

**CENTERS FOR MEDICARE AND MEDICAID SERVICES  
PRACTICING PHYSICIANS ADVISORY COUNCIL**

CMS Single Site Campus, Multipurpose Room  
Centers for Medicare & Medicaid Services  
7500 Security Boulevard  
Baltimore, Maryland 21244

Monday, August 18, 2008  
8:30 a.m.

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Public Witnesses

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### Open Meeting

Dr. Bufalino: Good morning. My name is Vince Bufalino. I'm the chairperson of the Practicing Physicians Advisory Council, and I want to welcome all of you to today's meeting, the 65<sup>th</sup> meeting of the Council, and an opportunity for us to have dialog with our partners at CMS. I'd like to thank all my colleagues and co-council members for taking time out of your schedules to spend the day here with us in Baltimore in an effort for us to try provide some advice to the members of CMS who are going to be presenting various issues to us over the course of the day, and I encourage all of you to have thoughtful and practical contributions to what we hope to be better healthcare in the United States. As you know, from looking at today's agenda, it is a power-packed meeting with a lot of things to be covered so we will ask that the presentations, after each presentation, an opportunity for you to have some dialog with the presenter, and after each of these, if there are recommendations from the Council for actions that we'd like CMS to respond to, we'll take those as we go along. And Dana will accumulate those over the course of the day and ask all of you to read slowly and be mindful of her ability to try to get down each of these recommendations. And then at the end, we will have a wrap-up session to add some additional recommendations as a matter of course, for things that might have gotten skipped over the course of the day and then, depending on time, we may or may not have the opportunity to have her complete that and have a written set of recommendations that we could look at before we leave. So that's the plan for today. We'd like to begin the morning, and welcome Mr. Kuhn, who as you know, is the Deputy Administrator for the Centers for Medicare and Medicaid. And we're always pleased to have Herb join us, and thank you for taking time out of your busy schedule to spend the morning with us. Thank you for that and we'd ask you to reflect on a few thoughts.

### Welcome

Mr. Kuhn: Thank you very much. And good morning everybody. And first of all, let me welcome the PPAC meeting members again, and also welcome to Baltimore campus at CMS. I know some of you, this is your first trip here. And I hope everybody from staff gave you the appropriate directions, in terms of when you got here, but what to expect at our front gate as you got in. I know as I was driving in, I passed

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1 and I saw some of the cars pulled over, and the hoods of the cars up and pulling the luggage out of the  
2 back, so security here, for some reason is extraordinarily tight, and you all experienced that, and I hope it  
3 was pretty easy for everybody to get in. But thank you all for being here. And for participating in this  
4 meeting.

5 This particular meeting comes at an interesting time to be sure. It comes on the heels of what we  
6 all saw happen on July 1, where the struggle with Congress in order to deal with physician payment issue,  
7 resulted in the lapse of current law and the reduction in about 10% payments. What I do want to say,  
8 though, is based on the good advice we've received from this committee in the past, the good work of Dr.  
9 Rogers and the PRIT team, and the work of the Center for Medicare Management, which Liz Richter here  
10 is the Deputy Director, I think CMS worked as hard, as best we could to make that as seamless for  
11 physicians and other Part B providers to the extent we could to make sure that cash flow was there and to  
12 deal with the payment issues the best we could, and also on our part, to deal with the issues in terms of  
13 reprocessing claims ourselves instead of asking physicians to resubmit those claims. That was a difficult  
14 period for everybody, but I think we all soldiered through the best we could. But having said that, this  
15 challenge is not going to go away for any of us. Those that have looked at that legislation know that coming  
16 up in January of 2010, we have an 18-month reprieve, but in January of 2010, unless Congress acts before  
17 then, we have another reduction in place. But this time, the order of magnitude is probably double what we  
18 saw this last time. We're looking at 20% at that time. And so the work of this committee, I think, over the  
19 next 18 months, is going to be more powerful and more important than ever before if you think of some of  
20 the issues. Obviously this particular agenda is pretty important. I think particularly when you look at some  
21 of the issues of the RAC, issues that we've got several of the demonstration projects that we have  
22 underway, people will be talking about today. As well as a proposed Physician Fee Schedule as well as the  
23 Outpatient Proposed Rule, as well as the Ambulatory Surgical Centers are all important discussions.

24 But I think it becomes more important for future meetings as well, particularly when you look at  
25 some of the things that were in the MPPA legislation, particularly one important provision that deals with  
26 the report that this agency needs to deliver to Congress here in the near future. It really begins to talk about

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1 value-based purchasing and how we would go about implementing value-based purchasing, at least on the  
2 physician payment side. We had a similar experience that we had last year where we did one for hospitals,  
3 that we delivered to Congress in November of last year. And we hope to replicate that same process and be  
4 as inclusive as we possibly can, and I know at future meetings, Dr. Tom Valuck, who's heading that effort  
5 will probably be talking to a lot of you about that report, because hopefully that, too, will reflect our ideas,  
6 hopefully the ideas of some of the round this group, in terms of trying to inform Congress as they move  
7 into that debate next year.

8 So with that, again, welcome, welcome to Baltimore. We've got a full day's schedule here, lots of  
9 good things to cover. But I think we also know that the work of PPAC will become ever more, I don't want  
10 to use the word "urgent," but I think ever more important over the next six to 12 months, as we continue to  
11 think about these important issues of physician payment and look forward to your engagement on those  
12 issues in the future. So Dr. Bufalino, thank you.

13 Dr. Bufalino: Thank you, Herb. I'd like to also introduce Liz Richter, who's the Deputy for the  
14 Center for Medicare Medicaid. Thank you for joining us and missing is Dr. Jeff Rich, who they tell me is  
15 doing bypass surgery this morning, so he's occupied and going to miss the meeting. But we will see him on  
16 the next go around. So let's begin the agenda, unless someone has something to raise ahead of time. Thank  
17 you for that update and I think an important thing for all of us to understand, the impacts of the new  
18 legislation and what it means to the agency and that we know that there's a number of January 1 deadlines  
19 that the new legislation has put in place and I'm sure is taking up some of the valued time of the agency, in  
20 an effort to meet those guidelines. So without further ado, we'll move into the agenda and ask Dr. Ken  
21 Simon who's the Executive Director of the Council, and Medical Officer here at Medicare to present the  
22 responses of the agency in terms of the PPAC recommendations for [May?].

### PPAC Update

24 Dr. Simon: Good morning to the members and the public. I'll read the recommendations from the  
25 May 19<sup>th</sup> meeting that was held in Washington, D.C.

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1           Agenda Item D, 64D-1. PPAC recommends that all agenda items, including testimony, be  
2   provided to councilmembers two Fridays before a Monday meeting, which is approximately 10 days in  
3   advance. CMS response: CMS will continue to make every effort to provide all meeting materials to the  
4   Council once they've been reviewed and cleared internally by the agency. As early as possible prior to each  
5   meeting.

6           Agenda Item G, the NPI Update. PPAC recommends that CMS allow physician practices and  
7   others to continue to submit transactions that contain both legacy numbers and NPI numbers for a  
8   minimum of six months after the May 23, 2008 deadline. The response: CMS did not have the authority to  
9   allow use of legacy numbers after May 23, 2008. Fortunately, most providers were able to comply with the  
10   NPI only mandate. And we're pleased to report that most contractors report over 95% compliance and in  
11   fact, the national aggregate is estimated above 95% compliance.

12           64G-2. PPAC recommends that CMS closely monitor the readiness of covered entities to submit  
13   claims with only the NPI number, and take appropriate steps necessary to ensure the industry does not  
14   experience wide scale disruptions in claims processing and payment during the transition. The CMS  
15   response: CMS agrees with this recommendation. CMS has been closely monitoring NPI implementation  
16   before and after May 23, 2008. With regard to Medicare, there was some concerns with secondary  
17   identifiers. These were quickly resolved by providers and clearing houses, with excellent results. CMS does  
18   not receive data related to NPI issues or implementation from individual payers, however, we monitor NPI  
19   implementation, based on the number of complaints and inquiries we've received on the list serve activity.  
20   To date, we have received less than 30 complaint and problem inquiries since the end of the contingency  
21   period on May 23, 2008. And all of those were handled within 24 to 48 hours of receipt. We have not had  
22   any new inquiries or complaints since July 20<sup>th</sup>, and we have not heard of wide scale disruptions in claims  
23   processing and payment during the transition.

24           64G-3. PPAC recommends that CMS determine whether compliance with regulations prohibits  
25   CMS from ignoring the legacy number on a claims submission as an alternative to rejecting all claims that  
26   contain both NPI and legacy numbers as of May 23<sup>rd</sup>, 2008. CMS response: The NPI is required to identify



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1 covered healthcare providers and HIPAA transactions. For Medicare Fee for Service, all Medicare claims,  
2 both electronic and paper, must use the NPI as the sole provider identifier.

3 64G-4. PPAC recommends that CMS continue to accept claims and other transactions that contain  
4 both legacy and NPI numbers until it is apparent that at least 95% of claims are processed successfully with  
5 only the NPI number. The response: CMS implemented the NPI on May 23<sup>rd</sup>, 2008 in accordance with the  
6 regulations. CMS closely monitored implementation and had daily meetings with all Medicare contractors.  
7 We again are happy to report that most contractors report over 95% compliance and in fact, the national  
8 aggregate is estimated above 95%.

9 64G-5. PPAC recommends that if the contingency timeframe terminates on May 23<sup>rd</sup>, 2008, as  
10 currently planned, CMS currently monitor the rejection rates in claims processing interruptions  
11 immediately following the deadline and be prepared to allow claims to be submitted or resubmitted with  
12 the NPI and legacy numbers together if there is significant interruptions. That is, if the claims rejection or  
13 suspension rates increase more than 5% over baseline PPAC requests that CMS report the results of  
14 monitoring to the Council at its August 18<sup>th</sup>, 2008 meeting. The response: CMS continues to closely  
15 monitor NPI progress, and results have been favorable and manageable. Most rejection and suspension  
16 rates have been well below 5%. And of course, the Council will receive an additional update on NPI this  
17 morning by Mr. Stuart Strimer.

18 Agenda Item H, Overview of CMS Quality/Value Agenda. 64H-1. PPAC recommends that CMS  
19 provide significant specific incentives, including process and outcome incentives, to physicians and  
20 patients to improve health. The response: CMS currently has not statutory authority to provide significant  
21 specific incentives, including process and outcome incentives to physicians and patients to improve health.  
22 CMS is seeking to establish the framework for financial incentives to physicians and other professionals for  
23 better quality care. The physician quality reporting initiative, commonly called the PQRI is an important  
24 part of the framework. Under PQRI, there are 119 measures for 2008. These include not only process  
25 measures, but also structural and intermediate measures, all of which relate to better quality care.

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1           64H-2. PPAC recommends that as part of the Healthcare Transparency Initiative, the Secretary's  
2 four cornerstones include as part of our information on quality, both process and outcome information, for  
3 example recorded patient compliance information. The response: PQRI contains both structural and  
4 intermediate outcome measures. CMS expects to include more outcome measures as such measures  
5 become available.

6           Agenda Item K, the PQRI Update. PPAC recommends that in the event that CMS plans to make  
7 any physician-specific PQRI data public, that it notify physicians and other eligible professionals  
8 prospectively that the data collected will be made public, and that notification will be given at least two  
9 years in advance of the information becoming public. The response: We appreciate the recommendation  
10 made by PPAC. CMS is exploring the initiation of a Physician Compare website later in 2008. This will  
11 complement the CMS Hospital, Nursing Home, Home Health, and Dialysis Facility Compare websites. We  
12 are actively soliciting input on how to best design and implement a physician compare website. CMS does  
13 not intend to post performance rates for PQRI measures at the individual or group level as part of a  
14 physician compare website for 2008. CMS intends to provide notice prior to the applicable date for  
15 submission of PQRI data, if such data may potentially be used to publicly report measure performance rates  
16 for individual professionals who participate in PQRI.

17           Agenda Item O. 64O-1. PPAC recommends that CMS support immediate Congressional action to  
18 avert the pending Medicare Physician Payment Rate Cut, scheduled for July 1 and replace it with the  
19 positive update of 0.5% for the remainder of 2008, followed by a 2009 update that adequately reflects  
20 increases in medical practice costs. CMS should again support measures to ensure that these updates not  
21 increase the size or duration of Medicare physician payment cuts in future years. CMS should recommend  
22 to Congress that time is needed to pave the way for longer term reform of the Medicare Physician Update  
23 Formula. The response: The Medicare Improvements for Patients and Providers Act of 2008, commonly  
24 called MIPPA, was enacted on July 15<sup>th</sup>, 2008, as a result of a new law that mid-year 2008 Medicare  
25 Physician Fee Schedule rate reduction of negative 10.6% is retroactively replaced with the fee schedule

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1 rates in effect from January to June 2008, which reflect a 0.5% update from 2007 rates. In addition, the  
2 Medicare Physician Fee Schedule rates will increase by and additional 1.1% in 2009.

3 64O-2. PPAC recommends that in view of the fact that medical necessity determination is  
4 subjective and requires extensive clinical review, CMS review medical necessity determination from  
5 RAC's purview. And RAC is the Recovery Audit Contractor. The response: CMS understands PPAC's  
6 concerns, however the comprehensive error testing rate, commonly called the CERT Program, continues to  
7 find that a significant portion of the Medicare Fee for Service error rate caused by providers submitting  
8 claims that did not comply with Medicare's medical necessity criteria, for a given service or a given setting.  
9 Therefore, CMS believes it is important to utilize the Recovery Audit Contractor Program as a tool to help  
10 detect and correct these kinds of improper payments. CMS has taken steps to expand the use of an  
11 independent verification and validation contractor, which began during the demonstration phase, to ensure  
12 that RAC's claim determinations are consistent with Medicare's rules and regulations. In addition, CMS  
13 has implemented a new issue review process that will allow a RAC to proceed with a review only after  
14 CMS agrees with the potential findings.

15 64O-3. PPAC recommends that CMS establish a comment and appeals process for physicians and  
16 other providers before making PQRI data publicly available, and that the process be reviewed by PPAC  
17 before it's adopted. The response: CMS as part of PQRI, has established a confidential feedback  
18 mechanism for physicians and other eligible professionals who submit data. This gives physicians and other  
19 eligible professionals the ability to review the reporting of performance results under PQRI. Under the  
20 statute, authorizing PQRI, there is no provision for an appeals process with respect to the calculation of  
21 reporting or performance rates.

22 64O-4. PPAC recommends that as CMS goes forward with the discussion of its quality roadmap  
23 and strategies for quality improvement, it include evidence that issues under discussion actually improve  
24 the quality of patient care. The response: As CMS and its partners develop healthcare quality measures, the  
25 measures are deployed and tested in several venues. One venue is within various demonstration projects  
26 conducted from our Office of Research, Demonstration and Information. The results of all such studies are

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1 widely disseminated out side of CMS and also shared with Congress. A second venue for establishing  
2 evidence is within the Medicare Quality Improvement program, a nationwide program, authorized by  
3 statute. The current contract for the QIO program includes an enhance measurement and evaluation strategy  
4 designed specifically in response to the Institute of Medicine's recommendation for more robust evaluation,  
5 of specific attempts to improve the quality of patient care. These projects will be evaluated by an  
6 independent, non-agency evaluation contractor. The results of these evaluations will be shared widely  
7 outside of agency. Finally, administrative data from the Medicare Claims files, allow quantitative  
8 monitoring of changes and quality measures over time, particularly as related to the implementation of  
9 value-based purchasing programs.

10 64O-5. PPAC recommends that CMS not allow the RACs to review Evaluation & Management  
11 Services. The response: CMS will continue to consult with the AMA and PPAC prior to beginning any  
12 reviews of evaluation & management services, based on the level of service. After such consultations, CMS  
13 will allow the RACs to proceed with reviews of evaluation & management services. CMS will direct the  
14 RACs to use the same review methodology utilized by the comprehensive error rate testing commonly  
15 called the CERT, that contractors, carriers, and Medicare administrative contractors currently use. That is  
16 to use either the 1995 or 1997 E&M guidelines, whichever is more advantageous to the provider.

17 64O-6. PPAC recommends that any item selected for reduction or inclusion in value-based  
18 purchasing initiatives, be open to public comment and that recommendations be published in a notice of  
19 Proposed Rule Making so that specialty societies can comment. The response: CMS anticipates  
20 implementing Medicare value-based purchasing initiatives through Notice and Comment Rulemaking,  
21 which provides an opportunity for formal public comment. CMS also hosts periodic forums, during which  
22 informal comments are encouraged.

23 64O-7. PPAC recommends that CMS preclude RACs for reviewing any claims with the past 12  
24 months and only authorize reviews for claims processed in the past 12 to 24 months, to allow time for fiscal  
25 intermediaries to complete their ongoing reviews of claims. Response: CMS has a RAC data warehouse,

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1 which will exclude those claims undergoing carrier or fiscal intermediary review from RAC review. This  
2 process worked very well during the demonstration phase of the RAC project.

3 That, Mr. Chairman, concludes the report from the May 19, 2008 PPAC meeting.

4 Dr. Bufalino: Thank you, Dr. Simon. Comments, questions? Seeing none, I appreciate that, thank  
5 you. And we'll move on to the agenda. Actually my little script says Ms. Cathy Carter is giving this report.  
6 You don't look like Cathy Carter. It has in there that she's a lifer here at the organization and maybe she's  
7 decided that she should be replaced. [laughter] Anyway, I'm sorry.

8 Dr. Simon: Stuart Strimer.

9 Dr. Bufalino: Strimer, thank you. Please take a moment to introduce yourself. I'm sorry I don't  
10 have your credentials in front of me.

### 11 NPI Update

12 Mr. Streimer: Good morning Mr. Chairman, good morning, members of the PPAC. My name is  
13 Stuart Streimer. I am the Director of the Provider Billing Group, in the Center for Medicare Management  
14 here in CMS. And unfortunately, Cathy Carter, at the last minute, for personal reasons is unable to be here  
15 and she sends her regrets and apologies, and I am her fill-in for this morning to give you basically an NPI  
16 Update and I think it's fortunate that the NPI Update for today is brief. There were a number of  
17 recommendations made at the last PPAC meeting which was prior to the May 23, 2008 deadline. I believe  
18 Dr. Simon has gone through those recommendations and our responses. Today, the NPI is implemented  
19 throughout the country. We are over 99% NPI-compliant throughout the country, which is clearly a very  
20 encouraging statistic. We have seen great progress since May 23<sup>rd</sup>. The one probably thing that stood out on  
21 May 23<sup>rd</sup> is that there were some issues associated with secondary identifiers, and using the NPI in the  
22 secondary identifier field. That issue was quickly resolved, and again, I'm pleased to report that we have  
23 over 99% compliance, with full NPI requirements. We have very few claims being rejected with regard to  
24 the NPI, and very few claims being suspended for further development as a result of the NPI.

25 I think one of the points that I'd like to make because I'm sure many of you, if not all of you, have  
26 still heard some stories with regard to some of the continuing products of NPI implementation. And I think

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1 first and foremost, if the NPI implementation surfaced any one particular item, it was the fact that some  
2 provider enrollments records were not current or up to date. I think we've heard stories about that for some  
3 time, even since the March 1 NPI requirement where the NPI was required on all claims, though you could  
4 have an NPI legacy pair, but we continue today to hear some issues associated with provider enrollment  
5 that surfaced as a result of the NPI implementation. Those issues are being managed by each and every  
6 contractor. We have been informed that those issues are very manageable; providers that are having some  
7 issues with provider enrollment are getting their enrollment applications into the contractors and those  
8 enrollment applications are being corrected, so for the most part, I think the news is good, and we are very  
9 satisfied and happy with the results of the NPI implementation effort.

10 Remittance advices have been going out since April with the NPI only and we have heard very  
11 little with regard to how that is working or not working at a particular physician's office. We assume that  
12 everything is well because quite frankly we haven't really heard anything with regard to the remittance  
13 advice. And that applies as well to all of the other transaction sets under HIPPA, that require an NPI. So  
14 that's basically my report. I'm certainly available for questions, but the NPI is fully implemented  
15 throughout the Medicare Program.

16 Dr. Bufalino: Thank you. Questions. Fredrica?

17 Dr. Smith: We've been told, my office and a number of other offices in my area, that if a physician  
18 moves from, for example, Oregon to New Mexico, he has to apply for a new NPI number. And I  
19 understood that it was a national number and assumed that it would just be a seamless transition. But we're  
20 being required to fill out new forms and send them in and just for your information, there appear to be two  
21 forms. And if you send in one form, it's rejected because you don't have the other form with it, and if you  
22 send in the other form, it's rejected because it's an old form. And so I think the provider enrollment process  
23 has some significant issues. But I would appreciate clarification from what national truly means. It's CMS  
24 that's telling us that you have to apply for a new number.

25 Mr. Streimer: OK, first of all, I don't know whether anyone is here from the Provider Enrollment  
26 area, but as far as the NPI per se, you only need one NPI. You do not need more than one NPI, no matter

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1 where you travel across the country. Now, when you move your practice, you may need to change your  
2 enrollment information in the Medicare Program for that particular contractor, with whom you'll be  
3 interacting.

4 Dr. Smith: Right, that I know, but they're being, they're telling people in New Mexico, not just  
5 my office—

6 Mr. Streimer: That they need a new NPI?

7 Dr. Smith: That they need a new NPI number. They have to enroll as a new, to get a different NPI  
8 number, since they changed—

9 Mr. Streimer: Well, I will be happy to follow up on that because that is not the way the program is  
10 set up to get a new NPI number.

11 Dr. Smith: ...I wondered because it said it was national, but that's what they're being told in New  
12 Mexico.

13 Dr. Bufalino: Thank you. Art?

14 Dr. Snow: Regarding your comments on no problems with the NPI. Au contraire. Let me tell you  
15 my personal story. I quit getting payments from Medicare, starting July 1<sup>st</sup>. My payments decreased to  
16 about 5% of what they had been previously. I filed my paper, nothing else had changed, and we've been  
17 working through the problems, and I finally found out on August 1<sup>st</sup>, when I got a remittance notice, of 207  
18 claims on it for \$25,000 that had a \$0 check with it, no payments whatsoever, every claim was denied. And  
19 I've been working with the carrier, WPS, they've been helpful trying to help me get payments and they  
20 may be coming in now, but it turns out, it appears that I had both of these problems you talked about. I'd  
21 never heard of a secondary identifier until Ken's report the other day, and I had UPIN numbers printed out  
22 on my forms, and apparently that was the reason for denying 90% of my claims. And I consider myself  
23 fairly knowledgeable about you know the process and what's required, but nobody had ever mentioned that  
24 to me. I couldn't find it any place, so I am way behind the 8-ball, but I think that's getting taken care of. I  
25 am signed up inappropriately with Medicare, and quite frankly, I don't think I can sign up appropriately  
26 with Medicare if I have to reenroll. And the reason for that is I'm a geriatrician, I practice in nursing

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1 homes, assisted living facilities, patients' homes where I go to visit them, occasionally in the hospital, very  
2 minimally in an office setting that I sublease. I may show up there an hour a month, sometimes an hour a  
3 week, so quite frankly, I have no address to put down if I have to reenroll. I'm not going to put my home  
4 address, because you're advertising that to the public, like you are my NPI, my old Medicare Number, to  
5 let everybody in the world fraudulently file claims, using my numbers, and I'm certainly not going to put  
6 my home address. So I have no, I feel I have no way that I could reenroll.

7 Interestingly, even though my corporation is not signed up with Medicare, my name is with my  
8 corporate ID number. So at least for right now, I just drop the MDPA from my forms, and I think I'm going  
9 to get paid. But I don't know. I've gotten two checks, since the first of August, and that's it. We've got a  
10 little group at our hospital that does some CME. There's about 12 docs in this. I asked them three weeks  
11 ago, how many of you are having problems with Medicare? Eight of the 12 said they'd gotten no checks for  
12 eight weeks. Now these people file electronically so it's not because I'm a paper filer. So au contraire, there  
13 are huge problems that NPI, the switch to the new carrier, contractor, cross-checking who is signed up with  
14 what, with the IRS. I'm still not sure we know what the problems are. Our WPS contractor has either  
15 knowingly not giving us information when our state finance person tries to get information on the problem  
16 rate, they repeat your story. There are no problems. Au contraire, there are problems. I think either the  
17 contractors don't know it and are not telling you, or they're lying to you, to be quite blunt. Now I'm not  
18 sure that you've got an answer for me today, but I want to let you know. I think there is a tremendous  
19 problem out there, sir, and hopefully it is getting solved, but it has caused tremendous problems, I think  
20 across the country and not just in my region. Thank you.

21 Mr. Streimer: May I respond?

22 Dr. Bufalino: Please.

23 Mr. Streimer: Thank you, Dr. Snow. And I am certainly happy to take your information and go  
24 back to find out what is going on with your claims. The point I made is that the NPI had surface problems.  
25 The NPI implementation itself, we believe there are very few problems remaining in terms of physicians  
26 complying with the NPI requirement. Case in point, over 99% of the claims coming into Medicare are NPI



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1 compliant. I think the issues that you were raising relate to provider enrollment records that were surfaced  
2 as a result of the NPI implementation. And what we are learning is that the claims processing systems are  
3 processing claims correctly, but it's really important for our provider enrollment records to make sure that  
4 we have the correct information so that we're correctly, we're paying the correct person and we're sending  
5 the payment to the correct place. So I'm very sympathetic to concerns that we've heard, during the course  
6 of the NPI implementation, especially over the past three months, that are surfacing provider enrollment  
7 issues, and we are working with our contractors to make sure that they are working down those backlogs of  
8 855 enrollment applications to make sure that we are able to pay claims correctly, pay the correct person,  
9 and to make sure we're sending payments to the correct place. But again, I'm more than happy to take your  
10 information and do a little bit of research to find out why in your particular situation you may be having  
11 some difficulties.

12 Dr. Bufalino: Thank you. Other comments?

13 Dr. Howard: I just want to say are you, I know you're looking at correct payments and to the right  
14 person, but have you looked at how long it's taking to get the physician paid? Do you have any of that  
15 data?

16 Mr. Streimer: I don't have data at my fingertips on that. I do know that there are national standards  
17 in terms of completing provider enrollment applications, but currently the contractors are meeting the  
18 claims processing timeliness standards, if that's your question.

19 Dr. Howard: I mean just it's taking a long time for you to get paid, right, as well? I mean I'm just  
20 curious if there's—

21 Mr. Streimer: No I think some of those circumstances, you're probably having trouble even  
22 getting your claim in the door, let alone the time frame it takes for getting the claim paid, and that's why I'd  
23 like to do a little bit of research behind why there may be difficulties with your particular claims. And if  
24 you're starting to see payments, why are some getting paid and some not? That's also a question we'd like  
25 to ask.

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1 Dr. Smith: Since you're saying that some of the problem appears to be the provider enrollment  
2 process, and again I'm speaking from Northern New Mexico, not just personal, but Northern New Mexico  
3 experienced seven to eight months to get somebody enrolled. Is there a way to expedite that process  
4 because if a new physician is brought into a practice, trying to get claims from that physician paid is pretty  
5 high priority in less than seven or eight months. And that's where most of the people in our area seem to be  
6 when they bring somebody new in.

7 Mr. Streimer: If it's taking that long to get a provider enrollment application processed, then that's  
8 a problem and we'd like to hear more about that. We do have standards in place, most applications,  
9 especially initial applications are completed within 60 days, and the effective date, providers, I believe can  
10 start billing the program when they send in their application. They do not need to, they need to wait to  
11 submit the claim, but the services are payable under Medicare at the point in time that I believe the  
12 application is received by Medicare. So it's not like they would losing the opportunity to bill, but they may  
13 be delayed in billing the program.

14 Dr. Howard: Do you know how well, nationally, that standard of 60 days is being met?

15 Mr. Streimer: I'm sorry, I don't know.

16 Dr. Bufalino: Other comments? Maybe take a moment to poll the Panel. Is anyone else having  
17 difficulty receiving reimbursements since the change?

18 Dr. Ross: Yes, Mr. Chairman. I'm still waiting for payment. We were hoping that this week, we  
19 might start receiving payment, but even at the last meeting, when we first described this problem, that's  
20 how long it's been for me to receive payment because of these numbers. So I'm one of those people as  
21 well.

22 Dr. Bufalino: OK. Dr. Smith, you also? Anyone else? So just some, please, Tye?

23 Dr. Ouzounian: Well, I hate to be the odd man out, but we had some troubles getting payment, and  
24 when we called them up it was clearly our fault and when we rectified the situation, we were paid  
25 promptly.

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1 Dr. Bufalino: OK. Good. Any other comments? There's some feedback for you, Mr. Strimer.  
2 Thank you for taking the time to be here this morning. We appreciate that. And hopefully you can help us  
3 with some of those details. Unfortunately, we're only a small microcosm of the country, and you know, we  
4 concern ourselves with how widespread is it, is it obviously bigger than the folks sitting at the table here?

5 Mr. Streimer: Thank you. I appreciate the opportunity.

6 Dr. Bufalino: Thank you very much. We'll move on to the next presentation and ask Dr. Rogers to  
7 present the PRIT Update. He's got his sign and we're glad to have Dr. Rogers, Director of the PRIT, in the  
8 Office of External Affairs and we're looking forward to your cartoons. [laughter] Good morning.

### 9 PRIT Update

10 Dr. Rogers: Thank you for inviting me to give my 4,287<sup>th</sup> PPAC report. [laughter] It's a pleasure  
11 to be here. I know just about everybody around the table, but the one thing I am known for is not being the  
12 brightest light here at CMS, but I always have a cartoon and I want to thank the stuff for sort of blinking as  
13 this cartoon goes by because I know it's not compliant with the current requirements for making all of our  
14 presentations accessible to everybody. Some of the issues that we're working on right now, the first issue,  
15 I'm embarrassed to say, we started working on in 2006. Unfortunately, because it impacts multiple  
16 agencies, Department of Defense, US Public Health Service, CMS, and because it involves lawyers, it has  
17 taken forever. We still don't have a resolution, and unfortunately the key person, right now is another  
18 country, and so we're still working on this, but this has to do with the ability of active duty military  
19 physicians to bill particularly Medicare.

20 We also have been very involved sort of as sounding boards on Recovery Audit Contractors. Of  
21 course that's program right now, is abeyance, but Melanie and Connie have done such a wonderful job of  
22 being responsive to providers' concerns that this has been a gratifying issue to be involved with. Talking  
23 again about NPI crosswalk problems. My experience and actually I talked to Art about his problem, is that  
24 most of physicians now have fixed their problems. We did have a lot of access problems with some of the  
25 carriers, particularly carriers that were losing their contracts, and it was very painful for some physicians to  
26 get through this. The wonderful thing is this is a one time thing. Once the NPI crosswalk is fixed, that's not

19

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1 going to be a problem again for the vast majority of physicians, and it's nice when unlike the Physician Fee  
2 Schedule, instead of being an annual event, it's a once-in-a-career event. We've down now to mostly  
3 hearing problems having to do with, again, with enrollment. And that one question that you brought up  
4 about physicians who are moving—since there are two forms and if you don't submit one form the other  
5 form gets rejected, that sounds to me like probably the 855 form and 588 form we now require that every  
6 physician who enrolls in Medicare accept electronic payments. So that sounds to me like it's probably an  
7 address change processing with the carriers with Medicare, rather than having to do with NPI. Most people  
8 get their NPIs electronically, so there's no paperwork that's submitted for the NPI. So I'm suspicious that's  
9 probably an enrollment problem.

10 Recoopment notice, identifying information. This is a down in the weeds issue, but very important  
11 to people who manage your offices. When you get a recoopment notice, the recoopment notice doesn't  
12 have any information on it about what claims that notice applies to and there's a very cumbersome process  
13 that your office manager has to go through, to reconcile payments to claims and things, and so we're  
14 working with the Healthcare Billing Management Association, the MGMA and others to try and get more  
15 information on that recoopment notice, but there's challenges because much of this stuff is all in the  
16 HIPAA electronic claims processing rules, having to do with where things go on fields and stuff, and it's  
17 really, it sort of makes your eyes glaze over. But it's one of those little things that if we can fix it, it's going  
18 to save every office in the United States hundreds of hours of work, and you multiply that time 800,000  
19 participating providers, and you've got real money.

20 [Ravadio?] label dosage. Unfortunately, Part D plans are not able to pay for drugs if the prescribed  
21 dose is in excess of the label, and pulmonary hypertension being treated by Ravadio, many of the  
22 pulmonologists and others treating that disease are using doses which is higher than the label. It's  
23 appropriate to use those, there's plenty of articles out there that say it's appropriate to use it, but  
24 unfortunately, the plans, the PDPs have to deny the claims and require an appeal, which because it's in  
25 excess of the label and it's a safety issue. And it's really an interesting problem because the manufacturers  
26 have no incentive really to raise, to ask the FDA to raise the label, so we actually have a pulmonologist

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1 who's going to try to submit paperwork to the FDA to get the label dose raised, and to the extent that we  
2 legally can, we're supporting her in that process. And it's going to be interesting to see how easy it turns  
3 out to be.

4 PQRI reports and payments. This has been a challenge for many physicians, particularly  
5 physicians who enrolled with Medicare before PECOS. There've been problems and we're a) trying to help  
6 with the problems, and b) trying to learn from it, so that we can do a better job next year of making those  
7 reports easily accessible to the physicians. And then another issue, pain management, it was an error on our  
8 part. When we updated the enrollment form, we accidentally left off 072, which is the old pain  
9 management specialty code, and only had interventional pain management, 009. It was our error. We  
10 figured out that it is, that the old specialty code still—I shouldn't say old, but the original specialty code  
11 still exists in the PECOS software, therefore if a physician's enrolling, and they want to be a, use the 072  
12 code, they can just write that in on the enrollment form and they will be enrolled under that specialty.

13 Dr. Snow: Excuse me, Bill, what is 072?

14 Dr. Rogers: It's the old, it's the original pain management. There was one code that was pain  
15 management, and then there was a new code that was proposed that was called interventional pain  
16 management. And we accepted that new code, but we didn't delete 072, because some physicians consider  
17 that as better describing what they do. So it was a clerical error on our part. Many people looked at the form  
18 and everybody missed it. And it's unfortunate. When we renew the form, revise the form, we'll include it  
19 on it. But we did let the specialty societies know about the work around so they could tell people training in  
20 that specialty if it was important to them to enroll 072.

21 Just some speeches that I'm going to be doing in the near future, just to demonstrate that we're  
22 still doing a lot of traveling. Matt Brown, my deputy, is also doing a lot of traveling. He just got back—it's  
23 107 degrees in Kansas City, thank you very much, Art. He had a great time. He couldn't wait to get back to  
24 cool Washington, D.C. Some of the case work that we're doing has to do with also some of the issues and  
25 often times with this case work that we do we learn about issues that we weren't aware of. But there have  
26 been issues with contractor transitions and accessibility as I said of contractors who were losing their

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1 contracts. We're still seeing a few Part D formulary issues, but that really has died down. I think a lot of it  
2 has just been as physicians have become more sophisticated about prescribing the appropriate drugs or at  
3 least the cover drugs, initially. And lastly, we've had a number of discussions with different specialty  
4 societies concerns about the hospital acquired conditions, and impact on payment. Physicians have been  
5 concerned that that might impact their personal payment or that it might impact the hospital's enthusiasm  
6 towards supporting their particular specialty in the hospital, like the Burn Association.

7 So sort of a bit of a joke. Our website was broken for probably the past three and a half week, and  
8 so we had to put our key website up, and if you keyed in HHS.gov/PRIT, you would have come up with  
9 error, page not found website. We finally I think have got that fixed this week. But it was not fixed when I  
10 made the slides, so I just figured I'd put it on there.

11 So that's my contact information. That's the cell phone that's on my hip and my email address and  
12 I look forward to hearing from you.

13 Dr. Bufalino: Questions, comments? Dr. Snow?

14 Dr. Snow: One quick one, Bill, sort of a different topic. I understand there's something the Tricare  
15 Fraud Unit, that the provider cannot use basically ABNs, cannot bill patients anything other than their  
16 copays. Do you know anything about that? Have you heard about that?

17 Dr. Rogers: That's a Tricare issue, so we can explain it to me more off line. I do understand  
18 Tricare pretty well, because I'm also in the Air Force, but we can probably talk about—it's not a Medicare  
19 issue so probably not appropriate to talk about it in the meeting, but I definitely be interested in hearing  
20 about it from you.

21 Dr. Snow: Well, other than that Medicare has Tricare as their secondary, and many patients do, so  
22 many of us dealing with primarily Medicare patients get involved with it, when Tricare is secondary.

23 Dr. Rogers: Sure. OK.

24 Dr. Snow: Like I say, it looks like it's a new issue. I don't have much detailed information about.

25 Dr. Rogers: Sure. Well let's talk about it during the break. I'd be interested to hear more about it  
26 and if it turns out to be something that we need to fix, we'll work on it.

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1 Dr. Snow: Appreciate it.

2 Dr. Bufalino: Other comments. Dr. Rogers, question I had, the PQRI, what we understood is about  
3 50% of the folks that submitted their data did not receive payment or won't receive payment. So when will  
4 that feedback be provided back to those individual physicians? Because obviously it's an ongoing process  
5 and if they either did poorly and want to change what their doing the second time around, for '07, we're  
6 already six months into '07, so we're, into '08, so we're still waiting for '07 feedback.

7 Dr. Rogers: Well, I think it's more accurate to say that about 50% of physicians that submitted at  
8 least one quality measure, actually receive payment. And in my unscientific survey, I think the vast  
9 majority of those cases were practices which either accidentally or sort of without any clear plan in mind,  
10 submitted a few quality measures. It's not inconceivable in a 2500 claims that you submit, that somebody  
11 would say, Hey, I wonder about doing this, or something and putting a code on there. I have not heard from  
12 physicians who have found that the system didn't seem to work for them when they've made a concerted  
13 effort to achieve 80% threshold that was required, but if you are aware of a case, I'd be interested in  
14 hearing about it.

15 Dr. Bufalino: Because I just checked at my shop the last two weeks, and we still hadn't had any  
16 feedback.

17 Dr. Rogers: Oh, OK, well you won't get feedback. You have to go and get the feedback yourself,  
18 and that for better or for worse, because you can see we're a fairly security conscious agency, requires that  
19 either one of the physicians in the practice or a person that the practice appoints, go through a process  
20 called IACS, and become qualified and identified as having a legitimate reason to access that data, and then  
21 they have to go into a secure website, using the password, and the user name that IACS give them, so that  
22 they can actually get your data. Your data will not be sent to you.

23 Dr. Bufalino: So could you explain again how we'd operationalize that? Who do we talk to or  
24 where do we go?

25 Dr. Rogers: There's actually, it was explained in a recent educational article that we sent out, an  
26 MLN article, but it's easiest if one of the physicians enrolls in IACS, then you don't have to go through the

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1 process of establishing a security officer, and I've forgotten what the names of all the various people, but  
2 there are three people that need to be involved if it's the practice that does it. But if one of your physicians  
3 decides to enroll, then the physician can go into IACS and it's pretty quick. I did it myself.

4 Dr. Bufalino: Can he enroll for his whole group?

5 Dr. Rogers: Yes. And then once he's gone through the IACS process, then he can go to the  
6 website and access the report and the data, and most of the practices, although the reports are sometimes  
7 voluminous, most of the practices have not had trouble accessing their data. Some practices still have their  
8 payment being held for reasons of verification and things like that, but the reports, I think should all be  
9 available. I'm sure we're going to have somebody speaking today who can answer this question more  
10 intelligently but that's the impression I got from—

11 Dr. Bufalino: I think we're actually not covered, PQRI, at least to my knowledge. So we're  
12 looking—

13 Dr. Simon: So Bill, I can talk with you off line, Bill and provide the information and I'll  
14 disseminate it to all the Council members so that they can share that in their local communities as well.

15 Dr. Bufalino: I just think there's a number of folks just trying to decide did I do it right, or didn't I  
16 do it right? Am I being paid aren't I being paid. You know, we're halfway through the year, and we still  
17 don't know what happened.

18 Dr. Rogers: Yes, we're not sending reports out. You have to go through this process and you have  
19 to access the report. And for better or worse that was a decision that was made, and so if you're waiting for  
20 a report to arrive, that's not going to happen.

21 Dr. Smith: Does the absence of a check imply that one was not successful?

22 Dr. Rogers: No, it doesn't. Most practices have been paid, but I was just speaking to somebody  
23 last week and I checked into it and their check had not been released yet and there was some verification  
24 issue, and I'm not sure how long it's going to take for those to be sorted out. Unfortunately, you have to  
25 call the carrier to find out if the check's been released and they should be able to tell you, if not, why not.

26 Dr. Smith: And if the carriers were changed, do people call the old carrier or the new carriers?



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1 Dr. Roger: They talk to the contractor who managed the PQRI, actually. And I can get you access  
2 numbers and things like that, if you want.

3 Dr. Smith: So it's not—

4 Dr. Bufalino: So that's a separate process to figure out whether we're going to be paid, versus the  
5 getting the information back, feedback?

6 Dr. Rogers: Right. Yes, the feedback report is just the statistical data about the various measures  
7 broken down at the NPI level, but the payment actually comes from, obviously from the carrier. It's a check  
8 from the carrier.

9 Dr. Bufalino: Other questions? Thank you, Bill.

10 Dr. Rogers: Thanks.

11 Dr. Bufalino: Oh, I'm sorry. Dr. Sprang?

12 Dr. Sprang: Do you want to take any recommendations?

13 Dr. Bufalino: No, I'm glad to take some recommendations. We skipped NPI, so we'll take  
14 recommendations for both of these areas.

15 Dr. Sprang: It is obvious so far, and again the AMA [unintelligible] surely want to work with  
16 quality improvement and try to get more people involved, but it still seems like a lot of physicians were  
17 having trouble and not having enough information and look at the data, and I know that the AMA wants to  
18 actively involve in working with CMS in trying to make sure physicians have enough data, and I guess  
19 what Ken and Rick are looking for too is getting access to some of the data file on 2007, to see why it  
20 worked so so, and not how many physicians participated, and out of those who did, many were not as  
21 successful as maybe they should be. The recommendation I'm going to make is just that PPAC  
22 recommends that CMS provide the appropriate data, the 2007 data, so that the AMA may immediately  
23 undertake and reduce this data, trying to improve it, going forward.

24 Dr. Bufalino: Second? Thank you. Any discussion? All in favor?

25 [Ayes]

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1 Dr. Bufalino: Thank you. Any opposed? Any other recommendations for either the PRIT or the  
2 NPI?

3 Dr. Rogers: And I guess, you know, sort of adding to that issue, once again I think a lot of  
4 practices probably either intentionally or accidentally submitted a quality measure or decided they were  
5 going to do it and after a few weeks lost enthusiasm or whatever. So it's going to be hard to interpret the  
6 data because we're not going to know how many practices made a concerted effort to participate and then  
7 were unsuccessful. And if anybody's aware of a practice that made a concerted effort to participate and  
8 were unsuccessful, I'd like to hear from them.

9 Dr. Bufalino: I think if nothing else, it would be helpful for us to just get a report as to who was  
10 successful, what percent of the country was actually successful. I mean obviously, this is a national  
11 program that if people are assuming people are complying with and as the electronic venue changes, and  
12 more and more practices become electronic, it'll make this easier, but I think it would be good to give  
13 feedback back to the physician community, either through us or through the AMA to be able to tell people  
14 10% were successful, 5%, 20%, whatever. I mean we were a little dismayed at the initial enrollment rates  
15 which seemed thin, but we really haven't gotten any feedback.

16 Dr. Rogers: It'll be interesting to see as we go forward with the combined added payment for e-  
17 prescribing, and the added payment for the quality improvement measures submission. It's turning into real  
18 money.

19 Dr. Bufalino: Exactly. Leroy?

20 Dr. Sprang: Just two other recommendations, all similar. Again our group kind of looked at it and  
21 hemmed and hawed, and just getting more information and obviously we're getting more data out there. So  
22 working again with organized medicine that may help do that, so I'm going to, PPAC recommends that  
23 CMS work with the physician community to evaluate and address continued barriers to participation in the  
24 program. Probably doing that already. Just encouraging you to do it. Got that one? And I guess a little more  
25 transparent—

26 Dr. Bufalino: Can I have a second on that?

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1 [seconds]

2 Dr. Bufalino: All in favor?

3 [Ayes]

4 Dr. Bufalino: Thank you.

5 Dr. Sprang: The big buzz word obviously in all of healthcare now is “transparency” and I  
6 wholeheartedly support it in many ways, as far as both physicians and insurance companies, and obviously  
7 in CMS. And I guess where the physician consortium for the performance improvements in looking at  
8 different criteria. A number of criteria were put forward and some of them were accepted, some of them  
9 were not. And the belief is that for some specialties now, there, they can’t participate because there are any  
10 criteria out there for them. And I guess the question is why some of them were accepted and some were  
11 not, so to kind of get, look for that information, PPAC recommends that CMS provide in the final review, a  
12 thorough explanation of why these measure were not included in the list proposed for the 2009 PQRI. That  
13 make sense?

14 Dr. Rogers: Were there specific measures you had in mind?

15 Dr. Sprang: Well, there, I don’t have the list of all of them in front me, but I know the  
16 performance, the Physician Consortium for Performance Improvement sent in a whole list of things. Some  
17 were selected, some were not. And I guess it’s not clear at all as to why some were and some were not and  
18 because some of them weren’t accepted, some physicians will not be able to participate, is my  
19 understanding anyway. So I guess looking for an explanation why some were accepted and some were not  
20 accepted. So again, PPAC recommends that CMS provide in the Final Rule, a thorough explanation as to  
21 why measures were not included in the list of measures proposed for the 2009 PQRI.

22 Dr. Rogers: Maybe we’ll just need to put to Rapp on the agenda for the next meeting. He’s  
23 running that program.

24 Dr. Bufalino: OK.

25 Dr. Rogers: Another emergency physician.

26 Dr. Bufalino: Second?

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1 [Second]

2 Dr. Bufalino: All in favor of the last recommendation?

3 [Ayes]

4 Dr. Bufalino: Opposed? Thank you. Any other recommendations or comments? Dr. Ross.

5 Dr. Ross: Yes, with what's been happening with the NPI numbers and the delays and with the  
6 rejections of claims, I would like to recommend that PPAC recommends that CMS provide more  
7 comprehensive guidelines and instructions to providers in regard to NPI and other numbers or identification  
8 numbers in order to prevent rejections and delay of claims, and to have carriers provide liaisons to assist  
9 providers in their claims as well.

10 Dr. Bufalino: Did you get that, Dana? Thank you. A second? Second. Any discussion? All in  
11 favor?

12 [Ayes]

13 Dr. Bufalino: Anything else for Dr. Rogers? Hearing none, thank you. We'll move on the agenda.  
14 This is a new area for us to cover today, is the Physician Fee Schedule proposed rules. I'd like to introduce  
15 Cassandra Black. Ms. Black is the Acting Director in the Division of Practitioner Services, here at CMS,  
16 and she and her staff are responsible for responding to the comments on the NPRM in the publication of the  
17 rule. Joining Ms. Black is James Bossenmeyer, is that correct? Mr. Bossenmeyer is Director of the Division  
18 of Provider, Supplier Enrollment in the Office of Financial Management, and is here to answer your  
19 questions related to enrollment. Ms. Black?

20 Physician Fee Schedule Proposed Rule

21 Ms. Black: Good morning. I'm happy to be with all of you today. I'm going to be talking to you  
22 about some of the issues and the Physician Fee Schedule NPRM. In the Rule, there were a whole host of  
23 policy issues, including things related to the Physician Fee Schedule. Those additional issues were Part B  
24 drug payment issues, ESRD payment, IDTF standards, enrollment issues, PQRI, e-prescribing exemption,  
25 physician self-referral and anti-mark-up, CORF and rehab agency issues, and there was a discussion of  
26 expiring provisions as well as other items. So in my remarks today, I'll be talking to you about the

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1 Physician Fee Schedule issues. I know you have other people on the agenda who will be addressing other  
2 parts of the Rule. One thing I should note is that the Rule was published on July the 8<sup>th</sup>, and the comment  
3 period closes on August 29<sup>th</sup>. So I'd encourage you to please submit your comments.

4 The first major issue that was in the Rule was a discussion of potentially misvalued codes.  
5 MedPac and other stakeholders, most notably primary care physicians, have suggested that our current  
6 process for reviewing Physician Fee Schedule are reviews, is not effective for identifying potentially over-  
7 valued procedures, and it tends to specialized services over primary care. In addition, Congress has also  
8 expressed concern about this issue. CMS and the AMA's RUC Practice Expense Subcommittee have both  
9 taken steps in the past to address this issue. The RUC has created a five-year review work group and it has  
10 identified some potentially misvalued codes. In this year's NPRM, we address this issue again, and we talk  
11 about some things that we'd like to work with the RUC on. We outline several of these approaches in the  
12 Rule. And we identified several codes that we would like the RUC to take a look at. And given the number  
13 of codes we were requesting that the RUC review, we anticipate that this process could take several years,  
14 and may become part of the next five-year review. But to begin the process, we analyzed the fastest  
15 growing high-cost procedures on the Physician Fee Schedule using 2004 to 2007 utilization data. Of these  
16 codes, we identified certain categories. In particular, those were codes with high unexplained practice  
17 expense and work RVUs, codes that had not been reviewed since the creation of the fee schedule, that were  
18 initially valued by Harvard. We also proposed a process to update the prices for high cost supply items that  
19 are paid under the practice expense methodology. This would be a two-year process.

20 We note that this is year three of implementing the bottom-up practice expense methodology  
21 change. In the Rule, there's also a discussion of some potential options for revising our localities for  
22 physician payment. We use the geographic practice cost indices, or GPCIs to measure resource cost  
23 differences among localities compared to the national average. We readjust these GPCIs at least every three  
24 years and we phase in any adjustments over a two-year period. In response to requests from California, and  
25 other parts of the country, over the last few years, we've been looking at some potential changes to our  
26 locality structure. In this year's NPRM, we announced that we have contracted with Acumen LLC to

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1 conduct a preliminary study of several options for potentially revising the payment localities. In the Rule,  
2 we mentioned that we're looking at several different potential options. However, the work on looking at  
3 these options, has just gotten underway and is in the early stages of development. In the Rule, we describe  
4 four options that we've been taking a look at, or having Acumen look at for us, and we announce that we  
5 will be posting an interim report, on these potential payment locality changes on our website very soon, and  
6 we expect that to be going up in the next week or so.

7 We aren't proposing to make any changes in the locality structure at this time, but what we wanted  
8 to do was to get the options that we're looking at out into the public and encourage people to take a look at  
9 those, let us know what you think about them, any operational concerns you see, if there are other options  
10 that you can think of that we should be having our contractor look at, we encourage you to tell us about  
11 those as well. We are going to ask the public to try to get their comments in to us within 60 days of the time  
12 the report is published. So it'll extend beyond the Physician Fee Schedule comment period of August 29<sup>th</sup>.

13 But in the event we decide to propose a change to the localities, that would be something that  
14 would be done in future rulemaking, so there would be many more chances for public input. This is just the  
15 beginning of this process.

16 In the Rule, there's a discussion of the malpractice RVUs, the professional versus technical  
17 component. BBA of '97 required that beginning in calendar year 2000, we base malpractice RVUs on  
18 malpractice data. The necessary data for the professional costs are taken from the malpractice insurer  
19 premium rate survey, which measures changes in professional liability insurance premiums. For codes that  
20 have a professional component, and a technical component, such as many of the radiology codes, the  
21 professional component malpractice RVUs reflect the data that comes in from that survey. And this was  
22 last updated in 2005. However, the technical component malpractice RVUs are still based on the charged-  
23 based data that was used when CMS implemented the Physician Fee Schedule. And this because we  
24 haven't been able to get an actual cost data that would reflect the malpractice costs associated with the  
25 technical component of these radiology codes. This issue has been a concern for the last couple years and  
26 the result of this has been that for some radiology codes, the technical component of the RVU is higher

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1 than the professional component. The physician community has expressed concern that these RVUs,  
2 whether they're accurate, and has asked us to try to make all of the malpractice costs based on actual data,  
3 and we've been trying to find a way to get actual data to do that. In last year's calendar year Final Rule, we  
4 acknowledged that we'd received several comments on these issues and we said that we were, we stated  
5 our intent to continue to solicit, collect, and analyze appropriate data. However, we haven't received any  
6 additional data since that time. In the proposed rule, we acknowledged that we've not received a response  
7 to our request for additional data and that there really is uncertainty about what's included in the insurance  
8 costs paid by many facilities, which would be part of that technical component. In the NPRM, we state that  
9 as part of our work to update the malpractice RVUs in calendar year 2010, as part of the five-year review,  
10 we'll instruct our contractor to research available data sources for the malpractice costs associated with the  
11 technical component of these radiology codes. We'll also ask the contractor to look into what's included in  
12 the general liability insurance paid by these facilities. If data sources are available, we'll instruct the  
13 contractor to gather the data for consideration in the five-year review update of the malpractice codes.

14       There are a number of coding issues addressed in the Rule. The first one has to do with payment  
15 for pre-administration related services for IVIG. And as you know IVIG is a product derived from blood  
16 plasma, pooled from many donors. Payment rates for IVIG are determined under the average sales price  
17 payment methodology and that's used to pay both Part B drugs and also under the OPPTS payment system.  
18 In addition, we also pay separately for the administration of IVIG. In the 2006 Physician Fee Schedule and  
19 Outpatient Prospective Payment System Final Rule, we discussed that we had received reports of  
20 difficulties in obtaining adequate supplies of IVIG on a consistent basis to meet patient needs. In order to  
21 address what we consider to be a temporary period of market instability, we created a separate payment for  
22 IVIG pre-administration related services, and this was intended to provide payment for the new additional  
23 services that were being provided by physicians and hospitals when procuring IVIG and scheduling  
24 patients. In 2007 and 2008, we continued to be concerned about the stability of the IVIG market, and  
25 resulting patient access to IVIG so we continued this pre-administration payment. In July of 2007, six new  
26 HCPCS codes were created for specific IVIG products to implement separate payment, and we believe this

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1 is more accurately paying for IVIG. We believe now that the transient market conditions that led us to  
2 adopt this temporary payment for the pre-administration related services have eased. In the 2009 NPRM,  
3 we're proposing discontinuing this pre-administration related payment.

4 Another issue that's discussed in the Rule is multiple procedure reduction, payment reduction for  
5 diagnostic imaging. This is something that was initiated January 1, 2006 and it affects certain diagnostic  
6 imaging procedures. In this year's NPRM, we're proposing to add several new procedures to the list. Six  
7 procedures represent codes that have been created since the list was established for other procedures are in  
8 the same family as the procedures currently on the list. We're also proposing to delete a code which is no  
9 longer active.

10 In addition, in the Rule, there's a discussion of a proposed G code for prostate saturation biopsy  
11 that we believe will more accurately pay for this procedure. There's also a discussion of Medicare telehealth  
12 services in the Rule. In the NPRM, we discuss our proposal to create G codes to pay for follow-up inpatient  
13 consultations in 2009. In addition, we describe two requests we received to add diabetes self-management  
14 training and critical care evaluation and management services to the approved telehealth list. We are not  
15 proposing to add these codes at this time.

16 And finally, there's a discussion of expiring provisions in the Rule. Some of these things, due to  
17 the passage of MIPPA are no longer expiring and have been continued. So that concludes my remarks  
18 today. I'd just like to reinforce if you have comments on the Rule, we encourage you to submit them and  
19 get them in by that August 29<sup>th</sup> deadline. Thank you.

20 Dr. Kirsch: In regards to what you're talking about making adjustments to the GPCIs and  
21 reworking it, you said that you're going to be putting out a proposal for public review?

22 Ms. Black: Mmhmm.

23 Dr. Kirsch: What is the date for that?

24 Ms. Black: We expect it to be going up in the next week or so. We've been working with our  
25 contractor on the interim report, but it's just about ready to go.

26 Dr. Kirsch: And where can I access that? Is that the website you have listed?



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1 Ms. Black: Yes. And there'll be a list serve message that goes out, telling people when it's been  
2 posted.

3 Dr. Kirsch: OK. So that's going to be within the next couple of weeks. Next on the GPCI floor—  
4 do you know how long, I'm sorry. On here you mentioned that the floor that's been set on the work GPCI,  
5 that that was just extended with the most recent Bill. Do you know when that expires?

6 Ms. Black: Was that a one-year extension?

7 Dr. Kirsch: Is it a one-year extension? Or was it 18-month along with everything else?

8 Ms. Black: Don't remember. We can check on that.

9 Dr. Kirsch: OK. Thank you.

10 Dr. Bufalino: Other questions? Greg?

11 Dr. Przyblski: Actually, just a comment, whenever I hear discussion about the RUC, it always  
12 makes my ears perk up as a AANS representative on the RUC. I'd like to publicly comment about a couple  
13 of factors. One, the RUC's responsibility was never to identify potentially misvalued codes. If you'd read  
14 its structures and functions book, that is not its responsibility. It is a reactive body that deals with codes that  
15 are brought to the RUC either by specialty societies or at the five-year review process by CMS. So to  
16 criticize the RUC for not having done that is out of reason, given that that was not its scope of work.  
17 However, understand that there are pressures that Congress, CMS, MedPac and others have put on the  
18 RUC, it has voluntarily created a work group, as you identified, the five-year ID work group, to look at  
19 different processes to perhaps identify codes that societies in CMS might consider bringing forth to the  
20 RUC. The problem that we're seeing at the RUC is that there is an apiary assumption that a potentially  
21 misvalued code is *over* valued. And people seem to get upset around the table when the RUC then looks at  
22 it and says no, not only is it not over valued, it is under valued. And one has to be careful, just because you  
23 identify codes via some process that the answer may not be what you're looking for. It may be over valued,  
24 but it also may be under valued, or properly valued. So as long as CMS has a realistic expectation, that this  
25 process as RUC reviews codes, that everything that is thought to be misvalued will not be identified as over

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1 valued and unless there is a criticism of how RUC goes through its deliberations to come up with a value,  
2 then that is a different story. Thanks.

3 Ms. Black: Right, and I don't think there was any intention to criticize the RUC. I think we were  
4 acknowledging the work that's already been done on this issue of looking at potentially misvalued codes,  
5 and it was an effort on our part to want to continue to work together with the RUC, and we realize that  
6 when you go through the process that some codes may be over valued, some may be undervalued. So I  
7 think we acknowledge those things.

8 Dr. Przyblski: Thanks, and just one follow up. One of the early things that were looked at were  
9 sight of service changes, so the five-year ID work group looked at codes in which they were thought to be  
10 inpatient codes, but a Medicare data base suggested that they were not. And the question came up of 23-  
11 hour stays where many of the procedures that were identified, the patients actually did stay overnight, but  
12 in the CMS data base, were identified as same-day procedures, whereas practically speaking they were  
13 overnight stays with a following day discharge day management activity being done. And I don't know if  
14 there's been a resolution on the CMS of how to separate those two issues out, but that would be important  
15 for the RUC to see. Thanks.

16 Dr. Snow: In your discussion you don't seem to cover or I missed what I think is also in the Rule  
17 having to do with the application of the healthcare associated conditions, i.e., never events, to other  
18 payment settings, i.e., physicians' practices, outside of the hospital. Could you discuss that a bit?

19 Ms. Black: I'm, I think what we were doing there and unfortunately, we don't have the experts on  
20 it right in the room here, but what we were doing was sort of asking the question of whether people could  
21 comment on what they thought about that and what we should take into consideration in the future if we  
22 were to do something like that. We don't have the authority to do it now, but it was more a as people are  
23 thinking of potential expansions, at this policy, what should some of the considerations be, issue. So it's not  
24 a formal proposal or anything like that.

25 Dr. Snow: Thank you.

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1 Dr. Bufalino: Any other comments, questions? Any recommendations from the Council,  
2 concerning the proposed fee schedule? Quiet group today. Dr. Snow?

3 Dr. Snow: You listed on your proposed rule, addressing a variety of issues, the independent  
4 diagnostic testing facility issues, and in particular, that physicians' offices be required to undergo additional  
5 certification etc. Is there a particular problem that brings about consideration of this kind of an issue to  
6 pardon my French, hassle physicians more for performing some of these things in their office for  
7 convenience of patients?

8 Ms. Black: Well, Jim Bossenmeyer is here with me at the table and he's going to be addressing  
9 those provisions shortly.

10 Dr. Snow: I apologize for asking the wrong person. I will save my question.

11 Dr. Bufalino: OK. Mr. Bossenmeyer, if you want to go ahead and jump in.

12 Mr. Bossenmeyer: In the calendar year 2009 Physician Fee Schedule, CMS proposed to expand on  
13 previous efforts to promote quality healthcare by independent diagnostic testing facilities and protect the  
14 Medicare Trust Funds. One of the proposals we issued three proposals for, IDTFs and a number of  
15 provisions for physicians, non physician practitioners, and physician organizations. With respect to IDTFs,  
16 or imaging services, more appropriately, we proposed that physicians and non physician practitioners in  
17 nonhospital-based settings meet certain IDTF quality and performance standards when providing diagnostic  
18 testing services. To limit burden on physicians' offices, and non physician practitioners, we propose a  
19 number of exceptions to the existing performance standards that IDTFs must maintain in order to be  
20 enrolled in the program or continue to bill Medicare program. Those items that we proposed excluding  
21 were maintaining additional comprehensive liability insurance, posting of hours, maintaining a visible sign,  
22 and requiring separately enrolled locations for an IDTF. We are seeking public comments on whether or  
23 not we should consider establishing additional exceptions to the performance standards found at 410.33G  
24 and those are listed last 2 years, we established performance standards for IDTFs, both in the calendar year  
25 2007 Physician Fee Schedule as well as in calendar year 2008 Physician Fee Schedule. We're also  
26 considering to limit the enrollment requirements to less than the full range of diagnostic testing services,

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1 such as procedures that generally involve more costly testing and equipment. Within the scope of imaging  
2 services, we seek comments about whether policies should be limited to advanced diagnostic testing  
3 services, such as MRI, CAT scan, or nuclear medicine. The second IDTF provision that we propose was a  
4 requirement that mobile IDTFs enroll and bill for the services that they're providing to Medicare patients.

5 Moving on to changes that we proposed regarding enrollment for physicians, non physician  
6 practitioners, we are soliciting comments regarding the effective date of billing privileges for physician  
7 organizations, physicians and non physician practitioners. We're specifically soliciting comments on two  
8 different proposals. The first proposal is requiring establishing an effective billing date at the data an  
9 individual organization for physicians files an enrollment application or the later of actually beginning the  
10 practice. The second item that we're soliciting comments on is whether or not the effective date should be  
11 established on the date of approval. Currently, physicians, non physician practitioners have limited  
12 retrospectivity in for billing purposes, so if they start working at a practice today, on January 1<sup>st</sup>, 2008,  
13 submitted file and enrollment application on June, they could potentially, depending if licensing was in  
14 order, retrospectively bill back to January 1<sup>st</sup>. So that's one of the reasons why we're proposing those  
15 changes.

16 We're also proposing to prohibit physicians from attaining additional billing privileges when  
17 there's, when the physician, non physician practitioner, group practice has currently suspended, or has an  
18 existing over payment with Medicare. We were proposing to require that physicians, non physician  
19 practitioners notify Medicare within 30 days of an adverse legal action, license suspension, license  
20 revocation, felony conviction. Failure to notify Medicare of those changes would result in an overpayment  
21 from the date of the reportable event. We're proposing that physicians and non physician practitioners  
22 maintain ordering referring documentation. We're also proposing to require that if a physician or non  
23 physician practitioner or IDTF had their billing privileges revoked from the Medicare program that they  
24 would be required to submit all claims to Medicare within a 30-day period.

25 Those are the, happy to answer any questions.

26 Dr. Bufalino: Thank you. Questions, comments?

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1 Dr. Snow: Thank you. Regarding the IDTF issue, I certainly respect your concern about quality of  
2 care, which is what I hear is the reason for making these requirements, but are there, and I don't want to  
3 address or have the question quite frankly posed to some of these radiologic procedures you mentioned. As  
4 a primary care physician, I don't know much about those things, never done those in the office, but a lot of  
5 the other lab things, I think is routinely done in primary physicians' labs across the country and it sounds  
6 like these additional requirements are going to apply to them. And with that setting in mind and that  
7 limitation, laboratory procedures, are there problems that lead you to think that there are quality issues that  
8 we have to do this additional regulation?

9 Mr. Bossenmeyer: Yes, I'm not exactly sure what you're referring to with labs, but with respect to  
10 imaging services, we're concerned on a couple items. First and foremost, whether or not the physician  
11 office maintains equipment and calibrates equipment appropriately, and that it has the appropriate trained  
12 staff to perform the tasks that would be done, that would normally be done or could be done in an IDTF  
13 setting. So we're concerned about the quality of care, the equipment that's being used, and we want to  
14 make sure that those services are being performed in a physician's office, that they are adhering to some  
15 basic performance standards to ensure that the outcomes are correct.

16 Dr. Smith: The way I read this initially, it sounded as if it did apply to in office laboratory  
17 procedures; even the simple things that fit under the [clear waved?] things. Are you saying that it does not  
18 apply to that—

19 Mr. Bossenmeyer: It applies to imaging services.

20 Dr. Smith: Imaging only, not laboratory services.

21 Mr. Bossenmeyer: Not laboratory services.

22 Dr. Standaert: That was a lot of stuff you went through with a fair number of acronyms. I'm just  
23 trying to process it all still. The, how does this relate to, I'm a rehabilitation physician, so we have electro  
24 diagnostic studies in our lab, we have X-ray in our office, other sorts of things. Other physicians have MRI,  
25 and CT scan embedded into their practice patterns essentially. I guess a concern from the physician  
26 standpoint would be if you have to then certify something that's already sort of integrated into your entire

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1 practice model, and you then have to break it out and separate it out and meet other criteria, it gets to be  
2 kind of burdensome in terms of how you use it and how you staff it and if you're talking about posting  
3 hours and doing other things, I mean you're, when you're doing these things in an independent practice, it  
4 isn't really functioning as an independent diagnostic facility. It's a part of your practice. And to then break  
5 it out and say it should be run as an, or meet criteria as an independent diagnostic facility for some things  
6 that are routinely done in physician practices is a difficulty.

7 Mr. Bossenmeyer: I don't think we're suggesting that you break this out into a separate item, but  
8 that I think that we're proposing, and soliciting comments on is trying to make sure that the services that  
9 are being performed in the physician's office or within a physician group practice, that if they are, and  
10 certainly we're propose—whether or not they adhere to certain quality standards and that you can continue  
11 to operate your facility within the way you have it set up today, but we would want to make sure that the  
12 equipment that is being used is calibrated correctly. If you were performing different types of services that  
13 you have the correct non physician personnel to perform those tests if they are qualified to perform those  
14 tests.

15 Dr. Standaert: OK. And how would that, I understand that part, if you're talking about calibrating  
16 an X-ray machine in orthopedist's office, or calibrating an EMG in someone's office to make sure I don't  
17 even know how you do that, frankly, to make sure that they're up to, I don't think there are calibrations to  
18 some of those things, like an EMG, I don't think there is a calibration. Often times the personnel, you have  
19 a tech taking an X-ray, but the personnel or the physician actually reading the films and doing everything in  
20 the midst of their day, so some of that again, breaking it out, I can foresee difficulties in terms of the  
21 physician trying to keep this in their office while trying to set it up as an independent entity.

22 Mr. Bossenmeyer: We'll look forward to seeing public comments such as that when at the end of  
23 the comment period.

24 Dr. Ross: Simple set of rules and regulations deal with basically the state agencies. I sit on my  
25 State Board of Health, and we have radiological commissions in the states and those states go out and  
26 inspect those X-ray machines and CT scans, and MRIs, and those individuals who are taking those "X-

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1 rays” need to be certified as either techs or trained individuals under the auspices of the physician or the  
2 healthcare professional in that office setting. So basically the states usually have jurisdiction over those  
3 medical offices and provide those inspections on a either yearly or bi-yearly or every three year schedule  
4 and then they cite the office if they are not in compliance, which is basically what you’re saying. So I  
5 would imagine that via the states, the state regulatory agencies, they’re providing what you’re describing.  
6 Not true?

7 Mr. Bossenmeyer: It’s unclear. From a Medicare perspective that information is not verified with  
8 the state, so the states are not providing information to us from an enrollment standpoint about whether or  
9 not a particular entities are meeting Medicare enrollment requirements and so as we get public comments  
10 back, if you believe that state entities are performing those functions and could be used in lieu of what  
11 we’re proposing, we’d be very interested in hearing that.

12 Dr. Ross: So what I’m trying to ask is, or what we’re trying to find out is is this becoming  
13 superfluous? Are we not already providing these investigations on a state level? And if they are, would that  
14 information or would those guidelines be suitable or sufficient enough to provide to you for the Medicare  
15 guidelines? Rather than you having to go out and add another “layer of bureaucracy” to what the physicians  
16 are going through already?

17 Mr. Bossenmeyer: I think we would look forward to seeing those comments come in.

18 Dr. Simon: Dr. Bufalino?

19 Dr. Bufalino: Yes?

20 Dr. Simon: I would probably just add that in the recent MIPPA legislation, there is a portion of it  
21 called the Advanced Diagnostic Imaging segment that pertains to PET scans, MRIs, CT scans, etc., where  
22 Congress has mandated that there will be a certifying organization determined by the Secretary, to perform  
23 site visits and review facilities to be assured that the equipment that’s being used to provide advanced  
24 imaging services, are up to specifications and that those technicians and so forth who are providing those  
25 services are properly trained and certified. So there has been some guidelines put forth in the recent MIPPA  
26 legislation that will take effect beginning 2012.

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1 Dr. Ross: So Dr. Simon, if I'm correct, this is for advanced imaging, more than it is for simple  
2 radiographic—

3 Dr. Simon: As it pertains to MIPPA. But as it pertains to the comments that Mr. Bossenmeyer's  
4 addressing, it's imaging related to services provided in an office setting so that they would be  
5 commensurate with those that are provided in an IDTF.

6 Dr. Giamo: As sort of an offshoot of that, there was a recent thing that came through MIPPA  
7 about sleep laboratories and there were some sleep laboratories that are in physicians' offices, echo  
8 cardiograms, sporometry, pulmonary function testing, how would those things be dealt with? Is there going  
9 to be a level of, if it's in your office, is there a certain level, and if it's in a standing facility will there be a  
10 different level that it's held to as far as sleep labs and sporometry and things of that nature?

11 Dr. Simon: I think some of that information that's contained in MIPPA currently is being digested  
12 by the agency, and so I think that as, over the next few months, we'd be able to articulate how the agency  
13 will interpret that information and be able to integrate it into our existing framework of operations.

14 Dr. Giamo: So MIPPA will sort of overrule this, which will be the overruling body, as far as sleep  
15 labs and those things are concerned?

16 Dr. Simon: I'm not sure, in regards to sleep labs. I'm saying that we'll have to digest the  
17 information that's in MIPPA and be able to inform you at a future date, at one of the future meetings in  
18 terms of how that information will be incorporated into our regulations and in terms of our framework for  
19 physicians operating providing care to Medicare beneficiaries.

20 Dr. Snow: Regarding the retroactive billing, is there any reason other than cost savings that CMS  
21 would cut the retroactive time to 30 days to the current 27 months?

22 Mr. Bossenmeyer: One of the things that we described in the proposed rule is that when we enroll  
23 an individual into the program, we're enrolling him at that point of time. We're not looking back  
24 retrospectively to determine whether or not licenses were suspended in January of this year, we're checking  
25 to see if licenses are active at the point of time in which the individual is enrolling. And if the individual is  
26 maintaining their enrollment information with Medicare and as they move from practice location to



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1 practice location, there should be little impact on that person having a continuity of enrollment within the  
2 Medicare program.

3 Dr. Snow: Since this hinges on the point of enrollment, do you have data on this delay in the  
4 enrollment process and how that is proceeding countrywide?

5 Mr. Bossenmeyer: There are no, while there are some pockets where are some enrollment delays,  
6 and we're working with those specific contractors, the vast majority of contractors are processing  
7 enrollment applications within the timeframes prescribed by Medicare. Now I recognize, and I heard some  
8 of the comments that were directed to Mr. Strimer, earlier today where some people said that it's taking an  
9 exceptionally long time. Medicare contractors will reject an enrollment application if they do not receive a  
10 complete application in after they've gone out at least once, and requested that information. So the  
11 physician's office, if they're using a billing agency or using a manager in their office that's not familiar  
12 with the Medicare enrollment process, and if they fail to provide information, either all the complete  
13 application at the time of filing, or in response to a contractor's request for additional information, the  
14 Medicare contractor currently can reject that application after 60 days of nonreceipt of information, which  
15 would in turn, require the individual or organization to resubmit a new application. So from a public  
16 standpoint, there could be a very long time process is the contractor's not receiving the information. One of  
17 the things CMS is working on to limit or reduce that type of delays in enrollments, related to the  
18 submission of incomplete application is that we're developing a web-based version of the enrollment  
19 process that we'll have more information about later this year.

20 Dr. Snow: And are you accepted electronic signatures on that 855 at this time?

21 Mr. Bossenmeyer: No.

22 Dr. Snow: So—

23 Mr. Bossenmeyer: It is a [wet?] signature, the signatures are compared for the, to help prevent  
24 identity theft for an individual. We also require or will be requiring effective August 26 is that any  
25 physician, non physician practitioner enrolling in the program having their information revalidated, that  
26 they have payments made directly to a banking institution and as you're aware, if you've opened up a bank

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1 account recently, you're required to provide identification, going into the banking institution off of that  
2 account. So we're doing a lot to prevent identity theft, and some of the procedures that we're implementing  
3 will help to prevent that.

4 Dr. Snow: But again, my question was, what is the backlog in applications? I understand there are  
5 lots of reasons that applications can be not processed and/or rejected, but do we have—

6 Mr. Bossenmeyer: There is always a pending work load for the Medicare contractor. I don't know  
7 if I would characterize it as a pending workflow as something being a backlog. To me, a backlog would be  
8 something where the Medicare contractor's not able to process the workload within the time frames  
9 prescribed by CMS. So we current, at any given time, Medicare is reviewing anywhere between 50 and  
10 60,000 enrollment applications, and those would be initial applications, changes, reassignments, on the Part  
11 B side, but it would not be fair to characterize that workload as a backlog, since many of those applications  
12 are processed within the mandated time frames.

13 Dr. Kirsch: Maybe we request an update on the GPCI review process at the next meeting? Is that  
14 in order?

15 Dr. Bufalino: A review of the GPCI review process?

16 Dr. Kirsch: Mmhmm. And update on that.

17 Dr. Simon: When you say that, what exactly do you mean?

18 Dr. Kirsch: Just how it's going, pretty they're going to be taking comments from around the  
19 country and just an update on what progress is being made on that?

20 Dr. Simon: [off mike] ...I know that by that time we will have the Final Rule, the Final Rule will  
21 have been issued and we'll have had the opportunity to compile all the comments related to the proposal so  
22 that we can bring that forth at the December meeting.

23 Dr. Bufalino: OK? Dr. Sprang?

24 Dr. Sprang: Prior, I thought we had requestors for PPAC's ideas and kind of CMS looking at  
25 extending the HAC policy to other settings, like physicians' offices. I know it was talked about a couple  
26 minutes ago, but I just wanted to go back and make a recommendation on that. OK? Clearly everybody is

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1 seriously interested in trying to improve quality and efficiency but simply not paying for complications or  
2 conditions that may or may not be entirely preventable is not an effective mechanism to improve patient  
3 care. Moving it into the physician office, I think would be extremely problematic, especially because it's an  
4 entirely different payment system, and the hospitals are simply not paying for the parts of the cost that were  
5 results of that matter. And in the office, it's quite different, so I would like to make a recommendation.  
6 PPAC recommends that rather than CMS looking at extending the inpatient HAC policy to other settings,  
7 such as physician offices, they instead focus their efforts on encouraging compliance with evidence based  
8 guidelines by healthcare professionals. We're all talking about trying to go to evidence based medicine.  
9 That makes good sense. And you could certainly apply that to physicians' offices, and I think would be  
10 both efficient and cost effective, so it makes better sense than trying to move the inpatient HAC policy into  
11 physicians' offices. So you got that, Dana?

12 Dr. Bufalino: Second?

13 [Second]

14 Dr. Bufalino: Any discussion? Yes?

15 Dr. Przybski: Not that I disagree with you, but if it shouldn't be in the physician office, I don't  
16 think it should be in the hospital either. And we've made comments at this table, I know I have in the past,  
17 about things that are "preventable," which we all know are not. Ventilator based infections, surgical wound  
18 infections, they can be minimized, but they are not preventable, even in the best of circumstances. So I  
19 think perhaps we should look at stronger language for CMS to relook at this whole issue of what is the  
20 evidence basis for saying that something is preventable and focusing on that. I think wrong site surgery is  
21 something that probably ought to be on that list. I think amputating the wrong limb ought to be on that list,  
22 operating on the wrong patient ought to be on that list. But many of the things that have been identified and  
23 are currently in place should not.

24 Dr. Sprang: Greg, could I suggest that we kind of pass this recommendation just that it not be  
25 moved to the office, and then make another recommendation that the entire process should be looked at  
26 again, so we have two recommendations?

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1 Dr. Bufalino: All in favor of Dr. Sprang's recommendation?

2 [Ayes]

3 Dr. Bufalino. Thank you. Would you like to add a second recommendation?

4 Dr. Przyblski: PPAC recommends that CMS reexamine the HAC policy in the hospital setting to  
5 focus on the evidence based medicine data that supports or does not support current recommended  
6 nonpayment, somebody come up with a word for me?

7 Dr. Bufalino: For those conditions.

8 Dr. Przyblski: Conditions, thank you.

9 [Unidentified speaker]: Complications.

10 Dr. Przyblski: Yeah but they're not all—conditions, I should say for now.

11 Dr. Bufalino: Second?

12 [seconds]

13 Dr. Bufalino: Any discussion? All in favor?

14 [Ayes]

15 Dr. Bufalino: Thank you. Other recommendations, comments, questions? Dr. Snow?

16 Dr. Snow: PPAC recommends that CMS not adopt the proposed changes to billing retroactively  
17 for the current 27 months, but instead consider other alternatives such as checking of physicians' licensing  
18 abilities for a 27-month time period, if that's the major detriment.

19 Dr. Bufalino: Second?

20 [seconds]

21 Dr. Bufalino: Do you have that Dana? Want to read it back?

22 Ms. Trevas: I'm sorry that last part about checking a physician's licensing ability for the past 27  
23 months?

24 Dr. Snow: Well, I understand if that's the problem, that they may not have been licensed 27  
25 months ago, but we only have their license now that the physician be asked to submit that license from 27  
26 months ago, if he bills that far back.

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1 [Unidentified speaker]: So you're asking that the policy stay as it is in tact?

2 Dr. Snow: Policy stay as it is and reconsider other methods of verification that they wish to have.

3 Ms. Trevas: OK, thank you.

4 [second]

5 Dr. Standaert: Does she read it again?

6 Ms. Trevas: PPAC recommends that CMS not adopt the proposed changes to the billing, proposed

7 changes to the policy of billing retroactively for the current 27 months and consider other methods of

8 verification instead.

9 Dr. Bufalino: Discussion?

10 Dr. Snow: In a convoluted way, I think that says what I wished to say.

11 Dr. Bufalino: All in favor?

12 [Ayes]

13 Dr. Bufalino: Thank you. Any other conversation? Dr. Ross?

14 Dr. Ross: In lieu of the discussion that we had earlier about this rigid new accreditation standards,

15 neither CMS nor physicians' offices have the resources to deal with the largely overlapping goals and

16 requirements of a more rigorous enrollment process in the new accreditation program. As a result, PPAC

17 recommends to CMS that it should abandon the proposal to treat physicians' offices as IDTFs and focus on

18 ensuring a smooth implementation of the new accreditation standards mandated by Congress.

19 Dr. Bufalino: Second?

20 [Second]

21 Dr. Bufalino: Discussion? All in favor?

22 [Ayes]

23 Dr. Bufalino: Thank you. The hour's late, any other discussion?

24 Dr. Simon: Point of information, §134 of MIPPA as it relates to the conversation earlier about

25 GPCIs extends the work floor GPCI through 2009, and allows for a GPCI 1.5 for Alaska beginning in

26 2009.

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1 Dr. Kirsch: Thank you.

2 Dr. Bufalino: Great. Otherwise, thank you Ms. Black, Mr. Bossenmeyer. We appreciate your time.

3 Let's wrap up with the last presentation before the break. We asked for the Stark Update, Mr. Don  
4 Romano's a resident expert in this area. Now as the Director of the Division of Technical Payment Policy  
5 at the Center. He joins us to provide the Stark Update. We did not receive any materials pertinent to this  
6 presentation, so we're looking forward to your talk. Mr. Romano.

7 Stark Update

8 Mr. Romano: Thank you. I actually have eleven separate issues to run through so I'm going to be  
9 brief and I'm going to confine myself to where we are and really not discuss how we got there. The first  
10 issue I want to talk about is the exception that we have proposed in the Physician Fee Schedule Proposed  
11 Rule this year for Incentive Payment and Reward Sharing Programs. Loosely known as "gain sharing,"  
12 these programs implicate three statutes, potentially; the Anti-Kick-back Statute, the CMP Statute that OIG  
13 administers as well as the Physician Self-referral or the Stark Statute. We had a solicitation of comments in  
14 the IPPS proposed rule, but based on departmental priorities, we quickly ratcheted that up to a full scale  
15 proposal this year in the Physician Fee Schedule Rule. So we have proposed using our authority to create  
16 additional exceptions that do not create a or pose a risk of program or patient abuse. We propose an  
17 exception for hospitals to provide remuneration to a physician or physician organization under an incentive  
18 payment reward sharing program that includes certain safeguards, and satisfies certain conditions. Many of  
19 these conditions mirror these conditions that OIG has approved in the 10 advisory opinions, that has issued  
20 allowing limited gain sharing programs. We propose excluding from the protection from the exception any  
21 incentive payment or reward sharing program that compensates physicians and physician organizations  
22 based on reduced lengths of stay, and there are a lot of other proposed conditions there and we look  
23 forward to getting comments on this proposed exception.

24 [off mike requests for speaker volume]

25 Mr. Romano: Well, the quick summary is that we propose an exception for incentive payment and  
26 reward sharing programs. So those would include both quality programs as well as cost savings programs.

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1           The next issue is not a physician self-referral issue per se. It's always closely linked with that and  
2   there wasn't any separate discussion of that and that is the Anti-Markup Rule. Last year, we proposed and  
3   finalized Anti-Markup Provisions on the TC and PC of diagnostic tests that were either purchased or not  
4   performed in the office of the billing supplier, billing physician or other supplier. After we finalized the  
5   rule, we got a lot of questions and comments about what constituted, for instance the office of the billing  
6   supplier. We ended up issuing a delay rule, on January 3 of this year, that delayed the rule's application  
7   except for certain anatomic pathology arrangements that were done in a centralized building that were not  
8   in the same building. We've now proposed further rulemaking for this area. We've come up with two  
9   alternative approaches to try and get at the concept of a physician who is sharing a practice; one would  
10   apply the Anti-Markup provisions, where the performing physician is not working exclusively for the  
11   billing physician group. The second approach, basically tracks what we did last year with some clarification  
12   as to what constitutes the office of the billing physician or other supplier, including making explicit that  
13   arrangements done in the same building would qualify. So for instance, if the diagnostic testing is done in  
14   the basement, because that's where the equipment is located, it has to be located, but the physician's office  
15   itself is on the third floor. The Anti-Markup provisions would not apply in that instance. We also proposed  
16   an exception for billing groups that do not have any owners that have the right to receive profits. So those  
17   are the two provisions in the Proposed Physician Fee Schedule.

18           Just recently in the IPPS Final Rule, we finalized several proposals. Most of these came from last  
19   year's Physician Fee Schedule rule. Two of them did not. Two of them were in this year's IPPS Proposed  
20   Rule and that is Stand in the Shoes, and the Period of Disallowance. Under Stand in the Shoes, are phase  
21   three Physician Self-Referral rule last year, said that a physician stands in the shoes of his physician  
22   organization, and has this same compensation relationships as that organization has with DHS entities. And  
23   therefore, needs to meet a direct exception. Prior to that time, the physician, the arrangement would only  
24   need to meet an indirect exception or maybe no exception at all, because under our definition of indirect  
25   compensation arrangements, it might not have been even an indirect compensation arrangement. After we  
26   published the rule, there was a lot of concern expressed by AMCs and integrated healthcare delivery

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1 systems. November 15<sup>th</sup> of last year, we delayed application of the rule for certain types of arrangements.  
2 We've not finalized the rule and under the final rule, only owners, and what we call "true owners" as  
3 opposed to titular owners, that is owners who have a right to receive profit distributions, dividends, and the  
4 like, stand in the shoes of their physician organizations; other physicians do not. Also we had proposed that  
5 an entity stand in the shoes of an organization that it owned 100%. We did not finalize that provision. We  
6 think that we have existing safeguards in the Physician Self-referral rules to deal with that type of situation.

7       The other proposal in this year is IPPS proposed rule that we finalize in the final IPPS rule is the  
8 period of disallowance. This is something that we believe is just a clarification of what is in sort of like the  
9 numbers of the statute, but we get a lot of questions about this, and it's not explicitly stated in our  
10 regulations and statute, and so we tried to give some guidance as to what is the end of the period for which  
11 where you have a noncompliant relationship, where a physician can begin referring again to the entity and  
12 the entity can begin billing Medicare. And it's not always possible to prescribe this, because we've always  
13 taken the position that the financial relationship which is the thing that was the underpinning of when you  
14 have a potential violation, that the financial relationship does not necessarily begin with the time that a  
15 written agreement begins, nor does it end necessarily when a written agreement ends, because there could  
16 be incentive built into the, expressed with the conduct of the parties or the intent of the parties that  
17 remuneration could be intended as a reward for past referrals, or an incentive for future referrals. So what  
18 we tried to do was to prescribe some bright line rules as to the outer period of disallowance. So we tell  
19 people that it would end no later than this period. It may end earlier, and you're free to make that argument,  
20 but we're going to give you some comfort that it ends no later than this period. So specifically if you have  
21 an arrangement that's noncompliant for reasons that don't relate to compensation, such as the failure to get  
22 a signature or written agreement, when you correct that, that would be the end, or the outside end of the  
23 period of disallowance. Again you could argue that it ended earlier, because the financial relationship  
24 ended, but we're at least telling you that it ends no later than that period of time. Where the noncompliance  
25 is related to compensation, such as too much compensation was paid or not enough under the rules, at the



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1 time that the excess compensation is paid back, or the shortfall in compensation is made up, again the  
2 period of disallowance would end no later than that point in time.

3 The next three issues are somewhat related and they were in the IPPS final rule and finalized from  
4 last years Physician Fee Schedule. And those are percentage based compensation formulae, per click leases,  
5 and services furnished under arrangements. These three issues or areas have a delayed effective date until  
6 October 1<sup>st</sup>, 2009. The other physician self-referral issues have the same general effective date, which is  
7 October 1<sup>st</sup>, 2008. But these three were delayed longer period of time. Percentage based compensation  
8 formulae, we last year, proposed to not allow percentage comp arrangements except for personally  
9 performed physician services, stating that that was our intent all along, however when we issued the final  
10 rule years back, that's not really what captured our intent. In this year's final rule, we did not go as broad as  
11 we proposed, and instead we finalized the proposal and made it applicable only to space and equipment  
12 leases, so for instance, a physician lessor would not be able to get payments that are percentage based from  
13 an entity lessee and it would work the other way in reverse as well.

14 Per click leases is very similar to that or per unit methods of compensation. The way that we  
15 finalized the rule is how we proposed it, which is that the lessor cannot receive a per click payment for  
16 services or for space or equipment that were utilized in providing services by a patient that was referred by  
17 the lessor to the lessee. And again, we contemplate in this rule that most of the time we're talking about a  
18 physician lessor and an entity lessee, but it can work the other way around. And the Rule works the same as  
19 to whether it is a physician individually that owns say the equipment that is leasing it, or whether it is a  
20 joint venture, composed of several group practices. Services furnished under arrangements, we proposed  
21 and we finalized revising the definition of "entity." You have to have a DHS entity somewhere in order for  
22 the Stark statute to be implicated. And up until this time, we considered only the person or the entity that  
23 was actually billing for these services to be considered the DHS entity. We've revised our definition to  
24 include the person or the entity that is also performing the services, so if you have a physician owner of a  
25 physician provider, service provider, and that service provider performs services that are then billed as  
26 DHS by an entity, that physician owner who makes the referral to that service provider would need to have

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1 an ownership exception or else the arrangement would be noncompliant with Stark. As a practical matter,  
2 that would mean being able to satisfy the rural provider exception. Of course, employees or independent  
3 contractors of that physician service provider would not need to meet an ownership exception, nor would it  
4 prevent physicians who have no connection whatsoever with that service provider from making referrals to  
5 it. We do seek comments as to whether we should have an exception. Again, we have authority under the  
6 statute, to promulgate additional exceptions to the extent that they pose no risk of program or patient abuse.  
7 So we seek comments on that. We hope that we get some before the rule becomes effective, which again, is  
8 October 1<sup>st</sup>, 2009.

9         Obstetrical malpractice subsidies. Before we finalized our proposal, we had an existing exception  
10 for this, which simply tracked the OIG's safe harbor. We felt that that was too narrow, so we have kept  
11 that, because that potentially applies to any entity but we've added a new exception within that, that allows  
12 hospitals, FQHCs, and rural health clinics to provide a subsidy to a physician who regularly engages in  
13 obstetrical practice, as a routine part of his or her medical practice, and the medical practice has to be  
14 located in a primary care HIPSA, rural area, or an area with a demonstrated need, which we would then  
15 determine through the advisory opinion process and the requirements as to also the patient population as  
16 well.

17         The next two issues I'm going to cover very quickly. Retirements plans. This is something that we  
18 simply just cleaned up. We have exclusions in the regulations as to certain things that do not constitute  
19 ownership interests; the reg text was written a little too broadly on this and we heard stories of retirement  
20 plans from one physician organization or entity that was then purchasing an interest in another entity. And  
21 then the claim was that the physician investors in the retirement plans did not have an ownership interest in  
22 that second entity. That's not what we intended, so that is something that we fixed in the rule.

23         Burden of proof is another clarification. We simply clarified that consistent with how the  
24 Medicare claims process appeals worked generally that the burden of proof would be on the claimant, and  
25 not on the government, so that the claimant would have to show compliance with the physician self-referral  
26 rules and the government would not be required to show that there was not compliance. Of course we were

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1 talking about the ultimate burden of proof, or the burden of persuasion. The burden of production can shift  
2 during the course of the proceedings, so if somebody makes out a prima fascia case, or on a certain point,  
3 then the burden of production may shift to the government, but the ultimate burden of proof always remains  
4 on the claimant, the appellant.

5 The last issue I want to talk about is the DFRR, the Disclosure Financial Relationship Report. This  
6 is something that we earlier had a Paperwork Reduction Act package published and we had a 60-day  
7 notice, back in May of 2007, and a 30-day notice in September of 2007. We withdrew the information  
8 collection request in April of this year and we reannounced it in the IPPS proposed rule, which constituted  
9 a 60-day notice for purposes of the PRA. We discussed the comments that we received in the final rule. We  
10 stated that we were proceeding with the collection. We revised the burden estimate to 100 hours, and we  
11 signaled that we may send a DFRR to less than 500 hospitals. So the Paperwork Reduction package will be  
12 sent over to OMB. It will be published in the *Federal Register* and there will be another 30-day comment  
13 period for that.

14 And lastly I want to mention something that we did not do this year; was propose rulemaking on  
15 the in office ancillary services exception. We solicited comments about that last year. It's not something  
16 that we did this year. It is however, an issue that we continue to be interested in. Thank you.

17 Dr. Bufalino: Thank you. Questions, comments?

18 Dr. Giamo: Yes, can we just get a copy of your testimony? Would we be able to get a copy of  
19 that?

20 Mr. Romano: If it's recorded somewhere. I can send you some notes, but—

21 Dr. Bufalino: I think his point is that the level of complexity of your presentation short of sitting  
22 here with a JD most of us would struggle, and I find myself reasonably conversant unfortunately with a  
23 number of the issues that you presented, and the level of complexity is pretty high. So for us to make, have  
24 a meaningful comment/input in this, I think we need some help in terms of trying to delineate those issues.

25 Mr. Romano: Well, I'm certainly happy to distill that down into a written product that might be  
26 useful.

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1 Dr. Simon: Good. And once I receive that from Mr. Romano, then I'll make sure that is  
2 disseminated to all the councilmembers.

3 Dr. Bufalino: Great. Chris?

4 Dr. Standaert: Along those same lines, just for future things, you went through a lot of stuff, and I  
5 had trouble keeping up with what you were saying, and having requested written information before the  
6 meeting as something to refer to, really is helpful for us to have meaningful discussion. When people come  
7 in with complex issues, giving us things ahead of time that we have in written format to refer to really  
8 would help us be of more use to somebody and help us process it better. Just a general comment.

9 Mr. Romano: Sure. Thank you.

10 Dr. Snow: Ken, assuming we get those written comments, would it be appropriate for us, if we  
11 have any comments or recommendations to make perhaps at the next meeting, would be allowed to do so  
12 then?

13 Dr. Simon: Well I think perhaps what we'll do is have Mr. Romano come back so that way, there  
14 would be an opportunity for you to be able to pose the questions to him at the next meeting.

15 Dr. Snow: Appreciate that.

16 Dr. Bufalino: That would be great. Thank you. Anyone else? Thank you very much. Why don't  
17 we take a 10-minute break and we'll be back to pick up with the OPPS. Thank you.

18 Break

19 Dr. Bufalino: OK, let's begin the second session. Our next speaker is Dr. Carol Bazell. Dr. Bazell  
20 is a pediatrician who's going to bring her expertise concerning the Outpatient Prospective Payment System  
21 and the Ambulatory Surgical Center payment system proposed rule that went into the *Federal Register* in  
22 July of this year. As you know, Medicare provides payment to more than 4,000 hospitals, and 5300  
23 Ambulatory Surgical Centers. I didn't realize it was that robust. And these two payment systems—Dr.  
24 Bazell's the Director of the Division of Outpatient Care in the Hospital, and Ambulatory Policy Group at  
25 CMS and is responsible for these two payment systems, so we welcome you to our Council this morning.  
26 Thank you.

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### OPPS/ASC Fee Schedule Proposed Rule

Dr. Bazell: Thank you. I'm pleased to be here to talk to the Council. I'm going to be providing you with an overview of the calendar year 2009 Hospital Outpatient Prospective Payment System, or OPPS, Ambulatory Surgical Center, or ASC, proposed rule. As people may have figured out over the last couple years, we have made a commitment to update these systems in synch, so our general plan is to come out with a proposed rule for both payment systems, because they are now linked, as you will see later on, and then a final rule, one final rule to address both payment systems. As was mentioned, the rule went on display on July 3<sup>rd</sup> at the *Federal Register* and it was published on July 18<sup>th</sup>. Public comments on most subjects will be accepted through September 2<sup>nd</sup> of 2008, and we look forward to hearing from the public on many of the issues we discuss. I will make a comment that there's one area that's a request to establish a new class of new technology, intraocular lenses. That's a very specific provision that has a 30-day comment period by law, and that is regarding ASC payment for new technology intraocular lenses for a new class. That comment period closes August 18<sup>th</sup>, which I think is today by my watch, and we look forward to comments in that area as well. I've also provided references to the OPPS in the ASC websites, CMS websites. There you'll find the rules, as well as a number of supporting data files that help inform people who are interested in specific areas of the proposal for 2009.

Now I'm going to be starting with the general, that's background quality reporting, and cost estimation, and then moving on to touch on several payment areas, as part of the proposal for 2009. Those would be payment for partial hospitalization, type B emergency departments, composite APCs, drugs and biologicals, radio pharmaceuticals, brachytherapy sources, drug administration, and those are all OPPS related proposals. And then I will also be talking about the proposal for the ASC payment system.

By way of background, the OPPS rates are based on the relative payment weights that are calculated for groups of services. The groups of services are called "ambulatory payment classifications," or APCs, for short. And those APCs basically have assigned to them HCPCS codes or CPT codes where the services are similar in terms of clinical characteristics, and the facility resource costs associated with those services. And we provide payment through those APCs. So every year we annually update those APC

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1 groups based on the most recent data available to us. That would be claims data from hospitals, so for 2009,  
2 we're updating it based on 2007 hospital claims data, the Medicare Cost Reports that are available to us,  
3 and the wage indices that are applicable. Now for 2009 the proposed market basket increase, which would  
4 parallel the IPPS, is 3.4% and overall the proposed rule would increase OPPS payments to providers by  
5 approximately 3.2% overall. We're on a trajectory in the OPPS to reduce copayment over time to 20%, and  
6 so in total, we estimate that the proposal would reduce estimated beneficiary copayment to 23% in  
7 aggregate for 2009 compared to 25% for 2008.

8       Next area is quality reporting. We've made a proposal again that we'll build on our efforts to  
9 continue to link and strengthen the connection between the quality of care and Medicare payment. For  
10 2009, by law, those hospitals that did not meet the reporting requirements for 2008, and those requirements  
11 include the reporting of seven measures, five of them related to Emergency Department transfers for acute  
12 myocardial infarction, and two of them are perioperative surgical care measures, those hospitals that did not  
13 meet those reporting requirements in 2008, will receive a 2% point reduction to their update for 2009.  
14 Further, as part of the proposal, for 2009, for those hospitals that want the update, the full update in 2010,  
15 we would require them, by our proposal to report 11 measures. We would continue the seven measures in  
16 effect for reporting in 2008, and in addition we would add in four new imaging efficiency measures, that  
17 have to do with things like the use of contrast in certain studies. We're also seeking public comment on  
18 about 18 other types of measures that could be applied in future years to hospitals for purposes of quality  
19 reporting. I will also comment that we have not made a proposal for quality reporting for ASCs, for 2009,  
20 for 2010, although we are seeking again comment on that area of quality reporting. We also, as part of the  
21 proposal, are proposing a validation approach for 2010, where we would randomly select 800 reporting  
22 hospitals to validate their reporting of the measures.

23       We have a fair amount of discussion in the rule about cost estimation under the OPPS. There's  
24 been a lot of this discussed as well with respect to the IPPS, recently. Hospitals often assign a lower  
25 markup to high cost items, and higher markups to lower cost items within a single cost center, and this is  
26 commonly referred to as charge compression. We recently contracted with RTI to evaluate the impact on

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1 the IPPS and the OPPTS of issues that are related to cost-based estimation and charge compression. RTI  
2 recommended a variety of short-term and long-term accounting changes for purposes of the OPPTS, and  
3 short-term statistical adjustments to improve our cost estimation. And I provided a link to the report on the  
4 RTI website on the attached slide.

5 In the proposed rule, we note our continued interest in focusing on long-term solutions to improve  
6 cost estimation, which would include the addressing of charge compression. The fiscal year 2009 IPPS  
7 proposed rule and now the final rule, include a proposition to split the cost center for implantable devices  
8 from other medical supplies to allow for more specific cost estimation for those two types of services. And  
9 under the 2009 OPPTS proposed rule, we've included proposal to separate cost centers for drugs. We would  
10 have hospitals separate drugs with high pharmacy overhead costs from those with low pharmacy overhead  
11 costs to allow in the future to provide better estimates in our cost estimations for rate setting for those two  
12 types of drugs, or those two groupings of drugs. We're also seeing comment in a variety of other areas on  
13 potential cost center refinements, including CT scans, MRI, and cardiac catheterization. I'll note that all  
14 these cost center changes that we might adopt would affect both the OPPTS and IPPS payment for services.

15 Now moving on to the specific. Partial hospitalization services are services that are basically the  
16 most intensive hospital outpatient mental health services that we've historically paid on a per diem basis.  
17 Basically we've paid per day of care. We provide payment to both hospital outpatient departments, and to  
18 community mental health centers for these services under the OPPTS. For this year, we're proposing for the  
19 first time, instead of one payment, to have two levels of payment. We've noted that while we never  
20 envisioned that these services would really be part day services, that's three services or fewer, we've noted  
21 that an increasing number of facilities are providing only three services per day, or sometimes even fewer  
22 to patients, whereas hospital-based programs in particular may be more commonly providing four services,  
23 or more to patients, so we're providing two APCs are part of the proposal. One of which would make  
24 payment for those services when there's three a day, and the other which would provide payment for the  
25 more intensive services as part of the partial hospitalization program when there are four or more services  
26 per day.

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1           The next area is emergency department visits. Under the OPPS, since 2007, we've made a  
2   distinction between Type A and Type B emergency departments. Emergency departments all have an  
3   EMTALA obligation and according to CPT, CPT codes require that the facility be available 24 hours a day,  
4   seven days a week in order to report the CPT codes. We've historically paid for emergency departments  
5   through five levels of APC, one for each level of the CPT codes and then for those facilities that were not  
6   available 24/7 prior to 2007, they should have been reporting clinic visit codes for those services and being  
7   paid through five levels of clinic visits, levels one through five, for their visits. Because it was brought to  
8   our attention that there are some hospital-based emergency departments that are available less than 24/7 but  
9   have an EMTALA obligation, in 2007, we established five levels of G codes that parallel the CPT codes for  
10   hospitals to report for services provided in those facilities. We've continued over 2007 and 2008 to pay  
11   those visits at clinic visit rates, while we collected hospital claims data regarding the costs of the type B  
12   emergency department visits. And in our analysis for the proposed rule, what we found is that the cost of  
13   visits to type B emergency departments, essentially were in the middle, between clinic visits and type A  
14   emergency department visits. It varied a bit based on the level. So our proposal would establish four new  
15   APCs for the levels one through four, Type B emergency department visits, and then for the level five Type  
16   B emergency department visit, those visits look from a cost perspective, very much like level five, Type A  
17   emergency department visits. Basically, those patients are requiring lots of hospital resources, so we're  
18   proposing that those two level five, type A and type B would be paid through the same APC.

19           Moving on, composite APCs are a concept we first introduced in the OPPS in 2008. While the  
20   OPPS packages payment, bundles payment for a variety of services and low cost items, basically it's  
21   provided previous to this, separate payment for every CPT code. What we noted is that there are patterns  
22   and combinations of services that are commonly provided together in the hospital outpatient department, so  
23   for 2008, in our effort to continue to encourage efficiencies, we decided to enlarge the payment bundles. So  
24   basically we would make payment for one comprehensive service. So the areas where we proposed  
25   composites in 2008 and are paying them and would continue for 2009, include cardiac electrophysiologic  
26   evaluation and ablation services, low dose rate prostate brachytherapy and extended assessment in



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1 management services, essentially a high level clinic or ED visit with a long period of observation, eight  
2 hours or more. So for example, in the low dose rate prostate brachytherapy case, rather than making a  
3 separate payment to the hospital for the insertions of the needles and then a separate payment to the  
4 hospital for the application of the brachytherapy sources, we're making one payment for that service, which  
5 is what you need to do to give the patient low dose prostate brachytherapy. We're proposing to expand this  
6 for 2008 to encompass multiple imaging services. Now people may recall that under the Physician Fee  
7 Schedule and the OPPS in 2006, both systems proposed a reduction policy for second and subsequent  
8 imaging services provided in the same family. Under the OPPS, we did not finalize that proposal, because  
9 an argument was made that efficiencies are already reflected in the cost-to-charge ratios we used for cost  
10 estimation, so instead, for 2009, we've basically said we're proposing to have five families. Those would  
11 be ultrasound, CT and CTA without contrast, CT and CTA with contrast, MRI and MRA without contrast,  
12 and MRI and MRA with contrast. Those families are constructed of the same codes that are part of the  
13 Physician Fee Schedule families for the multiple procedure reduction. And in the OPPS case, if you  
14 performed on the same day, in the same session, more than one service from the same family, we would  
15 provide a single payment for that imaging session. And we've constructed the payment rate for that from  
16 our claims data, so we've used the empirical data we have, based on the hospital costs reported in those  
17 kinds of cases that would be eligible for the composite. So again, seeking to promote efficiencies among  
18 hospitals by providing a single payment for those imaging services. So there's no reduction concept, like  
19 the Physician Fee Schedule. We've simply redefined the services as an imaging session, and we provide a  
20 single payment in those case. And we have the proposed rates in the rule, and we're looking forward to  
21 comments from the community on that proposal.

22       Drugs and biologicals, respect to the OPPS—Medicare Modernization Act requires payment based  
23 on average hospital acquisition cost, including pharmacy overhead costs if the Secretary chooses to make  
24 an adjustment. Our current policy is that we pay for drugs and biologicals that are separately paid at the  
25 ASP plus 5% in the OPPS. That number is a transition we stated last year, from ASP plus 6% prior  
26 payment to the claims-based payment, which we would have calculated for 2008 at ASP plus 3%. Our 2009

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1 proposal is ASP plus 4% for those separately payable drugs. And we have a packaging threshold in the  
2 OPPS, where inexpensive drugs, who's costs we estimate to be below a threshold, which we've updated to  
3 be \$60, it was \$60 also for 2008, we round to the nearest \$5. For drugs that fall above the packaging  
4 threshold, we provide separate payment. And our calculation in terms of the ASP equivalent from our  
5 claims data for 2009, in the proposed rule, was ASP plus 4%, and that is indeed our proposal. Hospitals  
6 would continue to include their handling and pharmacy overhead costs in the drug charges on their claims  
7 and we've proposed in this area, as I mentioned earlier, to sit the cost centers, so hospitals would be  
8 reporting drugs with high overhead pharmacy costs and low overhead pharmacy costs in different cost  
9 centers, which would help inform our future rate setting.

10 Moving on to radio pharmaceuticals, MIPPA requires payment for therapeutic radio  
11 pharmaceuticals at hospital charges adjusted to costs, and I'll make a note that we got a little carried  
12 away—it's not 2010, it's 2009—basically, MIPPA continued our payment at charges adjusted to cost for 18  
13 months and so I will note that our proposed rule does not reflect this MIPPA related change, because this  
14 came into effect after the proposed rule. Our proposal would actually have proposed to pay for radio  
15 pharmaceuticals in 2009, therapeutic radio pharmaceuticals, based on ASP, which we currently do not  
16 collect for these products. We would continue to package payment for diagnostic radio pharmaceuticals  
17 into the payment for the associated nuclear medicine procedures. Brachytherapy sources, same problem on  
18 the slide, MIPPA continued payment at charges adjusted to cost, through the end of 2009, and again same  
19 comment. We proposed to pay for brachytherapy sources based on our median costs from claims data, and  
20 so the MIPPA changes are not reflected in the proposed rule, but will indeed be reflected in the final rule of  
21 course.

22 In the area of drug administration, in our usual fashion, we've examined our claims data, and  
23 we're proposing this year to adjust our drug administration APCs from a six-level structure, to a five-level  
24 structure, which we believe more appropriately would align the payment rates with our claims data. We are  
25 also proposing to package payment for IVIG pre administration related services. Like we payment for  
26 preadministration related services for other drugs and biologics and not to pay for it separately in 2009.

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1 Moving on to the ASC Payment system, which is the last subject of conversation this morning,  
2 this is a reminder that beginning in 2008, we've implemented the revised ASC payment system, where the  
3 ASC payment system is based on the OPPS payment weights; the relativity of weights under the OPPS, and  
4 some of the OPPS payment policies about separately payable drugs for example. But takes into  
5 consideration the lower costs of services and ASCs and the budget neutrality requirement for the ASC  
6 payment in 2008. We have proposed a budget neutral ASC specific conversion factor to determine the ASC  
7 payments and as a remind again, 2009 is year two of a four-year transition. So the propose rates for 2009  
8 reflect 50% of the 2007 ASC rates, and 50% of the 2009 ASC rates, calculated according the standard  
9 methodology of the revised payment system. Our ASC payment proposal is modest for 2009. We proposed  
10 to include nine additional surgical procedures on the list. Right now, our own criteria for excluding  
11 procedure from ASC payment, are if we believe the ASC is not a safe site for the surgical procedure of if  
12 we expect the procedure to require an overnight stay. In addition, the proposal does not reflect the MIPPA  
13 related changes for brachytherapy sources. Under the final ASC payment system policy. If there are no  
14 prospective OPPS rates available. Brachytherapy sources are contractor priced in the ASC payment system.

15 And under MIPPA, where OPPS payment will be a charges adjusted to cost, in 2009, ASC  
16 payments will remain contractor priced. By law, there is no ASC payment system update factor for 2009.  
17 The key websites for you here that are included earlier in the slide, the OPPS website, the ASC website,  
18 and the location of the RTI report on cost estimation. I included several different questions for the Council,  
19 both couple around drug acquisition costs and associated overhead and handling in the physician's office.  
20 And then one just seeking some feedback on the environment in the ASC payment system. We obviously  
21 implemented the revised payment system in 2008. We've had an early look at the first quarter of 2008 data,  
22 but we're interested in any feedback the Council members might have to offer about whether ASCs are  
23 changing their portfolio of services, under the revised payment system both with our coverage of many  
24 more surgical procedures in 2008 as well as the changing rates for ASC payment system.

25 So thank you for you attention. I look forward to any comments or questions you might have.

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1 Dr. Bufalino: Thank you, Dr. Bazell. Comments, questions, would anyone like to assess the  
2 questions that she's asked the Council? Acquisition costs for drugs, hospitals, versus physician offices how  
3 they compare, different overhead, and the ASC payment system. Dr. Smith?

4 Dr. Smith: The question of drug acquisition costs I think is going to jump all over the map because  
5 it's a one-person physician's office pays less, pays a lot more per unit drug than the physician's clinic at  
6 Loveless that has 300 doctors of something. That's one. Hospitals probably have the same thing; a 50-bed  
7 hospital acquiring drugs for administration in either the inpatient or outpatient setting is going to use many  
8 fewer than a 2000-bed hospital, and so they probably also have wide variation, and I think the only way  
9 you're going to get those data is to send a survey, ask for direct cost input from various sources, and I don't  
10 know whether people are going to be willing to give it to you if they think you're going to use it to cut their  
11 reimbursement [agreements]. The question back on some of the comments that you made, I appreciate the  
12 detail on the slides, that's a big help to refer to. Did I hear you say that you're not going to be paying for  
13 drugs that cost less than \$60, or you're not going to be paying for them separately?

14 Dr. Bazell: We will not pay separately for those drugs. We consider their costs in setting the rates  
15 for the associated procedures. That's been our standard. We just won't be paying for them separately.

16 Dr. Bufalino: Other comments, questions? Pretty quiet group. Thank you for that thorough  
17 discussion of the issues. We appreciate it. Have a good morning. Thank you. We'll move on and ask the  
18 next group to present is Melanie Combs-Dyer, who's been here many times, and Amy Reese is joining her  
19 today. Melanie has had the task of assisting in the national implementation of the RACs, and Ms. Reese  
20 began working at CMS in July of '07 as part of this demonstration in the Office of Financial Management.  
21 Prior to joining CMS, Amy worked both in the research and treatment fields with children in autism  
22 spectrum disorders and she joins us to share in this conversation today. Thank you, welcome.

23 RAC Update

24 Ms. Combs-Dyer: Thank you for inviting us. I appreciate it. I believe that my name may be  
25 different now than it was the last time I testified. I have gotten married, and I am now Melanie Combs-  
26 Dyer, and in addition, Amy and I have had a change to the name of our division. We used to be in the

60

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1 Division of Demonstrations Management, and we now are in the Division of Recovery Audit Operations,  
2 and that change is reflective of where we are in the RAC program. We were running a demonstration. The  
3 demonstration is now over, and we are getting ready to enter into a new permanent Recovery Audit  
4 Contractor Program, no longer a demonstration.

5 Today we want to try to cover four things; background on improper payments and a look at the  
6 findings from the three-year demonstration, and Amy will cover those two points, and then some lessons  
7 learned and changes made and our plans for expanding the program are things that I'll cover. So I'll turn it  
8 over to Amy.

9 Ms. Reese: Thank you, Mel, and thank you for having us speak here today. The next few slides are  
10 pretty, I'm sure everyone's pretty familiar with them, so I'll go through them a little bit quickly. But the  
11 Improper Payment Information Act requires all federal agencies to measure their improper payment rates.  
12 And by that, we mean both overpayments and underpayments and our 2007 report released by OMB, CMS  
13 had the third highest rate of improper payments. It equaled about 10.8 billion dollars, and so Congress  
14 decided back in 2003 to give CMS a new tool to help reduce those improper payments and that's how the  
15 RAC demonstration was born, § 306 of the MMA required the demonstration, required it for three years,  
16 which started in March of '05 and ended this past March of 2008 and there's a typo in that next bullet there.  
17 It should be the Tax Relief and Healthcare Act of 2006, that required that the RAC program be made  
18 permanent and expand to all 50 states by January 1, 2010, so just as a reminder, CMS does not currently  
19 have any RACs under contract right now. We are in the procurement process for the permanent RACs and  
20 we hope to have those names sometime in September, but we're working toward that and Melanie will talk  
21 more about that expansion later. And both the demonstration and the permanent legislation gave CMS the  
22 authority to pay RACs on a contingency fee basis. CMS gave the RACs no money to start out. The RACs  
23 are tasked with detecting and correcting improper payments; correcting includes collecting back the  
24 overpayments from providers, and repaying the underpayments back to providers. Our RAC program  
25 mission in CMS is to detect and correct those past improper payments as well as to implement actions that  
26 will prevent future improper payments. And we think everyone can benefit from this. Providers will submit

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1 correct claims and be paid for them, CMS will lower its error rate, and the Medicare Trust Funds can  
2 remain solvent for future Medicare beneficiaries.

3       These next few slides will talk about the results of the RAC demonstration, and this information  
4 and a lot more can be found in our Demonstration-Evaluation Report, that was just released last month. It's  
5 on our website, [www.CMS.HHS.gov/RAC](http://www.CMS.HHS.gov/RAC), and the big number is our overpayments collected. Over \$992  
6 million in overpayments were collected from the RACs, and they also repaid back about \$37 million in  
7 underpayments back to providers. As of the end of the demonstration, \$46 million were overturned in  
8 appeals. Another \$14 million was returned to providers after CMS instructed its California contractor to  
9 rereview claims from inpatient rehab facilities, and the cost of the demonstration was about \$201 million.  
10 Most of that money was contingency fees paid to the RACs. So subtracting out all those costs from our  
11 overpayments collected left over \$693 million that was available to go back to the trust funds. We think  
12 that's a pretty big number. We do expect it to go down slightly as appeals make their way through the  
13 system. We do still have a number of appeals that are currently in the system, but we will update that  
14 number regularly until every appeal is finished and the first of those updates will be released on that  
15 website as well and we should have that within the next two weeks. And if you do the math, you can see  
16 that the program costs only \$.20 for every \$1 collected. Some more results of the demonstration, a little bit  
17 of information about our appeals. We hear a lot of complaints from providers and different organizations  
18 that it seems like every RAC determination is being overturned on appeal, and that's just not correct. As of  
19 the end of the demonstration, only 14% of all RAC overpayment determinations were appealed, and of that  
20 14%, about one-third was overturned in the provider's favor, and about two-thirds, the decision stayed with  
21 the RAC. So we think that's pretty significant. That equals out to only 4.6% of all RAC overpayment  
22 determinations being overturned on appeal and that little sentence there at the bottom does have a typo. It  
23 says only 4.6% of RAC appeals, and that's of all RAC overpayment determinations. It's a pretty significant  
24 difference. And like I said before, we do expect that number to change and that would be something, some  
25 information that would be updated in our report as well. And even though we think that that \$1 billion that  
26 the RAC corrected with both the overpayments and underpayments is pretty significant, compared to all of

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1 the Medicare payments that they were available to review, it's such a small percentage, you can see it's not  
2 really even a piece of the pie. It's a line in the pie charge. They corrected only .3% of the claims that were  
3 available to review. So there's definitely a lot more there for them to correct in the permanent program.

4 The next slide shows where the improper payments were found and you can see that the vast vast  
5 majority were found from inpatient hospitals. \$828 were found from those hospitals. The other places that  
6 the RACs found improper payments, inpatient rehab facilities, skilled nursing facilities, outpatient  
7 hospitals, durable medical equipment suppliers, physicians and other carrier billers. And you'll note the  
8 physician, 2% of the RAC overpayments were collected from physicians, about \$20 million and this is the  
9 first time that we're able to break that physician number out for everyone. In the past it was kind of  
10 combined with the ambulance and lab claims into just a general carrier overpayment category, and we're  
11 pleased to be able to separate that out for you all today based on your recommendations. And we'll  
12 continue in the permanent program to always separate physician data from the other carrier billers.

13 This slide is a little bit small up there, but it shows what kind of errors were being identified, and  
14 the slide on the left shows the errors that the RACs identified, compared to the pie chart on the right that  
15 shows the errors that CERT identified. They're pretty similar. Most of the payments or most of the errors  
16 were from claims that were incorrectly coded or were not medically necessary. We have a slightly larger  
17 other category, and we define other errors to be duplicate claims, applying incorrect billing rules, using an  
18 outdated fee schedule, things like that. The biggest difference between the RAC results and the CERT  
19 results we think is the documentation category. CERT had a much bigger documentation error category, but  
20 a lot of those seemed to come from DME suppliers, and as you saw on the previous slide, the RACs didn't  
21 focus so much on DME companies, so that's what we're attributing that difference to. And that's all we  
22 have on the demonstration results and I'll turn it over to Melanie to talk about the expansion.

23 Ms. Combs-Dyer: Thank you. First I'm going to go over a couple of key lessons learned. And the  
24 first one has to do with the financial impact that the RACs had on providers. The particular slide that is  
25 seen here is really about the financial impact on hospitals. I do not have a similar slide for physicians,  
26 although in the future I hope that I will. And I'm going to take just a minute to make sure everybody can

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1 understand this, because I know it's a pretty complicated slide, but I think it's important. The bars are  
2 colored by Recovery Audit Contractors, so you can see, the key on the right says that the dark color is  
3 Connelly Consulting, that was New York. The light color, which is second, was Florida, HDI was the name  
4 of the Recovery Audit Contractor that worked there, and PRG Shultz is the striped color. That's California.  
5 And then if you look down at the bottom of the graph, you can see groupings of those bars; the first  
6 grouping on the left says "no offset" so you can see that the vast majority of hospitals in California, in  
7 Florida, and in New York, had no offsets at all from the Recovery Audit Contractor. Either the RAC did  
8 not touch them at all, didn't ask for anything from them, or they asked for medical records, reviewed them,  
9 and did not have any findings. Did not collect any money. The next group of three, shows providers who  
10 were impacted to the tune of 0.2% to 5%. That means that that percentage of their annual Medicare  
11 financial revenue was taken back by the Recovery Audit Contractors to that amount. Actually I think I'm  
12 reading that wrong. It's zero to 2.5%. Sorry. So a few more providers fell into that category, and then even  
13 small numbers, all the way until you get to the far right hand side, which shows the providers where there  
14 was 10% or higher impact to their annual Medicare revenue stream. Although we're very pleased that most  
15 providers were over on the left or in the middle and not very many providers were on the right, we still  
16 think that that may have been a little bit too much on the right, particularly, you can see the variation  
17 between the Recovery Audit Contractors on the right, with California having higher financial impact on  
18 providers than the other two Recovery Audit Contractors. So we've made a couple of changes that we think  
19 will help to limit the financial impact on providers. The first is by limiting the number of medical record  
20 requests. During the demonstration, CMS did not mandate a particular medical record limit per 45 days.  
21 We encouraged each Recovery Audit Contractor to establish a limit. Two of them did, one of them did not  
22 and the two that did, chose one single number. For example, one of them chose 100 medical records per 45  
23 days. And it didn't matter if it was a solo practice physician or if it was a 700-bed hospital, it was 100  
24 medical records per 45 days. We think we can do better than that and we have decided to implement a  
25 sliding scale medical record limit and we will have a different limit for physicians and carrier billers  
26 separate from inpatient hospitals and other facilities. We are currently in the process of gathering



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1 information and trying to establish those medical record limits and we certainly would welcome any input  
2 from the Council on things that we should consider as we try to establish those medical record limits, but  
3 we do believe that using a sliding scale with perhaps a minimum or a maximum number is going to be the  
4 best way to do and certainly better than what we had during the demonstration. A second change that we're  
5 making to limit the financial impact on providers is to limit the RAC look back period. During the  
6 demonstration, Recovery Audit Contractors were allowed to look back four years and we're changing that  
7 under the permanent program, to be three years.

8         The second lesson that we learned during the demonstration had to do with the concern the  
9 providers raised about the Recovery Audit Contractors using unqualified staff. During the demonstration,  
10 the Recovery Audit Contractors were not required to hire physicians or certified coders. And we found that  
11 all of our RACs very quickly did hire certified coders, and they were in place during most of the  
12 demonstration, but it took a little while longer for our demonstration RACs to recognize the need to have a  
13 medical director, a physician medical director in charge of the entire RAC program. By the end of the  
14 demonstration, all three of them did have a physician medical director in place, but we don't want to leave  
15 that up the RACs in the future. We believe that it's important for all of our future permanent RACs to have  
16 a physician medical director in place from day one, and so when we make the announcements about the  
17 Recovery Audit Contractors, we will be announcing the names of the physician medical directors shortly  
18 thereafter. In addition, we have changed the statement of work to require that the Recovery Audit  
19 Contractor hire certified coders.

20         The next lesson learned had to do with accuracy. During the demonstration program, a number of  
21 providers questioned the accuracy of RAC reviews and we in CMS had chosen to use as our benchmark or  
22 our tool to measure RAC accuracy through the appeals process; we chose to look at the appeals numbers to  
23 see how accurate the RACs were being. And while that was a good general idea about how accurate the  
24 RACs were being in making their claim determinations, there's a big limit to using appeals data to tell how  
25 accurate a reviewer is being. Sometimes providers don't appeal, and so we don't think we were getting the  
26 clearest picture of how accurate the RACs were being. We believe that the changes that we've made in the

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1 new permanent program will help to assure us that our RACs are being accurate and let me go through  
2 some of those changes now.

3 First, we will be reviewing all new issues that a Recovery Audit Contractor chooses to review  
4 before they can begin reviewing. They have to come to us, fill out the form, tell us what the issue is, tell us  
5 where the Medicare policy is, tell us whether they're going to do the review through automated review,  
6 meaning they don't need to review the medical record, or whether they're going to be ordering the medical  
7 record and reviewing the medical record to make the determination. They will also have to share with us  
8 the language that they propose to send back to the provider, explaining why a particular claim contained an  
9 improper payment. Only after we've reviewed all that information, and perhaps even reviewed a couple of  
10 medical records ourselves, will we give the Recovery Audit Contractor permission to begin reviewing that  
11 issue.

12 Second, we have hired an independent validation contractor, or we will be hiring. We're in the  
13 procurement process for that contractor now. That independent validation contractor, we can ask to review  
14 any claim, any medical record from our Recovery Audit Contractor at any time, and we believe that that  
15 will be helpful to us when we want to sort of do a spot check and see how the Recovery Audit Contractor is  
16 doing. And in addition that independent validation contractor will be pulling a random sample of claims  
17 periodically throughout the year, for each Recovery Audit Contractor. And producing an accuracy rate for  
18 each one. And we will be publishing those accuracy rates in our annual report each year for each Recovery  
19 Audit Contractor. Key lesson number four is about transparency. There was concern throughout the  
20 program that we weren't sharing enough information, or that we weren't sharing enough information  
21 quickly enough. I was just having a conversation in the hallway before we came in at the break, with  
22 someone about how important it is for providers to understand when errors are being made and understand  
23 quickly. Although it's good that the Recovery Audit Contractor program put out an annual report and listed  
24 some of the findings each year, hearing it at the end of the year isn't nearly as good as hearing about it  
25 every month throughout the year periodically posted to a website, and so we are going to require our new  
26 Recovery Audit Contractors to post to their websites each new issue that they choose to review as well as

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1 each vulnerability that they find. New issues and vulnerabilities are very similar. Vulnerability just means  
2 that they found significant dollars. They might begin to review a new issue and find that there are only  
3 three claims that are improperly paid, but in the case where they find many claims that are improperly paid,  
4 we want them to describe on their website where the policy is, where it is the providers are going wrong,  
5 and what providers can do to bill correctly. In addition, we're going to have a claim status website for the  
6 RAC program. This is a situation where many providers felt that it was difficult to keep track of the  
7 medical record requests that were coming in which ones they had responded to, which ones they were  
8 getting denials on and while they certainly could pick up a telephone on a daily basis and verbally rattle off,  
9 tell me where this claim is, tell me where this claim is, tell me where this claim is, we think it's going to be  
10 much more efficient both for the Recovery Audit Contractor and for the provider to be able to look up that  
11 information a website and see which claims a RAC has requested a medical record for and where it is in a  
12 review process. Has the medical record been received? Is it at [nurse?] review? Has it been denied? We just  
13 think it's going to be clearer for everyone.

14 Our next steps are first to announce the names of the new four permanent Recovery Audit  
15 Contractors. We'll do that as soon as we know that. And we're deep in the procurement process. We are  
16 hopeful that in the next month or two we will be able to make that announcement. After we announce the  
17 names of the four Recovery Audit Contractors we will begin to do concentrated provider outreach. We  
18 think it's important that providers in every state where the RACs are going to be reviewing know that the  
19 Recovery Audit Contractors are coming, know how to get a hold of a Recovery Audit Contractor, know  
20 what their letters are going to look like, and really understand what the Recovery Audit Contractor program  
21 is all about and after we have done that provider outreach, the Recovery Audit Contractors can begin to  
22 review the claim data and begin reaching out to providers, either with medical record requests or with  
23 demand letters. Or both. The next slide shows the map of the United States and you can see that it's divided  
24 into four sections, region A, region B, region C, and region D, and there will be a Recovery Audit  
25 Contractor responsible for each one of those regions. So four companies, one for each region. And the  
26 colors on the slide indicate which states will be starting up first; which will be starting up second, and

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1 which will be starting up third. The yellow states are the ones that we will allow the Recovery Audit  
2 Contractors to begin reviewing first, although it's not a mandate, it's totally up to each Recovery Audit  
3 Contractor to pick and choose among those states, but they could not start any earlier than the dates that are  
4 listed on this map. So for example, the state of Texas and Oklahoma, appear to be that sort of green striped  
5 color, and the key shows that that says early 2009. The Recovery Audit Contractor for Region C could not  
6 begin reviewing claims in those states any earlier than 2009. Once we make our award and we hear back  
7 from our Recovery Audit Contractors about exactly which state they would like to review in, we will be  
8 updating this map and pinpointing the months a little more precisely, but for right now, this is about as  
9 precise as we can get, given that we don't have any Recovery Audit Contractors in place today. The next  
10 slide just gives you one more time that website, [www.cms.hhs.gov/rac](http://www.cms.hhs.gov/rac). That's the best place to go to get  
11 more information about all this and the next slide talks about our email address, if you would like to write  
12 to Amy or to me after this presentation or any time throughout the year, feel free to write to  
13 [RAC@cms.hhs.gov](mailto:RAC@cms.hhs.gov). And at this point, we will take any questions that you have.

14 Dr. Bufalino: Thank you very much. There's some robust interest. Let's start on the left here. Dr.  
15 Ouzounian?

16 Dr. Ouzounian: Would you mind going back to the slide that's labeled Key Lesson number one,  
17 and I'd look at slide and maybe you said this, but I somehow look at this a little differently in terms of the  
18 information that I pull off of that slide. And what I pull off of that slide is that there may be a significant  
19 difference in the criteria that's used by the different auditors. If you look at PRG Shultz, they have the  
20 lowest number of claims where they didn't ask money back, and the highest number of claims where they  
21 did ask money back, and I wonder if the different RAC contractors are using very different criteria to  
22 screen and supposedly find inaccurate claims. And that brings me then to a resolution or a proposal and I  
23 would like to propose that the RAC recommends, I'm sorry the PPAC recommends [laughter] that all of the  
24 RAC contractors be required to use the same screening criteria.

25 [second]

26 Dr. Bufalino: Second, thank you. Any discussion? Would you like to comment?

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1 Ms. Combs-Dyer: I think it would. I'm not sure that I understand what you mean by screening  
2 criteria and I think it may be helpful as we respond to your recommendations if you're a little clearer about  
3 what you mean?

4 Dr. Ouzounian: Well, can we get to the slide that say Key Lesson number one? PRG Shultz has  
5 the lowest number of claims where they didn't ask for money back, and then if you go to the right, they  
6 have the highest number of claims where they did ask for money back. And that implies to me that they are  
7 using, or may be using much stricter criteria or different criteria to say that something was billed  
8 incorrectly and ask for money back than the other RAC contractors.

9 Dr. Standaert: Those aren't claims, those are the percentage of hospitals that are affected. It's not,  
10 that has nothing to do with the actual number of claims, and so it's the, maybe you can clarify this, but one  
11 thing she said about that is they don't know how many of the hospitals actually received inquiries from the  
12 RACs about their records, and so the far left is just a sheer number of hospitals that either had no problems  
13 found they were pursued or they were just never asked about it. And I don't know that you have the data to  
14 break those two out, do you?

15 Ms. Combs-Dyer: I don't think I do, I will tell you that the Recovery Audit Contractors are  
16 allowed to pick and choose whichever claims they want, based on where they think the improper payments  
17 are in their area. In other words, CMS is not dictating to them that they have to go look at skilled nursing  
18 facilities, or they have to look at a particular type of DME or they have to review a particular claim type.  
19 We allow each Recovery Audit Contractor to select which claims they want to review. So if by screening  
20 criteria you mean that we should somehow require that they all be uniform in terms of which claims their  
21 choosing for review, that certainly is not something that we would not be interested in doing. On the other  
22 hand, it is true that all the Recovery Audit Contractors used the same Medicare policy. They all had to  
23 abide by the NCDs and LCDs that are on the books today and so I'm not quite certain what you mean when  
24 you talk about screening criteria.

25 Dr. Bufalino: Any clarification?

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1 Dr. Ouzounian: Well, some of my colleagues have said I may be reading this wrong. But I still see  
2 that one contractor is finding more problems, at least the way I'm reading the slide, than the other  
3 contractors and maybe I'm reading the slide wrong.

4 Ms. Combs-Dyer: I think the way I would read the slide is that some of the Recovery Audit  
5 Contractors focused in on certain providers more, whereas other RACs spread the joy widely and touched  
6 lots of providers a little bit, that's what I take from this slide.

7 Dr. Standaert: You said in the future, you're going to have data, you're requiring that the RACs  
8 have an independent auditor, which is something that came up when you were here in the spring, or the  
9 winter or whenever, that eventually you will have data on which RACs, sort of the efficiency or the  
10 accuracy of the different RACs compared to one another. I assume you don't really have that data now at  
11 the moment, do you know anything about—I think what he's trying to get after is sort of the, are the RACs  
12 approaching hospitals and providers differently and using different criteria by which they decide something  
13 is inaccurate or overbilled or under billed than other ones. Are they using a uniform approach once they get  
14 their data?

15 Ms. Combs-Dyer: They are using as uniform approach as CMS has on the books. With certain  
16 services, there are lots of guidelines that Medicare has issued to say this is exactly precisely what is covered  
17 and this is not covered. In other places, CMS is a little bit more vague where there isn't a local coverage  
18 determination. In those cases, the Recovery Audit Contractors have to use their clinical judgement, but I  
19 believe that this slide is really getting at individual some RACs focusing in on individual providers more  
20 than others. The point that you're making about having a validation contractor to compare accuracy rates  
21 across the Recovery Audit Contractors is true. We will be hiring that validation contractor. We had a  
22 validation contractor at the very tail end of our demonstration, but they were not able to produce results  
23 over a long enough period of time to be able to produce anything to report. It was really just for us to  
24 practice the exchange of information and see how the reporting would go. We really don't have anything to  
25 report from that during the demonstration, but of course, like I said, we will in the permanent program.

26 Dr. Bufalino: So let's just go back to Tye again. What would you like us to do with your—

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1 Dr. Ouzounian: I withdraw the proposal.

2 Dr. Bufalino: OK, thank you. Jeff?

3 Dr. Ross: Ms. Combs-Dyer, congratulations, by the way.

4 Ms. Combs-Dyer: Thank you.

5 Dr. Ross: I have a good question on your slide, the RAC demonstration pie if you could go to that  
6 slide for a second? It broke down where it showed the 85% inpatient hospital?

7 Ms. Combs-Dyer: Slide 10.

8 Dr. Ross: Yes, that's correct. I'm sorry. If you look to the lower right, you'll see a 1% durable  
9 medical equipment, one of the lower figures. My question is do you have a breakdown for physicians  
10 versus suppliers who either overcharged, or were involved with fraud of durable medical equipment and if  
11 there was fraud, who looks at the fraud.

12 Ms. Reese: We can say that as far as who looks at the fraud, it's not the RACs. If the RAC touches  
13 a claim that they think is fraud, they immediately stop their review and that—

14 Dr. Ross: Send it on. So you just deal with the overpayment?

15 Ms. Reese: Exactly.

16 Dr. Ross: And do you have a breakdown of that overpayment and differentiate between physician  
17 versus supplier?

18 Ms. Combs-Dyer: Are you talking about within the durable medical equipment?

19 Dr. Ross: Within the durable medical equipment figure of the 1%.

20 Ms. Combs-Dyer: That would be all the DME suppliers.

21 Dr. Ross: I understand that.

22 Ms. Combs-Dyer: And are you asking how many of them are also physicians?

23 Dr. Ross: No. There are two groups of suppliers basically—you have the physicians in office, and  
24 then you also have commercial suppliers who are also billing. So the question is do you differentiate  
25 between the two when you look at that 1% figure?

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1 Ms. Combs-Dyer: We do not and at this stage of the game, I'm not sure that we would want to  
2 break it down any further because it's already such a small piece of the pie—

3 Dr. Ross: Well, I realize that, but I'm leading to a discussion for this afternoon, and my question  
4 is, or my recommendation would be and this is my recommendation, Mr. Chairman, that PPAC recommend  
5 that the RAC provide data of overpayments collected for DME and differentiate between physicians and  
6 commercial suppliers.

7 [second]

8 Dr. Bufalino: Second, thank you. Any other comments?

9 Dr. Ross: If I could just give reason to why I've proposed this. Because there is a great deal of  
10 concern about DME and that physicians be accredited for supplying DME, and the question is is it the  
11 suppliers who are overcharging and involved with fraud or are the physicians doing their due diligence,  
12 doing what they're supposed to be doing, not overcharging, and providing that services?

13 Dr. Bufalino: OK, clear? All in favor?

14 [Ayes]

15 Dr. Bufalino: Thank you.

16 Dr. Ross: Thank you.

17 Dr. Kirsch: I'd like to refer to slide eleven. What captures my attention the 40% unnecessary  
18 claims and can you give me a little bit of background, if there is a certain group of issues that they're  
19 defining as medically unnecessary and is medical director determining that, or how are those  
20 determinations made?

21 Ms. Combs-Dyer: The medical director would not necessarily be involved in those, although he or  
22 she would be available if the nurse reviewers needed to consult with him or her. Most of those would be  
23 because such a large percentage of the claims with improper payments found in the three-year  
24 demonstration involved inpatient hospital, most of those medically unnecessary services came from very  
25 short stays where the patient was in the wrong setting; they did not need to receive the services in the  
26 inpatient hospital setting; instead they could have received the services in an outpatient setting, or in a



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1 skilled nursing facility or at home. And so that's what the largest percentage is. There was a certain number  
2 of physician services where there, the physician was billing for too many of something. For example, we  
3 had an issue with a drug, a Nulasta, where six units were billed for, actually six vials of Nulasta were billed  
4 for instead of one vial containing six milligrams, so that was another piece of that medically unnecessary  
5 pie. And there is more detail if you want to go to the website and pull down that report. There are lots of  
6 examples listed in the report.

7 Dr. Snow: Ms. Reese, you indicated on one of those first slides that only 14% of these RAC  
8 determinations had been appealed, and the agency found this "very significant," but you didn't explain that.  
9 What was the very significance you found in that appeal rate?

10 Ms. Reese: About the 14%

11 Dr. Snow: Yes ma'am.

12 Ms. Reese: Just that such a small number were being ultimately appealed in the first place. We just  
13 the, from the information that we were hearing from the societies and the providers, we expected that  
14 everything was going to be appealed and they made it seem like everything was being overturned, and once  
15 we crunched the data, as of the appeals that were decided by the end of the demonstration, only that 14%  
16 out of all the RAC determinations were appealed and from that, only about 1/3 was found in the providers'  
17 favor.

18 Dr. Snow: One-third overturn of the appeals, seems to me rather high, number one. Do you have a  
19 breakdown on that appeals request by the different types, in particular, by hospitals and physicians?

20 Ms. Reese: In the report, we break it down by Part A, and Part B. It's not specific to physician, but  
21 it's part A and part B, and we have it broken down by RAC as well.

22 Dr. Snow: Was there any consideration given to this low rate of appeals being in particular among  
23 physicians, it's typically going to involve very small amounts that perhaps the time involved in appealing is  
24 so great and the cost of that and the potential return so small that it is not financially viable to appeal it?

25 Ms. Combs-Dyer: Yes that is something that we have considered, and we have actually made a  
26 change in the way that the contingency fee works with our Recovery Audit Contractors. During the

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1 demonstration Recovery Audit Contractor was required to pay back their contingency fee only if they lost  
2 at first level of appeal, but they were not required to pay back their contingency fee if they lost at second or  
3 third level of appeal and we are changing that to require that the new permanent RACs will have to pay  
4 back their contingency fee if they lose at any level of appeal. We think that's really important and it really  
5 makes for, the Recovery Audit Contractor will have to be very sure when they're making a determination  
6 that will stick, that it's well documented, and that it will hold up through the appeals process if they want to  
7 keep their contingency fee.

8 Dr. Snow: Very good, thank you. Now you indicated, let me just ask one quick question, is it true  
9 that the RAC bounty hunters will not audit records for three months before a contractor transition and three  
10 months after a contractor transition. I've heard rumors to that effect and...

11 Ms. Combs-Dyer: The question has to do with what will happen with a Recovery Audit Contractor  
12 during a MAC transition, a Medicare administration contractor. I'm sure everyone is familiar with the  
13 carriers and the FIs giving up work load and being transitioned over to MACs and that can be a very  
14 complicated process where everybody really needs to keep their eye on the ball and make sure that nothing  
15 goes wrong during that transition. And so we have instructed our Recovery Audit Contractor that during a  
16 MAC transition, three months before and three months after, a MAC transition the Recovery Audit  
17 Contractor will cease operations. They will not send any information to that MAC, the carrier FI the MAC,  
18 and they will, they can certainly continue to review claims, they certainly can continue to review medical  
19 records; they can do things that don't impact the carrier, the FI or the MAC, but they cannot exchange files  
20 or send information or send demand letters during that black out period.

21 Dr. Smith: I want to comment on the time issue for compliance. I think it applies to physicians as  
22 well as to hospitals and everybody else although the relative values may or may not be similar, but I've only  
23 had one request to my office for information. It was related to whether a lab test was justified. I think that  
24 the lab test in question, based on what Medicare pays me was probably recovering if they decided it was  
25 unnecessary, something in the range of \$2. So that's the first issue. We got four different forms from two  
26 different places requesting this information. The forms were each 3 pages. The second and third pages did

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1 not transmit. The only thing I was getting was the phone number, saying it was a RAC and they were  
2 requesting this information. It required four phone calls from me, because my staff wouldn't know what  
3 this was about. I logged it, a total of 30 minutes of my personal time in order to find out what they were  
4 even asking about, telling me that it's on patient Romero comma, F was not helpful. It didn't give me a full  
5 name, it didn't give me a birth date, it didn't give me a date of service, anything like that. It was apparently  
6 on pages 2 and 3 that didn't come through, but I didn't have that. Those were not toll free phone calls. It's  
7 not an enormous expense, but it's not a trivial one and if you multiply it by many thousands, it would be.  
8 So it took 30 minutes of my time. If they had requested records for 3 years on this particular patient, it  
9 would have been 150 pages of records. They did not request records for three years, but if they had, I mean  
10 this is not trivial.

11 My other comment, which is kind of an outgrowth of that, is that I think you might want to  
12 establish a mechanism to define the burden on providers at large, physicians, hospitals, etc., of what this is  
13 taking and I don't know if you do that via a website where one can log in very simply, hopefully in a  
14 minute or something like that and say with respect to complying with request number abcd, I spent 30  
15 minutes, 17 minutes, 1 minute, whatever it is. I think that would be very valuable information for you to  
16 collect about what the burden is. And I think it would have to come from you folks, since you're the ones  
17 who know on what you or the RAC contractors on what's being requested. It's not a generic question that  
18 CMS could get by a survey or anything. The other thing I wonder, on your slide 15, your key lesson  
19 number four is how you're proposing to post these issues to the web, your new issues, vulnerability, claim  
20 status and I'm hoping that that's going to be broken down in hospitals, physicians, maybe the same kind of  
21 entities that you listed in your pie chart, so that one doesn't, a physician's office for example, doesn't have  
22 to page through a huge number of documents that are completely irrelevant to a physician's office in order  
23 to find the one line that is something that would be applicable to a physician's office.

24 Ms. Combs-Dyer: That's a great suggestion and we will pass that on to the Recovery Audit  
25 Contractors that those websites should be broken down that way, because you're right, that would be much  
26 more beneficial to providers if they could see it that way.

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1 Dr. Bufalino: Thank you. Other comments, John?

2 Dr. Arradondo: Thanks Mr. Chairman. I have a question, slide 9. It, the byline, the propaganda  
3 line is RACs affected a very small percentage of all Medicare payments. Is it 316 billion all Medicaid  
4 payments, I mean Medicare payments? Not just the ones that the RACs looked at—that's all—

5 Ms. Combs-Dyer: All in their states that they, not for the whole country but in the demonstration  
6 states.

7 Dr. Arradondo: And of course these are dollars, you haven't given us actual number. Assume a  
8 percentage would be based on that—just for that purpose. The \$1 billion figure in your slide 8 seems to  
9 represent the proportion, the total rather of RAC determinations that resulted in a correction. That's the 992  
10 and the 37.8. So that's the billion that you're talking about? So that represents the ones where there was a  
11 change. Did the RACs look at records where there were not changes?

12 Ms. Combs-Dyer: Did the RACs look at medical records where there were no changes?

13 Dr. Arradondo: Yes.

14 Ms. Combs-Dyer: Yes. The Recovery Audit Contractors certainly when they were requesting  
15 medical records, the reason that they were requesting medical records is that they were not 100% certain  
16 just looking at the claim whether it contained an improper payment or not. If they knew for sure, looking at  
17 the claim, that it contained an improper payment, they wouldn't hassle you for the medical record. They  
18 would instead just deny the claim. They only need to ask for medical records when they're not 100% sure.  
19 They need to review the medical record to see if there's an improper payment and once they reviewed the  
20 medical record, sometimes they denied it, sometimes they approved it. Their goal of course is to try to hit  
21 as many as they possibly can. They don't want to be asking for lots and lots and lots of medical records and  
22 then only finding that one or two percent of them contain improper payments. They would instead like to  
23 have a high percentage of the medical records that they review contain improper payments. It makes it  
24 easier for you to not to have to send in medical records unnecessarily and it makes it easier on their profit  
25 margin to not have to pay nurses to review claims and then not have any findings. So yes, they did find

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1 some medical records that they reviewed that didn't have improper payments associated with them, but  
2 they tried to minimize that wherever possible.

3 Dr. Arradondo: But that number's not been presented to us. Total number of determinations, some  
4 of which said no change and the ones you're presenting to us represent change.

5 Ms. Reese: Right, and we do have more information in that evaluation report that we were  
6 referring to and in an appendix, we have what Mel referred to as the Hit Rate. And I don't know that the  
7 numbers—

8 Dr. Arradondo: So was the hit rate on the average?

9 Ms. Combs-Dyer: Yes, it was the percentage times that an improper payment was—

10 Dr. Arradondo: Yes, I'm saying what is that rate on the average? 5%, 90%?

11 Ms. Combs-Dyer: I want to say it was around 30%.

12 Ms. Reese: It was yes, I believe it was in the 30s. And that's in an appendix in the report, for each  
13 RAC, each of their hit rates.

14 Dr. Arradondo: So when you say a RAC determination, does that mean a determination for no  
15 change or determination only for change? Determination is either or both?

16 Ms. Reese: When we say a RAC determination, we mean an im—where the RAC reviewed a  
17 claim and there was an improper payment finding, either under or over—

18 Dr. Arradondo: So a review that results in a change is what you define as a determination. My real  
19 interest here, Mr. Chairman is slide 8, not slide 9. This is the second or third time it's been presented to us  
20 and I just view this as a propaganda slide and the reason I referred to the little bylines under each of the top  
21 names—this one is very appealing. It says "Appeals were minimal." That's the headline that *New York*  
22 *Times* and *USA Today* are supposed to have after they see this slide. This has nothing to do with our  
23 presenters. Has to do with us. And with people who go and talk about this. Because if you talk about it the  
24 way it's presented, physicians should be intimidated and shouldn't appeal. But the data actually would  
25 warrant that that slide be relabeled. Let me justify what I've just said.

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1           The determinations or the total number here as far as we can tell and the determinations in this  
2 slide, are for overpayment, not just errors, realizing that most of them over, very few were under, so I'll  
3 stick with that. Overpayment determinations. At the bottom, the come on is 5% of RAC appeals were  
4 overturned, so you shouldn't try to appeal. Because you're going to lose 95% of the time. And that's not  
5 true. What the data shows is that of the appeals 33% succeed. Not 4%. So if you want to present this as a  
6 propaganda slide, you have to decide whether you're going to intimidate the potential appellant or give him  
7 neutral facts. And the neutral facts say that 14% of the overpayment determinations, which would logically  
8 be the only ones that the physicians would appeal, were appealed. I don't know if that's a high number or a  
9 low number, depends upon the contest. To me this is a relatively high number, but as I say, I don't really  
10 know. It depends upon the contest. And maybe the size of the determination. But of the 14% that were  
11 appealed, one out of three were determined, ultimately by the appeal judge in favor of the appellant, the  
12 physician. That's a pretty high number. Now if I were presenting this to say that the RACs were doing  
13 great, I'd say 5% were overturned. That's what it says here. So it depends I guess upon who this is being  
14 presented to. I didn't comment on this when it was presented to us earlier, although I had the same feeling  
15 and analysis as I have now, but I did choose since two of my colleagues got into this, I didn't think it was  
16 worth bringing up, quite candidly, but since two of my colleagues got into it I thought I would just present  
17 the simple fact that this slide is dealing with numerator data not denominator and numerator data, and we  
18 make errors when we deal only with numerator data. And in this particular instance, the slide is internally  
19 inconsistent. If you know nothing else about the program, you can look at this slide and see that the bottom  
20 statement, all the way down, is incorrect, because the data in the middle of the slide belie that. The line, the  
21 second line from the top, what I call the propaganda line, appeals were minimal is just that. It's meant to be  
22 a headline. That's what newspapers do and all, and it's kind of nice when you present to us to realize that  
23 some of us can count.

24           Dr. Bufalino: Thank you.

25           Ms. Combs-Dyer: Thank you for your input and we certainly will take that under advisement as  
26 we revise our slides for our next presentation.

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1 Dr. Bufalino: Other comments.

2 Dr. Standaert: I know we're running late, I'll make it quick. We keep coming back to the same  
3 slide, and I think one of the concerns, one I think a lot of this is hospital stuff, and hospital is the big, low  
4 hanging fruit that they went after. Not the physicians, physicians are 2% of this, but we're all concerned  
5 about the physician side largely. One other way of looking at this in terms of appeals is the idea that the  
6 burden on the person who has to appeal and from a physician standpoint, that's what we're concerned  
7 about. Somebody comes and says you were overpaid, we want the money back. And we have to make a  
8 determination whether it's worth going through the cost and expense of appealing to get that money back or  
9 not. And one piece of data might help on your appeal stuff is in the appeal data, is there a cost threshold at  
10 which people appealed and different levels of providers appealed? And are people making a determination  
11 that a certain amount of overpayment isn't worth trying to get back again, even if you think it was taken  
12 wrongly, because the cost is going to be so high. And then if there is sort of a cost threshold at which  
13 people will not appeal because it just is too expensive, do you adjust the process of appeals so that, it's  
14 almost like creating a small claims court, where people who are lower on the sort of cost end of it, the sole  
15 provider who has less overhead less expense, less everything else can't afford to appeal smaller numbers  
16 and you make an appeals process that is less expensive for them to go through to get back a smaller claim if  
17 they think it was taken away unjustly. To look at the cost basis for how people appeal, and the cost of  
18 appealing and how that would affect individual providers in their ability to appeal or choice to appeal. Does  
19 that mean--

20 Ms. Combs-Dyers: I am not a appeals expert, so I really can't comment on are there ways that we  
21 could build the system to make it cheaper for providers to appeal—

22 Dr. Standaert: No, I'm just throwing that in. But having that idea of what it costs to appeal would  
23 be useful, because then you might understand why some people aren't appealing, frankly.

24 Ms. Combs-Dyer: What we certainly can try to do in the future is see if we can break down our  
25 data to show us the cost categories or the dollar amount on average.

26 Dr. Standaert: You should be able to do that fairly easily, I would think. Thank you.

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1 Ms. Combs-Dyer: I would think. We certainly will try to do that in the future.

2 Dr. Howard: I just wanted to ask about the inpatient hospital side. Is the person who works out of  
3 the hospital a lot of times, is there any breakdown on if the physician was involved in some aspect of the  
4 inpatient claims issues? Because I certainly am not getting any of that information back to me so that I  
5 might be involved in something of that process if it was happening, if I was involved in it.

6 Ms. Combs-Dyer: I'm not sure if you were at the last PPAC meeting where I presented this issue,  
7 but I think the answer is yes. Certainly when I go and I show that slide that's got the big 85% piece of the  
8 pie where the most improper payments are coming from the inpatient hospital side of the house and I show  
9 that to hospitals, they frequently and explain to them that most often that is because the patient was  
10 admitted to the inpatient side when they should have been treated in the outpatient side, the hospital  
11 community says, why are you educating us about that? You need to be going and educating the physicians.  
12 It's the physicians who need to change their behavior to better understand when to admit to the outpatient  
13 and when to treat the patient on the inpatient side. I think that there probably does need to be a lot of  
14 outreach and education to providers from CMS and from the hospitals and I believe that by putting more  
15 data and information out on the website about the specific categories, where the RACs are finding improper  
16 payments, hospitals can use that information to pass on to physicians, so physicians can be better aware of  
17 when they need to be careful to treat the patient on the outpatient side instead of admitting them to the  
18 inpatient side. Or if admitting to the inpatient side is correct, making sure that their documentation reflects  
19 why they were admitting the patient to the inpatient side of the hospital.

20 Dr. Bufalino: OK.

21 Ms. Combs-Dyer: And any advice or suggestions that you guys can give me about how to reach  
22 out and communicate to physicians on that front, I would really welcome.

23 Dr. Bufalino: Great. Thank you very much. Thank you, ladies for presenting. We'll adjourn and  
24 resume the agenda at 1:00. Council's to meet for lunch up on five. Thank you. Conference Room B on fifth  
25 floor.

26 Lunch Break



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1 Dr. Bufalino: Thank you for joining again. We'll move to the next topic, the long-awaited DME  
2 Update. We have Mr. Joel Kaiser with us today. He's the Deputy Director of DMEPOS policy here at the  
3 agency. And Joel has addressed us in the past and we appreciate having you join us. Look forward to your  
4 thoughts on the new legislation and where this area is going. Thank you.

### DME Update

6 Mr. Kaiser: Thank you. Without further delay, yes, my name's Joel Kaiser. I'm the Deputy  
7 Director for the Division of DMEPOS Policy. We deal with Medicare's payment policies for durable  
8 medical equipment, prosthetics, orthotics, various other supply items paid for under Part B. Here to give  
9 you a quick update on DME. I know that two main issues, these days, are the National Competitive Bidding  
10 Program for DMEPOS, a program designed to contract with specific suppliers for specific items to achieve  
11 savings under the programs for both beneficiaries and taxpayers and also accreditation and quality  
12 standards. Now while I'm directly responsible for the Competitive Bidding Program, I am not directly  
13 responsible for accreditation and quality standards issues. I can try to answer questions, but that area is  
14 handled by our Program Integrity group.

15 The Competitive Bidding Program required that we start the program in ten metropolitan  
16 statistical areas in the first round and then move to a second round of 70 additional MSAs and then after  
17 that, we can move it to areas throughout the country. We were very busy with round one and in fact had  
18 begun implementation on July 1, and then the legislation passed the Medicare Improvements for Patients  
19 and Providers Act, specifically § 154, which called for a delay in the program and termination of the  
20 contracts. So what we're calling our round 1 that we had implemented and was terminated, we're calling  
21 that round 1.1, and the new round 1, we're calling round 1.2, just to avoid confusion about which round one  
22 we're talking about. Before I move into the legislation, I'd like to report for those of you who weren't  
23 following it, we had signed contracts with over 300 suppliers in 10 metropolitan statistical areas, covering  
24 product categories, ten product categories. Suppliers submitted bids for specific product categories in  
25 specific areas and could win one or more of those contracts. We had our published the list of contract  
26 suppliers. We were beginning to—in fact I'd implemented our supplier locator tool, which is our standard

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1 tool that's used by beneficiaries to locate DME suppliers. They type in their resident zip code, and then up  
2 on the screen will pop DME suppliers who are generally within a specified distance from the beneficiary's  
3 home. They can program that in. For competitive bidding, we had added a function to the supplier locator  
4 tool, specifically designed for competitive bidding, so that referral agents and beneficiaries could quickly  
5 find contract suppliers for product categories. We actually had met with some referral agents in Miami, and  
6 had asked them how things were going prior to implementation. And they said they understood the  
7 program. They were having no problem finding the list of contract suppliers and were beginning to get  
8 ready to start referring patients to those contract suppliers, and in fact for the very brief time that we did  
9 have round one up and running, for two weeks, there weren't any major problems reported to us. So we  
10 were happy that everything seemed to be working fine, claims processing systems were working, weren't  
11 any access problems reported. So just a quick update on the two-week round 1.1.

12 So what the legislation basically does is it requires us to rebid round one. It terminates the  
13 contracts that we entered into. We must rebid round one, we must rebid these items with a few exceptions in  
14 the same areas with one exception, we are no longer doing San Juan, Puerto Rico. So there'll be nine areas  
15 for round one. For round two, the same thing goes as far as the areas. For the areas, we must continue to  
16 phase in these 70 MSAs that we had already announced that we would phase in under round two. So  
17 nothing is changing as far as the areas for round 2. And then what the law does is it makes some  
18 refinements to the competitive bidding process for round one and also for future rounds, and I'll get into  
19 those in more detail.

20 Couple other things that the law does, which I'm sure you'll be interested in is it does include a  
21 couple provisions that address some issues that were brought here to this Council in the past and there were  
22 some recommendations surrounding some of these issues and I'll go over those real quickly. Before I get  
23 into competitive bidding, I would like to cover one other provision of the new law, § 144B repeals the  
24 transfer of title requirement for oxygen and oxygen equipment. Under the Deficit Reduction Act of 2005,  
25 the law had mandated that suppliers of oxygen and oxygen equipment after a 36-month payment period,  
26 would require to transfer title to the equipment to the beneficiary. We had issued rulemaking for

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1 implementing that provision. The first beneficiaries would have taken ownership of the equipment on  
2 January 1, 2009, because it was for items furnished on or after January 1, 2006, so the 36-month period  
3 would have started ending for the first beneficiaries in January. But of course now, this provision repeals  
4 the beneficiary ownership provision. Instead, what happens now is that the oxygen supplier, they only get  
5 paid for 36 months. That has not changed, but instead of transferring title of the equipment, they retain  
6 ownership of the equipment, but they are responsible for continuing to furnish the oxygen and oxygen  
7 equipment for any period of medical need until the reasonable, useful lifetime of the equipment expires.  
8 And currently that is five years for Medicare. So for oxygen and equipment, if after five years, the  
9 beneficiary elects to obtain new oxygen equipment, they can do so.

10 We pay nothing after the 36-month cap except for contents, delivery of gaseous or liquid contents.  
11 That's a mandatory provision of the statute. And we also have discretion to pay for any maintenance and  
12 servicing that we determine is reasonable and necessary. That quickly is the 144B provision.

13 Moving on to competitive bidding, as I said, we're mandated to delay round one, terminate the  
14 contracts, and redo round one. So we're busy planning and getting ready for that round 1.2. And the same,  
15 we must do the same product categories in nine MSAs and the bidding must occur at some point in  
16 calendar year 2009, so that'll give you a rough idea of when we'll actually be implementing the contracts.  
17 Probably looking at sometime in 2010. We do have some exceptions. The negative pressure wound therapy  
18 category is exempt from round one. We could add it in round two and later rounds, but for round one, it is  
19 exempt. Also, complex rehabilitative power mobility devices are exempt from competitive bidding in  
20 general. So we won't be doing those in any rounds. To help pay for the delay, Congress mandated a 9.5%  
21 reduction for 2009 for all of the items we were bidding in round one, so the same items that we bid in round  
22 one, most of the same items in round one, we were going to rebid in round two. So all of those items are  
23 going to get a 9.5% reduction for 2009 and so we'll be implementing that on January 1<sup>st</sup>.

24 One big refinement for round one is something we heard a lot about is suppliers who complain  
25 about not being notified as to what documents were missing from their bid package. And so the law  
26 mandates a document notification process, that 30 days prior to the end of the bidding period, we must

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1 notify supplies. Or that those suppliers who submit their bids by the 30<sup>th</sup> day before the end of the  
2 competitive bidding period, we then have a certain period of time to notify them to tell them what  
3 documents are missing; these are financial documents. And then they have ten days to submit that  
4 information. This is not a requirement that if we notify them and they submit documentation that we have  
5 to accept their bids; the documentation still has to be complete and it has to meet our financial standards.  
6 So it's no guarantee that you're going to get a contract, obviously, but we will be notifying suppliers and  
7 they'll have that time to submit that documentation.

8 Other changes to the program, rural areas are exempt, and MSAs that have a population of less  
9 than 250,000 people are exempt from future rounds. Of course round one and round two, the areas are the  
10 same, as we announced previously.

11 OK, moving on. Quality standards and accreditation. I think you all have a summary of the  
12 legislation and for quality standards and accreditation, physicians generally are going to be exempt, unless  
13 there are specific quality standards that are specifically written and established for physicians, and don't  
14 ask me what those might be because I don't know and this again, this is an area that I'm not directly  
15 responsible for. So I wouldn't be able to comment on plans for the future. Also there's a general authority  
16 to exempt physicians and other practitioners if their licensing and certification requirements already would  
17 satisfy what the quality standards would have intended to require. Another provision that was a  
18 recommendation here at the Council I believe a year ago was to exempt physicians who furnish off the  
19 shelf orthotics directly to patients as part of their professional service. That is an exemption in the law now,  
20 so physicians who provide off the shelf orthotics directly to their patients, those off the shelf orthotics are  
21 exempt from competitive bidding. So you don't need a contract to furnish those items. And lastly for  
22 certain durable medical equipment, furnished by hospitals during an admission or upon discharge are  
23 exempt from competitive bidding as well. These are the items that fall under our general exception for  
24 physicians prescribing DME and I'm looking for my list because I don't have it all memorized. These are  
25 the canes, crutches, walkers, folding manual wheelchairs, glucose monitors, and infusion pumps. And that's  
26 an update on the DME area. And I'll take any questions.

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1 Dr. Bufalino: Thank you, Mr. Kaiser. Comments, thoughts, questions?

2 Dr. Ross: Mr. Chair, thank you and I apologize for my lengthiness on my statements but I just  
3 would like to indulge our group. First of all, as we know, that the MIPPA law instructs CMS to halt  
4 application of DME POS quality standards and accreditation requirements to physicians and licensed  
5 healthcare professionals. The security act shall not apply to physicians and licensed healthcare  
6 professionals who supply DMEPOS unless the Secretary determines that the standards being applied are  
7 designed specifically to be applied to such professionals and persons. The Secretary has not yet made this  
8 determination. The second item would be that the Secretary has the authority to exempt physicians and  
9 licensed healthcare professionals from DME POS accreditation and quality standards, stating that the  
10 Secretary may exempt physicians and licensed healthcare professionals from the quality standards if the  
11 Secretary determines that licensing, accreditation, and other mandatory quality requirements apply to such  
12 professionals and persons with respect to the furnishing of such items. We hope that the Secretary should  
13 exercise the authority to exempt physicians and licensed healthcare professionals from the DMEPOS  
14 quality standards. The next items is that there has been a failure on the part of the Secretary to exempt  
15 physicians and licensed healthcare professionals from DMEPOS accreditation requirement, which would  
16 then cause a limitation of patient access to care. Without this accreditation exemption, those physicians and  
17 healthcare professionals will no longer provide durable medical equipment and those individuals as we've  
18 talked about in previous meetings will not have the opportunity to get durable medical equipment for  
19 various injuries or wounds or whatever leaving their office. And then last but not least, as you heard me  
20 mention this morning, we do not believe that the healthcare, the licensed healthcare professionals or  
21 physicians, are the reason for the problem with the DMEPOS accreditation process, but rather the fraud  
22 that's taken place with the suppliers and the over utilization. It's not the doctors that are the problem, or the  
23 root of the problem, it's basically the suppliers.

24 So given the fact that CMS staff has told both my organization and many of the other  
25 organizations, such as the American Academy of Ophthalmology, the American Association of Orthopedic  
26 Surgeons, the American Medical Association, the American Occupational Therapy Association, the

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1 American Optometric Association, the American Physical Therapy Association, the American Podiatric  
2 Medical Association, and the Medical Group Management Association that CMS wanted to try to find a  
3 way to exempt physicians from the accreditation requirement in the MMA, but they did not have the  
4 legislative authority then. But now they do have that legislative authority, and they continue to insist on  
5 physicians and new suppliers to be accredited. Therefore, I would like to make the following  
6 recommendation: The recommendation would be that the Secretary of HH&S as well as CMS, should  
7 immediately halt the DMEPOS accreditation requirements for physicians and licensed healthcare  
8 professionals. Second that PPAC recommends that the Secretary of HH&S and CMS should exercise the  
9 newly expanded authority to exempt physicians and licensed healthcare professionals from the quality  
10 standards and accreditation requirements based on the licensing, accreditation, and other high quality  
11 requirements physicians and licensed healthcare professionals must currently meet. Thank you.

12 [seconds]

13 Dr. Bufalino: Second, thank you. Discussion? Roger?

14 Dr. Jordan: Being an optometrist, which is basically what I'm dealing with is post-cataract care  
15 patients in the prescribing of spectacles and/or also contacts, depending on what the requirement is. The  
16 hardware, or the prescribing that, I went back actually and did about a three-year analysis of what I actually  
17 billed out, and I'm not sure—I'd like to know what the accreditation fee is going to be also and is it a  
18 yearly fee, and/or is it a 2 or 3, but anyway, my billing was actually less than \$2,000 per year. Now I've  
19 heard the figure of \$3,000 as far as being an accreditation fee, and I'm not sure if that's per office or per  
20 doctor, but if it's a per doctor, which I have four docs, that's a \$12,000 fee and I can tell you right now that  
21 I will not even come close to meeting that assessment that I'm going to have to be paying for what I  
22 actually take care of. And also being in a rural situation, which I think you, a lot of the country is, if many  
23 of the physicians do not go through this accreditation process, that access is going to be a huge huge issue,  
24 like I say, especially in the rural areas, and in areas again, with severe weather situations, be it snow,  
25 winter, or rain whatever. But again, we're dealing with an aged population, though that has a mobility issue  
26 that just make it so inconvenient to travel or make repeated visits over and over and over. So again, you're

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1 trying to accommodate a one-time stop if possible and again it's, this is something say that the Secretary  
2 definitely needs to be exempting all of us from.

3 Dr. Bufalino: Thank you. Other comments? All in favor of the motion?

4 [Ayes]

5 Dr. Bufalino: Thank you. Any other comments for Mr. Kaiser? I think they're letting you off the  
6 hook. Thank you for being here. Have a good afternoon.

7 Mr. Kaiser: Thank you.

8 Dr. Bufalino: We'll move to the next item on the agenda is the ORDI Demonstration Project and  
9 we ask Rachel Duguay and Jim Coan to come up and make a presentation. Rachel is the project manager  
10 for the Acute Care Episode Demonstration Project. She's been with CMS for the last six years; five years in  
11 the Washington office in the Policy arm, and she's also been involved in prescription drug policy and  
12 research. The ACE demonstration, for those of you that are not familiar with it, seeks to align financial  
13 incentives within the healthcare groups defined as in this case, the affiliation of at least one hospital with at  
14 least one physician group to improve the quality of care and produce Medicare savings. The Council is  
15 asked to consider some questions and I don't know whether you're going to cover those at the end of your  
16 talk. I'll leave them to you. Welcome.

### 17 ORDI Demonstration Project

18 Ms. Duguay: OK, Thank you. We're all familiar with the Health Policy and Clinical Practice  
19 literature, regarding the lack of a relationship between available services and health outcomes. And  
20 specially, we always refer to the Dartmouth Atlas and the variation in practice patterns across the country.  
21 As you know, there's also a lot of research going on regarding the misalignment of Medicare incentives  
22 and this demonstration specifically addresses that issue. CMS is committed to developing, as a purchaser of  
23 quality efficient services through various value-based purchasing initiatives and this demonstration is one  
24 of those initiatives.

25 The demonstration goals, Acute Care Episode goals are to improve the quality of care through  
26 consumer and provider understanding of both price and quality of care information. Sometimes this is

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1 referred to as “transparency.” And second major goal is increase collaboration among providers,  
2 specifically physicians and hospitals providing the select services for this demonstration. And third, to  
3 reduce Medicare payments for these specific procedures. There are contacts for the Acute Care Episode  
4 demonstration. Many of you are probably familiar with the participating heart bypass center demonstration  
5 of the early ‘90s and that was of course a CMS demonstration, and there have also be at least a couple  
6 examples that are ongoing in the private sector, including VCSQI and the Northern New England  
7 Cardiovascular Study Group. Eligible applicants for the Acute Care Episode demonstration are Medicare  
8 providers in the four states listed, Texas, Oklahoma, New Mexico, and Colorado. They’re all located in  
9 Medicare administration contractor region four. And we specifically decided to locate the demonstration in  
10 one MAC area because of the nature of the demonstration bundling part A and part B services. It would be  
11 administratively and financially expedient to locate the demonstration in one area, and we do have the  
12 ability after year one to expand to a new MAC area. Organizations should be physician hospital  
13 organizations. We’ve listed the minimum requirements on our website and they can either have already  
14 been formed or be integrated organizations or they can form for purposes of participating in the  
15 demonstration. And it’s a fairly loose definition of at least one hospital affiliated with at least one physician  
16 group. We want to make sure that the main players that will be involved in providing services to the  
17 demonstration beneficiaries are all on the same page of course, before implementing this demonstration in  
18 that physicians are very active along with the relevant hospital departments, in overseeing and dealing with  
19 the financial aspects of this demonstration. And also we had volume thresholds for [unintelligible]  
20 procedures. The organization had to complete at least 100 Medicare procedures and 200 total and there  
21 were similar volume thresholds for PTCA and also HIPAA need procedures. So what’s in it for Medicare  
22 providers? Why would a demonstration site want to participate in this demonstration? The largest incentive  
23 is potentially increasing volume due to CMS’s commitment to marketing this demonstration in the local  
24 market areas where it will be occurring, and the sites will also be able to market themselves and will be  
25 designated as value-based care centers. The can be selected for either the cardiac procedures that are part of  
26 the demonstration, and/or the orthopedic procedures. They can choose to bid on either or, or both. And



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1 there's flexibility in managing the bundled payments and the option of engaging in gain sharing. We will  
2 provide a bundled payment to the organizations and they can divide that among the relevant providers as  
3 they see fit. We'll also be highlighting the benefits to Medicare beneficiaries participating in the  
4 demonstration and basically most every Medicare beneficiary that goes to a designated site for one of the  
5 selected procedures will be part of the demonstration. Unless, for example, they do not have both part A  
6 and part B Medicare coverage. But we will be incentivizing beneficiaries to choose value-based care  
7 centers with help in paying their out-of-pockets costs. This is taking the form of a check which will be  
8 written to the beneficiary after the services have been provided, and the simplicity of a single co-insurance  
9 payment. That was also an element that beneficiaries cited as being very helpful in the heart bypass  
10 demonstration. And we hope that they gain a greater understanding of the value of their care. Again, we  
11 will be focusing on marketing and education in local areas, not only targeting beneficiaries, but also their  
12 referring providers.

13 And finally, we do have a web page. There is a lot of information on there, including the  
14 solicitation. Actually the solicitation period closed last Friday on August 15<sup>th</sup>, and we're hoping to finish  
15 the site selection process by early October and the demonstration will begin on January 1<sup>st</sup> and run for 3  
16 years, through the December 31<sup>st</sup> of 2011.

17 So the two questions that I had posted for your specific comment, if you care to comment, would  
18 be the feasibility of including Medical DRGs in a bundled payment demonstration. We did focus on  
19 surgical procedures, at least initially, for ease of defining the episode of care. I should note that the episode  
20 of care for which payment is bundled is a traditional inpatient stay. We're not going beyond the regular  
21 Inpatient Prospective Payment System stay at this point. Although that is something that we will be doing  
22 further research on and also tapping into existing research that's going on at MedPac and other places,  
23 dealing with the feasibility—this is the second question—of adding in post acute care services to the bundle  
24 and specifically cardiac and orthopedic rehabilitation is what we would perhaps like to include initially. So  
25 if there are any questions, I can try to answer them.

26 Dr. Bufalino: Thank you. Questions, comments, Karen?

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1 Dr. Williams: At the risk of irritating some of my colleagues, I'd like to point out that the payment  
2 methodology for anesthesia services is a little different than some of the surgical subspecialties [mike  
3 adjustment] in that we include time and that the anesthesiologist cannot control how long a surgical  
4 procedure's going to go on, even though the person continues to need anesthesia. My understanding is that  
5 we have tried bundled payments in the past in the surgical arena and that particular item needs to be dealt  
6 with effectively.

7 Dr. Bufalino: Other comments? Chris?

8 Dr. Standaert: You mentioned the cardiac ACE, which I'm not familiar with, you kept saying  
9 assuming we know that. I don't know much about that. So if that's a model, I don't know the model.

10 Ms. Duguay: Oh, the heart bypass demonstration?

11 Dr. Standaert: Yes.

12 Ms. Duguay: We do have the evaluation posted on the website that you have there, and there's lots  
13 of information about that, but basically it was a similar model, although it was a negotiated payment  
14 design, this demonstration is based on competitive bidding approach. And it focused only on heart bypass  
15 procedures and not—we've expanded beyond that to other cardiac procedures as well as some orthopedic  
16 procedures.

17 Dr. Standaert: Like hip and knee replacement sort of things?

18 Ms. Duguay: Yes.

19 Dr. Standaert: OK. Because I'm a rehab guy so your question about the rehabilitation services to  
20 the ACE, depending on what the episode is, I would think if you have something like a hip replacement,  
21 it's probably fairly straight forward.

22 Ms. Duguay: Right. Well nothing's quite that straight forward when it comes to our claims  
23 systems.

24 Dr. Standaert: ...compared to say a spinal cord injury or something else or even back pain which  
25 is so much more variable—

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1 Ms. Duguay: Right, which is probably the reason why we'd like to start with those types of  
2 services in terms of post acute care.

3 Dr. Standaert: Yes. I think from a practicality standpoint, things like that, like a relatively  
4 uncomplicated hip or knee or other standard surgical, common surgical procedure like that, you may be  
5 able to define what a normative amount of physical therapy would be associated with that.

6 Ms. Duguay: I guess part of the question is then how does the payment get divided? And does the  
7 organization have post acute care services that it's affiliated with, or do they create some site of linkage in  
8 the community to potentially autonomous organizations? It becomes a little more complicated in terms of  
9 the payment.

10 Dr. Standaert: Yes. You could cover the inpatient, if it's a hospital that covers their post surgical  
11 rehab, it's all in one facility, but when you get into the patient then goes home 40 miles away—

12 Ms. Duguay: Right, that's perhaps one area we could start in.

13 Dr. Standaert: And he needs outpatient rehab services, yes, you'd have to have some sort of,  
14 somebody would have to buy in to say, We'll cover post hip replacement outpatient rehab for X amount of  
15 dollars as single unit, rather than as a per visit thing. The only way I would think you could add that on.  
16 But you know I would see the same problem.

17 Dr. Bufalino: Thank you. The other question I had for you was I was trying to understand the  
18 specifics of the demonstration project. So is this bundling obviously the inpatient care around the coronary  
19 bypass, does it include anesthesia, cardiology, cardiac surgery and primary care as part of the bundled  
20 package?

21 Ms. Duguay: It includes all part B services provided during the inpatient stay.

22 Dr. Bufalino: And the payment is paid to the facility or paid to a combined entity made up of the  
23 facility and the physicians?

24 Ms. Duguay: The combined entity; the physician-hospital organization.

25 Dr. Bufalino: To the PHL specifically.

26 Ms. Duguay: [Yes.]

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1 Dr. Bufalino: So is this typical of the Geisinger model where it's basically an all-inclusive thing,  
2 regardless of complications, so that if someone has a pneumonia post operatively, or whatever complication  
3 afterwards and stays longer in the hospital or incurs X amount of other services, the payment is a bundled  
4 payment regardless of what happens.

5 Ms. Duguay: Right. And we do in the bid and the payment is included an outlier amount, and we  
6 have provided hospitals or organizations with their historic data on both part A and part B services. We  
7 matched all the part A services in their historic volume to part B services so that they would be able to form  
8 a bid using actual data and that we would be able to evaluate the bids more consistently across  
9 organizations.

10 Dr. Bufalino: So there's a buffer payment for the outliers?

11 Ms. Duguay: Yes.

12 Dr. Bufalino: Calculated based on their experience?

13 Ms. Duguay: Yes.

14 Dr. Bufalino: I understand. Thank you. Jeff?

15 Dr. Ross: So if your particular case, if the patient suffered electro physiological problems, and had  
16 to go down to the cath lab, or for whatever reason, for electrophysiology, treatment of those arrhythmias or  
17 anything, that's still included under the bundle?

18 Ms. Duguay: Yes, it would be.

19 Dr. Standaert: I'm trying to understand the buffer thing, because another issues that's come up  
20 several times is this thing of medical complications, and which are avoidable and unavoidable, preventable,  
21 that sort of thing. The idea that if you deal with a higher risk population, you have a lot more of those,  
22 whether you try hard to prevent them or not. And I'm trying to understand the buffer concept. I'm sorry I  
23 jumped in without asking permission—

24 Dr. Bufalino: Yes.

25 Dr. Standaert: But a buffer concept that you were getting into—how does, if you're, it's based on  
26 sort of a, when you have a higher risk patient there's an extra payment that goes with it? Or if you have a

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1 higher mix of higher risk patients, you have a higher baseline payment? Because if you have just a baseline  
2 payment, you have a lot of skimming of the service. Everybody would want the healthy people who would  
3 be cheaper than what they're going to get paid.

4 Ms. Duguay: It's, the bundled payment is updated annually but it's not, it does not vary outside of  
5 those updates.

6 Dr. Standaert: Is it an additional payment for a high risk patient, or is it—

7 Ms. Duguay: It's not additional, no.

8 Dr. Standaert: So that's just a flat rate, that one facility it sees because it historically has had a  
9 certain patient mix.

10 Ms. Duguay: [Yes] and they're free to bid. I mean as they wish, based on their historic data.

11 Dr. Standaert: Doesn't that discourage people from wanting to accept higher risk patients, though?

12 Ms. Duguay: They don't have a choice of the patients they accept in this demonstration. Anyone  
13 who meets the criteria will be considered a demonstration beneficiary.

14 Dr. Bufalino: See, so, basically this is an opportunity for them to control the cost, in exchange, the  
15 hospital's got to decide will they get an additional referral basis that X number of patients will come  
16 because they're able to market that they're the center, and therefore they're—Geisinger in Pennsylvania has  
17 made their name on the fact that they've set a number and said they will do it comprehensive for this  
18 number, regardless of what happens and they've said that it incentivizes them to keep their complications  
19 rate low and they use that as a marketing tool to engender volume to their institution.

20 Dr. Howard: I just did a study with my patient population which is very unique, and I looked at the  
21 amount of comorbid factors they came in with and that actually showed me how long they were going to be  
22 in the hospital, and it played out very nicely and I think that, I am always concerned when I hear these  
23 kinds of things because I don't have control over how they're taking care of themselves at home. And there  
24 are a lot of factors that play into this, and I can tell you that I get them to OR quicker if they don't have any  
25 problems, and I get them home faster. But if they come in and they have hypertension, diabetes, and other  
26 problems, it takes me longer to take them to the operating room and it takes me longer to get them well

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1 enough to go home. So I'm always concerned when I hear these types of issues come up and as bundling,  
2 because medicine isn't that clean, and I don't think it's just my patient population, so I really just have  
3 concerns about how you're approaching this. And I do have data to show you that these people come in  
4 with these things, they're going to be having problems, and they're going to cost more money and they're  
5 going to be there longer, and I shouldn't have to pay for those complications that they come in with.

6 Ms. Duguay: That should all be factored into the bundled bid that the sites provide to us, based on  
7 their historic volume and variation in patient population. It's something that they should be able to factor in  
8 based on their historic data.

9 Dr. Bufalino: They're saying that your hospital has to generate a number, and you have to decide  
10 can you do it for that amount of money, period? All inclusive, all complications, all the high risk issues,  
11 and either you want to play or you don't want to play, but they give you an opportunity to say I'm going to  
12 bid for this at this amount of money because I think I can do it for that.

13 Dr. Howard: If we don't, if the hospital doesn't play are they on the website somewhere as a bad  
14 hospital?

15 Ms. Duguay: No, of course not. It's a voluntary demonstration, and yes, it's a voluntary  
16 demonstration and we're not prescribing the level of bids or discounts that facilities have to provide.

17 Dr. Siff: I had a couple of concerns. The first being you're talking about this for the inpatient stay  
18 for cardiac surgery, when that patient goes home and a week later comes back through the emergency  
19 department or through the physician's office because they're having complications, will those, are those  
20 visits now bundled—the surgeon will be a global, but say for the emergency department, is that bundled  
21 into the...

22 Ms. Duguay: No, the episode is simply the inpatient stay. At this point, we're not bundling in  
23 readmissions. It's something that, as I mentioned, there is ongoing research at MedPac and internally here  
24 at CMS and probably elsewhere. We're interested in learning more about that research and that could be  
25 something that we look at doing in the future, but it would require either rebidding the project in the current

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1 MAC area, or expanding to a new MAC area and trying out a different type of episode of care that we have  
2 the bundled bids for.

3 Dr. Siff: And my second issue would be, I work at a tertiary referral center, and we often get cases  
4 that have been started at other hospitals and for whatever reason become beyond the resources of that  
5 hospital. How is that going to be handled in this? Is it just the first hospital that's on the hook for the  
6 bundled payment and if they have to transfer it out, the receiving hospital gets—

7 Ms. Duguay: The transfer rules are something I can follow up with you by email. It's a little  
8 complicated, but it, we do take into account whether one hospital or another, just like in IPPS, whether  
9 there was enough of a stay or enough services to generate the full IPPS payment or a portion of that, and  
10 we follow current IPPS policy in terms of the transferring hospital and that kind of thing. So let's say that a  
11 patient was admitted to an emergency room because they shattered their hip or had a coronary event. That  
12 emergency room that stabilized the patient perhaps might then forward the patient or transfer the patient to  
13 another facility that may be a demonstration site. The original hospital that stabilized the patient would  
14 receive services, I mean payment for services as usual. But then the patient would receive, or the hospital  
15 would receive a bundled payment for the patient during the actual stay for the hip replacement or the  
16 [unintelligible] so I can provide more detail about that off line, if that's helpful.

17 Dr. Siff: Yes, because this model works nicely if everyone's an employee of the hospital and the  
18 sharing can be figured out. But in the real world, both in emergency medicine and I think in other  
19 specialties, cardiology, the physicians often are not employees. And if you give them money or give money  
20 to the hospital and expect them to divvy it out fairly is having a lot of faith.

21 Dr. Bufalino: Most of it's under PHL rules, I think, that they're talking about basically when you  
22 have a multi-specialty physician to a hospital organization that controls the cost, then it works.

23 Dr. Siff: That's not the reality of the majority of hospitals.

24 Dr. Bufalino: Exactly. John?

25 Dr. Arradondo: Thanks. I think I understand some of the things you're saying. The eligible  
26 beneficiary's services would be all those services paid by part B and part A. The eligible applicants would

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1 have to have a track record of A and B, so that almost makes it a mandatory other than hospital entity, so to  
2 speak. You said it's an entity of various people entities, organizations, OK? What is the entry point of  
3 beneficiaries into this little system?

4 Ms. Duguay: An inpatient stay at a participating site.

5 Dr. Arradondo: Pardon?

6 Ms. Duguay: An inpatient stay at a participating site. We hope that beneficiaries are aware that the  
7 site is a value-based care center ahead of time, but we understand that most patients are following the  
8 advice of their referring physicians in terms of where they receive services. So again, we will be marketing  
9 directly to beneficiaries and referring providers in local market areas where the demonstration sites are  
10 selected.

11 Dr. Arradondo: But the entry point is inpatient?

12 Ms. Duguay: Yes.

13 Dr. Arradondo: So they wouldn't enroll while, before they're an inpatient and take advantage of  
14 prospective care and that sort of thing. But they would enroll once they're an inpatient, but then might  
15 utilize extensive outpatient services, so that they are not inpatient again.

16 Ms. Duguay: The purview of this demonstration is simply inpatient care at this point. We will be  
17 looking into expanding to including some post acute care services after year one of the demonstration. But  
18 that will entail a whole new solicitation period and that kind of thing. So right now, it's inpatient only.

19 Dr. Arradondo: So the coordination then of care is going to be the biggest lever of this entity?

20 Ms. Duguay: Coordination of care is one of the main drivers of this demonstration. We're hoping  
21 to be able to evaluate improved coordination and quality of care.

22 Dr. Arradondo: Would this be kind of like a little managed care organization, but just for  
23 inpatients mostly?

24 Ms. Duguay: You could think of it that way.

25 Dr. Arradondo: Kind of, but they are self-indemnified. You are indemnifying them.

26 Ms. Duguay: We're not changing that at all.



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1 Dr. Arradondo: So to speak. That's interesting so they have to know their stuff and take a gamble.

2 Dr. Howard: I'm wondering if you have a large physician-based group in town that's affiliated  
3 with the hospital, and then you have some private people in town, cardiologists, for instance, and then a  
4 patient comes in that then preferentially the referral pattern is going to be to those people that are affiliated  
5 with that hospital group? Is that right? I mean it's bundled—I'm trying to understand the structure, I guess.

6 Ms. Duguay: Physicians can refer wherever they want to, but we're hoping to educate them about  
7 what beneficiaries can receive for going to the demonstration sites and we're hoping to be able to highlight  
8 the quality, additional measures that are not available currently on Hospital Compare and so physicians are  
9 free to refer wherever they would like to refer, but one of the main drivers of interest in the demonstration  
10 will be the hope that there is some amount of steerage that the local level to the demonstration sites. We'll  
11 be evaluating that as the demonstration goes on.

12 Dr. Bufalino: I might answer that. I just think that you know, either you're in or out of the PHO.  
13 And if you're on the private side and not on the PHO, to be part of the demonstration project, you'd have to  
14 participate in the global pricing, so we've had those arrangements where a set of people were in but it  
15 allowed the other people to play and say this is how much you'll get if you want to be part of the bundled  
16 package, if you don't, then so be it. Obviously, they like to have everybody in and everybody steering  
17 patients in that direction, but you know, it's probably either or.

18 Dr. Standaert: And I'll just add to that, it sounds like the driver is incentivizing the patient by  
19 making several things easier, and cheaper for them to go through it this way. So instead of as a patient to go  
20 pick a group that does this, which then drives the physician behavior to cooperate with the hospital, and say  
21 I'll get in on this deal because I'll get patients and I do—it sounds like the model that they're using. It's  
22 incentivizing the patient to sort of pick that route preferentially and then marketing to the patients, and then  
23 using that as something to drive physician and hospital behavior to come up with a way to do this, is what it  
24 sounds like yes.

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1 Ms. Duguay: That's right, although we do know that Medicare beneficiaries as you know are not  
2 the most active in choosing their care so by dually marketing the demonstration to both beneficiaries who  
3 would be looking for these services and also the referring physicians, we hope to cover the area.

4 Dr. Kirsch: I just want to make sure I understand question two. Now, you're talking about  
5 including both inpatient stay and if someone were to go to a skilled level of care, combining those level of  
6 services? OK. And—

7 Ms. Duguay: I think we would start with outpatient rehabilitation services that would be provided  
8 in the hospital setting where the initial care was provided.

9 Dr. Kirsch: So that would be the entry point as opposed to the inpatient stay?

10 Ms. Duguay: No, the entry point would still be inpatient, but the bundle or the episode would be  
11 larger. So instead of just including the inpatient stay as it's currently defined, we would bundle in and  
12 accept a new set of bids to include some outpatient services that would be very, very well defined.

13 Dr. Kirsch: Then is the, if you're doing that, are you unlocking the 72-hour rule for the inpatient  
14 stay before going to SKIL?

15 Ms. Duguay: These are issues that we're seeking comment on. We're not there yet. We just  
16 received the applications for an episode that is simply the inpatient stay so this is to give you a heads up  
17 that we are interested in looking at that. We were public about that in the solicitation and we're going to be,  
18 we've already been in discussions with MedPac and will continue to do so, so there is ongoing research  
19 into this.

20 Dr. Kirsch: OK.

21 Dr. Bufalino: Thank you, Rachel. Ask Mr. Coan to take over and discuss Medical Home.

22 Mr. Coan: Thank you, good afternoon. Medical Home demonstration project is still in the design  
23 phase. We're working very hard right now to try and get to the point where we can get approval for it so  
24 that we can put it out on the street as soon as we possibly can. So I want to give some brief background,  
25 some of which you may have seen before. I apologize for the redundancy but quickly, according the Tax  
26 Relief & Healthcare Act of 2006 in § 204, the Secretary has directed CMS to conduct a medical home

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1 demonstration project to redesign the healthcare delivery system to provide targeting accessible continuous,  
2 and coordinated family-centered care to high need populations, and it's intended to be a three-year  
3 demonstration. For clarification, high-need populations are defined as people with chronic diseases that  
4 require ongoing care. Among the key features of the demonstration, according the legislative language, is  
5 the presence of a personal physician. A personal physician is described as a board certified physician  
6 providing the first point of contact, and continuous care to the individual patient, also providing ongoing  
7 support, oversight guidance, implementation of the plan of care, and also providing staff and resources to  
8 manage the comprehensive and coordinated care. A personal physician works under the guidance, or I  
9 should say under the structure of a medical home practice. The practice itself, would have to become  
10 qualified as a medical home through criteria. But the medical home providing the structure more or less for  
11 the personal physician, is expected to target beneficiaries for participation, providing safe and secure  
12 technology, so that they have access to their personal health information, developing that health assessment  
13 tool and provide training for the personnel that are involved in the coordination of the care. That's how it's  
14 envisioned, not only in the legislation, but also in some of the earlier writings that come from the medical  
15 societies, primarily ACP, AAFP, the Osteopathic Association, and the pediatricians. The services that are  
16 envisioned in Medical Home is oversee the development and implementation of the plan of care, using  
17 evidence-based medicine decision support tools, the use of health information technology to monitor and  
18 track the status of the patient, encourage patient self-management. A point I'd like to make on the health  
19 information technology is we're defining this as very broad-based technology, not necessarily electronic  
20 technology. Just so you get kind of a gist of what might be available. For the services of the Medical Home  
21 in the person of the personal physician, a payment that would be in addition to the fee for service payment  
22 for covered services the patient would normally receive, would be in addition to that, a care management  
23 fee to the personal physician and on top of that, incentives might be paid, if there are any savings to be  
24 shared above and beyond what is paid out in management fees. This will be made available to participating  
25 practices in the form of shared savings. What I bring to you today is some design issues; these particular  
26 four that we'll throw out in the form of questions, and give you something to mull over perhaps and

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1 comment on, if you like. We would definitely appreciate that. As you look through these, medical home  
2 definition, practice eligibility, beneficiary eligibility, and payment, you might look at that and say well,  
3 haven't you figured that out yet? And indeed, that's what we're working toward, but these four areas,  
4 primarily will be recurring themes, not only before the demonstration and during the demonstration, but  
5 probably long after because we're not quite sure that a medical home is a once-size-fits-all situation. And  
6 these might be things that might be considered now and down the line as issues that might have to be  
7 revisited from time to time. So under the definition, we have to kind of know what a medical home is, and  
8 how would we know one when we see it? So what are the minimum requirements that'll ensure that  
9 practices have capacity to act as the quarterback for the healthcare team that's administering care to the  
10 participating beneficiary? And should we recognize multiple levels of medical home practices? And if we  
11 do, what should differentiate them? This becomes a most perplexing problem because if we have to  
12 differentiate among levels of care, exactly what is the difference or the defining point from one level to the  
13 next? It could be interesting if we're talking about medical home tiers; what capacities actually define a  
14 higher tier of medical home, or a higher performing medical home? That's something that we're going to  
15 have to spend some time trying to get comfortable with.

16 Our second question or issue, practice eligibility. Should practices be qualified as a medical home  
17 before the onset of our demonstration? Should they be allowed for example to become medical homes  
18 during the course of the demonstration, or should they be allowed to change if we do go to multiple types  
19 of medical homes, should they be allowed to change during the demonstration to improve their status or for  
20 that matter, should they go backward if capacities are lost? We recognize that things are not that static and  
21 also, how will practice qualifications be conducted? Strictly through self-certification? Should it be an  
22 external certification recognition review process? Or some other process that perhaps hasn't been  
23 discussed?

24 Our third point, what beneficiary should be eligible to enroll in Medical Home? The legislation  
25 tells us high-need populations, and I specifically mention that in this case, that would include patients with  
26 multiple or I should say one or more chronic conditions, or should eligibility include all Medicare

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1 beneficiaries? And should the beneficiary be disenrolled from a Medical Home if they're seeing other  
2 primary care physicians? That again is a little bit dicey because it's possible for a patient to see several  
3 different kinds of physicians, some or all of whom might be providing some level of primary care to the  
4 patient. At what point do you decide that this patient is no longer in a medical home, no longer has a  
5 defined personal physician.

6 Our last one is payment. Should care management fees vary with practice characteristics? In other  
7 words, if we had multiple tiers, should the payment be commensurate with the tier level it's attained? And  
8 then we have to go back and ask the question, should that level change, either going higher or for that  
9 matter, going lower, and would that have a commensurate fee management adjustment? Should that degree  
10 of capability include health IT type use? There's a significant investment associated with that. Exactly what  
11 that investment is will vary from practice to practice, so how do you exactly characterize a practice expense  
12 or a fee that would cover some practice expenses depending on what level of IT they might be using.  
13 Should we use risk profiles for beneficiary populations? Should we be paying more for people who are  
14 sicker? And should savings be measured for all Medicare beneficiaries in a practice or only to those who  
15 enroll in Medical Home? One could make the assumption that the Medical Home practice is actually  
16 providing the same care to enrolled beneficiaries as well as non enrolled beneficiaries because what we're  
17 talking about in Medical Home in general, is a practice paradigm shift. It's pretty difficult I think, to  
18 practice medicine and have one classification of patient who is a medical home patient and another who is  
19 not and still provide good care, but somehow different care, to each group of people. Chances are, Medical  
20 Homes are actually going to be practicing medical home care on all of their patients. But in our  
21 demonstration, probably only being paid for just the ones who are enrolled in the demonstration.

22 What we have facing us now is among other things, our site selection. The legislation tells us up to  
23 eight states, which would include urban, rural, and underserved areas. Practice recruitment and selection is  
24 going to be very interesting. We understand there's a good deal of interest out there, but then we have the  
25 question about selecting appropriate practices. We're going to have to take a look at all those who apply to  
26 participate. It is a voluntary demonstration. But we also have to be concerned about balancing the urban,

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1 rural, underserved, large, medium, small practice capacities, as well as those who qualify as a medical  
2 home based on criteria. The number of practices and beneficiaries per site. We have a number in mind. We  
3 would like to see as many 400 practices in up to eight states, which would include up to 2,000 personal  
4 physicians in participation. Monitoring and measurement of medical home performance is another  
5 operational issue that we have to tackle. Exactly how do we monitor and measure performance? We are  
6 obviously looking to see if medical home services can reduce costs, but we also have to make sure that it's  
7 maintaining quality, and in fact, improving it, so that we can see those changes coming.

8 Finally, this is our demonstration site. You can take a look at this. Once you get to this site, you  
9 will have to navigate a little bit. You can also find Rachel's demonstration under the same site. We have  
10 very brief background there, because there isn't right now a lot to report, but whatever is available and will  
11 be available at a future time will be posted on this site. We encourage you to visit it as often as you choose  
12 to get periodic updates.

13 Dr. Bufalino: Thank you, Mr. Coan. Comments, questions? Start on the right.

14 Dr. Williams: I just would like to comment that this is the most positive project I've seen in a  
15 while. Speaking as a caregiver of several elderly chronically ill relatives, I think this will make it easier, not  
16 only on the caregiver, but obviously on the patient if the devil is in the details, and things are obviously  
17 worked out, I really applaud this effort.

18 Dr. Standaert: Just to make sure I understand the concept correctly. I mean by a medical home,  
19 you have to forgive my terminology, the nearest analogy that popped in my head is like a boutique  
20 medicine practice, where the provider is sort of paid by the patient as opposed to CMS or somebody else, to  
21 sort of be there and deal with questions and have their staff help them and manage their care. Is that the sort  
22 of model, where it's almost like a capitated thing where the physician gets a payment for example, per  
23 month per patient and they're responsible therefore for managing all their primary care needs—is that the  
24 model I'm following?

25 Mr. Coan: Pretty much, yes. What we're envisioning is a per member per month type of fee, none  
26 of which is approved at this point, so I can't really bank on that, but this is what we think will probably

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1 work. It could be defined or described, I guess in a sense as boutique, but it wouldn't be—it almost has a  
2 negative connotation to it, but the bottom line here is that certain people will be, practices will be  
3 compensated so that certain people can get a higher level of service and coordination of care than they  
4 might normally get. What we hear from the practices, what we hear from the societies is this is the kind of  
5 care that primary care practices would like to deliver if they had the time; this is hopefully an effort to kind  
6 of create that kind of time as well as the financial incentives to build the practice so that they can perform  
7 those functions.

8 Dr. Standaert: Right, that sounds like they can then use other types of service personnel to help  
9 them manage a patient without being relying upon the patient showing up to actually bill for service every  
10 time they see them, so it makes a smoother, that's the idea, that's the way the boutique thing's supposed to  
11 work, too, from what I gather.

12 Mr. Coan: Yes, it's likely that's how this will manifest.

13 Dr. Sprang: Obviously, I thought some of the same things as Chris just said and you can kind of  
14 think of it as a boutique model, which a number of physicians in my area do, and it has very positive  
15 connotations. I also go back to been doing this for a long time, and 1996 when the HMOs started really  
16 coming into play initially, their model was that patients could only go to see their primary care doc; they  
17 couldn't see anybody else, any other specialists, without a referral from them and that HMO model kind of  
18 has a negative connotation, and so clearly the devil is going to be in the details and I also clearly think  
19 something does need to change and I'm glad we're looking at different ways of doing it, but the specifics  
20 are really going to say how well it works and whether it's good for patients or not good for patients and  
21 good for the whole system. You really have your work cut out for you.

22 Mr. Coan: I think it's going to be career changing, actually. [laughter]

23 Dr. Arradondo: On your fourth slide, where you laid out some of the parameters for Medical  
24 Home Practice, you indicated that your that information was informed by ACP, AOA, and the  
25 pediatricians, to quote you. Were there others involved in that?

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1 Mr. Coan: Yes. The other of the, the other who are involved in the joint principles paper that was  
2 delivered last March actually, the American Academy of Family Practice, the American College of  
3 Physicians, the American Osteopathic Association, and the American Academy of Pediatrics. They  
4 combined to produce a joint paper, called “Patient-Centered Medical Home,” concepts, basically, and it’s a  
5 paper that’s available. You might want to take a look at it. It describes a blueprint if you would, for creating  
6 medical home practice, which is what we were talking about, along with other things as well, but that  
7 helped greatly to inform the design aspects of our demonstration as we not only used the paper, but we met  
8 with each of the organizations with the exception I think, of the pediatricians. But we’ve been in  
9 association with all of the organizations in order to inform the design concept aspect of this.

10 Dr. Arradondo: OK. I’m familiar with that paper, I just didn’t hear the AAFP at the beginning of  
11 your list of three. Thank you for involving, for picking up on what they collectively had discussed. Because  
12 they’ve been discussing this for a while. You talked about levels of medical homes, and I guess if you think  
13 of medical home as primary care, you’ve used these, but not necessarily interchangeably, if you take away  
14 comprehensiveness and point of first contact, there are a number of specialties that can, and sometimes do,  
15 and often espouse delivery of primary care; gynecology, psychiatry, pediatrics, family medicine, internal  
16 medicine, oncologists for certain chronic cancers—childhood ones in particular, gastroenterologists for  
17 certain chronic GI diseases and that’s just to name a few. So the definition would clearly be useful. You do  
18 have point of contact there, first point, and as I remembered that paper, they also almost defined it with  
19 comprehensiveness, which is kind of leaning more toward family medicine than say, pediatrics or internal  
20 medicine, but comprehensiveness, those are the three that you think of when you think of primary care,  
21 because almost none of them can delivery comprehensiveness beyond say gender or age, and whereas  
22 family does it all; gender, age, problem, setting, continuity, internal impedes, could collectively do it all  
23 individually do a majority of it. So those three traditional primary care providers. If—you asked a number  
24 of questions toward the end. I mean you implied, you said this can be talked about. Levels of Medical  
25 Home, I guess they could be. It would be great just to have one solid level, comprehensive, first contact,  
26 comprehensiveness, continuity, the coordinated piece of that, and maybe some relatedness in some other



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1 practices, as opposed to a level two and a level three kind of thing. That's kind of a philosophic context  
2 when you start having level one, level two, level three. There's what you want and there are portions of it,  
3 would be a concept that I would put on the table for you if you start having more than one. But I could see  
4 the primary provider in a Medical Home having just an increase in the fees that you usually pay them as a  
5 way of asking them to delivery a higher quality of care, both depth and comprehensiveness, both  
6 extensiveness and intensity, just to mention two levels of parameters, to axes of parameters. I could see you  
7 also paying them a fee for a person, a patient. I could see you paying them a fee for a family; you mention  
8 family in there. There's only one specialty that really in a bona fide fashion owns up to family. I mean the  
9 other two primary care specialties of necessity get into family, but family says that that's what it does. It  
10 trains people in relating to families in addition to individuals and parts of individuals. So I could see you  
11 paying a medical home practitioner or a medical home in at least those two ways and there are others.  
12 Managed care has tried some. I'm sure you're aware of all that. And those were discussed I think in that  
13 paper. If they weren't discussed, they were referenced in the bibliography of that March paper. I could see  
14 you doing fee for service, I could see you doing prospective payment, global or fee for service a  
15 combination thereof. It depends upon the incentive package that you agree on. I mean there are a lot of  
16 possibilities. I think the key thing would be to set a series of possibilities for at least one or two of the  
17 demos with the return, measurable return, so that it can be evaluated very clearly, I'm sure you already  
18 thought of that. The question of individuals, it seems to me would be reasonable. This is just a three year  
19 demo. That's not a lot in the health of people, but it's a lot in the spending of money, particularly if you  
20 have an annual fiscal budget. I'm sorry that you're bound by that. You're a more important agency than  
21 that. But that's the federal government. I would suggest that you sign up individuals for at least a year. A  
22 year might be the maximum you want to try to get someone to sign up, particularly with an unknown  
23 provider, although someone might sign up with a known provider, their own provider, but there've been  
24 some studies around, over the years, last 20 years, showing people who were attached to a practice for at  
25 least a period of time, six months, nine months, twelve months, fifteen months are the ones most frequently  
26 that I've seen over the years and the practice had an opportunity to do some things positively,

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1 comprehensively, intensively, all the different parts of primary care definition, and the individual had an  
2 opportunity in a sense to test the practice. Were they getting all the things that they needed? Or did they  
3 really feel constrained to get some services that were referred or shared or elsewhere kind of thing? Even  
4 emergency room services? So I could see you dealing with that but if the person could come and go kind of  
5 as they pleased, they could enroll and disenroll three months later. That would be a disincentive to the  
6 demo, but disincentive to the practice in a lot of ways if they wanted to practice continuity. So a year, I  
7 would suggest would be a good enrollment period for the individual patient. If it's going to be a family,  
8 maybe even more than a year, because it takes almost a year to make a baby. And you know bring them out  
9 and name them and do good things for them. So a year is a good number to start with; not a smaller  
10 number. I could say much more, Mr. Chairman, I've said too much. [laughter] And my voice isn't so good.

11 Dr. Bufalino: You could have seen my flag up, I guess—you were so focused. [laughter] Thank  
12 you for that conversation. Janice.

13 Dr. Kirsch: From what it sounds like you haven't really set up all the parameters for the design, but  
14 have you had discussion about including email encounters and phone call encounters and working them  
15 into that or were you thinking that that was going to be part of the single payment for each participant?

16 Mr. Coan: They were considered. Let me explain. The fee value, the relative value units, were  
17 provided to us by a great deal of work and a wonderful group of people from the RUC. They did this in 12  
18 weeks and it was remarkable work. In their deliberations, they considered all of the things that would have  
19 to be provided to a Medical Home patient, that was outside, above and beyond what an E&M visit might  
20 cover. So the coordination, all of the levels of coordination, communication that might have to occur were  
21 taken into account by the committee when they valued it. And it was I know it was pretty intense, but you  
22 have to consider that these are services that are provided to a beneficiary on a non visit basis. They don't  
23 have to see the physician every month in order to have the fee generated. It would be an automatic fee  
24 because people don't need to see the physician necessarily every month. But nevertheless, the coordination  
25 of care is available to them through that period of time.

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1 Dr. Bufalino: One last comment, just as a suggestion that you might want to consider having the  
2 patient sign a contract with the provider that they're making a commitment to being part of this care,  
3 because from the provider's perspective, if the patients don't come for follow up, don't take their drugs,  
4 don't follow any advice, you know, your outcomes are going to be obviously skewed, so you'd really like  
5 to have people that want to be part of this and having them commit to a social contract of sorts that they're  
6 committed to be a participant in their care delivery might get you a better set of results. And maybe it does  
7 skew it at a certain level, but it gives us the best chance to be successful if you've got the right docs with  
8 the right patients.

9 Mr. Coan: It's a very key point. I mentioned earlier that there are qualifications that medical  
10 homes would have to comply with; you can't be a medical home simply because you say you want to be a  
11 medical home. There has to be something of infrastructure created. It could take months, literally, for any  
12 practice to document that they have those capabilities. One of those things is exactly what you brought up.  
13 And it's an effort to do two things. One is to get that commitment. The other is manage expectations. How  
14 does a patient know what to expect from a practice if no one's told them what a Medical Home is going to  
15 provide to them? This is all part and parcel to the same thing. And once they agree, then they say this is  
16 medical home, this is my personal physician and I know what I should expect from this. It gives them  
17 something to deal with.

18 Dr. Bufalino: Good. Dr. Snow.

19 Dr. Snow: Speaking as one who was present during the '80s and setting up my practice at that  
20 time when HMOs came out with their capitated plans, which was really the first Medical Home concept if  
21 you will, which failed greatly for a variety of reasons and I think it's important that you not make the same  
22 mistakes that were made during that time. The concept is I think, superb, for a primary care practice in  
23 order to delivery high quality, comprehensive, continuous care to a patient and hopefully an extended  
24 family. One of the major problems I think that occurred from the primary care physician's standpoint was  
25 lack of adequate capitation payments for an extremely ill population when these concepts work very well  
26 when the HMOs were applied to the healthy working well who were employed, but when it was applied to

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1 the over 65 population, most of whom had multiple medical problems, it was extremely difficult to  
2 adequately reimburse. I think either hospitals or primary care providers, for the care that the provided. So in  
3 particular, you're asking several questions. What beneficiary should be eligible? If you limit it to high need  
4 only, I think you're doomed to failure, because you're doing exactly that; you're choosing the highest need  
5 individuals, and I would highly encourage you to make it available to all the beneficiaries; the best results  
6 you're probably going to get for the long run are going to actually be to have healthy beneficiaries enrolled  
7 in the plan, so that hopefully they'll stay healthy. Or as healthy as possible, because one of the primary  
8 concepts of the Medical Home is to provide services that are going to prevent bad things from occurring  
9 through use of immunizations, physical exams, early diagnosis, early treatment, so if you wait until those  
10 problems already develop, then I think you are selecting the wrong population that you want to get good  
11 results from. You've mentioned you asked the question, how will the practice qualification be conducted?  
12 Self-certification or external certification and your last comment kind of indicated that self-certification  
13 apparently doesn't work or there's a suspicion it may not work, and you're going to have to make the  
14 practices jump through hoops. Quite frankly, I think the more hoops you make them jump through in order  
15 to certify them, the fewer providers you're going to have that are going to be willing to jump through the  
16 hoops. Especially smaller practices in rural areas, and there certainly is probably a huge need for this  
17 concept, because that's probably the way most of these practices function anyway and they may simply  
18 choose not to jump even for a few extra dollars if you set up a lot of barriers there. Should they be  
19 disenrolled? And I certainly think there are reasons to disenroll, but I'm not sure it's a question of whether  
20 they see other primary care providers. Hopefully for a medical home concept to work, you know, if they  
21 sign up with me, I'm not available 24 hours 7 days a week, and no physician truly is, even though they try  
22 to be. They're going to have other providers, most likely in their practice who are primary care providers  
23 and they're typically going to be signed up with one individual, and they may see several in a group  
24 practice type setting. So I think you're going to have trouble from a retrospective standpoint saying, Hey  
25 they saw two different doctors here, so obviously they have to be disenrolled. However, it may be  
26 necessary for physicians if they don't sign the contract, that is if the providers, or if the patients, don't sign

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1 a contract and are willing to follow through with the things that they need to do to participate actively in a  
2 program for it really to work, a physician maybe should have the right to say, hey this is not the proper  
3 patient to be in this kind of a plan. But on the other hand, you know quite frankly, you want to do the best  
4 you can with each of those patients. So a few comments on a very good idea, I think, but I think the design  
5 of the plan is critical to whether it's going to succeed or not. And hopefully, however you design it, you're  
6 going to have the flexibility to be able to look at that plan and make changes as you go along. I was very  
7 impressed by this last discussion of the RAC, as much as I hate the bounty hunter concept, at least they're  
8 looking at it and they're trying to learn lessons from the demo project, and hopefully things can change in  
9 that program and hopefully things can change in yours once you get it going. Thank you.

10 Dr. Bufalino: Thank you both for the presentation. Appreciate the information and will get back to  
11 you on any other thoughts. You know what, I'm going to just take the chair's prerogative, just because  
12 there's a few folks leaving early and maybe delay the break and get the last presentation in. I'm told that  
13 Gladys Valentin and Colette Shatto are here. And if they are, we'd ask you to come up and begin the  
14 presentation a bit early. They're here to talk about the Medicare Contractor Provider Satisfaction Survey.  
15 This is the data gathered on the Medicare Contractors looking for feedback and the opportunity to have  
16 these two ladies with us today. Gladys is the MCPSS project officer in the Division of Provider Relations.  
17 She's been with this effort since 2002 when it started. Colette's been with us since 2006 and in the  
18 Division also of Provider Relations. So thank you and welcome.

### 19 Medicare Contractor Provider Satisfaction Survey (MCPSS) Results

20 Ms. Valentin: Thank you, Mr. Chairman. Good afternoon, everyone. And we would like to thank  
21 the Council for the opportunity to share with you a preview of our MCPSS survey results for 2008. The  
22 public report will be coming out soon, so this is a preview of our results. Basically what we would like to  
23 do today, is to provide an overview of the results as well as the results for 2008 and some, compare them  
24 with our results of 2007, sharing with you the key findings and also the predictors of satisfaction for this  
25 year, as well as our plans for the 2009 Survey Administration.

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1 MCPSS is a sound, reliable, and uniform method that CMS is using to measure provider  
2 satisfaction across all contractors and all provider types. Since MCPSS started, we have used the data to  
3 provide contractors with tools to support process improvement initiatives, also it has helped us to establish  
4 performance standards for our Medicare Administrator Contractors, or MACs, and it also has allowed us,  
5 the survey instrument is flexible and we can include questions related to the efforts of CMS, which we  
6 exclude from the scores for the contractors, but we can also measure our own performance. And last, it also  
7 has helped us to determine award fee plans for our MAC contractors.

8 Respondents have the opportunity to complete the survey via telephone, Internet or the traditional  
9 mode which is a paper survey. Our survey contractor, which is Westat, performs follow up to by mail,  
10 email, and telephone, to the non respondents. We provide to the provider community, a toll free helpline as  
11 well as an email address and a site that they could look at if they have questions about our survey or our  
12 project. For 2008, our starting sample consists of 35, 866 providers. They were divided among 13 provider  
13 groups, including physicians. Last year, this was like, slight decrease from last year. Last year was about  
14 36,500 providers. There were some sample changes in 2008, which consisted of the definition of a  
15 completed survey. Last year, we had two questions from the claims processing and one of any of the  
16 business functions in the survey. I just want to say that the survey consists of seven sections and so  
17 basically, we have changed the definition of completed survey, as well as the sample inclusion. This year,  
18 to be an active provider, you had to submit 50 or more claims for the prior year. In prior years it was just  
19 one or more claims. So we changed the definition. The questionnaire consists of 55 items as I said, with  
20 seven sections, similar to last year. It was a stable survey. We also asked respondents about their  
21 experience in the last 12 months with their fee for service or MAC contractor and these are customized  
22 surveys so they could understand the name of the contractor that they are rating. The data collection started  
23 at the end of November through April, and it was about a five-month period, and we are pleased to report  
24 for the first time, we achieved the 70% response rate. In prior years, we had in 2006 and '07, we reached a  
25 65% respond rate. And basically it's for a lot of outreach efforts that we put into this as well as many of the

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1 national provider associations have endorsed. Some of them are with us today. We have a list of the 17  
2 provider national associations that have endorsed this survey.

3 In this slide we present the response rates for the four major contractor types. As we can see from  
4 2007 to 2008, there has been an increase of response rates for the four major contractor types. As I  
5 mentioned in 2007 and '07 we have an overall response rate of 65, and this year for the first time we  
6 reached a 70% response rate. In this slide, we show the mode of survey completion for the three  
7 administration years, for the three modes that we provide. The web, mail, as well as telephone. If we  
8 compare 2007, the web completes have decreased from a 55% to a 29 and the telephone has increased  
9 substantially with 44 to 70%. Basically, we have changed our data collection methods. We do prescreen of  
10 the providers to get complete contact information and to know who is the most knowledgeable person at the  
11 provider site that could complete the survey and we prompt them if they would like to complete the survey  
12 over the phone, and it has been more successful this year. That's why we have seen the increase.

13 For the first time, as you can see in the last column, we have gotten the most completed surveys,  
14 for a total of 20,251.

15 In this slide we want to present the part B physician. The sample consisted of 8,007 '07 physicians  
16 which is about a 24% of the population and again, with the inclusion of criteria of that submitted 50 or  
17 more claims in the prior year. Our completed surveys for this year for the physicians were 5,323. If we  
18 include those numbers in a formula, include ineligible that we were not able to contact, the net result  
19 would be a 65% response rate. The mode of completion for physicians were 76% telephone, web 23,  
20 mail/fax less than 1. If we compare the response rate for physicians last year, it was 57, so there has been  
21 much of an interest this year with response rates or interest of the physician community.

22 The survey instrument consists of 75 items, and we use a one to six-point scale and we provide the  
23 data to our contractors by provider type, business function, as well as provider type and business function.  
24 So they could do their own analyses. We provide them access to an online reporting tool. They could do  
25 additional cross tabulations among provider types, business functions, as well as state comparisons. And  
26 the range of contractor scores this year was 4.08 to 5.25. 4.08 represented a carrier, which is Nuridian, and

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1 the highest score was a 5.25, which was an FI, which was Cosve. The key findings this year, the national  
2 average across all contractor types was 4.51, a bit of a decrease from last year, which was 4.56. Across all  
3 providers, 81% scored their contractors between a 4 and a 6, that's a decrease from last year. It was 85%.  
4 Claims processing received the highest scores and appeals the lowest, and that was the same pattern as last  
5 year. Provider inquiries as well as claims processing continues to be the two strongest predictors of  
6 satisfaction. And we have seen that I the three national administrations. Our survey contractor performed  
7 some regression models and found that for provider characteristics, such as time in the Medicare program,  
8 a number of facility and also geographic location, generally these were not strong predictors of satisfaction.

9 On this slide, we show the national average scores by contractor types. As we can see, the RHHIs  
10 have scored highest with a 4.68, followed by FI MAC with a 4.61. Pretty much, it was same pattern last  
11 year with exception of Carrier B MAC, that was higher than a DME MAC. Last year for the Carrier B  
12 MAC, it was 4.40 and the DME MAC was 4.34.

13 This chart shows the scores by provider type. The horizontal is the 4.51, which is the national  
14 average for this study. As we can see, the provider type served by a carrier B MAC or DME MAC are  
15 below the national average. The highest is the ambulance services with the 4.49, followed by the DME  
16 suppliers, with the 4.46, and the lowest to physician as a supplier with a 4.22. The key findings for the  
17 physician population, the national average for claims B MAC was a 4.38 and among physicians they scored  
18 the highest in the claims processing function with a 4.57, and the lowest was the enrollment function and  
19 more details are in the next slide. If we look at this slide, we want to demonstrate the scores by business  
20 function for the four main category or contractor groups and on the first column, we have the seven  
21 business functions that the survey consists of and if we look at the claims processing for all contractor  
22 types, is the highest, and we also added a column which is the part B physicians, so we could emphasize the  
23 scores and you could compare it with the Carrier B MAC and the lowest among all the contractor types is  
24 the appeals, and again, part B physicians, the lowest score is the provider enrollment section. If we look at  
25 part B physicians and compare it with the scores the carrier B MAC, they're pretty much higher with  
26 exception of enrollment, which is pretty much the same as the average score for the carrier B MAC with a



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1 4.23. It's the same pattern as last year. The RHHIs usually score highest and it's just with exception of the  
2 appeals which the FIA MAC rated higher. So it's just to give you a context of how the part B physicians  
3 compared to the other contract types. And I'll pass it to Colette, so she can continue about the performance  
4 standards.

5 Ms. Shatto: Thank you. I wanted to apologize in advance. I've been struggling with allergies this  
6 week, so if my voice cuts out, I'll do my best to speak up. In 2008, we have performance standards for the  
7 MAC contractors. The standards in the Statement of Work state that 1.5 standard deviations from the  
8 previous years national score. So for this year, the range for the performance standard is between 4.17 and  
9 4.95 meaning any contractor that scored below the 4.17 would be below the performance standard, and  
10 anything above the 4.95 would be about the performance standard for 2008. For this year, two carriers fell  
11 below that standard, and while I said it is in the MAC Statements of Work, we wanted to give you an idea.  
12 That would be Nuridian Administrative Services, with a 4.08 and then NGS, which is formally  
13 Administars, a 4.12. The highest scoring carrier or B MAC was Wisconsin Physician Services, with a 4.75.  
14 In looking at the 2008 scores and those areas that are important to providers, our contractors have the  
15 ability to use online reporting tool to view question level data, including the frequency tool that enables  
16 them to run cross tabs across all sections of the survey. They can break out their question level data to the  
17 provider type and state levels via this frequency tool. On the online reporting tool, each contractor has its  
18 own unique appendices for an analytical report, which contains contractor specific scatter plots, which has  
19 four quadrants and it indicates to the contractor which areas are high importance areas where they would  
20 score low of and this is where the contractor should target for improvement.

21 The next slide gives you an example of what this scatter plot would look like. This is what the  
22 contractor received in their analytical reports, and each contractor receives one tailor to their own results.  
23 It's based on all the responding providers. They do not receive separate charts by provider type, though.  
24 Looking at the scatter plot, the horizontal line, represents the average score for the carrier B MAC  
25 providers, which would be 4.35. The vertical line represents the visual mid-point at 0.55. What the  
26 contractors would focus on would be the bottom right quadrant of the graph, and these are items that are

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1 considered of high importance to providers but where the contractors received low ratings. And this is area  
2 where the contractors would need to focus their process improvement efforts.

3 In the 2008 predictors of satisfaction, our contractor, Westat, did an analysis that focuses on the  
4 overall study with models for each of the four contractor types. What they found is characteristics, such as  
5 the number of reporting facilities and memberships in a chain were not significant for any of the contractor  
6 types when looking in predictors of satisfaction. Also, provider time in Medicare was generally not  
7 significant, and either was geographic region, as measured by the CMS jurisdiction variable. For the  
8 predictors of satisfaction, regardless of which sections were included in the regression models, the provider  
9 inquiries was the strongest overall predictor of satisfaction across all the contractor types. Claims  
10 processing was the next strongest predictor. This pattern is similar as in 2007, however the strength of  
11 provider increase was even higher in 2008.

12 Analysis conducted using the 2007 MCPSS data found that the following three survey items  
13 explain the majority of provider satisfaction; those being satisfaction with modes of communication,  
14 satisfaction with contractors' ability to resolve problems without need for multiple inquiries, and  
15 satisfaction with accuracy of contractors' claims editing. The 2008 MCPSS marked the first year of  
16 formally trending our MAC contractors. What we are looking at in trending is to have a MAC contractor  
17 that has two full years of operational activities. So for 2008, the two contractors that were eligible for  
18 trending was the DME MACs. That being the NHIC DME MAC and the Administar Federal, now NGS.  
19 As we move into the MAC environment, we'll continue to include MAC contractors in the trending  
20 analysis as soon as they have two years worth of operations, this way we're able to do an apples to apples  
21 comparison, so we're looking at a stable environment. Looking ahead into the 2009 MCPSS, as I said, as  
22 those MAC transitions are completed, we'll be adding more trending and data available on line. Depending  
23 on emergent information needs and additional analyses, we'll be looking at our performance standards. We  
24 continually review our survey questions and the instrument. We continue to put focus on maintaining and  
25 improving our response rates and research on how to best measure our contractor performance.

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1           We have come up with some questions for the PPAC Council. Three questions, those being how  
2   to keep the physician and provider community engaged in MCPSS; how best to report results to the  
3   provider community; and are there concepts that the MCPSS misses in terms of provider satisfaction? The  
4   last two slides gives our general contact information, being our study website, the mailbox and the toll free  
5   provider line as well as our contact information, being GladysValentin@cms and PamelaGiambo@westat.  
6   Thank you.

7           Dr. Bufalino: Thank you very much. Comments, questions? Kind of quiet. I'm sorry. Tye?

8           Dr. Ouzounian: I'll make a comment. I just want to commend you for doing that study and  
9   bringing that data. I think it's helpful and I think it shows that they're doing a pretty good job and I  
10   appreciate your looking at the contractors. What would be helpful maybe for the future is that slide you  
11   showed with the four quadrants and lower right being the one for improvement, if we could get a little more  
12   information on that; what you're doing to deal with that with the contractors might be of interest.

13          Dr. Bufalino: Other comments? Any recommendations? Janice?

14          Dr. Kirsch: It may be helpful if we could see what the survey questions were. What exactly did  
15   you pose to the surveyors. It might help us to give you a little bit of feedback.

16          Dr. Bufalino: Great. Anything else? John?

17          Dr. Arradondo: Our presenters have over half of our presenters have given us websites that include  
18   evolving information, or in some instances transitory information, but information where there's a new bit  
19   every so often. At the risk of increasing emails to my colleagues, I wonder how useful it might be to have  
20   some of those evolving presenters and divisions and programs with evolving information on their websites  
21   to send us just a little news note. I mean this is something we talked to you about two months ago and here  
22   it is it's on the site, check it out. Just a relatively short email. There are a number of large organizations that  
23   do that, private and public, and if you want to unsubscribe, you can always unsubscribe. But it would be  
24   useful because I know we get a lot of paper and more and more people are utilizing electronic  
25   communications more and more physicians, and it's nice to have it up there and let us pursue it, have it up  
26   there passively and let us pursue it. It might be an interesting marketing tool to send us a little heads up

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1 when some mile stone is reached. That might be useful for the general physician population as well, but  
2 certainly for us here.

3 Dr. Standaert: Just to answer your questions. How to get physicians engaged. I mean how to  
4 communicate with physicians now about this?

5 Ms. Shatto: Well, basically we do work in the provider communications group, and we have a  
6 number of list serves as well as we announce it in the open door forums for the different provider groups  
7 that we target in the survey. And also we use national organizations. They help us disseminate information.  
8 We send articles.

9 Dr. Standaert: Right, I mean this isn't something I would have seen, myself, ever, as an individual  
10 provider, unless you had shown it to me here. So your means of getting at us may not be the most effective  
11 in terms of—to do this you need to reach the providers and you probably need to spin this as, How can we  
12 help you? Not CMS is looking to sort, we got the RACs and other things sort of coming at the physicians  
13 too, they don't want to hear all that stuff. You need to come at and say can we help you or are you happy  
14 with your contractor, are you happy how this is working? Let us know, give us that sort of spin on what you  
15 get at either directly through the physicians using back through the paying arm or with the broader  
16 physician organizations, sort of more of an advocacy wing, sort of How can we help you, and you might  
17 get more physicians popping in that way.

18 Ms. Shatto: Because we also use our Medicare contractors as well, because they post information  
19 on the web during the period of data collection, so we also use them, But is there something else that we  
20 should focus on?

21 Dr. Standaert: I guess you're assuming then that the contractors are then going back to the  
22 individual providers, saying please rate us and they may not be doing that quite as well as you would like.

23 Dr. Bufalino: Let's take an informal poll; who on the Council has been asked to fill out a survey?  
24 O for everybody.

25 Dr. Standaert: ...as effective as you might like. [laughter] You need to get at the individual—

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1 Dr. Bufalino: Just a perspective, not that we represent the country, but it's just a cross-section to  
2 say that none of us have been asked, so it's curious how you get to the folks that answer.

3 Ms. Shatto: So we're going to just have to reach out in a better means that what we are right now.  
4 But it's astonishing to have gone the 70%, I mean there is a—

5 Dr. Bufalino: I mean you're getting answers from the folks that you're asking. It's not that you're  
6 not getting answers. It's just are you getting them from the same set of folks—there's an awful lot of  
7 people that might be having an opinion, but haven't been asked.

8 Ms. Shatto: Thank you.

9 Dr. Snow: To help interpret the graph, I know you indicated that 6 was completely satisfied and 1  
10 was not at all. Did you have a definition for the numbers in between, or just let them—

11 Ms. Shatto: No, it's not labeled.

12 Dr. Bufalino: Other comments? Dr. Simon?

13 Dr. Simon: I would just like to share with the Councilmembers that it would be useful, too, for you  
14 to peruse the CMS website. CMS.HHS.gov. That's a living breathing document that changes almost daily  
15 that is updated and provides a wealth of information about all aspects of the program and almost every  
16 component has a webpage, if you will, so to speak, to where it will be maintained so that and that's  
17 something that I usually speak to physicians about as I go throughout the country speaking on various  
18 topics that we have in the Center for Medicare Management. But to encourage them to look at the website,  
19 because it has a wealth of information and it's maintained and updated daily.

20 Dr. Bufalino: Thank you.

21 Dr. Smith: This probably shows my ignorance on the issue. I mostly use that when I need to look  
22 up a specific question, and I find it very, very hard to navigate to get the answer to a specific question.  
23 Does it, I should know, but I don't, does it include a This is New in Medicare page, or do you really have to  
24 page through everything to look at and find out where new things are?

25 Dr. Simon: If you go, just to the first page and look in the right upper corner, it has some of the  
26 most current topics that are of interest to most people.

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1 Dr. Smith: Current topics, but that doesn't mean new information.

2 Dr. Simon: Well those topics are generally new and they are updated, and so I think that if you  
3 peruse on a more frequent basis, you'll find that those topics change rather quickly and address the issues  
4 that usually are of concern to people that go to the website.

5 Dr. Snow: I agree with you 100%. It would certainly be great to look at that website on a daily  
6 basis. But unfortunately, well, fortunately, you know it's an inexpensive way for CMS to communicate,  
7 and I understand the financial problems and I realize that's the way they've chosen to communicate at this  
8 point, but quite frankly there's not enough hours in the day by the time I practice medicine, and then to go  
9 to the CMS website to go to my contractor's website, to go to my specialty society's website, my local  
10 medical society, my state medical society, the AMA. There are about 50 websites that I could go to at any  
11 time and gather all kinds of information. But the information highway unfortunately has become so  
12 cluttered because there are so many places that now I have to take the initiative to go to get information that  
13 I need rather than having that pushed to me like used to come like the papers that CMS would send out on a  
14 regular basis and my carrier would send out on a regular basis, that I could flip through, see what was  
15 important to me, throw it away, and actually read it and get the information. It doesn't occur over the  
16 website. We need information. We need to be educated about what our contractors are doing and about  
17 what CMS is doing, and just because it's available out there on some page, on the internet, quite frankly it  
18 does not get to us.

19 Dr. Simon: Your points are appreciated. I would only mention that living in a rural state and  
20 having a chance to talk to my colleagues in Mississippi on a weekly basis, it is an opportunity for them to  
21 know what's happening in Washington and being updated at their convenience. Recognizing that yes, they  
22 do have to take the initiative to turn the computer on and go onto the Internet and look at it, but it is an  
23 opportunity to stay addressed in terms of what's happening here in DC without necessarily having to talk to  
24 the head of their local state medical chapter or the head of the state medical chapter, so it's just another  
25 vehicle. And we recognize that time is short, but it is an opportunity to have information readily available  
26 to all docs throughout the country in a very inexpensive expeditious sort of way.

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1 Dr. Bufalino: Yes, please.

2 Ms. Nicholson: Hi, I'm Gerry Nicholson. I'm the Director of Provider Communications. And I  
3 wanted to just say a couple things about how we try to reach providers. First of all, I'll say that what we do  
4 always leaves the hole of how do we get the individual practitioner to read what we send out, so we're open  
5 to any ideas you have on that. What we do now is we have everything go out on a variety of list serves, so  
6 if you sign up to any of our list serves, you'll get information as it happens. We have list serves, our open  
7 door forum list serves, we have individual provider list serves, our contractors have provider list serves.  
8 Our contractors put up electronic bulletins that are the papers you used to get in the mail that you can get  
9 electronically, and we require them to give paper if people insist, but we're trying to move into the  
10 electronic world, so. We also have a list serve for all of our MLN matters; any kind of fee for service news  
11 usually has associated with is MLN matters articles. If you're on the list serve, you'll get notice that that  
12 article came out. So besides that, we send all of these messages out to every national association and over  
13 1600 local associations. So normally what we hear is we're tired of getting repeat email, but there are  
14 always people we miss, so that's always been a question, because inevitably, no matter what we do, you'll  
15 have somebody say I never heard of NPI and it can be very frustrating for us because we would like to be  
16 able to get to the individual practitioner as well. So with that said, I hope that if you are interested, we can  
17 send through PPAC a list of all of our different list serves. If you sign up to one of them, you'll get  
18 everything and I hope that you're hearing these things from your associations. [laughter/chat] You probably  
19 don't want to get everything, but I'm saying that we have redundant list serves.

20 Dr. Bufalino: I think actually it would be valuable for you to send us maybe a review of the  
21 options so that people can pick and choose, but to just see what's available because I don't think any of us  
22 are really conversant with the number of opportunities to interface, aside from just the website.

23 Ms. Nicholson: And then each week, one of our divisions sends out a note that sort of captures all  
24 of the major news items from that week and sends it out to all the associations for dissemination. So that's  
25 another way if you're hooked into your association and you're not getting messages from Medicare, weekly  
26 messages that we send to them, then you may want to contact them and ask why because I mean that's

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1 really what we've been begging the associations to do for us so most of them are really great about it in that  
2 they take our messages and send it on to their members. But we'll get together a list of the different list  
3 serves, and by getting everything, I mean if you sign up to two, you're going to get it twice. So if you sign  
4 up for one, you'll at least get everything that we send out. And really anything that you could offer us to do  
5 more, let us know. Thank you.

6 Dr. Bufalino: Thank you. Any other comments? Thank you ladies, thank you for coming. So let's  
7 just take a moment and ask are there other recommendations that you'd like to make to the Council for  
8 consideration as we come to the closure of the agenda for the day?

### 9 Wrap Up and Recommendations

10 Dr. Sprang: Actually it's a repeat. The earlier recommendation I made on PQRI didn't get, well I  
11 guess I wasn't clear enough and not all of it actually got typed up and Dana was nice enough to tell me that  
12 maybe I wanted to rephrase it and present it again. So actually the group is voting on the recommendation.  
13 It was really on the 2007 PQRI data. And I'll read my new version of it so you can reconsider it because it  
14 will replace the first one that we did approve. PPAC recommends that CMS provide the 2007 PQRI data set  
15 file to the AMA. I'll give you a copy. So that the AMA can better understand possible barriers and stimuli  
16 to physicians' reporting, and assist in increasing the number of physicians that successfully participate in  
17 the PQRI.

18 [Second]

19 Dr. Bufalino: Seemed like there was some hesitation. No one was on board with you. [laughter]  
20 Just the end of the day. Any other conversation about that? That clarifies it? Dana you have that? Thank  
21 you. All in favor?

22 [Ayes]

23 Dr. Bufalino: Thank you. Other recommendations? Art?

24 Dr. Snow: PPAC recommends CMS prohibit any contractors from auditing physicians on  
25 consultations until a clear policy is in effect and to continue an open dialog with interested medical  
26 associations on the various concerns over the definition of consultations.



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1 [seconds]

2 Dr. Bufalino: Thank you. Discussion? All in favor?

3 [Ayes]

4 Dr. Bufalino: Thank you. Others? Jeff?

5 Dr. Ross: Just to revisit if I may, we were very fortunate that we ducked a bullet in this last  
6 legislative session when we faced the 10.6% reduction. However, we still face about a 21% cut in Medicare  
7 payments in the rate in 2010, and that may mean a total of 40% in the coming decade. I mentioned to Mr.  
8 Kuhn before the meeting that an article appeared in my *Houston Chronicle* and I'm sure that many of even  
9 your hometown newspapers articles appeared after the vote took place, which did not rescind the decrease.  
10 It showed in the state of Texas that 60% of the members of the Texas medical association are accepting  
11 new Medicare patients. That means 40% are not. We've asked CMS to furnish if at all possible, in the past,  
12 such data that might show whether or not we're developing a "drowning out process," where beneficiaries  
13 are not being able to get to their providers, either in a timely manner or being offered care at all. I'll give  
14 you an example: In the article that appeared, a general surgeon retired, went to seven practitioners, before  
15 he was finally granted access. And he was only granted access because he told the provider he was a retired  
16 physician. So the question is what's happening out there and what's going to take place in the new two  
17 years into the next decade? Will that 40% figure turn into 50% in my home state and in your states? So I  
18 don't think I have a specific recommendation that PPAC recommends, however, I would like to at some  
19 point, find, if there is any data, to whether or not there is a decreased in provider care to Medicare  
20 beneficiaries. I think we've been asking that for a while—

21 Dr. Bufalino: I think it's a question we've asked before and maybe you could reformulate it into a  
22 recommendation to see whether or not—I think they are measuring the number of providers that rip up their  
23 participation contract. We've talked about this with Liz before, looking at opportunities to see are the  
24 number of people not seeing new Medicare, is there a way to measure the decline in new consultations per  
25 physician per practice in an effort to try to get a flavor for, maybe not a precise number, but a flavor for this  
26 access issue.

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1 Dr. Ross: I think Mr. Chair, I think what we're probably trying to say is not just who are not  
2 ripping up their contracts, but who are decreasing the number of beneficiary visits per day, per week, per  
3 month, and per year. And so I guess I would like to recommend that PPAC recommends to CMS that if at  
4 all possible that we show data of trends of those providers that are showing decreased trends in beneficiary  
5 care.

6 Dr. Bufalino: OK. Second?

7 [seconds]

8 Dr. Bufalino: Thank you. Any discussion? All in favor?

9 [Ayes]

10 Dr. Bufalino: Thank you. Others? Art?

11 Dr. Snow: I have an article here about the Never Event. It is also being called now the Plaintiff's  
12 Bar Full Employment Opportunity Act. [laughter] Therefore, I would like for PPAC recommends CMS not  
13 expand the "hospital acquired condition non payment policy" from that inpatient hospital setting until that  
14 hospital setting non payment policy has been evaluated and analyzed in particular, determining the impact  
15 of the hospital acquired condition inpatient policy with regard to quality of care delivered to patients,  
16 especially in proportion to the additional costs to the Medicare program, required to simply comply with  
17 the hospital acquired condition requirement, the need, number two—

18 Dr. Bufalino: I'm dizzy now, so that about a paragraph and a half [laughter/chat]

19 Dr. Snow: I've got it written down if you need it. Secondly, and this is the second condition that  
20 needs to be analyzed, the need for appropriate risk adjustment techniques, third how to determine  
21 attribution issues with respect to when, where, and why a condition has occurred, and four, the reasonable  
22 number of incidences in which these conditions will occur in individual hospitals, especially with regard to  
23 high risk patients when evidence based guidelines are followed. And I give that to you in written form. Or  
24 repeat it again if everyone would like it! [laughter] One more time!

25 Dr. Bufalino: Anybody dare to second that?

26 [seconds]

**PPAC Meeting Transcription – August 2008**

1 Dr. Bufalino: Any other discussion? We'll look forward to reading that in the...[laughter]

2 Dr. Snow: It's a wonderful paragraph. And I'm sure Ken will have an equally good answer for it.

3 Dr. Bufalino: Absolutely. Sounds like it's a whole page from here. All in favor?

4 [Ayes]

5 Dr. Bufalino: Thank you. Anybody else dare to trump that? OK. I think that's the end. We will get  
6 from Dana within the next 24 hours, the follow up of the specifics of those recommendations, and maybe  
7 I'd ask Liz Richter to close with a final comment and thank you for your hospitality today and all the  
8 presentations, very well done, thank you.

9 Ms. Richter: I just want to say thank you to all of you. I know that sometimes the Baltimore  
10 security is a little challenging but it's helpful, as you can see. We can do more shorter presentations here.  
11 Based on the number of staff who are up here, versus in our Washington office. I think it's really helpful at  
12 least once a year to be able to have this sort of different sort of meeting where we've got you know, less  
13 intensive but more presentations and thank you for the very lively discussion. It was really helpful to all of  
14 the presenters and to all of us. And we'll see you at the next meeting in December.

15 Dr. Bufalino: So the next meeting, for those of you that haven't looked at it is Monday, December  
16 the 8<sup>th</sup> in DC, so mark that on your calendars and get your travel arrangements. Thank you all and have a  
17 safe journey. There's coffee and cookies in the corner, or water and cookies in the corner. Thank you.

18

19 Adjourned