

CENTERS FOR MEDICARE AND MEDICAID SERVICES

**PRACTICING PHYSICIANS ADVISORY COUNCIL**

Hubert H. Humphrey Building  
Room 505A  
Washington, DC

Monday, May 22, 2006  
8:30 a.m.

Council Members

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DR. KENNETH SIMON, Executive Director, PPAC  
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MS. LISA ZONE  
Deputy Director, Program Integrity Group  
Office of Financial Management

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Public Witnesses

*Dr. William Hazel, American Medical Association*

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MS. DANA TREVAS, Rapporteur  
Magnificent Publications, Inc.

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1 Open Meeting

2 Dr. Senagore: For those of you that don't know me, my name is Dr. Anthony Senagore. I'm the  
3 newly appointed chairman of the PPAC. And I'd particularly like to thank both Dr. Simon and Mr. Herb  
4 Kuhn for offering me this position. I've got some big shoes to fill, with Dr. Castellanos, but hopefully with  
5 your help, we'll be successful. We have, I think, a fairly interesting set of discussions today. And a  
6 distinguished panel for presentation, and four additional members that will be joining us at this meeting as  
7 well. I've served on the PPAC for a couple of years and I've been through various other committees,  
8 including the RUC and PERC and so I've at least a working knowledge of the terminology, if nothing else.  
9 So hopefully we'll be able to have a successful year. It's my personal pleasure, however, to welcome you  
10 on the 56<sup>th</sup> meeting of this council.

11 A couple of announcements to get started: We will have, as I mentioned, Drs. Bufalino, Williams,  
12 Ouzounian, and Ross joining the committee formally at this meeting. And at some point later in the  
13 morning, we will break for a formal swearing in, and I don't think we don't have a time for that yet, but  
14 we'll shoot for around 11:30. And they will be formal working and voting members at this meeting. In  
15 addition, I'd like to extend a cordial welcome to the remaining colleagues and my fellow council members.  
16 I realize it's difficult to get out of your practice and travel particularly long distances to join us, and we all  
17 appreciate your effort. Hopefully, we'll be able to have some significant impact as we evaluate today's  
18 issues. As you can see, I think we have some very interesting topics that we need to weigh in on, including  
19 the Medically Unbelievable Edits, the Disease Management and Provider-Based Models, Pay for  
20 Performance, the Cost Measurement Development, an Update on Quality Measurement Development, and  
21 the Practice Expense Update. Of course, we'll also receive the PRITT Update by Dr. Rogers, and that'll be  
22 in just a minute, and the latest response to your report and recommendations from the prior meeting on  
23 March 6 of 2006. I'm confident you'll give our presenters your attention and the full benefit of your  
24 practical knowledge and insight as we move forward. I'm anxious to get started this morning. And unless  
25 there's any questions or concerns, I think we'll go ahead and get started. I believe Mr. Kuhn is unavailable,  
26 at least for the first part of the morning, he's tied up at a meeting at Baltimore. So it's my pleasure to  
27 introduce Dr. Thomas Gustafson, the Deputy Director of the Center Medicare Management, Centers for  
28 Medicare and Medicaid Services to welcome you. Dr. Gustafson.

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1 Welcome

2 Dr. Gustafson: Thank you very much, Dr. Senagore. I'd like to on behalf of the agency, I'd like to  
3 welcome you all to the quarterly meeting, and in particular to welcome the new members, which are being  
4 sworn in today. The government very much appreciates your service and your sage advice as we wrestle  
5 with the difficult issues here. I'm going to stop right there, because I think we have lots to do and I think  
6 I've conveyed the essential message there. So thank you very much and welcome.

7 PPAC Update

8 Dr. Senagore: So we'll move right into the PPAC Update then. Dr. Kenneth Simon, the Executive  
9 Director for Practicing Physicians Advisory Council, Centers for Medicare Management, to provide us with  
10 responses from our previous meeting on March 6<sup>th</sup>. Dr. Simon.

11 Dr. Simon: Good morning, to the council members, and thank you Dr. Senagore. Reviewing the  
12 items that were discussed at the last meeting, Agenda Item 55-B-1: And if we could have the slides  
13 projected, please. [off mike discussion] PPAC recognizes and sincerely appreciates the work of Mr. Herb  
14 Kuhn and CMS staff for their efforts in implementing provisions to the Deficit Reduction Act in a timely  
15 and efficient manner. The response, CMS acknowledges the council's comments. CMS will continue to  
16 work diligently to implement the provisions of the Deficit Reduction Act in an efficient and timely manner.

17 Agenda Item C: Update of PPAC Recommendations 55 C-1: The Council recommends that CMS  
18 measure the costs of data collection incurred by physicians in the planned Coverage with Evidence  
19 Development program. Once data are gathered, the costs should be conveyed to Congress for inclusion in  
20 the Physician Fee Schedule. CMS should also ensure that trials conducted under the Coverage with  
21 Evidence Development program be subject to the same regulatory requirements as other clinical trials, such  
22 as Institutional Review Board participation and assurance that patients who decline to participate are not  
23 penalized. The response: To allay the cost of data collection, CMS recommends that the Coverage with  
24 Evidence Development take place in the context of existing data systems when feasible. CMS does not  
25 expect to provide additional financial support for data collection. The agency recognizes that the potential  
26 value of information generated through coverage linked to evidence development must be carefully  
27 considered in the context of the burden associated with collection of this data. To minimize the financial  
28 and other resources required, careful attention must be paid to collecting the minimum data necessary to

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1 answer specific questions. Collecting that data should use the least resource-intensive mechanisms possible.  
2 The use of routinely collected data from administrative sources represents an important potential efficiency  
3 in the conduct of evaluations linked to coverage decisions. Finally, greater adoption and use of health  
4 information technology by providers in all settings has the potential to significantly reduce the burden  
5 associated with observational and experimental data collection. This will significantly enhance our ability  
6 to simultaneously speed adoption while developing better more individualized evidence about new medical  
7 technologies and services. In the coming months, CMS expects to publish a second draft of the guidance  
8 document, entitled *Factors CMS Considers in Making Determination of Coverage with Evidence*  
9 *Development*. This draft clarifies many of the elements of CED discussed in the agency’s April 2005 draft  
10 document, including emphasis that the application of CED will be consistent with federal laws, regulations  
11 and patient protections.

12 Agenda Item D: Physicians Regulatory Issues Team (PRIT) Update

13 55-D-1: The Council recommends that CMS provide an online directory of National Provider Identifier  
14 numbers for use by physicians. The response: CMS is in the process of developing its NPI data  
15 dissemination policy. Once cleared by the administrative office of CMS and through OMB, both of which  
16 will need to review and approve the policy, this policy will be published in the *Federal Register*. The OMB  
17 semi-annual report indicates that we will publish this notice in August of this year.

18 55-D-2: The Council recommends that CMS publish in its proposed and final rules the Relative  
19 Value Units, commonly called RVUs, forwarded by the American Medical Association’s Relative Value  
20 Update Committee (RUC) for new physician services for which CMS has made a noncoverage decision.  
21 The response: CMS acknowledges the recommendation from the council and will consider the  
22 recommendation as it prepares publication of the Physician Fee Schedule Proposed Rule.

23 55-D-3: The Council recommends that CMS withdraw the proposal to create a list of “medically  
24 unbelievable edits” and resubmit the proposal through the normal, formal rulemaking process, working  
25 closely with the medical community. The response to 55-D-3: While edits are not normally addressed in  
26 rulemaking, CMS will continue to work closely with the medical community as we develop a list of  
27 Medically Unbelievable Edits.

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1           Agenda Item F: Moving Toward Pay for Performance. 55-F-1: The Council recommends that  
2 CMS use a payment methodology that uses bonuses rather than differentials to avoid damaging practices  
3 that serve patients who are socio-economically disadvantaged or noncompliant. The response: CMS will  
4 need to be able to adjust physician performance data for important differences among physicians' patients  
5 before we can use the data for payment purposes. Appropriate adjustment should give all physicians a fair  
6 opportunity to participate in the Pay for Performance program, regardless of their patient mix.

7           55-F-2: Given that many pay-for-performance measures will require more Part B services, which  
8 will 1) increase the future volume and intensity of services provided by outpatient providers, 2) lower  
9 future conversion factors as calculated under the sustainable growth rate (SGR) formula, and 3) penalize  
10 providers for implementing the quality measures CMS requires, the Council recommends that CMS delay  
11 implementation of pay-for-performance measures until the sustainable growth rate is replaced with a more  
12 equitable system. The response: Performance measures of both quality and cost of care are meant to  
13 encourage the appropriate utilization of services. Some services are currently underutilized, but other  
14 services are currently over utilized. The impact on the sustainable growth rate of implementing a physician  
15 Pay for Performance Program has not yet been determined. So it is too early to assume that performance  
16 measures will increase volume and intensity of services. Ultimately, Congress will decide the timing of Pay  
17 for Performance implementation and of any replacement of the sustainable growth rate.

18           55-F-3: The Council recommends that that some of CMS' pay-for-performance pilots be directed  
19 toward small practices, especially those that cover socio-economically and geographically diverse  
20 populations, and not just large, vertically integrated practices. CMS agrees. The Medicare Management  
21 Performance demonstration, which was mandated by MMA § 649, is focused on solo and small to medium-  
22 sized practices, typically composed of 10 physicians or fewer. CMS will implement the 3-year  
23 demonstration in both rural and urban areas in the states of Arkansas, California, Massachusetts and Utah.  
24 The demonstration proposes to promote the adoption and use of health information technology to manage  
25 and improve the quality of patient care for chronically ill Medicare patients. Participating physicians who  
26 meet or exceed clinical performance standards will receive a bonus payment.

27           55-F-4: The Council recommends that CMS initially focus on process measures rather than  
28 outcome measures. The response: CMS intends to focus on a mix of structure, process, and outcome

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1 measures as appropriate, to encourage the desired improvement in quality and avoidance of unnecessary  
2 costs. Certain types of measures are more effective for accomplishing certain types of goals. However, we  
3 recognize that outcome measures require particular attention because they need to be valid and reliable. In  
4 addition, such risk factors need to be risk adjusted for fairness.

5 55-F-5: The Council supports efforts of CMS to explore the possibility of incentivizing  
6 beneficiaries to be compliant with processes being measured. The response: As part of our long-range  
7 planning for Pay for Performance, we will be exploring the use of patient incentives. One option that we  
8 will be considering is use of incentives to encourage patient compliance with the processes on which their  
9 physicians are being measured.

10 Agenda Item G — Update on Implementation of the Part D Drug Program. 55-G-1: The Council  
11 recommends that CMS monitor the amount of time physicians spend appealing Part D pharmacy coverage  
12 decisions and the amount of time involved with/costs of care related to substituting medications. The  
13 response: CMS has attempted to design the Part D program so that the amount of time with the cost of care  
14 related to substituting medications is not a material concern. However, we remain receptive to specific  
15 physician concerns.

16 55-G-2: The Council recommends that CMS use the findings from evidence-based medicine and  
17 peer-reviewed journals to allow off-label use of medicines covered under Part D. The response: The off-  
18 label use for Part D drugs, is allowed based on statutory language including the compendia, USPDI, AHFS,  
19 and Drug Dex. These sources, as well as the USP Formulary Committee, that updates the classes and  
20 categories, are supposed to take into account best evidence for all of their decisions.

21 Agenda Item N — Medicare Health Support. 55-N-1: The Council recommends that CMS  
22 establish a pilot program that gives resources for disease management, such as funds to pay for translation  
23 and social services and the costs of management fees, to primary care physicians and compare the costs of  
24 primary care physicians providing the same services with those of the disease management industry. The  
25 response: Section 646 of the Medicare Modernization Act provides the opportunities that the PPAC has  
26 recommended. The Medicare Health Quality demo offers major opportunities for physician groups,  
27 integrated delivery systems, or regional coalitions of the above to restructure and redesign delivery and  
28 payment, including the opportunity to waive the restrictions that PPAC identified. The goals of the

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1 demonstration are to 1) improve patient safety, 2) enhance quality, 3) increase efficiency, and 4) reduce  
2 scientific uncertainty and unwarranted variation in medical practice that results in both lower quality and  
3 higher costs. CMS is looking for provider-driven models of delivery design that constitute major and multi-  
4 faceted improvements to the healthcare system. Proposals must be submitted no later than September 29,  
5 2006. And for additional information, one can go to the CMS website under the section of Demonstration  
6 Projects for additional details.

7 One other announcement, we are currently exploring the possibility of having the December 4,  
8 2006 PPAC Meeting in Baltimore. And I would anticipate that between now and the time of the next  
9 meeting, we will make that information available to the Council members as well as to the public at large.

10 Dr. Senagore: Thank you, Dr. Simon. Does the Council have any questions or comments for Dr.  
11 Simon? I think some of these topics we will face again with the presentations later today. So maybe we can  
12 compare this and reformulate it based on the new data that we hear today. We'll move on to the PRIT  
13 Update. And it's my pleasure to welcome Dr. William Rogers. As I think most of you knew, and for the  
14 new members, Dr. Rogers is the Medical Officer to CMS Administrator, Dr. Mark McClellan and he will  
15 provide us with an update on the Physician Regulatory Issues Team, better known as PRIT. Dr. Rogers,  
16 welcome.

17 PRIT Update

18 Dr. Rogers: Thank you, and welcome to you, our new chairman. In the spirit of economizing, I  
19 can see that my name is the same one I used at the last meeting. It's got scotch tape on it and everything  
20 else. Sorry about the delay. We've been very busy over the last quarter, and been doing a lot of traveling. I  
21 was in Indianapolis and Harrisburg last week, speaking to the Pennsylvania Medical Society and the  
22 Indiana, and that's really been very useful for us for keeping current with what the issues are that are of  
23 concern to physicians. Ken's gone over these issues well. I just should mention that on the Medically  
24 Unbelievable Edits, we have the American College of Pathologists here today. And I'm looking forward to  
25 their testimony. We've changed the issues on the website considerably since we had to submit these slides,  
26 so the handouts that you got are not exactly current. We've also added three new issues since we handed in  
27 the slides. There've been physician concerns about plans that have prior authorizations that are only valid  
28 for three or six months because obviously it's more work if they have to continue to renew these things four

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1 times or twice a year. And so we're going to be looking at ways to, whenever possible, make prior  
2 authorizations bound for twelve months. Also the new 855 Form which was just released brought some  
3 issues to us, particularly having to do with the requirement for the NPI and also the electronic funds  
4 transfer which we might talk about a little later. Apparently in rural areas, I was told in Alaska, there's only  
5 one bank that can accept electronic transfers. I don't know if that's true or not, but fortunately, we have an  
6 Alaska expert here and we'll find out about that. And then finally, there was a question about physicians  
7 having to be appointed as representatives in order to file appeals. And we have put on the website now, that  
8 at least for the first level of appeals, physicians do not have to be appointed representatives. They can file  
9 paperwork without that.

10 Written consultation orders. This was an issue of some concern because there was the appearance  
11 that we were going to require that consulting physicians verify by careful examination of the hospital  
12 record or the sending physician's office record, that an order had actually be written for the consult. And  
13 we've clarified on the website that that's not the consulting physician's responsibility. That's the  
14 originating physician's responsibility to write that order. And it is important that it be written, but it's not  
15 the consulting physician's responsibility to police that.

16 Dr. Urata: Does it have to be in the orders, or can it be in the progress note?

17 Dr. Rogers: There should be a written order for the consultation. Nurse practitioner services billed  
18 in the hospital is an issue that we're still working on getting the manual corrected on that. And I think  
19 that'll be accomplished in the near future. Non-valued surgical codes, and there's a later issue same thing  
20 over pediatrics. Both of these specialties and other specialties also would like to see codes, even codes that  
21 are not paid by the Medicare Program, to be listed in the Physician Fee Schedule. It has a number of  
22 benefits to them. A lot of them having to do with smaller commercial payers and Medicaid Programs that  
23 depend on the Medicare Fee Schedule. And so in June, when the proposed physician rule comes out, I  
24 expect that the specialty societies that feel that's necessary will submit requests to that effect. Seems like a  
25 good idea.

26 Diabetes self-management training. I think we've gotten most of the diseases except perhaps  
27 hemo-chromotosis on the list and we're working on making sure hemo-chromotosis gets on the list, too, of  
28 diseases which justify Medicare payment for diabetes self-management training. End of meeting we'll here

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1 from CAP about how this is going. But we've gotten very good reports that CMS staff has been wonderful  
2 about making sure that this is an interactive process and I'm really pleased with how that's going. Public  
3 availability of NPI numbers. Ken mentioned this. When I was in Indianapolis on Friday, the Indiana State  
4 Medical Association made it very clear that this was very important to the back office staff to have access  
5 to these numbers. It's important to them for a number of different reasons in claims processing. And so if it  
6 gets through the approval process, I'm hoping that we're going to be able to provide access to these  
7 numbers.

8         The CAH Provider response time. We're still working on this. We're trying to have the EMTALA  
9 language for emergencies apply also to this section and we think that that's a reasonable thing to do.  
10 Crossover Anesthesia bills. After 14 months of working on this, this is why Medicaid problems are  
11 sometimes the hardest ones to deal with, last week, we got this fixed, and this, I was speaking to actually  
12 one of the billing people who, in Indianapolis, because it was an Indiana issue, and she said that for one of  
13 the anesthesia groups, and these are anesthesia groups that take care of a lot of Medicaid patients, usually at  
14 teaching hospitals, difficult financial situation for many of these groups anyways. For the entire group, and  
15 it's a huge group, it may be as much as \$100,00 in back pay for them, so this is a great success story and  
16 they persevered and we were able to get this thing fixed. Basically, the anesthesiologists were getting paid  
17 1/15<sup>th</sup> of what they should have been paid by the Medicaid Program, and those Medicaid Programs don't  
18 pay too generously anyways. So when you divide the payment by a factor of 15, it becomes a pretty small  
19 number.

20         The issue of continuing medical education in cause and conflict with Stark, we're working on the  
21 Final Rule, but I think that the Final Rule is going to recognize the important role that grand rounds and  
22 other traditional hospital programs perform in helping physicians keep current. But there's obviously a  
23 concern that this might be seen as a back door or an end run around Stark Regulations by some  
24 organizations and therefore the language is going to be pretty clear that it's generally on-site and generally  
25 reasonable cause.

26         The volunteer teaching physician issue continues to be out there. We have not gotten a resolution  
27 to this yet. I know that AFP, AOA, I think ACP and the other agencies that are very concerned, specialty  
28 societies are very concerned about this are going to be meeting with Dr. McClellan in the near future to

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1 discuss the issue with him and see if we can't come up with a resolution that both protects the financial  
2 concerns of the people in Baltimore who worry about GME spending, but also allows physicians who want  
3 to volunteer their time as teachers to do so in a non-burdensome way.

4 ASP problems have really been settling down as far as we can tell. The calls that we're getting  
5 now and the reports that we're getting now suggest that the manufacturers' measures of ASP for almost all  
6 drugs, with the possible exception of IVIG have really begun to be an accurate representation of what's  
7 available on the market, and so physicians are getting 2% more from Medicare for some drugs, and 2% less  
8 for some drugs, but generally it's within the 6% margin provided by Congress. But we're still very  
9 interested in hearing from physicians on any drugs where that's not the case.

10 Our Recovery Audit Contracts. We, just a couple of weeks ago got calls from a couple of  
11 physician groups who have had claims already examined by the carrier pulled for examination for the very  
12 same reasons by the Recovery Audit Contractors. And it turned out that there was not a perfect  
13 communication between the contractors and the Recovery Audit Contractors as to what claims had already  
14 been reviewed. And the Recovery Audit Contractors were very helpful and proactive about getting this  
15 fixed and they're working on a software fix so that they will not pull claims that have already been  
16 reviewed by the carriers.

17 Competitive Acquisition Program. Bioscript, as you know, was awarded the contract, and we're in  
18 the election period now that lasts until June 2. And June 1<sup>st</sup> the company will begin to supply physicians  
19 who elect to participate with this program. We always have to put in here key websites; pretty simple with  
20 the PRIT because we only have one. And we've, Rob Bennett has done a great job of bringing our old  
21 issues onto the website now and I think it's turning into a pretty useful resource or database for physicians  
22 and billers and people who need to look up old issues when they are faced with problems. And that's my  
23 telephone number, and that's my email address and I'd like to thank Dr. Powers for 3 new cartoons that  
24 you'll see at my next presentation. Thanks.

25 Dr. Senagore: Comments or questions? Dr. Grimm?

26 Dr. Grimm: Bill, just a couple things. Can you just comment on the timing of the continuing  
27 medical education rule for hospitals? If I went back to my hospital, and said, OK, they'll have a ruling for  
28 you by, do you have any sense about when that might be out?

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1 Dr. Rogers: I'd say in CMS time, very soon. [laughter]

2 Dr. Grimm: Is that kind of like 15 minutes on the airplane?

3 Dr. Rogers: Fifteen minutes on the ramp waiting for the airplane's engine to get fixed. It is an  
4 important issue and I think all of the contentious stuff has been worked out now, so I think we're going to  
5 get a, do you know anymore about when that's coming out, Tom? That rule?

6 Dr. Gustafson: I thought it had some interaction with the Office of the Inspector General, which  
7 always makes like more complicated.

8 Dr. Grimm: Would you maybe—you went over this a little quickly for me, the electronic  
9 resubmission of denied claims.

10 Dr. Rogers: I went over it more than quickly. [laughter] I'm not sure. To tell you the truth, I'm not  
11 sure where we are on that issue. We're continuing to try and get closure on it, but it's been, I breezed over  
12 it for a reason. [laughter]

13 Dr. Gustafson: Appreciate your candor, Dr. Rogers. [laughter]

14 Dr. Rogers: I guess I'm glad you did because perhaps there'll be a little bit more energy around it  
15 now.

16 Dr. Grimm: It is a big issue for a lot of us, because it does create a lot of work, as you know, for  
17 resubmission of claims, is a real big issue for all of our billing services.

18 Dr. Rogers: Nothing has changed so far. So that's better than having a bad policy that we can't get  
19 fixed. But I don't know exactly, I'm sorry, what the resolution is—we've worked very hard to try and bring  
20 that to resolution. And it's been frustrating.

21 Dr. Senagore: And we're waiting to hear from who on for resolution, just to follow up on the  
22 question?

23 Dr. Rogers: We can talk about that.

24 Dr. Senagore: OK, fair enough. Dr. Powers?

25 Dr. Powers: What, you also sort of glossed over on the ASP issue, about the IVIG. What are we  
26 doing about IVIG? Because the market is really still messed up.

27 Dr. Rogers: Yes, the market is messed up. And I don't think that it's so much an ASP issue.  
28 Demand has hugely increased. I mean more than doubled in the past four years and there's a huge amount

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1 of IVIG which is being used for all sorts of diagnoses that it wasn't being used for before. And that has  
2 been in part responsible for I think the localized non-availability of the product. But it is an issue—I just on  
3 Friday or Thursday, I took a phone call. A physician had called in to speak to Mark about this and he was,  
4 he had a neuropathy. He lived in New York, and was having trouble finding IVIG for his neuropathy. As  
5 you know, there's the DRA, provider for temporary additional payment for the work of obtaining it.

6 Dr. Powers: But from what I've heard, it's not the issue. It's the availability and that because CMS  
7 sort of unwittingly promoted the drug companies to make available only the more expensive varieties of  
8 IVIG, and now, it's basically because of all that, it's moved out the physician office and into the hospital.  
9 But now it's becoming less available to the hospitals.

10 Dr. Rogers: Well, I think because it was an ASP methodology, there wasn't any incentive to  
11 produce one product over another product. The problem was that there'd been huge increases in demand for  
12 the produce without a simultaneous increase in supply of the product. And I don't know exactly what's  
13 going on with the producers and the companies that actually manage the flow of the product around the  
14 United States. But there are huge spot disruptions. When the margins shrank dramatically, a lot of  
15 physicians who had had huge IVIG practices, doing IVIG infusions which was quite profitable at one time.  
16 I did get out of the business and told the patients that if they wanted to continue to get the product, that they  
17 needed to go to the hospitals which were maybe a little less sensitive. But for a little while didn't even have  
18 the problem with the margins. They do now. But the real problem has been local availability of the product,  
19 at any price, just about. And it has been a problem. And I think we need to look at, personally, I think we  
20 need to look at two issues. One is the off label use, because I think it was only being used for diseases for  
21 which it clearly was helpful, then we wouldn't have nearly the problem with access to the product. And  
22 then look at the issue of how the product is moved around the United States and why it's not being  
23 provided in certain venues.

24 Dr. Powers: Who's looking at that?

25 Dr. Rogers: Oh, there are a number of different—I mean it actually is of interest even at the  
26 Secretarial level in the agency. It's a very, very high interest issue. We just had a meeting with Dr.  
27 McClellan about it last week.

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1 Dr. Williams: [off mike] for repairing the Cross-Anesthesia Crossover Bill, it's very helpful.

2 Thank you.

3 Dr. Rogers: It was very gratifying to see that come together.

4 Dr. Sprang: First, I commend you for obviously responding to concerns on NPI and inseminating  
5 the information. I guess there is also some concerns about making it available to physicians, but also not  
6 making it available to other people who may want to use the information to defraud Medicare or use it in  
7 nefarious ways. They're probably going to do it anyway. But PPAC makes recommendation to ask CMS to  
8 present to us how it's going to be presented and specifically on safeguarding and protecting the numbers  
9 from those people who shouldn't have access to them.

10 Dr. Rogers: That's an excellent point. I am very interested in this whole issues of security and  
11 because of my military activities, that's a big issue for the military. And frankly, I believe that anybody  
12 who believes that they can keep their Social Security Number or NPI or their UPIN a secret is setting  
13 themselves up to have the numbers misused. I really think that we should recognize that these numbers are  
14 publicly available, or at least available to everybody with criminal intent. [laughter] And we should behave  
15 accordingly. And in the military, basically security is based on two things: one thing that only you know,  
16 and one thing that only you have. And so now the military's moving to these common access cards and the  
17 card you carry with you, and unless you have the card or the fingerprint, or retina scan or something like  
18 that, you don't get access to the system. But to think that your Social Security Number is not known is  
19 setting yourself up to get in trouble. So I really think we ought to de-emphasize the issue of keeping this a  
20 secret. I mean it's going to be on claim forms that are going to be whirling—I get faxes all the time of  
21 things that I need to sign to get things paid for. And your number's going to be all over everything. So to  
22 think you can keep it a secret is really a mistake. Not to say that we won't secure the website in some way,  
23 but I think we need to tell our colleagues, and tell our office staff, and tell the world basically, that these  
24 numbers are not secret and we should behave accordingly. And there's no way for the agency to keep them  
25 a secret.

26 Dr. Sprang: So basically, if I, in the computer system in the hospital, a physician can have access  
27 to a patient, but also there's fingerprints that that physician had access to that patient. Is there any way of

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1 doing the same thing with NPIs, as far as yes, people have access to it, but they're leaving their fingerprints  
2 [to indicate that] they were the ones that looked at it.

3 Dr. Rogers: Well, you could to the extent that it's done electronically. But there's always going to  
4 be a lot of paper whirling around, too. You know, and I get CNNs almost every day that I have to sign and  
5 so you know, until we're in a totally digital world, I don't think it's possible. But I think the take-home  
6 message is: These numbers aren't secret. It's impossible to keep them secret no matter how careful the  
7 agency is, back office staff are going to have to have them, claims processing houses are going to have to  
8 have them. They're going to be printed all over the place. With the Internet what it is, they're going to be  
9 available, they're going to be data bases. Act as if it's not a secret; as if it's a publicly available number,  
10 and you won't be let down.

11 Dr. Sprang: Thank you.

12 Dr. Ross: Dr. Rogers, good morning. I was going to ask about the NPI, specifically for sub-  
13 specialties or on the list of specialties there are groupings of subspecialties. And what I'm trying to ask is  
14 will that pigeon hole those sub-specialties so that it will not provide for reimbursement for those who  
15 practice in a general specialty but now are being looked at as sub-specialists if you follow what I'm trying  
16 to say.

17 Dr. Rogers: Sure. Yes. I mean I don't think CMS has ever had a plan to restrict payment for  
18 services to specific specialties. We see that more as a responsibility to hospital credentialing process and  
19 the state laws and things like that, so there isn't any initiative plan to restrict physicians from billing for  
20 certain things. It would be so difficult to do I mean, there's a lot of good ultra sound work done by  
21 OB/GYNs, there's a lot of good pathology work done by dermatologists. So it's really, it wouldn't be a  
22 reasonable thing for us to do without a specialty database.

23 Dr. Ross: That was the first question. The second is on the MUEs—

24 Dr. Simon: Dr. Ross, excuse me, just to amplify Dr. Rogers's comments. CMS uses the CPT-  
25 Codes as the language and vehicle for exchanging currency with physicians who provide services to  
26 Medicare and Medicaid beneficiaries. Having said that, any physician who is licensed and provides the  
27 service to a Medicare or Medicaid beneficiary, is able to, eligible to use the CPT-Codes to describe the  
28 services that have been provided to patients, such that the services that have been provided in the

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1 reimbursement by CMS, that is given to physicians, is not based on board certification. It is not based on  
2 specialty designation. And so the scope of the services that you provide will be based on one's being a  
3 practicing physician and not practicing physician osteopath podiatrist, etc., and not based on whether one is  
4 certified in that area or their defined scope of practice, but the NPI actually provides a mechanism for CMS  
5 to have a current listing, if you will, of the specialty designation of the individual that's practicing. Here to  
6 for, what's happened is if someone has finished a basic residency program in internal medicine, surgery,  
7 etc., and then proceeded with fellowship training several years down the road, but in that interim was  
8 providing care to Medicare patients received a UPIN number, then whatever their specialty is, it would be  
9 based on the designation that was assigned to them when they initially entered the program. And the system  
10 has not been updated. This will just acknowledge the fact that it gives physicians a chance to have the  
11 current designation of what their practice is, but it does not limit them from a payment policy perspective of  
12 providing care only germane to their specialty of interest.

13 Dr. Ross: That was important because if for instance, in my specialty, it's listed as the general  
14 heading, and I then sub-specialized in let's say sports medicine, would I be just pigeon holed to sports  
15 medicine and not be able to provide with my CPT-Codes other areas of my specialty? That's what I wanted  
16 to make sure of. Getting back to the MUEs, there's going to be testimony today from the pathology group,  
17 is that correct?

18 Dr. Rogers: Yes, I believe they're presenting testimony.

19 Dr. Simon: Well there's written testimony, but I think that they have decided to decline oral  
20 testimony at the meeting today, at least—

21 Dr. Ross: And will we be able to bring up subjects at this meeting or in the August meeting in that  
22 regard?

23 Dr. Senagore: Regarding the MUEs, we'll be able to do it as part of the formal presentation that  
24 will follow here.

25 Dr. Ross: Great.

26 Dr. Przyblski: Two things, Dr. Rogers, thanks again for your presentation and thanks for your  
27 personal support of publishing RVUs in which non-coverage decisions have been made by CMS.

28 Obviously you point out that other payers use the publication in the *Federal Register* and it's helpful for us

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1 and I appreciate it. With respect to Dr. Simon's comments on our previous recommendation in which it is  
2 stated that you would consider doing that, am I to take from your comments that the rule that's going to be  
3 published in June may not have those published, and will be asking societies to comment yet again  
4 requesting that they be published in the Final Rule?

5 Dr. Rogers: Yes, they'll present comments and requests when the proposed rule is released in June  
6 for the Final Rule in November.

7 Dr. Przyblski: And a second quick thing. I've seen some email traffic of late about ICD-10 and  
8 somewhat of a push to look at that in lieu of CPT-Coding to describe physician services. To what degree is  
9 CMS looking at that? And is there a timetable?

10 Dr. Gustafson: Not at all. That's off the table.

11 Dr. Przyblski: That's a delightful response. Thank you.

12 Dr. Gustafson: Back on the prior subject, excuse me, in terms of the rule, Bill's not in a position to  
13 describe, nor am I at the moment, exactly what will come out in a yet to be published rule. It's always wait  
14 until the fat lady sings kind of thing. We understand the issue very clearly. Either way, it comes in the  
15 proposed rule. Those who are interested in this should comment for the Final Rule. If it's there, tell us you  
16 like it. If it's not there, tell us you need it. OK?

17 Dr. Senagore: Dr. Sprang—the technical difficulties resolved?

18 Dr. Sprang: Yes. Again just a comment, not just praising you, but I really appreciate your  
19 sensitivity to physicians and I think to PPAC as well, on specific things, like obviously different [inaudible]  
20 and specialists for radiologists doing ultrasounds or specific procedures. I know sometimes, there's been  
21 comments on who should be doing those, and I just kind of want to say that, I think you would probably  
22 agree as well, on some of the things, like I'll say OB ultrasounds, we believe anyway, the obstetricians are  
23 probably much more astute at it and can do a much more thorough job at doing OB real time. We do  
24 procedures, we do ultrasounds, we're doing amnios and I think sometimes the other non-radiologists in  
25 some of the areas actually have more expertise than the radiologists and so I'm glad to see that you're  
26 letting all of the specialists kind of be able to use those CPT-Codes and be able to do it, because they  
27 probably actually do it better.

28 Dr. Rogers: Was that in the record to show that I wasn't even nodding my head for that? [laughter]

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1 Dr. Sprang: I thought I saw the head nodding up and down. [laughter]

2 Dr. Senagore: Are there any other questions or comments. I think we'll take a quick break here for  
3 just a couple minutes. And then we'll reconvene in ten minutes, let's say.

4 Break

5 Dr. Senagore: As we reconvene, we're going to begin with the Medically Unbelievable Edits  
6 issue. We have Ms. Lisa Zone here, who's the Deputy Director Program Integrity Group for the Office of  
7 Financial Management of CMS. The Program Integrity Group is that the Center for Detection and  
8 Deterrence of all Fraud and Abuse issues related to the Medicare Program. And their job is to identify  
9 program vulnerabilities and advance change as necessary. This is one of the issues that they're bringing  
10 forward today. Welcome Ms. Zone.

11 Medically Unbelievable Edits

12 Ms. Zone: Thank you. I wanted to thank everybody on the committee for having me here today  
13 and I appreciate the opportunity to come and talk with everybody about some of our objectives within the  
14 Medicare Program within this Medically Unbelievable Edit initiative. And I think the first thing that I need  
15 to say is we realize this is an unfortunate and poor title. Especially after we started receiving a lot of  
16 comments from the various specialty societies and others saying "these things are not unbelievable. These  
17 things can happen in medicine. And you can amputate an arm more than once during a day." And so we  
18 realize that [laughter][off mike-chat] and so we have heard loud and clear from the provider community  
19 that we need to really take a look at this initiative. At least as it has first been rolled out and make sure that  
20 we're addressing things as we originally intended, which really, our initial intent was to detect implausible  
21 claims and to avert any inappropriate payments. We were really looking for the impossible types of edits or  
22 those types of typographical errors, somebody bills for 500 units, when it should have been 5 units, those  
23 types of things. And we clearly were not looking to set medical policy or payment policy, but trying install  
24 edits to detect true errors within the system. I think this slide outlines really the objectives of the initiative.  
25 Given that we've heard from various provider organizations about the medically unbelievable edits that are  
26 out there today for comment, we are not going to be going forward with the MUEs as they are out there  
27 today. The comment period ends June 19<sup>th</sup>. We're going to be taking the comments that we receive from  
28 the public from all the various societies that have been involved, and then look at the edits as a whole, and

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1 make some decisions about the best way to move forward. These are our thoughts so far for moving  
2 forward: Is that first, we would concentrate on developing some anatomical edits. We're not going to be  
3 removing more than one spleen in a day or those types of things. Next, we would develop edits around  
4 typographical errors, to prevent those types of errors I mentioned before where somebody bills for 500  
5 units and it was supposed to be 5 units. And then we'll decide on any next steps we need to take as far as  
6 the Medically Unbelievable Edits.

7 As I mentioned, the first round of comments is due June 19<sup>th</sup>. So that's coming up here fairly  
8 quickly. A little bit less than a month. We are going to go out for another round of comments before we  
9 would implement any type of MUEs. Like I said, we're not going to go forward with the edits as they're  
10 currently out there. And that's why we feel it's going to be important to go out with a second round of  
11 comments. Because we will be modifying the population of edits that's out there and look at a more staged  
12 or phased-in approach with first implementing those that most people, most prudent people can agree to.  
13 We will not implement the MUEs before January 1<sup>st</sup>, 2007, and that would be our earliest date for MUEs.  
14 Because as we develop edits into the system, there have to be hard-coded programming changes and things  
15 that need to happen within the Medicare claims processing system, and the soonest that we would be able  
16 to pursue something is January first. And like I mentioned earlier, we would be looking at having the  
17 anatomical type edits, as well as the typographical type edits, hopefully ready for January 1.

18 Today, or I guess it was in December and January, we've been working with a contractor, the  
19 National Correct Coding Solutions contractor, and they did release our initial set of medically unbelievable  
20 edits that covered all types in various series of CPT-Codes. That is what's out there today for comment.  
21 They were disseminated through the various professional organizations. I believe we've worked with the  
22 American Medical Association and others to distribute the edits for comment and to the various  
23 professional organizations. We may choose, again, we're going to utilize through our second comment  
24 period, after we take another look at this initiative and think more about how it needs to be staged and  
25 implemented. Obviously we'll rely on the professional organizations again to work with us, but then we'll  
26 also again, as I mentioned earlier, go out with another comment period to make sure that we're reaching as  
27 large an audience as we can for comments.

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1           Before we would implement any type of MUEs, we will do some type of test period, because as I  
2 mentioned earlier, there is some hard coding into the system that would happen and we would want to do  
3 testing around any MUEs that we would implement to make sure that we understand the affects on  
4 beneficiaries, providers, contractors, and that we're appropriately testing the edits so we can detect and  
5 know what types of denials may result so that we can test an appeals process. Because we realize the need  
6 for an appeals process so that we would test how modifiers would be implemented through the system,  
7 those types of things. And those are all the things that we're looking at and considering as we move  
8 forward.

9           We have received a lot of comments and a lot of questions about how do you select procedures  
10 and what is the basis for developing these medically unbelievable edits? We have looked at data. We've  
11 looked at claims data for past periods. We've also discussed the edits with many of our physicians within  
12 CMS, and now we're gathering comments from you all in the health care community. So we're very  
13 interested in what you have to say. I know we've talked already with a lot of the pathologists, we've talked  
14 to a lot of the lab groups and others about ways to improve and make sure that these edits are designed to  
15 achieve our true goal, which is again to detect error within the claims and to address the more medically  
16 impossible. Our ultimate objective is developing edits on which prudent people will agree. We want to  
17 have those edits to detect the errors within the claims processing system to make sure we're not making  
18 inappropriate payments, but in no way do we want the edits to affect medical practice, payment policy,  
19 those types of things. And so we are looking to you all for your assistance and cooperation as we go  
20 forward to make sure that these edits are sound; that they're protecting the program against error and  
21 unnecessary spending, but that they're certainly allowing the flexibility for medical practice.

22           What I definitely, as I mentioned earlier, the comment period is still open, and we are definitely  
23 interested in hearing from you all about your thoughts on next steps and other things, and so with that, I  
24 guess I'll open it up for questions, comments, other types of things. Thank you.

25           Dr. Senagore: Thank you, Ms. Zone. Dr. Grimm?

26           Dr. Grimm: What is the nature of this problem? What is the impact of this and why is it being  
27 brought up now? This is obviously something that's been going on for a long time. And how many claims  
28 would you say or percentage of claims actually fall into this category? And what kind of expense do you

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1 expect that [inaudible] to save anybody by all of this in terms of how much money is being lost, do you  
2 think, or why isn't the system working now to resolve this? These problems where, for example, this  
3 amputee issue. Why isn't there is a simple way to resolve that now? Why do we have to go through this  
4 whole process of doing this now? What is that?

5 Ms. Zone: Well, these types of errors really have come to the forefront through our  
6 Comprehensive Error [inaudible] testing program, our CERT program, which I'm sure most of you are  
7 aware of. We use the CERT program to measure improper payments. It's a federal requirement under the  
8 IPIA, the Improper Payments and Information Act that the agency measure all of the improper payments  
9 that we make potentially. We just released our report here in May, earlier this month, I think it just went on  
10 the public website on Thursday of last week. And our national paid claims error rate, within the Medicare  
11 Fee for Service program is 5.1%. So 5.1% of the claims that CMS or the Medicare Program pays are in  
12 error. And we know that I don't have the breakdowns in front of me, but I think it's something around 1.7%  
13 are related to improper coding or billing errors, another percentage are related to medical necessity  
14 judgments, other things. But when you look at the federal dollars that are expended for a coding error class  
15 of say 1.7%, it's in the billions of dollars. And so there are a lot of errors that we realize because of coding,  
16 because of typographical errors. One of our contractors, Empire, who is in the state of New York, actually  
17 had a claim pulled in their CERT sample that was miscoded, that was a typographical error. I think it was  
18 supposed to be 87 units, and it was like 870 units. And it turned into an error for that contractor that was in  
19 the hundreds of thousands of dollars, and that translated into a higher percentage error rate when you  
20 extrapolate that across all of the claims that could potentially come through the system. And so I think to  
21 get to your question, what is really bringing this to the forefront today and now, is our CERT measurement;  
22 is the fact that the Improper Payments and Information Act is asking the agency for this type of data and  
23 we're looking to reduce error whenever possible. And so to the extent that we can implement edits to detect  
24 these types of true errors, whether it's typographical, anatomical, others, we feel that it would save the  
25 program a lot of money, and that we would again be doing more and more to make sure that we're paying  
26 claims correctly.

27 Dr. Urata: So when you say edits, this is something that's going to be automatic in your computer  
28 and without, is there going to be notification that this edit was being done? And then you complete the

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1 billing process without input from the person that made the error or the clinic that made the error? So it's  
2 sort of like an automatic thing?

3 Ms. Zone: Right, it is. It would be an automatic process within the system so that if we received a  
4 claim for 500 units and we knew that the top level should have been 5, where we would deny that claim  
5 and send it back to the provider saying, we noticed an error in the submission.

6 Dr. Urata: So you would then just correct it, according to how you feel it should have been  
7 corrected and then just send it back, or you just send a check, and then how do we get notified that this was  
8 changed?

9 Ms. Zone: You would be notified through the Remittance Advice. So the claim would be denied  
10 and sent back to you saying, we believe this claim was submitted in error, and it would be up to the  
11 provider to then correct it and submit it appropriately.

12 Dr. Urata: But that's how it works now. But once you start doing these edits, it would be  
13 automatic, because otherwise you're not going to be saving anything. Is that correct? You wouldn't be  
14 saving time? Or it would automatically be sent back to be corrected? You wouldn't correct it automatically.

15 Ms. Zone: Exactly. It would deny within the system. We would not correct it at the Medicare  
16 contractor. It would be denied and returned.

17 Dr. Urata: So the way it works now is you would just pay it because you wouldn't notice the error.

18 Ms. Zone: Exactly.

19 Dr. Urata: Then how would you find out it's an error then?

20 Ms. Zone: On post-payment review, or through some type of audit. Like we recently completed  
21 our Comprehensive Error Rate Testing Program. We do random samples of claims. And if we pull a claim  
22 that we said this was paid on error because we paid for 500 instead of 5, and then those are the true  
23 government outlays that we're seeing today.

24 Dr. Urata: I see.

25 Dr. Ross: What will the future edit audit be like for that individual? Will you have them on a "hit  
26 list" if they've made an error? And the second question is, if you've got somebody who's a repeater, how  
27 will you be able to enforce that type of person who's had repeated errors?

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1 Ms. Zone: Well, there won't be a hit list, and we won't have people who make those types of  
2 errors on a specific list. There's a couple different things that happen. One would be this Medically  
3 Unbelievable Edit process, where things are happening automatically within the system. And certainly if  
4 we saw somebody who was hitting, a group or provider, who was hitting the edits much more frequently  
5 than somebody else, then the contractor may decide to do some education, to do some medical review,  
6 those types of things that we could follow much more kind of our progressive corrective action plan for  
7 somebody who is having problems submitting claims correctly. So we would first start with education and  
8 potentially medical review, those types of things. But that would be found based on data analysis of which  
9 providers are maybe hitting the edits more than others.

10 Dr. Gustafson: If I could just add a point or two here to help Lisa out a little bit. I think it's  
11 important for everyone to understand the nature of our system, which is that we process, give or take a  
12 billion claims a year. I don't know exactly what fraction of those come under the Physician Fee Schedule,  
13 but three-quarters, probably something on that order. I'm talking about a billion claims outside of the drug  
14 claims, which is another whole world that has just been added to us. And virtually all of these claims, the  
15 vast predominance of them are untouched by human hands, that go through our system electronically. We  
16 don't look at them on the way in, we don't look at them on the way out. At least when I say "we" we're not  
17 looking at them with human eyes, saying does this make any sense? I should call this guy up. So we need to  
18 rely what we can in terms of the sophistication of our edit systems to kind of make sure that things are  
19 coming through correctly. This is an attempt to make that exercise more sophisticated, the target resource  
20 where they can do the most good in terms of bringing down the error rates, discovering where there are  
21 problems, not a persecution exercise, intended to I'm sure all of the physicians in this room are stalwart  
22 upright citizens, most of the physicians in America are stalwart upright citizens. There's no intent to  
23 defraud to the system except for the very few bad apples. We want to target in on where the errors arise.  
24 Only a very small part of that may involve any fraud—but the point is let's get it right. The whole notion  
25 behind medically unbelievable edits is you know, you start doing hysterectomies on men. Something's  
26 wrong here. [laughter] It's probably just a simply coding error, but we really ought to kind of look at that. I  
27 think one of the questions over here earlier was aren't you doing that already? And the answer is well  
28 maybe not, so we need to, that's where we're going.

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1 Dr. Powers: I think part of the paranoia has been when looking at the initial numbers that we got  
2 from CMS or whatever, that some of those edits looked a little unbelievable in themselves because where  
3 did you pull this number, how many neuro-conduction studies you can do for a certain diagnosis or  
4 whatever. But I think we're fixing that, because I understand you're listening to us on that one. But I just  
5 want to clarify, do I understand correctly that there will be the opportunity to use a modifier under certain  
6 circumstances? Because we do have some testing for instance where a neuro-conduction study might be  
7 used multiple times in an unusual, like for [inaudible] monitoring where it can be done frequently different  
8 from one of the [inaudible] nerve conduction studies.

9 Ms. Zone: Yes, that's something that we're definitely considering as we get into some of those  
10 more service-specific or procedure-specific edits. The need for a modifier if there is a legitimate reason  
11 why this patient needed more than what would be say the standard, that the modifier would allow those  
12 claims to pay and go through.

13 Dr. Senagore: Just a follow up question. I think some of the concern out there in the practicing  
14 physician community is while everyone can understand a dosing issue or some things in order of magnitude  
15 outside of the possibility, how do some of these other things translate into a process that is outside of the  
16 current CPT Correct Coding Initiative where there is a process of code verification, modifier, use, I guess,  
17 to follow up on the question earlier from Dr. Grimm, what is the volume of that incorrect utilization of the  
18 current processes that leads to these issues?

19 Ms. Zone: I think if I'm understanding your question correctly, it really is about what we measure  
20 on a post-payment basis when we look at claims through samples, such as our CERT sample and things.  
21 And what we've found is that nationally our error rate is around 5.1%. And specifically coding errors are  
22 around 1.7%.

23 Dr. Senagore: But I guess to follow up on the question, while something like a hysterectomy in a  
24 male could have a gender specific edit, that would be I don't think anything that anyone would agree with,  
25 there are other opportunities currently in CPT to allow you to reasonably repeat an operation with current  
26 modifier use. So I guess in my mind, where do these codes differ from a duplicate submission by accident  
27 that can happen in anybody's processes, versus a truly repeated medically necessary procedure that should  
28 have had a modifier on that was forgotten, or something that there's no way you can repeat. I guess that's

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1 our concern. Is there a way to include this in the current CPT CCI process versus some other black box, if  
2 you will, approach to these edits?

3 Ms. Zone: Well, we have tried I think to follow the CCI process as far as making things publicly  
4 available and making sure that we get comments and things on the edits. And these edits or MUEs really  
5 were developed because there seem to be, when we looked at the different types of payment controls that  
6 we have, we have CCI, we have the CPT guidelines, all those things. We felt like there were some simple  
7 things that we were missing within the claims processing system. And that the claims processing system  
8 should be able to tell us or deny a claim when it's a gender issue, or when it's a basic kind of typographical  
9 error. And we don't have that type of coverage today within the claims processing system. And we felt like  
10 those were some of those basic edits that we should have within our system to make sure that we're not  
11 making erroneous payments in those instances.

12 Dr. Senagore: An example of one of those and we fell upon this by accident, looking at PLI issues,  
13 was the frequency that urologists treated skull fractures. And it has to do with simply transposing a five  
14 instead of a six in the first CPT-Code and that's something that CCI's not going to pick up. Although it's  
15 kind of harder to use specialty designation to find this sort of stuff, but you may be able to look at the small  
16 percentage specialties in certain CPT-Codes that it just doesn't seem to make sense is another way to look  
17 at this.

18 Ms. Zone: Thank you.

19 Dr. Hamilton: There is a considerably more angst among the medical community about this issue  
20 than might immediately appear because I don't think anyone would argue with wanting not to do things  
21 right and to do things in a way that is appropriate. What you have told us today is helpful in terms of the  
22 typographical errors, because nobody could argue with that. The anatomical edits that you've mentioned do  
23 have some possibilities. You've mentioned a spleen. There are people, I understand that do have accessory  
24 spleens. And although I don't do surgery, it is conceivable that you might have to take out a second spleen.  
25 But these situations are very confusing because of all of the specialties that have been involved in this, and  
26 there's something like 80 or 90 of them. Everyone sees this a little bit differently, and they all have  
27 concerns, none of which are readily answerable. And it would be very helpful to the medical community if  
28 you could express what you have in part told us today, and clarify just what sort of data you really do have

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1 that makes this something that is of importance to you, in terms of the frequency and the distribution and  
2 the types of errors that you're particularly referring to. As an endocrinologist, we don't do very many  
3 interventional things, and most of these problems really do come interpreting procedural type phenomena,  
4 but there are situations that could be important. For example, will you kick out someone that puts in adult  
5 on-set diabetes in a 8-year-old child. Well, actually, it does occur in 8-year-old children, and that seems to  
6 be an oxymoron, but in fact it's a very important medical condition. The same of true of thyroid nodules.  
7 There is a code for a goiter with a single nodule, and in some cases, that same code is confused with a code  
8 for a thyroid with multiple nodules. They're both similar codes. If you do three biopsies on a code that  
9 looks like there's only one node there, then that would automatically raise a flag. But in fact, it is  
10 something that would really need a modifier. And this is the point of my comment, is that I really think that  
11 you need to come up with a modifier for situations that don't appear to be straight forward before you bring  
12 this out and start subjecting people to all of these, this information. I would suggest that number one, you  
13 make this information available to the specialty societies specifically how it relates to the things that they  
14 deal with, such as prostate and brain injury and so forth, and secondly, that you come up with a modifier  
15 that can be used early on in this process.

16 Ms. Zone: OK.

17 Dr. Hamilton: Now I'm concerned as to whether you can do all this between now and two and a  
18 half weeks from now. So I think that that two-and-a-half week deadline probably is not going to be  
19 appropriate given these concerns, but I think that this is what we need to consider.

20 Ms. Zone: Thank you.

21 Dr. Senagore: I guess if I could follow up, too, I think that part of the issue arose from the title of  
22 the project. And I think if what we're hearing today, you're really after [off mike comment] then I think  
23 what we understand is this a correction of units of measure, which makes sense, for avoidance of duplicate  
24 claims, but I think if there is not a process to bring it back to vet it through the current CPT process, when  
25 there are medically plausible reasons why some of these things could occur, then I think that's the concern,  
26 is what will be the ability for organized medicine to respond back and adjust our processes for claim  
27 submission; avoid errors on our part as well as errors of submission on your part. I mean we learned that

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1 through the Practice Expense Committee where coronary bypass graft was being done by orthopedic  
2 surgeons and it's unlikely they were doing those things. But there were transpositions of numbers. So—

3 Ms. Zone: OK, thank you.

4 Dr. Simon: I think as a point of clarification, as well, the Correct Coding Initiative, CCI, is a  
5 separate, distinct program that bears no relationship whatsoever to the Medically Unbelievable Edits  
6 initiative. What the Correct Coding Initiative, however, when edits are proposed, those edits are sent to the  
7 AMA who in turn will send those edits to all the appropriate specialties that provide services to those  
8 patients. So I just want to make that comment so that people do understand that CCI bears no relationship  
9 whatsoever to the MUI initiative.

10 Dr. Senagore: Any other comments or questions from the Council? We have a little bit of time. I  
11 was going to actually wait until after lunch for recommendations but we have some time if anybody wanted  
12 to make specific recommendations related to the MUE, we could do that. Or reconvene after lunch. I'll  
13 leave it to your discretion.

14 Dr. Williams: That the Council consider changing the name of the Medically Unbelievable Edits  
15 [laughter] to a more appropriate name?

16 Dr. Senagore: OK, do you want to make a suggestion as to a more appropriate name?

17 Dr. Williams: I have no clue. [laughter]

18 Ms. Zone: We've thought about Medically Unlikely. We've thought about Medically Implausible.  
19 We've tossed around different ideas and I'm open to suggestions.

20 Dr. Williams: How about Unlikely, so you don't have to change the acronym.

21 Dr. Grimm: Medically unusual.

22 Ms. Zone: Medically unusual?

23 Dr. Grimm: Because that's what you're really looking for. You're looking for the unusual  
24 situation here? Don't you think?

25 Dr. Gustafson: Part of what I hear you saying is the believability to this may lie to some extent in  
26 the extend of detailed knowledge about what's going on in particular cases, I mean accessory spleens—I'm  
27 not a clinical person. I never would have guessed there was such a thing. What I sort of hear you guys  
28 saying is that insofar as we're capturing unit problems or inversion of numbers of stuff like that, that are

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1 true coding errors which is an important part of this entire enterprise, everybody should be able to agree  
2 with that, we then need to isolate those cases that are not essentially expected to arise in the routine practice  
3 of medicine, even in the specialty context except on kind of a zebra basis. Every now and then you see a  
4 zebra, and we've got to have some way of addressing that, so some modifier or something of that sort. And  
5 I think we'd all agree with that. This is not an enterprise, someone was raising earlier questions of savings  
6 on this; we do hope that there will be some savings from this, but that's not what's driving this in the first  
7 instance. We've brought the error rate down very substantially in the last year or so, largely by getting  
8 everybody to improve the documentation they send to us. Because it counts as an error if we don't have a  
9 full file. You bring down that error rate. We probably didn't save much money as a result of that. I don't  
10 know for sure. But this is in the same spirit. Let's get the payment system accurate, and I think that we're  
11 from the government, we're here to help you—I understand some suspicion about all of this. But the intent  
12 is truly to try to take care of they hysterectomies on men and those kinds of circumstances and try to do it  
13 in a sophisticated way so that we're not interfering with the practice of medicine on any noticeable extent.

14 Dr. Senagore: Not to try to wordsmith it here, but I think that the whole in my mind, the whole  
15 unbelievable part doesn't need to be there. I think what we're really after is an accurate matching of disease  
16 process, CPT-Code, and utilization of the product at the end of the line, and so where the mismatch is is  
17 where things are not reconcilable, with gender issues or dosing relationships. So I'm not even sure the word  
18 unbelievable needs to be there. What we're actually asking for is an accurate reporting scheme for that, so  
19 I'll obviously leave it to you folks for the wordsmithing but did we have a comment over here? Dr. Azocar?

20 Dr. Grimm: Just wanted to comment about unbelievable. Unbelievable is a value judgment. And  
21 you're judging already. And so you're going to get immediate reaction. You're unbelievable—yes, I am  
22 believable! [laughter] So I think just changing that word to unusual first of all doesn't change your MUE  
23 and everything else you put MUE on and it really accurately describes what you're trying to deal with,  
24 Medically unusual issues.

25 Dr. Azocar: Yes, just a comment, and probably your office has considered this. I see this as a long-  
26 term process because there will be things that will be surfacing in a few years from now, and my suggestion  
27 is maybe to consider some kind of open line of communication or with providers, which may improve, after

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1 the year, some kind of, giving your feedback on things that they develop as technology changes, as new  
2 procedures come, things like that.

3 Ms. Zone: That would be great. Thank you.

4 Dr. Sprang: Medically unexpected? It's a softer word and I think it really covers what you want to  
5 do and I don't think just not as obnoxious as unbelievable. [laughter]

6 Dr. Senagore: I would add the word "association." That would, medically unexpected associations  
7 would get at the process really of what you're trying to put together for all of the components of the billing.  
8 This way, when you get the EOB back, you understand what the issue is, that we don't understand how the  
9 hysterectomy occurred in a male—is this the right patient? At least you would know how to respond as a  
10 provider, versus simply getting back a denial with no understanding of how to respond. Dana, if you could  
11 read back what you have?

12 Ms. Trevas: I have three suggestions. [laughter]

13 Dr. Senagore: Start at the beginning, and we'll sort it out for you.

14 Ms. Trevas: OK. PPAC recommends that CMS change the name of the Medically Unbelievable  
15 Edits program to Medically Unlikely, Medically Unusual, or Medically Unexpected, or Medically  
16 Unexpected Associations.

17 Dr. Senagore: OK. Dr. Williams, seeing that you've made the proposal, we'll let you—do you  
18 have a preference as to terminology?

19 Dr. Williams: [off mike] has one more. Medically inaccurate.

20 Dr. Senagore: OK.

21 Dr. Urata: So as to not change the MUE, I though you could just make up a new word and say  
22 "medically unaccurate." [laughter]

23 Dr. Senagore: No grammarians in the room. So what's the pleasure of the Council in terms of our  
24 attempted wordsmithing?

25 [chat]

26 Ms. Zone: Those are all good options and we'll take it to the a vote at CMS.

27 Dr. Urata: Just don't spend a lot of taxpayers' money on it in terms of time!

28 Ms. Zone: We won't! I appreciate the suggestions.

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1 Dr. Senagore: Thank you, Ms. Zone. So Dana, if you can, we'll have it read each of options for  
2 their consideration.

3 Ms. Trevas: Would you like to hear it again?

4 Dr. Senagore: Please.

5 Ms. Trevas: PPAC recommends that CMS change the name of the Medically Unbelievable Edits  
6 Program to remove the term "unbelievable." Some suggestions include: Medically Unlikely, Medically  
7 Unusual, Medically Unexpected, Medically Unexpected Association, or Medically Inaccurate.

8 Dr. Senagore: OK. Second the motion?

9 [Seconds]

10 Dr. Senagore: All in favor?

11 [Ays]

12 Dr. Senagore: Thank you. Dr. Ross?

13 Dr. Ross: Just to go back to what Dr. Hamilton was saying, and he made a suggestion about a  
14 modifier. In cases where there may be a discrepancy or an unexpected diagnosis, this case about a child  
15 with Type II diabetes is a perfect example. If there will be a potential for an unrecognizable diagnosis,  
16 maybe we should have some type of modifier provision and then some way in which there could be some  
17 type of explanation and that might solve the problem. Except the only problem will be, it's automatic. And  
18 if it's going through the computer, it's not going to pick up the explanation. But the modifier might.

19 Dr. Powers: That was going to be my recommendation. Just because you said definitely  
20 considering, I want to make it more definite than that. PPAC recommends that CMS definitely develop  
21 modifiers for services that may be clinical outliers and develop an appeals process.

22 Dr. Hamilton: Second that.

23 Dr. Senagore: Comment?

24 Dr. Przyblski: More a comment than a second. Isn't the modifiers a CPT Issue, don't they have to  
25 go back to the AMA and the CPT?

26 Dr. Senagore: Well, I think there's two issues in there. And I was going to bring that up if we  
27 wanted to expand that proposal or not, is the discussion as you're describing it would be back with your  
28 group. The question would be would we want to recommend that those issues be referred back to the

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1 standard CPT process for resolution when it did require greater medical definition as Dr. Ross alluded to.  
2 That's just a comment to the committee, if we want to revise it.

3 Dr. Przyblski: Well, there's already precedence for CMS modifiers. There's the dash AS modifier  
4 that exists for Pas and Ps, so in theory CMS could create such a thing since what we're really dealing with  
5 is a CMS issue more so than a CPT issue.

6 Dr. Powers: I can reword that to say definitely allow.

7 Dr. Senagore: OK. Could you read that back for us, Dana? Allow after definitely?

8 Ms. Trevas: PPAC recommends that CMS definitely allow modifiers for services that may be  
9 clinical outliers, and that CMS develop an appeals process for denied claims. I guess claims denied under  
10 the MUE program.

11 [second]

12 Dr. Simon: [off mike] ...Council recognizing as we've talked about on other issues earlier today  
13 that other payers use many of the initiatives and systems that CMS has in place. Would one want to  
14 consider creating a modifier that would be usable throughout all payers' system, in which case CMS would  
15 not be the creator of that modifier. Versus having a modifier that may go through a body such as the AMA?

16 Dr. Senagore: I think I would prefer that it would go through the existing bodies of CPT when  
17 there were truly medical issues to refine, accessory spleen, or the adult onset diabetes issue. I mean  
18 obviously, a drug dosing issue doesn't need to go to that level. So another comment on the proposal.  
19 Otherwise I'll ask the question. All in favor?

20 [Ays]

21 Dr. Senagore: Opposed? Motion carries. Any other issues related to the M blah blah blah  
22 [laughter]?

23 Dr. Simon: I'd just like to make sure that the Council takes this opportunity to perhaps provide  
24 information to CMS in regards to vehicles that could be used to reach the physicians who are in the  
25 trenches taking care of patients everyday. What educational vehicles would you recommend be used to  
26 reach all of the physicians, recognizing that a group such as yourself, are involved politically in the aspect  
27 of healthcare for patients, but many of physicians are not involved, either at the regional, state or local  
28 levels. So how should that information be disseminated to them?

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1 Dr. Senagore: I think the inflammatory nature of it would die down if it looked much more like the  
2 way we currently process bills; that there would be a process for modifiers if that was appropriate for  
3 submission, otherwise you would get an ELB back with an identifiable error to consider and decide how  
4 you wanted to respond. As long as that were the loop, I think that the education piece actually would be  
5 dramatically minimized. I mean no one could argue a gender issue if it was an operation specific gender  
6 issue.

7 Dr. Simon: And I'm referring to education on the front end—before the program becomes  
8 implemented, so that physicians would be aware that these changes are in fact in place.

9 Dr. Senagore: Comment specifically to that?

10 Dr. Azocar: I can see a place for the network of the medical association, where the AMA with all  
11 these networks already in place, as possible corroborators in this effort for education.

12 Dr. Senagore: I guess the question would be for the issues that don't rise to the level of a CPT  
13 response but are aimed at the things that are related to a dosing issue or a gender-specific issue. That I think  
14 could come from CMS and maybe communication either to the organized bodies or whatnot would be an  
15 appropriate way to communicate that this is the reason for the program; is to correct the documentation  
16 errors and reporting errors, rather than what we felt might be—

17 Dr. Przybski: I would think since the MUEs are being brought to the specialty societies to  
18 comment on, that that would be the forum for the education back to their members, because it's going to be  
19 very specific specialty-to-specialty. Plus with the AMA's code manager product, and other such products  
20 that already deal with the CCI issue, listing all of those issues for particular CPT-Code could be expanded,  
21 obviously to include this as an easily accessible tool.

22 Dr. Powers: Also I think CMS has been doing a pretty good job of getting out to small practices. I  
23 know people who are in small practices and rural areas that say they have the opportunity to go speak with  
24 someone from the carrier periodically about information. I think that has been better in the last couple years  
25 and they can get the word out that way.

26 Dr. Hamilton: I just wanted to summarize some of this and make one additional recommendation.  
27 And that is that part of the confusion is because of a lack of this understanding. And what you've told us  
28 today I think clarifies this a great deal in terms of gender-specificity and in terms of dosage and terms of

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1 obvious typographical errors, these things are all easily understood. How it would relate to specific  
2 specialties I think is an enormous issue that nobody can answer and perhaps there aren't any answers to that  
3 forthcoming at this time. But I think that needs to be communicated to the AMA and the specialty societies  
4 and that this modifier that we've already suggested be put in place and because of the short timeframe  
5 between now and the 19<sup>th</sup> of June, I don't think that's reasonable. I think we ought to give them longer  
6 period of time to react to that and therefore, I would recommend that PPAC recommend to CMS that  
7 expand the comment period to the end of December of this year and that the implementation be deferred to  
8 the middle of next year.

9 Dr. Senagore: Is there a second for that?

10 [Seconds]

11 Dr. Senagore: If we could read that back, Dana?

12 Ms. Trevas: PPAC recommends that CMS lengthen the comment period on Medically  
13 Unbelievable Edits to the end of December 2006, and delay implementation of the program to mid-2007.

14 Dr. Senagore: Comments?

15 Dr. Przyblski: Given that that's less than a month away is that practical for CMS or does the fact  
16 that there's a second comment period that you've already entertained after you develop a proposal  
17 sufficient to satisfy Dr. Hamilton's concern?

18 Ms. Zone: Our concern because we have received a number of letters and correspondence  
19 suggesting that we extend the comment period through this year, and our concern in doing that is that we  
20 really are looking to get the first level of comments in next month so that we can take a look at the initiative  
21 as a whole, and start phasing it in. First, dealing with the anatomical and the typographical type errors. And  
22 not dealing with some of the other CPT-Codes and all the other series. We wanted to at first be able to at  
23 least take some of these first two initial steps and our worry was that delaying the comment period through  
24 the end of the year would not allow us to take at least these first initial steps. In a timely way.

25 Dr. Senagore: Could I ask what the timeframe would be for a second comment period when you  
26 do devise these new rules for the anatomical and typographical? Would there be an opportunity for a  
27 response to a proposed rule?

28 Ms. Zone: Yes.

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1 Dr. Senagore: What would be the timeline for that?

2 Ms. Zone: Again, we were hoping to get these first comments on all of the MUEs that have been  
3 developed to date, in June. And then create a subset of edits that we would go forward with in January that  
4 would focus on anatomical and typographical type errors. Go out with that second, much smaller package  
5 of MUEs for a second round of comment probably by the end of the summer. Probably by the end of  
6 August, and then allow another 60-day comment period for implementation of that small subset at the  
7 beginning of the year.

8 Dr. Senagore: I guess that would be the concern of the current motion. If there will be a role out  
9 automatically in January of edits, there likely won't be another opportunity to comment on those until  
10 they're already implemented, if I understood correctly.

11 Ms. Zone: No, the only things that would be implemented in January, would be that second subset  
12 of edits that we would go out for a comment period at the end of August for a 60-day comment period and  
13 that would be implemented in January. All of the other edits would be on hold.

14 Dr. Senagore: With hearing that, is there any discussion about the current proposal?

15 Dr. Przyblski: It seems to me if it's clear that it's just those two edits that you're dealing with that  
16 that's probably acceptable for the group. I think what they're concerned about is those big range of edits be  
17 dealt with all at once and everybody's a little bit afraid about it. I think that's what your issue was?

18 Ms. Zone: Right and we realize we're not in a position to do that right now. And that's why we  
19 want to close the comment period that's currently open on the full spectrum of edits, narrow it down to  
20 these two groups, and move forward with another comment period on these two smaller groups of edits  
21 with ultimate implementation of just those two groups in January.

22 Dr. Ouzounian: I'm a little confused. Are we, as the medical community going to get the two  
23 small subsets to look at or are we getting the whole group and you're going to pull out—if we get the two  
24 small subsets, I suspect that specialty societies could deal with those in the timeframe that you proposed.

25 Ms. Zone: Yes, that's the plan. Right now you have the whole vast, all the edits are out there now.  
26 And that's why we want to close down this comment period, create these two subsets, have another  
27 comment period on just those two subsets that would be run through all the specialty societies, and as we  
28 have in the past, and then implement those two pieces.

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1 Dr. Ouzounian: And we'll get those in mid-June? With the 60-day comment period?

2 Ms. Zone: It would be end of August. For a 60-day comment period, yes.

3 Dr. Sprang: With those comments, Dr. Hamilton, do you want to withdraw your recommendation?

4 Dr. Hamilton: Yes, I'll withdraw that, but I still think that in order to make a meaningful comment  
5 period, specialty societies are going to need a lot more information than they have now on what this  
6 historical data that you referred to is, what some of the specific concerns are related to their specialty, so  
7 that they can prepare and address them. I think that in many cases that modifier is going to be something  
8 that will really help you in terms of defusing some of this angst. But I think that you need to provide people  
9 with this historical data as to just what these issues are that have come up, because to my knowledge,  
10 nobody knows what that is now and maybe you don't either.

11 Ms. Zone: No, I think we definitely learned that through this first round of comments is that the  
12 more context and data or information around why these edits are necessary we can provide, the better. And  
13 that's something that we will do for the second round.

14 Dr. Hamilton: I would recommend, I would recommend PPAC recommend to CMS that you  
15 provide that information to us before the middle of August or whenever that period is so we can have that  
16 available for the AMA and the Specialty Societies.

17 Dr. Senagore: Should we ask that that be part of the submission in August, then? That the specific  
18 percentage errors that these two points that you're going to develop would address, would be helpful. I  
19 think that would be a great educational piece, to say of the unversive corrections you're wanting to make,  
20 this would account for 40% of the errors in this population that we're looking at. That would make it I think  
21 more educational and understandable to the medical community.

22 Dr. Bufalino: Supplement that it just seems like today, we understand it better today. We were all  
23 confused before. That one-page little description to the folks that are getting comments today to me would  
24 solve a lot of people's concerns of just making this clear. We thought it was X, it's actually Y. Could we  
25 generate a simple communication back through, and I guess I was, and I think Ken was trying to ask, how  
26 do we get to everybody? And how did you ask for the comments in the first place, I guess is the question.  
27 Did you go out to all 80 societies and ask for comments?

28 Ms. Zone: Through the AMA, yes. They did that.

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1 Dr. Sprang: Make a recommendation—

2 Dr. Senagore: Is it going to be separate from the one—let’s vote on this one first.

3 Dr. Sprang: Actually just adding to it making that information available in an educational piece  
4 and making it available for dissemination by the AMA and specialty organizations. Obviously bringing it  
5 back to PPAC, making it available to the AMA in national specialty societies for dissemination so that  
6 you’re getting the information out I think is what you’re asking as well.

7 Dr. Senagore: We’ll have to help Dana with that phrasing.

8 Dr. Simon: The reason for asking that question is that there are times when we hear that sending it  
9 only to the medical specialties does not reach the folks that are actually in the trenches, so that’s why I  
10 raised the question to the Council, that if you had an specific informations, currently we use MedLearn  
11 Matters articles to provide information through the CMS website, but if there were any other specific  
12 vehicles that you would recommend where we could reach people who may not be AMA members, who  
13 may not read the AMA news and who may not be attuned, but clearly would be impacted by the decisions  
14 that are made.

15 Dr. Sprang: AMA, National Medical Specialty Societies, and if you really want, there’s 50 states  
16 out there that have weekly monthly newsletters and that’s who you could—national, like the AMA,  
17 national specialty societies, and state medical societies. And you’ll get a lot more dissemination at the local  
18 level.

19 Dr. Senagore: Let’s help Dana kind of craft this—comment?

20 Dr. Urata: Just replying on Ken’s question, is what about an insert into a payment they’re going to  
21 get to every office. Because they do get reimbursement and they can use a website or something and that  
22 way it gets to every single office, contact with Medicaid.

23 Dr. Senagore: Let’s see if we can help wordsmith the proposal. OK.

24 Ms. Trevas: PPAC recommends that when CMS publishes the proposal for a subset of MUEs to  
25 be implemented in January 2007, CMS provide information on the context and rationale for the MUE  
26 program and data on the estimated percentage of errors that CMS hopes to address. The information should  
27 be disseminated through educational vehicles through the AMA and national and state specialty societies.

28 Dr. Hamilton: Add to that and routine CMS channels of communication. Such as your website.

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1 Dr. Senagore: I think that captured the flavor of it. I think we need a second still?

2 [Second]

3 Dr. Senagore: OK.

4 Dr. Sprang: Just for interpretation, you are actually adding not only the [inaudible] but some  
5 educational materials as well? Is that in there? You mentioned background and historical facts, but is that in  
6 educational materials? I just wanted to make sure that was in there as well.

7 Ms. Trevas: Yes.

8 Dr. Senagore: OK, all in favor?

9 [Ays]

10 Dr. Senagore: Against? Thank you. Thank you, Ms. Zone, for joining us. We'll move on to  
11 Disease Management, Provider-Based Models. I believe our next speaker is Linda Magno, Director of  
12 Medicare Demonstrations Group in CMS's Office of Research and Development and Information. Linda  
13 and her staff are responsible for developing and implementing the [inaudible] Medicare demonstrations of  
14 new models of healthcare delivery of the nation's 40 million elderly and disabled beneficiaries. Linda's  
15 prior experience includes [serving as] Managing Director for Policy Development and Director of  
16 Regulatory Affairs at the American Hospital Association in Washington, D.C. As Linda begins her  
17 discussion of Provider-Based Models, please consider the following questions: Medicare is currently  
18 expending significant amounts of dollars, testing whether 3<sup>rd</sup> party vendors can better coordinate care. What  
19 role should physicians play in this? Specifically whom should Medicare pay for care coordination? How  
20 much should Medicare pay? What services should be bundled? And what patient outcomes should be  
21 collected and reported? And welcome Ms. Magno today.

22 Disease Management Provider-Based Models

23 Ms. Magno: Thank you very much. Good morning. Pleasure to be here today. In talking about  
24 provider-based models of disease management, I wanted to go ahead, give an overview, starting by talking  
25 about the importance of chronic care. And then the evolution of some of our demonstrations, where we're  
26 going with respect to issues of delivery system redesign and then finally allow some time for discussion.

27 As you can see from the slide here, some 20% of Medicare beneficiaries with 5 or more chronic  
28 conditions account for two-thirds of Medicare spending or that, or \$200 billion. The number of

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1 beneficiaries with 3 or more chronic conditions account for 78% of spending, that's about 31% of  
2 beneficiaries. So chronic care, and most significantly, chronic care with multiple chronic conditions is an  
3 area that we feel very strongly we have to address. And we've been attempting to do so in a number of  
4 ways, and you've heard a good deal about Medicare health support I guess at one of your last meetings.  
5 And I'll be talking about some of the other approaches that we've taken.

6 In addition and this goes to the heart of one of the demonstrations I'll be talking about, there's a  
7 great deal of concentration of spending on a very few of the Medicare beneficiary population. So we've got  
8 6% of Medicare beneficiaries accounting for more than half of program expenditures. Or spending more  
9 than \$25,000 or more per year. These are 2002 figures, by the way. There of course also, as we've see in  
10 the literature over the past several years, significant opportunities for improvement in care; opportunities  
11 for providing the right care, appropriate care in accordance with guidelines, especially around chronic care,  
12 providing the right care at the right time, the right place. Meanwhile, we have a delivery system, while our  
13 population has shifted, and largely probably as a function of its own success, that is things that used to be  
14 acute have become chronic; we care for people much longer with conditions that used to do them in much  
15 earlier in the disease trajectory. We still have a delivery system that's largely acute-care focused,  
16 fragmented, modeled on medical management and in the case of a population that's increasingly chronic  
17 and needs to be able to deal with self-management, self-care, we continue to be a reactive system rather  
18 than pro-active. And with respect to the issue of fragmentation of care, this is a very serious problem,  
19 Medicare beneficiaries in general see about 6.4 physicians per year on average and fill 20 prescriptions  
20 annually. Those with 5 or more chronic conditions see 14 physicians on average and fill 57 prescriptions  
21 annually, and of course in a fragmented system, not all of these physicians know of one another's  
22 existence; talk to one another, coordinate services with one another. And there are lots of opportunities for  
23 handoffs that result in poor care, duplicative prescriptions of poly-pharmacy issues. You have a question  
24 over here?

25 Dr. Grimm: Just a point of clarity here. Are you talking about 6.4 different physicians?

26 Ms. Magno: Yes, different physicians, on average. With the, and I want to make a point here,  
27 because I've seen some additional work recently that breaks this down a little bit more and particularly  
28 when you get into the multiple chronic conditions 14 or more physicians, and so on, some of that has to do

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1 with hospitalizations, and the number of different physicians seen on a consultant basis in the hospital. That  
2 doesn't make the system any less fragmented, though, particularly when they're not—at least in the  
3 hospital, if there's a single medical record, there may be all sort of looking at the same patient, if you will.  
4 Once that patient leaves the hospital, the physicians outside the hospital haven't necessarily seen everything  
5 about that patient. Oftentimes, we hear of cases where individuals with chronic conditions are hospitalized  
6 through the ER and their primary care physician, their internist, the person who's generally taking care of  
7 that condition doesn't even know they've been hospitalized, and therefore doesn't know what's happened  
8 to them in the hospital. Prescriptions are given upon discharge that may be duplicative of prescriptions that  
9 the patient was already taking and so on. So these are of course some of the things that have driven us to try  
10 to be in focus on how we can, how do we change the system? Easy question, tough answers.

11 We've looked at a number of demonstrations, and I'll be talking briefly about these. I've got a lot  
12 of slides in here and I'm not going to dwell on all the details, but I wanted to put the slides in to give you a  
13 little bit more information about each of the demonstrations. So these are the main ones that I'll be walking  
14 through very quickly. Coordinated care, and these are their start dates, actually. The Physician Group  
15 Practice Demonstration, Medicare [inaudible] Management for High-Cost Beneficiaries, Medicare Care  
16 Management Performance, and Medicare Healthcare Quality. Those last two are still under development.  
17 And we hope to begin implementing care management later this year and the next one, Medicare  
18 Healthcare Quality next year.

19 The Medicare Coordinated Care demonstration was mandated by the Balanced Budget Act of  
20 1997, to evaluate care coordination models intended to improve the quality of services to chronically ill  
21 beneficiaries and to reduce Medicare expenditures. There's a provision in the statute that if this  
22 demonstration is successful, that is if it improves quality, and reduces costs or at least doesn't increase  
23 costs, and improves quality, the Secretary may continue the project, may expand them, or may implement  
24 beneficial components of the project as a permanent part of the Medicare program. We have eleven sites  
25 operating. We have had up to 15 at one point. Four of them have dropped out. It's a mix of urban and rural  
26 provider base, largely provider-based, but some of the ones that dropped out were also provider-based. We  
27 have four commercial vendors, a joint venture, and they're addressing various chronic conditions with a  
28 wide range of intervention around patient and provider education, prescription drug management, some

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1 technology, remote monitoring and the like on limited prescription drug coverage in the case of a couple of  
2 the plant projects and a good deal of focus on case management and disease management. This is a list of,  
3 you should have this in your handouts as a separate page since it's difficult to read in the reduced slide, so I  
4 made sure to get a handout. This identifies the projects, the targeted diseases, the type of intervention, and  
5 where they're located so that you have that information. I see not all of the locations showed up, oh yes  
6 they did, just not in the right line. The financing for this demonstration is per member per month fees. The  
7 fees are not at risk. They're not tied to specific quality improvement or savings goals. They're simply a  
8 straight forward fee. I think this is probably one of the last demonstrations of this type that we'll see given  
9 some of the constraints that we're facing in getting other demonstrations through that kind of quest for  
10 budget neutrality and for insuring that fees are either at risk or that there's some provisions for repayment  
11 in the event that demonstrations fail to meet the budget neutrality requirements. This is used in enrollment  
12 model, altogether across the sites, there are somewhat more than 20,000 enrollees who've been randomized  
13 into treatment and control groups. And each site has somewhere between 500 and 1500 enrollees in their  
14 treatment or in an intervention group in an equal number in the control group. And one of the things that I  
15 did say, that a few sites have dropped out and I think part of that is that in using an enrollment model, we  
16 have found that enrollment is very slow, even with provider-based sites in terms of finding the right people  
17 to reach out, and because it's a randomized model, you have to find two for everyone in the treatment  
18 group. So one would be randomized to the control group. And because of the slowness with the groups, the  
19 sites have been able to recruit sufficiently large population for statistically meaningful comparisons and  
20 analysis, we have extended the demonstration on a temporary basis, not using the overall Secretarial  
21 authority to extend if it's successful, but basically to extend to give us sufficient time to get enough data to  
22 be able to analyze and make determinations about whether or not these demonstrations are successful.

23         The next demonstration started just over a year ago in April of 2005. It's the Physician Group  
24 Practice demonstration, mandated by the Benefits Improvement and Protection Act of 2000. It's basically  
25 the first physician pay-for-performance demonstration in the Medicare program. One of the main features  
26 of it is that we are continuing to pay regular fee for service to the physician group practices participating in  
27 the demonstration and then we will also make performance payments that are derived from practice  
28 efficiency, and improved patient management. Basically there'll be shared savings to the extent that the

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1 practices generate savings as a result of the way in which they change their practice. And the shared  
2 savings will be shared on the basis of both financial and quality performance. The demonstration is because  
3 we're not making any additional payments unless there are savings to draw down from, the demonstration  
4 is by design, budget neutral. The 10 practices are all large; over 200 physicians each was one of the  
5 requirements in the demonstration. They represent over 5000 physicians and over 200,000 assigned  
6 Medicare Fee for Service beneficiaries for whom we're calculating savings. The objectives of the  
7 demonstration are to encourage coordination of Medicare Parts A and B services by these groups to  
8 promote efficiency again through investment in infrastructure and changes in care processes and then to  
9 reward physicians in the group, or reward the groups to in turn reward physicians for improving efficiency,  
10 quality and outcomes. Our quality measurement is based on a number of, some 30 plus consensus  
11 measures, NQF and [inaudible] that will be phased in over three years. There was a great deal of discussion  
12 with the groups over the pre-implementation about which measures would be used and how they would be  
13 collected and so on. The benchmarks for performance are based on a combination of absolute thresholds  
14 and then year over year improvement. We're using claims data for collecting some of the measures and  
15 basically populating a collection tool; an extraction tool that we're using, and then on a sample of Medicare  
16 beneficiaries, basically populating the tool and then our implementation contractor is sending that  
17 completed abstract out to the practices to then complete the tool for the chart based measures. And there's a  
18 complete measurement in reporting specifications manual for those of you who might be interested. All of  
19 this material is up on our website, which I'll have the address for later. And then there's an audit  
20 verification process during the demonstration on the measures.

21 As I say, we're rewarding both high quality performance, absolute performance levels, and  
22 improvement. The measures get phased in over three years. The first year, the focus is on diabetes, the  
23 second year on heart failure, and coronary artery disease, and then the third year, hypertension and cancer  
24 screening measures. Savings are based on group practice-specific base years, where we are comparing year  
25 over year growth in the total Medicare spending. For the beneficiary population assigned to the practice, to  
26 the year over year spending for all the other beneficiaries in the market area served by the group practice.  
27 And the beneficiary spending is, beneficiaries are risk-adjusted to that we're comparing comparable  
28 beneficiaries. Performance payments are earned if for the assigned beneficiary population fee for spending

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1 growth is less than the local market area growth rate for all other beneficiaries. The savings have to exceed  
2 the 2% threshold, and then we share savings over and above that threshold. This looks much better on my  
3 screen than it does here. [laughter] I'll have to change that slide to make it readable. Anyway, Medicare  
4 retains 20% of the savings in the PGPs, the physician group practices, can earn up to the remaining 80%.  
5 As I say, the performance payments are based on a combination of efficiency and quality. The efficiency  
6 component is declining over time and that's just the mere fact of their being savings. We designated it as  
7 efficiency and it goes from as you can see, of the 80% that remains, it starts out at 70%. The numbers you  
8 see here are 100%. But the numbers I'm going to use are of the 80%. Of the 80% of the groups can earn  
9 70% in the first year, 60% in the second, and 50 in the third year relates to having generated savings. So  
10 they get that much of the savings over and above the 2%. And then the counterpart growth from 30% to 40,  
11 and then 50% in the third year relates to quality performance. The actual quality measurements that are  
12 being done. And the maximum annual performance payment is capped at 5% of total Medicare spending on  
13 both Part A and Part B. So this ends up representing, can be about 20% or so percent, 20 to 25% of  
14 physician payments, but 5% of total Medicare spending is what we're pegging it to. The Process and  
15 Outcome measures, again, you have the handout, separate and apart from the slides on the various measures  
16 that are being used and some of these are italics. Those are the claims-based measures. And then the ones  
17 that are not are chart-based measures. So we're heavily weighted toward claims-based measures in the first  
18 year, but over time, growing increasingly toward chart-based measures that focus on things that we don't  
19 currently capture in claims.

20 We've just recently had a physician group practice site meeting, sort of recapping what's  
21 happened in the first year. How the practices have changed; what strategies they are using to improve care  
22 and improve quality, and efficiency. These are some of the strategies they're using that yield, we think,  
23 better care for Medicare patients. They're focusing on chronic disease management combination. Some of  
24 them are using outside disease management organizations to train their staff in some of the disease  
25 management techniques in intervention so that they can bring that function in how some of them are using  
26 disease management as a backstop to their own staff, doing a great deal of patient education and  
27 monitoring, some provider education, and feedback. They're also focusing on high-cost, high-risk cases,  
28 particularly those with multiple hospital admissions; those with multiple co-morbidities. I'm working with

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1 their local hospitals; the hospitals in which their populations typically hospitalized in order to intervene  
2 quickly upon discharge in order to try to prevent readmission. Then they're focusing care coordination  
3 efforts largely on care transitions, again, as patients move from one setting to another, in order to avoid  
4 some of the glitches that can happen with hand offs and some of the things that end up resulting in  
5 beneficiaries' not taking the right care of themselves, not understanding what they're supposed to do upon  
6 discharge, poly-pharmacy issues and so on. Medication reconciliation, and then finally, they're beginning,  
7 a couple of the practices have begun to focus on end of life care, and palliative care for their population.  
8 One of the interesting discussion points that came out from the group practices in this site meeting is that  
9 many of them have viewed this demonstration—I mean they're not at insurance risk for any increased costs  
10 that might occur. They simply wouldn't get any benefit from participating in the demonstration if Medicare  
11 Fee for Service costs increased. And they're not getting payments up front, but what they're finding is the  
12 ability to share in savings and the potential magnitude of the savings for some of the groups, has become  
13 both a catalyst for change; it's allowed them to begin to make investments in infrastructure that they've  
14 wanted to make but really didn't feel that they'd ever be able to get paid off for from the large population  
15 that Medicare represents. And it's also been a catalyst for change in some of their dealings with private  
16 insurers as well. It's not just Medicare, that because of the potential to share in savings to the Medicare  
17 program, they can then begin to use what they're doing to market themselves and position themselves in  
18 the rest of the insurance market in terms of some of their managed care contracts, and what they can offer  
19 as they build these platforms to capture quality related data and to be able to show improvement quality  
20 performance. I think one of the other important things of course from this is because this is the first  
21 Medicare pay-for-performance activity or initiative with physicians that the lessons learned here will  
22 inform further development of pay-for-performance activities within the program, and then also it's helped  
23 us to learn a great deal about quality reporting infrastructure, the kinds of measures that are acceptable to  
24 the groups, what makes a measure acceptable, and to develop in this case an electronic reporting tool and  
25 processes for collecting data electronically. This was well underway before the current Voluntary Physician  
26 Reporting program and so we didn't make any effort from the outside to rely on claims data exclusively.  
27 There was always an interest in a combination of claims and chart-based measures, and so it was really a  
28 matter of developing something that worked for the groups, given the various states of evolution that

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1 they're at with respect to their own medical records and their ability to retrieve this kind of data from  
2 medical records.

3 In addition, of course, we hope to learn something from this demonstration, and again, I think it's  
4 one of the questions for discussion here today about the applicability of some of what we're learning here  
5 to smaller practices and to individual physicians, since so much care that's delivered in this country is  
6 delivered by groups of 10 or under, or 7 or under, depending on which subset of care, I've heard both  
7 numbers. It's much smaller groups, obviously than these very large groups.

8 I'd like to turn now to the High Cost beneficiaries demonstration, or the Care Management for  
9 High-Cost Beneficiaries. And this was developed in response to some concerns raised by the physician  
10 community over the Medicare Health Support program, and it's focus on very large populations and on  
11 randomization, and so this was to allow alternative approaches, that might involve either randomizing  
12 providers or doing other comparisons. And also to be largely provider focused, that is the payments for care  
13 management going to providers rather than to an outside organization that might or might not share those  
14 payments with physicians. This was not limited just to physicians, but also to other providers. Again to  
15 coordinate care of high-cost, high-risk beneficiaries, in the Medicare Fee for Service program by providing  
16 support to those individuals to manage their conditions to enjoy better quality of life and to reduce cost.  
17 There are 6 sites, well, never mind. We'll get there in a moment. Provider-based organizations, as I said,  
18 using as it turns out a population enrollment model—so in some cases, there is randomization, and in other  
19 cases there are populations selected based on assignment algorithms to the practices that the practices have  
20 agreed to based on whom their serving in their [inaudible] area with the either conditions or the cost  
21 profiles for the demonstration as they designed it. A broad range of clinical diagnoses—again some heart  
22 failure, but also some chronic kidney disease. This was also an opportunity to test models of chronic care  
23 management, or chronic care improvement for diseases other than diabetes and heart failure, which were  
24 the index conditions used to identify the population in the Medicare Health Support program. So chronic  
25 kidney disease was one of those areas that we did want to look at. These organizations are at fee risk for  
26 guaranteed savings, net savings to the Medicare program, net of fees of 5%. It's a three-year demonstration  
27 and the earliest project was launched last October. I think the last of the six will be launched this June. And  
28 the organizations are listed here, Health Buddy Partners with a couple different large and medium

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1 physician practices, Care Level Management is a physician home visit service, in California, Texas and  
2 operating currently in California, Texas and Florida. The others Montefiore Mass General, which are  
3 familiar to everybody here, and then RMS is providing the chronic kidney disease management, and Texas  
4 Senior Trails is part of the University of Texas in west Texas. The services include physician and nurse  
5 home visits, largely to prevent hospitalization in very frail patients who might be better cared for in their  
6 homes rather than admitted to the hospital. When they do compensated services can be provided in the  
7 home to prevent that or to nip that in the bud. Use of in-home monitoring devices, electronic medical  
8 records linked back with depending on the particulars, linked back with the patient's own physician is the  
9 service is provided by another physician, or by a group, self-care, caregiver support, patient education,  
10 preventive care tracking and reminders, 24-hour nurse telephone lines, behavioral health management and  
11 some transportation services.

12         We've two other demonstrations under development, the Medicare Care Management  
13 Performance demonstration and the Medicare Health Care Quality demonstration. The Medicare Care  
14 Management Performance demonstration was mandated by § 649 of the Medicare Modernization Act, with  
15 the goals of improving quality and coordination from chronically ill fee for service beneficiaries and  
16 promoting the adoption and use of information technology by small- to medium-sized practices. I  
17 sometimes view this demonstration as an attempt to marry up some disease management services with  
18 physician practice and to reward the practices themselves, so we see this again as another attempt at pay-  
19 for-performance for physicians who achieve quality benchmarks for chronically ill beneficiaries, and who  
20 adopt and implement health information technology and use it to report quality measures electronically.  
21 Again this demonstration is required to be budget neutral. We are in the process of final review of this  
22 demonstration before we can begin to implement it. It will be implemented in about 800 practices in four  
23 states. The states were announced some time ago; Arkansas, California, Massachusetts and Utah, and the  
24 quality improvement organizations or QIOs in those states will be providing technical assistance to the  
25 physician practices in the selection and implementation of Health IT. The practices will be recruited from  
26 among those participating in the Doctor's Office Quality Information Technology project that is part of the  
27 QIOs' 8<sup>th</sup> scope of work.

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1           And again some of the quality and outcome measures are very similar to those that we're using in  
2 the Physician Group Practice demonstration. I've listed a few of them here. Then finally the Medicare  
3 Health Care Quality demonstration. There's a lot of detail here directly from the statute. This is § 646 of the  
4 Medicare Modernization Act, and this is the detailed statutory language. But we really view this  
5 demonstration as an opportunity for large scale system redesign and payment models that incorporate  
6 incentives to improve quality and safety of care and efficiency through the use of best practice guidelines,  
7 reducing scientific uncertainty, incorporating sheer decision-making and improving the cultural  
8 competence and sensitivity in the delivery system. One of the ways we talk about this demonstration is it  
9 provides an opportunity—this demonstration I talk about eligible organizations later. Is open to physician  
10 groups, integrated delivery systems, and regional coalitions of organizations that represent physician  
11 groups and/or integrated delivery systems. So it's really a provider-driven opportunity to redesign the  
12 delivery system, as opposed to something externally imposed through say other insurers, other payers,  
13 though there are many of them very interested in this to the extent that they want to partner with Medicare,  
14 they really have to partner with the provider community in the region or in the geographic area they are  
15 operating in. But we really view this as an opportunity to hardwire quality into the delivery system by  
16 making it easy to do the right thing through the way in which care is structured, care processes information,  
17 and so on. Our goal is to see projects that are designed to implement or to achieve some of the instituted  
18 medicine aims for improvement; safety, timeliness, the so-called steep principles, and to again, because  
19 we're looking at redesigning delivery and we're talking about the 21<sup>st</sup> Century, bringing health information  
20 technology up to a 21<sup>st</sup> Century level by using information technology that informs practice and connects  
21 clinicians and helps to improve care by providing, again, a better foundation of information about patients  
22 that clinicians can share.

23           Overall, I think in all of these, we're looking to, and I've used the term "efficiency" several times,  
24 and we're really looking for Medicare savings, but also better value for our patients. We're looking for  
25 system efficiencies across providers through things like care coordination, managing transitions across  
26 settings, some areas that we think are very important, areas to mine for improving outcomes and reducing  
27 some of the problems that result in higher and often unnecessary costs. We're looking at shared clinical  
28 information so that we can begin to see reductions in duplicative tests and procedures, improving processes

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1 and outcomes through evidence-based medicine, evidence-based guidelines, better compliance with that,  
2 use of best practices, substituting outpatient for inpatient care and ultimately all of these demonstrations,  
3 both these provider-based ones that I've talked about today, and Medicare health support are really focused  
4 on trying to reduce avoidable inpatient admissions, readmissions and emergency room visits for care that  
5 can be better in chronically ill patients who can be better managed and therefore avoid some of these acute  
6 exacerbations that result in their being hospitalized.

7 I have three discussion questions. Dr. Grimm I guess went straight to the third one, and I'm happy  
8 to start there if you'd like to since—

9 Dr. Grimm: Thank you, thank you. This is, you know the statistics in the beginning there are just  
10 actually astounding to me in terms of what these chronically ill patients represent in terms of overall  
11 expenditures, the Medicare dollars. When you look at the amount of hospital care for these chronically ill  
12 patients, what does that represent in terms of the costs—are we talking about 90% of this is hospital, or is it  
13 50%, 40%, do you have a sense about how much percentage out of that represents the hospital costs that  
14 you'll be saving by keeping these people out of the hospital?

15 Ms. Magno: Well, overall, I mean overall hospital costs represent some 40% or so of Medicare  
16 expenditures, across the board. And because these patients experience, multiple hospitalizations, I haven't,  
17 I don't have a breakdown of that but you're the second person in a week who's asked me that, so I'm  
18 clearly going to have to go back and pull apart kind of what's in that 66% of spending for the 20% or more  
19 beneficiaries with multiple chronic conditions, five or more chronic conditions. To see just how different it  
20 breaks from the overall populations, where about 40% of our spending is for inpatient care, see how much  
21 higher it might be. But there is a good deal of hospitalization, a lot of bouncing back and forth between  
22 hospital and home or hospital and nursing home. A lot of end of life hospitalization. And we saw just last  
23 Tuesday, I guess, the latest Dartmouth Atlas of Healthcare, some of the wide variation in the use of hospital  
24 services and in the use of intensive care units within hospitals for end of life care in the Medicare  
25 population. And while use of intensive care units in and of themselves don't change our payments, except  
26 at the margin in the case of hospital outliers, additional payments for particularly high-cost hospital stays,  
27 they clearly have an impact on hospital operations. They clearly have an impact on what's happening to a  
28 person at the end of life, and again, just because someone is back and forth in and out of a hospital, you

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1 know, significant impacts on our overall spending. We see that there's wide variation with not necessarily  
2 any real differences in either the underlying conditions that brought people into the hospital to begin with,  
3 they're ill, they're near the end of life. This was like in the last six months or in the last year of life, or in  
4 the last two years of life and they all end up the same, in the sense of its being the end of life. So I think  
5 there's a great deal more to be learned from kind of teasing apart that data.

6 Dr. Grimm: Just to finish on that same topic, when you are measuring these quality issues and  
7 incentivizing physicians and the group issues and these models, is there a mechanism for them to  
8 understand their reduction of hospital admissions. Do they know that? Are they incentivized?

9 Ms. Magno: The practices themselves are working, I mean each practice is kind of developing its  
10 own strategies for how to achieve both savings and the quality improvements. And so the practices are  
11 capturing certain data and working with hospitals to capture certain data on admissions, readmissions,  
12 knowing when their patients are hospitalized, when they're discharged. We will as part of our evaluation of  
13 the demonstration, we will be looking to see where the savings come from and we'll share that back with  
14 the practices. But that'll be a post-hoc analysis.

15 Dr. Grimm: Will they share in any of that benefit—they won't share any of that savings, though  
16 will they?

17 Ms. Magno: Yes they will. I mean that's where the savings to the practices actually, that's where  
18 the potentially large savings to the practices comes from is that to the extent that total Medicare spending,  
19 Part A and Part B, rate of growth actually, in Medicare spending, in the practice is slower than that in the  
20 rest of the community, then they will share in the total A & B savings, not just the physician component of  
21 the savings. So in the same way that most of the savings that disease management aims for is reduced  
22 hospitalization, reduced ER use, in order to be able to cover their costs, this is the same thing.

23 Dr. Senagore: We'll go Dr. Hamilton, Dr. Williams, Dr. Ross, Dr. Azocar.

24 Dr. Hamilton: Well, first I want to thank you for this presentation because it really has been very,  
25 very useful and very well presented, but it raises issues that are so profound and go to the very core of our  
26 healthcare system, for me to make some kind of a comment in 15 seconds or less related to the entire  
27 healthcare delivery system and how you can fix it is not possible. But everyone understands that the system  
28 needs to be fixed and you have to find pieces of it that you can fix in order to start somewhere because if

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1 you wait until you can fix the whole thing at once, you'll never get there I'm certain. The statistics you've  
2 presented are extremely important and they do need to be clarified and expanded, and I know that this  
3 information is probably available. But if you just look at the chart of numbers of patients that spend  
4 \$25,000 per year for their care, that represents 6% of the Medicare patients. Now if you take patients over  
5 the age of 65 with a life expectancy, perhaps of 20 years, that's pretty close to 6% a year are going to die. I  
6 mean that would just, mathematically make sense. In order to spend \$25,000 on your healthcare, you  
7 almost have to be in a hospital somewhere, so it is not too much of a stretch to think that a good many of  
8 these patients that spend large amounts of money, which are the ones we're really focusing on are those  
9 that are within the last year of their life. And we all know this to be true intuitively. You can spend one day  
10 in the intensive care unit being treated for sepsis and congestive heart failure, and you've probably spent  
11 \$25,000 right there. So if you're there two or three days, you're already far beyond this curve. So that  
12 addressing the concerns about the palliative care and end of life issues is critical if you're ever going to  
13 address cost factors in terms of the overall health care system. Now how can you do that? Well, I don't  
14 know that I can give you an immediate, quick, sound byte answer, but that's where you need to start  
15 looking. Now the other issue that you raised at the very beginning and I think is extremely important, has to  
16 do with the number of physicians that individuals in this group utilize. Now if you figure, well, the  
17 ophthalmologist and the dermatologist are probably two of those six, you know, you're not going to really  
18 eliminate that. So that's not an issue. But the fact is that it's not the fact that there are too many specialists,  
19 or that seeing the specialist is something that ought to be eliminated or restricted, it's the fact that the  
20 primary care doctor has been reduced to such a role in the healthcare system that nobody wants to do that  
21 anymore, and those that do find out that they very quickly can't afford to do that very effectively and they  
22 certainly can't do it and interact with patients the way you and I know that they need to be interacted with.  
23 So what the system needs to do is to strengthen the role of the primary care physician. And there are many  
24 specialty groups that are very interested in doing this and are trying to design studies that similar to what  
25 you're doing to strengthen the primary care physician and their role in these patients' care. So I would  
26 suggest that that's one place to look. The second place to look has to do with palliative care and end of life  
27 issues. If you can keep people from being transferred from the nursing home to the emergency room and to  
28 the intensive care unit, in the middle of the night, you will probably save a billion dollars right there.

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1 Ms. Magno: Actually that is an area that we are looking at and we are in the process of developing  
2 a demonstration we hope to conduct with several state around nursing homes, not just the SNF care that  
3 Medicare pays for, but because Medicare beneficiaries end up as residents of nursing homes, even when  
4 we're not paying for the stay, it's this ping ponging as you say back and forth.

5 Dr. Hamilton: Absolutely, I mean how many people, not only as physicians but just as people  
6 know of their relatives or their friends or loved ones or someone that was in a facility where everyone in  
7 the family knew that they were there for the end of their life care, and when something bad happens they  
8 become septic, they become unresponsive, and the nursing home people, or the care people that are  
9 involved immediately push the button that says call 911 and the ambulance comes and they take them to  
10 the emergency room, where an emergency room doc evaluates this situation and can't get hold of anyone  
11 that has any other information. So where do they wind up? Because they're septic? They wind up in the  
12 intensive care unit, and this \$25,000 a day clock starts ticking. I mean that's where you need to really direct  
13 the efforts. So strengthening primary care and doing something about end of life issues related to intensive  
14 care for people that have no reasonable expectation of any long-term benefit from that sort of intensive care  
15 is where you really need to go in order to try to do something about the costs of the whole healthcare  
16 system. And I really do appreciate what you guys are doing because I think it's where we need to start  
17 looking.

18 Dr. Williams: Well, I guess great minds think alike. I was going to echo exactly what Dr.  
19 Hamilton discussed. I was going to ask whether or not any of your physician groups in dealing with end of  
20 life matters, do they actually try to keep the patients out of the hospital using multi-disciplinary approaches,  
21 whether it's neurology, spiritual medicine, you know all the things that we use in the hospital when we're  
22 dealing with the end of life; pain management, that entire thing. And you partly answered my question in  
23 saying that I guess you're going to develop a separate demonstration project for that, is that what I heard  
24 you say?

25 Ms. Magno: Well we're in the process of developing a separate demonstration project around  
26 nursing homes and nursing home residents in order to avoid, in order to again avoid avoidable  
27 hospitalizations of nursing home patients for the very type of issues that Dr. Hamilton mentioned, where  
28 you know a little bit of decompensation—it's a classic things, my deputy's mother-in-law at 96, was in a

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1 nursing home, and she's been in and out of the hospital probably three or four times in the past year. A little  
2 bit of dehydration, or a little bit of beginning of a urinary tract infection, she becomes a little more  
3 cognitively impaired, a little dementia, I'm sorry, disoriented, exactly, thank you, and she's admitted and  
4 then through the emergency department, and then two day's later is back in the nursing home and she's fine  
5 and can hold a conversation and she remembers who people are again, and everything's back to normal.  
6 But this is maybe three or four admissions as I say in the past year or so alone and that's not uncommon in  
7 the Medicare population particularly as it ages. So it's avoiding those, it's trying to reward nursing homes  
8 for better managing that care, medicalizing care that's typically not medical care. These are you know,  
9 residential nursing homes, she's not receiving SNF care, but to the extent that the nursing home doesn't  
10 address these issues quickly, right as they start to emerge or prevent them all together, then their not the  
11 ones providing the medical services on catch up, they're hitting that 911 button. So we are developing that.

12 Dr. Williams: Is it unreasonable as far as the frequency with which end of life issues, most people  
13 are probably in a nursing home as opposed to in their homes? And would that be a different process to  
14 establish a similar offshoot of your project for people who are being cared for in their homes?

15 Ms. Magno: I think that the whole area of end of life—I had an interesting conversation with  
16 somebody at the Disease Management Colloquium about this very issue last week, because I think end of  
17 life issues really, I personally believe at this point, that they probably have to be addressed by patients' own  
18 physicians. I mean disease management organizations that are operating in Medicare Health Support or  
19 other demonstrations that we've conducted, I think it's very hard for them to go in to patient populations,  
20 even though some of those patients based on medical information that they collect claims information and  
21 so on, it may be very clear that they're sort of nearing the end of their life. They've have congestive heart  
22 failure that's worsening and so on. I think they're not the ones who can effectively be into broach end of  
23 life issues. I think it's patients own physicians who have to broach that. I don't want to hear from, I don't  
24 think anyone wants to hear from a stranger, even if that stranger is a really nice nurse, who's very  
25 sympathetic, if they're own doctor hasn't told them they're nearing the end of life and ought to be thinking  
26 about what kind of care they want at the end of life, I don't think they want somebody outside of that  
27 relationship who they, with whom they haven't developed a trust relationship to introduce that issue. And  
28 so I think the question really falls back to physicians. It's how do physicians broach end of life issues? And

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1 I think, some of you may think I'm speaking out of turn here, but I think by and large, I think there's the  
2 great American medical denial of death and we don't do a very good job as a society of dealing with end of  
3 life issues, or recognizing end of life, and I'm not sure that physicians—I don't know, my sense is that  
4 physicians just aren't comfortable telling their patients, we're nearing the end, and still thinking, for  
5 whatever reasons, if you're nearing the end, does that mean our relationship is ending? We're breaking up?  
6 What does that say? I think we haven't dealt with that well as a society except in pockets where there are  
7 clearly some differences in the way it's dealt with across the country if one looks at end of life care.  
8 Oregonians seem to be willing to kind of broach the subject through things like assisted suicide and so on,  
9 and even in care rationings, say years ago, they seem to have a different way of looking at the role of  
10 medicine and healthcare in their lives, at least that's what comes across. But in general, I think these issues  
11 and how end of life is dealt with is really better captured in these broader initiatives around physicians  
12 overall without trying to isolate—

13 Dr. Williams: Perhaps we could consider exposing physicians to more educational issues  
14 regarding end of life so that that discussion can take place with the family and the patient and maybe keep  
15 the patient at home and out of the nursing home if that's feasible.

16 Ms. Magno: And I think some of that has been, I think CMS has certainly attempted some of that,  
17 or Congress with things like Advanced Directives and so on. But there may be other things that we ought to  
18 look at.

19 Dr Ross: Two points I'd like to talk about, maybe expand on what Dr. Williams and what Dr.  
20 Hamilton mentioned. Earlier on, dealing with preventative measures, that might save expenses in the final  
21 analysis and maybe add to a quality of life issue for those seniors that maybe are living out their last years  
22 in a much more healthy fashion, rather than a much more debilitated fashion. In other words, why aren't we  
23 looking at preventative means in their fifties, or as they just become beneficiaries when they turn 65 and do  
24 studies to look at preventive interventional means before we do major interventional treatment later on,  
25 when it's in the last year and it's costing millions and millions of dollars. I think if we look at some of the  
26 things that you've talked about here for the diabetic, for the other groups, maybe before they're diagnosed  
27 as diabetics; before they develop congestive heart failure, looking at exercise, looking at diet, looking at

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1 primary care as a means to intervene before major intervention takes place. I think that's another area that  
2 we may want to start focusing on before we focus in on these seniors in their last years of life.

3 Ms. Magno: I think that was one of Congress's goals in enacting the Welcome to Medicare visit,  
4 was basically to get patients within the first six months, that they're in the Medicare program, to see their  
5 physician and have a thorough examination and risk assessment, essentially and also a number of screening  
6 examinations. We've also developed a demonstration that is stuck right now. But actually a senior risk  
7 reduction demonstration that's intended to test the use of health risk assessments or health risk appraisals  
8 for the Medicare beneficiary population pre-70 and then targeted feedback at varying different levels of  
9 feedback, based on those risk assessments to see whether or not, how tailored the feedback has to be for  
10 individuals and whether it has any effect on behavior, because behavior change is a critical issues. It's a  
11 critical issue whether it's us trying to affect Medicare beneficiary behavior through some of these health  
12 risk instruments testing whether or not those have an affect, whether it's disease management in large  
13 vendor type programs, or whether it's you as physicians, dealing with individual patients and trying to  
14 move behavior at the margin. I think how we get there I think continues to be—

15 Dr. Senagore: I'm sorry, I'm going t have to cut this topic, because we have other important  
16 issues. Doctor, I'm sorry, we have to move along from this topic. I'm sure we'll have the opportunity to  
17 invite Ms. Magno back for this topic, because it's going to engender a lot of—

18 Dr. Ross: It was a category that wasn't listed and I thought that would be prudent to their studies  
19 in the future. It was under coronary artery disease. I think Dr. Bufalino would agree, peripheral vascular  
20 disease is another area that was not mentioned. And these folks suffer from claudication, immobility,  
21 disability, amputation, ulcerations, sometimes peripheral neuropathy, venous stasis problems, and you  
22 might want to look at that as a subtopic with the coronary artery disease.

23 Dr. Senagore: We'll have an opportunity to revisit this when we make recommendations. So we're  
24 going to have to move on unfortunately. I need to change the agenda just a little bit. And I'm going to ask  
25 Dr. Valuck who is the Medical Director in the Center of Medicare Management, where he advises the  
26 [inaudible] Director and Deputy Director on clinical issues related to payment policy, including Pay for  
27 Performance. Prior to joining CMS, Tom was a pediatrician, a hospital executive at the University of  
28 Kansas, and an associate at the law firm of Laffim and Watkins. Dr. Valuck would like the Council to

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1 consider the following questions during his discussion of Cost Measurement Development under Pay for  
2 Performance: 1) How can cost of care measures be made meaningful, actionable, and fair? And the how to  
3 practicing physicians use the resource use reports that are currently being circulated by private health care  
4 plans in many markets. Dr. Valuck.

5 Pay for Performance: Cost Measurement Development

6 Dr. Valuck: Thank you, Mr. Chairman. In some ways, this presentation is a follow on to the  
7 presentation that I gave at the last meeting. It was entitled Moving Toward Pay for Performance. And as the  
8 chairman mentioned, we've done a little bit of rearrangement of the agenda, but on the initial agenda, we  
9 had a couple of pay-for-performance topics that were structured after lunch to include a Quality Measures  
10 discussion and also then a Cost of Care Measures discussion. And those are again, together, sort of a follow  
11 up to the presentation that I made on our movement toward Pay for Performance at the last meeting. So just  
12 to dive right in, the overview of the presentation is three main bullets. First is the link between quality and  
13 cost. And this is the first take away message as well. I want to make very clear that our implementation of  
14 Cost of Care measures is happening under the umbrella of Quality of Care. And I'll be explaining that  
15 linkage through the presentation this morning. Secondly, I want to talk about CMS's coordination with  
16 external entities on our Cost of Care Measures Development projects and this is very important because the  
17 second take away message is that we really want you to understand that we're working with the rest of  
18 industry as we're developing these Cost of Care messages, just as we are with the Quality measures, we're  
19 not working in a vacuum here. And then the third bullet, the third part of my presentation today will just be  
20 to bring you up to speed on the process of Cost of Care Measure Development that we've been going  
21 through, particularly focusing on the two prongs of that internal project. One is the development of  
22 physician resource use reports for highly utilized imaging service, and the second is an episode group or  
23 evaluation and you'll see how those tie back to point number two as well in terms of how we're  
24 coordinating our internal work with what's going on in the rest of the industry.

25 So what is Pay for Performance? This is the review from the last presentation that I made, but it's  
26 important because we need to see where cost of care measures actually fit in to the overall Pay for  
27 Performance implementation and also in relation to our Quality measures. So this is CMS's definition of  
28 Pay for Performance; what we're trying to accomplish. It's a mechanism for promoting better quality, while

1 avoiding unnecessary costs. Notice very important that you look at the modifiers to cost, avoiding  
2 unnecessary costs. We're not talking about arbitrary cost-cutting here and you'll see how that plays out  
3 through the rest of the presentation. Another way to look at this definition or this approach is that Pay for  
4 Performance can be used to use explicit payment incentives to achieve identified quality and efficiency  
5 goals. Again, the relationship between both quality and efficiency here, and I'm going to be talking more  
6 about that linkage through the rest of the presentation. Another important thing to remember here in terms  
7 of the first point that I'm really taking great pains to drive home, is exactly where efficiency fits in to the  
8 definition of quality. I know you all know this, but I just wanted to review quickly that efficiency is one of  
9 the IOM's key dimensions of quality and you can see their definition there, and sort of my paraphrase,  
10 which is again, not about arbitrary cost-cutting, but it's about getting rid of waste in the system, overuse,  
11 misuse, and things like patient errors. Medical errors.

12 OK, so I want to move on from the CMS definition of Pay for Performance and the IOM  
13 definition of quality to just give you one definition of efficiency. I'm not claiming that this is the only  
14 definition of efficiency, or that this is even an official CMS definition of efficiency, but I want to give you  
15 one way to think about efficiency that I think is relevant to this presentation. So efficiency can be defined  
16 as a given level of output, notice I put output in quotes, because this is a difficult issue, as you know, as we  
17 look at health policy questions, but a given level of output, achieved at the lowest total cost and for us, then  
18 for health policy purposes, if you think of the output as a given level of quality of care, then if you have  
19 high standard of care, then achieving that at the lowest total cost is where we gain, or where we achieve  
20 efficiency. Again, this is just one definition but I think it is a helpful framework for how we can think about  
21 efficiency in this context. So how do we translate that concept of efficiency into something that's actually  
22 measurable? So one way to do that is to look at the ratio of actual resource use to expected resource use,  
23 but again, you need the context. You need that we're also looking at an equivalent high level quality of care  
24 and then you can compare those levels of resource use and begin to move toward greater efficiency.

25 So just a quick review of a couple of things that we're definitely keeping in mind. Couple of the  
26 difficult issues, and again these are, I'm still setting up the presentation. These are things that are going to  
27 be revisited throughout this presentation. That these cost of care measures have to be fair, and in order to be  
28 fair, they need to be adjusted in various ways, and that also to look at measuring efficiency, you've got to

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1 look at not only measuring costs, but also measuring quality at the same time to guarantee that high level of  
2 quality so that we aren't looking at arbitrary cost-cutting. OK, so I think I've maybe over-emphasized some  
3 of these points, but given that's it's very important as we begin the discussion about this issue, I wanted to  
4 make sure that you understood where we were coming from.

5 So let's move into the second part of the discussion, which is our efforts to coordinate on cost of  
6 care measure development with the external groups in the industry, who are also working on cost of care  
7 measure development. And the first of those is Congress's advisory commission, MedPac. They are  
8 looking at using episode grouper software, which I'm going to be talking about in more detail later in the  
9 presentation. But they're using that technology to look at physician resource use at the individual physician  
10 level. They're doing an evaluation that's complimentary to the one I'm going to be discussing as our  
11 second internal project, and we're having monthly coordinating calls with them so that we're also working  
12 efficiently in a different meaning of the word. They began with the Medicare 5% sample and reported  
13 results of that to the commissioners in March and April and their next stage is to look at 100% of Medicare  
14 claims for particular regions that they'll be picking for particular period of time that they'll be picking. And  
15 their ultimate goal is to do exactly what we're attempting to do; which his figure out how to link episode-  
16 based cost of care measures to quality measures for an overall assessment of performance.

17 Next group that we're working with is the Ambulatory Care Quality Alliance. As you know, the  
18 AQA is working to standardize measures and efficiency measures is a part of that work toward  
19 standardization. There's actually an efficiency measures subgroup of their overall performance measures  
20 group that looks at both quality measures and efficiency measures and they're also looking at episode  
21 groupers as a way to address cost of care measures. And they have the goal of including these individual  
22 measures at the physician level into the data sharing and aggregation pilot projects that have been  
23 announced in the last couple of months.

24 Third group we're working with is the National Committee for Quality Assurance, NCQA. NCQA  
25 has commonwealth funding for a episode group reevaluation. Theirs is looking at the health plan level, as  
26 you might expect, but they're also interested in looking at the efficacy of the groupers at the individual  
27 physician level as well. And because NCQA has been working on this for some time, it has some

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1 familiarity with the episode groupers. They've been asked to take a more active role in the AQA process to  
2 speed the development of efficiency measures there for use in the data sharing and aggregation pilots.

3 Just a couple of other efforts in this particular arena that I want to mention before moving on to the  
4 next segment of the presentation, Also, ARC is working with RAN to develop an efficiency measurement  
5 typology to just get a view of all of the different kinds of measures that are out there for both the  
6 ambulatory care environment, and for the hospital environment. And then the GAO as part of their MMA §  
7 953 mandated reports, chose to look at public and private payer activities regarding physician efficiency.  
8 So we should be getting a couple of kind of comprehensive assessments of what's going on out there at  
9 large in the industry related to physician efficiency measurement from ARC and GAO in the next several  
10 months.

11 So shifting gears a little bit and moving from kind of our external relationships and how we're  
12 working closely with some of the other groups in the industry who are working on efficiency measure  
13 development, to more of our internal work, I just want to share with your goals first. And that's to develop  
14 meaningful, actionable, and fair cost of care measures, of actual to expected physician resource use. And  
15 you can see how that's going to play out during the two projects that I'm going to be talking about. And  
16 then our ultimate goal is to link cost of care measures to quality measures for an overall assessment of  
17 physician performance, that can be useful for Pay for Performance, education, and a number of other  
18 things. So in terms of the projects that we have, that we're working on, that we've been working on for  
19 nearly a year now, to greater or lesser extent, we're basically following up on a March 2005 MedPac  
20 recommendation and I want to read it because I think it's packed with some good information and it's  
21 background for the two projects that we have going. And that was the recommendation that CMS should  
22 use Medicare claims data to measure Fee for Service physician resource use, and share the results with  
23 physicians confidentially to educate them about how they compare with aggregated peer performance. So  
24 couple of things that we are doing. And a couple of things that we aren't doing. First of all, this is using  
25 claims data and not abstraction or any other kind of data. It's sharing the results with physicians  
26 confidentially, so at this point, we're not talking about any kind of posting on a website or anything like  
27 that, through this particular recommendation. And the projects that we've been working on. That its use is  
28 to be for educational purposes and for comparison with aggregated peer performance. OK, so we turn that

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1 into a couple of different projects, and they're listed here. One was the development of resource use reports  
2 for a couple of highly utilized imaging services. First was echoes for heart failure, and second MRCTs for  
3 neck pain, and then our second project is an episode group re-evaluation which is very much  
4 complimentary to or similar to the kind of group re-evaluations that are going on in other parts of the  
5 industry that I previously mentioned. So in terms of the Physician Resource Use Report project, the first  
6 project, this was our objective: Looking back at the MedPac recommendation, really to determine the  
7 feasibility of developing and disseminating those confidential claims-based resource use reports that they  
8 were recommending. So for the project focus, I already mentioned that we picked echoes and MRs, and  
9 CTs for various kinds of patients, and we also picked the states of Ohio and Wisconsin for a couple of  
10 different reasons. One was because of interesting variations there, but also because we had from practical  
11 perspective we had some support from a couple of our program safeguard contractors who have experience  
12 in this kind of report development and also have access to the Part B claims. So we worked with those  
13 PSCs to develop the report that you see here. This is the report that looks at the use of echocardiograms for  
14 CHF patients. And rather than spend a lot of time talking through the substance of this, because there's a  
15 whole lot of information in here, what I'm really interested in walking you through is the process that we're  
16 undergoing in terms of the cost of care measure development and the reactions that we've had from  
17 physicians, which has then led us to our next stage of development. So if you want to revisit the detail of  
18 these reports, feel free to talk to me either through your questions or afterward, following, using my contact  
19 information, but I'm going to go ahead and rather than talking through those reports, I'm going to move on  
20 to tell you about what we learned through the process. So we took this particular report that was just shown  
21 and we took it to cardiologists in January, at the Cleveland Clinic, and we took it to a group of cardiologists  
22 also in January in Wisconsin, so we covered our Ohio and Wisconsin physicians and these were clinicians  
23 that were invited in by Susan Nedza, Medical Officer at our Chicago Region, to convene these focus groups  
24 and take this report forward along with a description of the background, like I've given you, what we're  
25 trying to accomplish, along with a cover letter, stating basically, what we're trying to accomplish, and a  
26 two-page explanation of the actual report, like you get with your phone bill, that walks you through each  
27 part of that report that was just shown here and then the actual report itself with identified information for  
28 the particular physicians who were attending the vetting session so they could react to their own

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1 information. So what did we hear from them? And this is what I think is important. This is the take away.  
2 This is what's given us kind of our marching orders in some ways as to how to make these reports  
3 meaningful and actionable and fair so we can meet our objective. We heard that the physicians who were  
4 part of our focus groups get similar reports from private payers and they don't pay a lot of attention to  
5 them. They aren't a lot of use to those physicians, so they aren't meaningful and actionable. We heard that  
6 our data that the physicians saw in the reports appeared to be inaccurate. Some physicians said their  
7 numbers looked low, some physicians said their numbers looked high. We discovered that for some of the  
8 physicians, who we had convened in these focus groups, we didn't even have the reports available to them  
9 because they may bill under a group PIN number. We heard loud and clear that consensus standards need to  
10 be developed by specialty societies, that just because an aggregate group of peers performed a certain  
11 number of procedures, that does not equal a consensus standard. We heard that this kind of report must be  
12 adjusted for at least patient mix and severity to be comparable among the physicians we were comparing  
13 them to. That the peer group must be more precise than something like cardiologists, given that we have  
14 lots of different subspecialists now that do various different things with echoes than their sub subspecialist  
15 peers. We heard that the coverage guidelines may actually increase utilization. We heard the example that  
16 our ICD coverage guideline actually calls for an echo, where a cardiologists weren't necessarily getting an  
17 echo before and we also saw some finger pointing, that the specialists said it was a problem with the  
18 generalists, and the vice versa, and then we heard something that I thought was very interesting, was that  
19 the physicians of the focus group said this would be a great tool for you guys for investigating fraud and  
20 abuse. What are you doing with resource use? Go back to fraud and abuse. So well, this isn't really what  
21 we'd set out to do here, but we'll table that and maybe use it for another day. But the point of sharing all of  
22 this with you is that the first phase project is really a building block, just as all of our Pay for Performance,  
23 we're doing this by building blocks. We're attempting something, learning from it, and moving on over  
24 time hopefully to a better and better and more accurate and fair product over time. So in moving on into the  
25 second phase of the development of resource use for imaging services, instead of what we had originally  
26 intended to do, which was to look at use of MRs and CTs for head and spine generally, we thought maybe  
27 we could focus, I've used the term "auto-adjust" probably not a very good term, but thought maybe we  
28 could get rid of some of the variables if we could get more focused on more of a heterogeneous group of

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1 both patients and physicians and we made a big trade off here because when we implement anything for the  
2 Medicare program, it really needs to be broad to cover a great number of physicians, but we thought be  
3 getting very narrow and focused, we might be able to learn actually how to use this kind of a tool a little bit  
4 better and answer some of those issues that I shared with you on the last slide.

5         So we ended up with a different kind of report that was again much more focused. You can see the  
6 numbers are much smaller. Again, some of these trade-offs, you get from a large number problem where  
7 you've got a large number advantage, where you've got more robust findings to more of a typically small  
8 numbers type of problem, when you get so narrowly focused, but we were able to address a number of the  
9 issues that we had heard and learned from in Phase I. So what did we hear when we did vetting for phase  
10 II? We took this report to the Medical College of Wisconsin in Milwaukee and they told us that even  
11 though we had picked a procedure this time where there was actually guidelines, we heard that none of the  
12 attendees were acquainted with the guidelines, so we tried to solve the no standard issue with a standard,  
13 but we found out that the folks who we invited to look over their resource use reports weren't familiar with  
14 the guidelines, so in some ways we were successful, in some ways we weren't. Then they also said, but  
15 you've got to think about these guidelines more specifically. You're talking about Medicare patients here  
16 and there's some different things about Medicare patients in their neck pathology that you don't necessarily  
17 see in the general public. So you need to make sure that your guidelines are focused. They told us  
18 something that I think we knew about the report going in that it was unnecessarily complex and non-  
19 intuitive and all we're really trying to show here is utilization, a comparison standard, and where the  
20 utilization compares with the standard. It doesn't really have to be quite so complex. So again, we're still  
21 learning. And then as I told you, we ran into the small number problems. So I'm spending a lot of time here  
22 building up to what are the likely conclusions and recommendations for this Phase I project, but I'm doing  
23 that because I think it's important to demonstrate that we really are listening to what the physicians are  
24 telling us. And as we go into that next building block, which I'm going to be talking about, and even what  
25 might be the future beyond our next building block, which is the episode group re-evaluation, it's a  
26 progression of improving how we're trying to address the issues that are inherent in this type of  
27 measurement. So here are the likely conclusions and recommendations and what we need to address for the  
28 future.

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1           That when the physicians sat down with these reports, that they didn't really see their patient  
2 population. They saw a bunch of numbers that didn't correspond with their clinic day last Thursday, where  
3 these four patients came in. They could tell you all about those, but it didn't look the same when it  
4 converted to a resource use report. We also learned that the claims data just in the simple way that we had  
5 used it to develop these reports, simply just does not have rich enough information in it to generate reports  
6 that are meaningful and actionable for physicians. So that's the point that we're primarily trying to address,  
7 moving forward. Third that of course as I think you would expect, that the wide dissemination of this kind  
8 of resource use report that I've been describing, the costs of that would likely outweigh the benefits, and  
9 then lastly, there could be some uses for that kind of tool, however even though widespread dissemination  
10 probably wouldn't be a good one. We might be able to use it to help identify outliers, for example, if the  
11 QIOs were looking for ways to target their educational efforts for physicians, or we might be able to use it  
12 if we see a spike in it, for example, a new indication for a certain type of technique, that's very very  
13 expensive, we might want to find a guideline and follow up on that guideline with this kind of educational  
14 tool. But in general, probably not very useful. So what is the next step? Well the rest of the industry is  
15 looking episode groupers. We were, too, even actually in parallel to this previous work but I think it makes  
16 for a nice transition, because if the conclusion on the previous work was that the claims data, the way that  
17 we were using simply was not sophisticated enough to give the context for a meaningful report, then we  
18 have to come up with something more sophisticated; something that actually collects more information and  
19 presents it in a more meaningful way. So we wanted to understand one of the episode grouper could help us  
20 do that, what's it all about? What are its potential uses? And then how the grouper actually develops  
21 comparable episodes of care at the physician level and specifically for the Medicare population. So what is  
22 an episode grouper? On the next slide, you'll see I have five bullets there that hopefully will help you  
23 understand what that is if you're not familiar already with an episode grouper. But the basic premise is that  
24 the software takes the claims data and arranges it in such a way using algorithms to capture episodes of care  
25 for specific patients over time. If it's an acute episode, that episode of care will be time limited. If it's  
26 chronic, then we'd have to define a period time, whether that would be one year or two years. And then it  
27 uses all of the claims data, the coding data on the claims, to capture the relevant procedures, office visits,  
28 inpatient services, lab, pharmaceutical, other ancillaries and put those into a meaningful episode of care.

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1 And so again, you see we're moving from something simpler that didn't work to something more complex  
2 with more context around it. So just to give, for those of you who are more visual like I am, this is a visual  
3 example of how an episode grouper actually works. Starts with an initiating event. You'll see the third  
4 triangle from the left is the initiating event, which in this case is an office visit. It could be a procedure.  
5 Interestingly you also see some other, or I should say importantly you see some other triangles there that  
6 are either office visits or procedures that don't group to this episode. And so you see that there can be  
7 multiple episodes going on at any point in time and those would be grouping to another episode. And the  
8 point there being some events are not part of this particular episode. So from the initiating event, you have  
9 a look back period, where an algorithm could captures some ancillary services or drugs that are pertinent to  
10 that particular condition or that episode, and then at the end over on the right, you have a clean period,  
11 during which there are no more applicable services to that episode. So all of the things including that drug  
12 script there, all of the things that are relevant by the way that the grouper defines relevant, are grouped to  
13 that particular episode. OK, So I'd be happy to take questions about how this works after. But since I'm  
14 sure some of you are familiar with this at least, I'll go ahead and move on to the last couple of slides.

15 So what are some of the issues that we need to address to make the groupers as effective as  
16 possible? First of all, we need to make sure that as little claims data as possible is lost; that the algorithms  
17 in the group are sophisticated enough to capture all of the things that are appropriate to that episode. We  
18 need to risk adjust the information if we're going to be comparing physician to physician, just as we've  
19 been talking about for the other phases of the project. And there are actually tools that the vendors of these  
20 episode groupers have that will do the risk adjustment. We need to figure out how to do attribution. There  
21 are a number of methodologies out there. None of them are fully satisfactory, whether they depend on the  
22 largest number of visits, or the largest number of charges, or the preponderance of different procedures,  
23 there are various mechanisms for that attribution, but again, all of them have potential problems associated  
24 with them. And then last, we need to make sure that for the episode grouper to be robust, just as in any  
25 other measurement, we need to make sure that we have enough data and information to avoid the small in  
26 problem.

27 So what is the process that we have going on for, now that you understand a lot about what the  
28 groupers do, what's our process for evaluating them? Well, we have an evaluation contractor who's looking

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1 at the software features; looking at the methodology that the software uses from both an IT perspective as  
2 well as clinical perspective, looking at their risk adjustment products that go along with their groupers, and  
3 how they do attribution and how they would recommend doing attribution, and then how this all gets  
4 captured in terms of a meaningful and actionable profile for the physician who would be receiving the  
5 report. We're going to be looking at for the software products that I have listed below we're going to be  
6 looking at 100% of Medicare claims for six conditions in four market areas and we're beginning with two  
7 products called Episode Treatment Groups, [inaudible], and Medstet Episode Groups, or MEGs for  
8 Medstate, and we're trying to get a third vendor into our study as well, and we expect the final report will  
9 be due out at the end of October. One thing to point out that's different than some of the other episode  
10 group re-evaluations that I mentioned that are going on in the private sector right now is that we're going to  
11 be also doing a thorough analysis of the soundness of the clinical logic used for these products. We're  
12 going to be actually and we haven't decide how we're going to be doing this, but we are going to be using  
13 groups of physicians to actually sit down with the algorithms for a particular grouper and look at a set of  
14 claims and how that grouper put those claims into episodes and to say does that make sense or not? Should  
15 that particular ancillary service have grouped to another episode or was it appropriate to group to this  
16 episode? We need to understand the clinical logic as well as just understand how the software works form  
17 more of an IT perspective.

18 So just to quickly recap, our goal in the episode group re-evaluation as that next more  
19 sophisticated building block for cost of care measures is to end up with something that's meaningful,  
20 actionable, and fair to the physicians being measured, and then ultimately, when we have accomplished that  
21 to understand how to link that to the quality of care measures so that we're working under the quality of  
22 care umbrella so that we can, that we're not measuring cost of care in a vacuum. So that's the presentation.  
23 I'd be happy to take questions.

24 Dr. Senagore: Thank you. Unfortunately, we're going to have to pass on that. We have to make  
25 our new councilmembers legal here so we'll have to break here.

26 Dr. Valuck: Well, I'll just quickly point out, my contact information is here, and just as after my  
27 last presentation, I had a number of you contact me, feel free to give me a call and I'll be happy to talk with  
28 you about any questions you have.

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1 Dr. Senagore: Thank you, Dr. Valuck. At this time, CMS will conduct the swearing in of our four  
2 new Council members, Dr. Tye Ouzounian, Dr. Vincent Bufalino, Dr. Karen Williams, and Dr. Jeffrey  
3 Ross. To provide over the swearing in is the Deputy Secretary of Health & Human Services, Mr. Alex  
4 Azar. Please welcome Mr. Azar. Mr. Secretary.

5 Swearing In of New Council Members

6 Mr. Azar: Thank you very much for being here today. I'd like to extend on behalf of Secretary  
7 Leavitt, who, the only reason that he's not here is that he's at the World Health Assembly Meeting in  
8 Geneva. Otherwise, he would have been here personally to welcome you. So this meeting of the Practicing  
9 Physicians Advisory Council, I'm very familiar with Practicing Physicians Advisory Councils because I  
10 come from a medical family and my father's a practicing ophthalmologist in Maryland, so every  
11 Thanksgiving dinner for me is a Practicing Physicians Advisory Council. [laughter] On everything that we  
12 ought to be doing better, usually involves three little initials. S. G. R. Seems to come up a lot. I don't know  
13 why. But this is a critical time for anyone who is engaged in health policy. It really is a historic moment.  
14 That's why I've stayed here for as long as I have at HHS in the two positions that I've had. It's a unique  
15 opportunity that you have to improve the lives of our Medicare beneficiaries and improve the functioning  
16 of the Medicare and advise us in ways that will improve the functioning of the Medicare program that will  
17 help it stand on a sound financial footing for the future, but be a good effective business partner with the  
18 providers that we work with our beneficiaries, and to ensure that new technologies and innovation are  
19 constantly put into the system and the Secretary and I and Mark McClellan and others here very much  
20 expect to rely on your advice as we have in the past. The nature of the changes in our healthcare system  
21 that we're looking at are truly revolutionary. You've seen a couple of them already with the Medicare  
22 Program, with the Medicare Modernization Act, and the enhancements to the Medicare Advantage program  
23 offering more choices, cost savings, more preventive benefits to beneficiaries and hopefully also by having  
24 some competition, improving how we perform on the Fee for Service side of the fence. And then the Part D  
25 benefit which of course has been underway since January 1<sup>st</sup>, where we're seeing seniors having now  
26 access to the prescription drugs with historic savings for them on average, I think it's over \$1,000 in  
27 savings for senior citizens and this is of course for you as practicing physicians a critical preventive benefit  
28 that many seniors now have access to for the first time or have access to at greatly reduced cost. We also

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1 are trying to do some things that go to the core of our healthcare system even beyond Medicare that I think  
2 are very important for you all to keep in mind as you advise us on our Medicare system, because it is all  
3 related. The Medicare system does not operate in a vacuum and is such a dominant player in the health  
4 industry. Our initiative to improve transparency in the healthcare system so that patients can know what  
5 they're buying so that there can be better information about the quality of services that they're receiving.  
6 I'm sure that you all, even as doctors, have gone through the experience of going to a hospital emergency  
7 room or scheduling elective surgery and just trying to get a price for what will this cost me, and going  
8 through the frustration that I have and countless thousands of others have gone through. And we want to try  
9 to improve that where individuals have the ability to know what services will cost and so that we can have  
10 a way of deciding where high quality practitioners are. Now, that brings with it a countervailing issue,  
11 which is we have to make sure that quality measures are good measures; that they measure the right things,  
12 because if you set incentives up, you can lead, if you set them up in the wrong way, you can lead to bad  
13 outcomes, because you will lead to behaviors. And so we've got to be very careful and figure out these  
14 quality measures, but transparency is going to be a benchmark of our system in the future. We also are  
15 trying to fix some of the distortions in our health insurance system. We have a health insurance system that  
16 was created largely out of the World War II wage and price controls, as employer sponsored insurance that  
17 was off the books compensation to people that wouldn't count against wage controls and that has led to  
18 certain anomalies and that employers and the tax code subsidize the health insurance purchase and as an  
19 economist once says, what you subsidize, you get more of. And so we end up with a lot of close to first  
20 dollar health insurance coverage which has some fairly obvious incentives in terms of purchasing behavior  
21 by the healthcare consumer who doesn't internalize the full cost of their purchasing decisions. So what they  
22 end up having through health insurance in America is two things: One is health insurance for the  
23 nonrecurring unpredictable health expenditures and the other is prepaid health care. And we're trying to  
24 figure out ways in which we can level the playing field in our health insurance market that will allow  
25 opportunities for insurance vehicles that will create better incentives to be smart personal consumers of  
26 their own healthcare. And one of those vehicles is the health savings account vehicle which has a large  
27 deductible, lower premium, large deductible policy that has a true insurance element but that causes  
28 individuals even if the money that goes into the health savings account itself that they would spend doesn't

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1 come from them, even if their employer puts the money into that. When they go see the doctor, when they  
2 go to the hospital, they write the check. They're writing a check out of money that is theirs and so they'll  
3 become more price sensitive, cost-effective consumers of their own healthcare than if it's simply a third  
4 party health insurance company, the bulk of whose premiums are being paid by another party like their  
5 employer. So we're trying to experiment with a lot of different things in our health insurance and health  
6 care system today to try to improve the incentives because we are all very concerned about the increasing  
7 cost in our system, but we also want to make sure that we remain the finest quality healthcare system in the  
8 world, that our people have access to the most recent modern innovations and technologies and practice  
9 care of medicine. We also are working towards, as Dr. McClellan I'm sure will mention when he sees you,  
10 moving toward Pay for Performance. So we're not just talking about transparency on quality but making  
11 sure that our own payment systems reward quality. But again, the devil is in the details of what the right  
12 measures are and how we come up with the good outcomes but that is definitely a pathway that we're  
13 moving forward on and I'm sure that we will be seeking and be getting your advice on the Pay for  
14 Performance initiative and then another area that you need to be mindful of because Secretary Leavitt really  
15 sees it as the centerpiece of all healthcare system reform that we're engaged in is health IT; that the move  
16 to a portable, interoperable, electronic medical record for individuals that he is driving toward that and  
17 that's going to be a centerpiece of any type of reform that we're engaged in and of course the question has  
18 been raised. We raised it in our inpatient PPS Notice of Proposed Rulemaking and are raising it in other  
19 rulemakings is what should be the relationship of our payment systems to health IT adoption and  
20 standardization and inter-operability of those records. So I encourage all of you to be focused on these  
21 issues; the broad issues, and to help us because we need to get your advice from the level of actually  
22 practicing physicians to make sure that we are responsive, that we are running our payment systems,  
23 running our programs in ways that reflect reality, reflect the reality of the doctor-patient relationship, the  
24 business concerns, the health concerns that happen there. So thank you all very much for your service.  
25 These advisories committees like this are a tremendous commitment of your time. It's a very important  
26 avenue of public service to your fellow doctors, to your fellow citizens, to the beneficiaries that we all  
27 serve and so I really appreciate what you're doing here today in the time ahead, and Secretary Leavitt also  
28 appreciates that and we very much will value the advice that you have to give us. At this point, we will

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1 move to the swearing in of our four new members. So if I could ask the four new members of the PPAC to  
2 come over by the flags here and we'll go through one-by-one the administration of the oath of office to join  
3 officially the PPAC.

4 Dr. Simon: Those new members are Drs. Bufalino, Dr. Williams, Dr. Ross, and Dr. Ouzounian.

5 Mr. Azar: And for anyone that would like to use it, I believe we have a Bible floating about here  
6 somewhere. Is that correct? There. OK. Dr. Williams? If you would care to put your left hand on the Bible  
7 and your right hand in the air and repeat after me. I, state your name,

8 Dr. Williams: I, Karen Williams,

9 Mr. Azar: Do solemnly swear,

10 Dr. Williams: Do solemnly swear,

11 Mr. Azar: That I will support and defend

12 Dr. Williams: That I will support and defend

13 Mr. Azar: The Constitution of the United States,

14 Dr. Williams: The Constitution of the United States

15 Mr. Azar: Against all enemies, foreign and domestic,

16 Dr. Williams: Against all enemies, foreign and domestic,

17 Mr. Azar: That I will bear true faith and allegiance to the same,

18 Dr. Williams: That I will bear true faith and allegiance to the same,

19 Mr. Azar: That I take this obligation freely,

20 Dr. Williams: That I take this obligation freely,

21 Mr. Azar: Without any mental reservation,

22 Dr. Williams: Without any mental reservation,

23 Mr. Azar: Or purpose of evasion.

24 Dr. Williams: Or purpose of evasion.

25 Mr. Azar: And that I will well and faithfully discharge

26 Dr. Williams: And that I will well and faithfully discharged

27 Mr. Azar: The duties of the office,

28 Dr. Williams: The duties of the office,

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1 Mr. Azar: On which I am about to enter.  
2 Dr. Williams: On which I am about to enter,  
3 Mr. Azar: So help me God.  
4 Dr. Williams: So help me God.  
5 Mr. Azar: Congratulations.  
6 Dr. Williams. Thank you.  
7 Mr. Azar: Who would like to go next? OK, I state your name.  
8 Dr. Ouzounian: I Tye Ouzounian  
9 Mr. Azar: Do solemnly swear,  
10 Dr. Ouzounian: Do solemnly swear,  
11 Mr. Azar: That I will support and defend the Constitution of the United States  
12 Dr. Ouzounian: That I will support and defend the Constitution of the United States  
13 Mr. Azar: Against all enemies, foreign and domestic,  
14 Dr. Ouzounian: Against all enemies, foreign and domestic,  
15 Mr. Azar: That I will bear true faith and allegiance to the same,  
16 Dr. Ouzounian: That I will bear true faith and allegiance to the same,  
17 Mr. Azar: That I take this obligation freely,  
18 Dr. Ouzounian: That I take this obligation freely,  
19 Mr. Azar: Without any mental reservation, or purpose of evasion,  
20 Dr. Ouzounian: Without any mental reservation or purpose of evasion  
21 Mr. Azar: And that I will well and faithfully discharge  
22 Dr. Ouzounian: And that I will well and faithfully discharge  
23 Mr. Azar: The duties of the office,  
24 Dr. Ouzounian: The duties of the office,  
25 Mr. Azar: On which I am about to enter.  
26 Dr. Ouzounian: On which I am about to enter,  
27 Mr. Azar: So help me God.  
28 Dr. Ouzounian: So help me God.

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1 Mr. Azar: Congratulations.  
2 Dr. Ouzounian. Thank you.  
3 Mr. Azar: I state your name.  
4 Dr. Ross: I Jeffrey Ross.  
5 Mr. Azar: Do solemnly swear,  
6 Dr. Ross: Do solemnly swear,  
7 Mr. Azar: That I will support and defend the Constitution of the United States  
8 Dr. Ross: That I will support and defend the Constitution of the United States  
9 Mr. Azar: Against all enemies, foreign and domestic,  
10 Dr. Ross: Against all enemies, foreign and domestic,  
11 Mr. Azar: That I will bear true faith and allegiance to the same,  
12 Dr. Ross: That I will bear true faith and allegiance to the same,  
13 Mr. Azar: That I take this obligation freely,  
14 Dr. Ross: That I take this obligation freely,  
15 Mr. Azar: Without any mental reservation, or purpose of evasion,  
16 Dr. Ross: Without any mental reservation or purpose of evasion  
17 Mr. Azar: And that I will well and faithfully discharge  
18 Dr. Ross: And that I will well faithfully discharge  
19 Mr. Azar: The duties of the office,  
20 Dr. Ross: The duties of the office,  
21 Mr. Azar: On which I am about to enter.  
22 Dr. Ross: Of which I am about to enter,  
23 Mr. Azar: So help me God.  
24 Dr. Ross: So help me God.  
25 Mr. Azar: Congratulations.  
26 Dr. Ross: Thank you very much.  
27 [chat]  
28 Mr. Azar: I, state your name.

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1 Dr. Bufalino: I, Vince Bufalino,  
2 Mr. Azar: Do solemnly swear,  
3 Dr. Bufalino: Do solemnly swear,  
4 Mr. Azar: That I will support and defend the Constitution of the United States  
5 Dr. Bufalino: That I will support and defend the Constitution of the United States  
6 Mr. Azar: That I will, that I will bear true, I'm sorry, Against all enemies, foreign and domestic,  
7 Dr. Bufalino: That I will bear truth against all enemies, foreign and domestic,  
8 Mr. Azar: I'm sorry, let me start over again, I made a mistake. [laughter] I, state your name.  
9 Dr. Bufalino: I, Vince Bufalino.  
10 Mr. Azar: Do solemnly swear,  
11 Dr. Bufalino: Do solemnly swear,  
12 Mr. Azar: That I will support and defend the Constitution of the United States  
13 Dr. Bufalino: That I will support and defend the Constitution of the United States  
14 Mr. Azar: Against all enemies, foreign and domestic,  
15 Dr. Bufalino: Against all enemies, foreign and domestic,  
16 Mr. Azar: That I will bear true faith and allegiance to the same,  
17 Dr. Bufalino: That I will bear true faith and allegiance to the same,  
18 Mr. Azar: That I take this obligation freely,  
19 Dr. Bufalino: That I take this obligation freely,  
20 Mr. Azar: Without any mental reservation, or purpose of evasion,  
21 Dr. Bufalino: Without any mental reservation or purpose of evasion  
22 Mr. Azar: And that I will well and faithfully discharge  
23 Dr. Bufalino: And that I will well and faithfully discharged  
24 Mr. Azar: The duties of the office,  
25 Dr. Bufalino: The duties of the office,  
26 Mr. Azar: On which I am about to enter.  
27 Dr. Bufalino: On which I am about to enter,  
28 Mr. Azar: So help me God.

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1 Dr. Bufalino: So help me God.

2 Mr. Azar: Congratulations.

3 Dr. Bufalino: Thank you.

4 Mr. Azar: That I will bear true faith and allegiance to the same,

5 Dr. Bufalino: That I will bear true faith and allegiance to the same,

6 Mr. Azar: That I take this obligation freely,

7 Dr. Ouzounian: That I take this obligation freely,

8 Mr. Azar: Without any mental reservation, or purpose of evasion,

9 Dr. Ouzounian: Without any mental reservation or purpose of evasion

10 Mr. Azar: And that I will well and faithfully discharge

11 Dr. Ouzounian: And that I will well and faithfully discharged

12 Mr. Azar: The duties of the office,

13 Dr. Ouzounian: The duties of the office,

14 Mr. Azar: On which I am about to enter.

15 Dr. Ouzounian: On which I am about to enter,

16 Mr. Azar: So help me God.

17 Dr. Ouzounian: So help me God.

18 Mr. Azar: Congratulations.

19 Dr. Ouzounian. Thank you.

20 Mr. Azar: You're welcome.

21 [Applause]

22 Dr. Senagore: Thank you, very much. Before we break for lunch, Dr. Valuck had to leave and that  
23 was the reason we changed the agenda, and Dr. Simon kindly offered to invite him back. I know that that  
24 was an interesting topic and one that we didn't want to give short shrift to, but we'll bring him back for the  
25 next meeting, give a synopsis and a little update, and then at that point we'll be able to ask some more  
26 questions and comment on that topic, and I believe at this point we can adjourn for lunch. Thank you.

27 Lunch

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1 Dr. Senagore: Well I think for the more chronologically advanced members of the council, our  
2 next speaker requires no specific introduction, but we'll do one anyways. Dr. Michael Rapp is a former  
3 chairperson of the PPAC and he will continue on with the discussion for the Pay for Performance with the  
4 emphasis on quality and measurement development. Dr. Rapp.

5 Pay for Performance: Update on  
6 Quality and Measurement Development

7 Dr. Rapp: Thank you. Well the last time I was here and talked with you, I was with Dr. Haywood  
8 and we talked about the Physician Voluntary Reporting program. So today I was asked to update you on  
9 some modifications we've made in that with reference to the use of CPT II Codes, so that's basically what  
10 I'm going to talk about and then I'm also going to tell you where we are in terms of the development of  
11 additional physician quality measures that might be used in an expansion or an extension of the Physician  
12 Voluntary Reporting program. So let's just review for a second quality measurement. So when we talk  
13 about quality measures, we're talking about generally speaking, coming up with a percentage of a patient  
14 population for which a desired or process or outcome is achieved. We get those quality measures from  
15 different data sources, claims data are frequently used, or administrative data, which means something that  
16 doesn't come off the claim form but could be considered administrative, for example, lab results frequently,  
17 health plans get information that way to calculate quality measures, and then what we might call clinical  
18 data or chart abstracted data which is more complicated.

19 So basically, when we use claims data for quality measurement, claims of course provide a  
20 diagnosis and a procedure code, but they don't provide sufficient clinical information to measure quality  
21 and so we do have a different codes on there, but the CPT category II codes, you know well what they are,  
22 procedural codes developed to facilitate physician reimbursement, but there's another type of code that has  
23 been developed, the CPT category II codes, and these are supplemental optional codes that the AMA has  
24 developed that are based upon nationally evidence-based performance measures and are used to track  
25 services for quality improvement and accountability. So the purpose of these category II CPT Codes is  
26 different that the ICD-Codes and different from the CPT I codes.

27 So where do the CPT II Codes come from? Again, they are AMA codes and they are specifically  
28 devised to report on the claim form clinical information. There is a performance measures advisory

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1 committee, PMEG, which is advisory to the CPT editorial panel, and the PMEG includes various experts  
2 on performance measures that you see listed there. So just in terms of the mechanics of the category II  
3 codes, they do provide a vehicle to report data that can be used to calculate measures, just technically you  
4 have some information there about their format. They have their own section in CPT. There's a schedule  
5 for release and then interestingly, four exclusions, which I'm going to show you how that works. They use  
6 modifiers. So the next slide shows the various topics the CPT II codes have been developed for, asthma,  
7 coronary artery disease, etc., that you see listed there. And here are the various CPT II codes that again  
8 have been developed, and there's an organizational structure to these. First set is composite measures. So  
9 composite means when you group together related measures, perhaps for diabetes, and add them up and  
10 perhaps have a score. Patient management, patient history, physical examination, diagnostic screening  
11 processes are results, therapeutic preventive, or other interventions and follow-up patient safety and other  
12 outcomes. So if you look at all of those, you'll quickly realize that none of those are things that are going to  
13 show up on a regular claim form. If you put down a diagnosis you won't get any of those. And if you put  
14 down a procedure, none of those will show up, so that shows you clearly what is the purpose of the CPT II  
15 code. It is to put down that information on a claim form so that it can then be collected and once it's  
16 collected, then it can be used to calculate a quality measure when those elements are pertinent to the  
17 measure, and as you can understand in measuring and assessing quality, those types of things, whether you  
18 did a certain thing in connection with taking care of the patient, did you do a history, did you do some  
19 physical exam, did you do certain other processes and so forth?

20         So just technically, again these codes are not, the codes are devised specifically to relate to a  
21 quality measure, so it's not quite like a CPT I code that's designed to tell you about a procedure. You've  
22 already got the measure and so now we try to figure out those things that have to be reported to calculate  
23 the measure; what items you need. So the CPT II code is then devised to fit with the measure. So it's not  
24 like you develop the codes and then develop the measure, it's more that you develop the measure and then  
25 you develop the CPT II code to go with it. So that's what that is. And so some examples of what a CPT II  
26 code might be are listed there, like pre-natal are visit, or for example the blood pressure, less than or equal  
27 to 140 over 90. That's a good example of CPT II code. That's not anything that would come up in a  
28 diagnosis code or a CPT I code and next is an example of asthma. There's the asthma measure, the

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1 percentage of patients age 5 to 40 with asthma who were evaluated during at least one office visit during a  
2 reported year, etc., So the CPT II code that gives you that additional information that you would not  
3 otherwise get a on claim form is that asthma symptoms were evaluated.

4         This is just to demonstrate that this is a code that goes on a claim form like any other CPT code as  
5 you see in that column with the two gray lines. When you put there, and to the extent that there's a  
6 modifier, one could put that there as well. So how does this relate to what we've been doing? As you know,  
7 at the first of the year, we initiated the Physician Voluntary Reporting program, and in that, we I think  
8 really for the first time for physicians, devised a way that physicians could report clinical data through the  
9 claims process. And just to review that for a second, we did that basically to make it easy for physicians to  
10 report information and to get physician information. Otherwise, we basically had two choices. We could  
11 have a chart abstraction be done and that's a retrospective thing that's been done through the QIO program  
12 there was a doctors office quality initiative, and that's what was done there. There was a companion  
13 program to the DOQ Office project which was DOQ IT, Doctors Office Quality, with Information  
14 Technology and that demonstrated the ability to do the same things using electronic health records, but  
15 that's not feasible for broad scale use, so we needed to have something different and so to do that, we  
16 developed internally G-Codes, which are temporary HCPCS-codes which physicians can use to report a  
17 certain clinical data. However, we also worked actively with the American Medical Association because  
18 we were aware of their use of CPT II codes, but again, back to what I mentioned before, CPT II codes are  
19 non-developed, kind of independently they tend to go with the measure, so since ours is what we used for  
20 PVRP was adapted from existing measures but they weren't exactly the same just because of the data  
21 collection device, the existing measures didn't necessarily have CPT II codes related to them. So with the  
22 cooperation of the AMA, they worked with us to help develop some CPT II codes that we could  
23 incorporate into the PVRP and that's what we have done effective April 1, we listed on our website some  
24 certain of the measures that CPT II codes would work for. I believe it was six of the sixteen we were able to  
25 use CPT II codes for and again we are actively involved with the AMA as they have their meetings. They  
26 have also modified their schedule somewhat to provide for updates for the CPT II codes that we could then  
27 incorporate. So the G-Codes and CPT II codes again are also zero reimbursement codes, so although

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1 they're on the claim form, there's no money that's attached to them, and so it just says zero. At least there's  
2 no money attached to it right now. It allows reporting through the existing Medicare claims process.

3 Here are the list of PVRP measures that the CPT II codes were able to be used for, the beta  
4 blocker on arrival with acute myocardial infarction, hemoglobin A1C, and controlling diabetes, the LDL  
5 control in diabetes, blood pressure control, ACE-ARB for LDSD, beta blocker for prior MI and pre-op beta  
6 blocker for a patient with isolated CABG. And here are the CPT codes that go with them, the beta blocker  
7 on arrival with MI, the CPT II code is beta blocker therapy prescribed. And so that's that same CPT II code  
8 for each of those while beta blocker's relevant. The ACE-ARB that the ACE-ARB was prescribed. And  
9 then we have hemoglobin A1C, control the relevant information, the level of the hemoglobin A1C and same  
10 thing for LDL, the relevant CPT II codes are the level of LDL. And the blood pressure control for type I  
11 and type II diabetes. So that's sort of basically where we are with those. I did want to mention a couple of  
12 issues of just what the use of the CPT II codes. There's an issue that you might be interested in, and that is  
13 our beta blocker is sort of an example of one that we've struggled with, physicians' organizations and  
14 discussing it a little bit. The beta blocker prescribed in the measure is different than what we have in the  
15 PVRP. What we have in the PVRP is the beta blocker was received by the patient. We had that same issue  
16 that has arisen with pre-operative antibiotic prophylactic therapy. In that case, we have in the hospital  
17 measure, the hospital SKIP measure that that comes from, it's the antibiotic was administered. The patient  
18 basically received the antibiotic. The question is whether or not, from the physician's vantage point,  
19 frequently we've been told that physicians feel that what they should be measured on is that they prescribe  
20 it or they order it. They should not be reporting on whether the patient received it. So that's caused a little  
21 bit of I would say discussion in terms of use of that code and I guess you could argue it both ways. From  
22 the physician standpoint, frequently it is well, all we do is order it. We're not responsible for where they  
23 give it and we can't be expected to check up on that.

24 ??: It depends on whether you're measuring the doctor or the hospital.

25 Dr. Rapp: It may depend also on what you feel the role of the physician is; whether the physician  
26 has any role in making sure that, or at least being aware of whether things were actually done when you're  
27 in the hospital, do you check, well, did the patient get it? Do you review the record and that sort of thing.  
28 So I'm not raising it to really necessarily come to a total resolution of it, I just want to mention that when

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1 you deal with quality measurement you do have to struggle with the issue of what is, who you're measuring  
2 and what you feel they should be responsible for. And it's just an issue and it's demonstrated a little bit by  
3 the use of these CPT II codes and you see that the code that's been identified that the beta blocker was  
4 prescribed, rather than that the patient received it.

5 At any rate I just wanted to raise that and there are a lot of other technicalities in there. Our G-  
6 Codes have, we say that in the use of the G-Codes that a person was not eligible for a measure. The way the  
7 CPT II codes work is actually, I think, a good way of how it is because they have a modifier that specifies a  
8 more carefully why it is that the patient wasn't eligible for the measure and that either there's a patient  
9 reason or a system reason and there's a third one, but, there's three reasons that the modifiers specify as to  
10 why the patient wasn't eligible for the measure. So that's the way that works and actually is a quite good  
11 system, I think. One if medical reason, two is patient reasons, or three is system reasons. So if the patient  
12 had an allergy for example, that would be the reason that the measure didn't apply. Or if there was a, well  
13 that would be a medical reason. Or a patient reason might be that they just didn't want to have it, the  
14 refused hemoglobin A1C, or system reason might be not available. So at any rate, I think that's a good  
15 system for the CPT codes and they work pretty well.

16 So let me just sort of switch gears for a second, now that I'll be happy to answer any questions  
17 about the CPT II codes and what we've done and listen to any comments that you might have, but I wanted  
18 to let you know where we are with regard to the Physician Voluntary Reporting program. There are 39  
19 specialties in medicine, as identified by the Medicare Program. They don't necessarily track the ABMS  
20 classification precisely but there are 39 different specialties, at least according the Medicare classification.  
21 And of those 39 specialties, our PVRP covered 19 of them. And with our 16 measure starter set. And you  
22 see those listed there. So the idea is that we want to have measures cover as broad a range of specialties as  
23 we possible can. And we're actively working on that. And how we're working on that is right now, we  
24 have, we're doing it several ways. For one, we have a contract with a company called Mathematica.  
25 Mathematica has a subcontract with the American Medical Association and with the National Committee for  
26 Quality Assurance, NCQA and through that process, and the AMA is basically using its physician  
27 consortium, which has been developing quality measures for quite a few years, and through that process,  
28 we have identified those specialties that you see indicated there for completion of measurement

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1 development this year. And when that's completed, what that will mean is that the top 80%, or those  
2 specialties which account for the top 80% of Part B Medicare claims will have quality measures available  
3 that could be used in the PVRP program. Actually, it'll go beyond that because a number specialties that  
4 don't fall within that 80% are the ones that are already covered by PVRP. So it includes radiology,  
5 ophthalmology, dermatology, hemo, pulmonary medicine, anesthesiology, neurology, rheumatology,  
6 endocrinology, orthopedics and gastroenterology. Endocrinology's already covered actually, through the  
7 diabetes measures. So that way we'll encompass a 28-medical specialties and we'll continue to go on from  
8 there to expand that set of measures. But the ultimate goal is of course to cover all physician specialties  
9 with quality measures and to have them more robust. The initial effort is to get them covered to some  
10 degree or another, but obviously one wants to expand the depth and scope of those measures. So that's  
11 where we are with that, that's where we are with CPT II codes, and I'll be happy to answer any questions. I  
12 did just put a general question up there whether PPAC had any advice for us in terms of additional  
13 approaches in reporting of clinical information by physicians in support of quality measurement.

14 Dr. Senagore: I suspect we will, Dr. Rapp. Thank you. Dr. Williams?

15 Dr. Williams: Similarly to the confusion around who prescribes versus whether or not a patient  
16 received a beta blocker, my understanding is that there is similar concerns around pre-operative antibiotic  
17 administration. Who prescribes it, might be the surgeon, and the type of antibiotic and whether or not it's  
18 appropriate. Who gives it might be the pre-operative nurse, might be the anesthesiologist, etc. And how to  
19 report those measures when, for instance, the anesthesia codes are different than the surgical codes and how  
20 to sort through that. Has any progress been made on how to straighten that out?

21 Dr. Rapp: Yes, we've given that job to the our contractor. [laughter] That's when I found out how  
22 we worked. No. Appropriately in this case. So the AMA physician consortium is working on this with the  
23 anesthesiologist. But yes, that is a complicated issue. The measure itself comes from our surgical care  
24 infection prevention improvement program. Surgical care improvement program and it has these measures  
25 that include prophylactic antibiotics. That's a hospital-based measure. So as a hospital-based measure, that  
26 works fine and everybody does their portion of that. When we deal with trying to attribute that to  
27 physicians, we ran in first of all to the issue of the surgeons, OK, is the surgeon responsible for just  
28 ordering it or do they have some role in making sure the people get it? But then we ran into the issue of the

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1 anesthesiologist, which I didn't fully understand at the time, which is, OK, you start, and some of you may  
2 not be aware of this, but in the hospital they have ICD codes, which are procedure codes. They're not CPT,  
3 they don't use CPT codes, they use ICD codes for procedures in hospitals, and that's where we started with  
4 with the surgical care improvement program. So what we had to do is then now translate those into CPT  
5 codes for surgeons. So we did that, but that is an art form in and of itself. After we did that, then, OK, now  
6 how do these apply to anesthesiologists, because they have a role, and low and behold we find that the  
7 anesthesiologists have procedure codes for giving anesthesia related to certain procedures, but they're  
8 lumped together and they don't track one for one what surgeons do. So any rate, that's where we got to the  
9 point where we said, you know what, this is a good for that contractor to figure this out. So we haven't got  
10 it figured out, but they're working through that process. And they did have a technical evaluation  
11 committee meeting about a month or so ago I think to go through that. It's complex, isn't it?

12 Dr. Urata: So after you collect all this information, you're going to find out if this improves things,  
13 outcomes, in the long term, that's the idea? [laughter] I mean for those who have your hemoglobin A1Cs  
14 above 9 and below 9, better outcomes?

15 Dr. Rapp: Well, the goal for hemoglobin A1C greater than 9, that's considered bad control of  
16 course, but so the goal is to well, it's really focused on the patient. So one will get information back both as  
17 to the physician's performance in connection with the patient but also in the patient, to what extent to the  
18 patients, fewer patients have hemoglobin A1Cs that are in bad control range. But the whole purpose of this,  
19 yes, is to improve quality through measurement.

20 Dr. Senagore: Just to follow up on something we were talking about at lunch. There've been three  
21 med analyses that would suggest that beta blockade for vascular and general surgical cases offers no benefit  
22 to the patient in terms of cardiac events. Yet, one of our Pay for Performance criteria is to be sure we give  
23 it. Is there going to be some criteria that will update these things and either take them off or add them as  
24 they become validated by peer review medicine?

25 Dr. Rapp: Right. All of the measures are subject to modification based upon new evidence or new  
26 look at old evidence. The ACE-ARB's an example of that. That was modified and so I think all of these  
27 things, I know all of these things are subject to modification and there's a, and so insofar as these measures  
28 for example come from the AMA through the physician consortium they have a process for that, and the

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1 National Quality Forum, the NQF, that endorses measures has a process for it. And the hospital world we  
2 have weekly calls with the joint commission to maintain our measures on the hospital side in alignment  
3 with theirs and in so doing, we have occasion to modify things as new evidence comes along and we try to  
4 do that rapidly.

5 Dr. Senagore: Any other?

6 Dr. Bufalino: Is there going to be some movement past the initial process measures towards some  
7 essential outcomes, whether we're not, we have measure and ejection fraction or teach somebody about  
8 smoking cessation, or put them on an ARB we know, are again surrogate measures, and they don't really  
9 reflect whether or not we're going to actually lengthen life, improve quality, make consequential  
10 differences in outcomes of care.

11 Dr. Rapp: Well, I think if we step back for a second. The view of the Medicare program is that not  
12 that internally we should sit here and say this is how medicine should be practiced. Our view is instead: 1)  
13 the quality measurement is important tool to improving quality. But as far as what should be done, that's up  
14 to physicians and the healthcare community in general in terms of self-identifying what constitutes quality,  
15 so for that reason, we've actively engaged with physician specialties and are encouraging the development  
16 of quality measurement. It's not CMS says this is what doctors should be doing. It's doctors telling us what  
17 they should be doing and us saying simply providing a vehicle to measure that quality and effort to improve  
18 quality of care that the Medicare beneficiaries get. So I'll sort of get it back to you—what do you think?  
19 You tell us. Help us develop the measures. CMS has done a lot of funding of quality measurement  
20 development but doesn't, we don't develop them ourselves. We've done funding of the endorsement  
21 process as well, but we don't control that process either.

22 Dr. Azocar: In the final analysis of the outcome, I guess you may consider its own variables,  
23 which may affect the outcomes, which are demographics factors which affect compliance, including  
24 ethnicity and these kinds of things? Like measuring the outcome from one area against the same outcome  
25 from another area, with different socio-economical and other characteristics may affect the result, therefore,  
26 the conclusion of payment and these kinds of things.

27 Dr. Rapp: Sure, outcome is always what you ultimately want. Process presumably the evidence  
28 indicates that if you do this, then you're likely to have another outcome, but it doesn't necessarily turn out

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1 to be that case. I do want to just mention in terms of, since you're bringing up the issue of measurement  
2 development just in general, I'll give you some examples of what we're interested in in improving quality.  
3 For example, what are the big quality goals or quality challenges we face here with regard to our healthcare  
4 system? What are the unmet needs? One of the things that the Institute of Medicine recently did with the  
5 report on performance measures was to say that one of the things that we need is to have some  
6 organizations set health care quality goals. We don't really have that yet and they made some  
7 recommendations with regard to that. But let's just think of a couple—how about hypertension?  
8 Hypertension is a basic problem that causes all kinds of other secondary consequences. But could we do  
9 more as physicians and providers in general to tackling hypertension? You heard Linda Magno today talk  
10 about the interest in care as it goes across a continuum. I was reading, for example, just yesterday about a  
11 study in emergency medicine, my specialty. OK, people come into the emergency department, we say oh,  
12 they're blood pressure's up. We take it, and what do we do about that? Well this study showed that a  
13 couple weeks later, their blood pressure was still up. We say oh your blood pressure will probably go down,  
14 but we don't really do anything to follow up on it. Could we do more? Is there a way of measuring that  
15 cross cutting? I don't know, but how about obesity? What are we doing about that? What could we do  
16 about it? Are there quality goals that we could get, we could have everybody be part of it? So we get into a  
17 lot of the technicalities of the quality measurement, but really all we're trying to do is measure something,  
18 measure steps toward reaching some goal so it comes down to identifying the goal and then figuring out  
19 how to measure our progress toward that. And I would just urge you as my fellow physicians, to try to be  
20 engaged in that as much as you can.

21 Dr. Hamilton: Thank you very much. Dr. Rapp, I want to express my appreciation and approval of  
22 what you have here that I see in terms of these quality parameters, especially for blood pressure. I think it is  
23 quite interesting that your group has decided that both systolic and diastolic pressure are important and that  
24 your levels of less than or greater than 140 and less than or greater than 80 are really very, very current.  
25 The same is true of your LDL levels, this being less than 100. That's good. That's an improvement. Some  
26 people would argue that in diabetics, it really ought to be considerably lower than that. But that's OK, 100  
27 is good. And if you can get it down to that, you're doing pretty well and that is indeed quality. But I would  
28 really take issue, and I'm speaking now on behalf of the endocrinologists in this world, and those other

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1 physicians, specialists that take care of patients with diabetes that to use the term “quality” and the term  
2 “hemoglobin A1C of greater than or less than 9” is just a nonsequitur. And you really have created so much  
3 angst on the part of the endocrinology that I cannot begin to count the number of emails that I have  
4 personally received and these are just routed not just because I happen to be on PPAC, but just in general  
5 about what this level really ought to be. The fact is that greater than or less than 9 is not a meaningful level.  
6 Everyone knows that 9 or 8.6 is better than 13 or 14. But it isn’t enough better to really be important. What  
7 it ought to be is somewhere around 7 or 6 and a half or seven and a half or so. So if you’re going to use the  
8 term “quality,” which we all want to do, the term “hemoglobin A1C of 9” is really just not an appropriate  
9 level. Now do you want to make it 6 and a half or 7, or to be liberal 7 and a half, just as a categorical  
10 statement, like you do for pressure or for LDL cholesterol? Well, maybe not, maybe not because what that  
11 would do would be to punish those physicians, those caregivers that are looking after patients that have  
12 difficult to control diabetes for whatever reason. The concern that the cardiologist expressed over whether  
13 you order the beta blocker or whether they actually get the beta blocker and the concern on the part of the  
14 surgeons about whether you order the antibiotic or whether they actually give the antibiotic is well taken.  
15 They didn’t mention is it the right antibiotic or not, but [laughter] you might consider that next time around,  
16 but with hemoglobin A1C, it’s not a matter of did you order the right treatment for the diabetes? Or did  
17 they actually get the medicine, or did they refill the medicine after month that they decided they were going  
18 to have to pay for some of this, it’s a matter of did they take the medication? Did they take it the way you  
19 prescribed it? Did they take it consistently? Not for 30 days, or 90 days, but for several years. So what  
20 you’re testing by hemoglobin A1C is not just the quality of the doc that wrote the prescription, or gave the  
21 prescription to them, even if he personally handed it to them, you’re testing the quality of a whole  
22 healthcare system, and in which patient compliance is a major component. It is by far the major component.  
23 So there is a big discrepancy between these two situations. Between all of these situations and between  
24 hemoglobin A1C, and that is what has created so much concern on the part of doctors that look after  
25 diabetic patients. Now we’ve discussed this before at previous meetings, and in continuing conversations.  
26 What is much more important than the absolute level of the hemoglobin A1C from a quality parameter, is  
27 whether that level has come down. And it would be much more meaningful to set a value—are you above  
28 or below a really meaningful quality parameter, such as say 7 or even 7 and a half since we’re going to be

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1 kind of liberal here. We're in Washington, after all. [laughter] So to say it's either above or below 7 and a  
2 half, if it's below 7 and a half, then that's fine. You're doing a great job. The patient's doing a great job.  
3 The pharmacist is doing a great job. Medicare is doing great, everybody's doing great. If it's above 7 and a  
4 half, what really counts your next question ought to be, has this value been decreased over the previous  
5 year or whatever you want to put in there—I think a year would probably be appropriate—has it been  
6 decreased by 2% points, or more? And if it has, and the value is say 8 or 8 and a half, or even 9 and a half,  
7 and you've decreased it say from 14 to 9, you've done a very good job. The patient has done a good job.  
8 They can do better but they're doing a good job. So that is a much more meaningful statistic to have as a  
9 question. Now if you're going to ask doctors to fill these forms out and if you're going to ask them to do it  
10 for nothing, which of course we are, it really needs to be meaningful if you want to get their attention.  
11 Because if you ask them meaningless questions, and then don't pay them to answer the meaningless  
12 questions [laughter] it just irritates them. So why not ask them meaningful questions? And on behalf of the  
13 endocrinologists, I would be remiss if I didn't tell you and ask, plead with you to make these questions  
14 meaningful and to make them really related to what is best for the patient and then we will share the  
15 concern of the surgeons and the anesthesiologist and the cardiologist about whether they ordered or  
16 whether they wrote or whether the patient actually filled the prescription or not, but to understand the  
17 magnitude of the interactions necessary to lower hemoglobin A1C is something that is far beyond these  
18 concerns, and it is one that you really have to be cognizant of and to address to make these things  
19 meaningful to get the data that you want and need. I say that because I just want to—it makes me feel so  
20 much better. Kind of like group therapy, you know? [laughter]

21 Dr. Rapp: I want to thank you for your positive comments on that beta blocker. No, let's go back  
22 to the CPT II codes, so just to kind of deal with—you're the expert on diabetes, so I certainly accept  
23 everything you say about that. With regard to the technicalities here, CPT II codes will not have what  
24 you're asking for to be collected. What you're asking for to be collected is the value of if you're going to  
25 measure what you've talked about measuring, what we would get in would be what is the value? We'd ask  
26 the physician to report what is the value of this hemoglobin A1C on that patient? Because what we have to  
27 do is figure out what the value was one time and what the value is the next time, so with that we'd be able  
28 to calculate it. That's not a CPT II code, though.

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1 Dr. Hamilton: I understand that and the way you word these questions here, these are all either yes  
2 or no—most recent hemoglobin A1C is greater than 9. That’s either yes it is or no it isn’t. Well, the same  
3 could be done, say if it were say instead of 9, say 7 and a half. That’s either yes or no. That would be  
4 meaningful. The next question would be if the hemoglobin A1C is greater than 7 and a half, has it be  
5 decreased by 2 percentage points over the past 12 months? That’s either yes or no. So basically the  
6 questions could be designed to give you the same format as you have here, except they would be related to  
7 actual—

8 Dr. Rapp: Although the easier way is just to have the value and then we can figure out.

9 Dr. Hamilton: You could, I would agree, there’s no place on the form to write in well this patients  
10 was 13 and now it’s 10.

11 Dr. Rapp: No I’m not saying we can’t figure out a way to do it. It’s just that the CPT II codes  
12 don’t work that way. But then the other thing is what’s the right measure? So then the reason that the  
13 measures tend frequently to be the way they are is because there are measure developers, and the measure  
14 developers develop measures and then they go through these processes where you have—see the process of  
15 measurement development in terms of the government using them is they go through a widespread public  
16 comment and so forth, so for the AMA for example, they put their measures out for public comment. The  
17 NCQA does. When they go through NQF. All that goes for public comment. I will, the hemoglobin A1C—  
18 it’s not meant that 9 is good, less than 9 is good, it’s over 9 is bad. In terms of the measurement, but with  
19 regard to the 7, NCQA, who is an active measurement development, recently I was at their CPM meeting a  
20 couple of weeks ago, and the measure for hemoglobin A1C less than 7 went through that process. So I  
21 think, and that’s been out for public comment. So I think what you’re going to see is there will be a  
22 measure available for us to use, which will be hemoglobin A1C less than 7, so it sounds like that would  
23 be—and once it gets through the right processes it’s available for us to use. As opposed again, we’re not in  
24 the business of setting up the standards. We are just taking the standards that are given to us. And as far as  
25 the measurements, they go through a process that would pass muster, as opposed to us going to this doctor  
26 said we should do that. We can’t do that. But we do have the hemoglobin A1C less than 7, which will be  
27 available to us as a measure, and I think with regard to again at this same meeting, there were people that  
28 advocated what I think would suit what you want, or are suggesting, which is actually measure the amount.

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1 Like measure somebody's weight, or measure somebody's blood pressure, then you can check trends, like  
2 you're talking about and you can get overall information for the population. It's a lot more informative to  
3 see the for example the hemoglobin A1C, what's happening overall and you get that from the raw data as  
4 opposed to a range or a yes, no thing like you mentioned.

5 Dr. Senagore: Is there a place on each of the forms for the medications to answer those three  
6 questions? For each of the medications? Will it be asked whether beta blocker or antibiotic, is there a way  
7 on the form for each one of those things to say not medically indicated, or what the other two choices were?

8 Dr. Rapp: Yes, what happens is the modifier can do that for you using the CPT II codes.

9 Dr. Senagore: That can be used for any one of the medication questions?

10 Dr. Rapp: Yes, for the beta blocker, and for the—

11 Dr. Hamilton: Excuse me, before we completely leave this issue, I'm pleased that they are  
12 accepting this figure of 7, because the scientific evidence is very clear that the lower the hemoglobin A1C,  
13 the more likely you are to have a risk profile similar to the nondiabetic patient. What constitutes quality,  
14 what constitutes the goal you should strive for is a very complex matter of a lot of clinical judgment  
15 because the lower you want the target, the more likely you are to produce hypoglycemia and to have other  
16 problems and to order a diet that a person can't possibly live on. So there are lots of difficulties with doing  
17 that. A figure of 7 is an ideal figure. Now does ideal and quality equate? Are they the same? Probably not. I  
18 mean ideal is ideal. Quality means you're really doing a good job and trying hard. Everyone would agree  
19 that 9 is neither one. Nine is somewhere out in left field. So but to say that you have to have an ideal  
20 hemoglobin A1C as your goal and if you don't, you're not up to speed, not only is discouraging to the  
21 doctor, which is not too important, it's real discouraging to the patient, and what it does if you punish the  
22 doctor for not being ideal, it means that he's going to want to take care of some of these folks that simply,  
23 no matter what you do, can't possibly get there.

24 Dr. Rapp: So you think that you're arguing I believe for one thing—you should have the modifier  
25 available to be used, that there's a patient reason, or some—

26 Dr. Hamilton: That is a possible alternative.

27 Dr. Rapp: That would be one thing and another thing would be to connect up the absolute value  
28 and trend with any target like this.

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1 Dr. Hamilton: I think the trend would be a better indication of how good a job the doc's doing.  
2 The absolute figure is one that would put all of this together and would be nice, but it will tend to  
3 discourage the doctors from taking care of the difficult to control patient and it just doesn't necessarily give  
4 you the same type of information as some of these other parameters do. What I suggest, to me, the best way  
5 to do it is to have a figure as an absolute figure that is good, maybe not ideal, but it's certainly better than  
6 some of these others, and to have a change in the level which indicates that you're really working hard to  
7 make this patient get better. So that's the way I would deal with the problem. Doesn't mean that's the only  
8 way to deal with it, but it's a way.

9 Dr. Rapp: But your comments are very helpful. Thank you.

10 Dr. Ouzounian: Well, I'm not nearly as entertaining or articulate as Dr. Hamilton [laughter] but a  
11 couple of issues, part of which you talked about. I'm concerned that you're looking at two things. One is a  
12 physician measure of quality and one is an outcome measure of quality. I measure or I order antibiotics.  
13 And you know my job is to order the antibiotics. And looking the hemoglobin A1C, not only does the  
14 physician have to make recommendations, but then there's a whole response issue, patient compliance,  
15 which the physician really has not control over, and I think that's a different measure. You're measuring  
16 the physician's quality of care—did the physician do what he was supposed to do? Whether the patient  
17 complied with that I think is a different issue and that's not necessarily the physician's responsibility. We  
18 have an obligation to order the beta blockers before the surgery, order the antibiotics before the surgery and  
19 I think that's what you ought to be looking at.

20 The other, or greater concern that I have is it sounds to me like you're collecting a huge amount of  
21 information, you're asking the physician community to invest in information technology and report that to  
22 you, and I think I probably slept through it, but I didn't hear what we were going to get reimbursed for all  
23 that. And unless there's going to be some incentive at the other end, how are we going to be incentivized to  
24 give you that information?

25 Dr. Rapp: Well, with regard to the PVRP, there, first of all, it's voluntary. It's not something that  
26 anyone is required to do. It's a voluntary program and right now there's no money attached to it, as you  
27 say. In so far as there would be money attached to it, that would likely be Congress's decision. The way  
28 that things worked for the hospitals, it did start off as a voluntary program. It still is voluntary. There were

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1 incentives placed in the Medicare Modernization Act, 0.4% different market basket update for hospitals if  
2 they reported 10 quality measures. Before the incentive, there were 400 hospitals that reported. After the  
3 incentive there were 4,000 hospitals that reported. With the Deficit Reduction Act, that was increased to  
4 2% and CMS was given the authority to expand the quality measures whereas in the Medicare  
5 Modernization Act, there were 10 measures specified. So at this point, it is just like hospitals, still  
6 voluntary, there is no incentive for physicians, whether or not Congress will follow the model that it used  
7 for hospitals I don't know, but that's a possible model. In so far as physicians engage in helping develop  
8 the quality measures and in so far as they become familiar in how this process works, it may benefit them.  
9 It certainly will help CMS in terms of our having the feedback to make the system work better. So those are  
10 to a certain extent advantages for participating. We do encourage physicians to do that. And quite a few  
11 have chosen to do so, and quite a few haven't.

12 Dr. Senagore: Any other comments or questions? Dr. Ross?

13 Dr. Ross: Well, everybody if they talk long enough, they'll mention all the points that I had. I  
14 started with trends, knowing values, simplifying, compliance was definitely one point because if they're not  
15 complying, we're not going to get the values, we're not going to get the outcomes that we're looking for.  
16 But what about continuity? If I'm treating a patient for a certain amount of time with a problem, and then  
17 that patient moves on to another physician, i.e., I'm treating them let's say for a foot ulcer, they've got  
18 complications and then they're moving on to a wound care center. How can we value that trend or that  
19 outcome or what's happening to that individual patient? Let's say Dr. Hamilton's been treating this patient  
20 for a year and has them down to let's say one percentage point on their hemoglobin A1C, but then, due to  
21 insurance reasons, they shift insurance companies, or whatever the provider reasons, they go to another  
22 physician and that physician may not be as lucky to bring that hemoglobin A1C down. Whether it's the  
23 cardiologist, or whatever its specialty is, continuity has a lot to do with how we treat our patients and what  
24 their outcomes are going to be like. But I'll echo what Dr. Ouzounian said. As far as simplifying, if we  
25 can't simplify it, make it easy. Who's really going to spend the time to do all this investigation and to come  
26 up with this data or information for you?

27 Dr. Rapp: Well, I think what I heard primarily is that you're arguing in favor of continuity of care,  
28 as patients go from physician to physician. We talked early today about how many physicians patients see.

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1 We talked about efficiency of care. And there's some evidence that more physicians have patients see, the  
2 less efficient their care is. So we are struggling with how to measure the continuity of care and I think if  
3 you have some ideas on how best to do that, they'd certainly be welcome, but it is an important issue.

4 Dr. Ross: I would, definitely.

5 Dr. Williams: I was almost going to say exactly what you said, but to put a further twist in it,  
6 again, with the anesthesia codes being so different, my friendly endocrinologist controls the diabetes, and  
7 then the patient comes to the operating room. How do I report that code in a similar vein to continue the  
8 continuity that there's a different code system that we use? So I think I'm saying the same thing I said  
9 earlier.

10 Dr. Rapp: Well back to the kind of the hospital issue with the antibiotic prophylactics—another  
11 approach to it may be just to continue to measure it at the hospital level but to attribute achieving the  
12 process to the various parties involved, for example, they either got the antibiotic or they didn't. If they did,  
13 then everybody gets a little credit there, and if they didn't everybody gets some discredit. So that would be  
14 another way to approach the same thing. Certainly if the person didn't get the antibiotic an hour in advance  
15 of the incision, then the surgeon gets a ding, the anesthesiologist does, the hospital does, and whoever else  
16 you can find having anything to do with that patient. So that might be another way of approaching it. Now  
17 what we're doing here is really kind of the same thing, saying still it's the outcome that counts. It's did they  
18 get the antibiotic, and not going along with the idea that everybody can kind of separate it. So everybody  
19 said, you know what, everybody did great with that patient. The only thing is, the patient didn't do so well,  
20 because they didn't actually get it. That's what we don't want to have. And we run into that a little bit in  
21 medicine because we want to be responsible only for our own little area, naturally. That's just normal. But  
22 that's the way our [inaudible]-based system makes us behave to a certain extent. So as far as measuring  
23 quality, that doesn't really work that way.

24 Dr. Williams: So if there ends up being payback to the hospital for a successful job, assuming  
25 everything falls out properly is there then a way for you to mandate part of that payment? Come back to the  
26 people who actually executed what was—

27 Dr. Rapp: Well, this is beyond my pay grade [laughter] but just since you asked the question, I'll  
28 say this. First of all there is the gain sharing demonstration that would kind of, there would be some

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1 impediments to that currently, but with gain sharing that might be allowed. Secondly, there is the example  
2 with the emergency care and CMS did find a way of funneling money through hospitals that go to  
3 emergency physicians that take care of undocumented immigrants. So that's the second thing. The third  
4 thing is it doesn't necessarily mean that the money has to go through the hospital. You can give a physician  
5 credit for a patient's getting something that happens in the hospital, but they can still be reimbursed through  
6 their normal system, which is through however they get paid through Part B. So it doesn't necessarily mean  
7 money has to get funneled, but again that's well beyond my role in incorporating CPT II codes into these  
8 quality measures.

9 Dr. Senagore: Thank you, Dr. Rapp. I think with that segue, I think Ms. Magno was able to come  
10 back and discuss the demonstration project. So maybe we can ask her if that's the way to get paid.  
11 [laughter].

12 Dr. Rapp: Thank you.

13 Dr. Senagore: Thank you. So I guess just to refresh everyone's memories, were there any issues  
14 regarding the—or do you have any additional comments for us? Or are you just ready to entertain  
15 questions?

16 Disease Management—Additional Discussion

17 Ms. Magno: I think I covered everything, so it's really a matter of just discussion on your part,  
18 questions, comments, suggestions. I'm here to listen.

19 Dr. Senagore: This is regarding the demonstration projects in that presentation.

20 Dr. Azocar: I want to join Dr. Williams and Dr. Hamilton in congratulating you on your very  
21 comprehensive presentation. One of the strong components in your program was about prevention, which is  
22 basically location. And I wasn't sure about the coverage for that from the point of view of payment for the  
23 provider, to locational prevention—is that what we're talking about same chronic disease management?

24 Ms. Magno: Right. Now we pay for a number of preventive services, and we do pay for a  
25 comprehensive Welcome to Medicare visit for newly enrolled Medicare beneficiaries within the first six  
26 months of their time under Medicare. We don't make explicit additional payments to physicians over and  
27 above the E&M codes for patient education or for care coordination and in fact that was one of the  
28 questions that we had posed, is this whole question of coordination of care, what the role, in this case

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1 coordination of care, but it could apply equally to some of the other types of services that are provided  
2 under the sort of rubric of disease management, patient education, patient self-care, support, family  
3 member, other caregiver education, care coordination, case management, all of these raise the same  
4 question, namely, whom should Medicare pay for these services? Right now in the demonstrations that I  
5 talked about they're being paid for either out of shared savings, the organizations [inaudible] and the  
6 physician group practice demonstration, physician group practices are re-tooling and basically  
7 reconfiguring, redesigning the way in which they deliver care and care processes. And then, to the extent  
8 that there's a pay-off by undertaking all of these activities, then they will share in the savings with  
9 Medicare as a result of generating those savings. In the case of the care management for high-cost  
10 beneficiaries, or the coordinated care demonstration, we are making additional payments to the  
11 demonstration sites, to either the groups, the group practices, the physician groups, the outside vendors, or  
12 the other demonstration sites that were listed. Those are in addition to regular payments that we're making  
13 for Part B services under Medicare. Now the services, those payments, not in the Coordinated Care  
14 demonstration, but in the more recent demonstration, those payments to those organizations are at risk;  
15 those fees are at risk. So to the extent that those fees and those services don't yield savings sufficient to  
16 offset the costs, then Medicare can go back and recoup those additional payments. And this essentially goes  
17 to the heart of everybody who comes in and proposes one or another type of demonstration. We're  
18 changing Medicare says if you spend money here, you'll save money there and it's easy to spend money  
19 hear and it's always harder to save money there, and increasingly we're being pushed to go back and look  
20 at measure and reconcile whether or not we got those savings and if not to recoup the payments, the  
21 investment that we made that didn't pay off in those savings.

22 Dr. Bufalino: A question on your thoughts on how you're going to deal with the attribution issue  
23 of whether I control the LDLs at cardiologist department, a care doctor controls the LDL, the  
24 endocrinologist controls the LDL. The [inaudible]vascular specialist controls the LDL. How do you give,  
25 decide who gets credit in this world and how are you going to balance that?

26 Ms. Magno: Well, what we're doing in the Physician Group Practice demonstration is we do have  
27 a fairly elaborate attribution model. But these are very large group practices and we assign patients to the  
28 group practice based on whether or not they receive the plurality of their ambulatory E&M care from the

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1 practice. So that and the goal is to get at patients that the practice has a reasonable degree of being able to  
2 coordinate the care, the ambulatory care, the chronic care for patients in the multi-specialty setting. And the  
3 question I'm posing really to you is how do you do that? And that was one of the questions that I raised as  
4 well and it was interesting to hear some of your discussion just now with Dr. Rapp. What are appropriate  
5 ways to do that? Anything one does is an attribution level, and one can say as long as the patient got the  
6 right care, anyone who touched the patient gets credit. But in the absence of information about by one  
7 physician about who else touched the patient, you run the risk of everybody doing the same thing to the  
8 same patient until the patient grabs his arm back and says no more hemoglobin A1C test thank you very  
9 much. So the question becomes sort of how do you get at a model that works in a reasonable way without  
10 encouraging over use of services in the name of getting the right services done in the right amount of time,  
11 and I'd be interested to hear what people have to say about that.

12 Dr. Senagore: I'd just like to follow up on that concept. I think that is one of the issues here is that  
13 it's very easy to measure us. The reality is the patient is somewhat culpable in that, in that if I'm going to  
14 see my cardiologist and my endocrinologist and my primary care doctor at what point wouldn't it be good  
15 to say, you know, Dr. Bufalino just did this thing two days ago. Can't we get the results somehow? And I  
16 wonder if I know you're doing that in a demonstration projects, but what you're almost forcing the issue  
17 towards is the only delivery system that will work is going to be all of your care needs to be within one  
18 large multi-specialty group. And you have to choose your multi-specialty group, which is a different way  
19 than we delivery medicine today. So one of the things that we are actually talking about at lunch is, is  
20 Medicare missing an opportunity with this semi-mandatory initial visit, as you enter Medicare to use that as  
21 a way to capture initial data, give somebody an ID card with their key information on it, so there's a  
22 starting point. Now when you start with Medicare, you know I've had these prior surgeries, I have this  
23 chronic illness. Here's what my medications are. Be able to track the patient through that and so they are  
24 part of the process as well.

25 Ms. Magno: That would be that magnetic card that I've heard talk about from Medicare that I've  
26 heard talk about since my first stint here in the late '70s through the '80s. [laughter] But it's a really good  
27 idea, and I ruled the world, I would have done that a while ago.

28 Dr. Senagore: We'd vote for you.

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1 Ms. Magno: But actually that also goes to the issue of health information technology more broadly  
2 and whether or not we ought to be doing more to facilitate electronic patient records that are comprehensive  
3 in that all the practitioners who touch a particular patient have access to. Where I think the question is to  
4 how much transparency anyone wants, physicians and patients both. But it certainly does get at this same  
5 issue that rather than relying on patient memories, you could ask my mother if something was done and  
6 she'd tell you, well I had blood work, and that's probably what most of our beneficiaries would answer as  
7 they moved from one physician to another. But not necessarily known—

8 Dr. Senagore: I hate to invoke one agency that folks probably like even a little less, which would  
9 be the IRS, but you only get one standard set of forms on which to do your paperwork, and you can choose  
10 to do it on a different form, but you probably won't be met with much success. And I think that's the  
11 problem, even at a single institution level, because we're struggling with it. How do we get a physician  
12 electronic medical record that will have the data elements that will be able to track to the inpatient record  
13 and the lab fee and you only get to send one data element to one place. You can send it wherever you want,  
14 but you have to set up that template electronically ahead of time, and what if now, 15 different multi-  
15 specialty groups all have that one data element in a different place? I mean that's my fear, is that you're  
16 going to end up with a number of things that look good, but then they don't talk to each other.

17 Ms. Magno: I think that's also why there's a great deal of effort underway right now by the  
18 department to focus on appropriate standards for electronic medical records so that they can talk to each  
19 other across settings, across sites, across payers and so on. I mean these are critical questions in order to be  
20 able to get the full value of those kinds of investments.

21 Dr. Urata: You talked about the MCCD site characteristics and four people dropped out. Does that  
22 mean 11 sites are after the four dropped out or before the four and then why did the four drop out?

23 Ms. Magno: It's eleven sites after four dropped out. We had started at 15 sites. Four of the sites  
24 chose to drop, they had very low enrollment over the first three years of the demonstration, they still hadn't  
25 hit about four, even four hundred or three hundred enrollees.

26 Dr. Urata: It wasn't that the demonstration was overwhelming and costing them too much.

27 Ms. Magno: If it was, they didn't mention that. I mean it was really, I think some of the sites, I  
28 think it's easier to enroll people than it proves to be, and/or things happen within organizations such that

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1 the leadership is no longer as committed to a demonstration as prior leadership might have been, or other  
2 priorities on the agenda. In the case of one site that was with a continuing care retirement community,  
3 running a care coordination demonstration, they are now actually offering a special needs plan, so a  
4 Medicare Advantage special needs plan to their residents and we wouldn't permit them to operate both  
5 demonstrations simultaneously because of issues of contamination of treatment and control groups and also  
6 because of the ability to selectively engage in practices based on what information they had from the  
7 Coordinated Care Plan.

8 Dr. Urata: Thank you.

9 Ms. Magno: Certainly.

10 Dr. Powers: You had asked the questions about facilitating adoption of strategies for small  
11 practices. And this is more of a comment than it is a criticism. It seems that we've come to an impasse at  
12 this point that it's, I'm sure you're getting good data from these large practices that can be efficient,  
13 because they already have the economies of size and they already have IT, but at this point in time, without  
14 our incomes decreasing, the smaller practices cannot afford the IT that's necessary to demonstrate the  
15 quality that they're—I'm sure that they're willing to embrace quality and improve the quality of their  
16 patients, but they can't demonstrate the quality because they don't have the IT to do that and they can't  
17 coordinate the care because they don't have the IT to do that. I realize it's not the agency's responsibility to  
18 provide the monies for that but it needs to come from somewhere, because the practices don't have it. They,  
19 I have heard small solo practitioners say that they will not participate for instance in the voluntary reporting  
20 system because it costs them to report than they get back in return, than they will ever get in return.

21 Ms. Magno: I think that is clearly an issue. I think we sometimes overestimate the cost of the IT  
22 and underestimate the cost of actually restructuring some of the care processes around having the IT and  
23 using it to its full power. Certainly with the Medicare Care Management Performance Demonstration, we  
24 hope that the potential of incentive payments for achieving certain quality benchmarks and also reporting  
25 data electronically and the support of the QIOs will enhance adoption of IT. But we can only do so much  
26 and the administration is committed to not paying for IT in the same way that we don't pay for Fax  
27 machine or the things that help you bill better or the things that help you do your other aspects of what  
28 allows you to do your job better.

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1 Dr. Azocar: In the same that Dr. Powers has a comment, on the extrapolation that you may  
2 eventually have to do from this experiment or this problem, large group to extrapolate out those findings to  
3 small groups that only change, because of the financial resources to get IT, but also because of changes, or  
4 differences in the demographics and socio-economical things to other small practices, two, three small  
5 practices, just a concern about the valuables to be considered in this extrapolation.

6 Ms. Magno: If there was a question there, I'm sorry I missed the question.

7 Dr. Azocar: It was a comment on the fact that the group that you are doing these demonstrations  
8 on are generally large groups, with more resources than you will find in a small practices, two physicians,  
9 three physician-practices and where there will be changes not only in the financial resources for like  
10 information IT, but also because changes in the demographic, differences in the demographical  
11 populations, taking care into socio-economical and the location of co-morbidity factors and this kind of  
12 thing.

13 Ms. Magno: Right, and we do in any of, I won't say in any, because somebody will find an  
14 example, so in virtually any of our comparisons of patient populations, we do look at Medicare risk scores,  
15 to make sure that we are at least controlling for underlying differences in conditions, income morbidities  
16 and so on to get some sense of the overall risk and make sure we're looking at comparable patients. In  
17 terms of the applicability of some of the strategies, I mean, I think it's a really important question and I'd  
18 be interested in getting input from the committee on how to take some of these strategies that are being  
19 used by the large group practices, how they can be scaled down, or if they can be scaled down to smaller  
20 practices. One question is are there avenues by which smaller practices, while not becoming formally large  
21 groups, are there other avenues by which they can come together in order to share some of the kinds of  
22 resources and investments necessary to facilitate some of the same kinds, adoption and use of some of the  
23 same kinds of strategies as the large group practices. Another question I've had in my mind is whether or  
24 not the medical information, the health information that large disease management vendors are pulling  
25 together from multiple sources in our Medicare Health Support and other demonstrations, whether or not  
26 those IT, whether those information systems could serve as a platform for a common record for individual  
27 patients who are in those demonstrations where the physician could actually direct access the patient  
28 information and have a view of what all is going on with that patient, not just that physician is handling, but

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1 also what other physicians are doing. What problem lists, kind of complete problem lists that may be more  
2 complete than a physician's own problem lists because he or she is treating a patient for a single condition  
3 and may not aware of some of the other conditions. I don't know whether there's any interest on the part of  
4 physicians, or on the part of disease management companies in doing that, but as long as disease  
5 management is out there and being used, there may be some way to marry up some of the strengths with the  
6 disease management organizations in terms of the information systems they have and the personal familiar  
7 knowledge of the patient that the physician has to make better use of those systems and that information.

8 Dr. Senagore: But the problem really is if you borrow from the peer review literature, there is no  
9 scoring system that works at the individual patient level. Most of them are designed either for large  
10 populations or for the probability that an individual has, which usually is a range of complications  
11 happening, so what you'll find faced by a one-person group is that there won't be enough diabetic patients  
12 to say that there was unfairly skewed by more or less compliant patients let's say, you know, patients that  
13 have hypertension and diabetes or some other mix that skews it, and I think that would be the rub, is how  
14 you actually roll this out. Or with the de facto transition be it'll have to go to big groups so that we have a  
15 big end so that all of those things go away and now you're truly just measuring quality over more of a Bell-  
16 shaped curve population. I think that's what we have to be aware of as we go forward with this process.

17 Ms. Magno: Well, and I think that does raise a question of whether or not for those purposes  
18 physicians might want to come together into larger groups, where they are willing collectively to say we're  
19 going to make a common investment in improving quality along these dimensions and we will sink or swim  
20 together.

21 Dr. Senagore: The rub will be there, that's a dramatic economic shift in the way medicine's  
22 practice, the way, at least, US patients have historically chosen caregivers. They might go that group for  
23 their GYN doctor, and that group for their diabetologist and now you're saying, well, no if you're going to  
24 see me as a surgeon, you're going to use my anesthesia, my GYN, my family practice. And I would submit  
25 that's a significant from how we've practiced historically, but maybe we end up there or not, I don't know.

26 Ms. Magno: Well I was thinking more in terms of small groups coming together sort of virtually  
27 for purposes of measurement. So if not for purposes of...

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1 Dr. Senagore: But then we have, HIPAA regulations, we have other economic constraints on how  
2 much data we can share amongst ourselves. I mean I think there's other processes that get in the way of  
3 how virtual we can be integrated, if we're going to share my data with Greg's data to say how do we mix  
4 and match and where can we use it? I think those are all great ideas, I think as long as the vehicle exists to  
5 allow to do that without breaking the law or doing other things that would be less than optimal. I think Dr.  
6 Sprang had a comment.

7 Dr. Sprang: It's actually where I was going as far as trying to create virtual or more loose  
8 associations between individuals and smaller groups and various ways of doing that are out there, but  
9 you're right, it raises a lot of legal questions. But obviously if Medicare really wants to try to include the  
10 smaller groups, maybe you need some laws that allow that to happen. Other things obviously even smaller  
11 groups sometimes outsource their billing and they pay another company to do their billing, and give them  
12 information, maybe those billing companies can also extend what information they give and have forms to  
13 fill out to also send out their quality information. It's just otherwise the bottom line here, does the size  
14 preclude them from adapting set strategies efficiently and it's just either we come up with something new,  
15 or they're just not going to be part of the picture.

16 Dr. Senagore: My fear, at a completely structural level is doing a fair bit of clinical research. The  
17 more that you can make a clinical study look like business as usual, for the encounter, the more likely you  
18 are to get the data set filled out appropriately, timely, and accurately. The more different it looks from how  
19 that person's actually practicing medicine, the less likely that happens, and the more you need your clinical  
20 coordinator to go up there and actually collect the data, so at a different level, trying to collect the same  
21 issues, I can tell you it's very difficult, even under a controlled research setup it can be very difficult.

22 Dr. Grimm: One of the things that I'm, just looking at this from the outside, and just coming down  
23 from it, it seems to be the perception will be by the general physician, practicing physician out there, is that  
24 the general physician is asked to save Medicare billions of dollars. Right? For these programs.

25 Ms. Magno: If each one can—

26 Dr. Grimm: And as a consequence of that, the practicing physician gets the benefit of paying to  
27 help Medicare do that. To me, as a business man, that makes no sense. If I was going to higher a laborer to  
28 come in, I wouldn't ask him to bring in the fertilizer to make my farmer profitable. I would provide the

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1 fertilizer so he could put it out there. I mean doesn't it make sense to you guys? Am I off here someway? If  
2 you're going to save billions of dollars—if you bought a program for \$200 million and you save a billion,  
3 you've just save \$800 million.

4 Ms. Magno: I haven't had any demonstrations so far that successful, but when I do believe me.

5 Dr. Grimm: But you understand my point is that unless we can do something like that you're  
6 going to have a very difficult time with any success of any demonstration project or any project beyond  
7 that.

8 Ms. Magno: Well, unfortunately there are a lot of ideas proposed that I'm assured would save us  
9 money that so far haven't, and so we're being asked to hold things to a tougher test, or a tougher standard at  
10 this point, without good evidence from private insurers or Medicare Advantage plans or Medicare  
11 population on research study basis that shows that definitely doing X Y and Z for this type of patient or that  
12 type of patient will generate savings.

13 Dr. Grimm: If you convince us—

14 Ms. Magno: If no one's willing to, if everyone is so sure that it works, then somebody's got to be  
15 willing to guarantee that, because otherwise it's simply the program being asked to underwrite lots of  
16 assurances, none of which, many of which have not paid off, based on our working demonstrations.

17 Dr. Grimm: I understand your risk issue here, but all of us face that everyday and every business  
18 that we take. There are no guarantees for business. You take a risk, there's no promises, there's no  
19 guarantees. But you're asking us to take the risk, take the risk on this one without any evidence that this is  
20 going to be beneficial to us and the benefit is all for Medicare. So I'm just saying that is that you have to  
21 address that issue.

22 Ms. Magno: I'll be describing that in the context of demonstrations. If something becomes  
23 pragmatic because a demonstration proves successful, there are other ways to basically denominate how  
24 things are paid for so that risk doesn't become an ongoing part of the program, but in our demonstrations,  
25 we have to be able to test things, and in order to limit what we test to what we have resources to test, we  
26 have to limit to those projects where somebody is so convinced, or has such compelling evidence that they  
27 are willing to go at work.

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1 Dr. Senagore: I think where Dr. Grimm is going though if you borrow data from overseas where  
2 it's basically state-controlled healthcare, most of the success stories have revolved around mandating  
3 movement of volume to restricted areas. The most dramatic, typical cancer care is probably the best  
4 example that mandating movement of volume to one of ten sites or twelve sites is what has led to quality.  
5 And in fact there was a great study from Sweden where now they've come full circle because they  
6 presented data over the last decade of moving rectal cancer to specific sites. And outcomes dramatically  
7 improved. Now with the input of the work hour restrictions on trainees, actually local recurrence rate has  
8 doubled because now the experience level of people at those sites doesn't match the experience level of the  
9 people they used to do business with. So it's, you know, it's one of those things that if you don't continue  
10 to measure it and realize what you're really focusing on is the end result, it can be very difficult to control  
11 that through the process. But I minimize the challenge; I know it's very, very difficult but I think there's a  
12 lot more variables that need to be controlled. If there are no other comments, we can take a little break here  
13 and then reconvene for Practice Expense discussion.

14 Break

15 Practice Expense Update

16 Dr. Senagore: Let's resume with Practice Expense Update. Mr. Don Thompson and Mr. Rick  
17 Ensor are here today. They're responsible for defining the scope of Medicare benefits, for services  
18 furnished by physicians and non-physician practitioners. They also bear the responsibility for developing  
19 and maintaining the Medicare fee schedule and related policies relating to the geographic cost of practice  
20 and the SGR. As practicing physicians we're keenly aware of the complexities that this group faces and the  
21 consequences that it has for organized medicine. So we will go ahead and turn it over to our speakers for  
22 their presentation. Thank you.

23 Mr. Thompson: Thank you. Today we're here to talk a little bit about some of the recent history  
24 for how we pay for practice expenses under the Physician Fee Schedule. There'll be a new chapter in the  
25 history written soon in the 5-year review Proposed Rule that should be out shortly and in that rule, be  
26 dealing with some revisions to the practice expense methodology as well as the results of the 5-year review  
27 of work, at least our proposals resulting from the 5-year review of work. But the moment, just to kind of  
28 refresh everyone's memory about how we've gotten to this point and kind of the magnitude of the practice

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1 expense part of the fee schedule: We spend about \$30 billion on practice expense under the fee schedule.  
2 And that's about 45% of the overall Physician Fee Schedule payments. The bulk of the remainder is work  
3 and then a much smaller percentage for professional liability. So there's a large amount of money in the  
4 practice expense under the fee schedule. In terms of what the practice expenses are, they are the resources  
5 used in furnishing a service. They basically fall into two buckets. There are direct practice expenses, and  
6 that's about 36% of the practice expenses on average and those are clinical staff involved in the procedures,  
7 medical supplies, and medical equipment. So we refer to those as the direct costs. And the rest is indirect  
8 practice expenses, about 64%. And that's the office, the rent, the administrative staff, pretty much  
9 everything else that's not encompassed by the clinical staff, medical supplies and medical equipment. One  
10 of the policy issues under the practice expense over the years has been indirect expenses by their very  
11 nature cannot be uniquely allocated below the practice level. If we could uniquely allocate them down, they  
12 would be direct expenses, if we could find contribution of individual procedures to indirects, they would be  
13 direct practices expenses, but since we can't do that, for example, rent, the issue becomes how do you pay  
14 for that, given the Physician Fee Schedule we pay on a procedure code by procedure code basis, how do  
15 you get those indirect practice expenses that occur at the practice level down to the individual payment  
16 level, the individual code level that we pay on. In accounting, there are different ways to do this. There's  
17 different acceptable methods to allocate indirect expenses. Our general approach so far has been to allocate  
18 it based on the physician work and the direct expenses. And by allocate, what I mean there is if a procedure  
19 has higher physician work, and higher direct expenses, so more clinical staff time are involved, more  
20 expensive medical equipment, more supplies to the extent they have all of those, they get more indirect  
21 expenses. If you have less physician work, less equipment, less supplies, less clinical labor, you get less  
22 indirect practice expenses.

23 In terms of sources of data, the methodology relies on specialty specific survey data for both  
24 indirect and direct practice expenses under the current methodology. The original data that was used and  
25 this dates back to the late '90s, the original data used came from the American Medical Association  
26 Practice Expense Surveys. And those were surveys that were random surveys that were done across all the  
27 physicians in the AMA master file and those were surveys that were done years. And we took that  
28 information, the practice expense part of those surveys, and we used that in developing the practice expense

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1 methodology, at least to get an idea of what the practice expenses might look like at a practice level or high  
2 level and then come up with an allocation methodology on the indirects to get that down to the procedure  
3 level. We since that time, have incorporated supplemental surveys from some specialties. To date, there are  
4 four specialties that we've incorporated their data for. Vascular surgery, physical therapy,  
5 hematology/oncology, and independent labs. So for those four specialties we have supplemented the  
6 original data from the AMA with surveys that those four specialties have done.

7         So dig down a little more; in the NPRM for 2006, we had proposed certain changes to the practice  
8 expense allocation. In particular we proposed to discontinue the use of survey data for the calculation of the  
9 direct practice expenses. And instead rely on a kind of a micro-costing approach where inputs, direct cost  
10 inputs were determined by the AMA's Relative Value Update Committee and we would use those inputs in  
11 order to come up with a direct expenses. So what does that mean? So for example, for an office visit, the  
12 AMA went through and said well how many minutes of clinical staff time are involved in an office visit?  
13 What medical supplies are involved when you have an office visit? What medical equipment is involved in  
14 an office visit? And they listed all those out, so we have quite a large data base now for every procedure  
15 under the Physician Fee Schedule that lists all of those direct inputs. So how many minutes of clinical staff  
16 time, what equipment was involved with the procedure, how much that equipment costs, how long that  
17 equipment was used, and then on supplies, what supplies were used and how much those supplies cost. So  
18 what we had proposed in the 2006 NPRM was to start to use this database to come up with the direct part  
19 of the practice expenses, really by adding them up. So you would take the clinical labor time, and however  
20 much say the average salary was for a nurse. You would multiply that together, add that up whatever the  
21 supply costs were, add those up, whatever the equipment costs were, add those up, and that would give you  
22 the payment under the Medicare Physician Fee Schedule, at least in a relative sense. It would give you the  
23 payment under the Physician Fee Schedule for the direct expenses.

24         So then in the 2006 NPRM, we also said, well, what can we do with indirect costs? We proposed  
25 to use the specialty survey data, continue to use the specialty survey data for the indirect practice expense  
26 inputs. We proposed to included survey data for seven specialties that we had not previously incorporated.  
27 And those were cardiology, gastroenterology, allergy immunology, urology, radiation oncology, radiology  
28 and dermatology, so a pretty large expansion from the four supplemental specialties that we had already

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1 incorporated. We had proposed to do an additional seven, however, because those supplemental surveys,  
2 some of the values were quite a bit different from what we had been using in the methodology, and they  
3 had some large redistributive impacts, we had proposed to take the higher of the current indirect practice  
4 expense RVU, prior to the use of those surveys and the RVU that resulted after you accepted the surveys.  
5 So in the NPRM, we said, direct costs, we'll add them up and indirect costs, we'll continue to use the  
6 surveys and we will also accept the supplemental surveys that were done by those seven specialties. In  
7 addition, there is at least currently a special methodology that's used for services that do not have physician  
8 work RVUs. I mentioned earlier under the current methodology, we allocate indirect expenses based on the  
9 direct costs plus the physician work. For services that don't have physician work, we had received  
10 comments over the years that they were disadvantaged over the current methodology. The methodology  
11 that we use for all the other codes, and so we actually had a separate methodology that we used for codes  
12 that did not have physician work RVUs. Because we had accepted the surveys, and a lot of the codes  
13 without physician work RVUs, if you look at the specialties I had listed, such as radiology, a lot of their  
14 codes didn't have work RVUs, the technical components, we felt that the use of the survey data then made  
15 our special use of the methodology unnecessary. So we proposed to get rid of the special methodology that  
16 we used for codes that did not have physician work RVUs. And then again, looking at the redistributive  
17 impacts, and some of the payment level changes at the code level, we proposed a four-year transition. So  
18 that was the NPRM last year.

19           Then in the Final Rule, we had received a number of comments, and also we had some issues  
20 around how we calculated the RVUs for the NPRM and the related impacts. As a result of those issues and  
21 the public comments we received asking for more information on the calculation and more details, we  
22 made very limited changes to the direct and indirect practice expense RVUs. So we had proposed  
23 somewhat I won't say sweeping changes, but some significant changes to the methodology in the NPRM,  
24 and then as a result of the comments we received a desire for more information, we slowed down a little bit  
25 in the final and made some limited changes, and we indicated that we would seek additional input before  
26 going out with another proposal. So along those lines, we held a townhall meeting this winter. It was  
27 February 15<sup>th</sup> and in that we chose kind of four different methodologies that were not designed to be the  
28 universe of possible changes you could make to the practice expense, but were designed to be illustrative of

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1 some of the parameters in the Practice Expense issue, for example, what's the overall percentage of direct  
2 and indirect cost? If you're going to allocate the direct and indirect expenses, you need to have some sense  
3 of what percent of the total is going to be direct and what percent of the indirect? Right now, roughly 67%  
4 of the costs, as I mentioned earlier, and about 33 are direct in that range. It varies a little bit year to year,  
5 but and it was there we were seeking comment, on that and some other aspects of the methodology and  
6 trying to get more detailed input from some people and some commenters that had indicated they needed  
7 more information in order to make an informed comment on the original proposal from the prior year. So  
8 we tried to provide that in the public townhall meeting. So we took all those comments in and we expect to  
9 publish our new practice expense proposal for the 2007 fee schedule, as I mentioned in conjunction with  
10 the 2007 5-year review of work, those proposals. And we're looking forward to the public comments on  
11 both of those. I think we've learned a lot over the last two years or so. I think the public input has been very  
12 helpful and valuable in meetings we've had in terms of taking what was the initial proposal I think last  
13 year. The concept there being that we wanted to, the AMA had put together all these direct costs, and we  
14 wanted to start to utilize those. So I think that part of the proposal had a lot of merit and seemed to have  
15 some support among the different specialty societies and in the public comments, and we received a lot of  
16 good input on the indirect methodology and hopefully in the very near future, we'll have that published and  
17 then we can have a discussion about that proposal. But at least currently, since that's not quite out, it should  
18 be close, and by the next meeting, it will definitely be published, but that's not quite out. At least I am  
19 hoping to maybe take some comments now if anybody had any about the current methodology or some of  
20 the evolution over the last two years. I can't, obviously can't discuss in detail what might be in the NPRM,  
21 which would be probably the most interesting question. But aside from that is there anything at least under  
22 the current methodology or kind of how we were thinking and how we got to where we are today?

23 Dr. Urata: So I noticed in your indirect costs that rent and such was in there and you said  
24 something along the lines that if you're busy, it goes up, if you're not busy, it goes down. But when I pay  
25 rent and health insurance and some other things, those costs are fixed, no matter if I'm working or not. So  
26 what goes up and down is my salary. [laughter] And the other thing is that's really big in there is my  
27 malpractice premium. That's a fixed cost, too, over a year, so how does that work out with your, or, with  
28 your system?

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1           Mr. Thompson: For the fixed cost, let's take rent for example. For the fixed costs, it's not that we  
2 think your actual cost structure is going up or down. Obviously your rent doesn't change depending on  
3 procedure you do that day, it's more how we allocate that rent down to the code level. So what we would  
4 hope is at the end of the year, given the allocation methodology in a perfect world, we would have allocated  
5 your rent costs down to the procedure code level, using a certain methodology. So it's not to say that we  
6 believe that your rent's changing if you do a procedure that has a higher work RVU or has more clinical  
7 staff, it's just to say at the end of the day, at the end of the year, when you look across the range of the  
8 procedures that you do, hopefully that rent costs that was captured in the surveys we did of your specialty,  
9 has been allocated down to the procedure code, and then you've gotten at least in a relative sense, your rent  
10 back the same as the other specialties. And then on the malpractice, the second question, that's a separate  
11 RVU. So that doesn't come into this part. There's three components to the fee schedule. There's for your  
12 time, the physician work component, your time and effort, and then there's the practice expense  
13 component, which is what was the focus of kind of the NPRM and then the third component is actually a  
14 separate component, which is the professional liability. And that's separate and distinct from this, so it  
15 doesn't come into play on this one.

16           Dr. Urata: Is that going to be treated differently in the new system?

17           Mr. Thompson: This proposal will not address any changes to the professional liability  
18 methodology.

19           Dr. Sprang: Being an OB/GYN, obviously my question is around the professional liability aspect  
20 of it and how much that varies from specialties from locales. I practice in Cook County in Chicago, which  
21 is one of the highest premium rates in the United States. If the average costs for an obstetrician  
22 gynecologist in Cook County is \$140,000 a year. There's been a lot of questions, concerns on the source of  
23 data that Medicare is using and whether it's old and we're, sometimes, one year we've had a 35% increase,  
24 obviously if you were a year behind, it made a huge difference for the physicians. Can you just tell me a  
25 little bit about that, how you're looking at it, and how you're taking into account an  
26 obstetrician/gynecologist paying \$140,000 a year

27           Mr. Thompson: I think data sources for professional liability have been a challenge. I think for the  
28 agency over the year. We have gone out a number of times since the beginning of the fee schedule,

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1 especially since we've gone to kind of a resource-based payment for professional liability. Different  
2 comments from different commenters, possible data sources that are out there for us to use. I would not say  
3 that we have any perfect payment system under the Medicare program, but we always seek to improve  
4 them. So every year as we go out and we go out with a new proposal with professional liability, we're  
5 always looking for new data sources. I know most recently the Office of the Actuary is kind of also heavily  
6 involved in this issue and there is some talk among at least for the AMA's reinstating a survey, a  
7 physician survey which as you may know, they haven't done for a number of years. And I don't know  
8 whether malpractice may be a part of that survey or not. But on the malpractice, I think the key is finding a  
9 nationally representative data source that we can use in the calculation. I'm not the payment policy expert  
10 on malpractice by any stretch of the imagination, and if that is something that the Council wanted to delve  
11 into I'm sure we could get someone here who could speak much more intelligently than I on the issue of  
12 professional liability and the data sources.

13 Dr. Sprang: I've asked the issue because it varies so much by specialty and even by county. Like if  
14 you're in Illinois, if you're in downstate, you may pay half of what we pay, but in Cook County, it's  
15 \$140,000, and if we don't take that into an account as an expense everybody's paying, I know ten  
16 OB/GYNs in Chicago who have quit practice. So it is real, and it is there and try getting the real data for  
17 that locale.

18 Mr. Thompson: And there is definitely the fee schedule is designed to reflect geographic  
19 differences among the work RVUs, among the practice expense RVUs, and among the malpractice RVUs  
20 and it does that differentially. It's not the same adjustment for work as it is for practice expense, as it is for  
21 the professional liability. So I think that the underlying construct of the fee schedule does recognize the fact  
22 that there are geographic variations. I think the issue becomes do you have correct and are you using the  
23 best data sources possible so that you're essentially in a relative sense paying the person who's in upstate  
24 versus downstate or another geographic area versus another one. Are you paying them right in a relative  
25 sense? And I think that's I mentioned, an ongoing challenge for the agency.

26 Dr. Sprang: And using current data.

27 Mr. Thompson: And using current data.

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1 Dr. Ouzounian: Appreciate your coming here today and talking to us. It seems in a way your  
2 presentation may be a little premature, telling us that by the way you're going to have a propose rule out  
3 and when you read the proposed rule, you can talk to me.

4 Mr. Thompson: Diplomatically put.

5 Dr. Ouzounian: Yes, so I'm not going to pick on you there. I and some others in this room have  
6 worked carefully with the agency over the last probably six years and certainly do appreciate the efforts  
7 that the agency have made to do things correctly. I might not always agree with them, but certainly there's  
8 been an effort to do them correctly and I recognize they've done that. I am a little frustrated, or more than a  
9 little frustrated that there was a data set, the SRS data set, which admittedly is old, but it was collected from  
10 all specialties at the same time, and now some specialties have selectively submitted new data, which is ten  
11 years newer, which is probably going to be more expensive, and those societies are being allowed to use  
12 new data, whereas other societies were not allowed to use new data and that's not fair. The AMA is  
13 actively—there was an email that was sent out last week, trying to get—or not trying, I know that there's  
14 been verbal communication about a new SRS data set and getting contributions from the societies, and the  
15 only way to do it fairly is to allow all societies to participate equally on the same footing with the same  
16 survey at the same time, and to use that. But to cherry pick data that's now 10 years newer from four or  
17 seven specialties is not fair to the groups that didn't do it.

18 Mr. Thompson: I think there's, we received a number of public comments on this issue in the  
19 NPRM and many of them echoing exactly what you just said that it's an issue of equity, but we also on the  
20 other hand received comments from those specialties societies that did the surveys and I'm sure I won't be  
21 able to do their position full justice, but I think the thrust of their argument is that other medical specialty  
22 societies had an opportunity to do surveys and chose not to, and their assumption was that was because  
23 those societies felt that the value that they had was correct. So we've had kind of arguments on both side,  
24 and discussions on both sides. Obviously the specialties that went through the expense and did the surveys  
25 want us to use them and the other specialties now that they've seen the values are saying exactly what you  
26 said, that it seems a little unfair. I think obviously we want to use the best available data and we'd be very  
27 supportive, I think of the AMA going out and doing a survey, and if the data resulting from that survey is  
28 better than the data we have now, of course we'd want to incorporate that into the methodology, but at least

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1 for the moment, in terms of the supplemental survey data, we did go out with the specialty sides have  
2 argued, we went out, it was a public process, and we invited specialty societies to do surveys. We had  
3 criteria that we put ahead of time, about what we would do to accept the surveys. The surveys that were  
4 done met the precision requirements. You know, they were random surveys, they were internally consistent  
5 to the extent we could measure that, and we had proposed to use them on that basis. But I guess there is  
6 some sensitivity to the issue of the kind of disparate nature of the data sources now underlying the indirect  
7 expenses. When I say disparity, obviously different surveys—an individual survey versus a multi-specialty  
8 survey. And I think ideally, we would like to see more recent data for all specialties and are hopeful that the  
9 AMA process will be able to provide that to us.

10 Dr. Ouzounian: Would you be willing to maybe defer use of the new survey data until you could  
11 collect concurrent information from all the societies, so that all societies could be on a equal footing?

12 Mr. Thompson: I think because we don't have the propose rule out, it would be a little premature  
13 for me to prejudge the comment period, I would expect based on the comments we received on the last rule,  
14 we may also see those comments again. But there are many facets to the new methodology, so I guess what  
15 I would say is after everyone sees the methodology in its entirety, they can weight what comments they  
16 want to make about different aspects of it, and if someone looked at it and said, well given the methodology  
17 that you've proposed here, some of my concerns are not as strong as they were last year, or they may say  
18 their concerns are exactly the same as they were last year, but then they can make a decision about whether  
19 they want to give that comment. So I guess it's a little premature to answer the question, and we'll see, kind  
20 of the public comments we receive on the NPRM.

21 Dr. Przyblski: My original understanding of the key methodology was that you took the global  
22 cost to a practice and then dropped it down to the code level and that the 2006 proposal was to use the  
23 inputs measured by PEAC and RUC to come up with exact numbers at the specific code level. However,  
24 that doesn't address what happens to the overall practice expense dollars of different specialties. So does  
25 the new method imply that all the practice expense dollars are in a big bucket? We'll calculate the total PEs  
26 using this direct methodology and then divide it up so that PE values can swing aloft, or does it imply that  
27 the specialty pool stay intact and it's a redistribution within the specialty?

28 Mr. Thompson: The answer to that question lies in the NPRM. [laughter] Sorry.

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1 Dr. Przyblski: I had a feeling that would be your response. [laughter] It doesn't mean I won't ask  
2 the question.

3 Mr. Thompson: That's fine

4 Dr. Przyblski: Part II is do you plan to publish the impact that this has, since that, I know was a  
5 request in the original comments?

6 Mr. Thompson: Absolutely. There will be an impact analysis as part of this rule and hopefully  
7 we'll address some of the comments it received on the last one in terms of people wanting to kind of  
8 understand the details a little more, so yes, absolutely we'll have an impact in this rule.

9 Dr. Przyblski: Quick question on your indirect comments. You said because of the large  
10 redistributive impacts, we propose to take the higher of the current indirect versus the indirect calculated  
11 using the new surveys. To me that would imply that you're reinforcing the redistributive impact as opposed  
12 to correcting it. Help me understand where I'm confused.

13 Mr. Thompson: Sometimes it's given the, when you have a large redistributive impact like that, it  
14 may take some time for when people actually see the impact, or even under the bottom up when you kind  
15 of see what happens globally. There can be the case where sometimes things can look very good at the tree  
16 level, and then when you look at the forest, you may go back and want to relook at the trees, and so when  
17 we say you know, it's more of, when we say we're going to do that, it's more of a not an ultimate endpoint  
18 for the methodology, but what we're really saying is this will give people time in addition to the four-year  
19 transition, this will give people time to reexamine maybe some of the direct inputs or asking questions on  
20 the indirects. I didn't mean to say that that particular policy, we would say that for all time, because  
21 obviously that wouldn't make sense 10 years from now to go back to an RVU that was calculated 10 years  
22 prior and having that in the methodology, but it does give people an opportunity for us to kind of  
23 implement the new methodology and start heading in that direction. But also, recognizing that perhaps  
24 people may want to go back, take a step back and relook at some of the inputs That's what I should have  
25 explained that a little more fully, but that's what I meant by that. Not that that would be an end policy in  
26 and of itself, but you're right. That's not sustainable over time.

27 Dr. Przyblski: And finally the last comment, I know that PLI is calculated in a separate way, but  
28 you've heard some messages that that remains an issue. And since Rick Ensor is with you and had the

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1 pleasure of being on conference calls with us on a number of occasions about PLI, I would like to  
2 emphasize a comment that you made about indirect practice expense that it cannot uniquely be allocated to  
3 the code level. The same holds true for PLI, whether I do one discectomy or a thousand discectomies per  
4 year, my PLI cost is the same, and so to even use a work methodology, a work value to distribute PLI  
5 expense to the code level doesn't make sense, and I would urge some other alternatives to be thought about.

6 Dr. Bufalino: Two-part question. One, in the survey of the individual specialty, I'm assuming that  
7 we had a significant smattering of 2-person, 10-person, 30-person group, urban rural, multi-specialty,  
8 single specialty, and then part to that is in that group, did you have at least enough folks to make an impact  
9 of people that are fully electronic, because their indirect practice costs living that world myself, are  
10 considerably higher in the setting of maintaining a large electronic system in-house.

11 Mr. Thompson: On the first part, it was a random sample from the AMA master file, and it was a  
12 representative sample, so yes, it should have captured all that variation that exists out there in the medical  
13 community.

14 Dr. Bufalino: About how many people were in that survey?

15 Mr. Thompson: It depends on the specialty. I think that in its best years, the AMA survey total  
16 usable responses was in the 2,000 range across all specialties. But some of the cells for individual  
17 specialties might be somewhat smaller, 30, 40, 50, I think, kind of on the low end. What we did to address  
18 is we actually used a five-year average of the survey to try to boost up the sample sizes a little bit, the cell  
19 sizes, but one of the difficulties in any survey is the response rate. Ideally you want 100% response rate of  
20 any survey that you do, but under, it seems under practice expense, at least to date, history has shown that  
21 you know, response rates in the 20% to 30% range can be causes for popping the champagne corks.  
22 [laughter] So it's, the ideal being 100, but when year after year, when you have survey responses in a  
23 certain range, you seem to accept that as what's feasible. And then your second question was on the  
24 electronic health records, and this would, I think, to a certain extent, might go to the issue of the recent,  
25 going back to the earlier comment on how recent are the surveys? To the extent the world has changed  
26 since the late '90s in terms of practice costs, and changed differentially, if it changed the same for every  
27 specialty, then it wouldn't impact the answer at all, but if it has changed differentially in terms of electronic  
28 health records, or [inaudible] records, then yes, that could potentially have an impact on the practice

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1 expense calculation. Which is one of the reasons you know, ideally you'd have more recent data from a  
2 larger group of specialties. But the only data source that we have, the two of them, are the AMA survey,  
3 which is defunct, no longer being held, and then the supplementals. So to the extent we have data, we've  
4 used it or are proposing to use it, but again ideally, with a mechanism where we could capture more recent  
5 data on a more regular basis to try to capture those costs.

6 Dr. Grimm: Just one question, point of clarity, because I see some difference of opinion in terms  
7 of, Dr. Ouzounian had mentioned at least implied that not all the specialty groups were given opportunity to  
8 do the survey, and yet my understanding from you and from others is that everybody had an opportunity to  
9 do this that there were only specific specialty groups that actually elected to do this. And it was there  
10 choice not to do the survey. It wasn't the fact that somebody said you couldn't do a survey. Can you clarify  
11 that for me?

12 Mr. Thompson: I can play Devil's Advocate on either side of this issue. But I think that the  
13 counter argument would be I thought my specialty was correct in a relative sense, but now the relativity has  
14 been changed with the exception of the eight specialty surveys. Now I could counter that by saying well,  
15 you are correct, everybody had an opportunity to do a survey. It was a public process. We said anybody can  
16 go out and do a survey, submit it—here, we said it right up front. Here's the criteria we're going to use.  
17 You meet these criteria, we'll accept it. And we did that through notice and comment rulemaking, and I  
18 think again, kind of paraphrasing some of the public comments—yeah, but I didn't realize that one third of  
19 the fee schedule was going to come into our supplement and that all of a sudden that amount of money  
20 being under a supplemental survey, those seven specialties are quite large, the ones that I mentioned, the  
21 ones that have come in under the supplementals. Cardiology, radiology, those are not small specialties that  
22 now, because of the redistributive, if I had known what the results were going to be, then yes, now I'm out  
23 of whack in terms of my relativity, but there was no way [inaudible] know that. So that's the argument I  
24 think that some of the other specialties are making.

25 Dr. Grimm: The results have indicated that—

26 Mr. Thompson: Right. I was fine before, and now I'm not because of the new results that have  
27 come in.

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1 Dr. Ouzounian: I may have misspoken. We elected not to survey because our relativity was, we  
2 felt, accurate, and others elected to survey for whatever reason.

3 Dr. Williams: I would be remiss if I did not bring up and continue the fairness and equity  
4 argument, relative to anesthesia teaching programs. I know. But I have to put this on the record please. Our  
5 anesthesia academic programs are in serious jeopardy as you know. They have decreased from about 160  
6 programs to about 130 programs over recent years. There is already a shortage of anesthesia providers, both  
7 nurses and physicians, and the anesthesia academic programs are being singled out and discriminated  
8 against by being paid differently than our surgical colleagues and in fact, differently than any other  
9 physician specialty in trying to compare how supervising physicians supervise nurse anesthetists, versus  
10 teaching anesthesia residents. Which as I understand it, the teaching roles and the payment methodologies  
11 are completely different between physicians and nurses. That coupled with the SGR that we're hoping the  
12 government, Congress I guess, will fix, the academic anesthesia programs are having a double whammy, a  
13 double hit, such that they're losing between \$400 to a \$1 million a year in funds. This is obviously  
14 jeopardizing our research, our continued education, our production of high quality residents, and  
15 subsequently specialists that will ultimately replace us. And I would just like to ask is there anything in the  
16 evaluation in the small part that you have played in the evaluation of work, the five-year review, etc. that  
17 could possibly help any aspect of anesthesia payment.

18 Mr. Thompson: I would hope, as with any specialty the anesthesiology community would look at  
19 the proposal and provide us with inputs. I think we will be providing a lot of information, both in the rule  
20 and on the website in terms of data to look at. Unfortunately, a specific answer would, I'm going to have to  
21 echo my earlier comment. The answer to your question, how does anesthesiology fair is in the NPRM, but  
22 when it does come out, as with any specialty, we're encouraging a dialog on this, and to the extent you look  
23 at the methodology and you think certain aspects of it could stand with some improvement, we would look  
24 forward to those comments, but I can't specifically comment on what it looks like in the NPRM for  
25 anesthesiology.

26 Dr. Williams: Can you tell me why the prior discussions for the last five years have not yielded a  
27 positive result for our teaching colleagues?

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1 Mr. Thompson: It has been an ongoing issue as you mentioned, with respect to the anesthesiology  
2 policy, especially vis a vis the surgery policy. I know we've done a fair bit of comment seeking I believe in  
3 some prior rules, and I am again, unfortunately not an expert on the teaching issue, but I think at the end of  
4 the day, at least to date, there has seemed to have been insufficient evidence of similarity between the  
5 surgical policy and the anesthesia policy for a variety of reasons.

6 Dr. Williams: Did you say insufficient?

7 Mr. Thompson: And we haven't made the change by virtue of the fact that the policies are not  
8 exactly the same between the two. From an agency prospective [unintelligible] sufficient evidence to  
9 change the policy, the way the [unintelligible] but I don't have anything more to add, I'm sorry, at this  
10 point.

11 Dr. Przyblski: Just as a point of information, you illustrated one reason why specialties might not  
12 have done a supplemental survey, but it's important to understand that that survey had substantial  
13 encumbrances associated with it. It had to be done very specifically. It was very expensive to do, and  
14 subspecialties felt that the expense was just too much for them to undertake, and I can speak to  
15 neurosurgery that this was also discussed and it wasn't an issue of are we in the right place or not, it was  
16 the expense of doing this as a small specialty is just too much for us to do and we would much rather the  
17 AMA support a specialty survey of all specialties at the same time, where everyone is essentially  
18 contributing to that pool.

19 Mr. Thompson: There were many, I was trying to paraphrase some of the counterarguments. I was  
20 not trying to say that that was the sole reason why specialties may not have done one. So thank you for,  
21 that's a good point. It's not cheap to run a survey, as the AMA is finding in trying to reinstate theirs.

22 Dr. Ouzounian: Well, I may have misspoke, you heard what I said, and I'm not going to deny  
23 that's what I said, but [laughter] a lot of our understanding was that it was a relativity, it was a whole  
24 process. Those of us involved on the PEAC, it was a relativity. And if you felt that your society was  
25 appropriately represented, or relativity wise, and I think the cost of the survey was in the hundreds of  
26 thousands of dollars range, so if you felt you were in the right ballpark, you probably didn't. The question I  
27 have to you is some of the societies have come back with some new numbers. And is the percentage  
28 increase from where their prior data was, is that percentage increase similar for all those societies? Because

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1 all of us experience inflation. My office staff gets a raise, and every year the suppliers say well, we need  
2 more money. And the landlord says by the way, remember the lease you signed, it didn't get less, it got  
3 more and parking attendant says the insurance costs more, and the guy there gets more money and you  
4 know all of our expenses are going up. So to cherry pick some groups with an inflation factor, and not to  
5 allow an inflation factor to the other subspecialties is just I don't think it keeps everybody on an equal  
6 footing, and I realize the proposed rule isn't out yet, and it might be in there and we can comment. But I  
7 just think those comments need to be made. Everybody needs to be on an equal footing.

8 Mr. Thompson: The only thing I'd say on this one is we do update the older survey by the MEI  
9 every year, not by the update, but by the MEI, the actual, which is intended to be a proxy for the cost of  
10 operating a physician's practice. So they are updated for inflation. The supplemental surveys in theory are  
11 not getting that differential inflation rates. They are in theory getting at issues with the base survey, whether  
12 the base survey got it right. So it's not like we take the surveys from the late '90s and they stay locked at  
13 that amount. We actually update those actual values every year by the MEI. So we do update them for  
14 inflation. It's not that the supplemental surveys are supposed to get at inflation, whereas the old surveys  
15 don't, because we do try to update that. MEI runs 2 to 3% a year, so we update those every year for that, to  
16 try to get at that point. Just as a point of clarification. I wouldn't characterize the supplemental surveys, at  
17 least in theory, I wouldn't characterize them as inflation adjustments, because we are adjusting every year,  
18 even the old surveys, for inflation.

19 Dr. Senagore: We'll wait to see the post rule, and I think the message is, the operative word is the  
20 power of relativity. Seeing no more comments, I think we have—only one testimony was kept—OK, that's  
21 fine. Just wanted to confirm. I think today we hear from the AMA, Dr. Hazel, to give some testimony  
22 regarding the AMA's comments. Dr. Hazel.

23 *Public Testimony—American Medical Association, Dr. Hazel*

24 Dr. Hazel: Thank you. My nametag's coming off. I'm Bill Hazel. I'm an orthopedic surgeon from  
25 over in northern Virginia and I'm a member of the board of the American Medical Association and on  
26 behalf of the American Medical Association, I thank you for having us today. I know what I'm here to talk  
27 about, but I'm going to take a little deviation from that to begin with and update the Council about the  
28 upcoming Medicare payment crunch. And I'm aware that you know of it. I'm even impressed, I understand

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1 there are four rookies on the Council today but I didn't see any evidence of that in the questioning, so good  
2 for you. The recently issued Medicare Trustees Report projects an additional 37% cut over the next 9 years  
3 to begin with a 4.7% cut January 1, 2007. These cuts will occur as medical practice costs rise  
4 approximately 22% over the same period. I was interested to hear Mr. Thompson say he took the survey  
5 data and they used the MEI to increase the expense side. What about the payment side? These cuts will be  
6 most detrimental to Medicare patients. We did a survey of AMA members this year. Nearly half of the  
7 responding physicians said that the scheduled cut in 2007 alone would force them to either decrease or stop  
8 seeing new Medicare patients. By the time the full force of these cuts takes effect in 2015, expect 67% or  
9 2/3 of physicians say they will be forced to decrease or stop taking new Medicare patients. Further, nine  
10 years of cuts will cost 73% of surveyed physicians to defer the purchase of new medical equipment, and  
11 65% will defer purchase of new information technology. Next year alone, half of the physicians surveyed  
12 indicated they would defer purchases of IT as a result of the pending cuts.

13 AMA continues to work with CMS and Congress to advance the use of health information  
14 technology and quality of improvement initiatives, but as the AMA survey shows, positive physician  
15 payments, not the steep cuts that are slated to occur under the current formula, positive physician payments  
16 are vital to support the HIT investments, the quality innovations necessary to benefit patient care, and to  
17 generate system-wide savings. It is clear that the physician payment formula, the unsustainable growth rate  
18 is a major barrier to quality improvement programs and must be replaced with a payment system that  
19 reflects increases in medical practice costs. We urge CMS to support Congress in achieving this goal. We  
20 urge a 2.8% physician payment update in 2007 as recommended by MedPac.

21 With that out of the way, let me turn to today's major issue, which is performance measure  
22 development. The AMA convened physician consortium performance improvement, developed  
23 performance measures that are the foundation of emerging physician quality reporting activities in both the  
24 public and private sectors. The consortium brings together physician and quality experts for more than 70  
25 national medical specialty societies, as well as representatives from CMS and other federal agencies. To  
26 date, the consortium has developed 93 measures, covering 16 conditions. These existing measures cover  
27 clinical conditions that make up a substantial percentage of Medicare expenditure. The consortium is  
28 currently in the process of working to meet the commitments that the AMA made last year. For example,

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1 with the allocation of additional AMA resources, the consortium plans to have about 140 practice  
2 measures, covering 34 clinical areas by the end of the year. So we're well into that. AMA is also fast-  
3 tracking approval of the CPT II codes for reporting of approved physician level performance measures. It is  
4 critical that CMS build on the physician community's efforts in measure development, thus we urge PPAC  
5 to recommend that CMS use physician measures that are developed in a collaborative, transparent process  
6 by physician specialties as exemplified by the consortium. Then they should be vetted through multi-  
7 stakeholder groups, such as the NQF and the Ambulatory Care Quality Alliance. And we emphasize that  
8 CMS should implement measures as developed through this process to ensure measure integrity and  
9 uniformity. In addition all measures, whether quality or efficiency measures, must be evidence-based, valid  
10 measures. They must also have sufficient evidence to show that the measure will improve the quality of  
11 care. AMA emphasizes particular caution in developing efficiency measures. These measures must avoid  
12 the danger that the lowest cost treatment will supersede the most appropriate care for an individual patient.  
13 In addition, there must be broad based consensus regarding what constitutes appropriate levels of care  
14 before measuring for efficiency.

15 Our AMA looks forward to continuing our work with CMS to develop performance measures in a  
16 collaborative transparent process, with, by, and across the physician community. I'd like to take a moment  
17 to address the Medical Unbelievable Edits. I understand there's been some conversation and some thought  
18 that your group has given this today. I would make a few comments. We appreciate that CMS extended the  
19 MUE implementation date, and we appreciate that the public review period has been extended. However,  
20 we should encourage CMS to immediately make available the rationale and frequency data behind the  
21 proposed MUEs. Our AMA and the 90 medical specialties have requested CMS make this data available,  
22 but CMS has not done so. And without the data, the basis for the edits remains unclear and the review  
23 process is more timely and is more difficult. Because of this lack of data, we will believe that the MUE  
24 program's implementation should be delayed until June 2007 and allow the public comment period to be  
25 extended to December 31<sup>st</sup> of this year. This is needed to adequately review the proposed edits, which  
26 involve over 10,000 CPT and ASPCS level II codes. Thirdly, CMS should allow the use of modifiers for  
27 services that may be clinical outliers and develop an appeals process for these.

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1           We look forward to working closely with CMS to refine an MUE program that works well for  
2 patients, physicians and for CMS. And then as I close, I would acknowledge the four new members; Dr.  
3 Bufalino, Dr. Ouzounian, another orthopedic surgeon, Dr. Ross, and Dr. Williams, and our AMA looks  
4 forward to working with you and the rest of the Council here in the coming year. We appreciate your  
5 dedication and your contributions to our patients and the physician community. Thank you. Be happy to  
6 answer any questions if you have any. I know I'm last, and if you're like me, you probably want to get on  
7 the way.

8           Dr. Senagore: Any questions for Dr. Hazel? Thank you very much.

9           Dr. Hazel: Thank you.

10          Dr. Senagore: Before we review the recommendations we made earlier, are there any other issues  
11 from this afternoon that we wanted to come forward, Dr. Powers?

12          Dr. Powers: First, I just wanted to summarize, some of what was said earlier and then make a  
13 recommendation. Medicine as a whole has embraced the quest for quality in medical care. We are  
14 enlightened by the demonstration of potential cost savings and practicing good quality efficient care, but at  
15 this time, especially in small practices, the cost of reporting quality is not fully compensated by the reward  
16 for demonstrating quality. We providers are caught between a Congress that will not change the erroneous  
17 reimbursement process and the ever rising cost of providing quality care. Therefore, that's not the  
18 recommendation. The recommendation is PPAC recommends that CMS continue to use its influence with  
19 Congress to encourage changes in physician reimbursement, particularly the SGR, the outcome of which  
20 will enhance the agency's ability to improve the quality of care for beneficiaries.

21          Dr. Urata: Second.

22          Dr. Hamilton: Second.

23          Dr. Senagore: Discussion. Dana could you read that back before we vote on it, please?

24          Ms. Trevas: PPAC recommends that CMS continue to use its influence with Congress to  
25 encourage changes in physician reimbursement, particularly the SGR, the outcome of which will enhance  
26 the agency's ability to improve the quality of care for its beneficiaries.

27          Dr. Senagore: Any comments or discussion on that as read? Call the question? All in favor?

28          [Ays]

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1 Dr. Senagore: All against? Motion carries. Dr. Williams?

2 Dr. Williams: PPAC recommends that CMS continue to evaluate, pursue and correct the disparate  
3 payment plan to academic anesthesia programs, as it differs from other physician groups in order to  
4 positively impact the shrinking number of academic anesthesia training programs.

5 Dr. Urata: Second.

6 [off mike chat]

7 Dr. Senagore: Comment first and then we'll have Dana read that back to us.

8 Dr. Ouzounian: The question I have is I see a crisis in other academic training programs. Is  
9 anesthesia disadvantaged? Not to pick on you, but should it not be more encompassing to say there's a  
10 crisis brewing with all academic training programs?

11 Dr. Williams: The particular measure that I'm speaking about is when an anesthesia attending  
12 supervises two residents, they only get paid 50% for one resident, and 50% under Medicare, for the other  
13 resident. You as an example, get paid 100% for each case as long as you participate in the critical portions  
14 of the case. That's the particular part in addition to the SGR that's affecting anesthesia academic programs  
15 in particular. I'm not aware that there are other specialties where that is occurring. If you know about them,  
16 I'd be glad to hear it.

17 Dr. Ouzounian: No, that's fine, it wasn't meant as an argument. So there's a significantly different  
18 jeopardy that you people face.

19 Dr. Williams: Exactly.

20 Dr. Ouzounian: OK, thank you.

21 Dr. Williams: You're welcome.

22 Dr. Senagore: Can you read that back to us, please?

23 Ms. Trevas: PPAC recommends that CMS continue to evaluate, pursue and correct disparities in  
24 payment to academic anesthesia programs as it differs from other groups, to positively affect the academic  
25 training programs.

26 Dr. Williams: To positively affect, what do I want to say, the reimbursement. Positively affect and  
27 update, correct, positively affect reimbursement.

28 Dr. Senagore: You OK there? So I'll call the question. All in favor?

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1 [Ays]

2 Dr. Senagore: Against? Any issues in terms of practice expense? That engendered a fair number of  
3 questions. OK, fair enough. So maybe we should ask that they come back. Would the timing be OK for the  
4 next meeting that we could have them come back?

5 Dr. Simon: Yes.

6 Dr. Gustafson: I was already planning on that.

7 Dr. Senagore: Thank you. That was a suggestion, not a recommendation.

8 [off mike chat]

9 Dr. Gustafson: The target for the rule is give or take July 1<sup>st</sup>, so you'll have a 60-day comment  
10 period. We frequently don't make those targets, although we're certainly trying hard.

11 Dr. Sprang: Recommendation to commend CMS for using the consortium for the current reporting  
12 mechanisms for the voluntary physician reporting program, and that PPAC recommend that all physician  
13 measures used by CMS should be developed by physician specialties through the consortium, endorsed by  
14 the NQF, and implemented uniformly across public and private programs, by working through the AQA.

15 Dr. Urata: Second.

16 Ms. Trevas: I missed actually the first part that you commend CMS for using the input from the  
17 consortium on which issues?

18 Dr. Sprang: On quality measures for the Physician Voluntary Reporting Program.

19 Mr. Trevas: OK. PPAC commends CMS for using the input of the AMA physicians consortium on  
20 quality measures for the Physicians Voluntary Reporting Program, PPAC recommends that all physician  
21 measures used by CMS be developed by physician specialties through the consortium, endorsed by the  
22 NQF, and implemented uniformly across public and private programs by working through the AQA.

23 Dr. Senagore: There was a second, so if we're happy with that, I'll call the question. All in favor,  
24 say Ay.

25 [Ays]

26 Dr. Senagore: Against? Motion carries. Is there else?

27 Dr. Williams: I have a question. When Dr. Valuck was speaking about the measurement of the  
28 neck X-rays prior to MRI and CT scans, and how when they measure the outcome, it turned out that the

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1 doctors did not realize that they were being measured on that measure, does that reflect a disconnect  
2 between where developing measures through the subspecialty societies or not, I couldn't tell what—and we  
3 didn't have time to ask him a question. I couldn't tell if that was just lack of knowledge.

4 Dr. Simon: We have invited Dr. Valuck back and he has accepted the invitation to come back to  
5 the August meeting, and not only provide a brief synopsis of his talk today, but provide a progress update  
6 and be available to answer any additional questions.

7 Dr. Senagore: My understanding of the presentation was in fact that there was serious disconnect  
8 in terms of what were real guidelines or not, how they were applied, the interpretation of people's allegedly  
9 utilizing them, so I think it will be an interesting discussion when we reconvene. Is there, Dr. Azocar.

10 Dr. Azocar: Yes, this is just a comment, which may lead to a recommendation if you consider it  
11 appropriate. But I was thinking that the quality of the presentation that we have is such that I wonder if we  
12 may work out to get like CMEs, or to consider the possibility that CMAs may suggest, or we suggest that  
13 this may be valuable for CMEs for the physicians that participate in these meetings?

14 Dr. Senagore: Dr. Simon's working out the charge as we speak. [laughter] I think we'll have to  
15 reconsider that option. Any other comments or questions? I thank everyone again for taking time out of  
16 their busy schedules and thank you for your participation, and I'll look forward to seeing you next time.

17 [Adjourn]

18

19

20