

CENTERS FOR MEDICARE AND MEDICAID SERVICES

PRACTICING PHYSICIANS ADVISORY COUNCIL

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Public Witnesses

Dr. Paul Martin, American Osteopathic Association

MS. DANA TREVAS, Rapporteur
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Open Meeting

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Dr. Senagore: Well, good morning. I guess we'll go ahead and get started. I think we have a quorum. Dr. Sprang will be joining us in just a second, so I'm Dr. Anthony Senagore. I'm the chairperson of the Practicing Physicians Advisory Council. And it's my pleasure to welcome all of you to our 57th meeting. Just ahead of Tiger Woods right now, so. [laughter] I would like to extend a cordial welcome to my colleagues and fellow council members. And it's good to see everyone once again. I appreciate your willingness to adjust your schedules, because I know it's difficult to get away and take on these extra tasks, even though it is an enjoyable city to come and visit. Your input and guidance on these issues is appreciated by CMS Staff, and presents our formal opportunity to comment as practicing physicians, and have, hopefully, important impacts on the outcome of Regulations, and instructions which directly affect the physician community. I welcome your considered, practical input on many of the health care issues before us today. As you look at today's issue, you can see that we have another ambitious and timely list of issues to be presented for our consideration. Topics include the Medically Unlikely Edits, which was an improvement in the terminology, based on our last meeting, Medicare Pricing—for Fee-for-Service, and Advantage Plans, the Five-Year Review and Physician Fee Schedule, and Practice Expense, and update to the OPSS Ambulatory Surgical Centers, Pay for Performance Cost Measurement Development, Electronic Prescribing, and of course, we'll receive our Quarterly PRIT Update, as well as the latest report to our recommendations made during the May 22nd, 2006 meeting. I am confident that you will give our presenters your attention and the full benefit of your practical knowledge and experience. To get started with the agenda today, if we have any questions before we start, I'd be happy to entertain those now, otherwise it's my please to ask Mr. Herb Kuhn, Director of the Center for Medicare Management, Centers for Medicare and Medicaid Services to welcome you. Mr. Kuhn.

23

Welcome

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Mr. Kuhn: Thanks, Dr. Senagore. And thank you all again for being here for this meeting here in late August in Washington, D.C. I know it's pretty muggy out there today, so you know you're back in the city during August. I, too, want to thank you all for your service and for being here. These advisory panels are very important to the agency and particularly this one, because there are so many topics that are playing out in the physician payment world right now and to have you all here, folks with real practice-based

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1 experience, is absolutely critical to us as we continue to develop policy and move forward in collaboration
2 with the physician community on many of these issues. Likewise, I think these panels serve an enormous
3 value in terms of greater transparency for the agency for all to see what we're looking at, the things that
4 we're grappling with, and for all of you to opine on those issues for us as we go forward with them. So
5 thank you again, for your service and for being here. As a bit of a process thing for this panel, I just want
6 to remind everybody, not only on the panel, but those that are in the audience today and those that
7 ultimately will be looking at this transcript, is that the nomination process for next year's panel is open
8 now. And that closes on the 15th of September. I think if you look at all the people that serve on PPAC
9 now, we have five whose terms expire next year, and they would, they expire after the February meeting,
10 so we have five slots in play now for the May meeting beginning next year. So again, those nominations
11 are open, so I think those in the stakeholder community or that are interested in this, this is the time to get
12 information in, because again that is open until the 15th of September, before those terms expire. Let me
13 also reflect a moment in terms of the agenda as we go forward. Dr. Senagore gave a nice overview of
14 what's going on as is evidenced by this agenda. There's a lot going on in CMS right now and I think this
15 agenda reflects the busy time that we're all engaged in here. But just as a moment to try to touch on a
16 couple of important milestones that I think are important to everybody as we think about this meeting and
17 go forward, one, a week ago today, on the 21st, is when the Comment Period closed on the first of the two
18 Physician Proposed Rules that we had out there. This one dealing with the Practice Expense issue, and the
19 Five-Year Review. And so we got a lot of good comments on that and I think we'll probably hear a little
20 bit or you all still might have some things to share with us about that particular regulation, different
21 thoughts about that, based on the comments from your respective specialties. Also, on August 8th, just
22 about almost three weeks now, we published the second of our Physician Proposed Rule. This one dealt
23 with the DRA Imaging issues, but importantly, many of the other issues that are in the Physician Payment
24 Rule are out there and as I think everybody knows, our intent this year is to take those two particular
25 regulations, put them together in a Final Rule that will be published on or about the first of November. So
26 one is now, the Comment Period is closed, but the other one is wide open, and again, I think the timing of
27 this meeting to be here to talk about those two are pretty important. Also, what you see, I think in those
28 regulations, those proposed rules and the other discussion within the agency continues with the great

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1 collaboration we're having with the physician community to continue to look at quality based measures as
2 we go forward, and think about revamping the payment system as we go forward. And you'll hear about
3 that also at today's meeting as we move forward. And I think Dr. Tom Valuck is going to come speak to us
4 about that. But importantly, I think you see a lot of other things going on within the department, the
5 agency, to help support those kind of activities. Just last week, Tuesday of last week, the President signed
6 as new Executive Order, that deals with greater transparency in terms of pricing for medical services, deals
7 with greater transparency in terms of quality measures and metrics, but importantly also talks about IT,
8 interoperability, which I think is an important step as we move forward. Likewise, in the Outpatient
9 Prospective Payment Rule that we put out this month as well, the Proposed Rule, also continues to move
10 forward in the quality agenda that I think pretty robustly and pretty effectively, importantly this one is more
11 on the hospital side, but what we saw there is an expansion for FY-08 of the number of measures that
12 hospitals will need to report, including HCAHPS, which is the measure of patient satisfaction within the
13 facilities, the SCIP measures, and some other measures are out there as well. And also, importantly, in that
14 Proposed Rule, we make a recommendation to take the hospital reporting side, the voluntary reporting side
15 of which there is a kind of a 2% withhold in terms of the update for the hospitals, and now translate that
16 into the outpatient setting as well. So think two important areas there as well, so again, you see us moving
17 forward, I think collaboratively with the stakeholder community both in physicians and hospitals to
18 continue to drive this agenda forward, and again you'll hear more of that this afternoon from Dr. Valuck.
19 And then finally, and importantly, is what you heard is the Ambulatory Surgical Center Rule that's out
20 there, within the Medicare Modernization Act. We were asked to update and change that kind of
21 antiquated payment system, and we do have a proposal out there that I think is pretty important to everyone
22 in this area, but particularly for physicians, and we'll hear more about that proposal later today. So with
23 that good full agenda, and thank you all for being here.

24 Dr. Senagore: Thank you, Mr. Kuhn. I want to thank you and also Dr. Tom Gustafson, who's here
25 I believe, for your collaborative efforts with us on this committee. Now I'll invite Dr. Kenneth Simon,
26 Executive Director, Practicing Physicians Advisory Council, Center for Medicare Management, to provide
27 us with the responses prepared from our previous meeting on May 22nd. Dr. Simon.

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PPAC Update

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4 Dr. Simon: Good morning. The first response on Medically Unbelievable Edits, which we've now
5 changed to Medically Unlikely Edits, PPAC recommends that CMS change the name of the Medically
6 Unbelievable Edits Program to remove the term "unbelievable." Some suggestions include replacing
7 "unbelievable" with the words unlikely, unusual, unexpected associations, or inaccurate. CMS adopted
8 PPAC's recommendation and has changed the name of this initiative to Medically Unlikely Edits. All
9 public communication from this date forward will reference the new title.

10 Agenda Item 56 F-2, the Council recommends that CMS allow modifiers for services that may be
11 clinical outliers, and develop an appeals process for claims denied under the Medically Unlikely Edits
12 Program. CMS response: CMS is considering the need of a modifier to allow for medically necessary
13 exception to a Medically Unlikely Edit. CMS will make the decision about the need for a modifier based
14 on the number of potential claims that would ever be subject to an MUE. If that number is small enough, it
15 may negate the need for a claims modifier. Additionally, CMS has agreed that there will be an appeals
16 process for MUEs, including an appeals process for individual claim determinations, and for an MUE itself.

17 Agenda Item 56 F-3, PPAC recommends that when CMS publishes a proposal for its MUE subset,
18 that's to be implemented in January, of '07, CMS provide background information on the contents and
19 rationale for the MUE Program and specific data on the estimated percentage of errors that CMS hopes to
20 address. The information and data should be disseminated through educational vehicles of the AMA and
21 national and state specialty societies as well as the usual CMS communication channels. CMS response:
22 By stating, CMS accepts the PPAC recommendation and will include additional information about the
23 rationale and/or supporting data for the MUEs. The MUE subset that will be implemented in January 2007
24 will be based on anatomical criteria and will therefore not have a basis in data.

25 Agenda Item 56 N-1, PPAC recommends that CMS continue to use its influence with Congress to
26 encourage changes in physician reimbursement, particularly the sustainable growth rate, the outcome of
27 which will enhance the agency's ability to improve the quality of care for its beneficiaries. CMS is
28 committed to promoting high quality physician services to Medicare beneficiaries, and remains actively

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1 involved with both Congress and the physician community on this important topic. Our goal is to design a
2 payment system that aligns reimbursement with quality and efficiency, so that physicians are encouraged to
3 provide care focused on prevention and treating complications. Care focused on the most effective, proven
4 treatments available. CMS will work with physicians and their leadership in an open and transparent way,
5 in order to support the best approaches to provide high quality healthcare without creating additional cost
6 for taxpayers and Medicare beneficiaries.

7 Agenda Item 56 N-2, PPAC commends CMS for using the input of the AMA's Physician
8 Consortium for Performance Improvement, and the quality measures for the physician volunteer reporting
9 program. PPAC recommends that all physician measures used by CMS be developed by physician
10 specialties through the consortium, endorsed by the National Quality Forum, and implemented across
11 public and private programs, by working through the Ambulatory Care Quality Alliance. CMS appreciates
12 the leadership role that the AMA Physician Consortium for Performance Improvement has played as a
13 developer of physician quality measures and the role of the AQA and NQF in consensus endorsement.
14 CMS agrees with the importance of using measures that have gone through a standardized development
15 process that's supported by a broad consensus, such as is provided by the organizations previously named.

16 Agenda Item 56 O-1, PPAC recommends that CMS continue to evaluate and correct disparities in
17 payment to academic anesthesia programs to bring them in line with similar payment methodologies used
18 by other teaching physicians. CMS will continue to evaluate payments for teaching anesthesia services.
19 The CMS Deputy Administrator, technical staff, met with representatives of the American Society of
20 Anesthesiologists as recently as April of this year to discuss this important issue. We have previously
21 formally requested comment on payment for teaching anesthesiologists, most recently in the Proposed Rule
22 updating the Physician Fee Schedule for calendar year 2006. In the Final Rule, published in the *Federal*
23 *Register* on November 21, 2005, we discussed the comments we received. We noted the growth in
24 teaching anesthesia programs between 2000 and 2006, and the lack of information suggesting problems
25 with securing access to anesthesia services. We reiterated our belief that the critical portions of the
26 teaching anesthesia service, and the teaching surgical service are not the same. We noted the lack of
27 suggestions regarding sources of savings to fund any change in policy in this area. We stated that we
28 would continue to review the information and relevant data presented by the commenters, and consult with

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1 the appropriate stakeholders before advancing any formal proposal for changes in the payment for teaching
2 anesthesiologists.

3 Agenda Item 56 O-2, PPAC recommends that CMS resolve the issues related to electronic
4 resubmission of denied claims, as described in transmittal 104, released by CMS on February 11, 2005,
5 reflecting issues related to the ICD-9 Code. CMS will work with Medicare contractors and provider groups
6 to establish a process by which providers can submit previously denied claims electronically if one, the
7 contractor denied the claims because of simple clerical mistakes; and two, the claims are accompanied by
8 an indicator that the provider has previously submitted them. CMS will select a sample of those claims for
9 review by contractors appeal staff, to ensure that the corrections are consistent with CMS policy.

10 That concludes the responses from the Council from the May 22, 2006 meeting.

11 Dr. Senagore: Thank you, Dr. Simon. Are there any questions or comments from the Panel? Dr.
12 Williams?

13 Dr. Williams: A comment on Agenda Item 56 O-1. Anesthesia teaching payment response. I
14 would like to note and thank CMS for considering, reconsidering this issue and providing the background
15 material and the notes. However, it should be noted that it is the physician teaching programs that have
16 decreased by number, by 20 since the teaching rule was put into effect many years ago. And it's the nurse
17 anesthesia programs that have increased in recent years. And I presume that this is a physician panel
18 dealing with physician issues. So if we could perhaps take that back to the CMS to correct that issue, that
19 would be great. Also, please remind CMS that the current physician anesthesia teaching programs many,
20 most of which are being financially supported now by the hospitals, providing an average of 400,000 to a
21 million dollars per year, per department in order to keep those teaching programs afloat. Whereas, we used
22 to be stand alone, self-sufficient departments, as are most other medical subspecialties. Thank you.

23 Dr. Senagore: Dr. Williams, could I ask, we'll try to do as a housekeeping order, we'll try to do
24 our recommendations as we go, if it's possible, so it might be good to make your first comment a
25 recommendation if you want Dr. Simon to comment on that once again. Would you mind crafting a
26 recommendation for that? I think what you said would be perfect. We just need to get it in the record, so
27 that we can vote on it.

28 Dr. Williams: Do it now?

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1 Dr. Senagore: If you want to take a few minutes to think about it, we can just come back and
2 revisit it after the PRIT.

3 Dr. Williams: Great.

4 Dr. Senagore: I just had one comment about the MUEs. Will there be an opportunity to coordinate
5 with CPT so that there'll be maybe another instructional vehicle to learn how to use codes, and something
6 that comes to mind is a lumbar spine code where there's only five of them, just because, it's something I
7 could add up to easily. There's only five of them I hope, where you would be kept at five there, versus C-
8 spine code that would have a different number.

9 Dr. Przyblski: Some have six.

10 Dr. Senagore: I said mostly. [laughter]

11 Dr. Simon: I'm sure that once the information is released later in the year that the program
12 integrity section of the agency will look forward to receiving input from all of the appropriate specialty
13 societies as well as the other medical organizations so that those type of nuances can be appreciated and
14 incorporated into the guidelines under MUE.

15 Dr. Senagore: Great. Were there any other questions or comments? Now, I'd like to welcome Dr.
16 William Rogers for our PRIT Update. As you know, Dr. Rogers is the Medical Officer in the Office of the
17 Administrator of CMS and he's Director of the Physicians Regulatory Issues Team. He'll provide us with
18 a PRIT Update and he has a fledging business of delivering coffee for the panel members. [laughter] So we
19 want to thank him for that. So Dr. Rogers.

20 PRIT Update

21 Dr. Rogers: It's all about service. Thank you very much. I've been doing this for a few years
22 now. It's a pleasure. I appreciate the work that you all do as much as, more than you can imagine. I'm
23 going to primarily take the few minutes that I have here to go over some of the issues. And these are issues
24 that are familiar to you. But of course, I've got to start out with a couple of my cartoons. That's often the
25 most valuable part of my presentation. [laughter] And I'm going to pull the issues right off of our website.
26 As you know we went through an update, upgrade some would say, of the CMS website and I'm getting
27 used to it now. I can find some things. [laughter] My biggest disappointment is that our pictures

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1 disappeared. We're not allowed to have pictures on the website anymore. So maybe that would be a good
2 PPAC issue to bring up. [laughter]

3 Dr. Senagore: At least the cartoons.

4 Dr. Williams: Have cartoons on the website.

5 Dr. Gustafson: Pictures of PRIT leadership?

6 Dr. Williams: Or CNN leadership or...[laughter] We've got some photogenic people at the front
7 table. The issue of getting the problem, one problem with Part D for physicians is that physicians are
8 permitted to basically file first level appeals on patients' behalves without being appointed as
9 representative, but by law, and there's another issues that we'll get to in a second that also is tied up with
10 this, by law to go to the second level of appeal, it can only be done either by the patient himself or by
11 somebody who's been legally appointed or representative, and so a physician came to us and said, Would it
12 be permissible for us to for patients who have problems with mobility, or problems with sort of the logistics
13 of doing an appeal, would it be a problem to have us, have them sign an appointment of representative form
14 before we actually started to deal with the appeal process. And we checked into that and in fact it is
15 permissible to do that. The physician just has to be aware that by doing this they have taken on certain
16 responsibilities in terms of making sure that the appeal is appropriately pursued and that the information is
17 communicated with the patient. But it is one way for a physician, particularly physicians practicing in rural
18 areas to deal with this particular challenge in Part D. There's also a sort of minor issue which is getting
19 fixed now, that had to do with an inaccuracy in an E&M service guide, and that's been fixed, and updated,
20 and corrected.

21 855, as you know, we came up with a new 855 form, and I think that pretty much all of the
22 problems now have been resolved with that, with the exception that we came out with a auto-fill form,
23 model of the form, but unless the physician or the office manager has the full Adobe Suite, when they try to
24 save the form that they have laboriously filled out, it disappears. So we're working on a way around that
25 without buying the full Adobe Suite for all of the Part B practitioners in the United States.

26 Availability of the Exception Appeals forms. Almost all of the plans have now made the forms
27 available sort of within three clicks on their website. And we're also working very hard, and very grateful
28 to the AMA for their support in getting the plans more and more to use the standard form. Obviously the

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1 forms are a big logistical challenge for physicians, using the right form for the drug, for the particular plan,
2 and so anything that we can do to reduce the burden of that is important to us.

3 Definition of consultation. I was invited to speak to Indiana State Medical Association along with
4 Care & Medical Director because of confusion about what the definition was of a consultation. And we're
5 engaged with a bunch of specialty societies in trying to really sort of ferret out what the source of the
6 confusion is, because obviously we want our direction to be clear and easy to understand.

7 Electronic funds transfer. I think once we found out that all of the banks in Alaska accept
8 electronic funds transfer, we knew we were home free on this. There was some concern that some
9 physicians' practices would have a problem accepting electronic funds, but it turns out I think is going to be
10 not a problem for physicians. And everybody should understand that this was not an idea that we have, this
11 was actually required by law, since I think 1999. And we had been delaying the implementation, but it
12 finally became something that we just had to do.

13 Nurse practitioner services billed in the hospital. This is going to be corrected. We seem to
14 indicate that when nurse practitioners provide services in the hospital that the facility would have to bill for
15 their services, and so the correction should be done soon.

16 This is the other half of the issue I was talking about before; the ability to file coverage
17 determinations by physicians. And as I said, once you get to the second level of the appeal, you either have
18 to be appointed representative or the appeal has to be filed by the patient himself. And as I said, now
19 there's a work around about those. This is not something that we imposed on physicians but it was
20 something that we had the write implementing regulations for it to be in compliance with the law. But I
21 think that physicians now that they're learning how to deal with it, it's working more smoothly.

22 There's neurosurgical codes and pediatric codes that the specialties would like to see published,
23 likes the values of them published in our fee schedule, even though we don't pay for those things, and so
24 we're hoping that those specialty societies will comment on the Proposed Position Rule and that the values
25 will be hopefully in the Final Rule.

26 Written consultation orders. We very much feel that it is important that all of the Medicare
27 requirements with reference to consultations be complied with and one of the requirements is that the
28 referring physician write an order for the consultation. And that's very important for a lot of reasons.

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1 However, we don't think it's fair that if the referring physician fails to write that consultation that the
2 consultant be punished by not being paid for the service. So it's sort of a difficult situation because the first
3 instinct is to say well, we're not going to pay for a consultation unless the order's written. But on the other
4 hand, that's not really fair to the consulting physician because it wasn't the consulting physician that
5 neglected to write the order. So we're not going to expect that consultants would not be paid, but we are
6 going to very much insist that referring physicians comply with the regulations and write an order when
7 they do want a consultation done. And if that becomes a problem and it's not happening, we'll have to
8 figure out a way to encourage referring physicians to do it.

9 Public availability of NPI numbers is a little bit of a challenge because there are issues of privacy
10 and security, but the vast majority of physicians and office managers I think would like to see a directory so
11 that they can look up NPIs of referring physicians and things like that. There's a lot of reasons that it
12 would make offices operate more smoothly and so the final policy is in the final phases of being written,
13 but I'm hopeful and optimistic that there is going to be, with appropriate security, a way for office staff to
14 look up NPI numbers.

15 All I'll say is I was pleased to see "unbelievable" replace the previous term. I think the final list,
16 which is a huge list is going to be very reasonable. I know Lisa's going to be talking about this later, but I
17 think we're moving in the right direction on this.

18 CME, by hospitals, obviously the grand rounds and things that hospitals have done for a long time
19 are very important for a lot of reasons and should be used for CME when it's appropriate. But there are
20 concerns that if hospitals basically have free reign to provide any kind of program, any place, in the world,
21 that there would be opportunities for inducements and things like that that we want to avoid, so we're
22 working on a Final Rule to clarify just what's considered to be compliant with STARK and what's not
23 considered to be compliant with STARK. But the Final Rule is not out yet. It'll probably be out, I think
24 we're talking the beginning of next year.

25 CAH Provider Response Time, for those of you who read the Outpatient Rule in detail, you'll see
26 I think we came up with a very good proposed solution for this. The problem was that we imposed on
27 CAH's, on Critical Access Hospitals' standard for response time which exceeding the standard required in
28 EMTALA of the big hospitals. So we've written proposed regulations, which will bring CAH's

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1 responsibility for responding to emergencies in compliance with EMTALA. I think that's great. The more
2 consistency we have across providers, the easier it is to comply. And so hopefully the comments that come
3 in on the Proposed Rule will support this language and it'll appear in the Final Rule.

4 And this was the proposed language that's in the notes for those of you who want to look at it.

5 This has to do with the issue of physicians who volunteer to supervise residents in the outpatient
6 environment. And a number of societies would like to see us simplify the work that we require physicians
7 in hospitals to make sure that physicians aren't providing a service without compensation. And there have
8 been good proposals made and those are being considered by our specialists in Baltimore who are
9 responsible for this particular rule.

10 This like the neurosurgery issue, is an issue of codes that have values but that we don't pay for.
11 And the pediatricians would like to see them published in the physician rule because many Medicaid
12 Programs and many smaller private payers sort of use the Medicare Physician Fee Schedule photo copied
13 as their fee schedule, and it creates problems for these specialties when the codes don't have values.

14 Recovery Audit Contracts. I think this is really settled down at least as far as the information
15 we've gotten back. The big problem that we had a couple of months ago was that some physicians who'd
16 already been reviewed by the carrier were being, having the same claims pulled again for review by the
17 RAC and there have been software enhancements made, which now are seeming to prevent that from
18 happening. And the contractors were very, very responsive and enthusiastic to get this fixed quickly. It
19 was a hassle for the physicians that got pulled in and that was unfortunate but it's a complicated process
20 and it was just sort of an oversight. But it's been fixed and we'd like to hear if anybody's having problems
21 now.

22 Competitive Acquisition Program. We have not heard much one way or the other. We've allowed
23 physicians to be, use their own stock, here in the near term when there are problems with delivery and
24 things like that, and we've sort of liberalized our rules about that for the time being. And we have not, the
25 PRIT hasn't heard anything from physicians so far that are having problems with CAP, but we'd like to
26 hear if people are having problems.

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1 So that's still my phone number, and my office number. We've moved temporarily into sort of the
2 middle of the building, so my cell phone doesn't work so well anymore, so that's my desk phone. During
3 the day, that's a better phone to reach me. Thank you very much.

4 Dr. Senagore: Questions? Comments? Dr. Urata?

5 Dr. Urata: I was wondering if I could address this question to Mr. Kuhn. This is regarding
6 graduate medical education and volunteer faculty in a non hospital setting. I was wondering when can we
7 expect a final resolution to this issue. I guess it's been going on for three years, and a lot of meetings have
8 been held, and there seems to be a good proposal.

9 Mr. Kuhn: Yes, there's some really good proposals that have been put out there, and I think not
10 only the physician community, the family physicians, the American College of Physicians, the osteopaths,
11 others have really come through I think with some thoughtful proposals to help us kind of grapple with this,
12 as has the AAMC. And I think one of the critical issues for us trying to kind of weave through this thing is
13 the statute is very clear that it says all, or substantially all of the services need to be paid for in this kind of
14 setting. And so for us, what we want to do is maximize the opportunity for voluntary teaching. Maximize
15 the opportunity for people to be training in non hospital, ambulatory sites because that's where the need is.
16 And that's where our policies need to encourage that. At the same time, we want to make sure that we
17 don't violate any tenets of the statute; so again, I think there's been some thoughtful proposals come
18 forward. Every time someone says, When are we going to get this resolved I always like to think it was
19 resolved yesterday, but I think we're much closer than we were a few months ago. And I would just like to
20 say hopefully in the next few months we can find a proposal that works for everybody, meets the statute
21 requirements, meets our objectives as well as the objectives of everybody else to make sure that we can
22 encourage this kind of activity out there and move forward. So a real sincere effort I think by the
23 stakeholder community, all the physicians, the teaching hospitals, and for us to try to find a good
24 opportunity for a good outcome here.

25 Dr. Grimm: Just have a question about the [inaudible] medical education issue. You mentioned
26 the timing of a Final Rule regarding that. And you said I think you said the end of next year.

27 [off mike response]

28 Dr. Grimm: Beginning of next. OK, thank you.

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1 Dr. Bufalino: Dr. Rogers, just one question. Talk about the Nurse Practitioner Services. Could
2 you review for a moment the intent of the revision? What is—

3 Dr. Rogers: It was really a revision. It was a just a clerical error in the manual.

4 Dr. Bufalino: And the clerical error was that they weren't allowed to bill for services.

5 Dr. Rogers: No, it says in the manual, I believe, I should have gone back and reread the passages
6 that had to be corrected, but I believe it says in the manual, that nurse practitioner services are delivered in
7 the hospital must be billed by the hospital.

8 Dr. Bufalino: Oh the hospital.

9 Dr. Rogers: Yes. And it is possible for nurse practitioners to bill for services that they deliver in
10 the hospital directly.

11 Dr. Bufalino: Directly, separately from the hospital.

12 Dr. Rogers: Correct.

13 Dr. Bufalino: Thank you.

14 Dr. Przybalski: I want to thank Dr. Rogers for his continued efforts to get the non covered services,
15 at least have the RVUs published, and we appreciate that. I did respond to your email prompt and we did
16 comment on that for the proposed rule. I hope that this doesn't apply just to these exceptions that have
17 come up, but in the future, that applies to any specialty whose codes are not covered but would like those
18 values published because as you've commented already, a lot of other payers and even Medicaid payers use
19 the fee schedule to determine their payment as well. Thank you.

20 Dr. Rogers: [off mike] I mean if it makes sense to the PPAC, that's what you all are here for, is to
21 tell us how to do a better job.

22 Dr. Senagore: I have a couple of questions. One, the ongoing discussion of the consulter versus
23 the consultee. As you know that it hasn't often been in our lexicon as the person requesting a consultation
24 to send any documentation really to the person that we're sending the person to, and it would take a huge
25 paradigm shift, I would submit, in medical practice to make that the consistent barometer, for evaluation.
26 I'm not sure if the rest of the committee feels that way, but I think that would be an extra hurdle that hasn't
27 been done in the past.

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1 Dr. Ross: Dr. Rogers, concerning that, usually typically, when I would consult for an another
2 physician, infectious disease, a specialist, whatever, I'm just writing it in an order sheet: Request infectious
3 disease specialist and name the doctor. Is that documentation enough? Is that sufficient? Or in the history
4 and physical? Or the progress notes do you actually have to write need for consultation, suggest Dr. so and
5 so for consultation for this patient? How would you regard just an order sheet written note for consultation
6 being documentation, versus in the progress notes itself?

7 Dr. Rogers: Well, I'd better stay away from giving you specific documentation guidance, because
8 we have people that are a lot smarter than I am about that. The issue that we were dealing with had to do
9 with whether a consulting physician had to look through the medical records to see if that order had been
10 written, and it's difficult enough to do in the Inpatient Rule, but it's impossible to do it in the outpatient
11 world, because I would, what's he supposed to do? Get in the car and drive over to the ordering
12 physician's office and go through the patient's medical records to make sure that the consult was ordered?
13 I'm not sure where you order it, in an office record anyway since there's no order sheet. So we were just
14 trying to bring our guidelines into consistency with the real world.

15 Dr. Ross: That's a good point, too, now that you bring it up. Because in the inpatient I think it's a
16 lot easier. On the outpatient, if the physician is referring for consultation, do they have to now send a fax
17 over, do they have to send the written statement over with the patient?

18 Dr Rogers: Nothing has to be sent, and we never wrote anything that said that the consulting
19 physician has to have in hand a photocopy of the order—

20 Dr. Ross: Can it just be written in their notes?

21 Dr. Rogers: But we seem to say that if no order was written, then we wouldn't find the
22 consultation to be reasonable and necessary and therefore we wouldn't pay for the consultation. We just
23 wanted to clarify, we'll pay for the consultation and then we'll deal with the order physician's inadequate
24 documentation in a different way.

25 Dr. Ross: OK.

26 Dr. Powers: Just to support what—I'm not even sure it's worth your while to go out to eventually
27 find a way to go after the person who's requesting the consultation. Because I mean you'll have to ask for
28 medical records. It's hard enough for us to get the medical records. The consultant, to get the medical

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1 records. It just seems it would be an awful lot of expense to try to document, or try to get that
2 documentation that the consult has been written.

3 Dr. Simon: This is an area of concern throughout the community at large. And I know at the
4 CMD National Meeting, this issue came up and there's been a lot of discussion, because it has obviously
5 legal ramifications involved. But on the inpatient side, I think that most people would expect to see an
6 order written by the physician requesting the consultation.

7 ??: And it's required.

8 Dr. Simon: And it's required.

9 Dr. Senagore: The inpatient, that's really, I mean it may not be Consult, Dr. Simon, but it might be
10 consult vascular, and you know that would be a very typical way to do it on the inpatient side. I think the
11 concern is what happens on the ambulatory side, because that would be huge mission creep in terms of data
12 transmission back and forth between providers. And I don't know—and you would be asking the person
13 most vulnerable to be responsible for that data to even exist, so I think that may be a difficult challenge.

14 Dr. Simon: And the question of what constitutes a consult is a real issue, in terms of whether the
15 ward clerk, or the secretary calls the referring, the consulting doctor, saying that this patient, we would like
16 you to see this patient. Does that emanate from the physician and where does the physician provide the
17 request? Again, is there written documentation that the physician is actually required to request. So this is
18 an area that's being reviewed by both the contractors throughout the country. It's come to the attention of
19 the CPT Editorial Panel, and so I know that there's been dialog at that level as well, and whether there'll be
20 further clarification in the upcoming CPT book, we should find out later this year. But many different
21 organizations are looking at this issue very carefully.

22 Dr. Senagore: I think the ingrained response has become the consultee sending a letter back saying
23 thank you for letting me see Mrs. Jones in consultation, and that has been assumed to be sufficient
24 documentation to close the loop. So be interesting to know where that fits in versus any new benchmarks
25 that need to be built into the system.

26 Dr. O'Shea: My comment, Dr. Rogers, or my question is is this end to see that patients are not
27 self-referring? Is it just to—why is it that this is a new query. We know that second opinions don't have to
28 have another referral. But my query is that—is it to see that patients aren't just self-referring themselves?

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1 In my real world, I have to initiate my consult. I have to, I have a faxed order that has to have a reply back
2 from the consultant so I know when the appointment is, because then it fills my loop and I know that I can
3 expect that that patient is going to receive the services that I requested, and that's just for my own
4 edification. In hospital has to have an order. It seems that should be enough documentation. That's in the
5 medical record. And it would be outpatient that maybe doesn't have the same kind of documentation and
6 that's office culture, how each office actually does it. But my question, Bill, was is it because we don't
7 want patients Medicare recipients self-referring?

8 Dr. Rogers: I guess it is, it's an issue proving that the consult was necessary. That a physician,
9 after assessing the patient, realized that they needed the expertise, the special expertise of another
10 physician, and since the taxpayer's paying for that service, there should be some indication that somebody
11 actually decided that this was a cost that needed to be paid. So it is an issue of medical necessity.

12 Dr. O'Shea: My other comment was I think in prior meetings, we've also said that, and I think the
13 issue was when they new they had wheelchairs that CMS did not want to pay for a consult just for an order
14 to have the wheelchair given. And yet, here we're saying that we want it. And so this would be a meeting
15 with their primary care to almost act as gatekeeper. Again, so are you saying that it has to have a face to
16 face to make that—it doesn't?

17 Dr. Rogers: Oh, no, no, the requirements pretty simple. And it didn't change. The requirement
18 didn't change. What happened was some communication that we had seemed to indicate that we were
19 going to penalize the consultants if the ordering physicians were writing the orders. And we just wanted to
20 clarify do the consultation, take care of the patient. If an order wasn't written, that was a failure on the part
21 of the ordering physician. That wasn't a failure on the part of the consulting physician. We're not going to
22 punish the consulting physician because the ordering physician wasn't in compliance with our requirement.
23 So nothing's changed at all. You still have to write an order. The order physician does. The consultant
24 then has to write a report, and send the report back to the ordering physician. And those requirements are
25 the same, I don't know how long they've been the requirements, but it's been a good long time. That didn't
26 change.

27 Dr. O'Shea: So you're trying not to penalize the consultant.

28 Dr. Rogers: Correct, for the deficiency of the order physician, the failure of the ordering physician.

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1 Dr. Senagore: A follow-up question on that grand rounds issue, is the perception that the fairly
2 rigorous criteria already set aside for CME are not sufficient to cover that venue of activity? Or what is the
3 concern?

4 Dr. Rogers: I think the limit's \$300 a year in the current guidelines. I'd have to look back, but I—

5 Dr. Senagore: I think you're right.

6 Dr. Rogers: Yes. And I think people just get nervous about Stark, and so I think to the extent that
7 things are clear and the language is easy to understand, people will know that they're in compliance with
8 hospital-provided CME. I mean some of the CME gets to be pretty expensive. I think I heard in one
9 meeting somebody say you know, we didn't want to see people being sent to Hawaii by the hospital for
10 CME, that would probably be a problem.

11 Dr. Senagore: Which hospital do you apply to for that? [laughter] Were there any other questions
12 or comments for Dr. Rogers?

13 Dr. Przyblski: Since I got the invitation, I'd like to make a recommendation.

14 Dr. Senagore: Sure. Absolutely. That's where we were going.

15 Dr. Przyblski: PPAC recommends that CMS publish all Relative Value Units forwarded by the
16 Relative Value Update Committee even if a non coverage decision for a physician service is made by CMS.

17 Dr. Senagore: Is there a second?

18 [Seconds]

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

20 [Ays]

21 Dr. Senagore: I think she got it—yes, we're right on schedule, so let's take a little break here. We
22 can excuse Dr. Rogers. And why don't we go around and take any recommendations up to this point. I
23 think Dr. Williams had one for sure, and then—

24 Dr. Williams: It seems important to correct some of the information before I actually make the
25 recommendation. Is that all right to do?

26 Dr. Senagore: OK, no problem. We can pick it up any time.

27 Dr. Williams: It is noted that physician academic anesthesia training programs have decreased in
28 number, 20, by the number of 20, since the inception of the anesthesia teaching rule. It's the nurse

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1 anesthesia training programs that have increased. Furthermore, physician academic anesthesia training
2 programs are being subsidized by hospitals, by an average of \$400,000 to a \$1,000,000 per year, per
3 department. PPAC recommends that CMS re-evaluate their decision to equalize reimbursement for
4 academic anesthesia training programs, based on this new information.

5 Dr. Senagore: So I think we need to read that back. I think to put it in a little different structure we
6 have to start each of the first sentences with a whereas? No? We're OK as it? You have it all? Can you
7 read it back to us, then to be sure we all understand it?

8 Ms. Trevas: PPAC notes that physician academic anesthesia training programs have declined in
9 number by 20 since the inception of the Anesthesia Teaching Rule. However, nursing anesthesia training
10 programs have increased. Furthermore, physician academic training programs subsidized by hospitals, are
11 subsidized by hospitals in the range of \$400,000 to \$1,000,000 per year per program, department, therefore,
12 PPAC recommends that CMS re-evaluate its decision to equalize reimbursement for academic anesthesia
13 training, based on this new information.

14 Dr. Senagore: I'll take a motion to second?

15 [Second]

16 Dr. Senagore: Any discussion? Clarification, Dr. Simon?

17 Dr. Simon: This is a point of information. Would we be able to get background information
18 accounting for the decrease in programs? Surgery programs have undergone a significant reduction,
19 contraction in the number of programs over the last 20 years and it wasn't necessarily due to funding. It
20 was due to a change in the structure of teaching requirements by the American Board of Surgery, as well as
21 the American College of Surgeons, so it would be important to know what was the reason that the programs
22 were closed, or did they consolidate with other academic programs? So that the actual number decrease,
23 does that reflect that there's actually a decrease in number of programs or that there's been a convergence
24 of programs which has decreased in number?

25 Dr. Williams: Should we send that information to you?

26 Dr. Simon: Sure, that's fine.

27 Dr. Senagore: Any other comments or questions, discussion, regarding the motion on the floor?
28 All in favor?

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1 [Ays]

2 Dr. Senagore: Did someone else have one?

3 Dr. Urata: PPAC thanks CMS for three years of hard work on the issue of Graduate Medical
4 Education Volunteer Faculty Rule, but PPAC recommends that CMS expedite and raise the priority for
5 resolving this rule, which is the GME Volunteer Faculty in Non Hospital Setting Rule.

6 Dr. Senagore: Is there a second?

7 [Second]

8 Dr. Senagore: Do you have the verbiage? Why don't you re-read it before we vote.

9 Dr. Urata: For its three years hard work in the issue of Graduate Medical Education Volunteer
10 Faculty Rule.

11 Ms. Trevas: PPAC thanks CMS for its three years of hard work on the issue of Graduate Medical
12 Education Volunteer Faculty for Graduate Medical Education. PPAC recommends that CMS expedite the
13 efforts to resolve the rule on Graduate Medical Education Volunteer Faculty in non hospital settings.

14 Dr. Urata: Can you change that—PPAC recommends that CMS expedite and raise the priority for
15 resolving the GME or Graduate Medical Education Volunteer Faculty in Non Hospital Setting Rule.

16 [inaudible]

17 Dr. Urata: Say volunteer outpatient faculty.

18 Dr. Senagore: Ambulatory is fine.

19 Dr. Urata: Ambulatory.

20 Dr. Senagore: Is there a motion to accept the amendment? In any comments, questions?

21 Dr. Przyblski: Do you want to make it time certain, as opposed to whenever it gets expedited.

22 Dr. Urata: Sure. What would be reasonable? [laughter]

23 Dr. Senagore: Get an update at the next meeting?

24 Dr. Urata: Yes, update next meeting. I don't know where the negotiations are.

25 Dr. Senagore: Did you capture that last piece there? All in favor?

26 [Ays]

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1 Dr. Senagore: Is there another one from this side of the table or no? We're all set? I think we're
2 moving right along. Why don't we take the next agenda item, and then we can take a break after that.
3 They're not here, so let's take a break now. Executive decision. [laughter]

4 Break

5 Dr. Senagore: Why don't we go ahead and reconvene, if we could. As folks get settled in, one of
6 the issues that we've discussed as a panel, off and on, is the Medicare pricing for Fee-for-Service and
7 Advantage Plans. And it was clear that maybe we could benefit from a little more focused discussion on
8 that topic.

9 This was left in the lady's rest room if anyone would care to claim it, we'll have it in here. It's not
10 yours, Jeff. [laughter]

11 Medicare Pricing for Fee-for-Service and Advantage Plans

12 Dr. Senagore: We're fortunate to have several individuals from the Office of the Actuary of CMS,
13 Mr. Sol Mussey is the Director of the Medicare & Medicaid Cost Estimates Group, and Acting Director of
14 the Part C and D Actuarial Group in the Office of the Actuary. And he'll explain to us exactly how the
15 Office of the Actuary determines these payment rates for the Medicare Advantage Plans. He's also joined
16 by Mr. Kent Clemens. Kent is the Part B Team leader in the Medicare & Medicaid Cost Estimates Group
17 in the Office of the Actuary. And Ken will attempt to explain to us how the Office of the Actuary estimates
18 the cost of new benefits. And Sol and Kent are both joined by Mr. John Shatto. John is the Deputy
19 Director of the Part C & D Actuarial Group in the Office of the Actuary and is here to support them I
20 believe, and answer any questions that the two cannot answer for us. Welcome gentlemen. [laughter]

21 Mr. Mussey: Good morning everyone. I'm happy to be here today to tell you how the Medicare
22 Advantage payment rates are established. All of the MA payment rates and the backup data used in the
23 calculation of the rates are located on the CMS website at that location. The payment formulas to managed
24 care plans have changed a few times over the several past years. I'm going to focus on the latest set of
25 formulas. In 2004, the MMA established the Medicare Advantage payment rates as the greater of four
26 things. The four things being the minimum payment amount, and I'll go into a little detail about each of
27 these in a second, a minimum percentage increase, a blended amount, and a Fee-for-Service amount. We
28 would calculate all four of these things for every county in the country and then take the greater of the four

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1 things. The minimum payment amount was originally set at \$367 per month. And that was indexed to
2 Medicare per capital growth. In 2001, however, there was an ad hoc increase into the minimum amount,
3 and it was bumped up to \$475 for counties that had 250,000 people or less, and \$525 for counties that had
4 250,000 or more. The minimum percentage increase now is the greater of the national per capita growth
5 rate, or 2%. Prior to 2004, it was fixed at 2% per year. The blended amount is a blend of a local rate and a
6 national average rate. In 2004, it was 50% of a local rate and 50% of an input price adjusted national
7 average amount. And in the final of the four things was the estimated Fee-for-Service amount for 2004.
8 For 1998 to 2003, the Fee-for-Service was not considered in setting the payment rates. Prior to 1998, all
9 county rates were based on 95% of the Fee-for-Service so we sort of went full swing. It started out,
10 everything was based on Fee-for-Service and then went through a bunch of changes and we ended up
11 where Fee-for-Service is considered but not necessarily the final rate for a given county. For 2005, and
12 later it became a little bit simpler. The rates were based on only 2 options, now, at most. In 2005, and later
13 the MA payments are the greater of the prior year's rate increased by this minimum percentage increase,
14 again, which is the trend, or 2%, whichever is greater. Now the trend percentage increase is also adjusted
15 for prior years under or over-estimates going back to 2004, not earlier than 2004. OK, and then the second
16 thing considered is the Fee-for-Service rate if it's a re-basing year. And the law requires that we re-base for
17 Fee-for-Service amounts at least once every three years. In reality, what we've done, since the MMA was
18 passed, we had Fee-for-Service was considered in 2004, it was in 2005, it was not considered in 2006, but
19 in 2007 it was one of the options again. For 2006, and later, however, the new competitive program kicks
20 in, so plans submit bids of their cost for providing Medicare services to Medicare beneficiaries. These MA
21 payments rates that I've been talking about are not called "benchmarks." If a plan bids below the
22 benchmark, then $\frac{3}{4}$ of the difference between the benchmark and the bid is given back to the plan in return
23 for providing extra benefits, or reducing premiums to plan members. If a plan bids above the benchmark,
24 they only receive the benchmark amount.

25 Now I know one thing of interest is how are new benefits built into the payment rates. New
26 legislative benefits are built into the minimum percentage increase. When a legislative package comes
27 along, we estimate all the provisions of the package, and we explicitly adjust assumptions in our baseline to
28 account for the provisions of this legislative package. The baseline then would automatically affect the

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1 minimum percentage update, which affects the rate increases as we saw in the previous slide. Other benefit
2 increases, such as national coverage determinations are generally small and not explicitly accounted for in
3 the rate increase, generally. Since these NCDs are done every year, they're reflected in the historical
4 growth rates of the program. So there's certain amount of benefit levels for NCDs that are reflected in the
5 trends that we look when we project out our growth trends for the future. This is a basic general overview
6 of how the rates are determined. The last slide, this is my contact information. If anybody has questions at
7 any time, feel free to call me or email me. And I'd certainly be happy to answer any questions.

8 Dr. Senagore: That's always a risky slide to put up. [laughter] Any comments or questions at this
9 point?

10 Dr. Grimm: This was pretty lot of information, and it was fairly confusing to me. I'm sorry that I
11 didn't catch everything here on what you're saying here. In the future, if you would put everything on the
12 slides, it would be very helpful for us, particularly issues that any numbers, because it's very hard to follow
13 that, thank you. But when you say this issue about they're built into the increase, could you tell us
14 practically what this means, when a legislative benefit is included into this rate? When you say it's built
15 into it, that means that it's, is it, does it increase it?

16 Ms. Mussey: It depends on the provision of the legislation.

17 Dr. Senagore: Could I give a real world example, maybe it'll help. So there was a coverage
18 determination change for screening colonoscopy in terms of deductibles. So how would because that could
19 be both a volume number change by more people want to access the service and obviously a dollar
20 alteration, so something like that, if you could apply that to Dr. Grimm's question.

21 Ms. Mussey: Yes. Something which we know affects the price of a service or the utilization of a
22 service, depending on what service it is and which part of our model, we'll build in explicitly either
23 something into the utilization rate, if it's a particular thing that we can measure, utilization, or if it's a price
24 adjustment, we'll change the price. Sometimes utilization can't be measured directly but we know it
25 affects some residual factors that we built into our main line, our main baseline projections, so we'll build
26 them there. If we're talking about a new coverage or a new legislative provision, it's not going to be
27 reflected in the historical data, because it's new. OK, so we need to somehow explicitly account for that.
28 And we make our best judgments as to what the coverage or provision is going to affect. Either a price or a

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1 utilization and we'll build it somewhere into our model, to account for either the increase, or if it's a
2 particular provision that's saving some money, then we'll—

3 Dr. Grimm: Let's say something costs \$200. Whatever's legislated now costs us \$210. All
4 through how that impacts the physician, that's what we want to know. Forget the word "build in" and all
5 that other things that you're using. How does that impact the physician, and their payment.

6 Mr. Mussey: OK. I think you're going to get into some of that as part of your discussion, is that
7 correct?

8 Mr. Clemens: I can.

9 Dr. Senagore: Do you have a prepared presentation for us that would touch on some of these
10 topics, or just, should we just do it as questions?

11 Mr. Clemens: Questions, I think is a good way to go. The presentation I have is sort of an
12 overview of the considerations we look at, and because it varies based on legislation.

13 Dr. Senagore: OK. So we have time. If I can maybe paraphrase the question. If something has an
14 added cost for this year, and it gets built into your model, you could end up being absolutely on, and your
15 calculations follow through, you could be a little less than right and it costs more, or it ends up saving
16 money. How would those three things trickle into the fee schedule for this year and then the subsequent
17 year? Is that sort of where you're going.

18 Dr. Grimm: Yes.

19 Dr. Senagore: Without giving us a class in Certified Public Accounting.

20 Mr. Clemons: Well, do you want me to go through my presentation or—OK. We develop an
21 estimate for the impact, based on various considerations. The comparison that we do, as I was going to say
22 at the beginning, is what Medicare looks like with this legislation, as compared to what Medicare looks like
23 without this legislation. So that's the net impact. And that is looked at then as a factor to build into
24 whatever the appropriate part is. In this case, if it's for the Physician Fee Schedule, we, and it only impacts
25 that, we look at spending relative to the Physician Fee Schedule baseline, and we can build that in,
26 depending on the magnitude as factored to bump up or bump down our estimate of spending, going
27 forward. Then of course, there's the whole Sustainable Growth Rate system that needs to be built into on
28 top of that. So it affects the update based on the factor 4 in the SGR. Am I...

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1 Dr. Senagore: So you make a projection for a given year, this year, let's say. And now it ends up
2 actually being more expensive than the projections turned out to be based on actual experience. How does
3 that get folded back into your model then for the subsequent years, and I think where Dr. Grimm is going,
4 and then what pound of flesh is exacted within the system for that reallocation.

5 Mr. Clemens: Sure, there's of course, a two-year look back for the physician SGR, and as we can
6 and as we're able, we can compare actual versus estimated. And if they differ, we make adjustments to our
7 estimates and build that in, and factor four would change, and what we build into our baseline would
8 change.

9 Dr. Senagore: Did that clarify things, Dr. Grimm? Sort of? Sorta kinda? Dr. Powers had a
10 question?

11 Dr. Powers: Are you saying that in a way, are you saying that if there is an increase in utilization
12 expected or actual, because of some legislation that says we have to start doing something like the
13 colonoscopies, that that will increase the amount that's given to the contractor? Automatically? That
14 you've got a way to figure that in? If there's an NCD that says you need to do this many extra tests that for
15 the contract that that gets, that they wind up in the end getting more money because of that?

16 Mr. Clemens: I guess I think of it in terms of the, I guess it's a yes, in the long range. But it gets
17 complicated by this whole SGR that we're working with. Both the, there's the target versus actual. The
18 target would be increased for the piece of legislation if the legislation was estimated increased spending,
19 and then we would think that the actual would reflect that as well. When we have actual and we can do the
20 comparison, then we can match those two up. And make sure the target and the actual increase both get the
21 allowance for this legislation.

22 Mr. Shatto: Just, I guess as a way of a little bit of background, the payment rates for the physicians
23 each year are set on this SGR system as you've probably heard about and it's an actual versus target kind of
24 system, and right now, as you probably know, the actual spending is way about the target, so there's a lot of
25 projected cuts under the SGR system, going forward. Now what this does is if there's a new piece of
26 legislation enacted, and it costs \$200,000,000, we will add \$200,000,000 to the target, because we think
27 \$200,000,000 will be added to actual spending because of the legislation. So even though the actual may
28 be way up here, versus the target, and we had this new piece of legislation that moves the actual up to here,

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1 we're going to move the target up with it. And now of course as Dr. Grimm had mentioned earlier, when
2 does this affect payments? Of course because of the SGR system, with the several negative updates in the
3 near future, it's really not going to affect payments until several years down the road.

4 Dr. Senagore: Maybe a question that's on other folks' mind. So obviously this all gets sorted out
5 ultimately under the prism of the SGR, so if we play that out is there a role that you play in the Actuary
6 Office to allow both the physicians and CMS to understand the implications downstream of those
7 decisions, based on what might change in volume and/or pricing? Does that, is that part of your feedback
8 response to both practicing physicians as well as to CMS?

9 Mr. Clemens: When there is a particular legislation, yes, we provide a scoring and that scoring is
10 in the world of the SGR and how that plays through.

11 Dr. Senagore: So the report, I guess, since our role is to represent practicing physicians, what is
12 the vehicle that we hear that information when there may be downstream changes that might be two or
13 three years out? Is there an education process or a process to allow us to determine appropriate behavioral
14 changes that might be required to lessen the negative impact of those changes?

15 Mr. Shatto: We actually publish information on this twice a year. The *Federal Register* notice
16 that comes out in early November has not only what the payment update will be for the next year, but it
17 also does a lot of calculations on what the target level of spending is going to be. And included in that
18 target level of spending is the amount that we estimated for legislative changes as Ken mentioned earlier,
19 there are four factors of the SGR, and that fourth factor is changes in laws and regulations. And so when
20 we put out the Final Rule in November, it will say specifically for factor four, we built in this amount for
21 these provisions, and so that will come out as part of the Final Rule. Also along with that, we put
22 additional information on the website that under the Actuarial page that details what the spending has
23 looked like so far, what the target looks like, and a lot of additional calculations and numbers and
24 spreadsheets and that kind of thing. And we also do that in March as sort of a look forward to what's going
25 to happen the next year. We have the payment preview, and I'm sure most of you have heard about that.
26 But in March, like this past March, we came out and said, this is what we think the update for next year is
27 going to be, based on all this information and we put it all in the website document.

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1 Dr. Senagore: I'm trying the lead the witness for the benefit of the panel, but yes, is there a similar
2 comment opportunity for your reports that you do, twice a year, or no? I'm just trying to help the panel
3 understand how they might be able to interface with these calculations and what would be the appropriate
4 venue for us to revisit this as a panel over the next couple of years?

5 Mr. Shatto: I'm not sure that there's a comment period for either of those. I mean, essentially
6 what we're doing is we're taking the formula that's in the law, doing the calculations, and making that
7 available publicly. I know the Proposed Rule comes out in the summertime in which I'm not sure how
8 much is in there in terms in what the update's going to be for next year. I mean I know there's some on the
9 Medicare Economic Index. And that would be the time, I guess, to provide comment.

10 Dr. Senagore: Yes, I guess that's where I'm going, this is kind of an is what it is report, so if this
11 panel over subsequent years would like to revisit this topic, I think there would be an opportunity hopefully
12 to ask CMS to have this be maybe a recurring agenda item, particularly when there's new decisions made
13 in terms of coverage benefits.

14 Dr. Grimm: I think that your point being that if this is raised in the target, in relationship to the
15 actuals, it is a very important issue for all of us because we're concerned about legislative issues that are
16 being, we're asked to do—and if that target's increasing, proportionate, then that's good for this whole
17 process. But what we're interested in is how you do that. How this goes from a legislative decision to
18 actually get manifested out to how much money is being spent from this decision and how that affects the
19 target. Because obviously that decreases the difference in the sustainable growth rate and the percentage
20 that we're all being asked to, is going to be cut of 5.1%, it cuts into that.

21 Mr. Shatto: And I think Kent's presentation gives a general over view of that, so if this would be a
22 good time.

23 Dr. Senagore: I think it would be a good time to lead into that and then we can circle back and see
24 if we have any other questions of the panel.

25 Mr. Clemons: As John was saying, I have a general overview. A few introductory comments.
26 The estimates that we do are intended to be what we called "best estimates." They're not intended to be
27 conservatively high or conservatively low. We're asked for a point estimate, our best estimate of what the
28 impact will be of any particular legislation. In addition, we look at the impact on Medicare spending, the

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1 total impact, not any of their impact or implications of the legislation. We're concerned with the spending
2 by Medicare. Then, as I mentioned before, and it's not too bad to repeat it. The way we measure the
3 impact is the impact on Medicare spending with the legislation, compared to what it would have been
4 without the legislation, what we estimated it would have been without the legislation. And that differences
5 the impact that we try to quantify. I just have a general slide here on things that we consider when we look
6 at developing our impacts. And of course, it's at a general level because it varies depending on the
7 legislation. First of course, we talk with folks in CMS who are familiar with the policy implications and
8 how things would be implemented. So those two things sort of go together. We want to make sure that
9 when we're developing our estimates, we understand what the legislation will do, any implementation
10 things we should be aware, try to get a very good understanding of what the legislation is intended to do,
11 and how it will go forward. Then, of course there are physicians who work at CMS, and we contact these
12 physicians to get advice from them, make sure that we are taking into account implications that maybe we
13 wouldn't have thought of. Then we also look for relevant research. There may have been papers that have
14 been published. We ask, of course, all the policy folks and the physicians if they're aware of anything that
15 we should be looking at that would aid our estimates of the impact and we do research ourselves to make
16 sure we're pulling together the most information we can. Then of course data, any relevant data that we
17 can look at whether it's enrollment or claims information or if it's a new benefit, it may be more difficult to
18 latch onto something that is relevant because it's new, but there may be something similar that had
19 happened in the past when something was added in terms of coverage, and we can see if we can get a feel
20 for that. And then of course, we end up with assumptions. That is based on all of the above, the advice
21 we've gotten, the data what the data looks like, and the research to develop these assumptions. Pulling
22 these together, we then can develop our estimate of the impact, depending on what the legislation is. These
23 are the things that we consider when we're looking at legislation in general. And again as I said, it varies
24 from piece of legislation to piece of legislation.

25 I also wanted to make this point, which we have been talking about. Here is a section of the law
26 that gives a two-year look back to how this is built in specifically to physician estimates. So we do our
27 estimate for a particular piece of legislation, and as there is actual spending data that comes through, we
28 compare what our estimate was to what the actual data says, if there is a difference, we can then make an

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1 adjustment to the target and of course it'll already be in the actual, to try to ensure that the target spending
2 moves appropriately. For some examples, there were new items built into our 2005 estimates. These three
3 items, the initial preventive exam, cardio vascular blood test IV screening test. We had estimated the
4 impact on the SGR of about a 0.2% increase, which is about \$180 million to give some scale, just for
5 background. CVO has similar estimates for these three. Now we have some preliminary actual data. We
6 don't have everything in, but data is starting to come in for 2005 and given the 2-year look back, we will be
7 evaluating that for this fall and it's showing that the spending on these services, 405, is less than what we
8 had estimated, so you know, if it varies substantially enough, then we can make a change in the look back
9 of how it's built in. This is a very general overview, but it gets into some of the things we've been talking
10 about, but I don't know if you have questions?

11 Dr. Senagore: Are there comments or questions from here?

12 Dr. O'Shea: You've got these three and I would say these are three visits, or three initial things.
13 They also take into account the follow-up that has to be done with them?

14 Mr. Clemens: We do include that in some of our assumptions to some extent. Now, I'm not aware
15 of I didn't see any papers or studies that show the impact of preventive on spending in the future. It could
16 go one direction or the other. We do do an initial saying, well there may be spending earlier, than what
17 would have otherwise occurred. So there is some adjustment in our assumptions for that.

18 Dr. Simon: I think to add to that, on some of the tests that have come up, if we know that is
19 currently in place, then some of the advice that we would provide to them to help assist in their
20 assumptions would be typically what number of office visits, for example, would occur after someone gets
21 a diagnostic test for diabetes, for example, and it's found that they are positive. What's the typical amount
22 of visits that would be required in order to make sure that that patient is stabilized, and what oral agents,
23 insulin what have you, and what level of office visit, so that it helps them in their assumptions in
24 determining the calculations.

25 Dr. Przyblski: I think what might be hard and where some of us might have less confidence, things
26 like colonoscopy screening, and you pick up a cancer, and now the management of that cancer, and if that
27 hadn't happened, would that cancer have never been picked up and therefore no spending would have
28 happened or would it have been picked up late and different treatments would have been instituted then at

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1 the beginning, and how do you—and it's obviously complicated—how do you try to sort all of this stuff out
2 for that kind of specific example?

3 Mr. Shatto: That's obviously the most difficult part. And that's true with any of the preventive
4 measures. It's if you institute these preventive measures and you find things sooner, it's probably going to
5 cause more spending sooner, but is there savings further down the road because you caught them sooner?
6 And it's one of those things that I know individuals have tried to look at it, but I don't think we've seen any
7 studies yet that say this is going to save money in the long run, or this is going to cost money in the long
8 run, so for the time being, you know, as Ken mentioned, there are certain things that we know are going to
9 occur, and so we have some additional add-ons because of that, but the sort of long term effects we haven't
10 quantified at this point.

11 Dr. Simon [inaudible] with the triple X screening benefit, by doing an ultrasound, detecting those
12 patients that have aneurysms, than if you're unable to detect it, what's the typical cost required if you repair
13 through an endovascular approach, versus repairing it through an open approach? And what's the typical
14 hospital stay versus post-op care, versus dealing with those patients that present with ruptured aneurysms,
15 where you know that the, that there's more spending on the front end in terms of emergency surgery, their
16 ICU stays are longer, their hospital stays are longer, and then the post-op course. Then we work with them
17 to help determine is there savings down the road? And if so, they attempt to quantify that to provide
18 information their assumptions again whether that particular benefit for example, since it's a new benefit,
19 would lead to cost savings, which we believe it will by being able to identify the aneurysm when they're,
20 when those patients are asymptomatic in a state where you can treat it electively, versus when you can treat
21 it emergently. And of course, talking with the actuaries about that, it becomes challenging because you
22 know the clinical aspects of it, but trying to make those projections can be difficult.

23 Dr. Przyblski: Does that imply that if there's at best estimate savings that there would be a
24 negative calculation? Meaning if you're expecting you're going to save money in the Medicare system that
25 rather than your .2% increase, it's a .2% decrease?

26 Mr. Shatto: Right. That's what would occur.

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1 Dr. Przyblski: Have you thought about using the Episode Grouper business, to sort of
2 prospectively look at you know, colonoscopy screening, the people that you identify with a positive test,
3 that you follow them out so that you can in 2, 3 years from now figure out how good your estimates are?

4 Dr. Senagore: There'd be no way to identify that that group was picked up purely on a screening, I
5 mean I don't think the data's that robust, to say this many screening colonoscopies yielded this many
6 positive results, yielded this many curative resections, etc.

7 Dr. Przyblski: Is it that the CPT-Code is the same for non-screening versus screening?

8 Dr. Senagore: No, yes, exact same CPT-Code. But the ICD-9 would distinguish if you did it only
9 for screening and it remained screening. But I think the downstream data calculation of how many of those
10 folks ended up with a colectomy, how many ended up with adgetted chemotherapy. All those things, I
11 think would be difficult to find.

12 Dr. Przyblski: But could you do it on CPT level 2, basis, sort of the Pay for Performance issue, do
13 you create a way to track that? Would this be a more accurate way of really finding out what those dollars
14 are, as opposed to best guess?

15 Dr. Simon: [off mike] [laughter]

16 Dr. Senagore: In theory you should be able to track anybody on their Social Security Number and
17 then see what the downstream codes were from then.

18 Dr. Simon: And it may be easier if and when ICD-10 evolves onto the clinical landscape. But I
19 think looking at where we are with ICD-9, it'd be very difficult at this point to be able to track.

20 Dr. Grimm: Just for clarity, once again, because we have constituents out there who will ask us
21 these issues. So this \$180 million that you described at .2%, this would then be added to the target,
22 correct? Am I correct on that? I just wanted to be sure that I understand it correctly. OK, great, thanks.

23 Dr. Ross: Well, going back to the same, I think this is really a paradigm shift. And I think we've
24 discussed prevention before intervention, a number of times before, not just for the patient's benefit, but for
25 Medicare and the savings benefit for the next 10 to 20 years. If there's an opportunity to really track the
26 benefits of prevention before intervention, I think it behooves all of us to look at that, not only from a
27 physician standpoint to prevent catastrophe later on and increased costs whether it's hospitalization or
28 morbidity, or mortality, but rather to save finances in the long run, in the next 10 or 20 years. I think it

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1 behooves us to really start to look and track the numbers so that we can become more effective in our
2 treatment plan and at the same time give our patients the benefit of better care and savings all at the same
3 time. Really trying to focus on the prevention, whether it's the diabetic, the diabetic screening is one thing.
4 The heart screening is another thing. The obesity screening and the general physical health screening is
5 another thing, but these other areas, such as cancer, potential for breakdown of diabetic ulcers,
6 cardiovascular disease entities, orthopedic injuries, these are all things that we can prevent in the early
7 stages before they manifest and become very costly in the final analysis.

8 Dr. Sprang: Just along the same lines and that is saying for colonoscopy for example, I'll use bone
9 densities and DEXA Scans for Medicare patients. If you pick something up earlier, put it on appropriate
10 treatment and, if you pick up earlier, osteoporosis, osteopenia, treat them, and then subsequently prevent
11 the hip fracture, you're not only saving significant dollars from both the treatment and obviously
12 subsequent morbidity and mortality. But they do at least often in some of the studies, when you don't have
13 the solid data now, and you may look at figures from 10 to 20 years just to try to come up with some
14 savings, instead of doing that, there are various computer programs that can just take, if you screen so many
15 people, find osteopenia, treat them, the chances of preventing so many hip fractures going forward 5, 10, 15
16 years can be just actuarially guessed at, and computer programs can give you projections going forward 5,
17 10, and 15 years later. It'll just make a lot better sense to kind of take some of that into account. And I'll
18 use the DEXA Scan example, because obviously when you get to the DURs and Congress passed a lot of,
19 would cover DEXA Scans because they thought it was good preventive medicine. Now, obviously they
20 passed a law that's covered. More DEXA Scans are being performed, and we hope and believe that's good
21 for our patients. But now we're going to get paid less for the DEXA Scans because more are being done, and
22 it's contradictory to what it initially started for. And maybe if we had some data on computer programs
23 saying what the potential savings were going forward, we wouldn't need to cut what we're paying for the
24 DEXA Scans, could continue to do them, and maybe prevent more fractures and ultimately actually save
25 money. So I just think some of the things that are happening are going step backwards. We think
26 something's a good idea, we use it more, we spend more money, and then we take it back by not paying as
27 much for it. If we had computer programs that actually showed future cost savings to Medicare, maybe
28 wouldn't need to do that.

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1 Dr. Senagore: Would the panel be interested in a recommendation to ask them to evaluate one of
2 these prior determinations that was made on the downstream impact? I don't think that Sweden
3 colonoscopy is the right one because if you find a cancer, the diagnosis actually flips to colon cancer, and a
4 biopsy, so you probably would never catch them based on the screening colonoscopy coding system, but
5 something like a Dexa Scan and how many folks in five years ended up with a hip fracture or something
6 like that? Would we like to make that recommendation to have them come back with an example?

7 Dr. Bufalino: [off mike] maybe a clean one, because it is preventing the early rupture, and you
8 could track people, track the number of ruptures that we have in the last five years, versus how many
9 ruptures you have going forward. The question I was going to ask is is the data robust enough to actually
10 answer a science question? Because I think that would be the concern, is if we're just going to—we'd all
11 like to know, frankly. Because I think, as you would like to know, do you think you're going to be able to
12 extract it well enough to be able to answer the science?

13 Dr. Simon: I'm not sure. I think the numbers are fairly small for ruptured aneurysms nationally.

14 Dr. Gustafson: If I could sort of weigh in here, for a moment, put my economist hat on. I think
15 you have to be, the question of preventive benefits and the scope of preventive benefits, in the Medicare
16 Program, has been a lively one for as long as I've been associated with the program. I had hair when I
17 started. So that's been quite a while. And there is a great deal of enthusiasm in certain quarters. No doubt
18 many of you are in touch with them, about expansion of preventive benefits in general for the population,
19 for the very good clinical reasons that we've been discussing here. You can prevent disease, you can treat
20 disease early, you can reduce suffering. You may or may not reduce cost as part of that, and that's where
21 my flinty hearted economist soul comes to light here. This is most evident in the case of a number of the
22 screening benefits. You pick up stuff earlier, probably, you may be replacing costs on a Medicare payment
23 stream that were already being borne in some other fashion, so it isn't necessarily that this thing was just
24 invented, but it's now being paid for under the Medicare payment stream, and it may not be that expensive
25 per test, but if you're doing a lot of them, you're winding up with a pretty big screening bill. You then
26 have to look at what fraction of individuals actually manifest the condition you're looking for, and what
27 you're able to save by treating them earlier. And that equation doesn't always look all that great. Part of
28 that is because we tend to have our beneficiaries for a comparatively short period of time by comparison to

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1 their entire lifetime, so the preventive tests that might make sense when people are in their early 40s, we
2 don't pay for because we're not there then. We're not part of their payment environment, and we may or
3 may not reap the benefits of their having had it at some later stage. But it sort of, you have a different
4 situation here looking at this than you way in Great Britain, where everybody's in roughly the same
5 systems, sort of womb to tomb. So I think the questions are very good ones. We're adding preventive
6 benefits, we the country, are adding preventive benefits to the Medicare Program, kind of one by one, as
7 the result of Congressional action. We don't have a general coverage standard that allows us to add stuff
8 just because we think it make sense, but the peculiarities of the law are such that they have to be added by
9 Congress as early so that's been the pattern up to now. And the question has been evident for years. Are
10 we sure that this makes sense? You add benefit A, next year, the lobbying groups get going and benefit B
11 is added, whether you operate with the very best information you have in making those kinds of decisions.
12 I mean, we and the Congress do that. But it's not always evident exactly what happens. So I think the
13 question of do they make sense, are we saving money are lively ones. You have to be careful in asking
14 them because you might not like the answer and coming back to our colleagues in the Office of the Actuary
15 here, the sorts of projects you're speaking about here are really research projects. I mean you're speaking
16 about scientific data, and actuaries do do actuarial research, but this may be an effort that would be aimed
17 at a different part of the agency or even some other agencies.

18 Dr. Senagore: Dr. Gustafson, I would go head to head with you on economics but I think that is
19 one of the conundrums of the SGR, that as you add these preventative benefits, they basically come out of a
20 pool of dollars aimed at disease management, in theory. I mean that's the negative impact, is on the actual
21 management of diseases, whereas the benefit would be on something else economic, like the GDP, five
22 maintained productivity, etc. of those individuals. So it's a much broader question I think than we're
23 probably prepared to answer today.

24 Dr. Gustafson: Just to build on that point for a moment, we have folks coming out of the present
25 with preventive benefit issues, and the question is will they save money or not? And it depends on whose
26 money you're looking at. So we can, sure I can point to examples where we could conclude it would be a
27 net cost to the Medicare Program for doing this. It doesn't mean it's not a good idea. I mean it may
28 improve quality of care, it may improve a whole bunch of things. But can you get away with saving

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1 money? Well perhaps not in the budgetary sense of what affects Medicare. If you look at the entire cost to
2 society of having individuals affected by a particular disease, you're looking at costs they bear out of
3 pocket, you're looking at lost work time, you're looking at transportation expenses, a whole bunch of stuff
4 you can add up. That might shift the equation. That may cause Congress to add it to us, to our program.
5 But the calculus gets to be a little intricate.

6 Dr. Ross: That's a very good point, that you said, Dr. Gustafson. And just to add to the
7 discussion if you will, just for a quick second, that is that our beneficiaries may be living longer, they may
8 be healthier if you will, due to prevention from the private sector for a longer period of time, so when they
9 do enter into the program, they instead of being womb to tomb, they may be a little bit later on down the
10 line, but they are healthier and so we now may have more of an impact upon their lives with this
11 prevention, when they start to get as entry into the beneficiary program, and living longer, we're talking
12 about a lot longer period of time during the course of their life to keep them healthier and to save the
13 system money. So rather than those figures that may have been 10, 20 years ago, we're looking at now, the
14 future of the next 10 to 20 years as longevity numbers increase, and as our patients now become healthier,
15 and as these baby boomers, if you will, we become more active in our senior years. That's a whole
16 different equation. And if we look at the statistics, and we look at those studies, that I think we should be
17 doing, we might see a different paradigm than we saw 20 years ago, economically.

18 Dr. Senagore: Was there an appetite from the panel to have an example be presented back to us?
19 Or maybe pick one that was instituted 2 or 3 years ago so at least you would have a better chance of
20 tracking the results.

21 Dr. Ross: I have one example that I'm doing right now that I've actually done my research on
22 that's not covered by Medicare. It's actually covered as an extended visit. And that's a gate analysis
23 machine where I can predict pressure analysis of my diabetic patients or my patients who potentially could
24 be at risk for breakdown, for ulceration. And we were just discussing this. How can that benefit my
25 patients and how can that save the program money in the long run? Well, if I can predict where a pressure
26 area will develop either into a potential breakdown, and I can create a custom insole, or shoe to prevent
27 amputation later on, or morbidity in the hospital and long term stay in infection and breakdown in osteo,
28 I'm saving the system a lot more money in the future. Well, we've done some initial analysis as to how

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1 this works—whether it’s an EKG, whether it’s an EEG or nerve conduction studies. Right now, it’s not
2 covered. But I would love to see some, I would love to conduct some data, scientific data to show what the
3 outcomes of this would be, and we’ve got the resources to do it. And that could show obviously one
4 example where prevention could save in the long run.

5 Dr. Senagore: I think that would be fine to see. I’m not sure that CMS could answer that question
6 because that’s not a covered benefit at this time, so if we were going to ask them to come back, we would
7 need something that had become a covered benefit with maybe 2 or 3 years of a track record to see how it
8 bore out with the calculation and then real world experience. Is that something that we would—

9 Dr. Bufalino: I think it’s worth taking a shot at, understanding that the equation is complicated, at
10 the very least. But at least to get a beginning look to understand it and whether it’s aneurysm or whether
11 it’s DEXA Scans, I mean at least give us some idea over the next year or two whether or not there’s
12 something there, and we might not like the answer, but that’s actually OK. I think we should find out.

13 Dr. Gustafson: We should rejoice in the answer, right? [laughter]

14 Dr. Powers: It would be great to see the actual numbers, because here we are, we’re sitting here
15 constantly concerned that we get these NCDs and so we have, we’re doing all these tests and great, we
16 think it might help the patients, but it’s reducing our benefits in a lot of ways because the tests are getting
17 done by someone else, and then overall we get reduced because it triggers the SGR, whatever, so it would
18 be good to see the actual numbers and where everything fits in to the SGR.

19 Dr. Senagore: Dr. Sprang, are we close to a recommendation?

20 Dr. Sprang: We’ll give this a fly, and I think it may actually have to be more of a computer model
21 of using their [unintelligible] which can actually be set up and obviously go forward, because it would take
22 a great deal of time to actually get the real data and decrease fractures. And I would just recommendation,
23 PPAC recommends that CMS consider performing a study to evaluate the potential cost savings of
24 preventive benefits, such as DEXA Scan, and decreasing future fractures, and the costs associated with them,
25 and if the real data isn’t there, certainly computer models can be set up on what data we have, and
26 projections for what it’s likely to do, and come back with some numbers that even actuaries may be
27 comfortable with.

28 Dr. Senagore: Can we get that read back for just a second?

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1 Ms. Trevas: PPAC recommends that CMS consider performing a study to evaluate the potential
2 costs savings of preventive benefits, such as DEXA Scanning and the resulting decrease in fractures.

3 Dr. Senagore: I would actually phrase it a different way and I would say, remember what year that
4 was implementing, 2 years ago, three years ago? Could we see that in the frame of that test, could we see it
5 in the framework of what the original calculation projected and then how that trailed through the last 2 or 3
6 years? I'm not sure exactly how to say that but, I don't know how big a job that would be.

7 Dr. Sprang: That would take some time to actually see the decrease in fractures.

8 Dr. Senagore: But we would answer your question, which is when utilization increased with
9 obvious benefits, how did the real world utilization of that test compare? It's probably too early to say
10 fracture rate, but you might be able to see how the projections bore out with real world access to the test.

11 Dr. Sprang: And potential for decreased fractures and cost savings, dollars.

12 Dr. Simon: One suggestion I would have for the Council just to consider, is that perhaps that may
13 be something to ask the actuaries to come back at our February meeting. We're about to embark upon the
14 Final Rules right now, so there's a flurry of activity. And I think in order to be fair, in order to get a good
15 answer—

16 [chat]

17 Dr. Senagore: ...to be an agenda item? And we'll withdraw the recommendation. Is everybody
18 OK with that? Good. Any other questions?

19 Dr. Grimm: Solomon, you described several different method tests that going on 2004, 2005,
20 2006, and how this, the payment rates were established and they've changed, now based on these
21 benchmarks. These new benchmarks that you've mentioned earlier in 2004 that some of them were related
22 to the location in terms of population. Are those still in place?

23 Mr. Mussey: They're sort of in place in 2004, I believe you're talking about the minimum amount.

24 Dr. Grimm: Right.

25 Mr. Mussey: OK. When that was established in 2004, they were whatever it was, but then going
26 forward, everything changed to the minimum percentage update. So that would be applied to the prior
27 year's rate. So in a sense, we still have the—

28 Dr. Przybelski: The whole country, then, not just that county or whatever it was.

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1 Mr. Mussey: Well it's done for every county, but there are maybe 50% of the counties in the
2 country are at one of the two floor amounts. OK. And even though we explicitly don't call it a floor
3 payment rate any longer, because in 2005, there were only two options, either a Fee-for-Service or a
4 minimum percentage increase, that minimum percentage increase in 2005 was applied to a floor amount in
5 many counties in 2004. So we still have a lot of county rates that are the same number in 2005 and 2006.

6 Dr. Przyblski: But they're still different though. These counties rates are different. That's one of
7 the things I'm trying to establish. That those still are in place.

8 Mr. Mussey: Yes.

9 Dr. Grimm: The county rates.

10 Mr. Mussey: The county rates still vary.

11 Dr. Grimm: OK, all right. That's what I wanted to know.

12 Dr. Senagore: Anything else?

13 Dr. Urata: Is it possible to see what these [excess?] utilization rates and all that, how it has affected
14 the SGR as well?

15 Dr. Senagore: I think that was kind of the discussion that we would want for the agenda in
16 February. Any other comments or questions. Great. Thank you, gentlemen. Now that we're fully trained
17 actuaries [laughter] our next topic will be presented by another panel. Mr. John Warren is the Acting
18 Director for the Division of Practitioner Services in the Center for Medicare Management. John and his
19 staff are responsible for overseeing regulations, policies instructions related to physician and non physician
20 practitioners. Mr. Warren is joined by Dr. Edith Hambrick, Medical Officer in the Center for Medicare
21 Management. And they will present the topics related to the five-year review, changes in the Physician Fee
22 Schedule, and practice expense, and explain the proposed policy changes in the various outpatient settings.
23 And in addition, I believe they're going to talk about the DRA-driven payment policy regarding imaging
24 services. Welcome.

25 Mr. Warren: Thank you very much. Ladies and gentlemen thank you very much for inviting us to
26 speak with you about some very important regulatory issues with regards to the Physician Fee Schedule
27 this morning. To put this discussion into perspective, I'd like to point out that the Physician Fee Schedule,
28 under the Physician Fee Schedule approximately a million physicians and nonphysician practitioners

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1 receive payment for 7,000 different services that are provided in physician offices, hospitals, and other
2 settings. The Physician Fee Schedule was established in 1992, and replaced the existing Reasonable
3 Charge methodology. Section 1848(b) of the Social Security Act authorized the use of the fee schedule for
4 these physician services. Section 1848 contains three basic elements. The first of course is the
5 establishment of the Physician Fee Schedule for physician services. It also establishes the sustainable
6 growth rate and establishes limited charge provisions. Furthermore, that section requires relative value
7 units be established for the work, practice expense and malpractice portions of the payments made under
8 the fee schedules, and requires, as any adjustments made to those RVUs to be budget neutral. And that
9 means those changes must be less than \$20 million. Furthermore, it requires the RVUs to be reviewed
10 every 5 years.

11 The first issue I'd like to speak about is the 5-year review of work at CMS 1512 PM. And this is a
12 proposed notice that appeared in the *Federal Register* on 29 June of 2006. Of course this Proposed Rule
13 has a 60-day notice and comment period and it will be finalized in a consolidated Final Medicare Physician
14 Fee Schedule Rule that we will publish this November. CMS 1512 PM the 5-year review, sets forth 2 and
15 only 2 issues. The first of the results of this 5-year review of work. The second issue is proposed changed
16 to the methodology used to calculate practice expense. There are no other provision in this particular rule.
17 The law requires that we do this review, and this is our 3rd 5-year review. It's important to note that we did
18 not review malpractice RVUs, nor did we review the practice expense RVUs, only the work RVUs. The
19 reason we did that is because practice expense and the malpractice RVUs undergo constant refinement, and
20 we felt that additional review was unwarranted. As you all know, work is the accounting of the time that it
21 takes to perform a given procedure and the intensity that's involved in performing that procedures. The
22 work portion of the Physician Fee Schedule payments accounts for half of the payments made under the
23 schedule, or about \$35 billion in Medicare expenditures. When making revisions to work RVUs, we look
24 to the AMA's Relative Value Update Committee to make recommendation. Of course the RUC process is
25 a multi-specialty society, a multi-specialty process that allows for the vetting of codes that may be
26 incorrectly priced. This year 700 codes went to the RUC. Of those 700, 136 were subsequently referred to
27 CPT for coding updates. 151 proposals were withdrawn, and 413 proposals were reviewed by the RUC and
28 recommendations submitted to CMS. We accepted 299 of the RUC's recommendations as the

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1 recommendations stood. We rejected 123 of their recommendations and of those, we increased three codes
2 above what the RUC recommended, we maintained 48 codes at their current level, and 72 received
3 increases but less than that recommended by the RUC. This 5-year review resulted in some significant
4 changes to the payments made for the time that physicians use to care for their patients. Some of the
5 largest revisions ever proposed to the E&M-Codes resulted from this year's review. For instance, Code
6 99213, an average level physician code, receives an increase of 37%. As you know, E&Ms are in the top
7 10 most frequently billed services, so we have some pretty substantial increases as a result of this year's
8 review. Now as I mentioned, work RVU changes must be budget neutral. That is in the law. And
9 unadjusted increases resulting from this year's review equate to about \$4 billion and that's more than the
10 \$20 million that's allowed under the law so we're proposing a 10% adjustment be made to all of the work
11 RVUs. It's important to note that this is not an actual change to the RVU value, but it's built into the
12 calculation that goes along with that, and we did that so that private payers would not be adversely affected
13 by the decreases that we make. And that 10% is designed to make the update budget neutral. The second
14 part of the 5-year review rule is updates to the practice expense methodology. As you know practice
15 expense accounts for those costs that go into running an office. Direct costs, those costs that can be directly
16 attributed to the provision of a particular procedure, and indirect costs, those things like the heat, the light,
17 the electricity that you can't account for directly to a procedure but nonetheless are important in running an
18 office. Practice expense results in about 45% of the payments made under the Physician Fee Schedule or
19 about \$30 billion. We recognize that we wanted to create a better mousetrap, or a better methodology for
20 calculating practice expense. We wanted a process that made sense, that was reliable, and that was
21 accurate. We held a town hall meeting in February to gather ideas, and listen to concerns from impacted
22 stakeholders. What we learned as a result of that town hall meeting in February, was our proposed bottom-
23 up methodology. This methodology essentially uses procedure level data to calculate direct cost level
24 inputs and for indirects it will use surveys done by specialty societies and 8 of those were submitted, or a
25 calculation based on the direct cost inputs for a particular procedures. Furthermore, the bottom-up
26 methodology eliminates the zero work [fold?] that had traditionally accounted for those procedures that had
27 no physician work and were treated separately. Under our propose, zero work procedures are treated the

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1 same as procedures that had physician work. And we also proposed a 4-year phase in of this new
2 methodology, the first year being 25%, year two, 50, year three 75%, and full implementation after 4 years.

3 The second regulatory issue that I'd like to talk to you about today is CMS 1321P and this is the
4 update to the 2007 Physician Fee Schedule. This rule has 4 aspects to it, 4 portions to it, if you will. The
5 first being the annual update to the fee schedule. The second are a number of DRA policy
6 implementations, the third are several other discretionary part B policy changes, and finally discussion
7 items, not so much proposals, but issues we wanted to put out for discussion and comment. In this rule, we
8 are proposing this year to adopt the AMA's PERC recommendations to include supplies for a number of
9 90-day global procedures. Previously, these procedures had no supplies accounted into their payments.
10 We're proposing to change that this year. Furthermore, under the fee schedule, we're proposing to
11 continue to pay separately for splint and cast supplies using Q-Codes as they are currently billed, and
12 allowing billing by CPT-Code for the application of those supplies, and we're also including work relative
13 value units for medical nutrition therapy services in our proposal. You heard the actuaries talk before about
14 the calculations that go into the various payment amounts. This is an important aspect of this year's rule.
15 We know that the Physician Fee Schedule is updated based on the sustainable growth rate formula. We
16 also know that the sustainable growth rate, the SGR, is based in part of medical inflation, using the
17 Medicare economic index, as a proxy. The MEI is adjusted for productivity, using methodology and data
18 collected by the Bureau of Labor Statistics. The Bureau of Labor Statistics has recently changed their
19 methodology and gathered new data for the past 2 years, which result in a decreased MEI of .6% from what
20 it was originally targeted to be, which translates into a decrease in the fee schedule conversion factor of
21 negative 5.1%. The DRA implemented a number of preventative policy changes that we're implementing
22 through this proposal. The first is coverage for ultrasound screening for abdominal aortic aneurysm. This
23 is a new benefit that's included in the Welcome to Medicare exam. It's available to male beneficiaries, age
24 65 to 75, who exhibit certain risk factors, including a family history of abdominal aortic aneurysms or who
25 have smoked more than 100 cigarettes in their lifetime. This is a one-time benefit. So once the beneficiary
26 receives the screening, it cannot be performed again. Furthermore, we're proposing to exempt from
27 application of the Part B deductible, colorectal screening tests, and we're adding Diabetes self-management
28 training and medical nutrition therapy to the Federally Qualified Health Centers Program. It's important to

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1 note that that last bullet is actually a conforming change, as Diabetes self-management training has been a
2 statutory part of those programs for several years. Another DRA-related policy change that's implemented
3 through this regulation are changes to the payments that Medicare makes for imaging. And we have two
4 provisions that intersect in this regulation. The first, if you'll recall in last year's Physician Fee Schedule
5 rule, we proposed a 50% reduction on the technical component of certain imaging procedures phased in
6 over a 2-year period; 25% in 2006, and the full 50% in 2007. Furthermore, in last year's rule, we asked for
7 comments from the public on whether 50% was the right reduction to make and we received a number of
8 comments from a number of different organizations, suggesting that 50% was too great of a cut. What
9 we're proposing to do this year is to maintain the current 25% reduction on that technical component of
10 multiple imaging procedures, when they're performed on contiguous body parts in the same session. We
11 will not be implementing the additional 25% reduction as we proposed last year. The second imaging
12 provision that intersects in this rule, is the provision to cap payment on most imaging procedures at the
13 outpatient level. You can see these two provisions will have quite an impact on one another. What we are
14 proposing to do to implement the two provisions together, is to calculate the 25% reduction on the
15 subsequent payment amounts, and compare that amount to the OPPS amount for that same procedure, and
16 essentially pay the lesser of the two amounts. This is the more liberal way to interpret those two
17 provisions. Finally on DRA aspects in the rule, we provided discussion of outpatient therapy caps. We
18 provide a brief discussion of those caps, how they will go back into effect January 1, 2007, and that the
19 amount of those caps will be \$1,740 updated by the Medicare Economic Index. We provide a brief
20 discussion of the exceptions process that's been in place since early this year, that was mandated by the
21 DRA and we indicate that that process expires for services provided after December 31 of this year. We
22 finally provide direction to readers of the regulation for more information on both of those topics.

23 Some of the discretionary Part B policy changes that are in this year's rule that may be of interest
24 to the Council. The first is the establishment of supplier standards for independent diagnostic test facilities.
25 This rule establishes 14 supplier standards that are loosely modeled on the standards that exist for DME
26 suppliers and which must be met prior to an entity being enrolled as an IDTF, and must be maintained to
27 avoid having that entity's billing privileges revoked. We think this will go a long way to improving quality
28 and accuracy and the testing provided through IDTFs. This rule also includes a number of technical

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1 refinements for the ways manufacturers must calculate and report ASP for Part B covered drugs. We
2 discussed the treatment of service fees, bundled price concessions and nominal sales in that calculation.
3 Although it's not a part of this rule, I'd like to note that we recently published an additional rule that
4 modifies the definition of unit for ASP purposes and clarifies how sales under the Competitive Acquisition
5 Program for Part B drugs should be excluded from those ASP calculations. We further indicate that since
6 consumer price index data for the previous 12 months ending in June is not yet available, we'll be unable to
7 update the 2007 clotting factor furnishing fee until the final Physician Fee Schedule rule in November.
8 And lastly, in this ASP changes, we propose to maintain the 5% threshold for wamp and amp, that is the
9 threshold at which the Secretary can disregard ASP pricing for drugs, when the ASP price exceeds those
10 levels calculated by the OIG. We're soliciting comments on the operational issues associated with
11 implementing that particular provision, and look forward to hearing from the public on that.

12 We're also proposing some changes to ESRD calculations. Specifically the method that's used to
13 calculate the drug add-on adjustment, and we've proposed updates to the wage index adjustment, using the
14 most recent hospital data. We've closed a number of modifications in the rule that we feel better regulate
15 the use of pod labs. These small labs will now under our proposal need to meet minimum staffing and
16 square footage requirements in order to be used to provide Medicare covered testing services. Our rule will
17 also allow dieticians and other nutrition professionals the opportunity to opt out of the Medicare Program
18 and allow them to enter into private contracts for Medicare coverage services. We further clarify that we
19 will only pay hospitals for the technical component of lab services that are provided to hospital inpatients,
20 thus eliminating the possibility of potentially duplicate payments for these services. We outline the process
21 used to calculate pricing for new diagnostic lab tests, while we've been following a public process and
22 soliciting public input on new prices, the MMA requires us to codify this in regulation and we're using this
23 rule to do so. And last but not least, we further solicit comments on the feasibility of including the National
24 Board on Certification of Hospice and Palliative Care Nurses to the list of National Certifying Bodies for
25 Advanced Practice Nurses and we solicit comments on criteria that can be used in the future to add
26 additional organizations to that list.

27 The discussion items that I mentioned previously, again, these are not formal proposals in that
28 they're not proposing policy changes, but they're putting ideas out for discussion. The first is the

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1 expiration of the MMA mandated GYPSY floor. This expires at the end of this year. We wanted to put
2 notice out that that is going to be the case. We have a discussion of the chiropractic demonstration that
3 allows chiropractors to bill for certain E&M and other non-chiropractic codes. And we discuss our health
4 information and transparency efforts as well. The comment period for the 5-year review rule ended August
5 21, 2006, so my staff has quite a bit of work in front of them to go through the comments that they have
6 received, make sure that we create a good Final Rule and in addition, comments on the Physician Fee
7 Schedule Rule are due to CMS by 5 pm, October 10th of 2006. So we've got lots of hard thinking to do to
8 finalize both of these rules in a timely manner. Now because both of these rules have quite a range of
9 issues involved in them on the slides, I've provided contact names for the main issues that are in the rule. I
10 won't bother to read them to you. I'm sure you have the slides and you have that contact information there.
11 So at this point, I'd like to open up and see if the Council has any questions.

12 Dr. Senagore: Any comments or questions?

13 Dr. Przyblski: Let me start out with a comment that you made about the 10% adjustment to the
14 work RVU. I guess I'm not quite understanding. You say that that happens in some calculation, but the
15 work RVUs actually don't change. I guess then I can't figure out how, when you add the work RVU
16 practice expense RVU, PLI RVU to come up with total RVU times the conversion factor, that has to add up
17 to a smaller amount. How does that happen without changing the conversion factor?

18 Mr. Warren: In a nutshell, what we've done is instead of taking, let's say a conversion factor
19 who's, or an RVU that's 1.0 for math purposes. Instead of saying well, now that RVU is not 1.0, it's .9 and
20 having that RVU roll out sort of through private payers, and so on and so forth, we say in our calculation,
21 the RVU remains 1, but then reduce it by 10% and then put that number in the calculation.

22 Dr. Przyblski: So the published work RVU is the same. The total RVU published is the same, but
23 your calculation comes out with a 10% less number.

24 Mr. Warren: If I understand what you're saying, yes. [laughter] I have to admit my experts on
25 calculating these numbers are not with me today, so I'm in a bit of disadvantage at answering your question
26 in detail, but that is how I understand it to work.

27 Mr. Kuhn: But you're correct and that's the way it plays out. And the notion was to make sure
28 that manage the budget neutrality in a way we thought, you know, reflected everything on the work, but

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1 also to preserve the fee schedule, so that as it went out to the private payers, we didn't want to diminish that
2 in any way shape or form.

3 Dr. Przyblski: That's certainly I think what the physician community would want, but I don't
4 know how that does not create the reduction in the conversion factor. Because what's published is the
5 same total RVU for the physician service. The only way that comes into a dollar amount is multiplying it
6 by conversion factor. So to pay for the \$4 billion, there's got to be a 10% reduction in the conversion
7 factor, as I see the equation. Unless I'm confused.

8 Dr. Senagore: Actually I think it's a little different. There's actually now functionally two
9 conversion factors. So the question would be in the conversion factor on the work also exposed to the
10 overall reduction in the conversion factor, the old-fashioned conversion factor? If you're decreasing by,
11 pick a number, 10% on the work units, but you're keeping the RVUs the same, functionally you've
12 introduced a monetary conversion factor to that component of the RVUs or am I misunderstanding the
13 allocation?

14 Mr. Warren: No, I don't think you're misunderstanding the allocation at all. I think that's
15 exactly—those are not the words that we've used in Baltimore, but yes, I think that's essentially what
16 happens.

17 Dr. Powers: And in general, we understand the intent of trying to preserve our standing of our
18 RVUs, so with the insurance companies but when we actually look at the numbers with the 10% reduction,
19 compared to what it would be with the change in the conversion factor, it defeats with the 10% reduction, it
20 sort of defeats the purpose of trying to boost up the RVUs for evaluation and management services, and so
21 therefore, I have a recommendation. That PPAC recommends that CMS use adjustments to the conversion
22 factor instead of the 10% work value adjustor to maintain budget neutrality.

23 [second]

24 Dr. Senagore: Do we need to read that back?

25 Ms. Trevas: PPAC recommends that CMS adjust the conversion factor instead of the 10% work
26 value adjustment to maintain budget neutrality.

27 Dr. Senagore: Is there a second? OK. Discussion.

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1 Dr. Urata: So then when the privates get this RVUs, it'll be 10% lower than it currently is, is that
2 what you're doing?

3 Dr. Senagore: No.

4 Dr. Urata: It'll still be the same?

5 Dr. Hambrick: So instead of having conversion factor of \$37 per your—it would have a
6 conversion factor of \$34. That's what you would prefer to see?

7 Dr. Senagore: Right.

8 Dr. Grimm: Using a conversion factor in our specialty, versus a work percentage decrease does
9 affect us because some of our codes are combined with our technical components, so overall, it's a negative
10 to use the total decrease in the conversion factor. So we're somewhat opposed to that idea.

11 Dr. Powers: It works that way for, that is true obviously for some of the services, but I think where
12 I'm coming from is the intent was to change the RVUs was to boost the evaluation and management
13 services and we don't want to defeat that.

14 Dr. Przyblski: As I see it, the purpose of the conversion factor as it was developed, was to
15 distribute these costs among all of medicine, and I'm uncomfortable hiding these changes in some
16 calculation that doesn't clearly show to the public that what is happening is the dollar amount that we are
17 willing to spend for physician services is going down every year for the next 8 years or whatever's
18 currently being calculated. So I would strongly support the recommendation.

19 Dr. Grimm: Again, I'm opposed to the recommendation.

20 Dr. Sprang: I would strongly support the recommendation as well, and I'll give a series of
21 different ideas and things that have happened in the past. From 1993 to '95, CMS achieved a budget
22 neutrality by uniformly reducing the work relative values, which is what they're suggesting now. These
23 adjustments to the work relative values caused confusion among many non Medicare payers and physician
24 practices as well. In 1997, following a 5-year review, CMS modified the approach, budget neutrality and
25 implemented a separate work adjustor. In '99 they went on to use a conversion factor. And in fact, when
26 they look back at their own data of doing it the other way before, they said we did that find that work
27 adjustment to be desirable and actually the conversion factor was more appropriate and more desirable.
28 Adjusting for the conversion factor does not affect relativity of services reflected in recommended RVUs

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1 and it has less ability to confuse third party payers. Adjustment of the Medicare conversion factor is
2 preferable because it has less impact on the payers. It's also more clear as it is related to monetary costs,
3 which is what this really all about, is conversion factors are directly related to the money aspects of it. By
4 doing it with a conversion factor change, it's also I think easy more transparent for everybody to recognize
5 what is going on and in addition, to apply the budget neutrality to the conversion factor rather than to the
6 work adjustor is critical in light of the imaging costs mandated by the Deficit Reduction Act. It will have a
7 different effect because of the work component in those. It also further enhances the additions or the
8 E&M-Codes it's the conversion factor rather than a work adjustor. So it's multiple, multiple reasons in
9 history, I'll say, that would seem to make better sense. And CMS has said in the past that it makes better
10 sense to use the changes in the conversion factor. So I'd strongly support the recommendation on the table.

11 Dr. Ouzounian: I'm in favor of the recommendation on the table, but maybe there should be two
12 multipliers—one should be for physician work, and one should be for practice expense. Because I believe
13 that we're trying to make the adjustment for the physician work component. Am I incorrect in translating
14 to that? Because if you change the conversion factor to make up for the entire deficit, you're penalizing
15 your practice expense also.

16 Dr. Grimm: That's exactly my point.

17 Dr. Ouzounian: And that would protect his interest.

18 Dr. Grimm: That's exactly my point that it is differentially penalizing a proportion of this and not,
19 and the purpose of this is to effect the work effort, not the whole expenditure of efforts on the technical
20 side. That's the problem with this.

21 Dr. Williams: From a different angle, can you tell me how the intensity of work is calculated in
22 the value of the work?

23 Dr. Hambrick: In the proposal or in the usual sense?

24 Dr. Williams: Just in the usual sense. For instance, an office visit might be, the intensity might be
25 .03 to .09 as I understand it. A surgeon's intensity for doing a general surgical procedure might be .07 to
26 .09, but for an anesthesiologist to do a carotid endarterectomy, which involves operating on a high risk
27 patient that's at risk for myocardial infarction and stroke, using an arteriole line and vasoactive medication,

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1 that intensity is less than an office visit. So I just want to understand how is the intensity in this whole
2 work definition defined?

3 Dr. Hambrick: I should ask Greg to answer this question [laughter] but I'll take a stab, but I'm
4 sure he'll correct me when I stray. I would say that the intensity has been calculated in a number of ways
5 and determined in a number of ways by the RUC value update committee. We don't determine the
6 intensity. We receive that information from the RUC. So let me just run down several, and Dr. Simon I'm
7 sure will jump, several ways that I've seen it determined. One is by survey. And they ask physicians to
8 rank the intensity of this procedure with other procedures, and then that way they come up with a ranking
9 of intensity. The way that you seem to be talking about it is the IWPUT, which is inter-work per unit time,
10 which is a calculation that falls out of the RUC process. And in the calculation is purely driven by
11 numbers. How much pre-service work and intensity, how much post-service work and intensity, and they
12 take those factors into account first, and then derive the IWPUT. Another way that has been used to do it is
13 they've asked, now in this particular rule and recommendations to us, have the use of large data bases,
14 which have accounted for the intensity in different ways. By that I mean they might talk about the level
15 intensity of the hospital visits, or outpatient visits, that were associated with that. But implicit in your
16 question was actually talking about, I think, the IWPUT methodology, which is strictly a calculation that
17 falls out of the RUC process and how they assess those values. Greg or Ken, did you want to say anything?

18 Dr. Simon: I would say that the intensity for procedures are reviewed such that one looks at all
19 different organ systems where you find like intensities of services across different systems, so if we're
20 looking at a neurosurgical procedure, that's a someone from neurosurgery has to present it, you would find
21 during the RUC process and deliberation, one would find a procedure that may be orthopedic in nature or
22 general surgery in nature, that would have similar intensity of physician work with time that would be
23 linked to a similar RVU, and ultimately payment value, since the work load involves a different organ
24 system, essentially requires the same effort in order to accomplish it. One of the things that's unique to
25 anesthesia is that it has a separate payment system, which members of the RUC have for some time,
26 struggled to equate the payment methodology for anesthesia to the payment system that's used for all the
27 other medical specialties and of course, you know I think it would be fair to say, and of course Dr.
28 Senagore and Dr. Przyblski can speak, the RUC has asked the anesthesia community to consider looking at

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1 using the methodology that's used for all the other specialties, with the intent of making easier to compare
2 anesthesia services to all other services and I'm not sure that there's been a great deal of enthusiasm from
3 the anesthesia community at this juncture to fall into ranks if you will and come under the same payment
4 methodology as it currently exists for all of the specialties.

5 Dr. Bufalino: Help me because I'm now confused. I heard what Laura said, but I guess I don't
6 understand why we would effect, and Tye's point to me, makes some logical sense here. Why are we
7 putting a conversion factor, now \$34 instead of \$37 against the 45% work practice expenses, if instead,
8 what I heard them say is we just have a new conversion factor. Is that, we're just going to take the relative
9 work units and multiply them times .9, effect that only, not publish a new work value set of numbers on the
10 street, which is going to affect the rest of the payers. But that just internally is going to be a now double
11 conversion factor, .9 times work RVUs and then the usual conversion factor. So tell me why that's a
12 problem, I guess I'm not understanding.

13 Dr. Przyblski: So if I'm in the public and I see no change in the conversion factor, then I perceive
14 that physician payment has stayed the same, when in fact it has not.

15 Dr. Bufalino: You're assuming that the public cares about whether or not your payments went
16 down.

17 Dr. Przyblski: Public in general, I think some people in the public, and I consider myself in the
18 public, as well as in medicine, do pay attention to the conversion factor and what's happening. The other
19 problem I have as putting it with the work alone is that PLI calculations of which neurosurgery, among
20 other specialties are very sensitive to are affected by the work, if I'm not mistaken. That that has some
21 influence on the level of PLI payment. So if that's the case, then I get a double hit in our specialty,
22 emergency medicine, OB/GYN, etc.

23 Dr. Bufalino: I didn't understand that. I thought the conversion factor was going to be times all
24 three things, so if we affect the conversion factor we lower the malpractice coverage.

25 Dr. Przyblski: We lower everything, but the intent is to make it very transparent. There's \$4
26 billion less that's going to be spent and here's where it is. And everyone can see it, as opposed to hiding it
27 in some calculation.

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1 Dr. Ouzounian: If we could maybe modify her proposal a little bit. I'm basically in favor of what
2 Greg is saying, that if we could have understanding the intent of what CMS needs to do and why they need
3 to do it, to keep the RVUs as they have been proposed by the RUC and accepted, and then have two
4 conversion factors. One is a modified conversion factor that would be for the physician work to make up
5 for the \$10 billion that they need to make up for, solving their problem, and then keep the other conversion
6 factor, which would be for malpractice and practice expense, so it's all on the table and transparent. I
7 believe it solves everybody's problem, doesn't that, Greg?

8 Mr. Kuhn: One thing, if I could real quick here something that Greg mentioned here I just want to
9 be clear on is as a result of the RUC recommendations, of which CMS accepted, that means \$4 billion in
10 additional spending. The offset it to make it budget neutral. So it's a zero sum gain, because you were
11 indicating there was \$4 billion being taken out of the system. Maybe I misunderstood you. I just want to
12 make sure, this is just a budget neutrality adjustment. We're not reducing.

13 Dr. Przyblski: I probably used inadequate language.

14 Dr. Senagore: Do you want to make a formal amendment so we can understand where we stand
15 now based on the current text—would you object to a modification of your proposal?

16 Dr. Powers: But that really, because I'm asking to use the conversion factor for the work—I'm
17 asking to use the conversion factor, I'm asking not to use that 10% reduction on work value. So what you
18 said would completely change my recommendation. They are two opposite proposals.

19 Dr. Senagore: We could have a separate new recommendation to ask for a revisit of the discussion
20 of the implications of this current proposal of a 10% on the work only plus the conversion, versus how it
21 would look with only doing it using the conversion factor.

22 Dr. Ouzounian: That's probably way more than we can discuss here today.

23 Dr. Senagore: I understand. I'm just trying to offer a way to resolve the two competing interests.

24 Dr. Powers: I think what it comes down to when you look at the numbers is that, the reason we
25 went through this 5-year review is that the [inaudible] specialties worked so hard trying to increase the
26 value for valuation, the work values for evaluation and management, all that gets, a lot of that gets lost
27 when you do the 10% work reduction. I understand, when I first read the Proposed Rule, I felt good about
28 the intention of not wanting to the insurance companies to pick up on the change by using the conversion

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1 factor, but when we actually looked at the numbers, we weren't gaining anything, or we were gaining very
2 little, monetarily, by when you use those numbers. We came out, I guess we came out budget neutral. We
3 were getting better work values, but we weren't getting any more money. And I think our intent in doing
4 that was to begin to try to shift the practice of medicine from procedure related to patient-centered, rather
5 than procedure-centered care. And that's our point is that using the conversion factor makes that work
6 better right now.

7 Dr. Senagore: We probably don't want to revisit the RUC meeting with how that went. [laughter]
8 But I think since we're kind of struggling around these two concepts why don't we table it for now, we can
9 chat amongst ourselves over lunch and see if we can take a better stab at it after lunch.

10 ??: Can he be here after lunch?

11 Dr. Senagore: I don't know. No. Would you have more questions to ask about that? I mean we
12 could ask, we can get the information now. All I'm asking is let's table the final vote on the
13 recommendation until we can resolve it amongst ourselves.

14 Mr. Kuhn: John'll be gone, but Dr. Hambrick'll be here.

15 Dr. Ouzounian: But I have another question.

16 Dr. Senagore: We can continue the discussion.

17 Dr. Ouzounian: That's a different topic. Are we ready for a different topic? I have a question
18 regarding the 25% reduction in imaging services for the contiguous body parts? If I've read this and
19 understand it properly, that 25% savings is pulled out of the physician payment pool and is somehow put
20 into other pockets? Am I understanding that correctly?

21 Dr. Hambrick: I can't recall whether that is something that is a continuing removal from the
22 system or not, to answer your question.

23 Dr. Ouzounian: Well, I understood it to be maybe I read it wrong, and I forget where I read it, but
24 I understood that that money that was saved was taken out of the physician payment pool, and if that's the
25 case, can we get that relooked at?

26 Dr. Hambrick: I'm just going to say if it's really taken out by statutory means, and that's the only
27 way I can answer your question because I don't specifically recall, if the statute requires us to remove the

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1 25%, and reallocate it across into the general budget or some other thing, there's no way we could relook at
2 that.

3 Mr. Kuhn: I think the calculus that went in here is when we made this proposal last year and
4 finalized it, it was done in a budget neutral way so the 25% that was removed for the 11 families of
5 procedures that we had for the 25% reduction was redistributed back into the system for all physicians.
6 When Congress was working through the Deficit Reduction Act, they were looking for potential savings
7 opportunities in order to fund to make sure physicians did not receive a payment cut this year. And one of
8 those savings opportunities was to go ahead and capture those savings and pull them out of the system
9 rather than the redistribution that we did. But that money, and so one way to think about it is it is back in
10 the physician payment system, but it was there in order to eliminate the cut for this year to bring it up to
11 zero some gain. That's another way you can look at it.

12 Dr. Ouzounian: Thank you.

13 Dr. Senagore: Another other comments or questions for our panel?

14 Dr. Przyblski: On practice expense, I had asked this question before and the answer was wait 'til
15 you read the Rule, so I'm going to ask the question again. [laughter] And the question is in your new
16 methodology of bottom-up that's proposed, are the practice expense dollars that have been allocated to
17 specialty pools going to stay that way, or is it all of practice expense over all of medicine that's now going
18 to be divided up among CPT-Codes. Meaning is it staying within specialty pools or not?

19 Dr. Hambrick: Very good question, Greg.

20 Dr. Przyblski: And I got that same expression last time. [laughter]

21 Dr. Hambrick: Actually Don's not here, who actually did the calculations and stuff. We can get
22 back to you on that. I don't recall specifically, do you Ken? No I don't recall specifically what happened
23 with that.

24 Dr. Senagore: Could we have that as something on the agenda for the next meeting? Since you'll
25 be working on that anyway since you'll be working on that Proposed Rule?

26 Mr. Kuhn: Yes, we can come back and talk about that but I think importantly because you do have
27 a question that's been out there for a while, we need to get back to you directly with some information on
28 that. We will.

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1 Dr. Przyblski: Thank you.

2 Dr. Senagore: Dr. Sprang, I think there was a question?

3 Dr. Sprang: Just again, on the SGR, the sustainable growth rate, or as some people refer to it, as
4 the unsustainable growth rate, we've addressed it before, but I want to address it again. If you look at the
5 data from 2001 to 2007, physicians' costs are up 18% yet Medicare payments are down 5%. And if you
6 continue to do that in any business, it's just not possible to continue to do it. Physicians who actually, if
7 they're seeing primarily Medicare patients or a percent of Medicare patients, they're having difficulty
8 keeping their offices open, and some physicians who have the ability to, will either see less Medicare
9 patients, they can see patients that will help them be able to keep their offices open. Medicare
10 acknowledges that they're only recovering about 2/3 of the cost. A lot of other little changes are kind of
11 not really going to help. If we stay with the sustainable growth rate, recognizing that we're not \$50 billion
12 over that rate, no matter what other changes are made, it's just not going to work. And we're just to
13 continue to get the decreases. Only physicians are subject to arbitrary spending cuts, obviously hospitals
14 have had a 3.7% update, nursing homes a 3.1%, Medicare Advantage now gets 111% of the Fee-for-
15 Service and getting another 4.8% increase. So in spite of those number, and we know it's going to be up to
16 Congress to do something about it, in an area where there's tremendous budget deficits now, it's not going
17 to be easy to achieve. At the same time, saying all that, I don't think physicians are going to be able to
18 continue to see Medicare patients, and they certainly won't be able to provide some of the changes in their
19 offices, because CMS and the Administration is asking for namely electronic health care records, those
20 kinds of things. You can barely keep your office now open with the amount of reimbursement. You
21 certainly are not going to be able to do additional things. So in spite of the fact that it's been asked before,
22 I'm going to make a recommendation again, PPAC thanks the Secretary of HHS and the CMS leadership
23 for their previous support for preventing a negative update in physician reimbursement and requests they
24 continue to use their influence with Congress to increase Medicare physician payments by the 2.8% that
25 MedPAC asked for in 2007, and replace Medicare's flawed payment formula with one that actually reflects
26 physician practice cost inflation. I may be hitting my head against the wall, but I'm going to continue to try
27 to ask for what we think is necessary for physicians to continue to see patients.

28 Dr. Senagore: So could we reread that please.

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1 Ms. Trevas: PPAC thanks the Secretary and CMS leadership for their efforts to prevent, for their
2 previous efforts to prevent the negative update. PPAC requests that CMS continue to use its influence with
3 Congress to affect a 2.8% update as requested by MedPAC in for 2007, and that Congress replace the
4 flawed payment formula with one that takes into account actual health care inflation costs.

5 Dr. Senagore: Is there a second?

6 [Second]

7 Dr. Senagore: All in favor?

8 [Ays]

9 Dr. Bufalino: Can I ask a question of the group just because I'm trying to think of just a follow up
10 of Leroy's recommendation. We have in our community the beginnings of physicians walking away from
11 Medicare. We have 4 of the busiest internists in our town have said and have ripped up their agreement.
12 And I'm just curious has anyone else seen that around the country, or is that just an isolate pocket in terms
13 of what's going on?

14 Dr. Urata: We have an organization in Alaska stopped seeing new Medicaid patients.

15 Dr. Bufalino: We actually, we have now almost 50% of the town will not see new Medicare
16 patients. I mean at least four busiest guys say they're done. Completely. And walked away.

17 Dr. Przyblski: I think we're seeing that around the country. I can certainly speak for my area
18 where we're seeing that and one of the problems was what MedPAC has measured is physician
19 participation in the Medicare Program, which is at an all time high, yet just because you participate does
20 not necessarily mean that you see a Medicare patient, and what some practices have done is not see any
21 new patients anymore. And we get feedback from patients in our subspecialty practice that I'm having a
22 hard time finding a primary care doctor, now that I've reached this age because nobody's taking new
23 patients anymore. So we would echo in our area.

24 Dr. Williams: At Washington, D.C.

25 Dr. Senagore: Actually, I had to hear about it on the golf course. [laughter] I was paired up with an
26 elderly couple and all they could do is grouse at the fact that they—they had called to make an
27 appointment, and they just moved to the region. Called to make an appointment, and they said yes, you can

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1 come in in 10 days, we have an opening. What's your insurance? Oh, I'm sorry, we have no opening. So I
2 asked her to call the Congressman for the region to get that information upstream.

3 Dr. Powers: And I agree it's more common that what you see is that people are not disenrolling
4 from Medicare, but they've limited or they've quit seeing new Medicare patients. And especially for the
5 primary care specialties, I think that's where we see it the most.

6 Dr. Urata: You just can't afford it.

7 Dr. Senagore: Other comments for our panel?

8 Dr. Bufalino: So to take that, is there a place for us to take that feedback to the next level, and
9 obviously this is a Congressional issue, but I think we understand that—how do we begin taking that
10 information from around the country and saying this is a problem. And that the continuous need for budget
11 neutrality makes less and less sense in this environment, since we're expanding services and trying to keep
12 it stealing from Peter to pay Paul, as they say. So I guess I'm just asking where do we go?

13 Dr. Senagore: You could offer a recommendation to ask CMS to report back to us about any data
14 elements they might have that would either support or refute these issues of service accessibility.

15 Dr. Bufalino: OK.

16 Dr. Ross: I think we also have to look at as the expression goes, as Medicare Medicaid goes, so
17 does the private insurance industry. And what's happening, I know, in Houston is that we're seeing private
18 insurance companies now decreasing below Medicare rates, and as Medicare goes down, they go down
19 even further. And some of our programs at our hospitals of our associations just will refuse to deal with
20 those as well. So it's not only creating a Medicare Medicaid potential crisis, but it will also now filter
21 down to the private sector as well, which will affect health care in the community, generally.

22 Dr. Senagore: Dr. Sprang did you have another comment?

23 Dr. Sprang: Obviously, we're kind of saying the sustainable growth rate is unsustainable. I think
24 we know that we need to do some other things and eventually some more dramatic in the way of changes
25 and maybe even somehow thinking out of the box to make sure that adequate sources of funds, resources
26 are available to continue to be able to take care of Medicare patients. I'll surmise that physicians probably
27 essentially see 80, 90, or all, 100% of all the Medicare patients and the hospitals maybe see 30% of the
28 Medicare patients. Right now hospitals in Part A get about 40% of the Medicare dollar, physicians get

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1 about 20 or 23% of the Medicare dollar and somehow that just kind of seems like it's kind of being used in
2 the wrong places. And looking forward, if there could be a way that if physicians can practice more
3 preventive medicine, do things more in the office, they actually decrease hospitalization, and decrease the
4 money spent in hospitals, it would overall be a benefit to patients and to obviously the costs of Medicare. I
5 think hospitals are extremely expensive places to provide care, and the more we could do to prevent that the
6 better for all, especially including the dollars Medicare spends. So I'm going to make a recommendation as
7 far as this kind of thinking, looking forward, thinking out of the box, not expecting an answer back
8 immediately, or any dramatic changes immediately. But looking at potential ways of solving this problem,
9 going forward, I'm going to make a recommendation that PPAC recommends that CMS consider
10 establishing demonstration projects that could shift dollars, saved from Medicare Part A, saved by
11 physician action, into Part B and educating physicians on such a program. Now it's a broad, sweeping kind
12 of recommendation, just for something else to consider.

13 Dr. Senagore: I'll ask the indulgence of the submitter. Can we hold that for the P for P discussion
14 later? Because I think the concepts—so if we could hold that one, we'll revisit that when we do the P for P
15 this afternoon.

16 Dr. Sprang: Yes.

17 Mr. Kuhn: The point I could make is well put in the fact that you have these silos of Part A and
18 Part B and actually we are doing demonstrations right now with Physician Group Practice Demo, Medicare
19 Health Support Program. Hopefully others will be announced soon, where there is opportunity to look at
20 the total cost of care, rather than just the Part B cost of care, and create opportunities for sharing with
21 physicians [this?] coming back. We think trying to prove that concept is absolutely essential and we're
22 trying to do that now. So it's a good point you're making.

23 Dr. Senagore: So we'll wordsmith that later. Was there any inkling to follow up on Dr. Bufalino's
24 question?

25 Dr. Bufalino: So I'm sorry, could you help me with the wording—what we would ask them in
26 terms of a meaningful—

27 Dr. Senagore: PPAC recommends that CMS provide updated information regarding implications
28 of changes in the fee schedules and subsequent accessibility of beneficiaries to physician services. Close

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1 enough? So would you read that back so everyone agrees it's been seconded and then we can open it for
2 discussion?

3 Ms. Trevas: PPAC recommends that CMS provide updated information on the implications of
4 changes to the Physician Fee Schedule and subsequent beneficiary access to physician services.

5 Dr. Ross: Physician enrollment, or disenrollment.

6 Dr. Senagore: We've asked that, but I think that we already have data to say that that isn't the
7 problem, it's actually beneficiary access to services. I think what we heard. All in favor?

8 [Ays]

9 Dr. Senagore: Great. Any other questions for our poor panelists. OK, I guess there are.

10 Dr. Sprang: I do think it's related in that it's [inaudible] directly on the two issues in five-year
11 review, but obviously practice expenses have been talked about in the other area, is liability insurance, and
12 they was brought up and that is reviewed and looked at continuously and as a guy practicing in Illinois
13 where premiums are \$150,000 and it is putting numerous physicians out of practice, extremely important
14 issue to our specialty oral surgery, numerous specialties that have very high malpractice rates. In Illinois it
15 probably takes a physician to work the first three months of the year, to [inaudible] their malpractice
16 premiums the next four or five months to cover the rest of their overhead, and maybe the last three months
17 for themselves, which is again, becoming unsustainable. And so just looking at that piece of the pie of the
18 cost, I'd like to make a recommendation that PPAC recommends that CMS use reliable accurate, current
19 and geographically relevant information in establishing the true cost of physician medical liability
20 insurance. Unfortunately at this point, I think a lot of the data at least some specialists believe the data is
21 old and it's not really effective at this point in what's going on now, and what's going on [inaudible] and I
22 think it's relevant to all physicians, but especially relevant to physicians who have extremely high
23 malpractice rates and are being forced out of business.

24 [Second]

25 Dr. Senagore: Could we read that back, please?

26 Ms. Trevas: PPAC recommends that CMS use reliable, accurate, current, geographically relevant
27 information to establish the true cost of professional liability insurance.

28 Dr. Senagore: Any comments, questions.

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1 Dr. Przyblski: Just a comment to give CMS credit where credit is due. They've been working
2 very hard with the PLI workgroup of the RUC in making changes going forward, including looking at a
3 pilot project of more contemporary PLI data to be used, so that work is underway. I certainly support
4 reminding them, but they've already been doing a lot of work in that direction.

5 Dr. Senagore: I might propose an addendum to actually, and I know this will probably take
6 legislative change, to ask CMS to consider whether that should be a separate component of the RVU or be
7 folded more into the indirect practice expenses, because it really is not directly tied to an individual code,
8 even though we try to do that.

9 Dr. Przyblski: And I would echo that comment that something that the work group had made a
10 recommendation of in the past the fact that whether I do one vasectomy or a hundred vasectomies or 250
11 vasectomies a year, I still have a professional liability insurance bill that I get at the beginning of the year
12 that does not care how many I do, or what different procedures I do, the bill is the same. And so you really
13 can't translate PLI to a code level because they're unrelated. They're really related to specialty, and not to
14 specific procedures.

15 Dr. Senagore: And for example, someone in general surgery, it purely impacts whether or not you
16 take trauma call. Even though every night you're on call for the year, you see no trauma patients, it
17 impacts your trauma call, your overall liability insurance. So did we get that addition? I think we just put
18 in a comma and add in that short phrase, and consider whether it should continue to be a component of the
19 RVU system, or included in under our practice expense. So would that friendly amendment? You want to
20 separate it out? OK.

21 [off mike discussion]

22 Dr. Senagore: OK, we'll separate it out then. So let's call the question on the originally proposed,
23 without the discussion of where it's allocated. All in favor?

24 [Ays]

25 Dr. Senagore: And so the second recommendation: PPAC recommends that CMS consider the
26 appropriateness of continuing to include PLI as a separate component of the RVU system. I'll stop there.

27 Dr. Ouzounian: And instead incorporate it into the indirect practice expense.

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1 Dr. Senagore: And instead, incorporate PLI into the indirect practice expense calculation. Is there
2 a second?

3 [seconds]

4 Dr. Senagore: Discussion?

5 Dr. Przyblski: I guess I would add the comment that I don't know what the impact of that would
6 be and is it better to suggest it as one option as opposed to that's the way you want it if we have no idea
7 what impact—

8 Dr. Senagore: I think we ask them just to consider it, not to, if you have another option, that you
9 would like to include in that that would be fine.

10 Dr. Przyblski: No the option that I think would be the ideal is that if I perform 50% of my services
11 on Medicare patients, that I would be able to send my malpractice insurance bill to CMS and have 50%
12 payment of that. [laughter] I think that would be the ideal. Because then it would truly reflect my costs and
13 the proportion of work that I do for Medicare beneficiaries. So that was an alternative recommendation.
14 [laughter]

15 Dr. Senagore: So, call the question? All in favor?

16 [Ays]

17 Dr. Senagore: Any other questions for our panelists, who have been very patient. Thank you very
18 much. We have a question from the panel.

19 Dr. Hambrick: I was looking through the rule, which I happened to bring with me, Greg, about the
20 question you asked about [inaudible]. And all the calculations seem to be based on specialty specific
21 information, like step 6 says that we calculate the direct and indirect practice expense percentages for each
22 physician specialty and later on it talks about specialty specific, but the specific question that you asked on
23 the flip side, how is it incorporated? I couldn't find here. But we'll ask.

24 Dr. Przyblski: Thank you.

25 Dr. Senagore: Thank you very much. Think we've got enough time to get to the next topic? Next
26 topic. So our next speaker is [inaudible] on several actually our next speak is not, because he's not here.
27 So we have Ms. Joan Sanow, who's the Deputy Director, Division of Outpatient Services in the Center for
28 Medicare Management, related to Ambulatory Surgical Center Payment System, and I believe we're going

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1 to have a discussion—and Dr. Hambrick is going to join that discussion as well. So I'm happy to have your
2 presentation.

3 Outpatient Prospective Payment System/Ambulatory Surgical Center Update

4

5 Ms. Sanow: Thank you and it's a privilege to be here and I appreciate your patience. Jim had a
6 family emergency and could not join us today. I'm going to give some highlights very briefly of proposed
7 revisions to two payment systems that furnish payment for facility services, as opposed to professional
8 services. First would be the Hospital Outpatient Prospective Payment System and the other would be
9 payments to Ambulatory Surgical Centers. Forgive me, I'm technologically challenged, here. This is a
10 little fancier than mine. OK. In general, by way of background for the Outpatient Prospective Payment
11 System, Medicare pays hospitals for outpatient department services that the hospital provides based on
12 groups of clinically similar services that are called ambulatory payment classification groups. Those
13 groups are both homogeneous in terms of their clinical characteristics as well as their resource costs to the
14 hospital. Each year the statute requires us to revise the payment weights assigned to those groups and the
15 resulting payment amounts. We use hospital claims data 88 some million hospital claims are used, and we
16 also use updates to hospital cost reports, so we can capture the most recent cost-to-charge ratios that
17 hospitals furnish in their cost reports to determine what hospital costs are. For the year 2007, we are
18 proposing 3.4% adjustment for inflation, according the statute requirement. That's the hospital market
19 basket update that results in a net increase overall of hospital payments, for hospital outpatient services of
20 3%.

21 One unusual and new feature of the OPPTS Update for 2007 is relating to value-based purchasing.
22 As you may be aware, under the inpatient PPS some provisions were made final that will commence in
23 2007 and we are proposing to extend those provisions to payments for hospital outpatient, as well as
24 inpatient services. What prompted this proposal, you'll note that estimated calendar year 2006 spending for
25 outpatient services was 29 or is \$29.8 billion and I would note there's an error there. Estimated calendar
26 year 2007, that should read on the second line, 2007 spending is \$32.5 billion which is a projected 9.2%
27 increase in expenditures for outpatient services. We continue to pay money for services rendered and we
28 would like to extend this to take into account the quality of services that are rendered, so therefore, since

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1 beginning in 2007 hospitals will be reporting certain quality measures in order to receive the full inpatient
2 PPS Update, we are extending that and if hospitals fail to submit those quality measures, not only would
3 their inpatient payments be affected, but also they would receive payment for outpatient services that would
4 be 2 percentage points lower in terms of the update rate than they would otherwise receive. In other words,
5 they would receive a 1.4% update instead of the 3.4% update of the conversion factor.

6 There are some other things that we're proposing in this rule, including some coding and payment
7 changes for clinic and emergency department visits. We are establishing five payment levels for clinic
8 visits and emergency department visits, with some new G-Codes. We also are proposing a set of codes that
9 hospitals would use to report facility services furnished at an entity that meets the definition of a dedicated
10 emergency department under the EMTALA regulations, but that may not meet the more stringent CPT
11 definition of an emergency department visit or service, which requires that such services be furnished in an
12 entity that is available 24 hours a day, 7 days a week. So we are looking to collect data to see if services
13 furnished in such entities that are dedicated emergency departments under EMTALA might have different
14 resource costs than those furnished in a clinic. Current, but until we gather that data, we would continue to
15 pay for those services at the clinic visit level. We're also refining how we pay for drug administration
16 services, based on new data that we have collected. We are also proposing to refine how we set payment
17 rates for APCs that include payment for an expensive device. This is always a problem where you're
18 paying 16, 17, 18, and 20,000 dollars for a service of which all but a couple thousand dollars is attributable
19 to the cost of the device. So we are continuing to refine how we set payment rates for those services.
20 Moreover, we are also proposing to adjust how we pay for services furnished when a device is inserted, that
21 is furnished at no cost to the hospital because of a manufacturer's recall or a defect, or a problem under
22 warranty. Further we are proposing to continue our packaging of certain drugs whose per day cost is less
23 than \$55. We're proposing, currently the packaging threshold for drugs in other words we don't pay
24 separately for drugs whose per day cost currently is \$50 or less. We're proposing to apply an inflationary
25 adjustment to that \$50 threshold. So for 2007, the threshold would be \$55. Any drug's per day cost that is
26 less than \$55 would not be paid separately. It would be package into the associated service. Any drug
27 whose per day exceeds \$55 would be paid separately. We have analyzed our claims data and determined
28 that payment for drugs and biologicals as well as overhead pharmacy costs would be the equivalent on

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1 average of average, ASP plus 5%, in contrast to the current ASP plus 6%, that we're paying. There is, we
2 are also proposing to pay for radiopharmaceutical costs and handling based on our claims data, hospital
3 claims data and expiration of a provision affecting payment for brachytherapy sources. This was an MMA
4 requirement that expired at the end of this year. We are proposing to begin paying for brachytherapy
5 sources based on their median costs, based on hospital claims data.

6 So that is a very high level overview of the Hospital outpatient update. It's pretty standard. Pretty
7 routine with the exception of the proposal to start taking into consideration value purchasing. The rest of
8 the updates for OPSS are really refinements of existing provisions. So I will turn now to the proposed
9 policies for Ambulatory Surgical Centers, which perhaps may be of interest. This is, there are multiple
10 levels in these proposals for Ambulatory Surgical Centers. First I will focus on what we are proposing for
11 calendar year 2007. And just to refresh everyone's memory, there currently ASC payments are based on 9
12 payment groups, or buckets. Those buckets range in amount from \$333 to \$1,339. So needless to say it's
13 not a very elastic payment range currently. These payments are based ultimately on data that we collected
14 in 1986, so some would say that they are out of date. The payment buckets are clinically disparate. There
15 is no clinical homogeneity. CPT-Code is assigned to a payment group just based on what we felt its
16 appropriate payment rate, to reflect its cost would be. But we didn't look at any kind of clinical
17 characteristics at all when we set up these original nine payment buckets. The law requires the Secretary
18 every two years to specify the list of procedures that would be safely performed in an ASC. This is called
19 the ASC list. It consists of about 2500 CPT-Codes currently. The criteria that we follow to determine
20 whether a list is safely performed in an ASC currently in general, the procedures would not exceed more
21 than 90 minutes of OR time, and anesthesia time, and they would not require more than 4 hours of recovery
22 time. Currently, we're spending somewhere in the neighborhood of 2.5 billion dollars. We're estimating
23 expenditures in 2008 will be up to 2.7 billion dollars for ASC services, doing approximately 4.5 million
24 services and of the list of 2500 codes on the current ASC List, about 150 of those codes account of 90% of
25 ASC volume. So there is a long, long tail of codes that are very low volume, even though they are payable
26 in an ASC. Possibly because the payment rates are felt to be inappropriate, and not adequate for the
27 services, the cost of the services. We update the list as I say every two years. In years when we do update
28 the payment rates, we are applied by law to apply a CPI adjustment. However, the MMA has frozen the

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1 CPI adjustment for ASC services to equal 0 through the year 2009. The last time we updated the ASC list
2 was in July of 2005. We're proposing to update it again beginning January 1 of 2007 by adding 14 surgical
3 services of new CPT-Codes to the existing ASC list for payment in 2007. We also will be implementing a
4 requirement of the Deficit Reduction Act in 2007 which provides that no procedure furnished in an ASC
5 may be paid more than it would be paid under the hospital OPPS. And that's going to affect about 275
6 procedures, although we won't know that finally until the Final Rules are issued. In addition, it's not noted
7 here, but you might also note, if you have an opportunity to review the Proposed Rule, we are proposing to
8 streamline the process whereby application can be made to receive a special payment, this a benefit for
9 ASC's only, a special premium payment for new technology intra-ocular lenses. We're proposing to
10 streamline the process for making approvals of new NTIOLs and also to tie that process to the annual
11 rulemaking for the annual ASC Payment Updates.

12 Then turning to the 2008 proposal, we are a little bit unusual in the sense that we are proposing a
13 payment methodology for a payment system that would not take effect until January 1 of 2008. This is an
14 MMA requirement. We're to implement this revised ASC payment system by January 1 of '08. The
15 revised payment system cannot result in more expenditures that would then have been made had we not
16 implemented the new system. We are asked to take into account recommendations following a study by
17 the General Accountability Office, specifically directed at the appropriateness of the APC weights for the
18 revised ASC payment system, and their relevance for ASC services. That report is in process. We've not
19 yet received the report, so we proceeded with our proposal without benefit for this proposed rule of the
20 GAO requirements. And the statute, the MMA also provided that there would be no update for inflation as
21 I mentioned earlier until 2009. The revised payment system involves two aspects, one of course, are the
22 procedures for which payment would be made, and the other aspect is the amount that would be paid for
23 the facility services furnished in connection with those procedures. To address the first, which would be
24 the ASC List, MedPAC recommended that we turn from listing those procedures for which payment would
25 be made and we kind of look at the glass as being half full, as opposed to half empty, or the other way
26 around, depending on your point of view, and we would say, well, any surgical services could be performed
27 and receive payment under Medicare in an ASC except those that the Secretary specifies as either posing a
28 significant safety risk when they're performed in an ASC, or they require an overnight stay. So that has

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1 been referred to variously as the exclusionary list, or we could have an inclusionary list. The bottom line is
2 there are certain specified procedures for which Medicare would make payment, and there are other
3 specified procedures for which Medicare would not make payment in an ASC setting. We're defining for
4 purposes of this revised payment system, we're defining a surgical procedure as any procedure whose
5 description falls within the surgical range of CPT. That is, any code between 10000 and 69999 in the CPT
6 book. We would not allow payment for procedures that pose a significant safety risk. And we propose to
7 maintain our current criteria defining significant safety risk as a procedure that would involve significant
8 blood loss, or prolonged invasion of a body cavity, or major arteries, or procedures that are emergent or life
9 threatening in nature. Those are current criteria and we propose to continue those as a good standard for
10 defining procedures that pose a significant safety risk. Moreover, we would not include payment for
11 procedures that are on what is called the Inpatient List under the OPSS. That is, there's a finite list of
12 procedures for which payment is not made under the Hospital Outpatient Prospective Payment System
13 because those patient procedures are defined as inpatient services. We, for obvious reasons, would not pay
14 for those services in an ASC setting. And we've also, our medical advisors have reviewed, I think every
15 single CPT-Code in that surgical range, and looked at those that they felt would require that the expectation
16 would be that at midnight of the day that procedure is performed, there would be an expectation of active
17 intervention and monitoring of the patient. That is, this would be defined as requiring an overnight stay,
18 post-surgery. And we would not pay for those procedures performed in an ASC.

19 So taking this somewhat new view of how the ASC list would be defined, the bottom line is it
20 would add about 750 procedures to the existing 2500 codes. Interestingly, 2/3 of those 750, we would
21 define as office-based procedures, that is, they are performed more than 50% of the time in an office
22 setting. And heretofore under the current criteria for the ASC list, we have historically not allowed
23 payment under the ASC benefit for office-based procedures. So under our new view of the list, those
24 procedures performed predominantly in an office setting would be added to the list of payable ASC
25 procedures. They would no longer be excluded from payment of an ASC fee. However, we have some
26 concerns about what incentives this might pose, whether there would be a sudden rush to start performing
27 in an Ambulatory Surgical Center procedures that have historically been safely and appropriately
28 performed in an office-based setting. In an effort to try and keep, remain cognizant of the need that we

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1 establish a budget neutral payment system, we are proposing to try and hold costs on those office-based
2 procedures by paying the lower of either the ASC adjusted rate, which I'll explain in a moment, or the
3 nonfacility practice expense payment under the Physician Fee Schedule when those services are furnished
4 in an ASC setting. And also, we would like to receive comment on whether some of these procedures are
5 in fact, even though they are in the surgical range, whether they really are appropriately performed in an
6 ASC setting.

7 So to now to turn to the notion of how we're going to pay for these. We are proposing to adopt
8 the APC payment weights, that is the relative payment rates that apply to these surgical procedures under
9 the OPSS on the theory that a cataract is a cataract is a cataract, whether it's done in a hospital outpatient
10 setting or in an ASC and its relative costs would not be altered by where it is performed. However, we
11 would need to scale the weights, and scale the conversion factor for the ASC payment system to ensure the
12 required budget neutrality that we don't increase or decrease aggregate payments over what they would be
13 that first year. Per the MMA. We're also proposing to continue to adjust for geographical differences, and
14 we're doing that currently, and we would propose to continue recognizing geographical [age?] differences,
15 using the Inpatient Prospective Payment System wage index, we would also be applying to ASCs the new
16 core base statistical areas, which we have not yet applied to ASC payments. Therefore, again, just to
17 highlight the requirement for budget neutrality, in order to meet this budget neutrality requirement, we
18 calculated an adjustment factor of 62%. In other words, we determined that in the aggregate, if we adjusted
19 the outpatient conversion factor, multiplied it by 62%, .62, we would derive an ASC conversion factor of
20 \$39 and 6.688 cents in contrast to the proposed conversion factor for OPSS, which is \$61.551 so this is an
21 adjustment factor applied to the conversion factor for the purposes of sustaining budget neutrality. And
22 after we apply that conversion factor to the APC payment weights, we now come up with a payment range
23 as low as \$3.68 for a procedure, this is for the facility fee, or as much as \$16,146, which would be a device
24 related insertion and that is a significant change from what we are currently.

25 We're proposing to give ASCs an opportunity to adjust to the new payment weights and new
26 payment rates in '08. We would transition in the new rates by blending the current rates, or I should say,
27 blending the 2007 rates with 50% of applicable 2008 rate, and then we would fully implement the new rates
28 in 2009. And then the final slide, just by way of calendar, we're proposing to tie the ASC updates to the

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1 OPPS updates so that we would make final in the Final 2007 OPPS Rule, for which there is currently a 60-
2 day Comment Period in progress, we would make the additional codes to the current ASC list final, as well
3 as the payment rates reflecting the DRA caps, otherwise payment rates would not change in '07. And then
4 in early 2008, we would issue a Final Rule that would finalize the payment methodology for the revised
5 payment system, with the actual final rates and proposed rates for 2008 being a part of the annual update of
6 the OPPS.

7 And thank you for your attention. And we'd be glad to try and answer any questions.

8 Dr. Senagore: Thank you. Please convey our condolences to Mr. Hart.

9 Ms. Sanow: Yes, I shall.

10 Dr. Grimm: I'd like to address [inaudible]. This is a large concern to us who are treating prostate
11 cancer, and this is a prime example of economics going to determine medical care, based on an economic
12 budget. Much like if we had a cardiac patient who required a stint, it's up to the physician to decide
13 whether that's going to be a noncoded or coded stint, and that has some bearing on the patient's outcome.
14 That's a physician judgement. But if we motivate the physician economically to use a non coded stint,
15 guess what happens? You increase the risk of your population of having problems, but you've by creating
16 an incentive for your physicians to use this particular device. Similarly with brachytherapy by using a
17 median cost of brachytherapy sources, you encourage physicians to use a high erranergy seed, you increase
18 the chances that those patients are going to have complications. In addition, we have additional seeds that
19 are connected together that take more technology to do that, and encourages physicians to use non
20 connected seeds because they're cheaper, which as in shown in at least 6 studies to be worse in terms of
21 seed migration, in [inaudible] symmetry. So this is a prime example of how an economic decision can
22 influence medical care. And I don't think Medicare should get into the business of dictating medical care.
23 If they are, they should be libel. If that patient has a problem, has a complication, this policy that's being
24 proposed here is placing more of the population at risk. So what I would like to propose, PPAC is
25 concerned that the payment of brachytherapy sources based on median cost will dictate medical care to the
26 medical community, and increase the risk of patients and decrease the quality of care for cancer patients.
27 PPAC proposes that PPAC abandon this methodology and re-examine the claims, that's the proposed
28 payment is based on.

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1 Dr. Senagore: Could we hear that back. Did you get it all?

2 Dr. Grimm: Do you want me to read? PPAC is concerned that the payment of brachytherapy
3 sources, based on median costs will dictate medical care to the medical community and increase the risk to
4 patients and decrease the quality of care. PPAC proposes that CMS abandon this methodology and
5 reexamine the claims that the proposed payment is based on.

6 [second]

7 Dr. Senagore: Second and we can have discussion.

8 Dr. Urata: Are you proposing a new way of [inaudible] reimbursement, other than based on
9 expenses?

10 Dr. Grimm: No. The reimbursement is based on the number of sources that are used. And
11 number of sources that are used are based on the size of the prostate. So if you have a guy that's 15 cc
12 gland and a guy that has 60 cc gland, that's a difference between 50 seeds and 150 seeds. What they're
13 proposing is just sort some blend pay for some sort of average of 60. Well obviously if one year you have a
14 lot, large number of patients with large glands, you're going to be out of luck, because you still have to pay
15 the same amount per seed. Medicare is just proposing we're just going to give you one flat fee.

16 Dr. Gustafson: I'm not sure if that's correct. I'd turn to staff on this, but I thought what we were
17 doing was simply changing the method of payment, not the coding or how we would treat number of
18 sources.

19 Ms. Sanow: It's still per source.

20 Dr. Grimm: That was not my understanding. So maybe I'm incorrect in that understanding.

21 Ms. Sanow: Yes, well we still continue for this current year, we revised—

22 Dr. Grimm: The other issue is just the data that you're using that from, as I understand is incorrect.

23 Ms. Sanow: Well, we're using what hospitals bill us, what they charge for these sources.

24 Dr. Przyblski: Right and I think, the other issues is that the claims data that that's based on is
25 incorrect

26 Ms. Sanow: Well, the claims are what they are. And we use those for all—

27 Dr. Grimm: If I'm incorrect about that, Tom, I will change that statement because I was
28 misunderstood about that in terms of what she was saying.

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1 Dr. Gustafson: And we would certainly want to look at any possibility that the claims data was
2 incorrect or that we'd captured it inappropriately. I mean that's perfectly appropriate as, let's comment on
3 the proposed rule.

4 Dr. Grimm: Let's change that then to that PPAC proposes that we reexamine the claims data that
5 the proposed payment system is based upon. Would that be reasonable then? If that's incorrect about the
6 individual seeds, I'll stand corrected on that.

7 Dr. Gustafson: We'll double check on that to make sure our memories are correct, but we, there's
8 a history here that has a fair amount of energy behind it, not just radiation energy, but at one time, we
9 attempted to group them the way you described. We were told by Congress to cut it out and we sort of
10 learned a lesson from that. So we're not going back there. [laughter]

11 Dr. Grimm: Well there were some issues about some of these data that people were coded
12 incorrectly, like they'd have a high energy source, and they'd code it toward the I-235 source, which is a
13 seed that I would use for prostate, which is quite a big difference in cost. So there is some concern that that
14 data may be incorrect.

15 Dr. Senagore: So is there someone here who will accept the amendment?

16 [second]

17 Dr. Senagore: OK. And he was going to change—

18 Dr. Grimm: So I changed that, did you get that right, Dana?

19 Ms. Trevas: I'm sorry, did you take something out?

20 Dr. Grimm: Yes, I did.

21 Dr. Senagore: Let's just vote down the original one and then you can make a brand new one. So
22 all in favor of the original one, everyone say no.

23 [Nos]

24 Dr. Senagore: Thank you. [laughter] Trying to keep it straightforward.

25 Dr. Grimm: Here's the new one. PPAC proposes that CMS abandon the methodology for
26 determining the median cost of brachytherapy sources—

27 Dr. Hambrick: Could I just say proposed methodology? Because we haven't finalized it yet.

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1 Dr. Grimm: Yes, that's right, proposed methodology, and reexamine the claims data that the
2 proposed system is based upon. Does that work for you?

3 Dr. Hambrick: Yes.

4 Dr. Grimm: Thank you.

5 Dr. Senagore: And second for that.

6 [second]

7 Dr. Senagore: Comments or questions? Everyone in favor say ay.

8 [Ays]

9 Dr. Senagore: Any other comments or questions for our panelists?

10 Dr. Przyblski: Question and a comment. Question, how does one currently get CPT-Codes placed
11 in either the OPPS list or the ASC list? Because there are a lot of things that I see in my specialty that are
12 being done on an outpatient basis that are not on that list and really have no familiarity with the process to
13 get them considered for that list. Some of the criteria you mentioned, like 90 minutes of anesthesia I would
14 argue with since we do 3-4 hours procedures with patients that go home same day. So I'm not sure that
15 that's a reasonable criteria, but how does one approach this?

16 Ms. Sanow: Well, at any time, we would welcome comments and recommendations supported by
17 data and evidence, peer review literature, whatever the fees are being performed safely and appropriately in
18 an outpatient setting, and therefore would be safe and appropriate in an ASC setting. I defer to the
19 physicians because they're the ones that look at these as well.

20 Dr. Simon: In addition, we would also use the best data base, and also talk with the appropriate
21 specialty societies to find out whether the information that obtained from the best data base and from the
22 physicians corroborates with each other.

23 Dr. Hambrick: And as far as the OPPS inpatient list, let me just say that we request comments
24 every year on procedures that we feel that a commenter might feel should be removed from the inpatient
25 only list, so that's available at all times to anyone who would want to—

26 Dr. Gustafson: In fact, you can do that on a quarterly basis of protocol. So we're trying to keep up
27 as fast as we can, or as reasonably fast as we can with the evolving practice of medicine here without, on the

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1 other hand, opening the situation up to sort of exuberant over enthusiasm about where you can do
2 procedures.

3 Dr. Simon: And it's based on looking at Medicare population.

4 Dr. Hambrick: And as you might recall from Joan's presentation, for 2008, the 90 minutes that
5 you referred to is gone, the 4 hours, so, there will be some proposed changes for 2008, should you agree.
6 You might not agree, Greg, you might want us to put more things on the inpatient only list, I don't know.

7 Dr. Senagore: As long as that list can be fluid and allow for outpatient only, inpatient only and
8 some that crossover depending on clinical characteristics doesn't make it onerous, if you're in that
9 intermediate group, if it decides that it needs to be inpatient, that it doesn't require excessive documentation
10 to report that. Was there a question.

11 Dr. Simon: A comment. I think, too, that when there are codes and services that are being
12 considered to both the ASC list or the OPPS list, those services should be those that where there's a sizable
13 number of patients having those services done, in either the outpatient setting or the ASC setting. There
14 have been occasion where we'll get a request for a service where we've been able to identify in the
15 specialty society as well, has been identify only one physician in the United States that performs this
16 procedure in the outpatient setting, where again it may not be reasonable and in the best interest of the
17 patients or the physicians for that matter, to put it on such a list. So there's active dialog with the medical
18 community when these lists are reviewed.

19 Dr. Senagore: I had two questions, probably more structural than not. Is there a reason to need to
20 rely on a separate G-coding rather than rely on a current CPT-Code utilization for the ambulatory clinic
21 visits?

22 Ms. Sanow: You're talking now about clinic visits and emergency department visits under the
23 OPPS?

24 Dr. Senagore: Correct.

25 Ms. Sanow: Yes, we're currently using the CPT-Codes. The problem with the use of the CPT-
26 Codes is that those descriptors are very explicitly reflective of physicians' services which are not always
27 congruent with facility services during a clinic visit or an emergency department visit. So we're trying to

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1 focus the description of the services to more closely reflect what a facility would do during such an
2 encounter.

3 Dr. Senagore: Yes, I guess I would only counter that within there is a practice expense component
4 that ostensibly reflects items used during those various levels of visits, and you might want to be sure that
5 those kind of cover where we're at in terms of the physician level of encounters. Because there is some
6 confusion out there now of how it could be a one level for a physician visit, and it would be a different
7 level for the ambulatory.

8 Ms. Sanow: Again, I defer to clinicians. But I think for example in emergency department visit,
9 there may be very intensive facility resources that are brought to bear in the emergency department setting.
10 Not to in any way minimize that the physicians are doing, but also the nature, just by definition of the kinds
11 of equipment and technicians and so forth that may be involved.

12 Dr. Senagore: I think the struggle is what is the appropriate level of documentation to support a
13 given level of OPPS expense. That's the confusion out there, I believe.

14 Ms. Sanow: Right. And we are looking at guidelines. We have received some draft guidelines
15 from AHA and AEMA and posted those. We made some comments, revisions on those, and we are in the
16 process of soliciting public comment to try and establish some clearer national guidelines. Right now,
17 hospitals are each using their own individual guidelines to distinguish among levels.

18 Dr. Senagore: And the last question now that the APC and ASC payments are pretty much tied at
19 the hip, will they then track what the hospital cost-to-charge ratio going forward? Or what will be the, how
20 will you recognize if there is a difference in expense growth in one side or the other?

21 Ms. Sanow: Well, we're initially proposing to use the OPPS relative payment weights. You know,
22 the relativity in costs among different services. After the first year, the proposal, we are proposing to adjust
23 the weights to, we would update the conversion factor each year, we're proposing using an update for
24 inflation, but we would revisit the weights in the event that hospital resources, let's say there was a sudden
25 shift in hospital resources away from surgery more towards some other type of service, whether it would be
26 emergency or clinic types of visits or some new service not presently contemplated. So we would propose
27 to try and focus the surgical aspect of this and if necessary, adjust the weights on the ASC side, so they

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1 would not, ASCs wouldn't be penalized by a sudden shift of resources on the hospital side, out of the
2 surgical.

3 Dr. Przyblski: Just an observation. It seems that there is a general move toward value-based
4 purchasing and trying to incentivize better quality and part of better quality may include more cost effective
5 delivery of care, yet there seems to be a system set up here that essentially is penalizing ASCs compared to
6 outpatient hospital. It essentially says the outpatient hospital gets an inflationary target, whereas the ASCs
7 are capped until 2009, and I don't know whether it's more effectively provided as a service in an ASC or
8 the hospital, but you're essentially driving services to a hospital outpatient setting because you're making it
9 impossible as I see it, for ASCs to essentially make a living on Medicare patients. My observation of ASCs
10 is that at least in neurosurgery issues and pain issues and ortho that they tend not to treat Medicare patients
11 at all there because it's just not economically reasonable, yet they may be able to perform the care more
12 cost effectively, and it may be the savings to incentivize them to do so. I don't know that that's the answer,
13 but the system seems to be set up assuming that the ASCs aren't going to be able to do it better.

14 Dr. Gustafson: A couple of comments here. First is the CAP you're speaking about on inflation
15 adjustments in the ASCs is statutory. We don't have the opportunity to address that directly. We think the
16 updating of the payment system that we're doing, or proposing I should say, on the ASCs will have a
17 number of effects in terms of rebalancing where services are going at present. It's clear that there are some
18 very highly targeted instances where people are using ASCs extensively, obviously our payments rates are
19 favorable in those areas. It doesn't necessarily comport with good practice of medicine. We should have a
20 payment system that allows individual clinicians and their patients to choose where the services are best
21 delivered, and so that's what we're striving to do. The system we have now on ASCs can most generously
22 be described as rudimentary. It was an early effort. Hasn't been revised significantly. We're not sort of
23 trying to bring it into this century, if you will in a way that'll allow much more scientific, if that's not too
24 strong a word, but much more rational understanding of the pricing in the two sectors.

25 Dr. Ross: Just as a follow-up I'd like to echo what Greg has just said, as far as the ambulatory
26 setting, pure ambulatory, versus the hospital ambulatory setting. Examples, such as a diabetic who's
27 undergoing surgery that day, whether it's foot or orthopedic surgery, whether it's a Sharko foot or an
28 ulceration that requires overnight stay to monitor their diabetes, and their basic metabolic needs. So there's

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1 going to be a requirement for overnight stay to monitor after that surgery. So the question is, can the
2 ambulatory center do it for less? Or will the hospital do it for more? So that's where your question comes
3 into where is your cost savings because the diabetic patient is going to require an overnight stay, no matter
4 what, because of the factors that I've just talked about; you have to worry about bleeding, you have to
5 worry about glycemic control, you have to worry about blood pressure, renal, other factors. So after that
6 surgery, there's going to have to be a 23-hour observation. So the question is who's going to do it for less?
7 Where's the less cost going to be? Another thing is in multiple procedures, in my particular case, where
8 two hours of surgery may go into a second foot, or bilateral case, you're talking about two to four hours of
9 surgery. So it should not be penalized for anything over three hours due to the fact that you're doing two
10 feet at the same time, which in a sense saves Medicare money, because you're actually saving an operating
11 cost again by bringing the patient back to surgery a second time.

12 Ms. Sanow: Well, the four hour limited, again is one of those things that we've determined is no
13 longer clinically relevant as it was, maybe 20 years ago.

14 Dr. Ross: Just wanted to reiterate.

15 Ms. Sanow: And there is a multiple procedure, of there is a multiple procedure discount, but it's
16 always applies to ASCs does apply to outpatient and we're proposing to continue.

17 Dr. Senagore: Great. Thank you very much, and I think we'll adjourn for lunch and reconvene at
18 1:15. Thank you very much.

19 Lunch

20 Dr. Senagore: Do we have our next presenter? If we could reconvene. We have Ms. Norwalk, the
21 Deputy Director here to give a few comments here since we're still waiting for some our speakers this
22 afternoon. Why don't you give Ms. Norwalk your attention please.

23 Address by Deputy Director Norwalk

24 Ms. Norwalk: Afternoon everyone. I have a microphone, that's exciting, but I'm sure that my
25 voice will carry regardless. [laughter] Except for the guy in headphones, the important one, huh? I hope
26 that you've had a good meeting thus far. Certainly these meetings are critically important to those of us at
27 CMS who are particularly concerned about provider issues and in this regard, physician issues. I'm getting
28 a sense of where we are on the compass, are we moving in the right direction, what things do you care

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1 about most? As a general rule you're no different from any other group which I can imagine, money is the
2 thing top on your minds, so I suspect if I had to guess SGR is the number one concern that you have. I hear
3 that you have already been fairly well briefed on that and I think that CMS has been in an unfortunate
4 position since, oh for the past number of years, really, and I suspect that most of the action on SGR will
5 have been at the Congressional level this year as it has in the past. The other issues that are going on. One
6 of the things that we look for this group to do is to give us a heads up on other things that are going on that
7 care about a great deal and let us know particularly in the Office of the Administrator, where it is we should
8 be focusing our attention and if we've made a messed up in some way shape or form, and I appreciate that
9 Lisa Zone is going to be here shortly, once traffic clears up a little bit, to talk about Medically
10 Unbelievable, or what's the word. Unlikely. I knew it was not unbelievable. Unbelievable's a term that
11 people don't like. Medically Unlikely Edits. May not be a doctor, but sometimes lawyers have a clue.
12 [laughter] Medically Unlikely Edits, etc.. I know how you feel. [laughter] Put it right out there, it's OK. I
13 don't think doctors are perfect either, so it's an excellent match. [laughter] In terms of other things that
14 we're working on and particularly surrounding the SGR as you all know, Pay for Performance and figuring
15 out how it is that we do that. I think the most complicated setting is in the physician setting whether it be in
16 the doctor's office, outpatient ambulatory whatever it happens to be and making sure that we take into
17 account as we move in that general direction, what are things that we can do to take into account reality,
18 whether it's around Pay for Performance, whether it's adopting Health IT for example, and making sure
19 that we take into account what is actually happening in the doctor's office and in other settings, so that
20 whatever it is that we do, it makes sense for the entire practicing community. And without your help, that
21 would be very difficult for us to get there, so I really appreciate that. While we wait for Lisa to get here, if
22 there are a couple things that I know that Mark will be up later today, but if there are a couple of things that
23 you think you wanted to scream at me about or say, you know, nice job and that always happens. If there
24 are a couple things that you work on, I'd be delighted to hear them. Particularly if it's something hasn't
25 been addressed at today's session that you think we ought to be focusing on, either for our future session or
26 just generally as the weeks pass and as we have very little time left for Congress to be in town. Anything?

27 Dr. Senagore: Comments or questions?

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1 Dr. Bufalino: Can I ask something we discussed earlier. We're looking for some direction on
2 trying to get the message to the Congress that across the country, as we surveyed our colleagues this
3 morning, multiple people are walking away from Medicare or no longer taking new Medicare patients
4 because of at least from our perspective, this need for continuous budget neutrality. And the SGR and
5 whatever formula there. Do you have a forum, I mean, how do we begin to get that message to the Hill
6 and/or to the country since the patients are starting to feel it, in small pockets, but it's beginning, how do
7 we extend that?

8 Ms. Norwalk: I was in Alaska last couple of weeks, whenever it was, fairly recently, and it was
9 not surprisingly a fairly hot topic in Alaska, because I suspect perhaps almost more than anywhere, it's
10 such a frontier country. Yes. There you go, see I was visiting. And I went to St. Paul Island. I don't
11 know if you've been there, but if you ever want to go to the middle of nowhere, that's pretty much where it
12 is. [laughter] Literally, like it's practically in Russia. Not that Russia is nowhere, just this particular island,
13 just to be clear, before I get myself into big trouble. I think that we actually pay a fair amount of attention
14 to practice patterns and what happens, here we've done, our office our research office has actually taken a
15 look at what's out there, and we watch for participation rates, etc., every year, particularly as the rates come
16 out in January and want to be sure that if there were a rate change that we would be able to continue to
17 accept physicians taking assignment, etc. Trying to think of the best—it's hard for me. I'm trying to
18 decide how I can tell you this without violating the Hatch Act, which doesn't allow members of the
19 Executive Branch to suggest people lobby Congress. I suspect that, which I'm not going to do of course,
20 because I would always want to be legal, particularly when I'm on the Record, but in any event, your
21 colleagues are spending a significant amount of time at the AMA and all the other associations figuring out
22 a Hill strategy and typically in Washington won't be a surprise to you, when people do things in groups, it
23 tends to be more effective, unless and I would suggest that if any of you have personal contacts with
24 members of Congress, and many of you do, they all have doctors, that is often one way particularly when
25 they are on recess, that when things come, we'll hear a lot from members of Congress about their particular
26 area, whether it's Alaska, or frankly anywhere else in the country where there were fewer and fewer
27 Medicare patients have the ability to not so much see a physician who's continuing, but if your physician
28 retires, how do you get a new physician? Or if you're new to the Medicare program, or if you've moved,

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1 or whatever else? Typically it's accepting the new patients that we've seen to be the biggest difficulty and
2 I think that will, bringing it to someone's attention really is going to depend on your own personal
3 relationship with your members and how you interact with members of whatever associations it is that you
4 belong. Those are the most common ways to talk.

5 Dr. Bufalino: Let me just poke at it for two second more and just ask you, I guess we're looking
6 for some help, because we don't think participation rates, assignment rates really reflect what's going on.
7 Because it's about new patients being accepted. How do you think we'd get at that? How do you, I guess
8 I'm looking for help us with getting the data to make the case. As opposed to just going there and saying,
9 help, you know, give us more money.

10 Ms. Norwalk: With many issues, in the Medicare Program, it is not uncommon that an association
11 will provide that information to us when for example, like you raise exactly the right point. You can accept
12 assignment and you still may not take new patients, so whether someone does a broad base, whether it's a
13 state medical society, whatever it happens to be that makes the most sense particularly where you see that
14 there might be problems, we have done some work on that internally. I think it's been more, my
15 recollection is it was again more specifically focused on areas, I think 10 different areas across the country
16 we had problems, but we had a data log issue, I think that was, [inaudible] that project maybe a year and a
17 half two years ago. I don't know if you [inaudible]. Anyway, I suspect that the best way to go about that is
18 probably at the state level where you ask your state medical society to survey numbers. It's probably the,
19 and let us know what it is that you see. I'm not sure that again it may be helpful from a lobbying Congress
20 perspective. I'm not sure that it's something that, it may help inform the debate. I don't know from the
21 discussion around SGR if there's much that we could do about it internally. I'm trying to think of other
22 than thinking about, and GYPSYs are all, are done so I'm just trying to think of where it is it might impact.
23 But probably the most impact it would have is Congressional, but I appreciate the difference between
24 accepting assignment and accepting patients [inaudible]. Other, oh, great no problem. Oh, Mark, you don't
25 have to come upstairs. It's really not a problem at all. There's nothing going on.

26 Dr. Senagore: No, I think there's one more. You're not off that easy.

27 Dr. Sprang: Another area we started talking about, obviously there seem to be major issues and
28 obviously the committee was trying to look out of the box or how we make more dramatic changes that

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1 may be going forward will actually have a positive effect. I mean silos of funds into hospital-based Part A,
2 and then in the physician Part B, looking at whether it's Pay for Performance, quality issues, if physicians
3 activities can actually keep more patients out of the hospital, have less hospital dollars spent, having a
4 system where physicians are aware of a program that by saving dollars from Part A some of those dollars
5 are transferred to Part B, and therefore help some of the sustainable growth, or the unsustainable growth
6 program, those kinds of things. How do you feel—

7 Ms. Norwalk: There are a lot of actually very interesting issues within that. First, one of the
8 things, God love Tom Scully, my the last administrator, my former boss, because he did say, he said many
9 truths, but sometimes he got into trouble for them, but the one truth that I think makes the most sense to me
10 is that Medicare is a big dumb payer. Absolutely true. And by that, he meant that you raise one of the
11 many issues that because of how Medicare grew up over time, in a piecemeal fashion, starting with hospital
12 benefits and physician benefits, never the tween shall meet. So one of the things that happens when the
13 Actuaries in the Congressional Budget Office score, determine how much something is going to cost when
14 they make a change to the Entitlement Program, is the two don't intersect. So a hospital change or a
15 physician change—so let's say you did something on the physician side, the Part B side, that you would
16 think, wow that's going to save lots of money, or Part D, the new drug benefit, let me save hospital costs
17 down the road. You don't get to count the savings in a program that is not Part A, Part B, Part D etc., is has
18 to actually be in that silo. Which of course can make so sense. Now we have the authority in the Medicare
19 Program to do demonstrations, so one of the things that we've got a number of different types of
20 demonstration authority. One authority we have is to change payment rates. A second authority we have is
21 under the Medicare Modernization Act, § 646, we have the ability to change a number of things, including
22 but not limited to payment. And recently, we put out, in the past year, we put out a demonstration under §
23 646 where we're still in fact accepting applications, I think, through September, and I suspect we will be
24 doing more in that area, including around gain sharing. So one of the things that you could, is if you're
25 working in conjunction with a hospital, and figuring out how to keep people out of the hospital, you might
26 be able to share in those gains, which is to say in a sense, if the hospital and physician can figure out a way
27 to provide care more efficiently, the patient's better off, the provider's going to be better off, and the
28 physicians can share in those savings. Similarly, in New Orleans, one of the things that we're doing is

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1 trying to figure out if, we can pretty much start from scratch there. The Secretary's been very committed to
2 that. What can we do to restructure a program and to make it more intelligent? What can we do to include
3 things like quality measurement, Pay for Performance, perhaps changing how we look at the different silos
4 of payment and looking more along the continuum of care rather than saying, well, here's someone who
5 needs to be in a nursing home, and so on and so forth, particularly given the upheaval of that particular
6 health care market. And the willingness of many people in that community to think outside of the box and
7 really start from scratch, so there is a great opportunity there, probably more than we've had anywhere ever
8 to start over. And how would we do that? So we've got some, like I suspect, we're having a brainstorming
9 session later on this week on that topic internally just to figure out what are some of the things that we
10 could do in thinking about because we have some demonstration authority, we could ignore those silos in
11 the way that scoring would normally occur, and have the incentives correctly aligned, so the patient is
12 better off, the providers are better off, and to also infuse better quality of care health IT, Pay for
13 Performance and some of those things, medical home model, all of those things we've been talking about
14 internally that many think in the literature makes a lot of sense, but haven't really had an opportunity to
15 show. If that were to work, granted, it'll take a lot of time, I think we might have the makings of some
16 further reform in the system, so keep your fingers crossed.

17 Dr. Urata: If you have time, could you comment on the volunteer faculty and ambulatory care
18 setting issue that's been going on for about three years?

19 Ms. Norwalk: Be more specific?

20 Dr. Urata: In relation to graduate medical education? Sort of been held up because of the
21 volunteerism, people feel that they ought to be paid, and these are volunteers, particularly in the arena of
22 family practice, primary care?

23 Ms. Norwalk: So basically, let me make sure I understand the question. I don't know Tom if
24 you've been following this if you want to...

25 Dr. Gustafson: This is where the hospital is sending their trainees out into the community, local
26 practices are receiving them, and providing training and the question is who pays the cost of those? It's the
27 all or substantially all issue.

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1 Ms. Norwalk: So in as much as the, I think it's statutory. Is that not a statutory issue? So the
2 statute requires that in order for us to reimburse the hospital for that GME portion, that hospital has to bear
3 all or substantially all of the costs by statute, and you've got to have all the written agreement and so on
4 and so forth in order for that to occur. It sounds to me, if you say volunteer, perhaps the costs in fact aren't
5 borne by the hospital, in which case CMS can't reimburse for the GME piece? Is that the upshot of the
6 issue? And my recollection is that that's a statutory issue, so inasmuch as you wanted the Medicare
7 Program to pay for it, the hospital actually has to have costs in order for them to reimbursed.

8 Dr. Gustafson: In essence, but the basically what we're needing to try to work through and are
9 working with the AAMC among others are questions about exactly how we do the fine pencil accounting
10 on this. And what constitutes providing all or substantially all of those costs? This is an issue that turns
11 out to be very problematic because a way a finance person looks at the cost associated with this, if the
12 physician who is volunteering their time is in fact committing some costs, because they're still on salary,
13 then it's a volunteer activity from their standpoint. They could elect not to do it, but is there a cost or not is
14 a somewhat different question. And that's what has hoist us up and kept us from resolving this issue so far.

15 Dr. Urata: Yes, but most of who do this, do it at no charge to the hospital, and my experience has
16 been you know the medical school. And the medical school pays for the student to fly up to our area,
17 houses him, and gives him a little per diem for food and then we pick him up in the morning and—

18 Ms. Norwalk: So the issue is the medical school of course isn't a provider, it's the hospital that's
19 a provider, so there's no normal way for the Medical Program to reimburse—

20 Dr. Urata: Yes, some of the hospitals do have training programs, though, or residencies, and so I
21 assume that's what that's what they're talking about.

22 Dr. Gustafson: It's a work in progress is the short story. We're trying to work on it, more quickly,
23 but it's been dragging on for a while.

24 Dr. Urata: About three years. And the physician groups had thought they'd come up with a good
25 solution, but I guess sort of in your arena, and it's an issue we'd like to get resolved.

26 Ms. Norwalk: It's actually, well, sooner than you mean three years? It's also an issue in New
27 Orleans and one of the things that we're talking about there again from a demonstration perspective is
28 thinking about wanting, particularly if you want to train more people in a community setting, and less in a

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1 hospital setting, particularly in many areas of the country. New Orleans is certainly chief among them,
2 where the patients are spending way too much time in the ER for primary care visits and wanting to train
3 physicians to see them in the community and so on and not only that but have the patients have access to
4 them in the community, etc., and how do you have the money follow the person, which is a model we're
5 talking about in many other settings, not just GME but DSH and other things. Where is it that you could
6 have, how is it that you could legitimately ensure that the resident is appropriately supervised and trained in
7 a setting that isn't necessarily a hospital setting when that makes sense particularly for the community, so
8 it's something else that we're taking a look at in a different context, but I'll ask Tom to make sure that I'm
9 more filled in on the other piece.

10 Dr. Urata: Well, it's clearly a nontraditional setting, but I think it's a good setting, and it does open
11 the eyes of the student or the resident to other forms of care; not just the hospital care where you see a lot of
12 specialists and you become comfortable with specialists. This you take them out of the hospital setting, and
13 get them into the outpatient setting where I think we want to take care of the majority of our patients.

14 Ms. Norwalk: And that's not impossible, now, just depends on how it's structured.

15 Dr. Urata: Yes. Well this started out with volunteers, because then you put one student with one
16 doctor, because you don't have one teacher for 30 students, like in a hospital setting. So you need a whole
17 bunch of docs to take care of all these students.

18 Ms. Norwalk: I understand. We'll have further discussions internally. So how's that?

19 Dr. Urata: Great.

20 Dr. Senagore: Any other comments or questions? I want to thank you for your time.

21 Ms. Norwalk: Thank you very much. Have a good meeting.

22 Dr. Senagore: And is Ms. Zone here? Yes. There she is. [chat] Ms. Zone is here to revisit the
23 topic of Medically Unlikely Edits. They were kind enough to change that term based on our previous—
24 yes. And so I guess we'll open the table to you to revisit this topic.

25 Update on Medically Unlikely Edits

26 Ms. Zone: OK, well thank you for inviting me, and having me here today to talk to you about
27 Medically Unlikely Edits. We did change the name, as has been noted, and that was based on some of the
28 recommendations when we were here last time. And we have gone a step further to try to educate

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1 providers and meet with providers more and define a little bit more clearly where we're going in the future
2 with the Medically Unlikely Edits. Again the objectives of the edits are to detect implausible claims.
3 We're really looking at the outset to define those claims that seem outliers that seem to reach a threshold of
4 service that we could almost automatically say is inappropriate. We want to work closely with you all,
5 with the provider community to develop the Medically Unlikely Edits and this is not meant to establish
6 payment policy but rather to detect errors on the face of the claim. We recently sent out the edits that we
7 had developed for January 2007 and these are anatomical based edits. We've sent those edits—it's about
8 2800 edits to the AMA and I believe they've circulated those to the specialty societies already. Then, in
9 April 2007, we're going to do the final phase of anatomical edits and also look at establishing edits around
10 certain CPT-Code descriptors, descriptors, instructions, CMS policies, those types of things, where we say
11 we'll only pay for one urine collection in a 24-hour period if it's a 24-hour test. Those types of edits will
12 be in April 2007. The future is still to be determined. We haven't decided what types of edits we would
13 then go to next. It is our idea to implement edits on a quarterly basis, much like CCI and have this parallel
14 what we're already doing with the correct coding initiative. So that quarterly we would be improving upon
15 the process. And eventually that we would implement the 10,000 or so edits that were originally released
16 around this effort back at the beginning of this year.

17 As I said the edits, the 2800 or so anatomic edits that will be implemented in January 2007 have
18 been distributed. They're out there for comment through the specialty societies, and that comment period
19 will end September 23rd. We've tried to stick with our common practice of a 60-day comment period.
20 That's similar to what we've done for the correct coding initiative, and that's what we plan to do in this
21 effort. We will also soon be sending out the edits that will be implemented in April, 2007. Those are the
22 remainder of the anatomical edits as well as the CPT-Code descriptor edits and the comment period for
23 those edits would be October 1st through December 1st of this year. We have as I've said, gone through the
24 specialty societies. We've also mailed the edits to some specific professional organizations, lab
25 organizations who have been specifically interested in the edits and so we have also looked for them to
26 comment as well. And again, the 60-day comment period is similar to what we've done for the correct
27 coding initiative, I believe that it's worked well in the past, and these are substantially smaller sets of edits
28 than we had originally set out in January of this year, and we will be making sure that we're giving

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1 manageable I guess size edit files for review, and certainly we want to seek everybody's comments and
2 feedback through that process. And we have backed up, you'll notice, we've back up the comment period
3 fairly significantly. So a comment period for edits that will be implemented in April will end in December
4 and that gives us a fair amount of time, several months, to really take into consideration what we're hearing
5 from the professional societies, the specialty societies, and go back and forth and have additional dialog if
6 we need to through that period of time, through that extra 5 months once the comment period has closed.
7 And I believe that that time period, as well as the comment period will allow us sufficient time really to
8 have the back and forth and the types of conversations that we need to have to make sure that the edits are
9 well in line with standard practice. Again our process for the future—we're still working on what that will
10 be. What types of edits we will implement in July of 2007, but it is our goal to eventually implement the
11 full set of edits as we go through this quarterly process. As we develop the future periods, or the future
12 periods of editing, we will be looking at data for past periods and I know that's something that we've talked
13 with you all about in the past and we realize that it's going to be very important to make some of that data
14 available to you all in the future as we get to implementing those edits that are data-based. The edits
15 actually that will be implemented in January and April 2007, aren't data-based. They're really based on
16 anatomical considerations as well as some of the CPT processes and procedures, so there is no real data set
17 to share around those edits, but clearly as we get into July of 2007 and forward, we recognize that it's going
18 to be critical for us to be sharing the data and our statistical methodology behind some of those edits with
19 you all and other specialty societies as we move forward. We are also rely on many of our CMS docs. All
20 of the edits that we will be implementing will go through a panel of our physicians. Dr. Simon has been
21 gracious enough to be one of those physicians, and I hope we can solicit his help in the future. But he will
22 continue and I'm sure some of the other physicians will continue to work with us in the future as we
23 develop the edits and again make sure that they're well in line with standard practice.

24 An appeals process, we are developing an appeals process, and the process will be for the edits
25 themselves, as well as for individual claims, and so you will have both of those avenues, if there is a patient
26 that has the rare accessory spleen that we talked about last time when I was here, then certainly there's an
27 appeals process and there's a way to get those types of claims paid when you have that patient with an
28 extreme type of condition or anatomical feature. The modifiers, again, we're still thinking about modifiers,

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1 because the idea is that very few of these claims would really need modifiers. Really the goal is to deny the
2 very top, top percent of claims. And so we're expecting that there wouldn't be much need for a modifier if
3 individual claims that are potentially problematic can go towards an appeals process. But we certainly
4 want to get some experience with numbers and claims volume and things like that before we make any
5 final decisions around modifiers. But as the agency would go forward to the CPT-Coding Panel and others,
6 we would have to show that there would be a justified need for a modifier. That it would be used a certain
7 threshold of time, and we're just not sure about that yet. So we are still considering that. That's something
8 that again, we'll certainly look at the information once the MUEs are implemented, see what kind of
9 thresholds we're meeting, see what type of percent of claims are denied under there and whether or not we
10 really need the modifiers to go forward. And that's all. I think that's the update for now. And I would be
11 happy to answer any other questions or comments or things that you have.

12 Dr. Senagore: Thank you, Ms. Zone. Comments or questions?

13 Dr. Grimm: Thank you very much. That was very good. One of the issues about MUEs,
14 particularly in our specialty and maybe some of the other ones is that some of these look on the surface
15 could be MUEs, but actually are part of standard practice, in terms of coding a certain code, you know like
16 multiple codes of the same code, same code on the same day. That sort of thing. That would often trigger
17 an MUE, is suspect. My point being is when you look at these things, they're sort of systematic things that
18 are going to again and again always trigger this MUE and that it would make sense to have your specialty
19 organizations represented as these are being established. Is this an MUE to start with? Does it have to
20 trigger this whole process of review and all that kind of thing every single time? Because you'll be talking
21 sometimes thousands of reviews.

22 Ms. Zone: OK.

23 Dr. Grimm: So that would be one issue that I would be concerned about.

24 Ms. Zone: So involving the specialty societies, even when they're under development before the
25 comment period?

26 Dr. Grimm: Before they're under development say look is one that we've noticed, is this an
27 unusual, is this an unlikely event? Or is this something likely that's going to happen all the time, and

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1 identify those ahead of time so they don't get triggered so you don't overburden your system. I think that
2 would make sense. Does that make sense to you, Ken?

3 Dr. Simon: It does make sense. And for the CCI process, that's exactly what's done, with the
4 specialty societies, that information is sent out to the specialties society and it gives them an opportunity to
5 communicate with CMS and say, you know, this is a reasonable edit. This is unreasonable because usually
6 what happens in the clinical scenario is X, Y, and Z and so it comes back, through that mechanism we're
7 able to weed out things that probably should not have a correct coding edit in place because it does
8 represent the contemporary practice of medicine. And use the specialty society to endorse those code edit
9 payers that are appropriate, that reflect a variance that should be picked up and detected.

10 Dr. Grimm: Just one other thing, is about the timing of these comment periods. Because you've
11 got two initiatives going on here, you've got the MUE and you've got the CCI, right?

12 Ms. Zone: Right.

13 Dr. Grimm: They're fairly tight. You know these comment periods put a lot of stress on our staffs
14 or I think staffs around to get comments out. Because they've got a lot of work to do during the day. Does
15 it seem a little tight to you or are you happy with the staggering of these comment period? Have you heard
16 anything about it? It just seemed a little tight to me in terms of that for our staff, so.

17 Dr. Hambrick: Plus remember, for the CCI edits you will be asked to comment as those issues
18 arise. Their implemented on a quarterly basis, but they're not sent, they're sent out as people ask us
19 questions and things like that, so it's sort of staggers across all the specialties whereas in the MUEs are,
20 because in a set that we send out, maybe your specialty would only have three to ten things to comment on
21 because you know that would not be appropriate for you to comment on all the you know 700 or whatever.
22 So some of the work is divided up among the specialties, it just depends on the edits that go on. But I
23 wanted to ask you a question. You had spoken in your premise about different sets of codes being billed
24 together. Well the MUE as you may recall, is just about this one code. It's not like CCI, one against the
25 other. It's not a code pair. It's that code.

26 Dr. Grimm: Right. Well I was dealing with CCI and MUE.

27 Dr. Hambrick: Well, they're separate initiatives and CCI is about the billing of two services
28 inappropriately in certain settings. MUE is simply about the numbers of one service that could be billed.

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1 Dr. Grimm: OK, thanks for that clarification. That helps.

2 Dr. Senagore: I think the advantage of the MUE evolved to basically an anatomical detail, where it
3 was perceived to be originally coming from, because that made it much clearer now that it is anatomically
4 based. Are there any other comments, questions? Thank you, Ms. Zone, for braving the traffic.

5 Ms. Zone: Thank you.

6 Dr. Senagore: OK, we'll shift gears now and we'll talk about Pay for Performance: Cost
7 Measurement Development. Have the opportunity to introduce Dr. Tom Valuck. He has been here several
8 times, in case you don't remember Dr. Valuck. But he is Medical Officer in the Center for Medicare
9 Management, where he advised the Center and the Deputy Director on clinical issues related to payment
10 policy, including Pay for Performance. Prior to joining CMS, Tom was a pediatrician, I assume he still is.
11 Hospital executive at the University of Kansas Medical Center and an associate of the law firm of Laffin
12 and Lotkins. Dr. Valuck would like us to consider the following questions during the presentation today.
13 Number one, how can cost of care measures be made meaningful, actionable, and fair, for practicing
14 physicians? And two, how do practicing physicians use the resource use reports that are currently being
15 circulated by private health plans in many markets. Dr. Valuck.

16 Pay for Performance: Cost Measurement Development

17 Dr. Valuck: Thank you and thank you for having me back to present to the group on Pay for
18 Performance, specifically this afternoon, I'm going to be talking about cost of care measures. I think most
19 of you will recall that I was here in May and spoke on the same topic. The emphasis is going to be a little
20 bit different because even though I'm going to catch everyone up with some of the same material that I
21 used before, I want to really focus on the use of and our evaluation of the episode grouper technology that
22 I'm going to be talking about toward the end of the presentation. And what might also be different is last
23 time there wasn't any time for questions. So this time hopefully, we'll get some good dialog going about
24 cost of care measures, physician resource use.

25 So on the second slide, just give an overview of where I'm headed this afternoon. The first and
26 probably the most important thing to take away from this presentation is that as we're considering cost of
27 care measures, we're not working on costs in a vacuum. We're working on costs under the quality
28 umbrella. I'm going to demonstrate how Pay for Performance and specifically the efficiency part of Pay

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1 for Performance links quality and cost under that quality umbrella. Secondly, I'm going to talk about CMS
2 another important point. We're not working alone here. We're working in coordination with a number of
3 other groups in the health care industry who are also working on this very same topic. We're coordinating
4 our work with them and the attempt is to come up with standardized measures so that when you get reports
5 about your resource use, they'll make sense to you, in terms of the context of your whole practice. And
6 then the third point and where I'm going to spend most of the time today is to tell the story about what
7 we're doing at CMS in terms of cost of care measure development. Where we started, what we've learned
8 along the way and where we are right now and what we're looking toward in the future. The next slide
9 gives our working definition at CMS for Pay for Performance. You see a lot of literature out there. A lot
10 of different definitions, ours is very simple. Pay for Performance is a mechanism for promoting better
11 quality while avoiding unnecessary costs. Another way to look at that is using explicit payment incentives
12 to achieve identified quality and efficiency goals. And we're going to be focusing on the efficiency side of
13 this but remember that what I'm talking about efficiency, I'm not just talking about arbitrary cost cutting.
14 I'm talking about really focusing on that part of quality in terms of the ION's key dimensions of quality.
15 That is, efficiency. And in terms also of their definition of efficiency, which is really about taking waste
16 out of the system; waste, overuse, misuse and errors. Again, we're not talking about arbitrary cost cutting
17 for necessary services. We're talking about taking waste out of the system when we talk about cost of care.

18 So how do we translate these abstract notions of quality and efficiency into something that's
19 actually measurable? Well the first step is to look at another definition of efficiency, which is given level
20 of output achieved at the lowest total cost. Well what does that mean in terms of health policy from the
21 perspective that we're looking at it today? Well, what we would like to do is attain a given level of quality,
22 substituting quality of care for output, a generic output at the lowest total cost. So if you have two
23 physicians who are achieving the same level of quality but one can do it at half the cost, that physician is
24 twice as efficient. Remembering that we're starting with a given high level of quality. So how do we turn
25 that into a cost of care measure? The typical way to do this is to look at a ratio of actual resource use,
26 which becomes the denominator, to expected resource use, I'm sorry, the numerator, which to expected
27 resource use which becomes the denominator, again, starting at the standard given high level of quality of
28 care. And as I talk about our measurement development activities, I'm going to be taking all of these

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1 definitions and things that I'm talking about in the abstract here and show you how that would play out in
2 terms of a resource use report.

3 So just to summarize this kind of overview piece of what we're really trying to accomplish here,
4 first of all, just to reemphasize, the most important points from the introduction, that we're starting with
5 quality. We're working under the quality umbrella. We're guaranteeing a certain level of quality of care,
6 and we're measuring that first, and then applying our cost of care measures, and also that there's a fairness
7 issue here, because your practices are all different, the measures have to be adjusted to take in those
8 differences into account, and I'm going to be talking about how we're doing that through various risk
9 adjustment mechanisms. So the second major point I was going to make is that we're coordinating our
10 work on cost of care measure development with a number of other groups in the industry, and this is kind
11 of where we get into the alphabet soup. You see it listed there: MedPAC, AQA, NCQA, ARC, and GAO,
12 and I did talk about all of these. There's a bit of an update, at the last presentation I did in May, there's a
13 bit of an update with some of them, so let's run through them again quickly. First of all, MedPAC, since
14 our last meeting has issued their June, 2006 Report to Congress, where they used their episode grouper
15 technology to ratify percent Medicare sample. The reported back to the Commissioners on that and that
16 informed their June 2006 report. They're moving on to their next stage now, and they're going to be
17 looking at 100% of Medicare claims. Their goals is the same as ours and hopefully their work is going to
18 assist us in that goal of linking meaningful, actionable, and fair episode-based cost measures to quality
19 measures for overall assessment of performance as we're moving toward Pay for Performance. Second one
20 is the Ambulatory Care Quality Alliance. A lot of work happening there in the cost of care measure
21 subgroup to their performance measures, work group, in fact there's another call this afternoon. They
22 basically are looking at the three predominant vendors episode grouper technology, which I'm going to be
23 talking about a little bit later, and then looking at the same kinds of issues we are, with the goal of coming
24 out with meaningful, actionable and fair cost of care measures at the individual physician level. And
25 hoping to apply those to the transparency pilots that you may have heard the Secretary of Health and
26 Human Services and our Administrator talking about in various communities across the country. Third,
27 NCQA, of course their primary interest, at least initially was at the health plan level, looking at meaningful
28 comparison's of cost among health plan, but they're also moving toward being able to do that at the

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1 individual physician level and again we're all working together, so we all inform one another of our various
2 tacks of understanding how to do this right. Another couple of governmental entities working on this ARC
3 is doing a survey of all the different types of efficiency measures out there, and then our Government
4 Accountability Office, is also doing a survey of some best practices in this area. And we expect to see that
5 report out in the next several months. So that's however you want to look at it, that's kind of the evidence
6 that this isn't just CMS moving forward, this isn't just private health plans, there are a lot of in fact, most
7 everyone who's looking at cost and quality in the health care sector is looking at developing cost of care
8 measures and we're working with them along the way, learning from one another.

9 OK, so let's move into CMS's story here in the development of cost of care measures. Just to
10 repeat our overall measurement goals for this particular project; the development and meaningful,
11 actionable and fair resource use reports, and then ultimately taking the cost of care information, linking it to
12 the quality of care information for an overall assessment of physician performance. Again, not looking at
13 cost of care measures separately, but together with quality of care measures. This is in, this is also
14 responsive to MedPAC's work in this area, in specific, both their March 2005 recommendation and also as
15 I mentioned in the June 2006 report, they reiterated their idea that you know, CMS Medicare has huge
16 claims volume. We should be using it to understand physician practice patterns and help educate them
17 about the resource use compared with the aggregated peer performance. So we a little over a year ago, or
18 now, about a year and a half ago, I guess, launched into our measurement development process. There are
19 two primary prongs to this. One can also be subdivided in a couple different prongs. But the piece here
20 that's designated as number one of the first part, we've now completed. And this is kind of where we were
21 when I left off from the story in May. And now we're moving on and heavily engaged in the episode
22 grouper evaluation, but it's very important to tell the story of what happened during the first phase of our
23 development here in order to understand what it is we're trying to accomplish in the second phase; how
24 we've learned from that and how we're carrying that forward. So in terms of the development of the
25 Imaging Resource Use reports, our specific objective was to, as MedPAC recommended, look at this claims
26 set that we have and figure out if we can feasibly make a useful report that could be disseminated to
27 physicians about their resource use, remembering that we're just focusing on imaging in this first prong, we
28 picked the project focus was for phase one, echo cardiograms for heart failure, and then we moved on to

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1 MRs and CTs, and you can see how that played out as I moved through the story. We wanted to start with
2 a fairly narrow focus to get our arms around this as opposed to the episode grouper, which I'm going to be
3 talking about. It takes a more broad view of the entire practice. And we started it in a couple of different
4 states for a couple reasons. One, because there were interesting variations, both within and between those
5 states, but probably more importantly from our perspective, there was a practical aspect, these states, our
6 program safeguard contractors already have the claims and were able to help us, and had some experience
7 in actually developing these kinds of Resource Use reports. So in the next slide, you actually see one of
8 these reports, and the staff were very helpful in blowing this up for you. The report basically captures,
9 highlights at the top in terms of resource use compared to aggregate peers, some basic statistics there, also
10 at the top, with a bar graph comparison of the individual's rate to a couple of different peer groups, and
11 then couple of histograms showing the distributions for echo cardiogram use for cardiologists CHF
12 patients. I don't want to spend too much time on this, because we're not using this report. But it is a part
13 of this important story, so it's interesting to see also how it progressed into the next report. But we went on
14 and took this out to physician, cardiologists in those two states, in Ohio and Wisconsin. Started with the
15 Cleveland Clinic and then went to the University of Wisconsin at Madison and while that was going on we
16 also had cardiologists from Partners Health Care at Mass General also looking at these reports as well as
17 the raw data that went into constructing them just to sort of give us some ideas about how to use the data.
18 And so what did we hear? And this is probably more important than the actual report I was walking
19 through with you. This is what's most important to get out of this first phase of our vetting with the
20 physicians. Because we asked them a similar question to what I'm asking you today. What do you do with
21 the reports that you get from the private payers who are already doing this? I mean we found that they
22 didn't find them to be particularly useful. We asked them what they thought about the reports that we gave
23 them. They said well, your data doesn't look right and it's not just that my numbers look high, I'm not
24 complaining they look high, they also look low in some cases and they just don't look right so I can't trust
25 them. We heard that because UPIN numbers were our way of differentiating the individual physicians that
26 when physicians billed under a group UPIN we had a problem where it was the group and not individuals.
27 The physicians felt that if their specialty society, in this case, cardiology, hadn't specifically developed
28 consensus standards, how could we possibly use aggregate peers as an appropriate standard. That just

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1 doesn't work from their perspective. They felt that must adjust for patient mix and severity, which I think
2 is fair and that is one of the things that we expected to come out of this report that the peer group needed to
3 be more precise. Interestingly, we were comparing cardiologist with cardiologist and they didn't like that.
4 If they were an invasive cardiologist, they wanted to be compared with an invasive cardiologist. That
5 coverage guidelines that CMS has for things like ICD implantation were actually increasing utilization,
6 things that the physicians maybe didn't even agree with but they felt were necessary because of our own
7 guidelines. And then we came up to the problem of the generalists versus the specialists; the specialists
8 said that the real problem was uncertified physicians who were performing imaging in their offices or in
9 accredited facilities, and then last which really surprised me, we heard over and over from the cardiologists
10 who were vetting these reports, that these would be really good to detect fraud and abuse. So even though
11 that wasn't at all our intention, and we weren't moving in that direction with these particular reports, these
12 were the kinds of things we heard. So a real mixed bag of things, some which we were expecting, some
13 which weren't expecting, but the point is, these are all things that we have to address moving forward in
14 order to make these kinds of reports meaningful, actionable, and fair. Not that we're going to be able to
15 perfectly address all of these things, but we definitely need to get better than we did with this first report.

16 OK so we learned from that. We moved on to phase 2 of our Imaging Resource Use reports,
17 which were to generate a more precise report for MRs and CTs, moving on from echoes. We thought that
18 narrowing the condition would help take some of the static out of the data. If we had more homogenous
19 groups of patients and physicians that we might answer, at least partially, some of those issues that I
20 presented on the last slide. And we decided to do that with primary care physicians this time just to see if
21 they had any better idea for us about how to use and develop these things than the cardiologists did. So we
22 developed a report that has some differences. The major difference is that it's guidelines based. So we
23 actually had a starting place this time, to address one of the major issues, which was we don't have a
24 consensus guideline. Well, we picked a consensus guideline from the American College of Radiologists,
25 basically boils down to that plain film should be ordered before any MR or CT, and that CTs should only
26 be ordered if MR is contraindicated. It's more sophisticated than that, but that's basically what it said.
27 Again, we looked at basic statistics about the patient population and about the use of the various imaging
28 studies, did similar kinds of comparisons with peer groups and the histograms that you can see there. And

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1 so what did we learn from phase 2? We learned, we did the vetting again. We can see here it was at
2 Medical College of Wisconsin, Milwaukee. And what we learned was first of all, even though we had
3 improved some of the things that we didn't do well on the first prong, we still have a ways to go. First of
4 all, there was a guideline out there that was American College of Radiology guideline, and none of the
5 Family Practitioners and Internists who we talked with during the vetting had heard of the guideline. So we
6 had a disconnect between the radiologist guideline and the actual practice. Secondly, we found that these
7 guidelines that were good for most adult patients maybe weren't great for an 80, 85, 90 year old,
8 particularly when you're talking about the cervical spine, and so guidelines need to be specific to Medicare
9 patients. The next one we really should have thought about before but you know if all you're really doing
10 is looking at someone's basic statistics and how they rate in terms of the comparison to aggregate peer
11 group, the report really doesn't need to be this complex, and so that was really helpful feedback that I think
12 probably we should have picked up earlier on. And then the last thing was as we got more focused on a
13 narrower condition like neck pain versus CHF in terms of the types of patients and the types of problems
14 that could be presenting, we actually ran into a low numbers problem in terms of the statistics being less
15 robust. So there was a bit of a trade-off. We got rid of some of the static in the data, but we created
16 another problem with small numbers. OK, so I appreciate your indulgence in this, because what I was
17 really wanting to accomplish, we've sort of moved on from this effort, because of the number of problems
18 that were engendered in just looking simply at claims for specific procedure, but it's important because it
19 tells us what we need to accomplish as we move on with the more sophisticated tool; the kinds of obstacles
20 and hurdles that we need to overcome in order to do this right. Because from this we learned that it,
21 physicians really don't see their practices on this kind of a report. It doesn't translate from seeing John and
22 Mary and Steve last week in clinic to this report that has histograms and all kinds of data. So we need to
23 find a way of reporting this that makes more sense to the clinician from the clinician's perspective.
24 Secondly, the claims data for specific procedure, like we have for imaging or service, doesn't really yield
25 rich enough information in order to generate these kinds of reports. And you'll see what I mean when I talk
26 about the episode grouper that actually captures in some ways the whole practice. And obviously the cost
27 of widespread dissemination of these types of reports would outweigh the benefits, so that's why I'm
28 curious as to why the private payers continue to do it, and maybe you guys can give me some insight into

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1 that. And then last, that it was felt though that these reports could be used as a screening tool to identify
2 gross outliers, maybe at the 2nd standard deviation, where if you're really out there that far compared to
3 your peer group, there's something going on, I don't know what it might be. It might be just your patient
4 population, but it's probably something else and maybe that's an indication for intervention for example by
5 QIO through a QIO study or something like that. So that was what we learned from the first prong, and so
6 we moved into the second prong based on an episode grouper evaluation. So what were the objectives of
7 what we're working on now? Well, our objectives are to understand the technology and its potential uses
8 of course, and to compare and contrast the specific commercially available groupers that we have selected
9 and determine between them which if either best identifies comparable episodes of care at the individual
10 physician level, and for the Medicare population. Because we do have differences, not only in the type of
11 patients, but also in the way we do the coding and payment etc., compared to the private sector, which is
12 what they commercially available episode groupers were originally developed for. So I'll show you how
13 that plays out as we move through this. So of course the first and most obvious question is what is an
14 episode grouper?

15 Well, I have this both in written form and in graphic form. I tend to like the graphic form better.
16 But I'll start with the written form and it's actually relatively simple at a high level. Basically the grouper
17 takes the claims data specifically the codes from the claims data and organizes them in to clinically
18 coherent and easily comparable episodes. Because if we can't get comparable episodes among the various
19 providers, then there's no way that we can actually get a handle on some sort of comparative measure of
20 resource use. So the grouper takes all the codes from the claims and uses a proprietary logic to map them
21 into these clinically homogeneous episode groups. This is both for acute and chronic conditions, and it can
22 use the coding information from any of our various claims sets; ambulatory, hospital inpatient, outpatient
23 lab, now pharmacy through Part D, etc. So here's the graphic representation of that. Basically, if you'll
24 start with the third triangle or cone, to the left, that's the episode initiating event. And that can either be an
25 office visit, or a procedure. And that initiating event then sets off in the data analysis, a number of things.
26 First of all, it establishes a look back period, in which the software will go back and see if there are any
27 related claims for ancillary services for example, or drugs, prior to that initiating event, but then it'll also do
28 that for everything subsequent that's related to that initiating event, so that it can then capture all that

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1 information into a discreet episode. And then at some period of time, as you see on the far right, there's an
2 end of an episode after what's call a "clean period." So what you can envision is that for a complex
3 Medicare patient, there may be 4 or 5 different co-morbidities going on at the same time, and what the
4 episode grouper does is it separates out the codes related to the different episodes into different episode
5 buckets. So you could have a heart failure with diabetes and COPD, and you would get different episodes
6 going at different points in time, and the idea then is that one individual physicians diabetes episodes can
7 all be aggregated and you can see then how much on the average that physician's care is costing for that
8 specific type of patient and so you get the perspective of the whole practice. So in terms of understanding
9 whether this technology works well and especially for our Medicare patients, we have 3 research questions
10 under evaluation right now. The questions are: Would the technology work with CMS claims data, number
11 one. Number two, how well does the technology adjust for differences among patients, the unique things
12 about patients, and your specific practices, and then number three, can the technology be used to actually
13 produce these reports? More sophisticated than the ones we were looking at before, so that they're actually
14 meaningful, actionable and fair which is our final goal for the use of these reports. And then ultimately, we
15 would link those up with the corresponding quality measures as I've been mentioning. So, here's our
16 evaluation process. Three phases, based on those three research questions. We have an evaluation
17 contractor in California called Acumen, looking at two of the vendors who have agreed to participate with
18 us. One in Ingenics, the other is Medstat, and we have a final report due late this year, so we have a few
19 months to work on it. Another thing that's unique about our evaluation is that we're investigating,
20 investing in investigating the soundness of the clinical logic behind the episode groupers classification
21 algorithms, so when I mentioned that MedPAC and NCQA and others are looking at the episode grouper as
22 a tool for cost of care measures, one thing that we're doing differently, that we can provide them feedback
23 about is that we're actually looking at the clinical logic, of the algorithms, and I'm going to describe our
24 methodology for doing that.

25 So as I mentioned we have three phases of our evaluation; the first is the data configuration issues,
26 because again, if the grouper can't use the Medicare data in a way that's effective, then it's not going to be
27 helpful to us. So our evaluation contractor's looking at 100% of Medicare Fee-for-Service claims in 4
28 states, focusing on 6 conditions, that are representative of our population, and we started by setting up data

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1 bases so that we could use those data bases through the various parts of this evaluation. So the next slide
2 shows our preliminary results. We found what we're calling reciprocal validation because of the
3 similarities between, at the macro level, between the output from the two groupers, similar assignment of
4 dollar amounts, similar distribution of cost per episode, and episode counts per beneficiary. And even
5 though it's interesting that at that level, you see these similarities, because the actual logic or the way that
6 the episodes are grouped is actually different between the two commercially available products. So we
7 can't actually do a head to head comparison because of the differences in the episodes. But we can see how
8 they're similar and how they're different and we're finding that they're more similarities than differences in
9 the output from the various groupers. So the next thing is to continue to evaluate the open issues. So if we
10 do have a couple different approaches here, from these episode groupers, what are the advantage and
11 disadvantages of each of the different approaches? Other questions like what's the most appropriate
12 reporting time frame, you're probably going to have a different one potentially, depending on the kind of
13 condition, or you may want to standardize it. What about episodes that straddle years? If you're looking at
14 the data year by year? Episodes, chronic episodes especially can straddle over years. How do our various
15 revenue and procedure codes affect the grouping, this again may be specific to the Medicare data? And
16 how should inpatient expenses in the presence of concurrent episodes be assigned so we get into the
17 attribution issues, and I'm going to be mentioning that a little bit more when I talk about our phase 3. So
18 we've got a number of open issues that we're still investigating, but when I come back to talk to you about
19 this again, I'm sure I'll have more information about those specific questions. So the second phase, very
20 important to the fairness aspect of the resource use reports that we're working toward, is the risk
21 adjustment methodologies. So the first thing we're going to look at is each of the vendors actually has his
22 own unique risk adjustment tools either built into or as a separate product that they market along with their
23 episode groupers. So we're going to be evaluating that. But we're also going to be using our own HCC
24 risk adjustment model that Medicare has developed for a third party if you will, or a non proprietary
25 evaluation of the way that these groupers determine risk among the patients and the practices. So the goal
26 is to see how risk adjustment can be used to refine the episodes to enhance fairness here. So that's phase 2.
27 And then we'll have a phase 3 to our evaluation, which is really looking at how we can take the output
28 from these episode groupers and turn that into a useful report that you would receive. And we'd be

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1 focusing initially on those 6 conditions that I presented on a previous slide and really working to address
2 those technical concerns that we had found as problems during phase 1. So questions like can we
3 accurately and reliably attribute patients to specific physicians or to combinations of physicians using the
4 episode assignment algorithms. What about that low numbers problem that I had mentioned earlier. How
5 are we going to treat outliers using the episode groupers, and I think it's important as any, what about the
6 stability and consistency of these resource use reports over time. And so we need to be able to answer
7 these questions in order to develop that meaningful, actionable and fair report that is really what we're
8 seeking here. So I mentioned that we're doing, in addition to our 3-phase evaluation, I mentioned that
9 we're doing something that none of the other evaluators are really doing at least as far as we know. We're
10 looking at the clinical logic behind these and we want to determine whether the way that the grouper works
11 and how it establishes the episodes actually has face validity for practicing physicians. We think that's
12 particularly important if we're going to be sending out these reports to practicing physicians. And then,
13 basically saying does the way that the grouper assigns claims by getting from the actual claim itself, assigns
14 the codes from that claim to specific episodes, is that clinically logical? And the next slide shows the
15 research method that we're going to use in order to determine the clinical logic of episode groupers.

16 First of all, we've gone out to, with the help of the AMA and the Alliance of Medical Specialties,
17 we've gone out to the various specialties and we said, If your physicians treat patients with these 6
18 diseases, and it's the same 6 that were mentioned on slide 31, diabetes, heart failure, COPD, stroke,
19 prostate cancer and hip fracture, if your physicians treat those patients, would you help us out by giving us
20 a simple, an intermediate, and a complex case study so that we can go then into our data base of patient
21 claims and find patients that fit those case studies. We'll get lists of their claims with all the codes
22 attached, and then we're going to run that through the grouper, and then we're going to take the grouper
23 output from those case studies and have focus groups of practicing physicians, who are board certified and
24 practice in that area and see that kind of patient, we're going to have them sit down with that episode
25 grouper output and that claim set and that case study and say, does this make sense? If I were to take every
26 one of these codes from these claims, and manually, through a very laborious process, which they'll only
27 be willing to do through a focus group, but we're going to pay them, but where they would manually take

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1 and put those into episode groups, does the groupers output match what they would do manually? And
2 that's the bottom line for the clinical logic evaluation.

3 So here's what we expect to gain from our episode grouper evaluation, not just the clinical piece,
4 but generally. We want to understand the capabilities and limitations of the groupers in handling Medicare
5 data. Our data is different than the data that these products were developed to handle. Secondly, we want
6 to understand from the practicing physicians perspective if the grouper is logical from the clinical
7 perspective. And then third, we want to understand how we can use all this information to develop the
8 Resource Use Reports that I've been mentioning. So just to recap in slide 39. Our goals is to develop
9 meaningful, actionable, and fair cost of care measures that we can ultimately link to the quality measures so
10 that we can have a comprehensive assessment of physician performance as we move toward Pay for
11 Performance, based on both quality and avoiding unnecessary costs. So the last slide here just restates the
12 questions that were posed at the beginning of the presentation. And I'm anxious to hear your feedback.

13 Dr. Senagore: Thank you very much, Dr. Valuck. Any comments or questions?

14 Dr. Grimm: Was a very nice report, you really laid it out as clearly as possible for a fairly complex
15 idea.

16 Dr. Valuck: Thank you.

17 Dr. Grimm: The use report, as I see it would come across my desk, it raises, it should raise the first
18 question—am I an outlier? I think if it's any function it has here, it's that one. And then if I am an outlier,
19 what it should raise another question, what is the standard? I think what you encountered, particularly with
20 the radiology stuff is that, I thought it was an interesting thing that you found out, that people didn't even
21 know what the standard was. And maybe that might be the biggest function this thing does in the first
22 place is really illustrate to the medical community that they don't know what the standard is and they need
23 to know. That may be its primary function here. And once you let you let them know what the standard is,
24 you've done, half, about ¾ of your job and you've improved the health care of your community just by
25 doing that small thing.

26 And I think the next question should raise for physicians is how, should I change my practice
27 based on this use report? And maybe you could address this issue. One of the things as you were talking
28 about, as you know when you start dealing with variables, you can get down to very small numbers for an

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1 individual practitioner. Just take diabetes for a second, and take that down and use that as Jeff's comment
2 earlier, he's got the very complicated patient. He's got 10 variables going on here and that they could be in
3 10 different episode grouper, right?

4 Dr. Valuck: That's true.

5 Dr. Grimm: Potentially. So this guy gets the report back 6 weeks later, you're an outlier. It isn't
6 going to change his practice, because he knows that this is such a and he only sees that case once every
7 year, or once every two years. That's the problem with some of this, for those who have a lot of volume,
8 it'll change your practice, but I'm afraid where there's low volume for a physician, that it's going to have,
9 may not have much impact unless you're way out. I think just one other aspect and I'll finish. I think one
10 of the things for the use report, I think the basic fear for physicians is that this use report will be used as a
11 means to deny payment. It'll be taken by the private carriers to the next step, which is really to deny
12 payment to them. And I'd like you to—is there any reason why the private carriers wouldn't take that step?

13 Dr. Valuck: First of all, the private carriers have been using this technology for a number of years.
14 We're in some ways catching up, but I think we're also trying to be more deliberative, so that we can do
15 this in the right way. Because we're hearing that the reports that practicing physicians get from the private
16 carriers that use this kind of technology, or have some of the problems that were cited previously in this
17 discussion. I can't speak for whether or not they have any intentions to use it in the way you describe, I
18 mean I know that our goal is to get the reports to physicians to help them understand their own practice,
19 and then ultimately to be able to link the cost piece to a high standard of quality so that we can find that
20 right balance between increasing quality and avoiding unnecessary costs for a Pay for Performance
21 purpose, where the physician who actually works and takes the waste out of the system can be rewarded for
22 that.

23 Dr. Grimm: Did you find in the radiology example, did you find that once they understood what
24 the standard was, that they changed their pattern of practice?

25 Dr. Valuck: We only did that point in time discussion with them, so no, we didn't look at that over
26 time.

27 Dr. Azocar: In relation to the efficiency, I find very interesting that you consider that to be fair you
28 have to consider the differences among the different practices and one of them that you will find when you

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1 compare geographical areas. Different socio-economic, which are many issues that the physician cannot
2 control, such compliance and many co-morbid factors, especially in populations. Can you comment on
3 some how you anticipate to bring some of the adjustment to that?

4 Dr. Valuck: I think first and probably most importantly we expect that a high level of quality will
5 be met for all the beneficiaries. So we'll be putting quality measures in place that are going to give us a
6 standard or a place to start. Then we'll also be looking at cost, and as you commented, one thing that can
7 impact both of those is compliance. It's interesting when I've gone out to talk to physician groups about
8 not only the cost of care measures, but about Pay for Performance in general, compliance always comes up
9 as issue. But I heard for the first time when I was talking to the AAMC in Chicago a few weeks ago that
10 there were physicians in the audience who said, but hey we have an ability to have input in increasing
11 compliance and if we do increase compliance, shouldn't we also be rewarded for that. Shouldn't that be a
12 part of the overall reward in Pay for Performance? If we take the time or make the effort to figure out how
13 to get our patient population more compliant, we really feel like we should be rewarded for that. So I think
14 there are both downsides and upsides to compliance when you're looking at Pay for Performance, but we
15 do need to understand how to account for that as part of a meaningful adjustment.

16 Dr. Powers: How are you going to adjust for the small end?

17 Dr. Valuck: Well, there are a couple ways you can do that, first of all you can aggregate the data
18 over a longer period of time. You can do two years for the Resource Use Report instead of one year, and
19 you presumably, if you have twice as many, if you have a consistent number of those patients, you would
20 expect to see twice as many over a two-year time period than you would over a one-year. I mean if it's just
21 a single patient and a single point in time, frankly, I think for our purposes, we wouldn't be too concerned
22 about what happened with, I mean we'd obviously want a high level of quality, and as little waste as
23 possible, but we're going to not find the biggest pay-off with one off kinds of situations. But if it's for
24 example, a provider who doesn't see a lot of Medicare patients, but when they do, maybe they're very
25 resource intensive, maybe if we look at that over a number of years. The other way that you can do that is
26 actually aggregate the providers into a group, for example, and look at it that way. But we'll have to sort
27 that out as we move forward.

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1 Dr. Powers: Well, I'm thinking having relatively small ends and getting some reports on usually
2 drug utilization and things like that from insurance companies, and you may get a patient who is an outlier
3 and has a chronic disease and will always be an outlier. So they can't, you can't measure your, if you've
4 got one out of four patients, you're always going to be punished for that patient. There needs to be some
5 way, or they tell me that for this percentage of patients with this disease, I should be using this generic
6 medication. Well, first of all, their assumption may be wrong, that that generic medication is OK. And it
7 may not be OK for this patient because we've tried it and it didn't work, but they still fall into that
8 category. Or they may be allergic to the medications that they want us to use. You ought to be able to take
9 in that instance, because you being adversely affected by that one outlier, somehow you ought to be able to
10 throw that outlier away in a situation like that where you've got a really small number.

11 Dr. Valuck: On slide 35, some of the issues that remain to be addressed and developing these
12 Resource Use Reports, are listed there, and I almost wanted to make a separate slide, with just those
13 technical concerns because they're all extremely important, and you focused in on the one about how the
14 report would treat outliers. But even though they're a 3rd bullet down in the hierarchy here, these are all
15 extremely important issues and I appreciate that outliers is one of them.

16 Dr. Ross: I'd just like to follow up what Dr. Azocar mentioned about not just compliance, but
17 follow-up to the office, depending upon socio-economic situations, but now, getting back to the real
18 majority of co-morbidities, and I think we visited this on the last occasion, we talked about the 6 diseases,
19 but let's go further into the peripheral vascular disease patient, or the end stage renal patient, renal failure
20 patient, with all those co-morbidities and how we will assess the care and standard of care and quality of
21 care, for those individuals who have so many co-morbidities that the outcomes may not be that good, and
22 then going back, we may have mentioned this before, for those patients who are let's say on the outlying
23 areas, who don't get that care for these problems, versus those that come in to the major centers who are
24 treated by physicians who will take on those cases that really don't have better outcomes—the diabetics
25 with all the co-morbidities, the amputations, the COPD, or the pulmonary edema, and all the other
26 conditions that lead to maybe and MI and then lead on to demise possible situation. So the question is, how
27 do you differentiate between the outlying physicians, the care that's being given outside of the medical
28 center areas, the care that's being given to patients who let's say are noncompliant, or don't follow-up with

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1 their physicians, or don't have the means to get that attention or just even transportation to get to the
2 physician's office.

3 Dr. Valuck: I think again going back to our initial premise, we've got to start with the same level
4 of high quality of care. I mean we can't just say because you live in an outlying area, and you don't have
5 close proximity to an academic medical center that it's acceptable that you would have a lower level of
6 quality of care, so we have to hold the provider to a similar standard. But once you've said that, then each
7 of the providers, no matter what area they're in, or what their patient population is, should have the same
8 opportunity, if they're providing the same high level of quality and working to avoid and take those
9 unnecessary costs [inaudible], they should have the same opportunity for rewards under a Pay for
10 Performance system, so that's why we have to have the ability to appropriately adjust the patient
11 populations one to another so that you can really get to a true comparable situation, so that everybody has
12 the same opportunity to earn the rewards for Pay for Performance. So how you're going to do that, well, I
13 gave an example of how the episode groupers have risk adjustment technology that's built into them, and
14 just as a simple example, if you think of an array of the patients' co-morbidities across one access, and of
15 their severity of illness across another axis, which is very simply how one of these episode groupers treats
16 it, then instead of just having one patient compared to another patient without any kind of adjustment, the
17 array actually allows for 15 different cells where a patient with 3 co-morbidities and a level five of
18 complexity is only compared to a patient with 3 co-morbidities and a level 5 of complexity, so that's the
19 way that—

20 Dr. Ross: So if I'm reading it correctly, then you're saying that you're going to create almost like
21 a grid for these patients with different pigeonholing depending on how many co-morbidities and that will
22 create a level of difficulty if you will.

23 Dr. Valuck: Yes. Don't, that's an example of how it could work with episode grouper technology.
24 I'm not saying that's exactly how we're going to do it, but that's the level of sophistication we're trying to
25 get to so that we aren't just dismissing the very important issues that you're bringing up.

26 Dr. Urata: So in other words, if you have one visit and you take care of the person's hypertension
27 and coronary disease and lipid problems, and diabetes, and they're a stable patient and you might take care

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1 of it in one visit, so you wouldn't deal with one diagnosis per one visit, I mean, it really wouldn't matter
2 how many visits you had.

3 Dr. Senagore: If I could interrupt for just a second. I'm sorry. We can pick this up in just a second
4 if we could suspend this discussion. We're happy to have the Administrator, Dr. McClellan here, and I
5 want to thank him for coming, and if we could just break and have any discussions for Dr. McClellan.
6 Sorry Dr. Valuck.

7 Dr. Valuck: Not at all.

8 [chat]

9 Address by Dr. McClellan

10 Dr. McClellan: Dr. Senagore, thank you, and I want to thank all of you here with PPAC for the
11 time and effort that you're putting in as you've seen from the agenda today and from your recent meetings,
12 this advisory council is more important than ever before. I've been talking to a lot of doctors myself
13 around the country and those who follow CMS issues closely point out that this is a year when a lot of
14 different things really seem to be coming together. It's not just the usual – I hate to say usual -- issues with
15 the Physician Payment Updates and needing to make more progress towards a more sustainable and
16 effective payment system, but also our 5-year review with the RVUs with the RUC recommendations.
17 There are some geographic coding changes and other changes related to imaging from the Deficit
18 Reduction Act. The list goes on and on. What I've found to be particularly valuable in the past months
19 from your input is that you've not only brought the perspective of practicing physicians to the agency, but
20 you've done it in a way that's helped us take rapid action, and rapid action requires turning to you in good
21 part to identify practical important issues, but not only to identify the issues but to help us think through the
22 solution. So as we've been working on recent months on steps towards better payment with more of an
23 emphasis of supporting quality care by physicians, so that you won't be penalized when you take steps to
24 keep a patient healthy, so that if you've got innovative ways of delivering care, we can support that even if
25 it doesn't fit in well with our traditional fee-for-service payment models, that kind of input, whether it's on
26 how we should developing measures or the PVRP Program or on other very practically relevant issues, has
27 been extremely important. Not only has it been important to me to get the input, it's been important to me
28 that we're turning around this input quickly. So we've tried to work to the point where you all identify an

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1 issue in one of the meetings that by the next meeting or certainly very soon, we've had an opportunity to
2 take your recommendation and turn it around inside the agency to get back to you with what the
3 appropriate next steps would be. This is a long way of saying that I think this close interaction is going to
4 be even more important going ahead. I don't see these challenging issues with respect to making sure our
5 payments are appropriate, making sure that we're doing all we can within the tight budget constraints we
6 face, to support quality care for physicians, I don't see those issues getting any easier, but I also see a
7 tremendous number of opportunities, thanks to the leadership that you're providing and the very
8 constructive work that you're doing with us as we fully engage on many of these physician related issues.

9 Looking ahead over the next couple of months, I see the agency being very involved in the
10 legislative interests in getting to a better payment system for physicians. I see us continuing to make
11 progress on supporting physicians and issues that come up with the implementation of Medicare Part D and
12 most important, I see this agency continuing to make progress towards being what I like to call a public
13 health agency. You can't be the largest health care payer in the world and not recognize that your actions
14 have a big impact on the way that healthcare is provided on what is and isn't feasible as physicians keep
15 trying to develop better ways not just to make ends meet, but to deliver excellence in practice, in a rapidly
16 changing and often very challenging environment. So I want to thank you all for the work that you're
17 doing under your leadership, Anthony, but also to stop talking and see if there are any questions or things
18 that you'd like to point out particularly for me. Ken, good to see you, too.

19 Dr. Senagore: Anybody on the panel? I can start off while folks are thinking. One of the things
20 that we talked about over lunch was the concept of the EMR, how that's going to pan out and the idea that
21 none of them are truly best in breed in a reporting schema. So has the agency thought at all about making
22 some sort of at least reporting format consistent across the various vendors.

23 Dr. McClellan: We'd like to do that. One of our recommendations to the AHIC, that's the
24 department backed initiative to try to develop standards and other stuff to promote the adoption of
25 interoperable health care records was to get the AHIC, the American Health Information Community to
26 start putting more emphasis on standards for automatic reporting of quality measures and the like from
27 electronic record systems, and at the last AHIC meeting, back at the beginning of August, AHIC formed a
28 work group that's led by physicians, basically, some of the physicians that have been involved with the

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1 Ambulatory Care Quality Alliance and the AQA efforts. And I think that kind of a alignment's really
2 good, because we are really trying to get to a lot of standardization around the right measures of quality and
3 also the right reporting quality to reduce the burden on physicians, and since the AQA working with the
4 AMA Physician Consortium and NQF has really been helping to lead the way toward measures that are
5 valid, and physicians think are sensible and feasible, and useful, to collect, since they're doing a lot of the
6 work on the measure standardization, having them involved with guidance to the technical experts on
7 electronic standardization seemed very important. We are now sponsoring 6 pilot programs around the
8 country with the help of the AQA that the Secretary would like to see expanded as soon as possible to get
9 to practical reporting of quality in a way that works for practicing physicians. The communities that are
10 participating are some that many of you know well, including Indianapolis, the Boston area, Minneapolis-
11 St. Paul, Phoenix, State of California, these are areas that have been involved in physician quality
12 measurement and reporting and the use of electronic information for reporting for a long time now and I
13 see our efforts to support that really stepping up and interest in this really stepping up. There's, I think the
14 combination of health care payers, consumer groups, want better information, want better ability to pay, but
15 especially in the past year, the I think renewed leadership or very strong leadership from the physician
16 community has helped move these issues forward and hopefully in a way that is reflecting the key priorities
17 of physician leadership for this is very important.

18 Dr. Williams: Dr. McClellan, thank you for taking the time to meet with us today, we know you
19 have a very busy schedule. At the risk of sounding like a broken record, I would like to just on behalf of
20 the anesthesia teaching programs just point out that the number of anesthesia training programs has not
21 increased, those actually are nursing anesthesia programs that have increased in recent years, since the
22 institution of the teaching rule. We have lost about 20 academic anesthesia training programs, and the
23 funds that are currently being supplemented to programs by the hospitals, on average, I think as you know,
24 between \$400,000 and \$1 million per department per year on average is money that could be spent doing
25 research and other things that would further advance the science of our specialty. I was wondering if there
26 is any way, or any other mechanism by which we could reopen discussions with you in order to try to
27 revive our academic training programs for physicians.

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1 Dr. McClellan: Well, that's a very good question, and this is an issue that I've been watching
2 pretty closely. As you know, we asked for comments on that last year and the Physician Rule, and the
3 comments were unfortunately kind of more spread around than I had hoped, with other specialties wanting
4 sort of the same kind of—if it was going to happen for anesthesia, they want the same kind of expansion,
5 and that's something we weren't in a financial position to do, so we would like to keep the channels open
6 on trying to address this comments and this year's physician rule would be much appreciated. I would also
7 point out that we've been taking a look at some other aspects of our support for residents in teaching
8 programs, particularly in the non-hospital setting. As you know, anesthesiologists are increasingly
9 providing non-hospital-based services, too, and we're going to have more to say about that soon as well, so
10 these payment issues in teaching setting continue to be very important, and we'll keep looking for a good
11 solution on this one. I know how important it is, the anesthesiologists.

12 Dr. Williams: Well, we'd appreciate it, the cuts in general that all the other physicians are
13 experiencing are particularly problematic in our academic training programs because we're experiencing—

14 Dr. McClellan: That's why we really need to get a better payment system. I think that's the best
15 solution there and we're going to try to work very hard with Congress in the next few months to do that.

16 Dr. Urata: I want to bring up something I've been kind of talking about all day today is about our
17 graduate medical education volunteer faculty.

18 Dr. McClellan: Yes.

19 Dr. Urata: It's been going on for three years, and I just put in a plug to kind of come to a quick—

20 Dr. McClellan: I couldn't agree more. I come from that. I taught in that environment myself
21 before coming into government, and the problem is that the teaching payment system was designed in an
22 era pre all this ambulatory training that is going on and that should be increasingly going on in the future,
23 so we've had the problem of trying to fit a round peg into an increasingly out of shape hole, but I think
24 we've got some good ideas to do that that we're going to be seeking some feedback on in the very near
25 future and I would like to get that resolved at least addressed effectively very soon.

26 Dr. Senagore: Is there another, Greg?

27 Dr. Przyblski: Dr. McClellan, in your introductory comments you pointed out some of the lively
28 discussions we had in—

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1 Dr. McClellan: Oh, yes, trying to keep you busy while you're here.

2 Dr. Przyblski: One of the frustrations that I think other physicians have had. We understand that
3 Congress sort of strong arms you into a particular position as to what to do with that but one of the
4 discussions that we've had at this table was about the drugs in the Part B calculation, and could they be
5 removed or not? We had discussions back and forth, and we've heard from Congressional representatives
6 that they could be removed and we've heard from here maybe they can maybe they can't, and after a
7 number of recommendations from PPAC, we finally heard well we can't do it, we don't think we can do it.
8 So do you have some insight as to why not, or is that something that can be changed in the future?

9 Dr. McClellan: I think basically, and I'm not the legal expert, but I think if you look at, we dealt
10 with this pretty extensively in the Final Physician Payment Rule, last year for 2006 where we had brought
11 this up for comment, got a lot of comments on it and I think the legal conclusion was there was no obvious
12 way to differentiate that kind of physician administered service from other physician administered services
13 that were in and I think according to our lawyers, the pretty plain reading of the statute despite all our
14 efforts to look at whether something else was feasible was that they need to be included. I think the further
15 challenge here is that even if you were to exclude Part B drugs at this point, we are now so far in the hole
16 on the cumulative SGR deficit, that it wouldn't be I think until 2012 when you would even get a non-
17 negative update, even if you took drugs out and some have argued that well, if you remove them then the
18 total cost of fixing the Physician Payment Update problem would be less. Wouldn't be that much less and
19 certainly not for the 5-year budget window that CBO focuses on in their scoring. I think it wouldn't help at
20 all, really, with that, so we are going to need to find some other solutions to the problem, and I hope we'll
21 keep you actively engaged and busy in working with us on that.

22 Dr. Powers: Thank you for coming. You made a quick statement about being engaged in working
23 legislatively. Are we talking just to improve for a better payment system, are we talking just the quality
24 issues, the Pay for Performance or are we looking at getting legislative change to the SGR?

25 Dr. McClellan: It's a good question. I think most people view legislation as doing something on
26 both. My own view is the more that you can work towards getting to a quality-based payment system
27 where we're paying for what we really want, and quite frankly what physicians want to deliver, which is
28 better care at a lower overall cost, the easier it's going to be to address the SGR problem of the payment

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1 rates going down for the specific services being provided. And we've gotten a lot of very useful input from
2 many of the specialty groups and from many published studies identifying how quality improvement steps
3 can lower overall costs of care. I think the evidence now is very strong for a couple of conditions, heart
4 failure where you can see turnaround on and pay off to implementing steps to medication, compliance
5 monitoring, patient education and so forth, in just a matter of months. Diabetes, the pay off there is a little
6 bit longer, 2 or 3 years, certainly within a scoring window and we are going to try to say more about what
7 we know on the potential for savings here soon, see if we can get some more, shake the trees a little bit
8 more for other evidence. The more that we can identify steps that lead to reductions in overall costs of care
9 as a result of quality improvements, the easier it is to pay for getting to a more stable system on payment
10 rates. I think we'll have a lot clearer idea about when and how this whole legislative discussion will
11 proceed after the members get back next week. And I think there's some discussion about whether this is
12 something they'll take up sooner or later. We'll know more after they get back, but we stand ready to
13 provide technical assistance and we've said very clearly that we would like to see us get to a more stable
14 and sustainable payment system for physicians, and that's going to be easier to the extent that we can link
15 the quality improvements and steps to avoid unnecessary costs to the payment reforms.

16 Dr. Sprang: Again, thanks very much for coming.

17 Dr. McClellan: Sure.

18 Dr. Sprang: And thanks for your help in the past couple of years when they've tried to decrease
19 the update instead of increase it. The physicians having difficulty keeping their offices open now,
20 [inaudible] those are helpful, and maybe this year that's all that will be able to happen again, but at least
21 that would be useful for the coming year, and we certainly appreciate your help in that. We're talking right
22 now on the Pay for Performance and clearly they're doing a good job of getting a lot more details, and the
23 devil's in the details,

24 Dr. McClellan: Exactly.

25 Dr. Sprang: in trying to explain it. But most of the evidence out there seems to be as you really
26 follow guidelines more, and actually practice better medicine, and obviously try to get more value, which is
27 where we're all going, you may not really save money that'll now be actually in Part B,

28 Dr. McClellan: Right.

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1 Dr. Sprang: and the concerns going forward MedPAC has said we could probably save money
2 going forward into Part A. So I'm very pleased to hear that CMS is looking at a little outside of the box
3 and looking at some ways of kind of really stepping back and saying how we shift some of the money that
4 maybe you save in one part into another part. And ultimately that's the only way you're really going to
5 make any sense. Because even if we take better care of patients in the office, and see them more, we're
6 still going to have more money in Part B.

7 Dr. McClellan: Right, and it's that overall coordination of care that we want to improve. You
8 mention the Pay for Performance demonstrations which do seem to show some of that Part A savings and
9 potential for more. I just would remind everybody that the administration and budget this year, talked
10 about supporting performance-based payments reforms for physicians and frankly for other parts of the
11 Medicare system, provided they were budget neutral. And we didn't have a qualifier in there about budget
12 neutral within Part B, or within in some segment of the population. We really need to be moving towards
13 looking at the overall cost and quality of care. That's been a big theme in our, in the President's initiative
14 on transparency and a big part of our work with the AQA, the Hospital Quality Alliance and other groups
15 to get a better clearer picture of overall costs of care and how we can work together with physician
16 leadership to get those costs down. So that's absolutely, absolutely the case.

17 Dr. Urata: Thank you.

18 Dr. Senagore: Time for one question. So I will choose.

19 Dr. O'Shea: I think that our discussions are far-reaching, we talk about specific things, but in
20 general the push for Pay for Performance, just as long as it doesn't become perform like this to get paid.
21 And that's just simply stated that physicians are looking at it in the kind of the reverse. And that we want
22 to make sure that health care and health outcomes are number one. Sometimes we're just saying quality
23 and efficiency, quality equals cost. Well, it doesn't always just do that. And we want to make sure, and
24 because that's not really why any of us got into medicine to begin with, only that part of it. And we know
25 that if you know they can't pay the bills, the lights can't stay on. So we understand that the cost is the
26 bottom line, but as we're moving towards this and to make sure that it stays in the forefront that health care
27 and health outcomes for our patients are still our number one concerns, and that effectively that will
28 provide more quality care when our focus is health outcomes.

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1 Dr. McClellan: That's absolutely as it should be. In fact, many of the surgical groups have been
2 making a lot of progress toward proposals for payment systems that would be very outcome-based, the
3 Society for Thoracic Surgeons already implementing this in Virginia and want to do it elsewhere. Some of
4 the other surgical specialties have written me, written members of Congress, saying look, better quality
5 care in our specialties cost less; few complications after surgical procedure and the like, and we're also
6 looking at ways where either through a pilot basis or if there is more comprehensive legislation, we can
7 support more global overall payment comprising the whole hospital physician episode of care, and that
8 enables surgeons and other doctors to get paid more when they prevent complications. The internal
9 medicine specialists, family practice doctors and others have proposals for medical homes, and have kind
10 of the same concept. Let's give us more, we have responsibility over the patient's overall coordination of
11 care, give us more of an ability to take steps to get that care better coordinated and keep costs down,
12 hopefully as a result. Right now if an internist does things like invest in electronic medical record, or a
13 nurse practitioner to call a high risk patient on the phone ahead of time, we not only don't pay for it, we're
14 paying less because they'll come to the office less, they'll have fewer complications, fewer visits and
15 services and the like. So that's just the wrong kind of incentives and it makes it impossible for doctors to
16 make ends meet in their practice while improving quality, and I think we can change that, if we keep
17 moving forward carefully. And that's again where you all come in. We can't just do big changes, willy
18 nilly, we need to make sure that we are implementing approaches, as you all say where the rubber meets the
19 road, in a practical technical details here actually work from the standpoint of practicing doctors. So thank
20 you all again very much for your leadership, your time, your commitment, we truly appreciate it. We know
21 it's a big burden, but it's making a big difference. Thank you. [applause]

22 Dr. Senagore: OK, Dr. Valuck got a break there. [laughter] If I can start off the discussion again,
23 you have a working experiment now, with the recent rule on morbid obesity surgery. And where you've
24 mandated centers and certain volumes, it would be intriguing to know has your cost per case change, your
25 complication rate changed, your mortality changed with that mandate, because it's made a significant
26 dichotomy then, you've ostensibly rule out lower volume places and made it impossible really for a new
27 institution to get up and running.

28

Pay for Performance continued discussion

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1 Dr. Valuck: You know, another component of our agency may be looking at that, in fact I would
2 guess that that's probably true and we can get back to you. But I'm not familiar with that.

3 Dr. Senagore: I mean because your focus on quality, and that was ostensibly the rule so it would
4 be a great data element to think about. And then to follow up on the quality cost issue, and I'll just speak at
5 it from what I take care of. The biggest quality measure in all honesty is survival after your colorectal
6 cancer operation. Everything else is a surrogate measure. So if my local recurrence rate is 10% of
7 somebody else's, then anything else that got spent is a bonus from there, because the more, the higher
8 expense is caring for that recurrence. And I wonder to some degree at least for some of the diseases, it may
9 be better to take a 40,000-foot level big outcome measure, rather than worrying about all the little surrogate
10 measure outcomes, where you're worried about checking boxes off again a la our E&M-Coding, which
11 may or may not be germane to the outcome.

12 Dr. Valuck: Right. You know one of the things about the episode grouper that I think you're
13 pointing out too, is that we're not just looking at a snapshot in time, for resource use, we're really looking
14 at these services across a period of time, and so for your particular patients, we would be able to capture
15 let's say on a yearly basis on an every two-year-basis, or whatever time period we pick, then look at all the
16 services for all of your patients with colorectal cancer, compared to either some standard or compared to
17 risk adjusted comparable peer, and that's how we would account for that longitudinal look at your practice.

18 Dr. Przyblski: Two quick comments, and these are probably things you've heard before. One is
19 that it's obviously critical that you pick your measures appropriately. And there's been a lot of time
20 pressure that physicians have seen to develop measures very quickly. I was involved in developing with
21 colleagues of mine, all volunteer, guidelines for management of spinal cord injury in cervical spine. It took
22 us about a year and a half to come up with ten or eleven things that may not even be applicable to what you
23 would like to measure. And we're being asked in sometimes very short timeframes of weeks to be able to
24 come up with recommendations and I think it's very difficult to do. I know that one of the urologists from
25 the AUA had come up to me to discuss that pressure issue. I know that we as a neurosurgery organization
26 were asked to list CPT-Codes that would be applicable for DBT prophylaxis and in fact what we came up
27 with is probably no CPT-Codes but rather ICD-9 codes might be more appropriate, but under very tight
28 time constraints it becomes very hard to come up with accurate evidence-based information so I would ask

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1 that you keep that in mind when the timetable is getting pushed, and then finally that the evidence basis is
2 evidence rather than consensus. And I was bothered last time and bothered again about this CTMR
3 business, because one of the things that you are measuring was a plain radiograph obtained ahead of time.
4 And my understanding is that the ACR's recommendations are consensus based. As a spine specialist
5 taking care of patients, I don't know why I would get a plain x-ray on somebody with chronic neck pain.
6 So if one of your outcomes for these primary care physicians, who also weren't aware of these
7 recommendations, they didn't get the plain x-ray, I wouldn't get it and that's my field of expertise. So are
8 you really measuring the right thing?

9 Dr. O'Shea: Dr. Valuck when I read over and I read the Institute of Medicine's crossing in the
10 quality chasm report, it seemed that it was a weighted report, that they really thought that quality started
11 with a safety. It was one of their biggest issues, and rolled out from there. Effectiveness, and patient-
12 centeredness, and as I look at it, I know that we have money constraints, and that's really what we're trying
13 to grapple with; quality and cost-effectiveness, but as I had said to Dr. McClellan, we have to keep the
14 patient-centeredness and the effectiveness in there, and that it has to be health care outcomes at the same
15 time. And I think I agree with the other physicians here that we have to know where this effectiveness is
16 coming from, where these health care outcomes processes are being measured from, keep the physician in
17 mind when you're doing this and not just the cost-effectiveness. That's just not the only thing. You know,
18 just a band-aid doesn't always work.

19 Dr. Senagore: Great. Thank you for your time. Sorry for the interruption but you'll understand.
20 So we can stop here and take recommendations. I figured I would excuse him since they already had to
21 wait for a bit of a break.

22 Dr. Sprang: When he walked in, should we table the motion, or table whatever's going on. It
23 really came from England, when Parliament was discussing a thing, and if the King walked in, they'd stop
24 whatever else they'd do and table things, and we just kind of did that for him, which was very nice and very
25 appropriate. He also brought up, you just said this was the time I should bring up that recommendation
26 about the two things, and I think it fits very well with this. Because obviously I really am pleased with all
27 the increased attention to detail. I think that's what all the physicians worried about, making sure we really
28 do it right. But there is evidence that kind of doing it right does involve more physician time and care and

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1 we're going to end up spending probably seeing the patients more, and the money that will be end up being
2 saved and there can be money saved, will more likely be in Part A, not in Part B. So that's where the
3 projects that you guys are working on now as far as trying to maybe establish a demonstration project to
4 kind of look for possibly money flowing from one to the other is very appropriate and very useful, you
5 know, that's more a long time on time. So I just—

6 Dr. Senagore: You might actually have captured your original one, from—Dana? Or not. Nope,
7 she didn't, so sorry.

8 Dr. Sprang: PPAC first of all now that I know all this is going on we'll start out a little differently.
9 PPAC commends CMS for establishing demonstration projects that allow or potentially allow cash flow
10 form one silo to another and would recommend that CMS consider more of those types of projects and
11 specifically ones that could possibly shift dollars that are saved by physician activity from that are saved in
12 Part A and to go into Part B in such projects obviously educate the physicians in those areas about what's
13 going on.

14 Dr. Senagore: Did we get that, Dana, sort of? If you want to read it back we'll try and wordsmith it
15 for you. She's still typing and you've stopped speaking, so I'm not sure we've [laughter]

16 Ms. Trevas: PPAC commends CMS for establishing demonstration projects that would allow cash
17 flow from one silo to another. And recommends that CMS consider more of those types of projects,
18 specifically those that could shift dollars saved by hospitals as a result of physician action from Part A to
19 Part B and educate physicians about something.

20 Dr. Sprang: It's more dollars saved through physician actions—if I can explain where I was, from
21 Medicare Part A into Medicare Part B. Is that going to read right?

22 Ms. Trevas: Can I start with the recommendation?

23 Dr. Senagore: Yes, don't worry about the first part.

24 Ms. Trevas: PPAC recommends CMS consider more of those types of demonstration projects,
25 specifically those that could shift dollars saved through physician actions from Medicare Part A to Part B.

26 Dr. Senagore: Everybody OK with that? Is there a second? Leroy not quite happy yet?

27 Dr. Sprang: I'm not quite sure what you said at the end, was the very last part—just the very last
28 part.

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1 Ms. Trevas: Dollars saved through physician actions from Medicare Part A to Part B.

2 Dr. Sprang: To Part B and educate physicians in those areas about—

3 Ms. Trevas: I'm sorry I couldn't hear you.

4 Dr. Sprang: And educate physicians in that geographic area about the program. Sorry.

5 Dr. Senagore: OK Dana? We have it if you have it.

6 Ms. Trevas: OK, good. Thank you.

7 Dr. Senagore: All in favor?

8 [Ays]

9 Dr. O'Shea: PPAC recommends that CMS support the establishment of quality and/or Pay for
10 Performance systems whose primary goal is to improve the health care and health outcomes of the
11 Medicare population. These programs will need additional resources to support implementation. And to
12 reward those physicians who voluntarily participate. We believe that Pay for Performance should not be
13 budget neutral.

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

15 [seconds]

16 Dr. Senagore: We may have to leave out the editorial comment for the last bit, but [laughter].

17 Ms. Trevas: PPAC recommends that CMS support establishment of quality and/or Pay for
18 Performance initiatives whose primary goal is to improve the health care and outcomes of patients—

19 Dr. O'Shea: health care and health outcomes.

20 Ms. Trevas: and health outcomes of patients.

21 Dr. O'Shea: Of the Medicare population.

22 Ms. Trevas: and to—is that where the and begins?

23 Dr. O'Shea: No, these programs will need additional resources. Do you want me to repeat—

24 Ms. Trevas: Yes, I'm sorry.

25 Dr. O'Shea: I will, I will—I'll start from the beginning is that all right? PPAC recommends that
26 CMS support the establishment of quality and/or Pay for Performance systems whose primary goals is to
27 improve the health care and health outcomes of the Medicare population. These programs will need
28 additional resources to support implementation, and to reward those physicians who voluntarily participate.

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1 [off mike question]

2 Dr. O'Shea: No, no, I am not.

3 [off mike discussion]

4 Dr. Senagore: Is there a second?

5 [second]

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

7 [Ays]

8 Dr. Senagore: All against, no? Any other issues related to P for P? We can take a 5-minute break
9 or not at the discretion—

10 Dr. Powers: [off mike] recommendation

11 Dr. Senagore: OK.

12 Dr. Powers: Shall I read it again?

13 Dr. Senagore: That would be fine.

14 Dr. Powers: PPAC recommends that CMS use adjustments to the conversion factor instead of the
15 10% work value adjustor to maintain budget neutrality for the 2007 Medicare Fee Schedule.

16 Dr. Senagore: All set, Dana? Second, any discussion? All in favor?

17 [Ays]

18 Dr. Senagore: Now, do people need a 5-minute break or should we finish with our last
19 presentation.

20 [off mike discussion]

21 Dr. Senagore: Let's take a 5-minute break.

22 Electronic Prescribing

23 Dr. Senagore: I'd like to welcome Mr. Don Romano who's the Director of the Division of
24 Technical Payment Policy in the Center for Medicare Management. His staff evaluates policies developed
25 to improve the function, quality, and efficiency of Medicare services. The Medicare Modernization Act
26 provides for electronic prescribing in the Part D program, and Mr. Romano will explain this relatively new
27 component of information sharing and provide us with its implementation status and I thank you for your
28 patience, Mr. Romano.

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1 Mr. Romano: Thank you. I'm going to walk you through the regs. There's actually two
2 exceptions to the physician self-referral statutes that we promulgated on August 8th, and that was also
3 issued in conjunction with two Safe Harbors, by OIG, which more or less parallel what we did under the
4 Stark Statute. Everything that I say concerning the CMS regs are pretty much applicable to the Safe
5 Harbors, except that you have to understand that the anti-kick-back statute applies to more than just
6 physicians, so there's some differences in terms of who the eligible donors and recipients are, but other
7 than that, the Safe Harbors are pretty much identical given the underlying differences in the two statutes to
8 the exceptions that we promulgated under the Stark Statute.

9 We used two sources of statutory authority for these exceptions. There was an electronic
10 prescribing exception that was mandated by § 101 of the MMA. We have independent authority under the
11 Stark Statute itself, 1877(b)iv which allows us to create additional exceptions as long as there is no risk of
12 patient or program abuse, and that is the authority that we use for the HER exception.

13 So the first exception is the electronic prescribing exception. This exception was, as I said,
14 mandated by Congress and the approach that we took in the Final Rule is that we should do what the statute
15 commands us to do and no more and no less. And we see this exception as being pretty much subsumed in
16 the EHR exception. The comments that we got is that people do not expect it to be terribly useful, and part
17 of that is because of the statutory language that the item services must be necessary and used solely to
18 transmit and receive eprescribing information. So the extent that it would go beyond eprescribing, it's not
19 really able to be used for that. And there are a lot of software packages that are bundled packages that have
20 more than just eprescribing capabilities, so we do not expect this to be used very often by itself, but to the
21 extent that somebody has a program that does eprescribing and no more and no less than that, we're
22 required by the statute to provide an exception for that. The items and services that are covered under this
23 exception are hardware, software, Internet connectivity, training and support services. Note that hardware
24 as covered here is not covered under the EHR exception and I'll explain why later. There is no
25 interoperability requirement, which is a feature of the EHR exception, but to the extent that the system is
26 interoperable or compatible, the donor cannot disable or limit that compatibility in order to try and create a
27 closed system. The statute requires that the eprescribing software comply with applicable standards under
28 Part D and currently the foundation standards are codified at 423160 of the Regs. Under the Donors and

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1 Recipients, the statute again specified specific donors and recipients; hospitals to members of their staffs,
2 group practices to physician members, PDUP sponsors and MA organizations to prescribing physicians so
3 again, this is in contrast to the EHR exception which is a good bit broader than this but we stuck by the
4 statutory language. In terms of recipients, donors cannot take into account directly or indirectly the volume
5 or value of referrals. Again, this is in contrast to the EHR exception, which only has a prohibition on
6 directly taking into account. There is no cap on the value of the protected technology, and there is no
7 sunset date, as there is in the HER. So I breezed through that pretty quickly, but again, I think that
8 exception is going to be a very limited utility. Most of the interests that we received in the comments were
9 on the proposed EHR exception. We actually proposed two EHR one for preinteroperability, and one for
10 post interoperability. At the time, that we were coming out with the Final Rule, we thought that the state of
11 technology was sufficiently advanced, with certification standards underway that there was no need for the
12 preinteroperability exception, which was a good bit more narrow as proposed than the post interoperability
13 exception. And so under this exception, this covers software that is necessary and not used solely, but used
14 predominantly to create maintain, transmit, or receive electronic health records. Here, the software
15 packages can include other functions. They can in fact include billing and clinical support. We saw really
16 no practical way to try and separate that out. Most of the packages include those components and as long
17 as we have other program integrity safeguards in place, we were not concerned in having that as protected
18 technology. Again, the use has to be predominantly for EHR purposes even though there are these other
19 bells and whistles that come along with it. The software must include either an electronic prescribing
20 capability or an interface with a physician's existing eprescribing capability. Also protected are
21 information technology and training services, which would include for example, connectivity, and health
22 desk support services. Although it includes Internet connectivity because no hardware is protected, that
23 would not include for instance a modem. Training and support does not include the provision of staff to
24 physicians or their offices. Now, as I said, hardware was not protected. We did that for a couple of
25 reasons. Hardware, unlike software can be used for other purposes. To that extent it's more inherently
26 valuable to the physician. More susceptible of creating some type of a tying arrangement between the
27 donor and the physician. And also it's not as expensive as the software. During the Proposed Rulemaking,
28 we got a lot of comments from hospitals and physicians. The physicians were pretty much OK with not

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1 having hardware included. The hospitals really were not keen on providing the hardware, as they said they
2 wanted the physicians to have something at stake here. So that's why we made that decision. Again, under
3 the standards, the eprescribing capability that must be a feature of this must comply with the applicable
4 standards under Part D. The software must be interoperable. We have a definition of interoperable in the
5 Reg. that means it must be able to communicate and exchange data accurately, effectively, securely and
6 consistently with different systems. But there's another way that the donors and recipients can meet this
7 requirement. That is, the software can be deemed to be interoperable, under certain circumstances, that is
8 by if it's certified by a certifying body, recognized by the Secretary, and that certification would have to be
9 done no more than 12 months prior to the donation. It must be interoperable at the time of the donation.
10 So if there is something that comes along later and things change, and it would no longer be interoperable,
11 if it was given today as opposed to three months ago, that's OK. It's only judged at the time of the
12 donation.

13 Donors and recipients is pretty wide open. What we threw out there in the Proposed Rule were
14 just again the 4 categories that I mentioned for the eprescribing component, which was in the MMA, but at
15 the same time, we indicated some interest and willingness to hear comments on this issue, and we used
16 those 4 categories basically as a placeholder. Where we ended up is pretty broad, I think we're allowing
17 any DHS entity to donate to any physician. It doesn't have to be a physician on somebody's medical staff.
18 It's literally any physician. Now the donor cannot have actual knowledge or disregard that the physician
19 already has equivalent items or services and there must be a written agreement, signed by the parties, that
20 specifies the items and the services, and the donor's cost and the physician's contribution to that. On
21 selection of recipients, as I mentioned with the eprescribing exception, there can't be any indirect or direct
22 correlation between the volume or value of referrals. Here, we're saying that there cannot be any, that the
23 donor cannot directly take into account referrals when making the donation. So for instance, a direct
24 correlation would be the number of total prescriptions written by that physician, or the number of referrals
25 by the physician to that donor. But not directly related, for instance, would be the size of the medical
26 practice. The number of hours that the physician practices medicine. We give 6 examples in the text of the
27 Reg. and then we also have a catch-all category that says any reasonable and verifiable manner that does
28 not directly take into account.

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1 In the Proposed Rule, question whether we should have a cap on the amount of the technology that
2 can be given away. Needless to say we got a lot of comments on this, this was a very difficult issue. It's
3 really hard to even determine how much the technology costs. It seems to be not only a moving target, but
4 a lot of different estimates as to what things cost. We've got widely varying estimates so that we're also
5 concerned that if we set the cap too low, then there would be a problem in terms of donors being able to
6 give it away; there would be too much of a contribution that would have to be made up by the physician.
7 We're also warned that if we set the cap too high that that could translate into an expectation that that
8 would be the floor and that would be what the donors were expected to give to the physicians. So in the
9 end, we did not come up with any cap on the value of the technology. But we came up with a 15% cost
10 contribution by the physician. You notice, it doesn't say at least 15%. We've gotten some questions, well
11 does that mean that I can give the technology to this physician and he has to contribute 15%, but I want to
12 give it to this physician over here and she has to contribute 30%. Well, we have concerns about that. We
13 have less concerns if it's going to be 30% across the board for everybody. But these are some of the
14 interpretive issues that we'll have to deal with. The donor can't finance the physician's payment. Nor can
15 any related entity to the donor finance that. Another issue that we're going to have to address is we've
16 gotten questions about well, what if there's a subscription fee and it's being paid monthly and it's going to
17 extend over a couple of years. Does that mean that the physician's going to have to figure out what it's
18 going to cost over that time period, the entire time period and front the money, the 15% of that at once, and
19 we don't think that's really the case. As long as the donor is paying it on a monthly basis, then 15% of that
20 has to be paid at the time, prior to he receives it.

21 And then lastly unlike the eprescribing exception here, this exception's going to sunset on
22 December 31, 2013, consistent with the President's goal to have things pretty much up and running by
23 2014, with respect to EHR. This is also a feature that we thought would help minimize fraud and abuse
24 concerns by putting it out there but only for a limited period of time. And hopefully by that period of time,
25 this will be a recognized cost of doing business by the health community, and hopefully the cost of the
26 systems will come down appreciably also.

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1 Dr. Senagore: Thank you, Mr. Romano. Any questions on this topic? Thank you very much. At
2 this point in time, we allow testimony. And I believe we have some for today, Dr. Martin, yes? Welcome
3 Dr. Martin from American Osteopathic Association. Welcome.

4 Testimony: American Osteopathic Association

5 Dr. Martin: Thank you. Thank you very much for the opportunity to address the Practicing
6 Physicians Advisory Council on behalf of the American Osteopathic Association. That is the AOA, and
7 the nation's 59,000 osteopathic physicians, practicing in all specialties and subspecialties of medicine. The
8 AOA and our members appreciate the Council's continued efforts to address physicians' concerns with the
9 Medicare Program. Reforming the Medicare Physician Payment Formula and improving the care provided
10 to beneficiaries are goals that we share with the Practicing Physicians Advisory Council. The Osteopathic
11 profession remains concerned with the ongoing inequities associated with the Medicare Physician Payment
12 Formula, especially its sustainable growth rate. We support MedPAC's recommendation that every
13 physician participating in the Medicare Program receive a positive 2.8% update for 2007. Additionally, the
14 AOA worked with the American College of Surgeons to develop a new payment methodology that would
15 provide positive annual updates to physicians based upon increases in practice costs while being conducive
16 to quality improvement in Pay for Performance programs. This new system is known as a service category
17 growth rate. This proposal has been outlined in our written statement.

18 The AOA is committed to ensuring that future payment methodologies reflect the quality of care
19 provided, and include incentives to improve health outcomes of patients. We support programs that
20 facilitate the reporting and analysis of reliable, quality data. We support a fair and equitable evaluation
21 process of this data. However, the current Medicare payment formula cannot support the implementation
22 of such a program. To ensure that our members are prepared for new quality reporting programs, the AOA
23 has taken many steps, including the establishment of a web-based clinical assessment program for CAP.
24 CAP's goal is to improve patient outcomes by providing valid and reliable assessments of current clinical
25 practices and process sharing of best practices and care delivery. CAP provides evidence-based
26 measurement sets on 8 clinical conditions, including diabetes, coronary artery disease, hypertension,
27 women's health screening, asthma, COPD, child immunizations, and low back pain. Details of the CAP
28 program are also found in my written statements. As the Centers for Medicare and Medicaid Services

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1 move forward with quality and Pay for Performance initiatives, particularly in the area of physician
2 resource use, the AOA recommends the following 10 guidelines.

- 3 1. Comparative utilization or physician profiling should be used only to show conformity with
4 evidence-based guidelines;
- 5 2. Comparative utilization or physician profiling data should be disclosed only to the physician
6 involved. If comparative utilization or physician profiling data is made public, assurances
7 must be in place that promise rigorous evaluation of the measures to be used and that only
8 measures deemed sensitive and specific to the care being delivered are used;
- 9 3. Physicians could be compared to other physicians with similar practice mixes in the same
10 geographic area. Special consideration must be given to osteopathic physicians who practices
11 mainly focus on delivery of osteopathic manipulative treatment, OMT. These physicians
12 should be compared to osteopathic physicians that provide osteopathic manipulative
13 treatments;
- 14 4. Utilization measures within the reports should be clearly defined and developed with broad
15 input to avoid adverse consequences;
- 16 5. Efforts to encourage efficient use of resources should not interfere with the delivery of
17 appropriate evidence-based patient-centered quality, health care. Further more the program
18 should not impact adversely the physician patient relationship or unduly intrude upon the
19 physician's medical judgment;
- 20 6. Practicing physicians must be involved in the development of utilization measures and the
21 reporting process;
- 22 7. All methodologies, including those used to determine case identification, and measure
23 definitions, should be transparent and readily available to physicians;
- 24 8. Use of appropriate case selection and exclusion criteria for process measures and appropriate
25 risk management for patient case mix and inclusion of adjustment for patient compliance and
26 outcome measures need to be included in any physician-specific report;
- 27 9. Utilization measure constructs should be evaluated on a timely basis to reflect validity,
28 reliability, and the impact on patient care; and finally,

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1 10. Osteopathic physicians must be represented on any committee, commission, or advisory panel
2 duly charged with developing measures or standards to be used in the program.

3 In closing, reductions in reimbursement, increased regulatory and administrative burdens,
4 escalating practice costs, and third party influences, all have led to a negative effect on the practice of
5 medicine. As we move forward with reforms to Medicare and our health care system overall, we must
6 proceed with caution, so that the measure we take actually improve the quality of patient care and do not
7 exacerbate the problems that may already exist. Thank you very much for the opportunity to speak before
8 the Practicing Physicians Advisory Council.

9 Dr. Senagore: Thank you, Dr. Martin. Are there any questions or comments?

10 Dr. O'Shea: Dr. Martin, just in brief, I know a little bit about CAP so maybe this is actually an
11 inside, but I'd like if you could, Dr. Martin, take a little bit more time so that they know what our CAP
12 program is. It's very actually, very it's a much simpler approach to qualifying, quantifying improvement in
13 patient care.

14 Dr. Martin: Yes, let me make a few comments. Actually, the CAP program, or the clinical
15 assessment program started in year 2000 and it started in the osteopathic residency primary care residency
16 programs. That would be primarily in the family practice residency programs, and the internal medicine
17 programs. What we did was we picked a number of disease processes, which I outlined in my process, put
18 them on line and then what we had was the different residency programs provide data into this data base
19 that is centralized through the American Osteopathic Association. What would happen is basically they
20 would have inclusion and exclusion criteria that they would look at in the particular disease process. They
21 would also look at some randomization and what the resident would do would be provide data, and if we
22 take for example diabetes, they would provide data on, Did you do a foot examination? Did you get a
23 Hemoglobin A1C? How often did you do the foot exam? How often did you do the Hemoglobin A1C?
24 Right down the line of all the common things that we usually do when we evaluate our patients. We then
25 take these, this data, compare it to some kind of a national measure, such as HEDIS or NCQA, give a report
26 back to those residents, and those residents then can look at where am I in respect to my peers, other
27 residents, at the state level, other peers within the state or national level, and then against these national
28 standards, so that that way they get a good look as to where they really are across the country. Then, about

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1 6 months to a year later, they then get another group of patients. Twenty is what we have been using as the
2 data set that we've been using, and compare that second data set, the original data set to see has there been
3 improvement. And in fact, we've looked at our data improvement here, just in June of this year, compared
4 to a year ago, and we can show that in the residency programs, there's about a 42% increase in for example
5 foot care that's being provided that they're looking at the foot at least to see, is there something going on in
6 these diabetic patients. We also show decreases in HDL, we show decreases in Hemoglobin A1Cs, so
7 we're starting to get these kind of data, and this is very important. As of December of 2005, we opened
8 this up to the practicing physicians. So we pilot it first with the residents. Now we're using the practicing
9 physicians. The three clinical processes that we're using for the practicing physicians are diabetes,
10 women's screening techniques, PAP smears and mammograms, and coronary artery disease. Those are the
11 only three we have for practicing physicians. That just started in December of this year so we don't have
12 enough data yet to really show any differences there because we're not allowed enough time between initial
13 measurements and in the comparative measurements. We look at it as an excellent way to provide payment
14 for performance in the future, because this is a way we are actually having our residents and our physicians
15 come into a data base, be familiar with a data base, and then be able to show for example CMS, Aetna,
16 United Health Care, any of the third party carriers where we are with our physicians in our particular area.
17 This particular process is free to any resident, it's free it any practicing physician. You don't have to be a
18 member of the AOA, it is free. So we are doing this a service to our membership. I know that there's been
19 discussion with Dr. McClellan in this respect. He's heard some of these reports. I think you may have
20 also, Dr. Kuhn, so that we're trying from our level to present this out for someone to look out, is it an
21 excellent data base for going into Payment for Performance. There's been some discussion with 3rd party
22 carriers where they're saying instead of us doing all of the work in respect to the quality initiatives and as
23 far as efficiency of care, maybe we can just use this CAP program and those physicians who participate in
24 the CAP program would for example maybe in a UHC program, get a 2 star designation as how they work
25 to it. These things have been presented to these corporate interests and we're starting to work with them to
26 try to show how this process can be moved forward.

27 Dr. Senagore: Great. Sounds like a very good program.

28 Dr. O'Shea: We'll look forward to hearing more when you get the data.

