

REPORT NUMBER FIFTY-EIGHT

to the

Secretary

U.S. Department of Health and Human Services

**(Re: Physicians Regulatory Issues Team Update, Physician Fee Schedule for 2007,
Competitive Bidding for Durable Medical Equipment, Outpatient Provider
Payment System and Ambulatory Surgery Center Payment System for 2007,
Medicare Contractor Provider Satisfaction Survey, Physician Voluntary Reporting
Program, Recovery Audit Contractors, and other matters)**

From the

Practicing Physicians Advisory Council

(PPAC)

Centers for Medicare and Medicaid Services Headquarters

Baltimore, MD

December 4, 2006

SUMMARY OF THE DECEMBER 4, 2006, MEETING

Agenda Item A — Introduction

The Practicing Physicians Advisory Council (PPAC) met at the headquarters of the Centers for Medicare and Medicaid Services (CMS) in Baltimore, MD, on Monday, December 4, 2006. The chair, Anthony Senagore, M.D., welcomed the Council members and gave an overview of the agenda (see Appendix A).

Agenda Item B — Welcome

Tom Gustafson, Ph.D., Deputy Director of the Center for Medicare Management, thanked the Council members for their time and commitment and welcomed the presenters and audience to the meeting.

OLD BUSINESS

Agenda Item C — Update

Ken Simon, M.D., M.B.A., Executive Director of PPAC, presented the responses from CMS to PPAC recommendations made at the August 28, 2006, meeting (Report Number 57).

57-C-1: Because 1) the number of academic anesthesia physician training programs has declined by 20 since the inception of the anesthesia teaching rule (although anesthesia nurse training programs have increased) and 2) hospitals are subsidizing academic anesthesia training programs by as much as \$400,000 to \$1 million per program per year, PPAC recommends that CMS reevaluate its decision to equalize reimbursement for academic anesthesia physician training programs.

CMS Response: CMS acknowledges the concerns expressed by the Council. In general, Medicare pays for the services of residents and the teaching physicians' supervision of these services through graduate medical educational payments made to the hospital. Medicare allows a separate physician fee schedule payment when the teaching physician furnishes a direct personal service to the beneficiary.

For purposes of establishing physician payment policies, we base payments on the relative resource costs of the three components of physician payment — physician work, practice expense and professional liability insurance. For surgical services, payment can be made for the services of the teaching physician as long as the teaching physician is present with the resident during all critical and key portions of the procedure and is immediately available to furnish services during the entire procedure. In order to bill for two overlapping surgeries, the teaching surgeon must be present during the key or critical portions of both operations. Beginning in 1994, the teaching physician payment policy has been applied to anesthesiologists only when the teaching anesthesiologist is involved in one anesthesia case with a resident. If the teaching physician is involved with two

concurrent cases, then the “medical direction” payment policy for anesthesia services applies (i.e., payment is 50 percent of the full allowance for each anesthesia case).

There are differences between overlapping surgical and concurrent anesthesia cases. In overlapping surgical cases, the teaching surgeon does not participate in the second case until all the critical or key portions of the first surgical service have been completed. In contrast, in the concurrent anesthesia cases, one of the key or critical portions of the first case may still need to occur even while the concurrent case has begun.

What factors may cause the decline in the number of teaching programs in some specialties is not clear, though these factors may extend well beyond Medicare payment policies. CMS does not collect information on or review the extent to which teaching programs in various specialties have been consolidated or reduced.

The suggested revision for teaching anesthesia services would cost \$30 million to \$40 million in additional yearly Part B spending. We believe this issue would be most appropriately addressed by Congress as it determines possible priorities for any additional funds that may become available for health care providers.

57-D-1: PPAC recommends that CMS publish all of the relative value units (RVUs) forwarded by the American Medical Association’s (AMA) RVU Update Committee (RUC), even when CMS makes a noncoverage decision for physician services.

CMS Response: CMS appreciates the input received from the Council and various medical specialties on this issue. CMS published all of the RVUs forwarded by the AMA RUC, including those services not covered by Medicare.

57-D-2: PPAC thanks CMS for its 3 years of hard work on the issue of volunteer faculty in graduate medical education. PPAC recommends that CMS expedite and raise the priority for resolving the rule on volunteer faculty in graduate medical education in ambulatory settings. PPAC also requests that CMS update the Council on progress on this issue at the next PPAC meeting.

CMS Response: CMS continues to work closely with the Association of American Medical Colleges, the American Osteopathic Association, and the Academic Family Medicine Advocacy Alliance to develop a nonburdensome method for verifying that teaching hospitals have paid “all or substantially all” of the costs of graduate medical education training in nonhospital settings.

57-F-1: The Council asks that CMS present at a future meeting an analysis of the overall cost savings to Medicare of covered preventive services, using bone density screening by dual-energy x-ray absorptiometry (DEXA) and subsequent

decrease in bone fractures as an example. The analysis should also address how DEXA utilization rates affect the sustainable growth rate (SGR).

CMS Response: The CMS is aware of the Council's concerns and expects to present a cost savings analysis at the March 5, 2007, PPAC meeting.

57-G-1: PPAC recommends that CMS use an adjustment to the conversion factor instead of a 10-percent work value adjustment to maintain budget neutrality for the 2007 physician fee schedule.

CMS Response: CMS appreciates PPAC's recommendation to make the budget neutrality adjustment for the 5-year review of work to the conversion factor instead of the work RVUs. Many commenters to the proposed rule echoed this position, although there were a number of physician specialties who supported our proposal to make the adjustment to the work RVUs. We announced in the final rule that was released on November 1, 2006, that we would be applying the budget neutrality adjustment to the work RVUs. Adjusting the conversion factor would have the effect of reducing payment for all services on the fee schedule. This would include a number of services that have no physician work and are, therefore, outside the scope of the 5-year review. We believe it would be unfair to adversely affect those codes that have no work values associated with them. Therefore, we believe making the adjustment on the work RVUs is the best and most equitable approach.

57-G-2: PPAC thanks the Secretary of the Department of Health and Human Services and CMS leadership for previous efforts to prevent a negative update to the physician fee schedule. PPAC requests that CMS continue to use its influence with Congress to implement for 2007 the 2.8-percent update recommended by the Medicare Payment Advisory Commission (MedPAC) and replace the flawed payment formula with one that takes into account actual health care inflation costs.

CMS Response: We recognize that under the current SGR system, physicians are facing at least 9 years of negative updates. However, any changes to this system require a change in legislation. We are working closely and collaboratively with medical professionals and Congress on the most effective Medicare payment methodologies to compensate physicians for providing services to Medicare beneficiaries. We are engaging physicians on issues of quality and performance with the goal of encouraging the most effective approaches to achieve better health outcomes for Medicare beneficiaries. We are committed to developing systems to enable us to encourage quality and to improve care without increasing overall Medicare costs.

57-G-3: PPAC recommends that CMS provide the Council with updated information on the implications of changes to the physician fee schedule for subsequent beneficiary access to physician services.

CMS Response: We are fully cognizant of the potential implications of the negative updates on access to care. We are closely monitoring physician's participation in the Medicare program and beneficiary access to care. We will continue to provide PPAC with updates on our monitoring activities.

57-G-4: PPAC recommends that CMS use reliable, accurate, current, geographically-relevant information to establish the true cost of professional liability insurance.

CMS Response: CMS seeks to use the best data available to reflect all of the components of the physician fee schedule, including the cost of professional liability insurance. We receive professional liability insurance premium data directly from the departments of insurance of each of the States, unless a specific State refuses to release the data to CMS. In that instance, the CMS contractor goes to the insurance carriers in that State for premium data. We consider the States to be the most reliable and accurate provider of premium data. The premium data are updated every 3 years.

57-G-5: PPAC recommends that CMS consider the appropriateness of including professional liability insurance as a component of the RVU system and whether professional liability insurance should be incorporated into indirect practice expense calculations.

CMS Response: CMS will consider the appropriateness of this suggestion as we review the components of the physician fee schedule. However, we note that Section 1848(c) of the Social Security Act requires the separate computation of malpractice RVUs.

57-H-1: PPAC recommends that CMS abandon the proposed methodology for determining the median cost of brachytherapy sources and reexamine the claims data on which the proposed system is based.

CMS Response: CMS acknowledges the concerns expressed by the panel that hospitals may not have correctly reported Health Care Financing Administration Common Procedural Coding System (HCPCS) codes and charges for brachytherapy sources in the calendar year (CY) 2005 claims year used for the proposed CY 2007 Outpatient Prospective Payment System (OPPS) update. To address concerns regarding possible data inadequacies, we closely examined the full year of CY 2005 hospital claims data in preparation for the CY 2007 final rule. We note that hospitals have had over 6 years of experience with reporting the codes and charges for brachytherapy sources, upon which their specific source payments were based throughout that time period. We observed significant stability of claims-based source costs for the most commonly used sources over time, consistent with the findings of the Government Accountability Office (GAO) report, released in July 2006, regarding hospital brachytherapy source

purchase prices. Therefore, in light of the stable claims data and consistent with the recommendations of the GAO, we finalized the CY 2007 OPPS payment policy for brachytherapy sources to provide separate, prospectively established, per-source payment rates for all brachytherapy sources for which we had CY 2005 claims data, based on the median unit source costs from those claims. We have CY 2005 OPPS claims data for 11 of the 12 separately coded brachytherapy sources, which we used to establish their CY 2007 payment rates. The only area where we judged our data to be insufficient was for the twelfth source (yttrium-169). While the Current Procedural Terminology (CPT) code for the source was created in CY 2005, the source has not yet been marketed, and no cost data were provided to us during the CY 2007 proposed rule comment period. Once this source is marketed and external cost data are available, we will establish a prospective payment rate for the source.

57-K-1: PPAC commends CMS for establishing demonstration projects that would allow cash to flow from one silo to another. PPAC recommends that CMS consider more such projects, specifically those that could shift dollars saved through physician actions from Medicare Part A to Part B, and that CMS educate physicians in the relevant geographic areas about the demonstration projects.

CMS Response: We agree that the current Medicare payment systems for physician and institutional services encourage different, sometimes inconsistent, behaviors. For instance, the hospital prospective payment system encourages hospitals to conserve resources by discharging patients in a timely manner, while the physician payment system is based on resource consumption, not conservation. None of our payment systems is based on the quality or value (quality and cost) of services provided. We are seeking to address this through the implementation of value-based purchasing mechanisms, like pay for performance. Pay for performance uses financial and other incentives to encourage the provision of high-quality, efficient health care. To the extent that more efficient physician practice may lead to savings in institutional care in a pay-for-performance program, those savings under current law cannot be used to directly fund financial incentives for physicians. To better understand these and other issues related to the implementation of pay-for-performance programs, we are using our demonstration authority to explore ways to restructure our current payment systems to better support quality-based payment reforms.

57-K-2: PPAC recommends that CMS support establishment of quality and/or pay-for-performance systems whose primary goal is to improve health care and health outcomes of the Medicare population. These programs will need additional resources to support implementation and to reward those physicians who voluntarily participate. The Council believes that pay for performance should not be budget neutral.

CMS Response: The primary goal of CMS' quality and value-based purchasing initiatives, including pay-for-performance, is to enhance the value of services

purchased for Medicare beneficiaries. Value is a function of both quality and cost, so both of these are essential components of our initiatives. Attention to quality without attention to cost will result in an unsustainable Medicare program. Attention to cost without attention to quality will result in unacceptable care. Thus, we plan to measure and pay based on both the quality and cost aspects of value.

The President's budgets for fiscal year (FY) 2006 and FY 2007, various MedPAC reports to Congress, and the recent Institute of Medicine report, *Rewarding Provider Performance: Aligning Incentives in Medicare*, all recommended budget-neutral implementation of value-based purchasing programs for Medicare's payment systems. We recognize that CMS, physicians, and other health professional and institutional providers will all need to invest in quality measurement and reporting infrastructure to implement pay for performance. However, we believe that the investment will result in higher value health care services for beneficiaries and financial rewards for providers that improve quality and save unnecessary costs.

The Council thanked Dr. Simon for his report. Although CMS monitors beneficiaries' access to providers, Council members are concerned that CMS does not track whether beneficiaries are losing access to the highest quality providers or whether providers are limiting how often they will see Medicare beneficiaries in any given month.

Recommendations

58-C-1: PPAC recommends that CMS consider updating annually the proportion of physician reimbursement that reflects the cost of professional liability insurance.

58-C-2: PPAC recommends that CMS provide the Council at its next meeting a detailed explanation of how CMS monitors access to care for Medicare beneficiaries.

NEW BUSINESS

Agenda Item D — Physicians Regulatory Issues Team (PRIT) Update

William Rogers, M.D., Director of PRIT, gave an update on issues recently addressed by PRIT (Presentation 1). For example, for reference purposes, CMS will publish RVUs for neurosurgical and pediatric procedures that are not covered by Medicare. At the request of the Council, Dr. Rogers agreed to contact the carrier medical director of TrailBlazer Health Enterprises to discuss a local coverage determination limiting the number of wound debridement procedures for which health care providers would be reimbursed to three per wound or ulceration site.

Agenda Item F — Durable Medical Equipment (DME) Update

Joel Kaiser, Deputy Director of the Division of Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Policy in the Center for Medicare Management, described the competitive bidding program for DME that will launch at 10 sites in 2007 (Presentation 2). Council members said patients often come to their physicians' office with a completed form created by the DME supplier requesting only the physician's signature for approval of reimbursement. Some Council members said it would be helpful to have an approval form that spells out the criteria for eligibility for reimbursement.

At present, in the sites where the competitive bidding process is launching, physicians who wish to provide DME to their patients in their offices would have to enter into the competitive bidding process, including completing accreditation requirements. Mr. Kaiser noted that while the Medicare Modernization Act requires CMS to implement a competitive bidding process for DME, CMS may exempt items for which no significant savings are likely.

Recommendations

58-F-1: PPAC recommends that CMS determine the optimal means for physician documentation and compliance for DMEPOS claims submission to decrease the administrative burden for practicing physicians.

58-F-2: PPAC recommends that lower-cost DME items, e.g., orthotics, crutches, canes, and cast braces, be exempt from the competitive bidding process when health care providers capable of prescribing DMEPOS act as the supplier for those items.

58-F-3: PPAC recommends that CMS consider implementing a competitive bidding process for other medical supplies, e.g. disposable equipment used in the operating room and implantable devices, such as cardiac stents, to save health care dollars.

Agenda Item G —Physician Fee Schedule Final Rule

Amy Bassano, Director of the Division of Practitioner Services; Edith Hambrick, M.D., J.D., Medical Officer; and Carolyn Mullen of the Division of Practitioner Services described the physician fee schedule update, changes to the 5-year review of work and the practice expense calculation, and Deficit Reduction Act requirements (Presentation 3). Council members expressed grave concerns about the alarming impact that these changes will have on physicians, who can no longer absorb the reimbursement cuts.

Recommendation

58-G-1: To avoid the looming crisis in beneficiaries' access to providers, PPAC recommends that the Secretary of the Department of Health and Human Services and CMS leadership work with Congress to avert the reimbursement cuts planned for 2007 and beyond, implement a positive payment update that covers increases in physicians' practice costs, and repeal the sustainable growth rate methodology and replace it with a system that adequately keeps pace with health care costs.

Agenda Item H — Outpatient Prospective Payment System (OPPS)/Ambulatory Surgery Center (ASC) Final Rule

Carol Bazell, M.D., M.P.H., Acting Director of the Division of Outpatient Care, and Dr. Hambrick outlined changes to the OPSS and ASC payment system effective 2007 and proposed rules for ASCs for 2008 (Presentation 4). Dr. Bazell noted that CMS reviews input from both internal (e.g., medical officers within the agency) and external (e.g., medical literature, comments from medical specialty societies, RUC determinations) sources to determine whether a procedure may be appropriately performed in an ASC setting.

Recommendations

58-H-1: PPAC recommends that CMS establish a process to consult with national medical specialty societies and the ASC community to develop and adopt a systematic and adaptable means of fairly reimbursing ASCs for all safe and appropriate services, allowing for changes in technology and current-day practices.

58-H-2: PPAC recommends that CMS apply any payment policies uniformly to both ambulatory surgical centers and hospital outpatient departments as appropriate.

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

David Clark, R.Ph., Director of the Division of Provider Relations and Evaluations; Vasudha Narayanan, MCPSS Project Director; and Pamela Giambo, MCPSS Deputy Project Director, summarized the responses to the MCPSS (Presentation 5). Mr. Clark noted that CMS published a report that lists the average scores for each contractor but CMS cannot provide each contractor with an analysis of its individual strengths and weaknesses as identified by the survey.

Recommendation

58-J-1: PPAC recommends that CMS identify actionable items based on best practices identified by the MCPSS process to improve the provider-contractor relationship.

Agenda Item K — Physician Quality and Cost Measures Update

Tom Valuck, M.D., J.D., Medical Officer and Senior Advisor for the Center for Medicare Management, described the Agency's approach to measuring quality, improving efficiency, and cutting costs (Presentation 6). Dr. Valuck noted that additional clinical measures will be added to the Physician Voluntary Reporting Program (PVRP) for 2007, which are currently reported via "G" codes under HCPCS and CPT Category II codes. He also said the Agency is evaluating episode grouper software with input from physicians. The Council commended CMS for ensuring that measures developed by the AMA Consortium, endorsed by the National Quality Forum, selected by the Ambulatory Care Quality Alliance, and used in the PVRP reflect the wording and specifications developed

and endorsed by stakeholder organizations. The Council noted that the clinical measures used in the PVRP do not adequately reflect surgical measures of performance.

Recommendations

58-K-1: PPAC recommends that CMS determine the relative benefits of pursuing the G code submission process in light of the considerable benefits associated with the episode grouper methodology.

58-K-2: PPAC recommends that CMS support development of outcome databases as an alternative to performance measures in the Agency's quality and cost measures initiative.

Agenda Item N — Recovery Audit Contractors (RACs) Update

Melanie Combs, Senior Technical Advisor in the Division of Analysis and Evaluation, and Connie Leonard, Project Officer for RAC in the Division of Medicare Overpayments for the Office of Financial Management, summarized the findings of the RACs for FY 2006 (Presentation 7). Ms. Leonard said CMS will use the findings to determine where education is needed to improve claims submission and payment. She asked that providers who have concerns about underpayments (or overpayments) or the RAC process contact her office.

Agenda Item O — Testimony

Stephen Permut, M.D., J.D., of the AMA outlined concerns about the cuts to the physician fee schedule for 2007 and beyond, proposed clinical measures for the PVRP, and the method for determining when a procedure can be performed appropriately in an ASC setting (Presentation 8).

Agenda Item P — Wrap Up and Recommendations

Dr. Senagore asked for additional recommendations from the Council. He noted that the next PPAC meeting would take place March 5, 2007, and then adjourned the meeting. Recommendations of the Council are listed in Appendix B.

Recommendations

58-O-1: PPAC recommends that CMS change calculations to use the unadjusted work RVUs in calculating indirect practice expense for the 2007 physician fee schedule.

58-O-2: PPAC recommends that CMS use its statutory authority to remove Medicare-covered drugs from the SGR calculation.

58-O-3: PPAC recommends that CMS adjust the SGR calculation to account for increased spending due to national coverage decisions, just as it does for Medicare Advantage payments.

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

PPAC Members at the December 4, 2006, Meeting

Anthony Senagore, M.D., *Chair*
Surgeon
Cleveland, Ohio

Laura Powers, M.D.
Neurologist
Knoxville, Tennessee

Jose Azocar, M.D.
Internist
Springfield, Massachusetts

Gregory Przybylski, M.D.
Neurosurgeon
Knoxville, Tennessee

Vincent J. Bufalino, M.D.
Cardiologist
Naperville, Illinois

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

Peter Grimm, D.O.
Radiation Oncologist
Seattle, Washington

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

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

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

CMS Staff Present:

Amy Bassano, Director
Division of Practitioner Services
Center for Medicare Management

Connie Leonard, Project Officer

RAC Division of Medicare Overpayments
Office of Financial Management
Centers for Medicare and Medicaid Services

Carol Bazell, M.D., M.P.H.
Acting Director
Division of Outpatient Care
Center for Medicare Management

Carolyn Mullen
Division of Practitioner Services
Center for Medicare Management

Kelly Buchanan
Center for Medicare Management

Vasudha Narayanan, MCPSS Project Director
Westat

David C. Clark, R.Ph., Director
Office of Professional Relations
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William Rogers, M.D., Director
Physicians Regulatory Issues Team

Melanie Combs, Senior Technical Advisor
Division of Analysis and Evaluation
CMS

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

Pamela Giambo, MCPSS Deputy Project
Director
Westat

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

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

Public Witness:
Stephen Permut, M.D., J.D.
American Medical Association

Edith Hambrick, M.D., J.D., Medical Officer
Center for Medicare Management

Dana Trevas, Rapporteur
Magnificent Publications, Inc.

Joel Kaiser, Deputy Director
Division of DMEPOS Policy
Center for Medicare Management

APPENDICES

Appendix A: Meeting agenda

Appendix B: Recommendations from the December 4, 2006, meeting

The following documents were presented at the PPAC meeting on December 4, 2006, and are appended here for the record:

Presentation 1: PRIT Update

Presentation 2: DME Update

Presentation 3: Physician Fee Schedule Final Rule

Presentation 4: OPSS/ASC Final Rule

Presentation 5: Medicare Contractor Provider Satisfaction Survey

Presentation 6: Physician Quality and Cost Measures Update

Presentation 7: RAC Update

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

Appendix A

**Practicing Physicians Advisory Council
CMS Single Site Location
Multipurpose Room
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244
December 4, 2006**

08:30-08:40	A. Open Meeting	Anthony Senagore, M.D., M.B.A. Chairman, Practicing Physicians Advisory Council
08:40-08:50	B. Welcome	Herb Kuhn, Acting Deputy Administrator, Centers for Medicare & Medicaid Services Tom Gustafson, Ph.D., Deputy Director, Center for Medicare Management, Centers for Medicare and Medicaid Services
08:50-09:15	C. PPAC Update	Kenneth Simon, M.D., M.B.A. Executive Director, Practicing Physicians Advisory Council
09:15-09:45	D. PRIT Update	William Rogers, M.D., Director, Physicians Regulatory Issues Team, Office of External Affairs, Centers for Medicare and Medicaid Services
09:45-10:00	E. Break (Chair Discretion)	
10:00-10:30	F. DME Update	Joel Kaiser, Deputy Director, Division of DMEPOS Policy,

		Center for Medicare Management
10:30-11:15	G. Physician Fee Schedule Final Rule	Amy Bassano, Director Division of Practitioner Services, Center for Medicare Management
		Edith Hambrick, M.D., J.D. Medical Officer, Center for Medicare Management
11:15-11:45	H. OPPTS/ ASC Final Rule	Carol Bazell, M.D. Acting Director, Division of Outpatient Care, Center for Medicare Management
		Edith Hambrick, M.D., J.D. Medical Officer Center for Medicare Management
11:45-12:45	I. Lunch	
12:45-1:30	J. Medicare Contractor Provider Satisfaction Survey (MCPSS)	David Clark, R.Ph., Director, Division of Provider Relations and Evaluations, Centers for Medicare Management
		Vasudha Narayanan MCPSS Project Director, Westat
		Pamela Giambo MCPSS Deputy Project Director, Westat

1:30-2:30	K. Physician Quality and Cost Measures Update	Thomas Valuck, M.D., J.D. Medical Officer & Senior Advisor, Center for Medicare Management
2:30-2:45	L. Break (Chair Discretion)	
2:45-3:30	M. Transparency Initiative	Andrew Croshaw, M.B.A. Senior Executive Advisor to the Secretary, Department of Health and Human Services
3:30- 3:50	N. Recovery Audit Contract (RAC): Update	Gerald Walters, Director Financial Services Group, Office of Financial Management Centers for Medicare and Medicaid Services Connie Leonard, Project Officer, RAC Division of Medicare Overpayments, Office of Financial Management Centers for Medicare and Medicaid Services
3:50-4:15	O. Testimony- Stephen Permut, M.D., J.D., American Medical Association	
4:15-4:30	P. Wrap Up/Recommendations	

Appendix B

PRACTICING PHYSICIANS ADVISORY COUNCIL (PPAC) RECOMMENDATIONS Report Number Fifty-Eight December 4, 2006

Agenda Item C — PPAC Update

58-C-1: PPAC recommends that CMS consider updating annually the proportion of physician reimbursement that reflects the cost of professional liability insurance.

58-C-2: PPAC recommends that CMS provide the Council at its next meeting a detailed explanation of how CMS monitors access to care for Medicare beneficiaries.

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Agenda Item K — Physician Quality and Cost Measures

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Agenda Item O — Wrap-Up and Recommendations

58-O-1: PPAC recommends that CMS change calculations to use the unadjusted work RVUs in calculating indirect practice expense for the 2007 physician fee schedule.

58-O-2: PPAC recommends that CMS use its statutory authority to remove Medicare-covered drugs from the SGR calculation.

58-O-3: PPAC recommends that CMS adjust the SGR calculation to account for increased spending due to national coverage decisions, just as it does for Medicare Advantage payments.