program
13 who make these phone calls and a relatively small number of those calls are either for or need to go to carrier
14 medical directors, and I think it's confusing or misleading or worse, to talk about percentages and hundreds of
15 thousands of calls when we're really mixing up apples and oranges and just talking about fruit. We are very much
16 concerned about getting doctors the appropriate answers to physician-related, medical-related questions that they
17 had. That's very difficult, very different than determining whether or not we're going to cover a wheelchair for this
18 beneficiary and are they eligible. And can you give me the status of my claims for these patients. I don't think that
19 one is more important or less important to the questioner than the other, but the size and the enormity in the way that
20 you answer them result in very different kinds of resources to be directed at the problem.

21 Dr. Rapp: Dr. McAneny?

22 Dr. McAneny: Let's make that a motion.

23 Dr. Rapp: Okay. Would you restate the motion then?

24 Dr. McAneny: The PPAC would recommend that the PRIT monitor the accuracy of carrier information
25 and provide a mechanism to improve it and measure the improvement.

26 Dr. Rapp: Could you explain that a little? I'm not sure I follow.

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1 Dr. McAneny: Well, we were previously told that the accuracy level of what physicians receive when they
2 ask questions, particularly of carrier medical directors, was approximately 80 percent accurate. But physicians who
3 are doing coding, billing and etcetera, are relying on that information to avoid allegations or fraud, etcetera. If that
4 information is inaccurate, then the physician can't rely on it and it really makes the whole project a lot more
5 difficult. So, rather than saying, can you get through on the phone call, once you get through I want to make sure
6 that the information that I'm given, in regards to my question, is accurate, and that I can truly rely on it.

7 Dr. Rudolf: Can I ask a question? I wasn't aware the GAO surveyed only carrier medical directors. I
8 thought --

9 Dr. Rapp: Oh, no, no.

10 Dr. Rudolf: I thought it was the entire carrier organization....

11 Dr. Rapp: It did, it did.

12 Dr. Rudolf: Well, I understand that but there's no indication that the carrier medical directors are only
13 giving you correct advice 80 percent of the time. So, I think that, that's what I think is confusing, is that this project
14 has to do with carrier medical directors and the GAO report has to do with the whole carrier, and there are hundreds
15 of people working at a carrier, many of whom respond to questions from providers and billers, and I'm not sure that
16 that -- I mean it's fine to make that motion but I'm not sure that that's germane to what this, no one knows the
17 accuracy rate of information dispensed by carrier medical directors.

18 Dr. McAneny: Well, I meant it by entire carriers actually, because you are, whether you're given the
19 information by the carrier medical director, and usually that's more of a, for me, can I give this drug to this patient
20 for this disease, or I've already done it, will you pay me for it, kind of questions. But often when we call up to day
21 how much more information do you want. Are the Guaiacs sufficient and we get information and we're told to rely
22 on that, or how do we code? Do we need to put this modifier on this particular code and we're given that
23 information by someone in the system. We need to be able to rely on that, and as I understood the GAO report, it
24 looked as if a significant percentage of that information that we were relying on was inaccurate.

25 Mr. Grissom: That is correct, and the number in there is totally unacceptable in terms of incorrect answers,
26 whether they're incorrect answers on a coding issue, or a payment issue, or whether or not there's a local

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1 competitive policy or a national competitive policy. And I certainly don't have any problem with your motion. I
2 can tell you that we already have, we have things in place in this year's contract and will be in next year's contract
3 that will allow PRIT to get that information from our Medicare contractor management group. Now, it's not going
4 to be as precise or as generalizable as I would like it or as you would like it. But we're already doing that and we're
5 going to continue to do it in '04.

6 Dr. Rapp: Okay. Can we read the motion back then?

7 Dr. McAneny: PPAC recommends that the PRIT monitor the accuracy of carrier information, provide
8 mechanisms to monitor improvement and to measure improvement.

9 Dr. Rapp: Is there a second to that motion?

10 (Motion seconded).

11 Dr. Rapp: And further discussion?

12 Dr. McAneny: It wasn't just to monitor improvement but to just improve it, and to measure it.

13 Dr. Rapp: Okay. Okay, read it back again, then.

14 Rapporteur: That PRIT monitor the accuracy of carrier information, provide a mechanism for carriers to
15 monitor, I'm sorry, to provide a mechanism to implement improvements? To monitor improvements?

16 Dr. Rapp: Do you want to read it again, Barbara?

17 Dr. McAneny: Just to provide a mechanism --

18 Dr. Rapp: Start over.

19 Dr. McAneny: Okay.

20 Dr. Rapp: Give us a whole motion.

21 Dr. McAneny: That the PRIT monitor the accuracy of carrier information and provide mechanisms to
22 improve the accuracy and to measure that improvement.

23 Dr. Rapp: Do you want to read it back?

24 Rapporteur: PPAC recommends that the PRIT monitor the accuracy of carrier information, provide
25 mechanisms to improve the accuracy of information, and to measure improvement.

26 Dr. Rapp: Okay? We got a second to that. Any further discussion? All in favor?

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1 [Multiple] Aye.

2 Dr. Rapp: Anybody oppose? Okay. That carries. Yes, sir, Dr. Wood .

3 Dr. Wood: I think we should actually endorse the work that the PRIT has done so far on working to
4 improve the availability of phone numbers and website addresses.

5 Dr. Rapp: I certainly agree with that. Is there anybody in a disagreement with that? Okay. PPAC would
6 like to endorse the work that you've done so far and thank you for it. Dr. McAneny?

7 Dr. McAneny: I'll make this in the form of a motion for the statute purposes but I would like to request
8 that PRIT find an indicator sample of physicians and document their ability to obtain accurate information and
9 education from the carriers. The idea that comes to mind would be, for example, people who had denials. Or people
10 who have been accused of up-coding or down-coding or some sort of a question along that, and find out whether or
11 not that was based information they got. It seems to me that you've done a great job of looking at it from the carrier
12 side. And I recognize that surveying the physicians across the country is a ridiculous and expensive task. But I
13 would wonder if it might be possible to select a indicator group who might really give you concise and inexpensive
14 to obtain information on how well the provider community is able to solve their problems using the carriers.

15 Dr. Simon: I think it enters into the terrain of quality and so I certainly would welcome discussion with
16 Margaret and Paul at a future date as we explore being able to address that question.

17 Dr. Rapp: Okay. There was ... Dr. Rogers mentioned the last time he was here that the PRIT was taking on
18 the job looking at the Secretary's Advisory Committee Regulatory Reform Recommendations. Have you done
19 anything with that in Dr. Roger's absence? Is that still in your bailiwick?

20 Dr. Simon: Still in that arena.

21 Dr. Rapp: Then there was something on the translation service's request. He mentioned that physicians are
22 required to have a translator for their patients who don't speak English. Anything...

23 Dr. Simon: Yes, there's actually, about 2 weeks ago the Office of Minority Health sponsored a two-day
24 forum that had members from the Department of HHS, and several physicians from different medical specialties
25 attending this meeting will be met. This issue of interpreter services, and not only language as a barrier but also
26 culture as a barrier that impedes the physician-patient relationship. And this was the first meeting of a three-staged

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1 meeting whereby in March of 2004, this group that's headed by the Office of Minority Health, will deliver a paper
2 to the Secretary of HHS that will outline the framework by which they would recommend we address the issue of
3 language barriers and interpreter services for physicians and hospitals in their offices, etcetera.

4 Dr. Rapp: Okay. And then there was, I think there was something about the direct coding issue but I think
5 Dr. Rudolf already mentioned something about that earlier today. Is there anything else?

6 Dr. McAneny: Yeah, I did make mine in the form of a motion.

7 Dr. Rapp: Okay. Would you state the motion then?

8 Dr. McAneny: Okay. That the PRIT may modify it to say, to work with the Office of Quality ... I may not
9 have the right title of that office ... to find an indicator sample of physicians and document their ability to obtain
10 accurate information on education and on carriers.

11 Dr. Simon: I guess it's a question of whether that's in his bailiwick at all. In other words, we will confer
12 with the appropriate individuals of the agency, you know, to answer that question.

13 Dr. Rapp: Okay. Could we read back the motion?

14 Rapporteur: That PRIT work with the appropriate quality staff to find an indicator sample of physicians
15 and document their ability to obtain accurate information from their carriers.

16 Dr. Rapp: Is there a second to that motion?

17 [Seconded.]

18 Dr. Rapp: Is there a discussion?

19 Dr. Wood: Yes.

20 Dr. Rapp: Yes, sir.

21 Dr. Wood: What's different than simply measuring performance in your first motion?

22 Dr. McAneny: In terms of, the first one was just getting accuracy of information, and this one is trying to
23 say whether or not, from the physician's side, they can truly reach into the CMS system and get what they want. So,
24 it's really access as well as accuracy.

25 Dr. Wood: Well, would you be measuring that as part of the response of the first?

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1 Dr. McAneny: I meant the first one was more specific in terms of what the information that was being
2 given, but this is more the access. It seems, to me there's two parts. I just separated them. One is having access to
3 the information and the first one was once you get there, is it accurate?

4 Dr. Lawlor: Dr. McAneny, I think your motion is duly noted and we would like to work with our Office of
5 Quality to identify those groups. However, I just wanted to point out that we need to balance that with the value of a
6 random sample of physicians, and then we wouldn't want to pre-direct the outcomes to any groups.

7 Dr. McAneny: My concern was that a random sample would be that it might be too dilute. That the
8 majority of people who are out there and practice don't contact their carriers. They don't have questions. They do
9 it, whether they're doing it right or wrong, who knows? But they're doing it the way they do it and they don't do the
10 questions. So it might be easier to see small changes if you select a group where those changes are going to be more
11 than likely to occur.

12 Dr. Lawlor: I understand.

13 Dr. Rapp: Dr. Wood?

14 Dr. Wood: I have some concern about the indicator selection in that we would have a biased sample, and
15 we'd consider that an unbiased random sample should be effective if the results of the initial GAO survey, in fact,
16 were an unbiased random sample that ranged from physician groups of four to six hundred. So if we were going to
17 do this, my recommendation would be that we stay and follow the methodology that was used by the GAO in terms
18 of developing a range of groups and a range of questions to get accuracy. My concern is that if we wanted to
19 measure, we have a baseline in place already. And if we wanted to continue to see the improvement, which I think
20 is important, then it would be also important from my perspective that we maintain consistency of methodology, that
21 we go forward.

22 Dr. Rapp: Okay. Could we read back the motion? Have we done that?

23 Rapporteur: ... that PRIT work with the Office of Quality to find an indicator sample of physicians and
24 document their ability to obtain accuracy of information from their carriers.

25 Dr. Rapp: Okay. Any further discussion on that?

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1 Dr. Heyman: I was wondering how Dr. McAneny would feel about us incorporating Dr. Wood's
2 suggestion into her motion that we use the same methodology and if we're going to, my understanding is that we're
3 interested in seeing how things move forward and we have a baseline from the GAO study which, quite frankly, I'm
4 familiar with. But it sounds like it was a very good study done by the GAO. And I was wondering how you would
5 feel about just continuing forward the methodology and any further looking at it so that we had something that we
6 can compare it with, or do you want to start with a new way of looking at it?

7 Dr. McAneny: Mr., Dr. Chairman?

8 Dr. Rapp: Go ahead.

9 Dr. McAneny: I think that the GAO study was very good in that it did look at a broad random sample, but
10 my concern as I read that was that there were going to be more specific changes that would occur faster than would
11 be detected by the random sample of physicians. And that you might get an idea, you know, if they surveyed 10,000
12 physicians and only a 100 of them have had any particular problem with the Medicare system that required
13 assistance through the carrier, you would not see a percentage change. It would still come out as .001 percent had a
14 problem. Whereas if you selectively looked at a group, and I agree the selection could be biased, but I think --

15 Dr. Rapp: But she's not in favor of that.

16 Dr. McAneny: I think that, well, I'm not in favor of biasing the selection.

17 Dr. Rapp: But you're not in favor of changing your motion.

18 Dr. McAneny: No, I'm not.

19 Dr. Rapp: Okay. Any further discussion on that motion? All in favor?

20 [Multiple] Aye

21 Dr. Rapp: Anybody opposed? Okay. The motion carries. Thank you very much. The next item will be
22 the volume performance measures, volume intensity adjustments. John Shatto? This is the man with the numbers.
23 Thank you for coming.

24 Mr. Shatto: Good morning. My name is John Shatto and I'm an actuary working at CMS. I was asked to
25 talk to you today about our volume assumptions and specifically our volume response assumptions. But I thought
26 I'd start it off by doing a little background on where we are right now with our estimates for the 2004 update. This

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1 is the estimate that we just published in March. As you can see, we estimate the annual update would be 2 percent.
2 A current estimate of the performance adjustment for next year is a -5.9 percent, and there's also a legislative two-
3 tenth's reduction making our current estimate for next year's update -4.2. As you all probably know, there recently
4 was enacted a consolidated appropriations resolution, which changed the 2003 update -4.4 percent to a positive 1.6.
5 And when this was passed, it was thought that that would also give positive updates into the future. So, the question
6 will be, what happened? Here's what happened since last summer. Last summer we had estimated that the 2004
7 update would have been a positive 1.7 percent. Since that time, the estimate of the Medicare Economic Index is
8 about three-tenths lower. The GDP numbers are quite a bit lower than they were over the summer. And, in
9 particular, the GDP for 2002 is now estimated to be 1.5 percent whereas it was 2.3. And then the estimate for 2003
10 was significantly reduced. Another important factor is that we estimated the physician administered drug spending
11 to be about 20 percent for 2002 and now it's looking more like 25 percent. So, that was a further reduction in the
12 update. And overall, the total spending growth in 2002 was quite strong, and we had estimated at that time it was
13 going to be about 4.2 percent. And we're currently estimating it to be about 6 ½ percent. So the net effect is that the
14 non-drug rule reduced the update by about 2.6 percent. Accommodation of all these factors makes the 2004 update
15 a current estimate of like -4.2 percent.

16 Mr. Grissom: John, are those numbers additive? You don't multiply. In other words, if you...

17 Mr. Shatto: They're actually multiplicative.

18 Mr. Grissom: They multiplicative? So, the minuses, if added up, and subtracted from the 1.7, do not end
19 up in the -4.2?

20 Mr. Shatto: They actually do. I don't have that on my head, but that's not, they worked out...

21 Mr. Grissom: That's an accident.

22 Mr. Shatto: It just happens that they work out, out of the budget.

23 Mr. Grissom: Okay.

24 Mr. Shatto: As a result, and since the system itself is cumulative and takes into account prior year spending
25 and that kind of thing, we have an update over 2004 that's estimated to be a -4.2. Our estimates for the next couple
26 of years after that are also small negatives. But as we stated before, this system is quite volatile. And this year's

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1 March estimate tries to quantify the volatility in next year's update. This perhaps can look at little strange but
2 essentially what it is, is it's a 95 percent confidence interval for next year's updates. So we have, with 95 percent
3 confidence, we think it's going to be between -5.8 and +0.6, which is a very big range. The reason the range is so
4 big is that the 2004 update is going to take into account a lot of information including allowed spending and GP
5 numbers for 2003, which are completely unknown at this point. So, given the fact that they're completely unknown,
6 we have a large degree of variability in next year's update. But as you can see, the heavy weight of the range is
7 more toward the negative end. The reason that there's a huge spike at about -5 percent, is because the performance
8 adjustment is limited to +3 and -7, and so there's a number of trials in which the -7 is reached. So, as we've seen,
9 the big impact here is because 2002 spending was quite high. Despite the large payment reduction in 2002, the
10 spending growth under the SGR managed to grow by 6.5 percent. The next slide just has some of the areas in which
11 there were, you know, different spending increases. The major procedures, surgical procedures had actually
12 decreased from 2001 to 2002. But most of the other areas had substantial increases, especially the physician
13 administered drugs which grew by 25 percent.

14 Mr. Grissom: And John, are you measuring the numbers of prescriptions, or are you --

15 Mr. Shatto: This is dollars.

16 Mr. Grissom: -- are you holding that --

17 Mr. Grissom: I know it's dollars. What portion of it is from price increases on drugs, and what portion of
18 it is on the increase in number of prescriptions?

19 Mr. Shatto: Well, we have about a little over a 3 percent increase in the price for drugs, so a good portion
20 of this is going to be in the volume of drugs. That concludes everything I had to say about next year's update, so
21 before I get to the volume intensity portion of this, does anybody have any questions?

22 Dr. Rapp: Any questions from members of the Council? Dr. Urata?

23 Dr. Urata: Where does the increase of the drug use in clinics come from? Is it because there are fewer, less
24 drug use in the hospitals because we're doing more outpatient, or has that been flushed out?

25 Mr. Shatto: These are mostly -- these are physician administered drugs, so these are drugs that were given
26 in a physician's office.

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1 Dr. Urata: You're saying that the volume increase is the reason for most of the increase, the 25 percent?

2 Mr. Shatto: Yes.

3 Dr. Urata: So, why do you think that is?

4 Mr. Shatto: I don't know. We're just looking at the numbers.

5 Dr. Urata: Okay. So, you don't have that information.

6 Dr. Rapp: Dr. McAneny?

7 Dr. McAneny: Speaking as the oncologist who's probably responsible for a good bit of that, I think a lot of
8 it's oncology, a lot of it is Remicade -- there are some other infusions but over the past 10 years, a huge amount of
9 what we used to do in the hospital, all this is platinums, all the tougher drugs like that to administer, have now come
10 to where we can administer them in the office. But there has been no transition in terms of money from the in-
11 hospital parity to the in-house office ancillary pool. So it just causes a decrease, so the price we pay for being more
12 efficient and able to do this in a more convenient user-friendly and less costly system, is that we penalize all of
13 physicians in terms of their fee schedules. The other part is that there are large quantities of very new drugs that
14 have come out which are expensive, which we purchase and have no control over the price of them. But it would be
15 unethical to not offer them to Medicare patients. So again, the penalty that we get for ethically treating people with
16 the advancements that our wonderful technology has made available, is that all physicians take a hit on their fee
17 schedule.

18 Dr. Rapp: All right. Any other questions. Dr. Heyman?

19 Dr. Heyman: To what extent do all of the increases that you have listed up there, have to do with changes
20 in population, you know, growth in older people and...

21 Mr. Shatto: Right. The population growth for 2002 was a little over 3 percent.

22 Mr. Grissom: That's an absolute increase in beneficiaries, John?

23 Mr. Shatto: It's an increase in the number of fee-for-service beneficiaries, because there's only about a one
24 percent increase in older beneficiaries, but there was drop-outs from the Medicare Plus Choice Program that would
25 be included. So, the increase in the number of fee-for-service beneficiaries is a little over 3 percent.

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1 Dr. Heyman: And, what about say, the population of people who are over 80? What has been the increase
2 in that group?

3 Mr. Shatto: I haven't looked at that specifically, and I don't think we have that data specifically for fee-for-
4 service beneficiaries.

5 Dr. Heyman: Well, the reason I asked is because as people get older, obviously there is more of the need
6 for all these services, and if that older population is increasing, I'm wondering whether we're making some sort of
7 accommodation for that, or are we just going to have a consistent year after year drop in physician payments until
8 there are no physicians left in Medicare? I'm just, I just don't understand how we're dealing with that. And it
9 seems to me that we should certainly be looking at the population of people who are over 70 and over 80, and seeing
10 what happens because certainly they're the biggest users, I would assume, per beneficiary of all these services.

11 Mr. Shatto: Right. Well, that could very well be that the population is definitely aging and that could
12 cause more services, but the way the SGR system works is it's very prescriptive in the law; it says specifically
13 taking into account number of people, and that's it.

14 Dr. Heyman: No, I understand that, but what I'm wondering is without actually looking at the information
15 it's hard to have evidence to make a persuasive argument that we need to change something. I mean, it seems to me
16 that we need those figures, and it would be great to have them, and the only people who have them are you. So, I
17 would like to recommend that somehow we get a breakdown on that at some point.

18 Dr. Rapp: Any motion?

19 Mr. Grissom: Two things. One is we do have numbers on the breakdown of what's happening to the
20 demographics of the beneficiary population and it's typically 85 and older, and that number is growing dramatically.
21 And I believe that Dan Crippen and his colleagues over at the CBO have precise information on the expenditure of
22 Medicare funds by beneficiary groups and the ages. If it would be useful, perhaps we should have that presentation.
23 Their study follows beneficiaries as opposed to spending in Florida versus Texas, and then follows them in the last 6
24 months of life, and by age group, and if that would be useful, we should have that presentation.

25 Dr. Rapp: Would that --

26 Dr. Heyman: Yeah, I think it would be wonderful.

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1 Dr. Rapp: -- meet the need to do that?

2 Dr. Heyman: Well, I think it would be wonderful. I mean, I don't know that it's going to solve anything.

3 Dr. Rapp: No, but I'm ...

4 Dr. Heyman: It certainly is frustrating to see these numbers and not have that explanation. I mean, it may
5 turn out that that has nothing to do with it, but it seems to --

6 Mr. Grissom: You're right. I didn't want you to get the answer next month that this is the percent of
7 people who are at the age of 85, because then your question would be, well, how much Medicare spending is there --

8 Dr. Heyman: Right.

9 Mr. Grissom: -- for people over the age of 85, or in the last 6 months of their life. Or, if they fall into this
10 demographic group, but I think the CBO has done as much or more than anyone to follow the beneficiaries, and
11 that's what I was suggesting.

12 Dr. Rapp: Would that meet ...?

13 Dr. Heyman: Yes, yes.

14 Dr. Rapp: Dr. Gaughan?

15 Dr. Gaughan: Just to add to Dr. McAneny's comment that physicians are getting penalized for actually
16 moving people into outpatient and being more efficient. I think it would be interesting to know also the chronic
17 illnesses, the number of chronic illnesses. It seems like we're getting penalized for giving good care, doing the
18 screening exams, or actually preventing illness and keeping people alive longer. And it seems like we'd make a lot
19 more money if we didn't keep people alive and we didn't treat chronic illness, and that obviously shows that a stable
20 growth rate just does not make any sense to physicians because we all know, I think Dr. Wood talked about it last
21 night, that we're keeping people alive through chronic illnesses, and we're keeping that population, not only are they
22 over 85, they have multiple illnesses. They have kidney failure. They have diabetes, hypertension, and I'd like to
23 see that, because I really think, obviously this formula is flawed, but that just shows you even more how it is flawed,
24 and I wanted to add to Dr. McAneny's comment.

25 Dr. Rapp: Dr. Leggett?

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1 Dr. Leggett: I was just going to echo a few things. I was just going to echo Joe and Barbara's point earlier
2 that this chart is particularly disturbing, and it is incomplete and is totally insufficient for you to come here and say
3 that you're just a numbers gatherer, because to blindly present this without any regard for how you get to these
4 numbers or any solution, to the larger community on how to fix them, I find that simply just indefensible. But I
5 think the bigger point has already been made, that there is no way of looking at these numbers you can ever expect
6 that negative number to change.

7 Dr. Rapp: Anything else? Dr. McAneny?

8 Dr. McAneny: I wanted to go back to the MEI estimate. I noticed in looking at the MEI, or for the
9 hospital, that they looked at employment rate and saw the increase that they were going to estimate of about 5
10 percent for non-physician wages and salaries, yet on the physician side, the estimate of an increase was only about 3
11 percent which was equivalent to the general salaries across non-healthcare workers. We're really in the same pot.
12 We recruit nurses and radiation therapy technicians and various echo techs and various other people who, and were
13 in direct competition with the hospitals and other facets of the healthcare market. We are not recruiting those people
14 out of burger flippers from, you know, the fast-food chains. It really is not the same group and it does not require
15 the same salary level as the general population looking for jobs. So, I would like to recommend that PPAC requests
16 that the salary levels for healthcare workers be equivalent in estimates to those given to the hospital part, rather than
17 to salaries from the general population.

18 Dr. Rapp: Now, what impact would that have now?

19 Dr. McAneny: When our estimate for a salary increase was 3.7 percent, for the MEI?

20 Dr. Rapp: Yeah.

21 Dr. McAneny: Whereas in the hospital part, they recognize that in 2001 they had the increase at 5.4
22 percent compared to the general increase of salaries that crossed general workers everywhere, which was estimated
23 at 3.6. And in 2002, it was 4.4 percent compared to 3.2, which means that in order to get healthcare workers, you're
24 paying a significant increase in your wage structure compared to the rest of the economy. Hospitals have been given
25 this as an update. Physicians have not. And I think it should be equitable. We are competing for the same
26 workforce as the hospitals. When you hire a nurse for your office, you're competing with floor nurses.

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1 Dr. Rapp: How does that fit into this formula that Mr. Shatto was talking about?

2 Mr. Shatto: The wage is a portion of the MEI, so if the wage portion were higher, then that share of the
3 MEI will be higher, therefore raising the total...

4 Dr. Rapp: And is there that kind of data available? Wages for healthcare workers in non-hospital settings?

5 Mr. Shatto: Actually, I'm not that familiar with the MEI or its calculations. It's something I could check
6 into for you.

7 Dr. Rapp: All right.

8 Dr. McAneny: It's provided in the MedPAC report, and in terms of looking, you have to look at the part
9 that looks at hospital reimbursement and how they selected their fee schedule for hiring in a hospital. But there's no
10 equivalent selection for the Part B Medicare for physicians' office expense, and there should be. It's the same group
11 of people.

12 Dr. Rapp: Okay.

13 Dr. McAneny: So that was a motion.

14 Dr. Rapp: Okay. What's the motion?

15 Rapporteur: To request that the salary level for healthcare workers be equivalent to those established for
16 hospitals rather than to salaries for the general population, for calculation of the MEI.

17 Dr. Rapp: Recommends.

18 Dr. McAneny: Right.

19 Dr. Rapp: Okay. Is there a second to that?

20 [Second.]

21 Dr. Rapp: Is there a discussion on that? If not, all in favor say aye.

22 [Multiple] Aye.

23 Dr. Rapp: Anybody oppose? Okay. Anything else – you have something. Yes, Dr. Hamilton?

24 Dr. Hamilton: It was mentioned earlier that we should take into consideration the aging of the population
25 in calculating some of these figures. You had mentioned that this is a significant factor. I think it would also be
26 very helpful to have information concerning the amount of expenses generated during the last months of people's

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1 lives, because I am convinced that a great deal of money is spent in terminal situations where the likelihood of
2 prolonging useful life is minimal. This sort of information would be very helpful, and if you coupled that with
3 incentives to provide the sort of end-of-life care that people want outside of hospital intensive units, the opportunity
4 to save money would be enormous.

5 Dr. Rapp: Is this something in your bailiwick, Mr. Shatto?

6 Mr. Shatto: Actually, our office is currently working on a last year analysis at the moment.

7 Dr. Hamilton: It would be very helpful.

8 Mr. Shatto: That should be completed shortly.

9 Dr. Rapp: Okay. So --

10 Dr. McAneny: I have a question. Were the comments earlier about looking at the incidents of chronic
11 disease and the addition to the expense by keeping people alive with a chronic disease that Becky was talking about,
12 and that Joe were talking about -- was that a form of a motion, or do we need one on that?

13 Dr. Heyman: I think Mr. Grissom indicated that that information would be forthcoming at the - that there is
14 a study already.

15 Dr. Rapp: We discussed that -- the Congressional Budget Office.

16 Mr. Grissom: The CBO study also follows beneficiaries by the number of co-morbidities, so, and
17 spending. So, my hope is that at the next meeting we'll have a presentation.

18 Dr. Rapp: The plan is to put on the agenda a report involving that and then Mr. Shatto agreed to, when the
19 report on spending in the last year of life comes out, he'll get that presented to PPAC. Did you have something else
20 for us, Mr. Shatto, or is...

21 Mr. Shatto: I was also going to present our numbers on capacity.

22 Dr. Rapp: All right. I don't think we're going to get done with you at this point. We have Dr. Nelson who
23 wanted to make relevant comments to this point. Were you planning to stay through lunch, Dr. Nelson, or?

24 Dr. Nelson: Whatever you think.

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1 Dr. Rapp: We might listen, we might, rather than get involved in this more detailed subject, we'll let Dr.
2 Nelson make his comments and then we can go have lunch. And then have you come back with that after lunch.
3 How would that work? Council, is that okay? Okay. Then we'll take –

4 [Unidentified]: Is that going to impact on the afternoon schedule because there are some points there that
5 are important for this session.

6 Dr. Rapp: Impact – well, it'll impact it some but I think we'll get everything done. How's that?

7 Dr. Rapp: All right. Maybe Mr. Shatto will go on for another five minutes or so. Why don't you initiate
8 your, what you're going to say about the volume intensity part, and then we'll...

9 Mr. Shatto: I can try to go through this quickly.

10 Dr. Rapp: That's all right.

11 Mr. Shatto: I thought I'd start off by saying that our basic assumption is that we're assuming that in
12 response to a Medicare physician price cut that the level of volume of services, intensity services given that year is
13 going to be higher than it otherwise would have been. I thought I'd start off by saying that this has almost no impact
14 on the updates on a given year. This is merely for our assumptions about future updates. For example, for 2004, if
15 the -4.2 price cut actually had been, we'll assume that they will be higher volume in 2004 because of that price cut.
16 But then when we actually get to using the data from 2004 to determine the update, we use actual data, not our
17 assumption. So, that the assumption doesn't get into the price increase or decrease. It seems to have skipped a slide.
18 I'm sorry. What we do is, when we do our spending projections, we're looking at a lot of things. We have to do
19 projections for changes in law regulations. Now, the purpose of this study is to see if we have an idea of what the
20 price is going to be in the forthcoming year. Do we have some indication from that of what the volume and the
21 intensity is going to be in that year. In other words, are they correlated in any way. This is just a – to illustrate what
22 we mean -- volume increases and intensity increases as the volume changes. But that's not the only thing we're
23 talking about here. We're also talking about changes in the intensity of services delivered. More expensive
24 services, that type of thing. Now, there's a couple of examples on the paper that show sort of how this happens. For
25 this practice, there was a large increase in the prices, namely 27 percent for the procedures that they performed. And
26 during that same year the visits that they performed went up by 84 percent. The other example has to deal with

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1 intensity. This particular practice, as I perceived here, is the procedures were cut by 24 percent in a given year. So,
2 that was a substantial cut. Of the offices it's only grew by 8 percent, but the dollars – the payments from those
3 office visits grew by quite a bit. I realize this is a lot to take in but the reason for that is sort of the average level. As
4 you can see the new patient visits in '94, most of the new patient visits were under the third level, and the fourth
5 level, the same type of thing happened with the established visits. So the level of a visit on average went up. And
6 this is just what we've seen so far for 2002, is that the average coding level for the office visits have remained
7 relatively stable over the last several years but then went up in 2002. There were a couple of other studies that we
8 looked at when we were doing our own study. The first was done by Sandra Christiansen. This was from the late
9 70's, I believe, and that's what said that the offset was about 50 percent so that any price cut was meant by about 50
10 percent more volume and intensity of services. That's the assumption that we had been using up until we did this
11 study. We figured since the fee schedule had come along, we had the Medicare going with the performance
12 standard which was similar to the sustainable growth rate. It was time to do a new study and figure out if anything
13 had changed. This study here looked at just the reductions in response to the cuts over 1989. And it found that there
14 was about 40 percent response to price reductions for the years 1989 and 1990, and that this response tended to vary
15 by specialty. PPRC also did a few studies on this in response to several of the pieces of legislation. In each of their
16 studies they concluded about a 30 to 40 percent response to the price reductions. For our own study we used data
17 that we had available for the period of 1994 through 1996 and it was a 5 percent sample. The prices we measured
18 were an average price of a mix of services done by a practice. We also tried to look at some other variables when
19 we did this, like number of physicians in the area, number of hospitals, admissions, that type of thing, to try and see
20 if we could figure out some of the factors that would cause a change in volume and intensity of services. And this
21 analysis was done at the locality level by specialty. One of the reasons we looked at this period was as far as, from a
22 statistical point of view it was a good period to look at because there were a large number of practices that had big
23 pay decreases and some practices that had big pay increases, so there was a wide range so that we could figure out
24 what happened to the ones with the big decreases versus the ones that had the big increases. We did that regression
25 analysis essentially. This looked at using a price as an independent variable and trying to determine what the
26 volume and intensity increase would be. Symmetric versus asymmetric – what that means is we looked to see if the

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1 reaction occurred both to pay increases and pay decreases or just one versus the other, to look at it both ways. Some
2 additional ways we looked at it – we looked at it for just the medical specialties versus the surgical ones. We looked
3 at it by the individual specialties by themselves and we looked at each of the two years individually. This is sort of a
4 graph of what we found as far as the volume intensity versus the price increases. The price increase, the more
5 negative price increases had the higher volume intensity over this period and the positive increases had less. And
6 you can see there was quite a big range here from -15 percent to +15 percent. This is the results of our regression
7 analysis. What this shows is that the symmetric responses, as it occurs on both price increases and price decreases, a
8 lot of the things here weren't that significant, statistically significant, that is. In other words, it showed some
9 variation that that could have occurred by plan and chance. For the asymmetric ones, we had a lot better statistical
10 significance and they tended to show around 30 percent volume intensity response for a price increase for all
11 surgical specialties, for surgical and medical. They were all about the same. And the other thing to note here is that
12 the '94 to '95 period, we found very little significance. And most of that was because in 1995 the physician
13 payments at the MVPS, the private sister of the SGR, calculated a 7 ½ percent illness for that year. So most of the
14 specialties received price increases, like about three-quarters of them. And then for 1996, there was a small
15 reduction due to the MVPS and so most of the practices, about 90 percent of them received pay reductions. So,
16 what is the conclusion of this? The conclusion is that we changed our assumption from our 50 percent assumption
17 to the 30 percent assumption that we generated from our study, plus looking at some of the other studies, and we
18 will continue to use no offset for price increases. And, unfortunately because of the data we use, we could not get
19 enough information to see if there was any variation by specialty. That's all I have, so are there any questions?

20 Dr. Rapp: And, once again, how is this used in terms of the fee schedule?

21 Dr. Shatto: It's used in a few different ways but the biggest way is it's used for our projections. So, when
22 we say in 2010 spending is going to be at a certain level, we're using this volume intensity response assumption to
23 get to those spending levels, the biggest one, 2004 we're currently estimating that it would be a pay cut of 4.2
24 percent. So, we're assuming that 2004 is going to be a little bit higher than average. Volume, in particular, the cut
25 is 4.2 percent so it was in 30 percent of that cut would have extra volume in 2004. So, this is for our projections in
26 the future.

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1 Dr. Rapp: Just one comment. One of your slides I studied that's on the term up-coding. The term up-
2 coding is frequently used to indicate a fraudulent type of activity as opposed to maybe changing in service that your
3 provide. It doesn't necessarily, if up-coding implies that you're providing the same service, you're just charging
4 more for it, but the volume in response is, okay, I'm going to give it a different service or more of a different service
5 than the cheaper service. But you're not, or maybe you're more accurately coding but it's just a little, I think it
6 implies more to say they're up-coding than to say that they're providing a higher level of service. It implies
7 fraudulent – if it was OIG here they would say, wait a minute, who is that, where did you get that slide and take
8 them to the false claim they had going there. So, at any rate. Dr. Wood?

9 Dr. Wood: A couple of methodologic questions. I noticed you used the term residual increase. Could you
10 define residual increase?

11 Mr. Shatto: I'm not sure where in this presentation I used residual increase. When we do our projections,
12 what we mean by residual increase is generally volume intensity increase because that's everything that's left once
13 we take out price and the normal increases. I'm not sure if that's where you were referring to.

14 Dr. Wood: It was actually about three slides back, and the concern actually is when you project the overall
15 spending, and you were good enough to show some of the reasons for the changes on the estimate, the change in the
16 number of visits, tests, imaging, etcetera. On the perspective of then figuring out the volume, the volume could be
17 driven by a large number of factors. It could be driven by the change in the number of beneficiaries. It could be
18 changed by the burden of illness among the beneficiaries. So that the more chronic conditions that are present, there
19 would be, in fact, an increased utilization in services. The slides on the website are very good, many of which came
20 from your office which showed the contribution of the change in population and the number of chronic conditions in
21 utilization. The intensity related to acuteness of illness, in fact, things like catheter implantations for coronary
22 angiography, for heart attack, or use of newer devices. I mean, the technology contributions to that. All of those
23 may, in fact, require additional visits. For example, an implantation of a device would require a couple of follow-up
24 visits. Or, to the extent that in a DOQ project, for example, we fully implemented all of the diabetes quality
25 improvement process or project recommendations. You would then anticipate that there would be an increase in the
26 frequency of visits if physicians achieved the quality targets, because we're asking that they have three physician

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1 visits a year plus an ophthalmology visit and a foot examination. Now, as you presented that it doesn't appear to
2 mean that you'd incorporate all of those kinds of contributing factors, you look at only the things that are specified
3 by law and regulation. But when there are, in fact, other parameters like we want to improve the quality of
4 healthcare delivery but when that quality, in fact, incorporates additional volume and intensity, it's not reflected in
5 your estimate. And that's kind of what I'm getting back to in terms of residual increase. My own sense, actually, is
6 that the volume increase here, in perspective of the price sensitivity, is considerably less and there's a much larger
7 increase related to the other factors that I've mentioned. But it doesn't seem like you incorporate those in
8 projections or volume.

9 Mr. Shatto: Well, actually our prediction of the volume and intensity increase, we have an underlying sort
10 of volume and intensity increase that happens year to year. I don't know that we look at, you know, specifically
11 each year what's going on but it's more of a trend analysis of what the underlying growth of volume and intensity is,
12 and then this response to a price reduction would be on top of that. So, there are sort of two things that go into our
13 volume intensity increase. It's not like if there were no price reduction, volume intensity growth we would assume
14 would be zero. We assume that each year there is an underlying growth in the volume intensity of services
15 delivered.

16 Dr. Wood: I found the examples. How and why did you pick those three examples?

17 Mr. Shatto: Actually, there were two examples. One was just a volume example and one was an increased
18 level of visit example, and the reason they were picked is that it illustrated what we were trying to get at as far we
19 wanted them done to illustrate a volume increase, and one, we illustrated an increase in intensity of services
20 delivered.

21 Dr. Wood: In our work to look at changes in evaluation of management codes, we looked at a large
22 number of data of coding patterns across even subspecialties over the last decade. And Paul will have to make sure
23 I've got this right but in general we see a lot of change in the distribution codes across the subspecialty. If that were
24 the case, then I think the conclusions here would be different than what you've reached based on the application of
25 both the symmetric and asymmetric models to the data that you have.

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1 Mr. Shatto: I think one thing I would say is, we're not saying that the level of the coding level or the
2 number of visits shouldn't go up. Maybe they should go up but I think what we were just looking at is I was trying
3 to find a correlation between those that went up and the individual practices that have price reductions. And it
4 seemed like there was a correlation between the practices that had the price reductions and the practices that had the
5 larger volume and intensity increases.

6 Dr. Wood: Again, I guess from looking at all the data available to us across the spectrum, having seen it in
7 the context of thinking about what we could shift be, in physician coding patterns, it seems inconsistent with what
8 both know.

9 Dr. Rudolf: I don't want to make John's point for him but I – tell me if this is wrong. I don't know that
10 you can look at in a whole specialty level, because looking at a specialty, some practices perform a different mix of
11 services. So, you look at this practice that happened to perform a high volume of cataract operations, that took a big
12 pay cut. Another practice that did not do any cataract operations or did retina operations that went up in payment –
13 it still would have been ophthalmology but there would have been a different physician with regard to this particular
14 practice. So, overall you might - I think you could do even more at an individual level rather than at a specialty
15 level.

16 Mr. Shatto: Right. Actually, the study itself was aggregated to specialties by locality. So, for each of the
17 localities around the country, each specialty was hooked into one data point.

18 Dr. Rapp: Dr. McAneny? And then Dr. Urata, and then Dr. Gaughan.

19 Dr. McAneny: A couple points. I'm not sure really what the intent is. With the volume distributions that
20 you're describing, if you expect a physician practice to remain viable yet you cut their fees, they're going need to do
21 something to remain in practice and therefore be there to be the infrastructure healthcare in this country. Yet when
22 take a practice which has seen a reduction in a price that's been their main stay of business, it seems logical to me
23 that they would say, well, if I can't make money providing cataracts and I have 6,000 other patients who want to
24 come in for a different service, I should shift and modify my business to do that. So, it seems to me that the
25 incentives that are set up in this, when there is a decrease in services, to push physicians into modifying their
26 practice in a way that maintains financial viability. There is also a very interesting cottage industry that sprung up

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1 lately where, you know, in the mid-90's when you data was collected, the economy was doing well and everybody
2 was doing pretty well. When people got hit with the fee decreases, what we're seeing now is this cottage industry of
3 consultants who go around and tell you how to bill for everything that is legal and ethical to bill for, to make sure
4 that you're not leaving any money on the table, as they describe it. And, in order to maintain a financially viable
5 practice, one has to do that. One has to bill for every specific thing that you can. So, there is this cottage industry
6 that has probably resulted in some of what you're seeing here. There's also, in the mid-90's, there was a culture of
7 fear that people were under-coding, I suspect, and there is some data that supports that as well, because everyone
8 was afraid that if they didn't have the right number of points on their code, that they didn't describe whether or not
9 the patient's hearing had decreased when they were visiting the urologist, that they would be cut down a level in
10 terms of their compliance with E&M coding guidelines. I know that in my own practice, looking at compliance, we
11 have a couple of people who were under-billing out of fear of fraud and abuse. And we have then gone through a
12 whole educational process where we say, if you do this then this is your proper code. And I know that's a
13 nationwide event, so as the level of fear diminished in the late 1990's and early 2000's, that people started to try to
14 more accurately track it. And I don't suspect that there's any way to sort that out but it seems that the incentives,
15 from what this produces, are not what Medicare intends, and I would like to hear some comments on that.

16 Dr. Rapp: Well, basically you're supporting what he's saying. You've given an explanation for it but
17 you're supporting that there is that volume and intensity change one way or the other based upon price reduction.

18 Dr. McAneny: There may be a volume intensity based on reduction, but I'm wondering whether or not
19 using this data as at is in the SGR to lower physician reimbursement is really the incentive that we want to create.

20 Mr. Shatto: I would just like to say that this assumption in itself, because of not lower payment updates
21 but, what I was trying to get at earlier, we use this assumption to do our projections.

22 Dr. McAneny: Uh-huh.

23 Mr. Shatto: As an example, again in 2004 we're assuming that there's going to be a price cut so we're
24 assuming that there's going to be higher volume in 2004. When we include the 2004 data in the 2005 update, we
25 will use actual spending data for 2004, not our assumption.

26 Dr. Rapp: Dr. Urata?

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1 Dr. Urata: I'd like to back up what you said. Now we audit our partners' charts to see if we're doing fraud
2 and abuse, and that takes even more time to run a practice nowadays. And we go to classes to make sure our E&M
3 codes are up to date and I found myself, in some ways, needing to up-code but I refuse to because I just don't
4 believe in it. But, back to the issue, I'd like to just comment that I find it interesting that you would look at the price
5 decreases and correlate that with volume of services. To me, it seems like you'd be able to predict better if you
6 would just look at the age of people coming into the program and those that leave the program, and look at the
7 diagnoses and how sick they are. And, I guess I'm puzzled how, you know, why a person would look at the price
8 and say, and they notice that in these two practice studies that the intensity of services increased. I don't understand
9 how you get there, you know, in the beginning. And then you just look at a bunch of numbers and all of a sudden
10 came up with this number, and it kind of looked good and so you just took it. Because, to me, the thinking doesn't
11 make sense. The correlation between those two things doesn't quite make sense. I mean, it's as if you would look
12 at a bunch of physicians and say, gee whiz, you know, if we decrease the prices then they're going to do up-coding
13 which is fraud, and in order to recoup, but, you know, that doesn't necessarily, I mean, that would imply that we're
14 all dishonest.

15 Mr. Shatto: I think it would help to maybe put this in a little bit of context. The reason that we do this is
16 we have to make our spending projections, and one of the big reasons we make these spending projections is to set
17 the financing for upcoming years. And in setting the financing we need to have decent spending projections of
18 what's going to happen in these upcoming years so that the Part B trust fund doesn't go broke. So in doing that, you
19 know, we try to put forth our best estimate of what's going to happen in those years. That's part of the reason for
20 doing this. You're right in that health status and those kinds of things may help out in those projections but that's a
21 much more complicated thing to look at, and we haven't gotten to it yet. Aging of the population is something that
22 does have an impact but it's not that big especially when you're looking at physician services. It's a much bigger
23 factor for, say the hospital side. So, that's why we do it. Does that answer your question?

24 Dr. Urata: That's fine.

25 Dr. Rapp: Dr. Gaughan?

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1 Dr. Gaughan: Dr. McAneny stole my thunder but I would suggest that under slide, “up-coding” be labeled
2 “correct coding in ’95,” it’s interesting their study was from ’94 to ’96, because in ’95 the new E&M guidelines
3 came out. Before that doctors were just putting anything down. And, all of a sudden we had to learn something
4 and, as you know, there’s a learning curve, so a lot of us – we did a study in the state of Kansas were under-coding,
5 And then we had to get education to correct the coding. I would submit that on your side, what drives the increase
6 in volume was that we actually all learned how to code and, you know, we’re doctors, it takes a while. We had to
7 learn how to do it. Now, we know how to do it and it’s correct coding and I do take offense at the word up-coding
8 because that does invite the OIG into my office. Thank you.

9 Dr. Rapp: Okay. It’s 12:15 and we have a hot lunch. It was hot, so.

10 Dr. McAneny: I think the comment that I had wanted to make earlier, when my examples were given, was
11 that two things can occur the same part of time. And that doesn’t mean that they’re cause and effect and therefore
12 we can’t make the assumption that if there is another decrease in the prices paid, that there will be a concomitant
13 increase in volume and intensity because other things were occurring at the same time. The correct coding, the
14 things that Dr. Wood referred to – all of those things occurred. That situation is not the same. A decrease in volume
15 now, or a decrease in price now may not result in the same increase. There is a limit to how much of those changes
16 we can make.

17 Dr. Rapp: Dr. Johnson?

18 Dr. Johnson: In Table 3 in your notes, it’s noted that in ’94 to ’96 that the volume of new patients - in ’94
19 you had a 104 total and 178 in ’96, whereas on your established visits there was only a difference of eight visits.
20 Taking into what Dr. Wood and my other colleagues have talked about on the changes that occurred towards
21 education of moving from the fear and doing it more accurately, and some of the software that had come into flow, it
22 seems like that in some of these, that there is the argument of more accurate coding to some degree, but in this
23 particular illustration there was a rather significant increase in the number of new patients coming into the practice
24 that had some shifts in there, that I don’t think was brought out accurately in your notes. Whereas the established
25 visits over that period of time only changed by a total of eight, eight more volume on the visits.

26 Dr. Rapp: All right. Did you want to comment on that?

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1 Mr. Shatto: I was just going to say that MedPAC didn't use the word up-coding but.

2 Dr. Rapp: Definitely not.

3 Dr. McAneny: You better take it off your slide.

4 Mr. Shatto: What I was looking at was whether or not they were correlated with practices that had price
5 decreases.

6 Dr. Rapp: Well, the way, the different code is a different service. It's not like the same service just put
7 down a different code. When the physician submits that as a claim they're basically stating this is the service I
8 provided, not that service. So, it's a different thing. It's like the difference between doing a cataract operation and
9 doing something else. It's a different service, the E&M service, so that's why we tried to disabuse you of this idea
10 of calling it up-coding. The doctor may be looking for more expensive things to do because they want to make more
11 money. Just like, you know, General Motors would rather sell Cadillacs probably, than Chevrolets. But that doesn't
12 mean that they're selling Chevrolets but calling them Cadillacs. So, that's the thing, I think, we want to make the
13 point, because that's what the OIG calls fraud. And it's one thing to say that doctors won't look for a different way
14 to look for the opportunity to provide more expensive services to make up a price reduction. That sounds like, and
15 whether it's true or not, that sounds like it makes some economic sense. But it's totally different to say that they're
16 providing the same service but just calling it something different. So, it just makes us feel better if you just say,
17 well, we're looking for ways, like anybody else, to make more money perhaps. But we're not looking for ways to
18 defraud people.

19 Dr. Powers: I have one comment. It seems inherent that there ought to be something in the ceiling in the
20 calculations somewhere because you can only increase what you do so much, only so many hours in a day that you
21 can work. And certainly there has to be a ceiling somewhere where a plateau in number of the increase in services
22 and you can't just calculate, you know, sure it can increase for a certain number of years but after that it couldn't
23 possibly increase that much further.

24 Dr. Rapp: So, if it's okay, the lunch is less hot. And then we'll resume. Now, would you like to limit our
25 lunch to 45 minutes? Okay. It's 20 minutes after 12:00.

26 [Lunch break]

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1 Dr. Rapp: I would like to call the meeting to order again. We have Dr. Nelson here from the American
2 Medical Association, I believe, who wants to give some public testimony on the volume performance measures. We
3 have your written comments, of course.

4 Dr. Nelson: Well, thank you. I am John Nelson and like you I am a practicing physician. I'm an
5 obstetrician down in Salt Lake City, Utah, and currently serve as the Secretary of the American Medical
6 Association. I might just reflect very quickly the significance of being again in this room, and on several occasions
7 have addressed this very group a couple of times prior to your being here Mr. Chairman. I was a member of the
8 original Prospective Payment Assessment Commission in 1982. We never imagined that what we started talking
9 about then would get to this. We're grateful to have a lot more people participating. Also served on the National
10 Advisory Council in HRQ after whose director this room was named, Dr. John Eisenberg. So, it's an honor to be
11 back. It's interesting to see what's gone on over the years. I'm here today speaking for the American Medical
12 Association. Again, we'd like to express our appreciation to the efforts of HHS Secretary's Advisory Committee on
13 Regulatory Reform. Dr. Wood was the chair, we appreciate his report, and he's also a member of this Council, of
14 course. And we appreciate its efforts – thanks. We're concerned, however, about the status of recommendations
15 made by the committee including, among others, those relating to EMTALA, CLIA, limited English proficiency,
16 overall carrier review and audits, and physician enrollment. We encourage CMS to update PPAC and provide the
17 Council with an opportunity to address these issues. Further, we're disappointed that PPAC will not be updated
18 today about the recently proposed physician enrollment rule. And the rule has an impact on physicians. We
19 encourage PPAC to recommend that CMS include this issue on the agenda in the near future and before they finalize
20 the rule, to tell PPAC to provide input. Finally, we're here at PPAC to request that CMS ensure that adequate
21 funding be available for physician education and training. We know that the administration's proposed budget
22 request has cut that funding by about 85 percent. Now, for the issue at hand. The administration, CMS and
23 Congress took action in mid-February to stop the 4.4 percent Medicare pay cut that was scheduled for the rest of this
24 year. The AMA, the physicians we represent and most especially, the patients we serve, thank you for your good
25 effort. We appreciate it. And yet now you heard, despite that, because of the presentation you just heard before
26 lunch, CMS is now predicting another 4.2 percent pay cut for 2004. This is despite the fact that spending for

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1 physician services is going to go up, GDP is lower than previously estimated, the estimated payment rates will be
2 cut in 2004, '05, '06, and '07. Just a few months ago the 4.4 percent pay cut was stopped because of clear
3 indications that physicians could not keep seeing Medicare patients in the face of another cut. This is just as true
4 now as it was then. Something has got to be done, and it's got to be done now, to avert another round of physician
5 pay cuts. The AMA urges PPAC to recommend that CMS support the replacement of the current physician update
6 formula with a system that beginning in 2004, at least keeps pace with the annual increase in the cost of the practice
7 of medicine. Starting with a 2.5 percent increase in 2004, already recommended by MedPAC. The current
8 physician update formula has a number of flaws with which you're all familiar. Staked on a spending formula
9 called the sustainable growth rate, the SGR, or to those of us in practice, the unsustainable growth rate, that results
10 in arbitrary and steep pay cuts never intended by Congress. And, by the way and for the record, the American
11 Medical Association did not ever recommend the SGR. It was simply one of two very difficult choices. It wasn't
12 quite as bad as the awful one, it was kind of awful. It's mainly flawed, though, for two primary reasons. Number
13 one, the payment updates are tied to the gross domestic product. The medical needs of patients do not decline
14 during economic downturns. As a matter of fact, they may increase. That simply cannot be one of the numbers. It
15 makes no sense. Second on the SGR, physicians are penalized with lower payments when volume increases exceed
16 the SGR spending target. Yet the factors that make those things go up are beyond physicians' control. For example,
17 the government actively promotes greater use of physician services that are new coverage decisions; that's good for
18 patients. Quality Improvement Act; that's good for patients. And a host of other administrative decisions, all good
19 for patients. Specifically as you know, coverage has now been added for PET scans, cryosurgery, Medicare Quality
20 Improvement Organization. They've got 5 percent increased use of mammograms. That's great. A 16 percent
21 increase in lipid testing for targeted groups. That's wonderful. Well, all these efforts are good for patients – not
22 surprising that they increase the volume. So, on the one hand you do what's right for patients, you get nailed. The
23 impact on spending resulting from these efforts are not reflected in the SGR target. In addition, although
24 preliminary data has shown Medicare's spending growth for all services in 2002 was about 6 ½ percent, this was
25 driven in part by a 3.2 percent increase in the number of beneficiaries enrolled in fee for service, an above average
26 growth in clinical lab services, ten percent, and drugs, as you already heard, went up to 25 percent. The cost of all

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1 this additional care cannot continue to be covered by repeated cuts in physician payments. We heard this morning
2 that physician participation in the Medicare program is increasing. Well, maybe, maybe not. Two responses – first,
3 participation rates do not indicate whether the physicians are seeing new patients or cutting back on services offered.
4 The American Academy of Family Physicians indicated a year ago that 24 percent of family physicians will not see
5 new Medicare patients. There's a new survey out right now, and they'll update you on that when they have it, I'm
6 sure. Although CMS has addressed the participating physicians, it's not clear what's happened to the non-
7 participating physicians. If non-participation numbers are declining, it may contribute to an increase in participating
8 physicians. So, we need to know how many there are. But even so, participation rates do not tell you if the patients
9 are actually being seen or not. If everybody participates but nobody's taking new patients or cutting back on the
10 service they have, that's not terribly helpful. So, the numbers we have here are incomplete at best. A new payment
11 system that can keep pace with inflation, is needed to ensure access to high quality care for our nation's senior
12 disabled patients. As previously discussed with you, PPAC and also other problems with the SGR administratively.
13 For example, we will continue to oppose the inclusion of drugs in this group. Certainly, as you were told this
14 morning, excluding that at one time may cause fatal flaws in another direction. That can be fixed. But it makes no
15 sense when the increase for that is 26.7 percent or 3.9 for physician services. Finally, most importantly, we've made
16 23 decisions on that issue just the first three months of this year alone on the SGR. We believe that the full impact
17 of all laws in the regulatory opposition studies should be analyzed more thoroughly by CMS and calculated as part
18 of the SGR. We're here at PPAC to make this recommendation to CMS. In short, we understand that if you
19 continue to use the same formula that's flawed, even though the numbers are right, what's going to come out the
20 other end is wrong. This formula is basically not working. It's got to have the right appreciation for those things for
21 which we cannot collect in full. In the last 2 years, as a practicing doctor out of the state of Utah, way far away on
22 the other side of the Potomac River, my liability rates have doubled in the last 2 years. There've been no lawsuits
23 against me, no threats of lawsuits. My crime – I deliver babies. Now, that isn't a Medicare issue per se, but it is
24 indicative of how much the rates are going up. So, as much liability premiums and other things have made my
25 overhead go up, my reimbursement goes down, I'm going to have a really good great economy, though, or I'm out
26 of business and therefore my patients won't have access to me. Physicians in my state and around the country are

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1 having that occur as well. One simple story to illustrate, in Tallahassee, Florida, the other week, a group of family
2 doctors said, you know, we did an analysis of taking care of patients for Medicare. It costs us \$10 more to see the
3 patient we take in. It would be better for us to have a receptionist stand at the front door with \$5 bills in her hand
4 and hand them to new Medicare patients and tell them to go across the street. Now, that's not what these doctors are
5 in practice for. They're in practice to take care of patients. We want to do that. We're certainly going to try. The
6 AMA wants to work with you. We want to work with our colleagues. We want to make sure that access to care
7 continues. The SGR is not the way to do that.

8 Dr. Rapp: Thank you, Dr. Nelson. Are there any questions? Dr. Urata?

9 Dr. Urata: Do you have an alternative?

10 Dr. Nelson: We have an alternative. We can work with you on that. The AMA is happy to work on things
11 that are real, taking into the real account, what really occurs in the practice of a physician. The overhead costs and
12 so forth. One of the problems that's got to be addressed someplace – I don't know why we're so quiet about this – is
13 as we increase the number of patients in Medicare, as people live longer, as we can do more things for them and we
14 should do more things for them, it has got to cost more. Now, the government doesn't make money, I understand
15 that. We've got to find a way to be more efficient. It's time to look at a restructuring of all of Medicare, including
16 the inclusion of prescription medications. We can do that. The AMA has a very detailed plan. I'd love to comment
17 about 6 hours to tell you about that.

18 Dr. Rapp: Anything else? Thank you very much, Dr. Nelson. Yes, ma'am.

19 Dr. McAneny: I'd like to make a motion, that PPAC request an opportunity to provide comment on
20 provider enrollment prior to the final rule, and discuss the every 3 year enrollment. Currently, there is about a 6 to 9
21 month waiting period for people to be able to enroll as a Medicare provider, and to re-enroll everyone has never
22 been discussed before this committee. We have no idea what the rationale is for doing this. We are concerned, or
23 I'm concerned that it will increase the overhead and the administrative expense without improving patient care at all.

24 Dr. Rapp: The enrollment item is not something we have on our agenda.

25 Dr. McAneny: It was brought up so I thought perhaps we could discuss it.

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1 Dr. Rapp: Well, I know it was brought up but it's not something that was published in the Federal Register
2 as part of our agenda, so I can't really make a formal recommendation on the subject. I could think we could, you
3 know, ask about it. We could ask for it to be on the agenda and that sort of thing, but I don't think we can --

4 Dr. McAneny: When is the comment period ending?

5 Dr. Rapp: Maybe we can get some information.

6 Dr. Rudolf: Yeah, I don't know. As we've just discussed and I wasn't even aware of it myself, so I think
7 that the spirit of the Council wants to know more about this. We can certainly comply with something in
8 September. The comment period is going to be over within 60 days of when it was published, so it'll be over way
9 before the September meeting. And I think that we're trying to make an effort to get information about it to the
10 Council. That way you can all submit your own comments if you want. I do think, though, that the point is, is that
11 when we reference or announce a meeting in the Federal Register, we can't just start discussing agenda items not on
12 the agenda. I understand that this is something the Council wanted to discuss, but unless we announce it in the
13 Federal Register, just because someone brings it up, doesn't mean that anyone else has had notice. They didn't
14 know to come here to talk about it. And the point to a public meeting is that it will be fair so that anybody has
15 notice that a topic is going to come up so they can make remarks. You can't just have one commenter come in and
16 raise an item and then start discussing it. It's just a matter of fairness. I mean, I personally would put this on the
17 agenda if I had known about it, and for that, I apologize. But I really don't think that we can start having official
18 recommendations when no one has had a notice that they should have been here to comment. I'm just not sure it's
19 fair to the public.

20 Dr. Rapp: Well, I think we could, you know, get information, ask questions, maybe we'll get a word in at
21 the end of the day. Yes, Dr. Heyman.

22 Dr. Heyman: Well, I think that, though, in fairness, I think that this is a good example, though. We could
23 feel a lot more effective if we knew that when CMS was starting to think about a particular new regulation or rule
24 that affects physicians, that they would come to us before they even sent out something for commentary, just so that
25 they could get our opinion on it, I think, beforehand. But if what happens is that at the last minute something is just
26 published and then we have to rely on Paul being informed about it, I think that what happens is that in our attempt

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1 to be fair, so that it can be on the public record before we discuss it, we end up losing the opportunity to discuss it at
2 all. And that's not fair either. So, I don't know how to fix that problem, but I think we need to make certain that
3 people understand that if we don't have it, that we get to talk about these things before they become regulations.
4 What happens is that we feel that we are using the agenda to avoid having to discuss issues that have an effect on
5 physicians. And I think that's worse than not having a public notice in the first place. So, we don't want to
6 continually feel that the agenda is being used to avoid discussion of issues that are important to physicians. I guess
7 that's my point.

8 Dr. Rapp: Well, I think as Paul said, it would have been on the agenda ...

9 Dr. Heyman: Yeah, I know. I'm trying to raise the -- I'm not criticizing Paul -- I'm trying to raise the
10 consciousness of CMS, that they need to come to us much earlier in the process. Much, much earlier, before it even
11 goes out for commentary. While they're thinking about imposing a new rule or regulation, we're the folks who are
12 here to help them make their decisions about whether or not to even consider that rule or regulation.

13 Dr. Rapp: Thank you for that statement, Dr. Heyman.

14 Dr. Urata: A quick question. Are we not allowed to have new business? Is that what this means?

15 Dr. Rapp: Well, the --

16 Dr. Urata: In a lot of meetings I go to, you can add things when you get there.

17 Dr. Rapp: Well, that's the way it is with most meetings and if this were -- this is subject to the Federal
18 Administrative Committee Act, Advisory Committee Act, and in your reference manual that we have provided to
19 each new member, there are requirements of that Act, but basically the whole purpose is the advisory committee or
20 advice given in a formal way like this to the federal government, has to be done in a certain way. In other words, in
21 public --

22 Dr. Urata: That's fine.

23 Dr. Rapp: We have to know what we're going to do. The public has to know what we're going to talk
24 about. Dr. Nelson did come here today to talk about something, and we can see what's on the agenda, and we're not
25 going to take up something totally different.

26 Dr. Urata: Thank you.

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1 Dr. Rapp: So, that's the basis of it.

2 Dr. McAneny: I remain a little procedurally confused here. Because the AMA testimony was submitted
3 beforehand in writing.

4 Dr. Rapp: They're not, they don't set the agenda. They --

5 Dr. McAneny: Well, I understand that but because they were submitted beforehand in writing, then that
6 means that it is a public notice.

7 Dr. Rapp: No, it's not.

8 Dr. McAneny: It does not.

9 Dr. Rapp: In the general registration -- how about if we put this off till later. This is sort of an
10 administrative thing. We've got a lot of things that are on the agenda, and are properly noticed and if we talk about
11 this too much we won't get to them. So, yes, Dr. Heyman.

12 Dr. Heyman: Is there any more testimony on the update that we're going to hear this afternoon?

13 Dr. Rapp: Well, actually the, I don't have the notice but I'm not sure exactly what the notice -- do you have
14 the Federal Register notice because what's on the agenda is dealing with volume performance measures and volume
15 intensity adjustments.

16 Dr. Heyman: So, is there an opportunity for us to make a recommendation supporting the MedPAC
17 recommendations? Supporting the placement of the current Medicare-Physician payment update formula with a
18 system that, beginning in 2004, keeps pace with annual increases in the cost of practicing medicine, starting with a
19 2.5 percent increase in 2004? I think that was in response to the Federal Registry Notice. And I would like to make
20 a motion that we make that recommendation.

21 [Unidentified]: Second.

22 Dr. Rapp: Yeah, I think we can do it except our basic job is to recommend any regulatory changes. This
23 would be a legislative change, so it's not really within our basic purview, but if you want to make a motion --

24 Dr. Heyman: Well, I can remember the first meeting that Tom Scully came to, he requested PPAC
25 specifically to make a recommendation asking CMS to support legislative changes in the --

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1 Dr. Rapp: Let's go ahead and do that then. But it's not - our basic purview is to make recommendations
2 with regard to regulations. That's what our charter says. That's what the statute that set up the committee says. But
3 go ahead and make a motion.

4 Dr. Heyman: I move that in accordance with the MedPAC recommendations that, in other words, I'm
5 supporting MedPAC, that we support replacement of the current Medicare-Physician payment update formula with a
6 system that beginning in 2004 keeps pace with annual increases and the cost of practicing medicine, starting with a
7 2.5 percent increase in 2004.

8 Dr. Rapp: Is there a second to that?

9 [Unidentified]: Second.

10 Dr. Rapp: Is there any discussion on that? All in favor?

11 [Multiple] Aye.

12 Dr. Rapp: Anybody opposed?

13 Dr. Heyman: I recommend that we -- I move that in accordance with the MedPAC recommendations, we
14 support replacement of the current Medicare, that PPAC supports replacement of the current Medicare physician
15 payment update formula with a system that beginning in --

16 Dr. Rudolf: That's what I thought you said. So, but that's why I'm not clear. What's your
17 recommendation to CMS? All PPAC is saying that they support something but there's no recommendation in there
18 for CMS.

19 Dr. Heyman: Well, I guess what I'm asking CMS to do is to support the same thing. So, I'm --

20 Dr. Rudolf: Well, then maybe you should add that to your motion.

21 Dr. Heyman: All right.

22 Dr. Rudolf: I'm trying to help you out, Joe.

23 Dr. Heyman: Thank you, Paul. You're always a great help. I move that PPAC request CMS to support
24 replacement of the current Medicare physician payment update formula with a system that beginning in 2004 keeps
25 pace with annual increases in the cost of practicing medicine, starting with a 2.5 percent increase in 2004. I think
26 that could not be clearer said.

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1 Dr. Rapp: Would the reporter read that back please? We'll see.

2 Reporter: PPAC requests CMS support replacement of the current Medicare physician payment update
3 formula with a system that beginning in 2004 keeps pace with annual increases in the cost of practicing medicine,
4 starting with a 2.5 percent increase in 2004.

5 Dr. Rapp: All right. Is there any discussion on that? All in favor?

6 [Multiple]: Aye.

7 Dr. Rapp: Anybody opposed? The motion is adopted.

8 Dr. Heyman: Unanimously, I might add.

9 Dr. McAneny: Is this the time when we might make motions related to the volume intensity studies we
10 heard before lunch?

11 Dr. Rapp: Sure.

12 Dr. McAneny: I'd like to move that PPAC recommend that CMS study the transition of services from the
13 inpatient to the outpatient arena to consider transferring the savings from Part A Medicare into Part B. May I speak
14 to that?

15 Dr. Rapp: Sure. Is there a second?

16 [Unidentified]: Second.

17 Dr. Rapp: Okay. Go ahead.

18 Dr. McAneny: It may be that that requires some Congressional action. However, part of the increase in
19 volume intensity and services that are received may be, and probably is, that a lot of services, once performed in Part
20 A in the hospital are now perfectly safely performed in Part B, and therefore will increase both volume and intensity,
21 and account for some of this update we saw that has nothing to do with a price decrease. And I think that needs to
22 be taken into consideration. I think also a mechanism needs to occur where when Part B is taking increased
23 responsibility for doing this, that some of the money follow the procedures.

24 Dr. Rapp: All right. Is there a discussion on that motion?

25 Dr. Castellanos: Yeah, I'd like to speak to that also. Simplistically, what we're doing is taking some of the
26 expenses out of Part A and we're putting them in Part B, but the revenue isn't shifting from Part A to Part B. So,

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1 what it's really doing is increasing our practice expense and it's helping the hospital of Part A but it's hurting Part B,
2 and I think to make it fair or even it out - I'm not sure if we can do this without a congressional act - is that we need
3 to be able to shift some of the revenue from Part A to cover those shifts into Part B.

4 Dr. Rapp: All right. Any other discussion on that? If not, could our reporter read back the motion?

5 Reporter: PPAC recommends that CMS study the transition of services from inpatient to outpatient, to
6 consider transferring the savings from Part A to Part B.

7 Dr. Rapp: Okay. All in favor of that motion?

8 [Multiple]. Aye.

9 Dr. Rapp: Anybody oppose? All right. The motion is adopted. If there's nothing else on the volume
10 performance measures, volume intensity adjustments, we'll move on to the next item on the agenda which is the
11 very simple topic, Stark II. Do we have Paul Olenick here? My apologies. Good afternoon, Mr. Olenick.

12 Mr. Olenick: Good afternoon, doctor, and to all the rest of you, also good afternoon. I found it interesting
13 the discussion that just took place about PPAC being on board before the rate cuts so far down the road. Well, here I
14 am addressing the reg that everybody thought was going to be published by this time and, of course, is not. So --

15 Dr. Rapp: Well, that would be our goal actually.

16 Dr. McAneny: Right.

17 Dr. Rapp: To get in on the agenda before -- when people are thinking about it and formulating the issues in
18 their mind and even ones that would benefit from comment of the practicing physicians before the issues are
19 actually resolved. So --

20 Dr. Heyman: Excuse me, Mike. I think it's great that we're going to hear from this fellow, and I look
21 forward to it. But I would like permission to address the issue that you're addressing right now at the end of the
22 meeting so that we have a chance one more time to talk about it.

23 Dr. Rapp: Okay. That'll be fine. Go ahead, sir.

24 Mr. Olenick: Okay. Thank you. As I just mentioned, the Phase II of the Stark final regulations are not yet
25 out. I thought what I would do is just hit on some of the high points of Stark generally and then get into what some
26 of the topics are that we're going to address in Phase II. You also, in the packet that is in the back of the room, there

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1 were also a couple of questions about items that we would certainly be happy to hear from PPAC about. And, in
2 fact, as we get further along here I'll actually raise another one. Just to start off, you know, Stark, the conception
3 called Stark actually is the physician anti-referral rule but everybody always refers to it as Stark. The physician and
4 the referral rule, of which there have been numerous amendments when it was first passed in the late 80's, I think
5 it's important to realize that unlike the anti-kickback statutes of the Inspector General, the physician anti-referral law
6 is a strict liability statute, which means that even if you don't know that you're violating the statute, if you're acting
7 against what's in the regulations or you're not within one of the many exceptions, then whether you knew it or not,
8 doesn't make any difference as far as assigning, you know, guilt or whatever else you want to call it to you. This is
9 particularly important, I think, for hospitals because the Stark rule mainly affects physicians and hospitals. And if a
10 service is provided by a physician or a hospital under terms where the relationship between the two of them is not
11 within the Stark perimeters, then everything that is paid to the hospital by Medicare not only for the specific
12 situation that causes them to be out of compliance with Stark, but anything that is paid to the hospital that is a result
13 of the physician services is prohibited. And so you can see that it doesn't take very long for, you know, if you have
14 a situation that goes on for several years, it doesn't take very long for the hospital's overpayment to Medicare to
15 grow in a substantial way. And, of course, there are also in the statutes some other sorts of penalties that can be
16 applied to physicians and to the hospitals. But I'm just trying to make a point that this statute is a very important
17 statute and seen such by CMS and the Department and the Department of Justice, as an important tool in the
18 armament against fraud and abuse. However, while it's important armament, we have tried within Phase II and in
19 the coming – both in Phase I and in the coming Phase II – to interpret our prohibitions narrowly and the exceptions
20 broadly. If you remember back to our original proposed rule in 1998, there we interpreted the rule, the law broadly
21 and exceptions narrowly, and that resulted in almost 13,000 public comments. And so we got the message on that,
22 and we flipped so that now we look at the exceptions very broadly so that we have the least effect on the way the
23 physicians practice consistent with the basic philosophy behind Stark. We designated health services to which Stark
24 applied their, you know, it's in your handouts, and I'm not going to go over those but I would say that in our Phase I
25 final rule that was published on January 4th, 2001, we covered the issues that 75 percent of the comments brought up
26 to us. In Phase I we basically took care of the large majority of issues in Stark. And that included the basic

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1 prohibition, the definitions, and the exceptions in the law that applied to ownership, investment and compensation
2 relationships and used our authority to create exceptions for situations in which there is no risk of program or patient
3 abuse. This means that the statute has exceptions, but the Secretary also has the authority to grant additional
4 exceptions where there is no risk of program or patient abuse. And, so we have a fair market value exception that
5 we apply to almost any direct compensation relationship, a special exception for academic medical centers, an
6 exception for non-military compensation up to \$300, an exception for medical staff benefits, and an exception for
7 indirect compensation relationships. Those are all exceptions that were done under the Secretary's general
8 authority. Let me move on to Phase II.

9 Dr. Rapp: So, does the Secretary have a broad authority to pretty much grant whatever exceptions he
10 would like?

11 Mr. Olenick: Let's put it this way. The statute basically is a broad authority. However, when we draft
12 regulations such as this, we take account of not only the comments that we get from outside parties including
13 yourself, but we also draft this in conjunction with the Office of Inspector General. The Department of Justice has a
14 big interest in it. It has to go through OMB. It has to go through the Department so there are many, many
15 checkpoints along the way. So, I would not say that the Secretary can do whatever he or she wants, but certainly can
16 impose whatever he or she wants as long as there's no risk of, in his or her assessment there's no risk of program or
17 patient abuse. In Phase II we do several things. We respond to the comments we've seen done in the Phase I Final
18 Rule. Phase I, as I said, was published in January of 2001. It had a long comment period which was then extended.
19 The effective date for all but a couple of the provisions was a year after it was first promulgated, so not until January
20 2002. So, there was plenty of time for individuals to send in comments and for us to look at those comments and see
21 what they might mean with respect to Phase II. In fact, one of the comments that we received the most of had to do
22 with a section in Phase I which said that in order to meet a certain exception the group practice's compensation had
23 to be set in advance. And we made the statement that since percentage compensation, you know, our compensation
24 was done on a percentage basis, you never know what the actual amount is going to be until the end of the period
25 and so we said that percentage arrangements did not constitute compensation set in advance. Well, we got many,
26 many, many, many comments on this saying, and I think rightly so, that this was really going to upset a lot of the

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1 arrangements that physicians had with respect to determining the compensation of the members of a group. And
2 again, we always want to take into account what physicians said. If we've got a lot of them saying that something is
3 going affect them deeply and cause them a lot of money to change around, we want to take another look at it. And,
4 what we did here was we delayed the effective date of that one little section in Phase I that would have put into
5 effect the prohibition against comp percentage arrangements, and that little section still has not gone into effect.
6 And we will be dealing with it in Phase II, we'll be dealing with it in Phase II and I can assure you that we're going
7 to take all those comments that we received under advisement and look at them very seriously. Unfortunately,
8 because the rule has not yet been published and we're technically out of the, we're in the rulemaking period but out
9 of the official comments period, I can't discuss in detail what's going to be in it. But I can say that there are going
10 to be exceptions in that rule, Phase II, that apply to ownership and investment interest such as public trade and
11 securities and mutual funds, how Stark applies to hospitals in Puerto Rico, rural providers and hospital ownership.
12 We're also going to discuss compensation relationships, that is, the rental of office space and equipment,
13 employment, personal service arrangements, remuneration unrelated to the provision of designated health services,
14 physician recruitment, isolated transactions, and payments made by physicians for items and services. And again,
15 this sounds like a long list and some of the topics are attained, they are not the ones that we've received a whole lot
16 of comments on, on the proposed rule. But again, we'll respond to all of those comments we do get as well as any
17 comments that we got as a result of the Phase I Final Rule. The Phase II Rule will also consider the many requests
18 for exceptions for professional courtesy and charitable donations by physicians, and as I said, we will address this
19 second advanced provision which is the only one in Phase I of Stark that has not gone into effect. One of the things
20 that will be a thread throughout Phase II and was also a major part of Phase I, is this exception that the Secretary
21 promulgated under his authority, and that is the fair market value exception. We have a lot of exceptions in the
22 Stark rule, however, the fair market value exception basically says that, you know, with a few other bells and
23 whistles, that if the relationship you have, say with a hospital, and the remuneration being paid by the hospital to you
24 for something that you're doing for the hospital, that as long as that arrangement is based on fair market value -- in
25 other words, it's not very, very high, it's not obviously a kickback, then it will generally be okay under the Stark
26 rule. And, in Phase I we did talk about some of the ways that fair market value could be determined. None of it's

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1 kind of exact, but you ought to make sure you take a look at that in Phase I and then when Phase II comes out, also
2 read that because that will be, like I said, that will be the thread that will run all throughout Phase II. One of the
3 other things that we will deal with in Phase II is the subject of lithotripsy, which since I've been involved in the
4 Stark rulemaking and even, I know, before that. The status of lithotripsy under Stark has been a very contentious
5 issue. In Phase I, we said that lithotripsy was a designated health service and, as such, fell under the, because of the
6 way it was performed, that it fell under the Stark prohibition. We received lots of comments on this from individual
7 physicians and major organizations, and there was also a court case since we've published Phase I which basically
8 took the position that a lithotripsy was not a designated health service. So, we have to take account of all those
9 comments plus that court case when we decide how we're going to address lithotripsy, Phase II.

10 Dr. Rapp: Does that court case have a binding effect on the government?

11 Mr. Olenick: Let's put it this way. I don't – usually court cases, they're at the district level, they're
12 effective in whatever district they were rendered.

13 Dr. Rapp: Where was that?

14 Mr. Olenick: This one, I believe, was somewhere out in Michigan or somewhere out that way.

15 Dr. Castellanos: It was in the federal district here in Washington, Federal Court.

16 Mr. Olenick: It was in the Washington Federal Court?

17 Dr. Castellanos: Yes, it was.

18 Mr. Olenick: Okay. In the Washington Federal Courts, that was the second thing I was going to say. In
19 the D.C. District Courts, even though technically the decisions only apply in the District, all the courts in the country
20 take great notice of what the District Courts decide in Washington and the appeals court, the appellate court. And
21 so, generally if we lose a case in the District of Columbia, that's a much more serious matter than if we lose it in
22 some other district. And, I don't believe the Department ever appealed that case. So, therefore it stands on the
23 books and it's up to us to decide how to deal with it in the Phase II Rule. Unfortunately, I can't be any more specific
24 than that.

25 Dr. Castellanos: You did appeal it and then you withdrew the appeal, so it's final?

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1 Mr. Olenick: Right. Yes, yes. We withdrew the appeal. That's what I meant by saying appeal it in the
2 long run. We do have a couple of questions that are spelled out in the packet that's at the back of the room that we
3 wanted you to consider and we would be happy to hear any comments that you have now, or any comments that you
4 care to send us. And, you can certainly send them to me by e-mail. It's E. Olenick, E-O-L-E-N-I-C-
5 K@cms.hhs.gov. I also have one other question, and again, it's something you can think about or address now,
6 however you would like. Whatever time constraints you're under. Because the STARC rule is, everybody,
7 including us views as quite complicated, it's very difficult to read it and have it stay with you. It's somewhat like
8 Chinese food, I guess, as people say. And one of the things that we were considering was, unlike most regs., in this
9 Phase II reg., we were going to publish not only the changes that we are actually making in the regs., but we were
10 going to publish, thinking of publishing the entire Stark reg. text of Phase I and Phase II so that people can then go
11 back and forth, and I was just wondering, is that something that you would find, or your attorneys would find
12 helpful, or would you rather we just put in this reg. the things to change and the things that are new, you know, and
13 then you'll have to piece it together yourselves. So, that's basically the end of my presentation at this time.

14 Dr. Rapp: Dr. McAneny?

15 Dr. McAneny: To answer your last question, yes, it would be very helpful to have the whole works with
16 the changes somehow highlighted so that, you know, underline or something so that we knew what the changes
17 were. I was curious, if someone set up their practice - to use the example you were talking about - percent basis and
18 therefore that was prohibited under Stark I that many people are assuming that they will not be prohibited under
19 Stark II.

20 Mr. Olenick: Well, we haven't put that into effect. We haven't put it into effect. We got a series of
21 Federal Register Notices that have said, this isn't in effect yet. And then when that's about ready to run out, we
22 publish another one until we can finally get this big reg. out. I see Tom Grissom smiling over there. We want to get
23 this big reg. out, when we take care of it for good and all.

24 Dr. McAneny: So, no one could be subject to a Qui Tam lawsuit or something like that. There's some
25 way they had structured it if that were the case now, because that reg. is not the force of law. I'm just confused on
26 how it goes when there's an interim rule.

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1 Mr. Olenick: Well, no, an interim rule, an interim final rule is the final rule.

2 Dr. McAneny: Okay.

3 Mr. Olenick: Usually you do it because you're asking for comments at the same time. Now, I think our
4 opinion would be that, you know, that section isn't into effect and that you would not be subject to penalties but, of
5 course, you know, I would not have, nobody has any control over who might want to file a Qui Tam case at any
6 particular time, but that's our position.

7 Dr. McAneny: One of the issues that comes up frequently in rural areas where health resources are more
8 difficult to obtain, the only person who really has an interest in having a certain widget available to them is the
9 physicians who, and to use that widget, yet there are all these laws that make it, this particular law makes it difficult
10 for say physicians to share and therefore get the maximum use out of this particular device. To give an example, if
11 you wanted to put an MRI machine because in my town there is not sufficient capacity, MRI people are waiting 2
12 and 3 weeks to get one when it's medically more important that they get it sooner. We see this surge as oncologists,
13 the neurologists in the community also saw this surge. We originally thought that perhaps, since none of us could
14 afford one of these things outright, that the oncologists could get together and own it halftime and then put it in a
15 truck and then move it the neurologist's area, and they can own it halftime. Then we discovered that that's a Stark
16 violation. If I have it sitting in my parking lot on a specific pad and I send my patients, it does not meet the in-office
17 ancillary exception to it, and therefore it's a Stark violation, where if I buy the whole thing myself and put it in the
18 building... I don't feel like this is what the Stark law really wanted to do, to prohibit physicians from sharing
19 resources and using it in a cost-effective manner. Yet that's, in effect, what it does. So, I'd appreciate your input on
20 that.

21 Mr. Olenick: Let me say two things. There is a rule hospital exception for Stark, where the Stark doesn't
22 apply. You're right, we did --

23 Dr. McAneny: Make it a poor state exception.

24 Mr. Olenick: What's that?

25 Dr. McAneny: Can we make it a poor state exception?

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1 Mr. Olenick: Unfortunately, it's only rural right now. But these are the kinds of things that we like to hear
2 about. Also, you're correct that, you know, if you got something on a trailer and it goes from place to place, we
3 decided in Phase I not to allow that because we thought it was, and I'm not passing any kind of accusations but in
4 general, we thought that that was much more subject to abuse than one of these machines that was in a certain place
5 for good and all. What I would do is, since frequently when we handle those kinds of problems, we sit down, we
6 talk about them and we give them a lot of thought. I wouldn't want to, off the top of my head, give you an answer
7 here. But again, if you want to send that question to me in an e-mail or however you would like, we'll get you an
8 answer back.

9 Dr. Rapp: Let me ask you about the basic definition of a referral? Is the referral just simply ordering
10 something without connecting it with a place? Like, for example, let's say I decided I'm going to set up one of these
11 designated health services any time by Mega laboratory or Mega anything, and then I'm practicing medicine
12 separate from that. And I say to them, you need to go get a CBC someplace, and I write it out on a prescription
13 thing, CBC or some blood test, and the patient then – I mean, I don't tell them where to go. I say go wherever you
14 want. And they happen to go to this place that I happen to own an interest in. Is that a referral that would make a
15 Stark violation, as opposed to go over across – I'm referring you to this place. And, in any event, it would seem like
16 that would be a way to narrow it – to separate the practice of medicine from ownership interest, which it would seem
17 like in America you should be able to buy something in interest in anything you want.

18 Mr. Olenick: Well, let me say two things. Number one, yes that would be a referral under Stark.

19 Dr. Rapp: Is that a regulatory thing that you could narrow down?

20 Mr. Olenick: I think the way we've handled those sorts of things is, that's why we have all these
21 exceptions, and it's, you know, depending upon your specific situation it might fall under one or another exceptions.

22 Dr. Rapp: What I'm thinking, though, is that would take care of a lot of exceptions if you just could put
23 some notice on there that by telling you you can go anyplace you want to for this service and I'm not suggesting any
24 place, and you know, put some blanket disclaimer. I'm just asking you to go get one of these tests, and go over it
25 wherever you want. Then you might be able to save a lot of exceptions that way.

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1 Mr. Olenick: I think, you know, that's certainly an interesting concept and has a lot behind it, but again, I
2 think that's something that would have to be changed legislatively.

3 Dr. Rapp: Well, I've seen the agency make some definitions that have seemed pretty dramatically
4 different.

5 Mr. Olenick: Yes.

6 Dr. Rapp: Yet plain language seems to be, the EMTALA regulations come to mind specifically. Come to
7 the emergency department and it got to the point that it was any place that the hospital had any property, which was
8 a broadening of it ... this would be a narrowing of it but it's common sense narrowing of it.

9 Mr. Olenick: The only thing I think I can say is that, to reiterate what I had said earlier, that all these regs.,
10 every reg. that we do goes through many layers and has many, many individuals involved in its
11 drafting and we have to, you know, we might want to, let's say, we meaning CMS, we might want to do something,
12 we've got to persuade the Office of Inspector General of that. We might have to persuade the Department of Justice
13 that. And, frequently they're much more literal than we might want to be.

14 Dr. Rapp: Right. How many pages that this regulation would be printed out or amount to?

15 Mr. Olenick: I would guess it could be like, like this [gestures]

16 Dr. Rapp: Well, that's what I'm thinking.

17 Mr. Olenick: Let's say about, well, when I say regulations I'm talking about the whole package with the
18 preamble and all that. Now, in Phase I, you know, that was a pretty big Federal Register package, but the
19 regulations themselves, I think, only cover, were only 11 pages. The rest of it was all explanations.

20 Dr. Rapp: I know. And that's one of the things, the biggest criticism of the regulatory process for doctors,
21 you know, it is hard enough to try to figure out how to practice medicine and keep up with all the changes that go
22 into taking care of patients. And in this situation where you're dealing with hospitals and all this and that and the
23 other things, it would seem that a nice, simple, narrowing of the statute might eliminate something like that. But
24 anyway, one of the goals --

25 Mr. Olenick: And, let me just say one thing, that the physicians self-referral statute, the so-called Stark
26 rule, has ever since it was passed, has gone through a number of sort of critical times where there's been efforts to

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1 greatly simplify, to rescind it, to do all kinds of things, and I think it's fair to say that Congress, that any of the
2 Congress, since it was passed, there have been a number of members who would like to see something done either to
3 it or about it.

4 Dr. Rapp: Now's the time. At any rate - lithotripsy. The other --

5 Dr. Castellanos: Well, first of all, I appreciate you recognizing that we would hope that CMS would follow
6 the mandate by that lawsuit and comply with the law. The other issue I have is at a fair market value, now I
7 understand fair market value is what, the definition of it, but most of us physicians are aware that there are least two
8 markets in medicine. One is the Medicare market and the one is the private pay market. And, quite honestly, they
9 are different in reimbursements, and usually the private pay is a little higher than Medicare. And my understanding
10 is that the OIG and CMS indicate that they want one fair market value, and they're going to prosecute it as a split or
11 a blended rate. In medicine today, we have two markets, and I think that may be an issue that we need to consider
12 when you discuss the fair market value.

13 Mr. Olenick: Of course, I agree with you. But when we're talking about fair market value, we're talking
14 about not what it's worth with respect to Medicare payment as opposed to some other kind of payment. We're
15 talking about what it would be worth with your, any particular individual dealing at arms length with another party.
16 Now, I realize that that may not be the reality because, as a matter of fact, you know, only doctors going to be
17 involved with these machines for the most part, and some of them treat Medicare and some of them don't treat
18 Medicare. Or, and some treat Medicaid and some don't treat Medicaid. So, I can see how that would all work in
19 there. Yeah, we have sort of a, we've tried to make a simple rule but I think we realize that we get comments and all
20 that, that it's more complicated then. And, I believe in Phase II, we'll be addressing some of those comments that
21 we've received on fair market value.

22 Dr. Castellanos: Just one other comment. Your last comment was about distortion of pricing in the market
23 place. You know, lithotripsy has been present now for about 15 years in the United States. Over the past 15 years
24 the Medicare economic index has gone up 47 percent. The CPI has gone up over 123 percent, and lithotripsy has
25 gone down 50 percent. So, I think if you look at the data you'll see that there really has not been a lot of distortion
26 in the marketplace over the past 15 years. And I think that data is available to you.

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1 Mr. Olenick: Well, if you could, again, send us an e-mail or a letter and say where we can find that and all,
2 we'd be happy to have that.

3 Dr. Castellanos: Thank you.

4 Mr. Olenick: We are not here to make things generally tough on physicians. We're here to take the law
5 and in this case, since we have 13,000 comments to go through, and make it as physician-friendly as we can, and
6 hospital-friendly as we can, recognizing at the same time that it is a law and that it needs to be enforced.

7 Dr. Rapp: Dr. Powers and then Dr. McAneny.

8 Dr. Powers: When you talk about the rural exception, would that include allowing rural hospitals to bring
9 in a specialist physician who can afford another rent for that day, another office rented that day and letting them
10 consult, do outpatient consultation at the hospital without having them pay the extra day's rent?

11 Mr. Olenick: Yesterday's rent to the hospital?

12 Dr. Power: We have rural hospitals who would like for us to come and do outpatient consultations, but we
13 can't go because we cannot afford a third office rent.

14 Mr. Olenick: I honestly don't know the answer to that. But if you, again, want to send an e-mail, we'd be
15 happy to consider and respond.

16 Dr. Rapp: Dr. McAneny:

17 Dr. McAneny: One issue that's come up as we try to provide a new service in our area, is how does one
18 determine fair market value. I don't know what it is. There's no book I can look it up. If I call somebody else
19 across the country or in a similar market to try to figure out what fair market value is, that would be collusion. You
20 know, and price fixing, I don't want to be without those particular laws. So, you can hire a consultant for a zillion
21 dollars to come in and tell you what they think fair market value would be and then I guess you're relying on what
22 they tell you. But there is no way for us to know, if we're the sole provider of the service we want to bring to our
23 community, how fair market value is. So, some education on how we might arrive at that sort of a price would be
24 helpful.

25 Mr. Olenick: I would start off by saying that in the Phase I Rule, in the preamble we did, I believe give a
26 number of examples by which fair market value would be determined. I mean, I hear your problem and I know that

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1 at least one court case, and I'm a little bit hazy on the court case, because I've seen so many and been involved in so
2 many with different areas with different subjects but I think fair, the determination in fair market value was one of
3 the things that was at the heart of the case. We could certainly consider what you've said. I don't know whether it's
4 something that we could do or not. I frankly don't – I think it's a good – in other subject areas I'm involved in
5 we've got the same kind of question on some other guidelines that we put out ... what do they mean? Teach us what
6 they mean. And I think lots of times we say that, well – there is no ... we give some examples about where you go to
7 get some information, the kinds of people that you might want to bring in to consult with. But since every situation
8 is unique, it becomes very difficult to set out, beyond guidelines, to set out any hard and fast rules.

9 Dr. Rapp: On the various subjects that you brought up as to what you're dealing with at future – you talk
10 about publicly traded corporations.

11 Mr. Olenick: Yes.

12 Dr. Rapp: So, you're going to, well the issue with regard to what you're going to do is what level of
13 ownership would be appropriate in the public department?

14 Mr. Olenick: That's one of the things, yes.

15 Dr. Rapp: And then like a hospital, the specialty hospitals, is that an issue, what level of ownership you
16 can have and still do surgery in there and admit the patient and so forth?

17 Mr. Olenick: Especially hospitals is a – we've sort of broken it off into a topic by itself because it is so
18 sensitive and we have another regulation underway that'll be a proposed regulation that will deal with the specialty
19 hospital situation. We're not going to deal with it in this.

20 Dr. Rapp: That's not a Stark II issue?

21 Mr. Olenick: Yeah, it's a Stark issue but we're going to deal with it separately.

22 Dr. Rapp: What is the basic issue – whether it should be allowed at all or ?

23 Mr. Olenick: Yes. I think that the basic issue is should they be allowed at all and, if it should be allowed,
24 what sorts of parameters should be put around them. And I will tell you that within CMS and also within the
25 literature that we've read, there are a number of different opinions about specialty hospitals and a number of

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1 different suggestions about ways to go about making sure that we have a level playing field out there. And, beyond
2 that I'm not going to say anything else.

3 Dr. Rapp: Well, I still like my idea of narrowing the definition of referral, because that would get – a lot of
4 these issues that seem to be brought up - Barbara said, well, the only people that will provide the service are these
5 doctors that are willing to put the money into something. And, now with the definition of referral that says even if
6 you don't refer them, just letting them go there is illegal. Then you have to come up with an exception dealing with
7 it instead of just allowing the doctor to say, I'm requesting or recommending or ordering the service but I'm just
8 claiming, I'm giving you notice, you take it where you want to go. I disclaim any intention to suggest you go to any
9 place but if she happens to be in New Mexico or someplace and that may be the only service in town, if you don't do
10 something like that you end up, the person can't get the service. It would seem like a simple way that would fix a
11 lot of problems, and then the things where you are going to definitely recommend somebody to go someplace, like
12 put you in a hospital, or do surgery on you, that's something different. And, then you can deal with it on the
13 exceptions. But I think the biggest problem with the Stark, this strict liability that you talked about, is you have to
14 avoid as a physician all these thousands of things, or spend your life reading these things and hiring lawyers and all
15 those sort of things, and it just makes life so complicated.

16 Mr. Olenick: Like I said, we'd be happy to hear that, you know, laid out in writing but I, as I said before, I
17 mean, that would be a change in the statute. I think probably some of the biggest readers of the Stark rules are not
18 physicians, in fact, but attorneys. This gentleman here hasn't said anything.

19 Dr. Rapp: Dr. Heyman.

20 Dr. Heyman: What about just informing patients that there is ownership by the physician before the patient
21 goes to see them? If the patient is informed and chooses to go there, what's the harm?

22 Mr. Olenick: Again, that's not something that I could, something I could answer. All I know is what we
23 have to work with now.

24 Dr. Heyman: Is that something that's absolutely excluded by the Stark law? You couldn't have that sort of
25 an exception that if the patient is informed ahead of time, that the physician shares ownership in this particular entity
26 that...

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1 Mr. Olenick: It's possible that you could have that kind of an exception, if it were determined that that
2 exception would not be to program or patient abuse, and again, that would have to be decided in the context of
3 rulemaking and the context of the various people that we have to deal with, which of course, you know, they all
4 come from a different direction and they all have their own agendas.

5 Dr. Rapp: Dr. Heyman.

6 Dr. Heyman: Well, let me just say, in answer to your first question that you've got printed here, the answer
7 is definitely yes, in the sense that many physicians who would have done something have not done something that
8 might have provided good care because of their fear of the Stark rule even without even knowing for sure that they
9 were disobeying any. I mean, I've been in that situation myself.

10 Mr. Olenick: It's a deterrent.

11 Dr. Heyman: Oh, definitely. It's a deterrent to, I believe it's a deterrent to both physician referrals in some
12 situations and also to specific investments by physicians in things that would help their communities because they're
13 afraid.

14 Mr. Olenick: And I would guess that the complexity, I don't want to put words in your mouth, but the
15 complexity of the statutes and the regulations means that, gee, I might be in trouble. I really don't know, but I might
16 be so I better not.

17 Dr. Heyman: Exactly.

18 Dr. Rapp: Dr. Castellanos?

19 Dr. Castellanos: Just to comment on your questions. I think Stark II has had good intent. I think one thing
20 that it really has stopped is the referral from physicians to siblings or spouses. I think that's totally stopped and I
21 think what Stark II has done has just added a layer of expense and anxiety to physicians who are law-abiding. When
22 we make a decision whether we should or should not do something, unfortunately we incur an excessive legal
23 expense. It's not unlike HIPAA, which is an unfunded mandate. I mean, it's unfortunate that the physicians are
24 incurring these legal expenses. Obviously, there's no other way of doing it but I hope CMS recognizes that it does
25 cost us a lot of money and it costs us a lot of anxiety. And, as Joe Hammond stated, perhaps some referral patents
26 are not done.

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1 Mr. Olenick: Yes, and I hear you there and the only way I can think to address the question is that by
2 making as many exceptions as we can, and making those exceptions easier to obtain, we've hopefully tried to make
3 things easier on the physicians, recognizing, of course, that we still have this statute that's on the books where we
4 have a responsibility as public servants to implement.

5 Dr. Castellanos: I would like to make one recommendation.

6 Dr. Rapp: Yes, sir.

7 Dr. Castellanos: I'd like to make the recommendation that PPAC support that the regulations be modified
8 to reflect the federal court decision in the American Lithotripsy Society versus Secretary Thompson decided on July
9 12th, 2002 that held that lithotripsy was not a designated health service.

10 Dr. Rapp: Is there a second to that motion?

11 [Unidentified]: Second.

12 Dr. Rapp: Did you get it?

13 Reporter: No, I didn't get the details.

14 Dr. Rapp: Try that again, Dr. Castellanos.

15 Dr. Castellanos: Yeah. I'd like to make a recommendation that PPAC recommend that the regulation be
16 modified to reflect the federal court decision in the American Lithotripsy Society versus Secretary Thompson
17 decided on July 12th, 2002, in the Washington Federal Court, it upheld that lithotripsy was not a designated health
18 service and that CMS comply with this court order.

19 [Unidentified]: I don't know that CMS needs that recommendation. It's pretty obvious.

20 Dr. Rapp: Did you get it?

21 Reporter: I did. PPAC supports that the regulation be modified to reflect the federal court decision that
22 lithotripsy is not a designated health service.

23 Dr. Castellanos: That's close.

24 Dr. Rapp: Okay, is there any discussion on that? Yes, sir.

25 Dr. Urata: Can I have an explanation what means? Does that mean it's – what does that mean?

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1 Dr. Rapp: The law says that you can't refer for a designated health service and defines that as clinical
2 laboratory service, physical therapy, etcetera. Includes radiology, including MRI CT scans and ultrasound services,
3 etcetera, etcetera.

4 Dr. Urata: I understand.

5 Dr. Rapp: And apparently there was a court case that, that issue was, was lithotripsy one of these things,
6 like ultrasound services, I suppose. And apparently, the court held it wasn't. And so, what Dr. Castellanos is urging
7 is that PPAC recommend to CMS that they basically adopt that point of view, that lithotripsy does not fall within
8 this bulleted list. Is that right?

9 Dr. Castellanos: That's correct.

10 Dr. Rapp: Okay. Any further discussion on that? All in favor?

11 [Multiple] Aye.

12 Dr. Rapp: Anybody oppose? If not, the motion is adopted. Any other motions?

13 Dr. Heyman: Not on this subject but are you opening it to my motion at this time?

14 Dr. Rapp: No, no.

15 Dr. McAneny: I'd like to make a request that when Stark II is published, I assume it will published for
16 comment period?

17 Dr. Rapp: I guess it'll be published for comment on the, I think it's going to be comment on the new stuff.
18 I thought it was the stuff that was commented on before that we changed.

19 Dr. McAneny: When it's published for comment, that it be brought, that that be sent to PPAC and be
20 brought back as an agenda item?

21 Dr. Rapp: When do you think it will be, maybe I missed it, when do you think it --

22 Dr. McAneny: He didn't say when.

23 Dr. Rapp: Well, do you think it will be published at such time that possibly the comment period will still
24 be open in September?

25 Mr. Olenick: Yes, that's possible.

26 Dr. Rapp: All right. So, we'll pay attention to that as we would like to see it come back on the agenda.

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1 Dr. Heyman: It does sort of segue into my motion, however.

2 Dr. Rapp: We'll get to that.

3 Dr. Heyman: All right.

4 Dr. Rapp: I'll get to it before the end of the day.

5 Dr. Heyman: Okay.

6 Dr. Rapp: And if I don't you can holler at me.

7 Dr. Heyman: All right.

8 Dr. Rapp: Anything else on the arcane topic of Stark II?

9 Dr. McAneny: I don't have a motion but you asked the question of what changes do you want to make to
10 the statute of regulations. I think the idea of whether something is mobile or immobile is pretty much irrelevant to
11 whether or not it's abusive in the community. I think there ought to be a way for groups of physicians to band
12 together to provide needed services without being in one group practice because then they don't make, you know, if
13 you're not in the same group practice you don't qualify for the in-office ancillary exception. However, if you have
14 two different groups who want to band together to provide a needed service for the community, Stark prohibits that
15 and that does not improve healthcare.

16 Mr. Olenick: You can't have a shared service, however it requires basically that the shared service be in a
17 certain building and that both parties that are using the shared service are, or however many parties there are, they
18 also be in the same building, so that's not any good for you.

19 Dr. Rapp: Okay. Anything else? If not, thank you very much for coming and we'll look forward to the
20 official public published regulation.

21 Mr. Olenick: You're welcome. Thank you very much.

22 Dr. Rapp: The next item on the agenda will be, and I'm hopefully not doing too bad. HIPAA privacy rule.
23 Cell phone communications, in particular. I believe ...

24 [Everyone talking at once]

25 Dr. Rapp: Oh, it is formally used. Good afternoon. Are you Linda Sanches?

26 Ms. Sanches: Yes, I'm Linda Sanches.

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1 Dr. Rapp: Jodi Goldstein is?

2 Ms. Sanches: Ms. Goldstein won't be able to join us this afternoon.

3 Dr. Rapp: You're from the Office of Civil Rights. I understand the Office of Civil Rights has been given
4 the responsibility for enforcing this.

5 Ms. Sanches: Yes, we have.

6 Dr. Rapp: How many people do you have in the office?

7 Ms. Sanches: That's a good question. Not enough to help you actually. We have, and this is just an
8 estimate, approximately eight people, and we are in the process of hiring ... about seven additional people to work
9 out in the regions and temporaries.

10 Dr. Rapp: And your job was to enforce this thing?

11 Ms. Sanches: Well, yes. We have a great deal of preamble. The rule itself is not that long. I think that the
12 gentleman before me pointed out, the actual regulations are not nearly that long. But yes, we we're focusing on a
13 great deal of technical assistance, and we're also handling enforcement.

14 Dr. Rapp: All right.

15 Ms. Sanches: I actually do have a PowerPoint presentation. I understand a screen is supposed to come
16 down.

17 [Everyone talking while getting projector ready]

18 Dr. Rapp: Do you want to talk while we wait for you?

19 Ms. Sanches: Dr. Rapp, I was asked to be prepared to be here for an hour. I did notice that you're perhaps
20 behind in the agenda. I'm wondering if you want me to speak for a shorter amount of time?

21 Dr. Rapp: Uh-huh.

22 Ms. Sanches: Okay.

23 Dr. Rapp: Well, if possible, to try to help us make up the time.

24 Ms. Sanches: I'm here prepared to speak on a few topics. My understanding is that people from my office
25 have been here before to provide overviews. So, I thought I would talk about some common compliance issues that
26 we've seen. I'll also talk about our administrative requirements and answer some very common questions we're

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1 having on compliance and enforcement. If you rather, I can speak on just a portion of those and leave a lot of time
2 for questions. So, feel free to stop me at any point. Well, I'll just start as we're waiting for the slides. My
3 understanding is you don't actually have a copy of these slides but they are available to you, and I believe our office
4 has them. The first thing I wanted to mention just off the top is that we provide a standard disclaimer which is all
5 the written materials have been improved by the office. But if you ask me for my opinion that would just be my
6 personal opinion and it's not necessarily vetted by OCR. Okay. Great, thank you. The first point is reporting to
7 OCR. I thought I would mention this because we have had people call our regional offices asking where to send
8 their policies and procedures. There actually are no required reporting, regular reporting to OCR. You are required
9 to create policies and procedures but you can just keep them in your office. If, in fact, we, someone were to actually
10 do some sort of compliance work with you, we may ask for certain reports but that would not be a regular reporting
11 requirement. I'd thought I'd talk a bit today about permitted disclosures and uses for treatment payment healthcare
12 operations, clarify some issues around minimum necessary and incident 2 disclosures. I'll briefly describe the
13 administrative requirement, and talk about compliance. I also wanted to mention that there's a great deal of
14 guidance available on our website and I believe you already received a copy of our summary. And the summary
15 also contains sites that you can click on to, sources of other information including the CMS website etcetera. Under
16 the privacy rule, covered entities can use and disclose protected health information to carry out essential healthcare
17 functions, treatment payment, and healthcare operations. We usually refer to those internally as TPO. And no
18 authorizations are required for this, and we have been getting some confusion from practitioners so I did want to
19 make sure that everyone here was comfortable with this. Covered entities may use and disclose information for
20 treatment payment and healthcare operations without a signed statement from an individual. When we asked you all
21 to attempt to get an acknowledgement that your patients have received a notice of privacy practices, if they refuse to
22 arrive at that acknowledgement, you can still go ahead and treat them, and it's not required that you get it. We have
23 had some patients call with concerns that they have been denied access to treatment because they wouldn't sign the
24 acknowledgement. So, I just wanted to be clear that they may chose not to sign it or get it back to you and that's
25 okay. So, what is treatment? Treatment is a fairly broad definition; the provision, coordination or management of
26 healthcare for one ore more healthcare providers, including consultations and patient referrals. That means if

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1 another doctor calls you up and wants to consult with you about a patient, he's certainly not in violation of the rule
2 doing so, and you may certainly refer patients to another doctor and actually provide information to that doctor
3 without getting that patient's authorization. This is allowed under the treatment disclosures. Payment – payment,
4 again, is a very broad definition, as far as extensively discussed in the rule itself, but it means activities or providers
5 are paying payment. They're to be reimbursed for their services. That means that if an individual has provided you
6 with their insurance card, you can go ahead and, you know, seek payment from that insurer. If you're seeing
7 someone under worker's compensation or auto insurance, it doesn't matter that the coverage is not being provided
8 by another covered entity by a health plan. You can still go ahead and disclose information as needed for you to be
9 appropriately reimbursed. That includes being reimbursed by the family members or the individuals themselves.
10 Health care operations. You can use and disclose information without an individual's consent for administrative,
11 financial, legal, and quality improvement activities. We have a whole list of what these things are but you can
12 generally think of them as things you need to support you in your work of providing treatment, and getting paid for
13 that treatment. This includes quality assessment and improvement, training, accreditation, and certification, certain
14 treatment in hospitals have training as an important part of what they do, and we certainly assume that uses and
15 disclosures will be made for those functions. Other things that are important for this group like the medical review,
16 legal services, business planning and development, business management and general administration. That includes
17 things like customer service. So, what is it that you can actually do under the rule? You can use and disclose
18 protected health information about your patients for your own treatment, payment and healthcare operations
19 activities. You can disclose information for treatment activities of another provider. So, if a hospital calls you up
20 and requests information about your patient because they're now seeing them in the emergency room, you can
21 certainly go ahead and make that disclosure that is permitted under the rule. Likewise, if a doctor calls from another
22 state and says they're now treating your former patient, the patient has moved and they are requesting from you a
23 copy of the medical record, you can go ahead and disclose that. That's certainly an appropriate treatment disclosure.
24 Now, you may already have your own policies and practices in place where you try to get some sort of written
25 permission from the patient. Before that, we don't say that you cannot do that, but there is no paperwork required
26 under the privacy rule for these types of disclosures. You can also disclose to another covered entity or another

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1 provider and we make that distinction because, of course, there are providers who are not covered entities who only
2 accept cash, for instance. And, unfortunately I have some providers like that. Those providers, you can disclose to
3 them for the recipient's payment activities. This is a very important issue for paramedics, for instance, for
4 emergency transport. Often they don't have the billing information for their patients. When they drop them off at
5 the hospital, the hospital certainly can provide that information back to the emergency treatment organization in that
6 community so that they can get paid. This often is also the case for things like radiologists who provide radiological
7 services in a hospital. The hospital can certainly provide that information so the radiologist can do appropriate
8 billing. Covered entities may also disclose to another covered entity if there's a mutual relationship with the
9 individual. For instance, a community provider and a hospital for your patient who's being seen at the hospital. For
10 the other covered entities, quality, training or credential activities, fraud and abuse detection activities. And it may
11 be that, in fact, you are part of an organized healthcare arrangement with another covered entity. For instance, if
12 you are a provider providing services at a hospital, you're clinically integrated. You can certainly share information
13 with that other covered entity for your joint healthcare activity. You might be doing joint quality improvement
14 programs together. I wanted to speak a moment about minimum necessary because we had some questions about
15 this. The general rule is that covered entities must make reasonable effort to limit the use and disclosure of and
16 requests by patients' health information to what's reasonably necessary to accomplish an intended purpose. And
17 there are three different types of functions here. There's use, disclosure and requests. So, use would mean within
18 your organization. If you have a small staff of people, use might encompass discussion you have with your billing
19 clerk and your nurse and associate. If you're a hospital, use would mean everything that happened with everyone on
20 staff and all the volunteers and trainees in that hospital. The request form, we might actually call a hospital and ask
21 for them to ask for information status of your patient, or if you called someone else and wanted information. So
22 minimum necessary applies to all three of these types of functions but it's different depending on whether it's for
23 treatment, payment or healthcare operations. If you are using critical health information, we generally are requiring
24 you to create role-based access strategies. It may be in a small office with a nurse and yourself, that all of you need
25 access to all the records, because a nurse really does need to be taking notes and handling what's going on. It may
26 be, though, if you're a large facility, it may be that the lab technician does not need access to the entire medical

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1 record and that you might create policies whereby that lab tech does not get access to everything. And, so we need
2 to think about what the roles of your staff members are and make sure there is adequate and appropriate access by
3 those individuals. For disclosures and requests for information, we certainly expect covered entities will create
4 standard protocols for routing and recurring requests for information or disclosures. For instance, you commonly,
5 I'm sure, are billing Blue Cross or Medicare. You can certainly come up with standard protocols by which
6 information flows or you handle Blue Cross information for those large carriers. It may be, though, that you
7 occasionally get requests that you're not used to. Someone from out of state for a purpose that's very unfamiliar to
8 you. For those types of requests for information, we will be required to actually case by case decide what
9 information should be provided in response to that request. Covered entities, of course, aren't always in the position
10 to know what is the reasonable amount necessary by someone who is requesting information from you. And, so we
11 do, under the rule, permit you to reasonably rely on requesters' determination of what they actually need. As you
12 get a request from a public official in writing saying they're asking for this information in their role as a public
13 health authority for a particular public health investigation, and it comes on letterhead, well, you can just rely on that
14 and provide the information they request. We don't require you to think what the protocol should be and how much
15 information they really need for this investigation. Similarly, if another covered entity at a hospital or another
16 practitioner asks you for information so that they can treat a patient, they are, in fact, only supposed to be requesting
17 what they actually need. And, so you don't have to independently determine what it is that they need. If they ask
18 for the entire medical record, again if this is reasonable, you can go ahead and provide it.

19 Dr. Rapp: This is the one thing that makes me a little nervous because it seems a little vague. And it seems
20 like somebody could always say, oh, you didn't need that. And I'd say, well, I mean you're just asking for some
21 references. How do you envision enforcing – how would this work that you would, somebody would complain
22 about that and how would you analyze that? It makes me a little nervous about asking. It sounds great that the
23 treatment, the payment operations don't need any consent, anything like that, but now all of a sudden somebody
24 could say, well, wait a minute, you asked for too much.

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1 Ms. Sanches: Well, again, it depends what you're asking for. Under the rule, just as today, I'm sorry, not
2 today – just as before April 14, if you as a practitioner called someone up and asked for records on a patient, they
3 could certainly have denied you access, or asked you why that you wanted it.

4 Dr. Rapp: No, they'll ask for a consent.

5 Ms. Sanches: Sure.

6 Dr. Rapp: And I'll just say, have the patient sign the consent and that's it.

7 Ms. Sanches: Right. That's certainly allowed now. We don't prevent anyone from getting a patient
8 consent for this information to flow. If that's the kind of practice that a particular provider wants to institute, that's
9 certainly permitted under our rule. We just say that it's not required.... Within a large organization, as you're
10 sharing information among a variety of practitioners, you would need to come up with policies and procedures for
11 uses for treatment. As I mentioned before, lab tech is actually providing a treatment service, but it may not need
12 access to the entire record. It is not actually required for disclosures to request by providers for treatment. So, let's
13 say you asked for the entire medical record, as you commented a moment ago, of an individual, and you get the
14 record. You have, if you feel like you need the entire record, you ask for it. That's appropriate. You have not
15 violated the rule nor has the provider that provided it to you.

16 Dr. Rapp: So that wouldn't be second-guessed, if you tell them what you need.

17 Ms. Sanches: No. Now, the question would be, of course, if you were asking for information for a non-
18 treatment purpose, then you would need to be thinking through what you actually needed.

19 Dr. Castellanos: There was a previous policy about AIDS and HIV, releasing that information. We used to
20 have to have separate, you know, release policies for that. How does this figure into this now, under privacy?

21 Ms. Sanches: Well, HIPAA is, you might think of it as attitude here. There are lots of other state and
22 federal laws that have to do with specialized issues like substance abuse. There are state laws regarding HIV and
23 AIDS disclosures. And we don't take away those privileges. So, if there's a state law in the books that is more
24 protective of privacy, for instance, that requires greater scrutiny of release of AIDS treatment, for instance, our rule
25 is not to do away with those requirements. So, those would also stand.

26 Dr. Rapp: Dr. Heyman?

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1 Dr. Heyman: Well, where there is no state law and you request records, and you get the records, and it's
2 solely for treatment, and there's something in the record that you didn't actually need for treatment, but, of course,
3 you just requested the record so that you would know whether or not you needed something for treatment, the
4 patient discovers that this information that she did not want released, was released to you, and then makes a
5 complaint to the department about you because you asked for the thing, or makes a complaint about the person who
6 sent you the information. What process occurs after that?

7 Ms. Sanches: That's a good question. I actually have some discussion in a few minutes on how we handle
8 complaints. But, in general, in a situation like that, if you had requested the information so you could provide
9 treatment to the individual, and then you received information you didn't expect, I, again speaking personally,
10 because this is just a theoretical, I don't actually see a violation. I understand that the patient might be --

11 Dr. Heyman: Well, even on the part of the person who sent me the information? You know, that person
12 was complying with my request and included some sensitive information. I mean, they're not going to - I don't
13 know whether, you know, if you have to read every record completely, 100 percent, before you release it, to make
14 certain that there's nothing sensitive.

15 Ms. Sanches: Right. Minimum necessary does not apply to disclosures, to providers for treatment.

16 Dr. Heyman: All right.

17 Ms. Sanches: So, they are, in good faith, providing information, they believe is for treatment, to another
18 provider and the rule has not been violated. Or, that provision of the rule has not been violated.

19 Dr. Heyman: Okay.

20 Ms. Sanches: There are other places where minimum necessary does not apply.
21 It doesn't apply to disclosures to an individual. We don't have to assess what the individual needs when they ask
22 you information about themselves. The use of disclosures with an authorization. If you're getting authorization
23 from a patient, asking that information go to their life insurer, as long as the authorization is valid authorization
24 under the privacy rule and it's clear what information they want to be disclosed, you can go ahead and just follow
25 the authorization. The use of the disclosure is required for a HIPAA standard transaction. Basically, CMS started to
26 determine what is minimally necessary. And you need to follow all the requirements of the standard, so you can just

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1 go ahead and do that. Disclosures to the Office for Civil Rights for enforcement. You don't need to determine what
2 we need for an enforcement action. And that there is a disclosure that's required by law. Again, we are not going to
3 hold you on the line for determining what is actually required, when a state or federal agency requires you to make a
4 disclosure. So, just to be clear, though, minimum necessary does apply to uses for treatment. But it's not applied
5 for disclosures to treatment. So, within your facility, it is important for you all to be thinking about that. We have
6 had some misunderstanding out there about that. Okay. Overheard and seen in passing – the incident to uses of
7 disclosures. I did receive a question about cell phones and I wasn't exactly clear what the concern was, but I was
8 bringing up all these because it might actually be germane to the cell phone question. There has been some anxiety
9 about when someone might be in violation of the rule if someone overhears them. Or, you know, their cell phone –
10 we actually have had questions about whether cell phones were permitted, in general, because someone could, in
11 fact, use it, or get access to it. Whether emergency treatment personnel, whether paramedics, they use radios, and
12 those could be intercepted. We do require that minimum necessary be followed, and that appropriate administrative,
13 technical and other safeguards are put in place. But if those things are actually done and someone overhears you or
14 sees something, then you are not in violation of the rule when that happens. So, some examples of that, and these
15 are really gross examples, just to make a point clear. You can certainly talk on a cell phone when you're making a
16 permitted disclosure. You can call a colleague of yours and discuss treatment of the patient. That's fine. On the
17 other hand, you couldn't do that in the middle of a party or in the waiting room with a lot of patients listening to
18 you. Then you're not, perhaps, taking reasonable safeguards. It might be better for you to step into a room
19 somewhere or speak softly, or just step aside so other people can't hear you. On the other hand, recognize that
20 sometimes people are going to overhear you, that you can't always find an empty office space. And, in those cases,
21 you do what you can do following certain general professional standards, and provide treatment as you need to. We
22 certainly understand there are going to be semi-private rooms, that you're going to have to talk to nurses in the
23 hallways, things like that. But we do ask for you to think about whether, you know, things could be slightly changed
24 or modified in the way you conduct your business to actually enhance the privacy you're providing to individuals.
25 Yes?

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1 Dr. Heyman: Well, I think the question about the cell phone was specifically about the idea that when
2 you're using the cell phone, it is open to others electronically to get the information. I mean, I personally, usually
3 what I do, is I start out my conversation by saying I'm on a cell phone and tell the patient that it's possible on a cell
4 phone that somebody else could hear, could get this information. And I usually don't say the patient's name. But
5 I'm just wondering, is that necessary? I mean, I think that's what the question was about, was the actual use of the
6 cell phone and just how much precaution you had to take if you're alone with the cell phone.

7 Ms. Sanches: Uh-huh.

8 Dr. Heyman: Okay. And, it's just how much precaution is there with the cell phone, in general, just
9 because of the technology of the cell phone.

10 Ms. Sanches: Yeah. OCR does not have a written interpretation out regarding cell phone usage. Speaking
11 personally, I don't believe there's any intent to prevent you from using cell phones. It sounds like you were actually
12 already thinking through appropriate safeguards when you are not talking about someone's name, or not providing
13 someone's name on the cell phone. So, those are the kinds of things we would ask people to think about. We don't
14 prohibit the use of any particular technology in the rule itself. In the interest of time, I will move through these very
15 quickly. But the information is also in our summary document which, I believe, you already have. There are a great
16 deal – a great deal, I shouldn't say that – there are processes and procedures that are required in the rule, for
17 instance, in setting up your minimum necessary program. And the rule requires that you write these down and keep
18 all of them, and that you change them as necessary to comply with applicable laws. The administrative safeguards
19 section, I'm sorry, the administrative provisions of the rule also require that safeguards be put in place, as I
20 mentioned earlier - appropriate administrative, technical, and physical safeguards, to protect your health
21 information. There's also a requirement that covered entities mitigate harmful effects of use of disclosure that
22 violated the rule, to the extent, practical, and if you know of the violation. There have been some interesting
23 examples of this, and again, I should say this - the example I'm about to give was not a violation of the rule, this
24 happened before the privacy rule came into effect. But there was a large covered entity that discovered that they had
25 sent the wrong e-mails to certain of their members. They basically thought they were sending a response to Joe
26 Miller when actually the response went to John Smith, and it had Joe Miller's information in the e-mail. This went

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1 out to hundreds of people. When they found this, they immediately stopped all the e-mail communication, fixed the
2 problem, contacted all the people who received the erroneous e-mails, asked them to delete it. I figure they took
3 appropriate mitigation efforts and they contacted everyone whose information was inappropriately disclosed. So,
4 these are the kinds of things that covered entities can think about if they discover that there has been violation of the
5 rule, despite their best efforts not to. The rule requires that covered entities provide training to all of its workforce,
6 as necessary and appropriate to their functions. We certainly don't expect that everyone will get the same training.
7 We certainly expect that medical staff and the custodian might need different amounts of training and have, you
8 know, different aspects of the rule mentioned to them. But it is required that everyone receive some kind of training
9 as is appropriate. The covered entities are also required to develop and imply a system of sanctions for employees
10 who violate the policies or requirements of the privacy rule. Covered entities have to designate a privacy official
11 and a contact person or office responsible for receiving complaints, provide a process for making complaints, not
12 require individuals to waive their rights, and refrain from intimidating or retaliatory acts. The next couple of slides
13 are just examples of things where you would need to keep documentation. And the rule does require that you keep
14 this documentation in some form, written or electronic, for 6 years. For instance, if you have received an
15 authorization from an individual, you would need to keep that for 6 years. If you enter into business associate
16 contracts, those would need to be kept. The last point has been the subject of some confusion. In creating your
17 policies and procedures, you would need to determine what our designated record says, because individuals have the
18 right of access to information in a designated record set. So, you would need to determine what those sets are. This
19 last bullet just means you need to keep for us a list of what the sets are. But that doesn't mean you have to
20 independently keep all the information in that set for 6 years. Certainly, designated records - that would include
21 medical records and billing records. There might be additional records that would be required to be designated
22 record sets. I'm going to, in the interest of time, move to compliance and enforcement. But we are focusing our
23 efforts on voluntary compliance and working with covered entities to help them come into compliance without
24 having to move on to a formal application of monetary penalties, although certainly that option is available to us. If
25 you look in the statute itself and in the privacy rule language, there's a great deal of language in there on our
26 requirement to provide covered entities with education to cooperate with them and to provide technical assistance,

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1 and to find ways to make sure CMP's, and covered entities are moved strictly to voluntary compliance when a
2 compliance issue is brought to their attention. We also believe that this is the most efficient way to promote privacy,
3 is to actually work with people to meet our rule. OCR is empowered under the regulation to investigate complaints
4 and to conduct compliance reviews separately from that. At this point, however, we are focusing on responding to
5 complaints. An informal review may resolve issues quickly. We have had cases already where we've gotten a
6 complaint, we've picked up the phone and called the covered entity, and they responded very quickly and the
7 problem went away. And, so those are the happy win-win situations and we certainly hope that lots of things will
8 work that way. We've been able to work things out informally in many situations already. If not, we will begin a
9 formal investigation but voluntary resolution is always our goal at any point along the process. Now, CMP's can be
10 imposed by OCR. \$100 for violation capped at \$25,000. And covered entities do have a right to a notice and a
11 hearing before that becomes final, so again, there are procedural ways, methods ongoing there. And, no monetary
12 penalties will be imposed if the person didn't know and exercising reasonable diligence would not have known the
13 violation, their failure to comply was by reasonable cause. And again, they correct it quickly. And the other time
14 the CMP would apply, however, is where the event is punishable by criminal sanctions. And that's part of the
15 statute itself, and the statute provides that where a criminal offense has occurred, or is believed to have occurred,
16 that that would be administered by the Department of Justice. So, we would be referring cases there. So, again,
17 there are some exceptions to when we would apply the CMP's. There's a 30-day cure period, and we can reduce
18 CMP's, if the amount is in excess of the violation. Just a reminder, the criminal penalties, and I hate to end on this
19 note, however, it is up to \$250,000 and 10 years in prison if there is an intent to sell, transfer or use for personal
20 advantage, personal gain, or malicious harm. And this language is in the statute itself. So, I'm happy now to take
21 questions.

22 Dr. Rapp: Barbara?

23 Dr. McAneny: Thank you. Are there any rules that have been published yet on small practices? There's a
24 small practice exemption and I've had comments from several people who are confused whether or not they are
25 truly exempt if they have less than 10 employees, etcetera, and the rules haven't been published, so people are

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1 confused. Plus, some people are confused whether or not if they ever use a fax machine, does that count as
2 electronically transmitting data?

3 Ms. Sanches: Okay. Your first point actually refers to a CMS regulation. I'm not actually expert in it.
4 But, in fact, under HIPAA there is not an exemption for small practices. Under the statute, there's a one-year
5 extension of when small health plans need to come into compliance. But Congress did not provide an extension for
6 small practices, so if you are a small practice who conducts electronic transactions, the compliance date was April
7 14. Then, the question, of course, would be what is an electronic transaction? I'm sorry, I didn't come prepared
8 with slides for that, but basically if you're conducting any of the transactions that were part of the CMS transaction
9 pool, and there are eight of those, and if you were doing those electronically yourself or through a billing agent -
10 what have you - then you would be a covered entity under the rule. So, if you're doing electronic billing, remittance
11 advice --

12 Dr. Rapp: I think it's Medicare doesn't require you to do electronic billing if you're a small practice.

13 Ms. Sanches: Yeah, right. That's right.

14 Dr. Rapp: If you do electronic billing, then you have to comply with the privacy rules.

15 Ms. Sanches: It's actually that you have to comply - my understanding is that CMS would be requiring
16 practices with 10 or more to submit electronic claims to CMS.

17 Dr. Rapp: Right.

18 Ms. Sanches: By so doing, that would mean you have been a covered entity under the privacy rule.

19 Dr. McAneny: Right.

20 Ms. Sanches: Because you become a covered entity if you do an electronic transaction. But if you are
21 otherwise a small provider and you're doing electronic transactions, you are still covered by the privacy rule.

22 Dr. McAneny: But the question was, there are small provider exceptions for people who are not doing
23 electronic billing, and they're wondering, are they going to be forced into doing electronic billing? Is that the goal?
24 And, secondly, are things like faxes under electronic transmission of information - is that sufficient to make them
25 out of that small provider exemption and into compliance?

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1 Ms. Sanches: Well, you're actually asking about Congressional intent, and I believe Congress' intent was
2 not to force providers into conducting electronic transactions. That's why they basically said if you are a provider
3 that doesn't conduct electronic transactions, then these rules do not apply to you. So, it doesn't matter what size you
4 are, although I agree, you're more likely not to be conducting electronic transactions if you are small. Regarding
5 faxes, we actually do have, there are some FAQ's on the government website about this. I believe it's on the CMS
6 website and I think it might also be on ours, but we link to each other. Generally speaking, if you are a provider that
7 is sending something on a standalone fax machine, the classic fax machine, that is not considered an electronic
8 transaction. There are some faxes that are sent through computers. That gets a little more dicey, and I can't answer
9 that right now but I'd be happy to provide follow-up, if you'd like.

10 Dr. Rapp: Anything else? If not, thank you very much. This is about the third or fourth time I've heard
11 about HIPAA and been trained in it a couple of times, and maybe another half dozen more, I'll get it.

12 Dr. Heyman: Well, while we have her, although it's not on HIPAA, can I ask her a question about
13 Medicare patients under the Office of Civil Rights? Are you the folks who are responsible for the rules that have to
14 do with translators, interpreters? What, how does that apply to Medicare patients and what do we have to do, if I
15 could just ask, if it can be answered?

16 Ms. Sanches: The Office for Civil Rights does enforce both the privacy rule and other civil rights laws
17 including the ones you're referring to. I'm, unfortunately, not able to address your questions on that.

18 Dr. Heyman: Is anybody --

19 Dr. Rapp: You went to the right place.

20 Ms. Sanches: And certainly, if you would like, someone from OCR could certainly come and do a
21 presentation on the topic.

22 Dr. Heyman: Okay.

23 Dr. Rapp: Thank you very much. Let's take a five minute biological break, but only five minutes.

24 [BREAK]

25 Dr. Rapp: All right. We're not too far behind schedule, fortunately. The next item on the agenda involves
26 access to physician services. We have two individuals here apparently. Renee Mentneck. Is that right? Who is an

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1 R.N., and an M.S.N., who's the Director of the Division of Beneficiary Research for the Office of Research
2 Development and Information at CMS. And we have Kevin Hayes, who's a Ph.D. with the Medicare Payment
3 Advisory Committee, otherwise known as MedPAC. Thank you both for coming and I'll let you get started.

4 Ms. Mentneck: Thank you. Several months ago, I can't exactly remember when, on a strategy that had
5 been designed to monitor access to physician services -- at that time, we had been hearing a lot about anecdotal
6 reports that beneficiaries in certain parts of the country were having difficulty finding physicians to accept within
7 their practices the number of Medicare patients they received -- so, we were asked to develop a monitoring strategy
8 which we've done and now we're in the process of implementing. So, the purpose of today is to give you an update
9 on where we are on our monitoring strategy, and wherever results we have to share. Just to refresh people's
10 memories, our strategy includes data from a variety of sources including claims, surveys, beneficiary inquiries to the
11 1-800 Medicare number, and environmental scanning activities. We now have concluded the carrier monitoring
12 activities and from a 12-week period of time where we had the carriers monitor the number of inquiries beneficiaries
13 were making regarding physician access. The number was very limited and there did not appear to be any national
14 problem. From the 1-800 Medicare call center we have now about 15 months worth of data on a monthly basis for
15 every state. We have two particular scripts that are related to beneficiaries asking about access to physician
16 services. And what we found is that the number of inquiries related to access problems is very small relative to the
17 number of inquiries that the call center gets overall. It represents only about .03 percent of calls. So, it's a very
18 small number. In terms of the number, it's about 2,300 inquiries out of 9.4 billion inquiries over that 15 month
19 period of time. So, when you look at this, nationally it does not appear to be a problem. However, when you look at
20 individual states, the numbers change a little, the picture changes a little bit. Again, these are based on very small
21 numbers of calls, but nonetheless, there are several states that repeatedly over the 15 month period of time, came to
22 the top in terms of the number of inquiries per thousand beneficiaries. So, we used that information along with the
23 information from the carrier call center and the regional office scanning activity, to identify whether there were
24 particular parts of the country that seemed to suggest that there might be an access issue. We also used data from a
25 survey that we've been administering for a few years now called the Fee for Service Medicare CAHPS Survey,
26 which is a beneficiary survey. It's fairly large, and it covers the entire country, and gives us the ability to look at

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1 access issues down to a small geographic level. So, there are several questions on that survey that focus on the ways
2 and difficulties in getting care. So, we used data from 2000 and 2001 for this CAHPS survey coupled with the other
3 data sources that we mentioned, to identify particular parts of the country where we thought we wanted to dig
4 further. The fee for service CAHPS survey does give us some sense of whether beneficiaries are having difficulty in
5 getting care, but it doesn't tell us why. So, we decided to administer another beneficiary survey in as many
6 geographic areas as we could afford to go to, to try to get below the surface and understand why beneficiaries were
7 having problems, and to see whether they were related to the Medicare program, or whether they were more generic
8 in nature. So, again, using the CAHPS data, the 1-800 Medicare data, and the regional office scanning activity
9 carrier calls, we identified several areas to administer this targeted beneficiary survey. And we are in the field right
10 now. We anticipate finishing the survey in June and expect to have results sometime in late summer or early fall.
11 The 11 areas that we went to include Phoenix, Arizona; San Diego, California; San Francisco, California; Denver,
12 Colorado; Tampa, Florida; Springfield, Missouri; Las Vegas, Nevada; Brooklyn, New York; Forth Worth, Texas;
13 Seattle, Washington; and the state of Alaska. These areas were picked, again, because the evidence and the data that
14 we had suggested that beneficiaries in those areas were more likely the beneficiaries in other areas to be
15 experiencing difficulty. We also wanted to balance that with geographic representation, and also because we didn't
16 have enough money to go to all the areas that we probably would have liked to have gone to. So, we anticipate
17 being able to go again into the field to an additional 14 areas sometime later this year or beginning next year,
18 depending upon funding. There is a cast? in the contract to allow us to go back into the field again, if necessary.
19 The other piece of data that I mentioned the last time I spoke to you, was a database that we had designed that
20 allowed, hopefully was going to allow us to look at case load information at the physician level, the county level,
21 over time, to determine whether actual case loads per physician for the overall medical specialty within each county,
22 whether those were changing over time. And, what we discovered with the database - we have the file - it goes back
23 to 1995 and all the way through 2001. The 2002 data should be available soon. When we looked below the surface
24 at the data, we started to discover that because of the way that bills were coming into the claims processing system,
25 we were not able to accurately capture unique physicians, particularly if it's a group practice. On the billing
26 process, the billers can put a PIN number down. So, we had hoped that the PIN number would be unique, but what

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1 we have in looking at the actual claims data, is that it appears, for group practices in particular, that the folks going
2 out, the bills, will put down a PIN number that gets through the system. And it doesn't necessarily reflect the unique
3 physician providing the care in that practice. So, we thought well we could potentially still use this measure as long
4 as the noise in the data was constant over time. But what we found in looking at data from '95 forward, that the
5 actual noise in the data was getting worse over time, reflecting probably consolidation of practices, that there were
6 more and more group practices. And it didn't seem to be an issue for certain specialties. It was sort of across the
7 board. So, while we had hope to use this case load variable as a way of tracking whether fewer and fewer
8 physicians were seeing more and more patients within a county level, it doesn't look like it's going to be that
9 promising of a measure to use. We're quite disappointed. So, the other data system that we designed is a claim
10 based monitoring system. It's at the county level, we implemented it about a year ago. We had to wait for a year's
11 worth of time to go by before we had a complete data set. And it provides quarterly data on the number of
12 evaluation and management services at the country level and emergency room visits. So, we're going to be using
13 the quarterly monitoring system to look to see whether, at the county level, there are fewer E&M visits and more ER
14 visits. Beneficiaries are having trouble getting access to a physician's office and they need care – they'll show up in
15 the emergency room. So, we don't foresee any difficulties using the data. And again, we just had to wait until one
16 year's worth of time went by. It's now complete, so we'll start to use it. We've done some preliminary analyses of
17 the files, and what we have found is that the period January through March 2003 compared to the preceding 3 years
18 of data at the national level - because we do have that same quarterly monitoring system at the national level - their
19 proportion of claims for evaluation and management services, paid on assignment has not changed in 2003 relative
20 to 2002, relative to 2001. So, we took some comfort in knowing that, at least, that proportion of E&M services
21 providing on assignment doesn't seem to be going down. I think that's it by way of update. We will probably be
22 having a report on the survey, and we will continue to do analysis of supplying factors. We're now looking at the
23 area of resource files, because we want people to really use the case load variable with much confidence. We're
24 now turning to using the area resource file at the county level to get some sense of what the supply looks like within
25 the county, the number of physicians treating patients.

26 Dr. Rapp: Any questions?

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1 Dr. Urata: Yes, just a comment. You talk about seeing the difference between ER visits and clinic visits –
2 in our community, because our ER is somewhat, it takes a long time to get through – a new urgent care clinic has
3 opened up for after-hours care. I don't know if that that would skew your data or not. But that's something --

4 Ms. Mentneck: It depends on the bill. If they're billing as --

5 Dr. Urata: As a clinic?

6 Ms. Mentneck: -- an ER, it would be showing up as a clinic, I mean, if you're billing as a clinic, it'll show
7 up as an E&M code, so it could skew the results.

8 Dr. Urata: Yeah. I'm sure they're billing as a clinic. They call themselves the Family Care Clinic and
9 Surgeon Care. They have after-hours.

10 Dr. Iglar: On that same line, I've seen that's a very regional type of thing, too. Immediate care or urgent
11 care clinics that are starting up more and more in response to physicians from their private practices, and how they
12 see and how they book their schedules, etcetera.

13 Dr. Rapp: Barbara?

14 Dr. McAneny: In both the comments from CMS and in the MedPAC Report, there seems to be the
15 assumption that being a participating physician means approval and acceptance of the Medicare fee schedule and
16 some sort of confirmation of it's adequacy. And I just wanted to let you know that the reason why I'm a
17 participating physician is not because I feel that the fee schedule is so adequate, but because if I do not participate,
18 the check goes to the patient and I never see it. And there are a lot of other reasons why physicians will participate,
19 and it does not imply acceptance of this. And I have a question – as you look at access to care, I want to give you
20 my own scenario to see where this would end up in your ability to detect a difference in access. My practice does 30
21 to 40 percent of the cancer care for the state of New Mexico. Because of the recent, this threat of another fee drop,
22 and because of the proposed changes in AWP, we are currently looking at whether or not we need to limit the
23 number of Medicare patients we accept in the practice. This just irritates the daylights out of me because, in my
24 philosophy of being a physician, I have never before in 20 years had to do any sort of calibration of people's ability
25 to pay. My practice has prided itself on the ability to take care of anybody who comes through that door. Yet now,
26 we're looking at, for financial viability reasons, I'm having my CPA run a spreadsheet to tell me what level of

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1 Medicare patients can I continue to accept and remain financially viable. So, I'm a participating physician. We will
2 still be, because when the patients take the Medicare checks and go and pay the rent with them, there's not a whole
3 lot we can do to recoup that money. And, we have a poor state anyway. So, when that happens, what are you doing
4 that will detect the decreased ability of cancer patients in a state like New Mexico, to get care in a timely fashion?

5 Ms. Mentneck: Generically, that's what we had hoped to be able to get out of, not specifically cancer
6 patients, but generically, we had hoped to be able to get that type of information out of the case load variable, which
7 unfortunately, isn't panning out. And that's a reflection of billing practices from the physician community. What
8 we have done for the survey, and New Mexico may be one of the areas we go to in the next round, we've designed
9 the survey sample in such a way that, the theory behind this is that beneficiaries seeking new relationships with
10 physicians may be more likely to have a difficult time than beneficiaries who already have an established
11 relationship. So, we designed the survey to be as efficient as we could, oversampling beneficiaries more likely to be
12 seeking to end the relationship. For example, people moving into the area or aging into the program – that doesn't
13 address cancer care specifically, but it's to try to get at new relationships. The survey also asks about whether, to try
14 to distinguish between difficulty getting primary care versus difficulty getting access to specialists. So, we're asking
15 them in the surveys questions that are specific to both to try to see, if they tried to get specialty care and couldn't,
16 what were the reasons? Was it because they couldn't get an appointment in a timely manner? Was it because the
17 physicians at the practice said they weren't taking Medicare patients? That "below-the-surface" why question is the
18 bit of information that we have not had to date. Now, the problem with that is, it is limited to 11 geographic areas.
19 It doesn't tell you what's happening to the rest of the country. But we tried to be, again, efficient in picking the
20 areas where, at least the data we have, seems to suggest that there were potential problems in those areas relative to
21 other areas.

22 Dr. McAneny: I do applaud your attempt to go beyond just looking at the number of participating
23 physicians which is not going to tell you much of anything, but I think that a continued survey of what, and
24 sometimes by specialty, because some specialties are going to be more adversely impacted by Medicare changes and
25 rates than others. What percentage of people are either limiting their Medicare new patients, or the way to look at it

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1 from the beneficiary survey might be, how long does it take you to get into a physician practicing in “X” specialty?
2 And that might provide some good data on access to care.

3 Ms. Mentneck: One challenge with the survey approach is it is expensive. So, we’ve taken the tack that
4 we’re, we’ve decided in the survey to try to do something that others weren’t doing, and you’ll hear from Kevin.
5 Kevin and I have tried to collaborate in our access monitoring activities, to make the dollar stretch as much as they
6 could. So, we chose not to survey physicians because MedPAC was administering a physician survey, and also the
7 Center for Study Health System changed – his administering a physician survey. So, our efforts have been focused
8 on the beneficiaries perspective.

9 Dr. Rapp: Thank you. All right. Next, Dr. Hayes?

10 Dr. Hayes: Good afternoon. What I’d like to do is to just take a minute or two to explain a little bit about
11 MedPAC, and then talk just to provide some context on our physician survey to explain how we assess payment
12 adequacy. And we’ll talk here mostly about the physician survey but I’ll also touch on some of the other data
13 sources that we work with. And, just to round out the story, then I’ll explain how all that comes together into a
14 payment update recommendation that the commission makes. The commission itself is an independent, federal
15 body established under the Balanced Budget Act of 1997, and it advises the Congress on Medicare payment policy.
16 The commission represented a merger of two other commissions; the Physician Payment Review Commission, and
17 the Perspective Payment Assessment Commission. We now have 17 commissioners. They serve 3-year terms. The
18 Chair is an independent consultant who was also a health plan executive, and in the 1980’s was the Deputy
19 Administrator of Healthcare Planning for the administration. Vice-Chair is the President of an economic and social
20 policy research organization here in Washington. Other commissioners include four physicians, some health policy
21 researchers, health plan executives, and the like. Other provider representatives are also on the commission. It
22 meets in public 7 times a year, and issues two reports. One, in March, focused primarily on Medicare payment
23 policy, and another report in June which tends to cover Medicare in the marketplace, for healthcare services more
24 generally. Now, moving on to how we do this thing called assessing payment adequacy - this is by way just a kind
25 of setup - your context for why we would do a physician survey. And the commission is essentially, in it’s March
26 report, for the most part, making payment update recommendations for different sectors; in-patient hospital care,

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1 physician services, home health, skilled nursing facilities, the works. And the commission has chosen to break
2 down the process for doing this into two parts. The first is to just assess the current level of payments, and whether
3 they are too high or too low. And that, you know, with some analysis, can be reduced down to a percentage change
4 in payments that might be necessary, either up or down. The other thing the commission looks at is just what, going
5 forward, what can we anticipate in terms of changes in costs. So, we have a baseline at the top part of this graphic
6 then, and a forecast of what's expected for the coming year on the bottom part. Put all those things together and that
7 reduces down to a payment update recommendation. And, so the other thing to say about this, I suppose, is that in
8 looking at whether the current level of payments is adequate, the commission looks at a lot of different data. In the
9 case of facility services, we're operating at a bit of an advantage because we have cost reports, and it's not easy but
10 it's possible to compare the level of payments with the level of provider's costs. In the case of physician services, of
11 course, we don't have cost reports, and so that puts us in a position of needing to look at the data from a lot of other
12 different sources, and a physician survey is one thing that we have used for that purpose. We're following here kind
13 of in the footsteps of our predecessor, the Physician Payment Review Commission. They administered two of these
14 surveys in the early 90's to monitor the effects of implementation of the fee schedule. And, then MedPAC has
15 sponsored two surveys; one in 1999, and one more recently in 2002, primarily to gauge the effects of the payment
16 reduction that occurred in 2002. So, the survey itself was intended primarily to serve as a tool for monitoring access
17 to care, or for Medicare beneficiaries to show things like whether or not physicians were accepting Medicare
18 patients or not. To put things in context, we also asked questions about other aspects of medical practice that might
19 be related to access. And, as I say, this was all focused, the primary motivation here was the payment reduction that
20 happened in January '02. We hired a team of contractors who worked for us on this project, an Oakland, California,
21 organization. The questionnaire that was administered was similar to the earlier surveys. It touched upon a number
22 of different topics; satisfaction with medical practice, concerns about medical practice, and things related, of
23 particular relevance to Medicare payment policy, issues having to do with reimbursement levels, concerns about
24 billing paperwork, and so on. Other changes in practices that might be occurring in terms of referrals. To draw the
25 sample, we used the AMA's master file. Eligibility for the survey was based on several criteria that you see here.
26 We wanted physicians who were informed about Medicare and how the fee for service Medicare program works.

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1 And we, of course, were involved in providing care to Medicare beneficiaries, so we limited eligibility to physicians
2 who were providing at least 20 hours per week to patient care, who spent at least 10 percent of their time providing
3 services to Medicare beneficiaries, fee for service patients. And we excluded some specialties, some facility-based
4 specialties because we felt that they were not quite as able to control their acceptance of patients as some other
5 specialties. And, of course, we excluded some specialties because they don't often provide services to Medicare
6 patients. Let me see where I am here. The administration of the survey – we used multiple modes. About 66
7 percent of physicians responded to the survey by mail, 28 percent by phone, and 6 percent used the Internet form of
8 the survey instrument. Went into the field of April '02. Timing was important here. We felt that it would be
9 necessary for physicians to become aware and have some experience with the payment reduction that occurred on
10 January 1st and so field work started in April and continued through August of that year. It ended up with 782
11 physicians participating in the survey, a response rate of 54 ½ percent. Previous surveys have done a little better
12 than that in terms of response rate. We had over 60 percent on earlier ones, but we're told that it's getting harder
13 and harder to find physicians who are willing to participate in surveys like this. Now, I just wanted to kind of go
14 over some of the key results here, and in the time available I'm prepared to answer, you know, to explain and
15 answer questions about our responses to the survey questions on concerns about the Medicare program, how
16 Medicare compares to other payers, and acceptance of new patients. If you need further details on the survey, we
17 have a nice report that's available on our website, www.MedPac.gov. All the details are there in terms of results,
18 survey history, and all that. Let's see. So, we're moving on now to concerns about fee for service Medicare. And,
19 we're dealing here with a number of different possibilities: concerns about paperwork and administrative burden
20 associated with the program, reimbursement levels, external review of clinical decision-making, timeliness of
21 payment, and concerns about Medicare's actions to pursue fraud and abuse. And, as you can see, all the numbers
22 here on this chart are percentages. The highest level of concern has to do with reimbursement levels. If you look at
23 those who are either extremely concerned or very concerned, the total here is 60 percent. Also, a high level of
24 concern with respect to billing paperwork here; 50 percent are either concerned, extremely concerned, or very
25 concerned. Other high levels of concern had to do with fraud and abuse investigations. Let's see. It's also possible
26 with the data that we collected, to compare Medicare to other payers. And we do so on the dimensions that I just

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1 described. And, in general, the way it looks is that - and these are just cases where, from a statistical standpoint,
2 Medicare is significantly different from other payers. And, so we see that with respect to other HMO's, this would
3 be HMO's, let me see here, HMO categories, Medicare, excluding Medicaid HMO's, I believe. And, so we see that,
4 so this would be HMO's in general, including Medicare HMO's. And, what we see is that, in general, Medicare is
5 better. I believe it is better than HMO's fee for service Medicare, with respect to billing paperwork, timeliness of
6 payment and fees obtaining of insurance information. Medicare's fee for service is also better than Medicaid with
7 respect to this obtaining insurance information on patients. Medicare is a bit worse than Medicaid with respect to
8 external review of decision-making, clinical decision-making, and worse compared to a private fee for service, and
9 PPO's with respect to reimbursement levels and the external review.

10 Mr. Grissom: So, Kevin, the adjectives in your boxes refer to Medicare.

11 Dr. Hayes: Right. Medicare.

12 Mr. Grissom: They are not statements about Medicaid being worse on external review. It's Medicare is
13 worse than Medicaid.

14 Dr. Hayes: That's right. That's correct. All right. We'll now move on to responses and questions about
15 acceptance of new patients, and this was clearly an important focus of the survey. This was our key measure of
16 access to care. And, the wording in these questions was very similar to that in our 1999 survey, so it was possible to
17 compare our results. And, what we're seeing is that overall not much changed comparing the '99 to '02 with respect
18 to private fee for service, fee for service Medicare, HMO's and other - other being primarily self-paying patients.
19 There was some drop, though, with respect to acceptance of Medicaid patients. The other thing to point out about
20 this, of course, is that acceptance of the private fee for service in PPO patients is highest. Medicare fee for service,
21 second highest. And Medicaid would be the lowest, no surprise there. We then - yes.

22 Dr. Urata: There wouldn't be any sense in looking at HMO Medicare in this comparison?

23 Dr. Hayes: Our primary focus was fee for service Medicare, and there were some questions about whether
24 we would be confusing things if we try to make that fine distinction, even in this one survey between fee for service
25 Medicare and Medicare HMO.

26 Mr. Grissom: Kevin, are your response rates between the two surveys, are they roughly the same?

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1 Dr. Hayes: The response rate in the '99 survey was a little over 60 percent. So, this one at 54 ½ percent is
2 a little bit lower. We then looked more specifically at the response to these questions about acceptance of new
3 patients, and here you can see that we've drawn a distinction between whether physicians are accepting all new
4 patients and some new patients. And, in general, you know, the bottom line here is that it appears that physicians
5 have become a bit more selective with respect to most payers, except for private fee for service and PPO, in that they
6 were somewhat less likely to accept all new patients in the later survey. Note that the bars on the right side for each
7 payer category are the '02 results, and on the left side, '99. And, so if we look at fee for service Medicare, for
8 example, you can see that, you know, 76 percent of responding physicians were accepting all new patients in 1999,
9 but then it dropped down to 69 percent in '02. So, the total is about the same. It's just that there is some selectivity,
10 I guess you could say, heightened selectivity among patients accepted. We also ask physicians why and the two
11 major considerations here were reimbursement levels and that administrative burden - the billing paperwork,
12 coverage information, that kind of thing. Those were the two standouts in terms of reasons why physicians were
13 reluctant to accept Medicare patients. That's it for what I wanted to say about survey results, but I'm happy to try to
14 answer any questions you have about this. Maybe I should just go on through the rest of this - and we have a few
15 more slides - and then we can talk some. We also, it's important to mention that we look at things like participating
16 rates. We also look at data on the number of physician billings, billings to Medicare, and that is sort of put together
17 as a measure of entry and as an indicator of whether their payments are adequate or not. And I'll say just, you
18 know, given the comments made earlier about the par rates, that the commission is not sold on any one measure.
19 And, what they try to do is to look at all that they can. And so, putting together information from a variety of
20 sources, physician survey, entry and exit, we also compare Medicare's rates to the rates of private health plans, and
21 how the differences in other rates are changing over time. It's another indicator we used, the first time in a long
22 time. We did that for this March, our March 2003 report. I've had a question mark beside this item having to do
23 with volume of services. We heard an earlier presentation today about this matter of volume responses to changes in
24 payment rates. That's one question about how we would interpret numbers on pages and use of services from a
25 payment adequacy standpoint. And, then the other is just all the research that's been done on geographic variation
26 in use of services. The commission is just having some difficulty in interpreting what changes in the volume of

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1 services means, from a payment adequacy standpoint. So, they're kind of leaning more toward using some of these
2 other measures rather than use a service. So, let's just talk for a minute about how Medicare compares to other
3 payers. We did a couple things here. We obtained claims data from a number of large insurers operating in markets
4 all across the U.S. We were able to obtain those data for the years 1999 through 2001, just to compare payment
5 rates with Medicare's. Given that the claims data stopped in 2001, and given that the payment reduction happened
6 in 2002, we did something else which was to hire another contractor to do some interviews with health plan
7 executives just to find out what they do. You know, do they follow Medicare's lead, for example, in changing
8 payment rates, or what? We know that the private plans often use their resource data relative to value scale and
9 establish their own conversion factors, but the big question was, how are those conversion factors changing over
10 time? And, so we were able to get 30 to 35 health plans to participate in this part of process. And, in general, what
11 we found was that Medicare's rates are below private health plan rates. It varies. It depends upon the part of the
12 country and on the type of service, but depending upon the data source, it looks like Medicare's rates are somewhere
13 in the area of 70 to 85 percent of private rates - once again, depending upon the market, depending upon the type of
14 service. The interesting thing was to see what they did in terms of changing those rates over time. They do talk
15 about how they're under pressure to increase their rates when Medicare's rates go down, but it doesn't sound like
16 they respond necessarily to that pressure. I mean, it's not to say that they wouldn't in the future but they do say that
17 they have not - they're concerned about this and they hear about this, but the responses haven't varied to any great
18 extent, that we've been able to detect. So, where that leads us is that, you know, Medicare's rates, the gap between
19 Medicare's rates widens then when Medicare's rates go down, but then narrows. So, we saw a narrowing of the gap
20 in 2000 and 2001 when Medicare's rates went up, you know, four or five percent a year. But then that gap widened
21 again with the drop in rates in 2002. And it's now somewhere in the area of where it was in 1999. So, this was just
22 one source, an additional source of information for the commission to consider when trying to assess adequacy of
23 payer's payment rates. Renee talked about the work that CMS is doing to look at what's going on in specific market
24 areas, targeted beneficiary surveys and such. We thought in our experience with comparing Medicare and private
25 rates at the national level, that we would work with CMS on doing the same kind of thing but for specific market
26 areas, and we're doing this in six areas; Alaska, two markets in California - San Diego and San Francisco, Denver,

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1 Seattle, and Las Vegas. And the contractor is at work on the project. They're not quite there yet. And it's kind of
2 hard to characterize the results but I'll try anyway, which is that it looks like we're probably not going to get a real
3 clear answer to the question, you know, based on just this information. I mean, it looks like it varies. In the case of
4 California, for example, it looks like private sector rates are often lower than Medicare's. But in places like Denver
5 and Seattle, they're higher. So, what do you do with that? I mean, it's the old story, I guess, of just having to try
6 and assemble as much information as you can from different sources and interpret it. But at this point, at least, it
7 doesn't look like there's going to be one obvious, you know, type of situation that we're encountering in these areas,
8 at least from a payment standpoint. Just to wrap this up then, when the commission takes all this kind of
9 information together and tries to make an update recommendation, in the case of our March 2003 report, the
10 commission concluded, based on the available evidence, that payments appeared to be adequate in 2002. I should
11 point out, probably should have said this earlier, that we are looking at overall levels of payment rates here, and
12 clearly there could be some situations in individual markets, specific types of services and so on, where there are
13 problems but remembering that the payment update is just an across the board change in the conversion factor.
14 From an overall standpoint, the commission concluded the payments were adequate in 2002. We know that at the
15 time that the commission made this update, recommendation was somewhat unclear what was going to happen in
16 2003. Since then, the Congress has prevented a payment reduction in 2003. The commission also looked at what
17 was expected to occur in 2004 in terms of changes in costs, and projections of changes in input prices of 3.4 percent,
18 these are the input prices that are measured by the economic Medicare Accounting Index, excluding now the
19 productivity adjustment that's in the MEI. The commission considered the productivity growth issue separately and
20 came up with an adjustment there of 0.9 percent for a net of 2 ½ percent. Of course, these numbers, you know, will
21 change some over the intervening, coming months. The input probably is going to get better. Can't help it, of
22 course, but for purposes of the March report, this is where the commission was. I'd be happy to answer any
23 questions.

24 Dr. Rapp: Thank you. Are there any questions or comments? One thing for sure, is it seems like the
25 Medicaid payment rates are insufficient, which would indicate that although it seems like things are doing still pretty
26 well for Medicare, there is a risk out there.

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1 Dr. Castellanos: Do you have any data on the Medicaid access at all?

2 Dr. Hayes: No. The PPRC had some responsibility with respect to Medicaid, but as a result of the merger,
3 the focus of this commission is entirely Medicare.

4 Dr. Castellanos: What would be the cost estimate to implement the cross changes for 2004?

5 Dr. Hayes: Compared to current costs?

6 Dr. Castellanos: Yes.

7 Dr. Hayes: At the time that the commission made this recommendation, we were anticipating, under the
8 SGR system an increase, a positive update for 2004. This update would have been somewhat higher than that, not
9 by much, but somewhat higher. And our estimate at the time was that this would cost a bit over a billion and a half
10 dollars a year to do this. Now, of course, we've seen that – you saw it in the presentation this morning - that now
11 the anticipation is that there may be a payment reduction in 2004. Our current estimate is -4.2 percent. That would,
12 you know, substantially increase the cost of this recommendation, but as far as I know, no one has costed it out.
13 That would be a job for say, the Congressional Budget Office, something like that.

14 Dr. Rapp: Anybody else? If not, thank you very much for coming. We appreciate the information. All
15 right, it is five minutes to four – are you going to print out the recommendations that we have made today? So,
16 we're at a wrap-up time and if there are any other motions or anything that you want... Yes, sir.

17 Dr. Heyman: I would like to make a motion to change our agenda process just by a little bit. I think that it
18 actually would be helpful to us as well as to CMS, and if there's a better wording for this, I would entertain it. But I
19 was going to move that all future PPAC published agendas include a statement that any official notices of proposed
20 rulemaking published between the notice of the PPAC meeting, and the actual PPAC meeting, will be included as an
21 agenda item, so that our agenda would actually have as one of it's items at every meeting, any proposed rulemaking
22 that has occurred since this agenda was published. And that way we would always have the opportunity to comment
23 on any proposed rulemaking, and we wouldn't have to worry that people would be excluded from the process,
24 because they wouldn't realize that we were going to be commenting on that particular proposed rulemaking idea.

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1 Dr. Rapp: In other words, what you're trying to do is deal with the situation now that we have something
2 that's actually in a comment period that would be pertinent, that hadn't come out. And even if we knew about it, it
3 would be too late to put in on the agenda.

4 Dr. Heyman: Exactly.

5 Dr. Rapp: We almost ran into that with EMTALA. We had to go back and re-publish.

6 Dr. Heyman: And this has actually occurred on several occasions even prior to that - my first two years on
7 the counsel. So, I think it would be a great rule and it would be helpful to CMS also because it must be difficult for
8 them to have a particular proposed rulemaking come out. They're in the comment period and the one group that
9 can't comment is PPAC, which just seems crazy. So, that's my motion.

10 [Unidentified]: Second.

11 Mr. Grissom: I was fine until that last part. There's nothing that keeps PPAC from commenting during the
12 comment period.

13 Dr. Heyman: No, it does actually, because what actually happens – anyway, that's not part of the motion.
14 But the problem that happens is, for example, on the particular issue that we wanted to deal with today, which was
15 the issue of having to re-enroll every 3 years - as you know, that was published on the same day that our agenda was
16 published, and Mike felt that because – and I agree with him – that because it wasn't listed as an agenda item, it's
17 not fair to organizations that might want to testify on that issue, for us to take it up when it wasn't on our agenda.
18 And, what this would do, would be to let people know that whenever there's a rule that's published after our agenda
19 has come out, but before the meeting, that that item would automatically be an agenda item. So that people would
20 have previous knowledge that we were going to discuss it even though it wasn't in our agenda, because we didn't
21 know that it was going to exist. So, that was the point.

22 Mr. Grissom: In response to your question, there are a couple of ways to handle this and I don't have any
23 objection to what Dr. Heyman wants to do. We should have caught it in our quarterly – we publish a quarterly
24 agenda, unified agenda, and I'll just take credit for making a mistake. We should have been prepared to discuss this
25 at this meeting so that you all could - in your formal comments or passed comments on to staff, what I would do is
26 to use a few minutes during my summation to talk about it. But I'm fine with it, and I think that if we canvass

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1 people on our quarterly rulemaking in advance of the publication and of the agenda, we would cover this objection.
2 The problems are that we have payment rules and we have what I call discretionary rules, and this falls into
3 discretionary rules. And we've kind of been focusing on payment rules for the purpose of EMTALA and Stark. But
4 I don't have any problem with that motion. I apologize it happened.

5 Dr. Rapp: So, are you able to read his writing and so forth? Okay. Any discussion on the motion? All in
6 favor?

7 [Multiple]. Aye.

8 Dr. Rapp: Any opposed? The motion is adopted. Okay. Are there any other further motions before we go
9 to our final wrap-up? Yes.

10 Dr. McAneny: I do not remember whether or not in talking about the differential in the MEI between the
11 non-physician workers rates and the hospital rates. Will we make that a formal motion, or did we just discuss it?

12 Dr. Rapp: She's got in here for us. Are you going to hand that around to us? In five minutes, you're going
13 to get them all, so my recollection is that it's in there.

14 Dr. McAneny: Okay.

15 Dr. Rapp: Okay. So, we'll, in five minutes, have those to hand out and would you like to make some
16 remarks in the wrap-up session, or are you -- I mean, I think --

17 Dr. McAneny: I have one other motion that I wanted to make.

18 Dr. Rapp: Okay. All right.

19 Dr. McAneny: And I was concerned to see the decrease in the physician-education budget for CMS. So, I
20 would like to move that PPAC recommends that CMS would ensure adequate physician education to help with
21 compliance with the copious Medicare rules, regulations and laws. We have Stark II, we have HIPAA, Part II. We
22 have multiple other things going on and --

23 Dr. Rapp: Could we just get some information about that first? Because that was something, the AMA
24 thing ... Maybe we just ask questions about it and see what the thinking is there. I think it's pretty obvious that we
25 like physician education. Can anybody fill us in on what the thinking was there?

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1 Mr. Grissom: The physician education and training budget for '03 is at the limit that it was at in '02. I
2 don't think there's been a cut in the budget. We don't have as much money to spend. We asked for it but the
3 amounts are the same as they were in the previous year.

4 Dr. Rapp: The AMA included in their remarks – see if I can point it out.

5 Dr. Johnson: 85 percent cut.

6 Dr. Rapp: They stated that – it went from what to what?

7 Dr. Johnson: 41.5 to 6.5 million. That's for 2004.

8 Dr. Rapp: Yeah. The budget has drastically reduced. It would seem that there is probably some
9 explanation for that.

10 [Unidentified, reading]: "Reduction in funding for physician provider education and training – budget was
11 significantly reduced from 41.5 million in 2003 to just about 6.5 million requested for 2004... 85 percent cut."

12 Mr. Grissom: I don't want to disagree with the AMA, but that's incorrect. There's a huge disconnect
13 there, and there may have been funds moved from account to account, and there may be a drop in a particular line in
14 the budget of that amount, but I can assure you that it's picked up somewhere else. But --

15 Dr. Rapp: Maybe we can just ask for some information about --

16 Mr. Grissom: Yeah, but I don't want to wait until September because we're in the process of doing the '04
17 budget.

18 Dr. Heyman: It says here that it's 29 million over fiscal year 2003, that there's an actual increase. The
19 administration's recommended funding level of \$2.497 million for fiscal year 2004, an increase of \$29 million over
20 fiscal year 2003.... "We're alarmed about the reductions in funding for physician provider education and training."

21 Mr. Grissom: Well, one sentence says there's an increase of 29 million dollars --

22 Dr. Heyman: For the total – that's for the total.

23 Mr. Grissom: Okay.

24 Dr. Heyman: Yeah, I just showed him the same one.

25 Mr. Grissom: How about if I do a direct – let me deal with that directly to you Dr. Rapp and then you
26 communicate with the members but we not wait until the next meeting?

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1 Dr. Rapp: No, that's okay.

2 Dr. Heyman: That'd be great.

3 Dr. Rapp: Okay? Will that be satisfactory?

4 Mr. Grissom: All right. Let me just speak for a minute about this snafu and call the members of the
5 council's attention to the rule that was published in draft form on April 25th, which is unfortunately the same issue of
6 a Federal Register that announced the agenda for this meeting. And it is a change in the enrollment procedure for all
7 providers - not just physicians - but all providers. And I will, in fact, let me just pass this out now. Everybody on
8 this council is well aware of concerns about, expressed by the GAO and the IG and members of Congress and others
9 about how easy it is to get a Medicare billing number. I think the saying goes it's a license to print money if you can
10 get UPIN or a provider number. The stories are legion. There's been legislation passed, and since 1996 we have
11 used the form, I think it's 855, for individual providers to enroll in the Medicare program. What this rule will do is
12 to change that process and codify all the different places within statute and regulation where there are references to
13 how one obtains enrollment, and consolidate that and put it in a form so that it's understood by all providers. And it
14 does make one change to the process and implements, asks for the authority, to do what is known as cyclical
15 revalidation. For those of you who are physicians now, once you get a physician in, you never have to apply for it
16 again unless the who, the what, or the where of your individual situation changes. The result all the time is that
17 there are a lot of PIN numbers out there that are for providers who are deceased, who have quit practice. They
18 enable providers to move from place to place, state to state, and what we are attempting to do is to change the
19 process and put into effect one that will make sure that beneficiaries are not stuck with inappropriate billing, and that
20 the trust fund is not stuck with inappropriate billing by providers. In order to do this, it means that everybody is
21 going to have to fill out enrollment forms. Enrollment forms were changed in November in 2001. They're simpler.
22 They're easier to complete. We have two sets of those. The ones post 2001, and those before 2001. What this rule
23 will do is, the agency will take the responsibility for pre-completing a new enrollment form for all providers. In
24 other words, using the information that we currently have in our files. We will then send it out to all providers, and
25 they have the opportunity to either confirm or change the information in the form, and it gets returned to the agency.
26 And that will be the enrollment, although every 3 years there will be another cycle. That cycle will again take the

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1 information. It will send it to the provider. The provider – all he really has to say is “yes” or “no”, or change the
2 information and they will be part of the Medicare billing system. Because this affects physicians and it is so
3 important, I felt like that when it was called to my attention, that we needed to discuss this with you and to make
4 sure that you understood what the process was and why we are doing it. And if we can get past this first period, it
5 will be implemented in 2004, if we can get past this first period. The process for enrollment will be simpler. We
6 think that by the next time we cycle this around, it will all be electronic. We can’t do it electronically now because
7 we still are having legal and technical problems with the electronic signatures. So, I’m asking for your input, your
8 cooperation. I see that Jack Emery is here and I can’t imagine that physicians won’t comment on this rule. The
9 comment period is open through the third week in June, but I apologize that you didn’t get a full detailed briefing on
10 this at today’s meeting. I think that’s all I wanted to say, Dr. Rapp, or I can answer questions if anybody has them.

11 Dr. Rapp: I appreciate your comments and explanation. It does give the opportunity for any individual
12 PPAC members to make comments. So the comment period is open, so as individuals you can - there’s nothing on
13 the agenda that prohibits us from giving an official recommendation. I think we can discuss it. I think if you’ve got
14 some thoughts that you want to express at this point with regard to that, I think you can do that. It’s just that we
15 can’t make an official recommendation that’s going to show up in the minutes. Otherwise, I think --

16 Mr. Grissom: Well, you could. I think what’s missing is we didn’t have a chance to explain it to you and
17 allow you to ask questions and make an informed comment as a group. You’re certainly welcome to make a
18 comment in writing or otherwise.

19 Dr. Rapp: Does anybody have any thoughts about this?

20 Dr. Castellanos: My only concern is the carrier. This is going to put a tremendous burden on their – are
21 they going to have the ability to be able to do this in a timely manner?

22 Mr. Grissom: Well, yes, we think so. We hope so. Most of the work will be done back in Baltimore and
23 then out to the carrier. Because depending on which are not carrier specific - they’re in the common working file
24 and the information that we keep back in our systems, because no matter which beneficiary you see, or where you
25 see them, if you file a claim you’ll get paid for it. So, that information resides in our systems.

26 Dr. Rapp: Barbara, then Joe.

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1 Dr. McAneny: I think I understand the rationale for wanting to get dead and retired physicians off the list.
2 That does make sense. Is it not possible to get that through the registries for licensure, and when a physician does
3 not renew their license, have it automatically go to Medicare without the expense of sending out forms to
4 everybody, and having somebody enter data in and reconnect it?

5 Mr. Grissom: The only qualification for the degree is the information in the state licensure laws and each
6 physician carries with him. And rather than us obtain that information from state licensure boards, we think that the
7 cleanest and best system that is least susceptible to manipulation or control or interference is the one directly
8 between the provider and us, and so we ask for that information. What this will do going forward, Barbara, is any
9 time that there is not billing activity for at least 60 days, there will be notification of the carrier to the provider
10 asking for a change in status on the enrollment information. We currently do not do that, and I think the longer you
11 hear me talk, the more I answer your questions. You'll see the extent to which there are huge gaps in our coverage
12 of this problem, and why it has occurred. And, please understand, this is not provider enrollment only. It's all
13 providers and the real area of carrier concern is not with physician enrollment and changes in physicians moving
14 around to obtain provider numbers. It's with a whole other group of providers.

15 Dr. Rapp: Go ahead.

16 Dr. Heyman: I was on the list...

17 Dr. Rapp: Oh, Joe, you are on the list.

18 Dr. Heyman: He's more than welcome to go first.

19 Dr. Rapp: No, no, no. I was ready to say something myself. Go ahead.

20 Dr. Heyman: I just wanted to raise the consciousness level about railroad Medicare. There's two separate
21 trust funds, apparently one for regular Medicare and one for railroad Medicare. And when I enrolled for April 2001
22 into Medicare and tried to enroll into railroad Medicare, I couldn't enroll in railroad Medicare until I had been
23 already enrolled in regular Medicare. And, so the patients I saw in railroad Medicare, I couldn't get paid for, and
24 I'm just wondering whether when we have this re-enrollment, whether there's going to be a problem with, you can't
25 re-enroll in railroad Medicare until after you've re-enrolled in regular Medicare. So, I just wanted to raise that
26 consciousness level that, if we don't want to create a problem that wasn't there, and so, that was my only point. And

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1 I would like to complement the CMS on the fact that these things will be pre-populated and we don't have to fill
2 them out all over again. That's a wonderful thing.

3 Mr. Grissom: Would you be sure and get that in the minutes?

4 Dr. Heyman: Thank you.

5 Dr. Rapp: Dr. Urata?

6 Dr. Urata: We have a situation where we have – if you work for 10 years in our clinic, you have a
7 sabbatical and such and it varies from a month to 6 months. So, if somebody goes off for 3 months, we can still fill
8 out that short form and it won't take 6 months to start payments and such like that, like it does when you initially
9 enroll.

10 Mr. Grissom: The answer is yes, and I believe we've already shortened – we have shortened the period of
11 time when the carriers have to give new enrollees their PIN numbers. And, of course, if your clinic was billing as a
12 group practice, it must not.

13 Dr. Urata: Yes.

14 Mr. Grissom: It doesn't? Is it a group or is it individuals?

15 Dr. Urata: Well, I have my own PIN number.

16 Mr. Grissom: Okay. If it's a group practice, you won't get covered unless you were to go out and the
17 group was going to go out of business.

18 Dr. Urata: Right.

19 Mr. Grissom: Individual PIN numbers, what happens is, is if there's a 60-day – and I think this is
20 important to comment on – if there are no claims received for two consecutive months, then there'll be an edit put in
21 that will stop claims.

22 Dr. Urata: That's what I was speaking for. So, if somebody leaves for 3 months, you're not going to get
23 bills from them for 3 months, although sometimes their billing office is slow, we can peter it out.

24 Dr. Heyman: The UPIN number, you bill under your Medicare number.

25 Mr. Grissom: I'm sorry. I talked to staff today and they need to find out how to handle the 60month,
26 whether it's for sabbatical or somebody who's ill or left the country or whatever. And, I'm not 100 percent satisfied

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1 that we figured it out, or had the easiest way to respond to it, so Jack, I'm counting on you to make comments, and
2 I'm going deal with it in staff also.

3 Dr. Emery: We have a specialty society meeting this week to talk about the comments, and to get
4 comments from the specialty societies. We will incorporate those in our comments to the Secretary and the
5 Administrator.

6 Dr. Rapp: Yeah, that 60 days is making me shiver. Because if you have a license, they don't say, hey, did
7 you see anybody? Just periodically you'd have to renew your license... Like it is for licensure, that would seem
8 reasonable but the idea that you didn't bill anything in 60 days, so what? Maybe just giving your services away for
9 free, or whatever. But anyway, that would bother me. But this doesn't sound so terrible as long as it's every 3 years
10 or something and you expect it was going to be renewed and so forth. The one thing from my standpoint that's more
11 problematic from your standpoint, is the reassignment issue. Medicare is set up as a fee-for-service, like we're all
12 like Joe. We've got our own office and we're doing our own thing. But that's not the way it is for probably half the
13 physicians. But whenever I show up to work in a hospital emergency department, the first thing they do is give me a
14 stack of things about this thick to fill out, including another Medicare enrollment form. That's the danger, that they
15 could just start billing whoever, either mistakenly or on purpose. And, if there's anybody that ought to have to
16 periodically make clear that they have authority to bill in somebody else's name, it should be a reassignment issue,
17 not so much the UPIN number. If you've got one, I think, every 3 years, we verify that you're alive and have a
18 license or something like that - fine. But it's the reassignment that I think is the bigger danger, because although
19 Medicare is set as a fee-for-service type thing, and the whole theory of it is based on individual response billing, I
20 don't have any - I may have responsibility but I don't have any ability to do anything about it. I see patients. They
21 give them charts. They send off the bills. They take the money. They put it in their pocket, and that's that. So,
22 anyway, I would look into that.

23 [Unidentified]: I think I need to find a practice like that. Private practice - do it all yourself.

24 Dr. Rapp: Well, there are good and bad things about it.

25 Dr. McAneny: This is the part about they keep the money.

26 Dr. Rapp: You missed the part about they keep the money.

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1 Dr. Johnson: I applaud the administration for what you're doing with, you know, the updates, and I think
2 you've done it for the right reason, and also having it pre-printed. The thing that I have concern is some of the
3 carriers, we've heard horror stories about people trying to get their numbers and having long delays in months in
4 being able to get this information. So, initially, on the thought of, you know, how long are they going to take to turn
5 this information around. And I think with what you have got pre-printed and doing much of it here in Baltimore,
6 that certainly would help. But that's a concern. The carrier locally being able to turn the information around timely.

7 Dr. Rapp: Joe?

8 Dr. Heyman: Can we assume that they won't be changing our Medicare numbers? That it'll be the same
9 Medicare number, we just re-upping it. I hope they're not changing our Medicare numbers.

10 Mr. Grissom: Terry, do you know?

11 Dr. Kay: Could somebody repeat that question?

12 Mr. Grissom: He's worried that in the switch from one enrollment form to another, or systematically
13 making everybody come in for a formal enrollment, we're not going to make them change their numbers, are we?

14 Dr. Kay: No, I'm not aware of the number change, no. That would be –

15 Mr. Grissom: I think it's all – if you look at the information, it's who you are and what you are and where
16 you are, and proof of the qualifications which is licensure. And my understanding is, is that any of the information in
17 those fields can change and you still can enrolled. And if you were still enrolled, you would have the same number.

18 Dr. Rapp: Okay, anything else? Yes.

19 Dr. Gaughan: Mr. Grissom, what's the magic of 60 days and not 90 days? Is there a cost saving? I mean,
20 it seems to me that's a lot of paperwork for you all, and if you did it quarterly, it would make just as much sense. It
21 would be a decreased hassle for us. Is there a cost savings by doing it every 60 days? Or, has that been analyzed on
22 how much it's going to cost you to do this?

23 Mr. Grissom: I don't know why 60 days was chosen. It sounds like a great commenting question to me,
24 and I will make sure that there's a justification for that period of time.

25 Dr. Gaughan: Yeah, I was just wondering what the reason was?

26 Mr. Grissom: No, it's arbitrary, but I don't have evidence that that's the number.

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1 Dr. Gaughan: I mean, quarterly sounds --

2 Dr. Rapp: But it's even worse, though, to me, because you don't go for 60 days, then. It's not that you
3 have to fill out another form.

4 Dr. Gaughan: No.

5 Dr. Rapp: They send in a bill and it gets denied.

6 Dr. Gaughan: Yeah.

7 Dr. Rapp: And then you got to go back and start all over.

8 Dr. Gaughan: Then there's no one to answer the phone when you call to talk to them.

9 Dr. Rapp: Yeah. How come your claim got denied, you know? You're no longer enrolled in the Medicare
10 program.

11 Dr. Gaughan: Yeah, it's going to be a disaster.

12 Dr. Urata: Yeah, we have 6 months to send out a bill on a patient before it's worthless. And maybe that
13 would be a good time to enroll.

14 Dr. Gaughan: 60 days just sounds onerous.

15 Mr. Grissom: I'm sorry that we didn't have more time.

16 Dr. Rapp: Is this all there is to the rule, or is there something more detailed? The part about, I don't see the
17 60 days and all that stuff.

18 Mr. Grissom: Oh, no, no, no. This is a summary of published regulations. No, this is a cliff notes version.
19 It is not the rule itself. There's much more in the rule.

20 Dr. Rapp: Diana, can you send this?

21 Mr. Grissom: Well, this will tell you how to get a copy of the rule. Okay. See the address URL at the
22 bottom?

23 Dr. Rapp: It looks like there's an awful lot of parts. But, at any rate --

24 Mr. Grissom: That's because we're consolidating. A lot of these have to do with all the different people
25 that are ...

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1 Dr. Rapp: That's why I was going to have Diana maybe get us the part that pertains to physicians - and not
2 everybody else. Non-durable medical equipment?.

3 Mr. Grissom: Okay.

4 Dr. Rapp: Just send that out and then maybe we can play with our e-mail and get some individual
5 comments together and send them in with multiple people's names on it, but not officially PPAC.

6 Dr. Gaughan: Can you have her include the part that tells us how to submit those copies?

7 Dr. Rapp: Yeah, we can do that.

8 Mr. Grissom: We will communicate with you all directly on this whole issue within a week to 10 days and
9 we'll give you all that information.

10 Dr. Rapp: Thank you. All right, so now we've got the PPAC draft recommendations. You see them
11 written here. I'll just give you a chance to look at them and make sure they're written right.

12 [Unidentified]: Is Dr. Heyman's last motion going to be included?

13 Dr. Rapp: We've got that - it's not printed out here. He did that while this was being printed, but he wrote
14 it out, so that's in there. Okay. All right, do you have some additional comments?

15 Mr. Grissom: No.

16 Dr. Rapp: Okay. All right, if not, I want to thank you all for - yes.

17 Dr. Gaughan: I just want to make sure that we get the limited English proficiency - is that okay? When
18 Office of Civil Rights was here and she couldn't answer the question on limited English proficiency, but there's
19 seven other workers, but we have that on the agenda next time.

20 Dr. Rapp: So, we will note that we would like to hear from the Office of Civil Rights with regard to the
21 limited English proficiency translation requirement for doctors in their offices. We'd like you to request for that as
22 an agenda item. We already talked about the GAO coming and giving us a variety of information items. ... CBO,
23 excuse me. Information about the costs in the last year of life, and things like that. So, there's a request for that. As
24 far as additional agenda items, I would encourage the members of PPAC that as you come up with them, or realize
25 that there are things that you might want to talk about - and we were discussing earlier - of course, if there's a rule
26 that comes out, we want to be able to comment on that, but ideally, to the extent that we could get to things before

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1 they're ever actually sort of in stone, once I think all the decisions are made, but we would like, ideally, to have
2 issues come to us that the agency is struggling with, or pertinent to physicians, that we could comment on before the
3 final policy decision is made. So, if you can get that far in advance on things that are pertinent to us, that would, I
4 think, be the thing that Council would like to see most. Once they're already sort of to the point that they're
5 published, then this probably will be more difficult to change them. So, otherwise, any other comments?

6 Dr. McAneny: If EMTALA has been published ...

7 Dr. Rapp: It's supposed to coming out soon.

8 Dr. McAneny: I've heard that before.

9 Dr. McAneny: When it comes out, can we put that back on the agenda?

10 [Unidentified]: We'll follow-up with the recommendations.

11 Dr. McAneny: Okay.

12 Ms. Motsiopoulos: As soon as it's published, I'll send it out to all of you.

13 Dr. Rapp: The other thing that we discussed was a meeting place, and there's a unanimous request by the
14 PPAC that we have the meetings in Washington. You will note that all of the members of the committee, except for
15 one, I think, are here at the bitter end. Whereas, in Baltimore, people have to leave, it's harder to get to the airport,
16 and although I know it's more difficult for the CMS to have, from our standpoint, it's much better to have it here.
17 It's closer to National Airport and so forth, so if that's possible, that would be our request.

18 [Unidentified]: I think it is possible.

19 Dr. Rapp: That's our request. Is there anything else? Okay. Thank you all.