

CENTERS FOR MEDICARE AND MEDICAID SERVICES

PRACTICING PHYSICIANS ADVISORY COUNCIL

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Baltimore, Maryland 21244

Monday, December 4, 2006
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Public Witnesses

Dr. Stephen Permut, American Medical Association

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Open Meeting

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Dr. Senagore: In the interest of staying on our agenda so that we can finish up in a timely manner, we'll go ahead and get started. Good morning. I'm Dr. Anthony Senagore. I'm the chairperson of the PPAC, and it's my pleasure to welcome you to our new venue here in Baltimore on the occasion of our 58th meeting. I'd like to extend a cordial welcome to my colleagues here on the Panel, and I know it's difficult and we all talked a little bit last night about the changes in travel plans and whatnot that it took to move to Baltimore, but I think we enjoyed last evening. We have, I think, a pretty interesting agenda today that we'll be able to talk about some of the new regulations and instructions that affect our colleagues out in practice. In particular, we'll be talking about the DME Update, the Physician Fee Schedule Final Rule, the OPSS and ASC Final Rule, the Medicare Provider Satisfaction Survey, Physician Quality and Costs Measures Update, the Transparency Initiative, and an Update on the Recovery Audit Contracts. And you'll get our always entertaining PRIT Update as well. So I'm confident you'll give all our presenters their full due attention, and again what we'll try to do depending on time intervals, we'll either take recommendations as we go, or maybe save some time in a block to review some of the preceding discussion. So if you're working on recommendations, go ahead and just work them at your table and we'll take them in turn. I guess we'll go ahead and get started with the agenda. Mr. Herb Kuhn could not join us today, but in his absence, we have the able Dr. Tom Gustafson, the Deputy Director of the Center for Medicare Management, Centers for Medicare and Medicaid, who'd like to give us some opening remarks. Dr. Gustafson?

20

Welcome

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Dr. Gustafson: Well thank you, very much. I'll be brief and to the point. I want to thank all of the members of the committee for their time and service in coming to share their thoughts and recommendations with us yet again. This has been a long-standing committee of great value to the agency. I want to thank those members of the audience who journeyed up here as well. Certainly hope the committee finds our headquarters a suitable place to have meetings, would like to do this from time to time up here. I apologize for the weather for those of you from out of town. Southern climates. But we have to make due with what we have here. But let me turn this back over to the chairman very quickly. Thank you, Mr. Chairman.

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PPAC Update

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Dr. Senagore: Thank you, Sir. Then we'll move on with the PPAC Update. I'd like to invite Dr. Kenneth Simon, the Executive Director for the PPAC and Medical Officer in the Center for Medicare Management to present the responses to our recommendations from the August 28th PPAC Meeting. Dr. Simon?

6

Dr. Simon: Good morning, Council members, and to the public. Reviewing the PPAC response report from the August 28, 2006 Meeting.

8

Agenda Item C: The council members expressed concerned about the CMS response to recommendation 56-0-1 regarding payment to academic anesthesia programs. Because the number of academic anesthesia training programs has declined by approximately 30 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 in the teaching physician 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 a relative resource cost of three components of physician payment. Namely, physician work, practice expense, and professional liability insurance. For surgical services, payments can be made for the services of the teaching physician, as long as the teaching physician is present, with the resident, during all critical, 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 applied to anesthesiologist only when the teaching anesthesiologist is involved in one anesthesia case with the 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% of the full allowance for each anesthesia case. There are differences between overlapping surgical and concurrent anesthesia cases. In

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1 overlapping surgical cases, the teaching physician does not participate in the second case until all the
2 critical or key portions of the first surgical procedure have been completed. In contrast, in the concurrent
3 anesthesia cases, one of the key or critical portions of the first case may still need to occur, even while the
4 concurrent case has begun. What factors may cause a decline in the number of teaching programs in some
5 specialties are not clear. Though these factors may extend well beyond Medicare payment policies. CMS
6 does not collect information on or review the extent to which teaching programs in varying specialties have
7 been consolidated or reduced. The suggested revision for teaching anesthesia services would cost between
8 \$30 to \$40 million in addition to yearly Part B spending. We believe this issue would be most appropriately
9 addressed by the Congress, as it determines priorities relating to possible priorities for any additional funds
10 that may become available for health care providers.

11 Agenda Item D. Under the PRIT Update, 57-D-1. PPAC recommends that CMS publish all of the
12 RVUs forwarded by the RVU Update Committee, even when CMS makes a non-coverage decision for
13 physician services. CMS appreciates the input received from the Council and various medical specialties on
14 this issue. CMS published all of the RVUs forwarded by the AMA RUC committee, including those
15 services not covered by Medicare.

16 Item 57-D-2: PPAC thanks CMS for its 3 years of hard work on the issue of Volunteer Faculty
17 and Graduate Medical Education. PPAC recommends that CMS expedite and raise the priority for
18 resolving the rule for Volunteer Faculty and Graduate Medical Education in Ambulatory Settings. PPAC
19 also requests that CMS update the Council on progress on this issue at the next PPAC meeting. CMS
20 continues to work closely with the Association of American Medical Colleges, the American Osteopathic
21 Association, and the Academic Family Medicine Advocacy Alliance, to develop a non-burdensome method
22 for verifying that teaching hospitals have paid or substantially all of the costs of GME training in non-
23 hospital settings. This issue is under active review and we hope to provide additional information and
24 follow up at our next meeting.

25 Agenda Item F: Medicare Pricing for Fee for Service, and Advantage Plans. 57-F-1. The Council
26 asks that CMS present at a future meeting, an analysis of the overall cost-savings to Medicare covered,
27 preventive services, using bone density screening by dual energy X-ray absorptiometry or dexascans, as it's
28 commonly called. And subsequent decrease in bone fractures, as an example. The analysis should also

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1 address how dexe utilization rates affect the sustainable growth rate. CMS is aware of the Council's
2 concerns and expects to present their cost-savings and analysis at the March 5, 2007 PPAC meeting.

3 Five-Year Review Physician Fee Schedule Practice Expense Update. 57-G-1. PPAC recommends
4 that CMS use an adjustment to the conversion factor instead of a 10% work value adjustment, to maintain
5 budget neutrality for the 2007 Physician Fee Schedule. CMS appreciates PPAC's recommendation to make
6 the budget neutrality adjustment for the Five-Year review work to the conversion factor instead of the work
7 RVUs. Many commenters to the Proposed Rule echoed this position. Although there were a number of
8 physician specialties who supported our proposal to make the adjustment to the work RVUs. We
9 announced in the Final Rule that was released on November 1st, 2006 that we would be applying the budget
10 neutrality adjustment to the work RVUs. Adjusting the conversion factor would have the affect of reducing
11 payment for all services on the fee schedule. This would include a number of services that have no
12 physician work, and are therefore outside of the scope of the five-year review. We believe that it would be
13 unfair to adversely affect those codes that have no work values associated with them. Therefore, we believe
14 making the adjustment on the work RVUs is the best and most equitable approach.

15 Item 57-G-2. PPAC thanks the Secretary of the Department of Health and Human Services, and
16 CMS leadership for previous efforts to prevent a negative update to the Physician Fee Schedule. PPAC
17 requests that CMS continue to use its influence with Congress to implement the 2007 2.8% update
18 recommended by MEDPAC and replace the flawed payment formula with one that takes into account
19 actual health care inflation costs. CMS recognizes that under the current SGR system, physicians are facing
20 at least nine years of negative updates. However, any changes to the system require a change in legislation.
21 We are working closely and collaboratively with medical professionals and the Congress on the most
22 effective Medicare payment methodologies to compensate physicians for providing services to Medicare
23 beneficiaries. We are engaging physicians on the issues of quality and performance, with the goal of
24 encouraging the most effective approaches to achieve better health outcomes for Medicare beneficiaries.
25 We are committed to developing systems to enable us to encourage quality and to improve care without
26 increasing overall Medicare costs.

27 Item 57-G-3. PPAC recommends that CMS provide the Council with updated information on the
28 implications of changes to the Physician Fee Schedule for subsequent beneficiary access to physician

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1 services. CMS is fully cognizant of the potential implications of the negative updates on access to care. We
2 are closely monitoring physicians participation in the Medicare Program and beneficiary access to care. We
3 will continue to provide PPAC with updates on our monitoring activities.

4 Item 57-G-4. PPAC recommends that CMS use reliable, accurate, current, geographically relevant
5 information to establish true costs of professional liability insurance. CMS seeks to use the best data
6 available to reflect all of the components of the Physician Fee Schedule, including the cost of professional
7 liability insurance. We receive professional liability insurance premium data directly from the Department
8 of Insurance of each of the states, unless a specific state refuses to release the data to CMS. In that instance,
9 the CMS contractor goes to the insurance carriers in that state for premium data. We consider states to be
10 the most reliable and accurate provider of premium data. This data is updated every 3 years.

11 Item 57-G-5. PPAC recommends that CMS consider the appropriateness of including professional
12 liability insurance as a component of the RVU system and where the professional liability insurance should
13 be incorporated into indirect practice expense calculations. CMS will consider the appropriateness of this
14 suggestion as we review the components of the Physician Fee Schedule. However, we note that § 1848 C of
15 the Social Security Act requires separate computation of the malpractice relative value units.

16 Agenda Item H. The Outpatient Prospective Payment System and Ambulatory Surgical Center
17 Update. PPAC recommends that CMS abandon the proposed methodology for determining the median cost
18 of brachytherapy sources, and reexamine the claims data on which the proposed system is based. CMS
19 acknowledged the concerns expressed by the panel that hospital may not have correctly reported HCPCS
20 and charges for brachytherapy sources in the calendar year 2005 claims year used for the proposed 2007
21 Outpatient Prospective Payment System Update. To address concerns regarding possible data inadequacies,
22 we closely examine the full year of calendar year 2005 hospital claims data in preparation for the calendar
23 year 2007 Final Rule. We note that hospitals have had over 6 years of experience with reporting the codes
24 and charges for brachytherapy sources, upon which their specific source payments were based throughout
25 that time period. We observed significant stability of claims based source costs for the most commonly
26 used sources over time, consistent with the findings of the GAO report, released in July 2006, regarding
27 hospital brachytherapy source purchase prices. Therefore in light of the stable claims data, and consistent
28 with the recommendations of the GAO, we finalized the calendar year 2007 Outpatient Prospective

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1 Payment System payment policy for brachytherapy sources to provide separate, prospectively established
2 per source payment rate for all brachytherapy sources for which we had calendar year 2005 claims data,
3 based on the median unit source cost from those claims. We have calendar year 2005 Outpatient
4 Prospective Payment System claims data for 11 of the 12 separately coded brachytherapy sources, which
5 we use to establish their calendar year 2007 payment rates. The only area where we judged our data to be
6 insufficient was for the 12th source, i.e., Yttrium 169. While the CPT-Code for this source was created in
7 calendar year 2005, the source has not yet been marketed and no cost data were provided to us during the
8 2007 Proposed Rule comment period. Once this source is marketed, and external costs data are available,
9 we will establish a prospective payment rate for the source.

10 Agenda Item K. Pay for Performance Cost Measurement Development. 57-K-1. PPAC commends
11 CMS for establishing demonstration projects that would allow cash to flow from one silo to another. PPAC
12 recommends that CMS consider more such projects, specifically those that could shift dollars saved
13 through physician actions from Medicare Part A to Part B and that CMS educate physicians in the relevant
14 geographic areas about the demonstration projects. CMS agrees that the current Medicare payment systems
15 for physician and institutional services encourage different, sometimes inconsistent behaviors. For instance,
16 the Hospital Prospective Payment System encourages hospitals to conserve resources by discharging
17 patients in a timely manner, while the physician payment system is based on resource consumption, not
18 conservation. None of our payments systems is based on the quality or value (quality of cost) of services
19 provided. We are seeking to address this through the implementation of value-based purchasing
20 mechanisms, like Pay for Performance. Pay for Performance uses financial and other incentives to
21 encourage the provision of high quality, efficient health care. To the extent that more efficient physician
22 practice may lead to savings in institutional care in a Pay for Performance program, those savings under
23 current law cannot be used to directly fund financial incentives for physicians. To better understand these
24 and other issues related to the implementation of Pay for Performance programs, we are using our current
25 demonstration authority to explore ways to restructure our current payment systems to better support
26 quality-based payment reforms.

27 Item 57-K-2. PPAC recommends that CMS support establishment of quality and/or Pay for
28 Performance systems whose primary goal is to improve health care and health outcomes of the Medicare

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1 population. These programs will need additional resources to support implementation and to reward those
2 physicians who voluntarily participate. The Council believes that Pay for Performance should not be budget
3 neutral. The primary goal of CMS's quality and value-based purchasing initiatives, including Pay for
4 Performance is to enhance the value of services purchased for Medicare beneficiaries. Value is a function
5 of both quality and cost, so both of these are essential components of our initiatives. Attention to quality
6 without attention to cost will result in an unsustainable Medicare Program. Attention to cost without
7 attention to quality, will result in unacceptable care, thus we plan to measure and pay based on both the
8 quality and cost aspects of value. The President's budget for Fiscal Year 2006 and Fiscal Year 2007,
9 various MEDPAC reports to Congress, and the recent IOM report, rewarding provider performance,
10 aligning incentives in Medicare all recommended budget neutral implementation of value-based purchasing
11 programs for Medicare payment systems. We recognize that CMS physicians and other health professionals
12 and institutional providers will all need to invest in quality measurement and reporting infrastructure to
13 implement Pay for Performance. However, we believe that the investment will result in higher value health
14 care services for beneficiaries and financial rewards for providers that improve quality and save
15 unnecessary cost.

16 That concludes my report, Mr. Chairman.

17 Dr. Senagore: Are there any specific questions for Dr. Simon? And when you do speak for Dana's
18 purposes, if you could talk directly into the microphone, there are some issues with volume. Dr. Sprang?

19 Dr. Sprang: A couple of issues, Ken. One, just on the overall SGR and budget neutrality. It seems
20 like a heavy part of the burden is really on physicians, and we're neutral, but it seems like all the other
21 players, the hospitals, the pharmacies, the labs, all get increases from year to year. And it just seems that if
22 it is going to be reasonable and fair, obviously, maybe the budget neutrality has to be on the total dollars
23 Medicare is spending and I know there's a broader picture, but I think it is a real issue. We understand they
24 have limitation of dollars, but we also believe that physicians are being selectively burdened more than any
25 of the other players in health care.

26 On the access to care problem, you guys continue to look at the number of physicians who take
27 Medicare, even though the numbers may not change that much, more physicians are actually not taking
28 new patients in their office. You know, say, besides the numbers themselves, the quality expertise as

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1 [unintelligible] physicians that are no longer going to take Medicare, is going to be a dramatic immediate
2 access problem. I'll use an example: In my institution, an orthopedic surgeon who's the busiest and the best
3 at doing hips, effective January 1, will no longer do Medicare hips. Medicare patients will then be not have
4 opportunities to have again, the best person out there doing it and that may not show up in your statistics,
5 because maybe somebody else comes right out of residency and adds on as numbers. But the quality and
6 experience of the people taking care of those patients is going to decrease, and it is immediate access issue,
7 and I'm sure that will come out throughout the day repeatedly, but I really do think there is a looming, very
8 short-term looming crisis and we'll talk about it more I'm sure during the day.

9 Specifically on the malpractice premium issue, we talked about reliable accurate current data, and
10 it said in your response, that CMS looks at it every three years. Is that by law, or just by CMS's rules, or
11 why is it done every three years instead of annually?

12 Dr. Simon: It's not by statute. The information is reviewed annually, however, the updates are
13 incorporated at three-year intervals.

14 Dr. Sprang: OK, I guess seeing as how, especially liability issues make up such a large part of
15 some of the specialties, especially my specialty for OB/GYN, looking in at every three years doesn't take
16 into account times when things are really going up 35% annually and so I guess I would add a new
17 recommendation and respectfully request CMS to consider updating it annually rather than every three
18 years.

19 Dr. Senagore: Do you want to make that a formal?

20 Dr. Sprang: Yes, I do. PPAC respectfully requests CMS to consider looking at the costs of liability
21 on an annual basis and updating it on an annual basis rather than every three years.

22 [Seconds]

23 Dr. Senagore: All in favor? Or comments first, I guess. Any? All in favor, ay?

24 [Ays]

25 Dr. Senagore: Did you get that Dana? Thanks. Dr. Grimm?

26 Dr. Grimm: Yes, I'd like to reinforce this. I think the American public and the Medicare
27 beneficiaries in this country should understand that we are reaching a crisis status in terms of access to
28 medical care. The promise to the American people through the Medicare beneficiaries is that they would

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1 get high quality care in a timely fashion. That is being severely, severely tested at this point and that we are
2 reaching crisis state with our physicians who are able to provide that service. One of the concerns that
3 we've expressed many times at this meeting in fact, I think at every meeting for the past two years is that
4 this crisis is looming and it's not being addressed appropriately by the legislation. We've been told
5 repeatedly at this meeting that legislation is the answer. We've given suggestions in terms of how Medicare
6 itself can resolve some of this problem and been rebuffed and said there's so solution except at a legislative
7 level. I think it behooves all of us in this room and all those who are standing behind us to understand that
8 this is a crisis; that the American public needs to know about, and their legislators need to know about. One
9 of the issues that we asked for in G-3 was the fact that, we wanted updated information on the implications
10 of changes in the Physician Fee Schedule for subsequent beneficiary access to physician services. And as
11 stated today, Medicare stated that they are monitoring. What I would like is Ken and Tom, is a explanation
12 in terms of how this monitoring was conducted in the past and how it's being conducted now, and how it
13 will be conducted in the future so that the American public will know that their access to care is being
14 limited.

15 Dr. Senagore: Did you want to make that as a formal recommendation?

16 Dr. Grimm: PPAC recommends that CMS provide the Council with a detailed explanation of how
17 access to care for Medicare beneficiaries will be conducted.

18 Dr. Senagore: Is there a second?

19 [Second]

20 Dr. Senagore: Discussion? Dana could you repeat that please?

21 Ms. Trevas: PPAC recommends that CMS provide the Council with a detailed explanation of how
22 access to care for Medicare beneficiaries will be conducted—how monitoring of access to care for
23 Medicare beneficiaries will be conducted.

24 Dr. Senagore: Comments?

25 Dr. Williams: Would you also like a report at each quarterly meeting about the results?

26 Dr. Grimm: I guess it would depend. How often do you monitor that data, Dr. Simon? Is it yearly
27 that you look at?

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1 Dr. Simon: We would have to talk with the appropriate groups within the agency, but I'm not sure
2 that it's monitored that frequently.

3 Dr. Grimm: Let's see if we can have the report maybe for the next meeting and we can decide
4 frequency from there.

5 Dr. Sprang: Yes, clarification, Ken, maybe some of the details of how the monitoring is actually
6 conducted.

7 Dr. Senagore: I think that was the spirit of the proposal.

8 Dr. Sprang: Because as I said before, sometimes it's not just the numbers, in the experience and
9 the expertise of the individuals who are no longer taking care of Medicare patients is very significant.

10 Dr. Senagore: I'll talk to Dr. Simon off-line, maybe we can make this an agenda presentation item,
11 rather than a typical recommendation report. Dr. Bufalino?

12 Dr. Bufalino: Not to nitpick this, just I think we should have some thought about the details of this
13 analysis, because I think there's a lot of different ways to answer and ask this question. And we've been
14 surveyed in a variety of ways. I think this may be something to ask the agency to consider, you know, a
15 nationwide surveys of sorts; to go to providers and ask them specifically I think what a lot of us are
16 concerned about is access to new patients and although many of us are continuing to provide opportunities
17 for the patients that we serve today, so we'd like to specifically ask that how many providers are continuing
18 to see new Medicare cases.

19 Dr. Senagore: That's interesting. I just redid my Michigan license and it was on the survey at the
20 end of the application process to report whether or not you were accepting new or existing Medicare
21 patients. Who was first, I think Dr. Ross was first?

22 Dr. Ross: At the last meeting, it was mentioned about those providers who were going to de-select
23 or leave the as providers. The real question isn't who's leaving, the question is who is remaining as
24 provider, but who is not just taking on new patients, but who is now limiting the number of beneficiaries
25 per day, per week, per month into their practice, and I think that's another issue that we need to look at.
26 Because if the trend is such that doctors are practicing medical economics 101, where they're limiting the
27 number of beneficiaries per day, per week, per month, then the access is also going to be deteriorated. And

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1 I think that's another important issue in how we can assess those providers who are giving less care, and I
2 think that's a very important point.

3 Dr. Przyblski: I would echo that comment. It's almost managed Medicare on the physician side,
4 where from a business perspective, if you are unable to make up the cost of a practice with non Medicare
5 patients, one of the ways that some physicians do that is simply see fewer patients per unit's time of
6 Medicare patients, so simply measuring access of the new patient, I may still see a new patient, but I may
7 only see one a month as opposed to 10 a month that I used to see. So it has to be drilled down to that detail.

8 Dr. Senagore: OK. I think we'll probably revisit some of this material at the Fee Schedule update
9 discussion a little bit later this morning. So I think we need to call the question because I don't think we
10 voted on that yet. All in favor?

11 [Ays]

12 Dr. Senagore: Great. Any other questions for Dr. Simon at this point that aren't going to be
13 covered by upcoming agenda items? Then I'll invite Dr. Rogers to come forward. Dr. Rogers is the
14 Director of the Physician Regulatory Issues Team in the Office of External Affairs and he'll provide us
15 with the well-known PRIT Update. Dr. Rogers?

16 PRIT Update

17 Dr. Rogers: Thank you, Dr. Senagore. My reputation. Before I start, too, you know, one of the
18 things you might think about I think when Congress or the agency looks at surveys of physicians, whether
19 they accept Medicare or not, or accepting new patients, there may be a skeptical that maybe physicians are
20 over-reporting in order to try and make it seem that a crisis exists where some are convinced that a crisis
21 does not exist, but actually surveying beneficiaries about problems with access might be the most valid
22 measure of whether a problem exists or not. So that's just a suggestion that occurred to me while I listening
23 to the conversation.

24 I was recalled to active duty for September and October so we, Rob sort of kept things going while
25 I was gone, and we're back in the saddle now and made three trips in the past three weeks. I spoke to
26 orthopedists, oncologists and then the American College of Allergy Asthma and Immunology. And we're
27 continuing to manage our issues the best we can. So I'm going to go over the PRIT issues and then we'll
28 have some time for questions.

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1 I've got to apologize. The issues seem to be a little out of date, and the reason is because for some
2 reason, my speeches have to be looked at pretty carefully, so I have to submit them ahead of time, so that's
3 why some of these things are a little out of date, but I've got some more up to date stuff. So the first issue
4 that I'm just going to mention: We heard from some urologists in California and also some oncologists that
5 they had received RAC letters requesting records, but it was very vague about exactly what was being
6 requested. The doctors were glad to comply, but it was unclear what they needed to send, and so they sent
7 us a copy of the letter, and in fact, the letter was obviously written by a lawyer and not a clinician. And so
8 we made some suggestions about how to make the letter more clear and that's being reviewed and I think
9 we'll probably in the very near future have a better letter.

10 The next issue I got when I spoke to the oncologists. And this is an interesting marketing tool. One
11 of the manufacturers of colony stimulating factors is bundling two drugs and giving a better price if you
12 purchase both drugs at once. Well, unfortunately, most patients don't need both drugs, and if they do them,
13 they don't need them at the dose that they're being bundled, so that's creating a problem for particularly the
14 smaller oncology practices to deal with, so we've asked them for some information about the bundling and
15 then when we get the information we'll make sure that the people at CMS who are involved with the whole
16 ASP process will share the information with them and try to decide on a strategy.

17 The next issue there were particularly physicians who were practicing in rural areas had concerns
18 because sometimes they wanted to do second level appeals for patients who had trouble traveling and
19 didn't have Internet access and didn't have very strong sort of clerical abilities to deal with appeals. But in
20 the regulations, the only person that can do a second level appeal is either the beneficiary themselves, the
21 patients, or somebody who has been officially appointed as their representative. And so we did determine
22 that in fact a physician who wants to can have the appointment of representative form filled out by the
23 patient during an office visit and then they can go ahead and help the patient by submitting the second level
24 or third level appeal.

25 Definition of consultation has been an interesting issue. We all thought we knew what
26 consultations were. And that's a little less clear because of Transmittal 788, Indiana State Medical
27 Association and the Care & Medical Director there invited me up there and we had an interesting meeting
28 with a whole bunch of coding specialists and billing people and things like that and so the AMA has sent a

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1 very well-written sort of suggested language for clarification to CMS and that's being looked at internally,
2 but this should be a pretty easy problem to fix.

3 I'm glad nobody to the right or the left can see my cartoons, but they are there in the hand-out.
4 Simplifying the work of enrollment. What we found, we had a great idea, the 855 Form is now in a format
5 that can be filled out on your computer which saves the physician or the office staff from doing a lot of
6 handwriting, but unfortunately, if you don't own the full suite of Adobe Acrobat, you can't save it. So that
7 really was an oversight, and so we have actually spoken to, we are speaking to Adobe, and I'm hoping
8 we're going to have a fix for this in the next week or so. There will be the ability to save that completed
9 PDF even if you don't have the full Adobe Acrobat Suite.

10 PDP exceptions and appeals forms, we asked that are required that all of the plans have the
11 exceptions and appeals forms available within three clicks of the website, and we had an intern this
12 summer, and he was very diligent about checking on the progress that the plans were making. That was
13 awfully helpful because we were able to get back to the plans that didn't seem to be complying. We don't
14 have the intern anymore, so we're not following this, but we have not heard from physicians about
15 difficulties finding a form, so if somebody's having problems with that, we would like to know specifically
16 which plan has not complied.

17 Coverage determination submissions, this is sort of the first TRP and in fact physicians can submit
18 the first year without being appointed a representative. This was actually an issue which sort of preceded
19 the one about becoming an appointed representative.

20 Nurse practitioner services billed in the hospital. This was a clerical error on our part. We put
21 some language in the manual that seemed to indicate that nurse practitioners or nurse specialists could not
22 bill for services they provide in the hospital. And so we developed corrective language, for one reason or
23 another, it didn't make it through the approval process, so revised corrective language is now in the
24 process. And hopefully in the next week or so it'll be through.

25 Surgical codes, Greg should be happy about this. And I'm very happy. We're going to be
26 publishing all of the RUC values, whether or not the service is covered by Medicare. And this is apparently
27 very helpful, particularly for physicians who have patients who are in small plans, because apparently some

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1 of the smaller plans sort of import the Physician Fee Schedule into their own fee schedule and so it was
2 creating problems for them. This was also a pediatric issue.

3 Public availability of NPI numbers. This is actually politically a pretty sensitive issue. The doctors
4 offices would like to have an online directory of NPIs so that when they get a referral or need an NPI for a
5 physician that they work with but is not in their office, they can look up the NPI. And I think it absolutely
6 should happen. I think you know the mistake that we've made with many of these numbers is we've tried to
7 sort of keep them secret. And when we sort of keep them secret, then people start to think that maybe
8 they're secret enough that you can use them to verify that the person is who they say they are. Really, if we
9 kept, if everybody's Social Security Number was on the Internet and everybody's NPI was on the Internet,
10 then nobody would be getting in trouble because insurance companies and others would know that you
11 can't ask somebody for their Social Security number to verify who they are. The military, which is very
12 involved in security, and interested in this whole subject, you know, obviously would never rely on these
13 numbers to verify that somebody was who they are. So we're very in favor of having an online directory of
14 NPI numbers, but some people think that this is a number that they need to keep secret. I think keeping it a
15 secret's a mistake.

16 Can hospitals provide continuing medical education? This is a complicated issue because it is an
17 issue which has very circumscribed by statute, particularly STARK, and AMA has submitted a letter which
18 is being responded to concerning how to make sure your complying with STARK, and there's going to be a
19 Final Rule now which is going to actually lay out the specific ways that hospitals can provide CME, but
20 remain compliant. And that will be out in the near future.

21 DME was mentioned. This has been difficult because on the one hand, we absolutely have to make
22 sure that the teaching hospital pays all or substantially all of the costs of the training, but many physicians
23 particularly in the primary care specialties, orthopedists and others, very much enjoy their time with
24 residents and so while we need to make sure that we're verifying that all or substantially all the costs are
25 being paid by the teaching hospital, we also don't want to burden these physicians with a bunch of
26 paperwork, so it's been a difficult sort of balance to maintain and we're not at the end of this issue by any
27 means.

28 RVUs for pediatric codes, also the non-valued codes are now listed in the fee schedule.

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1 Competitive Acquisition Program. We've not gotten much feedback from physicians who've been
2 having problems, but we are going to have a presentation today in the PPAC, so that'll be a good time to
3 talk to somebody who knows more about it than I do. But we haven't heard much from physicians about
4 problems.

5 So any questions that you have, I'd be happy to take now. And there's my contact information, as
6 always.

7 Dr. Senagore: Any questions for Dr. Rogers?

8 Dr. Przyblski: I would just like to personally thank Dr. Rogers and CMS staff for listening to the
9 PPAC recommendations and the comments submitting about publishing all the RVUs submitted by the
10 RUC, whether or not CMS covers those services, I think it's very important because CMS obviously is not
11 the only payer, and many payers have chosen to use the RB RVS system in defining their fee schedules so
12 it's exceedingly helpful to us and very much appreciated.

13 Dr. Senagore: I have one comment that came up with Trail Blazer. Which I think is Texas,
14 Virginia, DC and somewhere else, Maryland maybe. There was an issue related to wound care and numbers
15 of debridements but and they're wanting to limit the number of debridements, but I think there's really
16 confusion between using the 11,000 series of codes, and the 90,000 series of codes. The former's with
17 anesthesia. The latter is without and by arbitrarily limiting the number of debridements, it would severely
18 disadvantage where the 11,000 codes are typically used; open abdomens that frequently go back everyday
19 or every other day for anesthesia management. It would be an unfair burden for those wounds that truly
20 need more complex care, so it would be something that I think it would be helpful to have the PRIT look at.

21 Dr. Rogers: Be happy to.

22 Dr. Senagore: Dr. Ross.

23 Dr. Ross: I just like to echo the sentiments of the chair on that because when we heard about this
24 clarification or this interpretation by Trail Blazer, I spoke to many colleagues and many diabetic wound
25 specialists who deal with debridement of wounds. Now we're not talking about hypokeratotic tissue
26 lesions, which is basically debridement of a non-diabetic wound, but we're actually talking about
27 debridement of the wound itself. And limiting the physician to three debridements total is totally
28 unacceptable and unexplainable. When a diabetic wound comes in, may be infected, may be with necrotic

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1 tissue. The wound has to be cleaned, has to be done periodically. From a personal standpoint, I see patients
2 sometimes once a week to do this type of cleaning and even though the research may show that there may
3 be discrepancies in the research, I should say, which shows that debridement of the wound may not be as
4 effective to be done as often. The truth of the matter is, if the wound's not cleaned, if necrotic tissue's not
5 removed, the wound doesn't heal. There's no promotion of a granulation bed. So the bottom line is you can
6 over-debride, yes, but you can also way under debride, and to limit three times in the course of treatment
7 for this one wound is unacceptable.

8 Dr. Rogers: Well, the Care & Medical Director and I are old friends, so we can talk about this.

9 Dr. Senagore: Thank you.

10 Dr. Ross: Thank you.

11 Dr. Senagore: Any other comments, questions?

12 ??: So do I take it that that has been sufficiently noted and you will resolve that with the Care &
13 Medical Director, because we're involved with that issue also. We don't agree that it's appropriate. It's a
14 local coverage decision. It's not a national decision. So that's something you deal with?

15 Dr. Rogers: I'll talk to Larry about it today.

16 ??: Thank you.

17 Dr. Senagore: Dr. Simon?

18 Dr. Simon: Does that LCD cover both the 11,000 series of codes as well as the 97,000 series of
19 codes?

20 Dr. Senagore: There's confusion I think, between the two. That's part of the discussion I think that
21 wasn't enjoined was that distinction between, they were going to, my understanding of the discussion was
22 it was going to limit both the 11,000 and the 90,000 series and there are significant wounds in the 11,000
23 that are medically necessary to do as many times as you need to do them. So to arbitrarily limit those
24 seemed to be onerous.

25 Dr. Simon: And the question to Dr. Ross—was that three times for the patient's lifetime?

26 Dr. Ross: No, per wound, per ulceration site, not per lifetime.

27 Dr. Simon: We will work with Dr. Rogers as well to find out more information about this.

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1 Dr. Ross: I know it's—when we heard that our recent meeting, our representative was beside the
2 word “incensed” it was just flabbergasted is the word because we could not believe that our patients were
3 being limited to that number of treatments when we know that the research has shown much better
4 outcomes and it's evidence-based, by the way.

5 Dr. Simon: Excuse me, the decision is evidence-based, or ...

6 Dr. Ross: The evidence based on the improvement of those wounds with additional debridements.

7 Dr. Simon: I see. I'm just clarifying it because I'm not implying that the decision that the OBC
8 was made was—

9 Dr. Ross: No, no absolutely not. [laughter] Quite the contrary, Mr. Administrator. Dr.
10 Administrator.

11 Dr. Senagore: Any other comments, questions for Dr. Rogers? Thank you, Dr. Rogers. Let's go
12 ahead and do the DME Update and then we'll take a short break because the next topic may take a little
13 more time. We'll invite Joel Kaiser, who's the Deputy Director of DME POS policy and has an extensive
14 working knowledge of this DME visit. Joel's not here? Actually under the chair's discretion, we'll take a
15 break now, [laughter] since the next presenter is not currently available.

16 Break

17 Dr. Senagore: If the panel members could reconvene please? Members of the Council? And now
18 we have Mr. Kaiser here. Thank you for coming. Joel Kaiser is the Deputy Director for the DME POS
19 Policy with an extensive working knowledge of the DME Benefits. Joel would like to begin by discussing
20 CMS's plan to phase in a competitive bidding program for Durable Medical Equipment beginning in '07.
21 Contracts will be awarded to suppliers for select items in 10 metro areas through the course of the next two
22 years. And then 80 additional sites I believe will be brought on site in '09, and then the remaining '09.
23 Medicare payments will be based on bids submitted for furnishing the items to beneficiaries residing in
24 these areas. Based on authority provided in the statutes, CMS has proposed a physician authorization
25 process as part of the national competitive bidding program, whereby a physician would be able to
26 determine that a particular brand or mode of delivery on that item was necessary in order to avoid an
27 adverse medical outcome for the individual. The contract supplier would then be required to either furnish
28 that specific item, or mode of delivery, assist the beneficiary in finding another contract supplier in that

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1 area that could provide that item, or consult with a physician to find a suitable alternative produce or mode
2 of delivery for the beneficiary. So with this background, Joel will begin his presentation and then there's a
3 couple of questions that we'll bring up at the end.

4 DME Update

5 Mr. Kaiser: Thank you very much. Thank you very much. And actually I'm going to save
6 competitive bidding for last because that's by far the biggest item happening these days in DME. First all,
7 before I begin, can I get a show of hands of how many people know what DME POS is? Close to 50%.
8 [laughter] That helps. At least some of you will know what I'm talking about.

9 Dr. Senagore: I guess we needed you to come here this morning.

10 Mr. Kaiser: I'm sure DME, DME POS is on the agenda today because there's been so much
11 activity in recent years and there's a lot of changes that are coming for the very near future, so I'm here to
12 sort of give a past, present and future status of DME. I am the Deputy Director of a newly created division
13 that concentrates exclusively on DME POS payment policy. A lot of you probably know that divisions
14 within CMS, within the Center for Medicare Management are comprised of approximately 10 to 20
15 analysts, who work on developing policy and implementing policy relating to various items and services
16 that are paid for under Medicare. When I came to CMS in 1988, I was part of a division that dealt with
17 DME policy, DME POS policy, in addition to the payment policy for physician services as well as
18 ambulance services, as well as clinical laboratory services, as well as all Medicare Part B drug payment
19 policies, so needless to say that that was a simpler time in some ways. Those, all of those areas now are
20 handled by different divisions within CMS. There's been a lot of growth and activities in all of those areas,
21 and DME POS is no exception, hence the need to have a separate and distinct division that focuses on the
22 policy issues for only DME POS.

23 So what I'm going to go over today is I'm going to quickly define DME POS, I'm going to go
24 over the current payment structure that's been in place since 1989 for most DME POS items. I'm going to
25 summarize recent, legislative, and regulatory changes. I'm going to briefly talk about some new codes that
26 were recently implemented for power mobility devices, and I'll close with an overview of the competitive
27 bidding program and a couple questions that I'm raising today for the Council to consider.

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1 So for the little more than 50% of you who didn't raise your hand, DME POS is an acronym used
2 to describe a group of device and supply benefits covered under Part B. The claims for these benefits are
3 processed by four regional contractors. The regional contractors processing DME POS claims, they've been
4 in place since 1993. The largest component of DME POS is DME. That's durable medical equipment used
5 by the beneficiary in their home. Examples, oxygen equipment, wheelchairs, hospital beds. DME accounts
6 for over \$7 billion of DME POS expenditures. Prosthetic devices are devices that replace all or part of an
7 internal body organ, or the function of an internal body organ and some examples would be the cochlear
8 device to help with the hearing impaired. Also included as prosthetic devices under this benefit are parento
9 and entral nutrition and ostomy, tracheostomy, and urological supplies. Medicare spends approximately \$1
10 billion per year on prosthetic devices. The next category would be PNO, prosthetics and orthotics. These
11 are artificial limbs and braces and this benefit accounts for approximately \$1 billion of DME POS
12 expenditures. And finally, the S in DME POS is for different supply items; therapeutic shoes, surgical
13 dressings, and other miscellaneous supply items. As I said, there's been a tremendous growth in the
14 different benefits in the Medicare over the years. For DME, there's been a dramatic increase in
15 expenditures over the past 10 years. It's grown from about \$5 billion annual, to more than \$11 billion
16 annually, today. And when you look at DME POS, there's three categories of DME that really stand out in
17 terms of being the real biggies. That would be oxygen, oxygen equipment, wheelchairs, and diabetic testing
18 equipment and supplies. Oxygen is really the mainstay of DME. It always has been and still is.
19 Expenditures for oxygen and oxygen equipment have grown from about \$1.5 billion in 1995, ten years ago,
20 to approximately \$3 billion, or close to \$3 billion today. Coming up close second and gaining are
21 wheelchairs. And the biggest reason for the huge increase in spending for wheelchairs is what I term a
22 power surge. We've had a power surge. [laughter] You may have noticed these power surges in when
23 you're watching TV at night, you see a lot of advertisements for power wheel chairs on TV at night. Just to
24 give you a little flavor of how things have changed in the wheelchair benefit, again remember these are
25 devices for Medicare purposes, that are covered for use in the time. Ten years ago, in 1995, 80% of
26 expenditures for wheelchairs, the \$200 million in 1995 was for manual wheelchairs. Today, the exact
27 opposite is true. 80% of expenditures, which are now approximately \$1 billion are for the power
28 wheelchairs as opposed to the manual wheelchairs. Just one more little fact. In 1989, right or about when I

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1 came to CMS, Medicare was paying less than \$5 million annually on power wheel chairs. So that category
2 has really grown. And finally, there's been a huge increase in payments for diabetic testing equipment and
3 supplies, primarily because of the recognition of how important blood sugar testing is for diabetics. The
4 landmark diabetes control and complications study which concluded in 1993, really advocated frequent
5 testing of blood sugar for diabetics. So the diabetic equipment and supply spending really took off because
6 of the increase in utilization as a result. In addition, in 1997, the Balanced Budget Act added type II. We
7 started covering diabetic equipment and supplies for the Type II diabetics beginning in 1998, I believe.
8 Projected spending for 2006 for test strips alone is \$1.2 billion. And then there are other really fast growing
9 items of DME. CPAPs, continuous positive airway pressure devices, have been growing over the past
10 several years. We paid about \$40,000 in 1989 when these were relatively new devices. Today we're
11 spending close to \$400 million a year. And another real quick grower is a negative pressure wound therapy
12 pump, which is used in helping complex wounds heal faster. We added this device, we added coverage for
13 this device in 2000 and it's steadily climbed the charts to number seven now on the list of top DME POS
14 items in terms of Medicare expenditures. So it's up to about, projected for 2006, about \$265 million. So
15 that's another one to keep your eye on in terms of a lot of growth in the DME area.

16 Real quick overview of the payment structure. I don't want to take up too much time. The current
17 payment structure for DME was implemented in 1989. It is a fee schedule methodology. Many of you are
18 familiar with that term. The fee schedules—basically it's medical payment based on a fee, which is based
19 on average reasonable charges under the old reasonable charge payment methodology. Many of you who
20 were in practice prior to 1992 know what the reasonable charge methodology is. So those historic payments
21 were locked in place in 1989, and then they're updated annually by an update factor. Most, other than
22 DME, most of the benefit categories we pay for on a purchase basis. For DME it's rental or purchase,
23 primarily it's rental. And the DME benefit, the payment rules in the statute divide the benefit up into
24 different payment categories, payment classes. Real quickly, there's a category for inexpensive routinely
25 purchased items for which Medicare pays on a purchase basis. There's frequently serviced items, like
26 ventilators, which require frequent and substantial servicing on the part of the supplier in order to avoid risk
27 to the patient's health. For those items, we pay on a rental basis, and it's continuous. The rental payments
28 continue for as long as the device is used. Oxygen and oxygen equipment also used to be a continuous

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1 rental category. Recent legislative changes however, change it, for the equipment after 3 years now, the
2 beneficiary takes over ownership if they're still using oxygen equipment after that period of time. And
3 finally, any DME that doesn't fall into any of those other categories I mentioned, fall under a category
4 called Other Covered Items in the statute. And we commonly refer to this category as "capped rental."
5 Because the rules for this category are that Medicare pays rental payments up to a certain number of
6 months, and then the payments cap. Well the recent legislative changes have also made this a beneficiary
7 owned item after so many months that would be 13 months Medicare, payments cease, and ownership of
8 the equipment transfers to the beneficiary.

9 So going over real quickly, the Medicare Modernization Act of 2003 did two major things for
10 DME. I'll start with supplier standards, quality standards. It required accreditation of DME POS suppliers
11 and establishment of quality standards that all DME POS must meet and will be enforced by the accrediting
12 organizations. These quality standards were issued earlier this year, and the accreditation organizations
13 were recently announced by CMS and are beginning to accredit the DME POS suppliers. The accreditation
14 organizations will be focusing first on those areas that are likely to be or will be subject to competitive
15 bidding next year. The other major change for DME that was mandated by the Medicare Modernization Act
16 was the competitive bidding program. This is going to be a national program where we will for certain
17 items in certain areas, we will enter into contracts with suppliers for furnishing DME POS items to
18 Medicare beneficiaries who reside in those areas. So this system will base Medicare payments on bids
19 submitted to become one of these contract suppliers and then these payments would replace the fee
20 schedule amounts that have been in effect since 1989. And I'll be providing more details on the competitive
21 bidding program a little later. We did publish a Proposed Rule May 1st and we will soon be publishing the
22 Final Rule for competitive bidding, hopefully within the next few months. Other recent legislative changes
23 just last year. The Deficit Reduction Act of 2005, mandated some changes for the two biggest categories of
24 DME. As I mentioned, oxygen equipment, which used to be paid on a continuous basis is now paid for for
25 up to 36 months or 3 years, after which title to the equipment transfers to the beneficiary. Also for the other
26 covered items, the CAP rental items, the beneficiary takes over ownership automatically after 13 months
27 have been paid. The law requires that we pay for maintenance and servicing, and we spelled out in the Final
28 Rule exactly how we would do that. We will pay for any necessary repair and servicing of the beneficiary-

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1 owned item as it's needed, and in addition for oxygen equipment, we are implementing a payment for
2 general maintenance and servicing, which we will pay every six months. And the idea here is that the
3 supplier will be paid for going out to the beneficiary's home to check on the equipment, do all the general
4 maintenance that needs to be done, and in order to ensure that the equipment continues to function for the
5 next six months for the beneficiary.

6 Other things that we did in addition to implementing the DRA changes, the Deficit Reduction Act
7 changes, in this Final Rule we established a new payment category for Newer Technology Oxygen
8 Equipment. It's a new payment category and an enhanced payment for newer technology oxygen
9 equipment. These would be the transfilling units that take concentrated oxygen and fill up portable
10 canisters in the patient's home. So there's no longer a need for suppliers to delivery tanks. The beneficiary
11 uses this equipment to fill the portable tanks in their home. Also, portable oxygen concentrators, which the
12 beneficiary can now carry around with them outside their home, inside their home. There's an enhanced
13 payment now for those items as well. These enhanced payments in this payment category will be phased in
14 over a few years and beginning January 1, 2007. The other thing we did with the Final Rule in
15 implementing the Deficit Reduction Act was, we realized that supplies now will be losing title to
16 equipment after so many months of payment, and we just wanted to make sure that there was interruption
17 in the beneficiary service, and so what we did was we're going to implement some beneficiary safeguards,
18 some requirements for the supplier to make sure that the equipment is there for the beneficiary. I'll just give
19 you two examples. One, if you're a supplier of oxygen equipment, and you start furnishing the item to a
20 Medicare patient, you must continue to furnish the item to the Medicare patient for the full 36 months. You
21 can't for example, leave in month 36. There will be exceptions, obviously, for this, such as when a
22 beneficiary moves across the country, and other exceptions. But that is something that we felt was
23 necessary to ensure that the beneficiary always had access to this equipment. One more example I'll give
24 you is the supplier cannot swap equipment in the middle of the rental period. Of course there will be
25 exceptions for this if there's a change in medical condition, if the equipment just no longer is functioning
26 and needs to be replaced. Things like that. So there will be exceptions to these rules, but we want to make
27 sure that the beneficiary has quality item throughout the entire rental period.

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1 Next, I'll touch on recent events in the wheelchair category of DME. We revised the codes for
2 power wheelchairs back in 1993. Actually we revised the codes for all wheelchairs, back in 1993. We used
3 to have a small number of codes that described complete wheelchairs. Then in 1993, we decided to change
4 it to several base codes for the wheelchairs with all the options, the different types of seating systems,
5 different types of accessories billed separately. So primarily it's been that way since 1993. The big problem
6 with that is that there's been a lot of change in technology with power wheelchairs. They're much different
7 than what they looked like in 1993. Primarily because of the rehab market. The rehab market has gotten
8 very sophisticated. The seating systems, the wheelchairs that are designed to accommodate these seating
9 systems have changed dramatically, and we've been paying primarily under one code all these years for all
10 of those devices, both the rehab chairs that can accommodate these special features, and those chairs that
11 can't, also known as the consumer chairs that I mentioned you see on TV, advertised at night. So we
12 thought it was very important to establish new codes for power wheelchairs, primarily because of the fact
13 that there was such a huge growth because of the demand for the consumer chairs and the rehab chairs were
14 sort of being lost in the shuffle. We have one payment, regardless of whether you're providing a rehab
15 chair or a non-rehab chair. So now on November 15th, we have implemented approximately 64 codes, I
16 think it's 64, that's why I say approximately, for power mobility devices, different scooters, different power
17 wheelchairs, and these power wheelchairs must be tested based on certain resina standards that we've
18 adapted in order to grade the chair, grade the product and put it in a hierarchy of coding. It's a hierarchy
19 based on performance and durability. And so we now we have this hierarchy of power mobility devices that
20 we now or will be basing our medical decisions on in terms of covering what level of power mobility
21 device does this patient need. And it goes all the way up to the most sophisticated rehab devices. So we
22 have very distinct codes for all the different types of power wheelchairs.

23 Now just to go over the Competitive Bidding Program, we are going to begin phasing it in in
24 accordance with the statute we must begin phasing the Competitive Bidding Program in next year. What
25 the program calls for is we start the programs in 10 areas in 2007, then we do 80 areas in 2009, and then
26 additional areas after 2009. Medicare payment will be based on bids submitted by suppliers for furnishing
27 these items. Of course, these will be accredited suppliers that meet our quality standards and other
28 standards that the law requires that we establish, including financial standards. Once we enter into contracts

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1 with these suppliers, they'll be our suppliers for these items in these areas. Beneficiaries will go to these
2 suppliers and receive these items and the Medicare Program and taxpayers will of course benefit as a result
3 of the savings generated by the competitive bids. The law requires that the bidding rounds be no more than
4 three years and the scope of the Competitive Bidding Program is limited to three major areas. I'll start in
5 order of prominence; durable medical equipment other than class 3 devices, including supplies used with
6 the durable medical equipment. The one notable exception is inhalation drugs. Inhalation drugs used with
7 nebulizers are excluded by the law from the Competitive Bidding Program. The next category of items is
8 enteral-nutrients, equipment and supplies, and finally off-the-shelf orthotics, and I did want to note one thing
9 about physicians who act as suppliers. Someone had a question before the presentation so I wanted to cover
10 that real quickly. This is a mandated program for all suppliers of items in these areas of these Part B items
11 in these areas. So there can't be any, I mean we will be signing contracts with suppliers for furnishing these
12 items. If you happen to be a physician who is also a supplier, in some cases, physicians will furnish out of
13 their office, things like canes, crutches, for the convenience of the patient, so that they need a cane right
14 away, they should be able to have the cane as they leave the physician's office. You're probably familiar
15 with the STARK anti-referral rules and these items being an exception to those rules. In our proposed rule,
16 what we proposed for competitive bidding is that physicians would have to submit bids to become suppliers
17 and to continue to be suppliers for these items, but they wouldn't have to furnish the items to the whole
18 area; they could furnish them just to their patients in their office. So that is what we propose in our
19 proposed rule. We did get a lot of comments on it, and again, as I noted, the Final Rule will be coming out
20 soon.

21 And finally, under competitive bidding, the law provided authority for us to establish a physician
22 authorization process so that as you're probably aware, durable medical equipment supplier, they don't
23 furnish all brands of items. They don't furnish every type of item that a HCPCS-Code might describe.
24 There'll be certain suppliers who furnish certain brands and others who furnish other brands. What this
25 process would allow is for a physician to prescribe a specific brand or mode of delivery. And then we
26 would establish a process for the supplier to honor that. What we propose is that, first of all, we propose to
27 include this process under Competitive Bidding Program, and the process we propose which is on the slide
28 here, is that the supplier either a) furnish that item, if it's something that they already customary furnish,

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1 that's no problem. If it's not, they might have to go the extra mile to do it. They could also assist the
2 beneficiary in finding another contract supply area who furnishes that brand, and lastly, they can consult
3 with a physician to find an alternative produce or mode of delivery for the beneficiary. If the beneficiary
4 would insist on that brand, then of course the supplier would have to do what they have to do to furnish it.

5 So that again, that is a proposal under our proposed rule. So we have to wait 'til the Final Rule to
6 find out exactly what we're going to be doing under competitive bidding. And so that brings us to the
7 questions that I had today for the Council. First is a real general question. This is a whole new program, a
8 whole new infrastructure for Medicare where we'll be working exclusively with these contract suppliers for
9 furnishing these items, so we're going to really need to educate a lot of different people on this program;
10 beneficiaries, referral agents, suppliers, and physicians all need to be educated on this new program. So I
11 would like to open up the discussion for any ideas that anyone might have on things to consider and the
12 whole physician education process, and maybe some specific suggestions for how we would go about
13 educating physicians on this new program.

14 Dr. Senagore: Can we turn the lights up? Thanks.

15 Dr. Azocar: Yes, I appreciate very much, your comments. Very interesting and there are a lot of
16 questions. I'm a primary care physician, and most of the time when I receive, or the patient brings a form, I
17 don't know where the form comes from. I think that this is motivated by a commercial thing, maybe,
18 television, late night television programs, or things, but most of the time we find, primary care providers
19 will find ourselves with a large form that we have to fill and we're not certainly sure, sometimes of the
20 technical differences. And that has become difficult. In addition to that, another issue, that maybe best not
21 to go into that now, I mean the time that we need to spend filling those forms, and the pressure we have
22 from the patients, because you know, if you don't fill it in, the patient thinks that you just denied that to
23 him, and I think there is a big need for education, as you suggested, how to do it I'm not sure yet. And
24 maybe we should take a look at how the initial request is started—who started that? Who initiated that?
25 And one question. When you talk about suppliers, are you talking about manufacturers, or just anybody
26 who distributed that? Would you make a contract with the supplier for durable medical equipment, these
27 are normal manufactures?

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1 Mr. Kaiser: No. Primarily, they're not manufacturers. They're suppliers, and they would be
2 suppliers that are enrolled. We have a process that's been in place for many years now for enrolling
3 suppliers, DME POS suppliers under Medicare. And you have to have a supplier number and be an enrolled
4 supplier to furnish the item.

5 Dr. Azocar: So basically, I don't have any answer. I have a little more question to your question.

6 Mr. Kaiser: Sure, yes. Regarding the power mobility devices, there's a lot of information on our
7 website relating to that. We're very well aware of the issues that you presented. And I would suggest that if
8 you don't have a copy of our contractors' local coverage determinations, that would be a good resource to
9 have, because it provides the contractors determination as what types of patients and what types of
10 conditions warrant different levels of power mobility devices, so that would be a good resource to have, if
11 you go to the website and you could probably click local coverage determination and you'll probably get
12 hits from our contractor websites and can download that policy.

13 Dr. Azocar: I'm thinking more in terms of the general physician population, you know, that
14 information that will help them know what option they have and things like that.

15 Mr. Kaiser: Yes, I think there are, that's not exactly my areas, but I think there are initiatives that
16 have been under way and will be underway to educate physicians more on this benefit.

17 Dr. Senagore: Yes, I'm a general surgeon. It's hard for me to understand how there could be 64
18 characteristics for a power mobility device, and under what circumstance I would check which box, but I
19 think one of the onerous things that every specialty feels with this whole area is it's difficult to understand
20 how certain things get started, either home care for wound management or other issues like that. More
21 importantly, how to stop it and many of these forms you get, you get retrospectively. The service has
22 already been delivered. It's a fait accompli, and if you don't validate it, then, it puts you in counter-
23 distinction to your patient. Because the patient's already gotten the service, felt it was warranted, if you
24 deny it, now they're going to be financially on the hook for that. It would seem to me that because we all
25 have to file our forms for billing, that more of the administrative burden should be placed on the suppliers
26 to appropriately provide these forms ahead of the service being provided, and provide their documentation
27 for us to either agree or disagree with. Right now, it's the other way around. The physician is the one
28 responsible or ends up being the bad person to deny something or say it's not medically indicated, when we

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1 have actually no dog in the fight. We don't prosper. We actually do suffer I suppose, because it comes out
2 of the Part B schedule and quite often, it does disadvantage us. But I think that the suppliers are actually
3 getting away scott free on any of these determinations and making us be the people that have to say no. So
4 that, if there could be administratively some action, that should be something CMS should consider.

5 Dr. Ouzounian: Joe, I have a whole bunch of concerns and questions about the whole process.
6 Maybe I can touch on a few. One is as a provider, when we provide DME, which we do frequently as an
7 orthopedist, or we used to do with Medicare beneficiaries, that the burden for competitive bidding is just
8 completely unrealistic. As a physician, you cannot go out and competitively bid for the crutches, orthotics,
9 cast, braces that you're going to do. It just isn't something that we can realistically do. So you've not taken
10 the physicians out of being able to provide that in their office because that's not a realistic hurdle that we're
11 going to jump over. The second is that it then seems that there's going to be a limited number of suppliers
12 in the area where you practice, and as you've indicated, how do you educate the physicians to that, and how
13 do you then get them to direct their patients there? And I see that as a burden. But I'm also a little surprised
14 that this seems so different than the way we've structured many other payment processes. I worked with
15 RUC and I worked with the PEAC, and it's based upon expenses and costs. And it may be way to late, but
16 why isn't the DME done the same way? You know, you have this brace, and this brace costs X dollars from
17 the supplier, so you put in a reasonable profit margin and that's what you pay. And whether I be a
18 physician or whether I be a supplier, that's what you pay. In my area, we've got a variety of brace shops
19 and it sounds like the way you've structured this, a lot of them are going to be taken out of business. And I
20 don't think that's appropriate. And then I see that happening to them, and I wonder what's going to
21 happen—you're going to turn around and competitively bid for physician services? And the lowest bidder's
22 going to get to do all the work? And the other guys are going to be out of work? I have a lot of concerns
23 with the way I think you've described this process.

24 Dr. Ross: I'd like to echo some of those same sentiments, particularly dealing with accreditation of
25 an office, the cost burden of accreditation, and then having someone to come into the office, spend the full
26 day, to then site search that office, and to go through an accreditation process. That's the first point The
27 second point I echo again, that if we decide to opt out of this process, now my senior patient, who comes in
28 with a broken foot or ankle or whatever injury after X-rays are taken and the diagnosis is made, may be told

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1 now you have to go to a brace shop or some type of establishment to get a boot or to get a brace, or get
2 crutches, and the patient's going, wait a minute. This isn't possible. How come you're not treating me right
3 now in your office? So that puts a burden both on the patient and the physician, and puts us at risk, medical
4 legally as well. The third question I really have deals with clarification of the broad physician definition in
5 the Final Rule. In other words, will all Medicare recognized physicians be able to bid supplies to their
6 patients only, or will CMS extend that privilege to MDs and DOs only? In other words, podiatrists may be
7 regarded as suppliers in the MSA, rather than providing that care and that service individually to the
8 patient. So in terms of the clarification of definition, podiatrists as well as optometrists, who are regarded as
9 physicians already, should be included in that definition.

10 Dr. Williams: I think my question was can you give a couple of examples of some of the quality
11 measures that you use when the competitive bids go out and what you expect from your suppliers?

12 Mr. Kaiser: Well, we do have and have had for a number of years, some core supplier standards
13 relating to the services provided, and the quality standards give a little bit more detail on exactly what
14 suppliers should be doing when furnishing the items. I think if you go to our website that's in one of the
15 slides, the Competitive Bidding Program website, I think that's slide 13, you'll find a link the quality
16 standards there. Sorry I don't know them off the top of my head, but you can access them there at that site.

17 Dr. Powers: Just going back to the previous question about making things easier. The forms that
18 we have to fill out for DME right now are a bit confusing and burdensome. They're not as clear and it's
19 written very tiny and you don't have the rules. You get yes, no, yes, no, yes, no on a wheelchair. And there
20 are about six different things you have to answer, but they don't tell you what the rules are. I know that
21 there's a book. I've seen the book that the social workers in the hospital have about the rules required for
22 different kinds of DME, what qualifies for a hospital bed, what qualifies for a wheelchair, that sort of thing.
23 And I don't think it is as widely distributed and it's true that you can go to website, but a lot of people don't
24 want to go to a website. I think you need to send the books out to all physician practices. The rules out to
25 all physician practices.

26 And did I understand correctly that with this new program that you are no longer like on a
27 wheelchair or a hospital bed, once the cost of the device has been reached and the monthly payments, you
28 pay no more except for servicing?

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1 Mr. Kaiser: Yes, that was something that was mandate for durable medical equipment.

2 Dr. Powers: What took you so long? That DME has been abused for so many years, you could pay
3 for a hospital bed monthly for years four and five times its cost. That's, I congratulate you for finally
4 figuring that out.

5 Mr. Kaiser: I think the question is more what took Congress so long? [laughter]

6 Dr. Powers: That's another one of those government how much you pay for the hammer things.
7 But it would be, you do need to simplify things. I didn't NOR rehab for a long time and worked on a rehab
8 unit and prescribed a lot of DME and it is very confusing and I know that a lot of those power chairs are the
9 forms are being signed by people who don't know the rules, because they don't have the time to sit there
10 and go to the website and get it, the rules need to be right there with the form at the time so that they can
11 check off some of those things. It needs to be really clear. Sometimes even the rules on the power chair are
12 not quite as clear as they ought to be about the fact that it's not for use in the home, for getting around
13 inside the home.

14 Dr. Senagore: Well, even take it one step further. What control does CMS have over the process to
15 be able to mandate that the supplier provide a form with those things clearly articulated and answered for
16 us to either validate or not. I mean it's very unclear, rules about home wound care issues, numbers of visits
17 for home care, wound care, you really have no power. Things like wound cultures that happen without your
18 approval. They've already been done, submitted. You have never have approved that up front. It would be
19 much cleaner rather than making the physicians once again take the burden to memorize all these rules is to
20 have the one who prospers, which is the supplier, stake their claim of what they think is appropriate and
21 indicated and let us validate it or not. So to get the form back clearly identifying for a wheelchair, X, Y, and
22 Z have been met or not and we agree, rather than us having to fill in X, Y, and Z out of our memory banks.
23 That seems to be an undue burden for the practicing physician.

24 Dr. Ouzounian: I just want to kind of go along those same lines. We get the DME forms for the
25 wheelchairs, the election forms, and it's funny, it always has a little sticky next to the box and it tells you
26 what answers to give so that they can get it approved. I think it would be helpful if they were required to
27 send out the criteria that you have on your website. So here is the requisition, here is the criteria, and then
28 it's right there for us, we can say what the patient—you meet this, you don't meet this. Because

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1 unfortunately now we're the bad guy and it puts us in a very bad situation. Patient shows up: I'm entitled to
2 my electric wheelchair. I heard it. They told me it's my right.

3 Dr. Senagore: I mean that is actually a legal issue, because it's been debated at a number of state
4 medical society levels is who actually assumes the legal responsibility under the False Claims Act for
5 validating whether or not those criteria have been met?

6 Dr. Ouzounian: You signed the form doctor.

7 Dr. Senagore: And again, what Tye just said is exactly true. No, they told me, I can have the bed at
8 home and the power wheelchair that goes 0-60 in 33.2 seconds [laughter] and you already have a patient
9 who's had maybe some adverse outcome or difficult problem, it puts us in a terrible position of how to
10 validate these things, so we take the risk, every component of that interaction for what gain? It's
11 administrative cost, it's legal risk, it's financial risk. I think those are not inconsequential things to put into
12 this policy.

13 Dr. Powers: On those commercials, they do say Medicare will pay for it, or we will if Medicare
14 doesn't approve it, we'll pay for it. So you can always say no and make them pay for it.

15 Dr. Senagore: Yes, but they only don't pay for it if you don't sign it.

16 Dr. Azocar: Just another side of this issue is that to fill in one of those forms, and to write you up
17 so you don't have any complication from this thing, and you want to help the patient, that requires time to
18 do this form. And I'm not sure how the physician is compensated, especially as to where to give our
19 reduction. I know you don't have the answer, but maybe, are we—having an evaluation for somebody that
20 requires wheelchair, or prosthesis or orthotics, it requires some work. And I hear sometimes that this is not
21 part of the medical service, so therefore you cannot bill for that. I don't know.

22 Dr. Senagore: Well, I think that is the problem. Is these forms just appear and there is no process
23 under CPT to submit a bill for those things. And in every other medical delivery process, we have a face to
24 face encounter that is captured through the CPT process, so what's missing in this is all of the burden of the
25 risk and expense has been put on the physician's back and there is no mechanism to be able to deal with
26 this in a timely way, so there's no code for, I guess you could use discharge day planning to go through
27 these forms, or another office visit. But that's another burden on the beneficiary to do this.

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1 Mr. Kaiser: If I could interrupt, and just touch on some of these things. I do appreciate these—
2 these are really good comments. As far as the power mobility device benefit itself, there has been an
3 education effort underway for a couple years to educate physicians on how to document medical necessity.
4 I'm not in charge of that area, so you know, comments on the effectiveness and things like that of that
5 process, would be directed to someone else. I would note that the MMA also did require conditions for
6 coverage for certain DME, and one of the specific things mandated was face to face evaluation of a patient
7 before a power wheelchair would be paid for by Medicare. So we currently do have a requirement for a
8 face to face evaluation by the physician before the wheelchair can be prescribed and paid for by Medicare.
9 And if I'm not mistaken, I don't know for sure, but I think there may be extra payment for that face to face
10 evaluation, if my memory serves me correctly. As far as the physicians who are currently acting as
11 suppliers for certain limited items. Again, we did have a proposal in the proposed rule and I do appreciate
12 the comments, and I would just note that we hear those issues, and I can't say exactly what kinds of
13 comments we got on the proposed rule, and what they were and what we're going to do with those
14 comments, but we have heard those issues loud and clear, and I appreciate that. But and again, the problem
15 with the wheelchairs and the suppliers advertising them on late night TV and beneficiaries feeling that this
16 is their right to have this mobility device whether they need it or not, I think that problem will be helped by
17 the Competitive Bidding Program, where we have a limited number of contract suppliers that will be
18 furnishing those items in the future, that we can deal with to try to make sure that they're furnishing only
19 those power wheelchairs that are needed. We'll be able to scrutinize those suppliers more so than we can all
20 of the suppliers of wheelchairs today. So I think it can only get better in the future in terms of that issue.

21 Dr. Senagore: I think what would be helpful, though, in the process and what you've heard a
22 couple times here is the patient shows up on your doorstep, already having been told by the social worker,
23 the company, etc., no no, they said that if you just sign the form, we're good to go. And it would be helpful
24 to have something like a Truth in Lending policy that the banks have to do for mortgages to have the same
25 sort of thing that the people that are advocating a service have to have a truth in identification of criteria
26 before they come to us. And now we're in a position of either validating medical necessity or not, rather
27 than trying to uneducate the patient on what they already think they deserve.

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1 Dr. Ouzounian: Joe, I'm sympathetic to the over expenditure for some of these things, but in
2 solving that problem, I'm very concerned that the little things, the braces, the crutches, the canes, are, you
3 just made a disaster out of them. They're a small expenditure. And they're things that are typically done in
4 a provider's office or on a local area and you have created a nightmare for that. I don't mean that to you
5 personally, but in solving the problem with the power mobility devices, it's a nightmare for the small
6 things. And there's got to be a different solution. Yes, we need to reign in the power mobility devices.
7 That's a big problem. But we need access for the patients.

8 Dr. Kaiser: Yes, competitive bidding is something that we're mandated to implement. But we also
9 have authority to phase in items, starting with the highest volume items, which is something we proposed to
10 do in our proposed rule, so you know, I can't say what the Final Rule's going to look like, but we at least
11 did propose to phase in the program starting with the high volume items first. So we'll get to learn a lot of
12 things about the program, starting with the high volume items. And the smaller items will be something that
13 could be phased in later and also the statute gives us the authority to exempt items for which there is not
14 likely to be significant savings. So one of the these small items that you mentioned could possibly be
15 exempt as well, at least the statute would allow that.

16 Dr. Ouzounian: Thank you.

17 Dr. Ross: I think if you look at some of those small items, I think we rank particularly in our
18 specialty area as number one or number two in dispensing those materials, particularly a diabetic who
19 comes with a severe wound or Sharko foot with an arthropody situation where bottom line is they've got a
20 bag of bones and they're not walking, and they need to have a boot, and they need to have some type of
21 appliance in order to walk out of the office, or for that matter, other types of durable medical equipment,
22 such as extra depth shoes, which CMS provides for those diabetic individuals. So some of those providers
23 may not want to get involved with this if it's going to be that kind of hassle and again, the people who
24 suffer the most are the people who need it the most. And so it's kind of like a knee-jerk reaction here, and
25 that knee-jerk reaction has been overdone. In this particularly situation, I think you'll see that.

26 Mr. Kaiser: Well, we certainly are, as always, are going to make sure that we're implementing
27 policies that are in the best interests of the beneficiary. Just in that one technical thing, the therapeutic shoes
28 are not part of the Competitive Bidding Program. They're not subject to the program.

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1 Dr. Ross: Good.

2 ??: I would like just to lay my personal experience on this issue, and again with orthopedic issue
3 that I had with a foot, that I went into the office, and it would have been very, very difficult for me to get to
4 some sort of facility to get a brace for my foot, but my orthopedist had that in his office, who give me right
5 there, gave me relief. And I was greatly relieved that he had that there for me. Just to think how many
6 people would suffer needlessly for a very small cost here difference, to me, I agree totally with Tye on this
7 issue. It just doesn't make sense.

8 Mr. Kaiser: OK, thanks.

9 Dr. Senagore: Any other comments or questions? Dr. Gustafson?

10 Dr. Gustafson: Sort of weigh in here just a little bit. I'd like to underline that the agency regards
11 access by patients to suitable medical services as a premiere goal. The situations that you've been
12 discussing about you know, low-cost braces and cases and all that sort of thing, we get it. We are not knee-
13 jerk people. Joel in particular is a very thoughtful individual and the staff that have been working with him
14 on this program have been very thoughtful in attempting to construct it. So I think when you see the Final
15 Rule, you will see and the subsequent documents that follow that you will see a fairly reasonable set of
16 policies in this areas addressing some of those concerns. High volume items have to go under this program.
17 We are also have concerns about access in those circumstances, and want to make sure that beneficiaries
18 can find the services they need without jumping through a lot of unsuitable hoops. That having been said,
19 we do have to change the way business is going on at the moment. The number of durable medical
20 equipment suppliers in any major city exceeds 1000. They're all over the place. And whether the existing
21 structure of durable medical equipment payment has led Congress to very severe questions about whether
22 we are paying suitably, and so they after demonstrating this in two cities, have asked us to proceed to
23 competitive bidding for this sort of category of supplies, if I can use the term generally. I just wanted to hit
24 on one point that Dr. Ouzounian if I'm pronouncing your name correctly, raised earlier. I don't think that I
25 have heard anyone in Washington or Baltimore contemplate competitive bidding for physician services as a
26 routine way of setting prices in the Medicare Program. That sort of is not on the table in any very serious
27 way, at least not in the same sort of way we're proceeding with competitive bidding here. We have two
28 Competitive Bidding Programs we have been charged with operating at present. One on durable medical

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1 equipment, and its associated supplies and so forth, and one on the Part B Incident-To drugs that I think
2 you've been briefed on a couple of times. We are also under a Congressional mandate, or legal mandate, to
3 proceed with a demonstration of doing competitive bidding for laboratory services. All of these areas are
4 input supplies to providers. And sometimes they do them themselves, in the case of physician office,
5 laboratories, also, obviously, but it is a very different environment for attempting to figure out how to price
6 something than is the case with physician services. In the physician service world, the country has
7 demonstrated its willingness to proceed on the basis of a micro-costing kind of model, where senior leaders
8 of the profession get together and say, yeah, this requires 10 minutes of nursing time, and three sets of
9 gloves and get all the inputs down and work through the work values and all that sort of thing. It's been an
10 extremely interesting example of cooperative behavior on the part of the profession. We cannot assume that
11 kind of attitude on the part of the supplier industries. There is no panel like the PEAK for durable medical
12 equipment or for laboratory services, and I frankly think it would be very difficult to imagine such a thing
13 being constructed where you would get free sharing of information about inputs and all that sort of thing.
14 They guard their cost structures much more closely which is what has led the program in the direction of
15 competitive bidding as a way of trying to reflect market prices better for these kinds of circumstances.
16 Obviously, when you do that, you have to balance. You know, we're not just out to save money. Want to
17 make sure we secure access, want to try to do this in a smart way rather than a dumb way, but I just wanted
18 to sort of put some perspective around that kind of concern.

19 Dr. Sprang: Just what you just brought up Tom, on the Competitive Bidding Program and just
20 something, another hat I wear, as I'm chairman of a small health insurance company, we don't have
21 contracts with the hospitals or anything else, so they actually send us a bill. That's actually what I pay. And
22 if you see the cost of I'll say, a lot of the little even implantable things, stints, cardiac stints, and they cost
23 \$2800 and the hospital charges my insurance company \$9,600. A lot of disposable things we use in the
24 operating room. We punch a hole in the lady's abdomen and we throw away that \$500 device and it's
25 obviously never used again. Some of the things we use for [unintelligible], we put it in, do one oblation,
26 and throw a \$900 little device. So I think the reality is we're talking about trying to save healthcare costs
27 but still provide good care for patients. I think some of those individual medical suppliers are almost kind
28 of opportunists and actually I will say gauging for the prices. So if some of that stuff could be looked at,

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1 and you could have competitive bidding on some of that, you could save huge sums of money, and it would
2 be in everybody's best interest. Because I think sometimes the profit margin is clearly outrageous. So I'm
3 just kind of saying looking at this idea of competitive bidding for some of these other items could save
4 huge sums of money and may put more dollars into providing good health care and not into maybe the
5 pockets of some of these companies. I'll give one other example and I will back off. [laughter] On
6 endometrial oblations which we do a lot of and there's a lot of different devices we can use. We use
7 balloons, we use a Novasure, which is a little electronic device that then oblates the endometrium. \$900.
8 One of the devices, one of the companies we actually cryo-surgery, the endometrium, for the endometrial
9 ablation, that machine was the least expensive because we reused the same one. And the manufacturer
10 actually one of the manufacturer reps actually told me they were going to do away with the permanent ones
11 and make them disposable just simply so they could charge more for each one. I mean that's just, it's
12 egregious, but that's a fact of life, if we pay \$900 for these little things, somebody's going to make them,
13 and somebody's going to make a huge profit. So competitive bidding in this whole area can save huge sums
14 of money on medical, and these kinds of supplies that we use. This is the Practicing Physicians Advisory
15 Council, and that's practicing physicians seeing what's going on and being outraged by the excessive
16 profits that are out there.

17 Dr. Przyblski: It's kind of curious the Congress thought about this in the DME field, but with
18 Medicare Part D we didn't think about it in the pharmaceutical field. [chat]

19 Dr. Senagore: That'll take another piece of legislation. [laughter] I'd like to take a stab at a
20 recommendation. PPAC recommends that CMS determine the optimal means for physician documentation,
21 and compliance for DME POS claims submission to decrease the administrative burden for the practicing
22 physician.

23 [Seconds]

24 Dr. Senagore: Did you get that Dana? Any questions? Comments?

25 ??: Anthony, one of the issues that you're talking about the issue of responsibility and liability.
26 The concern was that I think I heard you express and some of the other express is the fact that the burden is
27 being placed on the physician entirely for the liability, this decision about supplying the wheelchair for
28 example. And one of the issues that I see is that part of the responsibility is to take that back to the supplier

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1 and to the patient; that there's an attestation of condition here that puts them at a liability. I don't know if
2 that applies to this but—

3 Dr. Senagore: I'm certainly not an attorney but I think we would, well actually what I'm
4 envisioning is the concept of a claims form to me. And I can sit down then and let the patient say, well you
5 know, you really don't have this, do you? And you're asking me to sign a form that says you do. That's a
6 lie. And I don't think the patient knows. I certainly don't know in a number of these things all of the
7 criteria. Even something simple as stoma wafers and bags. There are certain numbers that are allowed
8 under certain conditions at certain times of the patient's course. I don't remember all those criteria, if it's
9 10 a month or 30 a month, or and it would be much more helpful to have a claim form submitted to me that
10 has those specific items checked off, that the patient has wound issues, and that's why the stoma bag is
11 allowed 20 times a month instead of 10, so that would be the discussion I would like to have enjoined.

12 Dr. Ouzounian: I agree. With the wheelchairs, these are the criteria that you have to meet, and you
13 can sit down with the patient. You met this, you don't meet that. And I'm not the bad guy. Because the
14 patient realizes they don't meet that.

15 Dr. Senagore: And you are correct, Joel, there is a coding for that face to face discussion. The
16 problem at a functional level is the patient comes and says just sign the form and I'm ready to go. And it's a
17 very difficult discussion at that point to say well, you don't really need—you can have four gears instead of
18 five on your wheelchair. It'll be OK. Call the question if there's no more discussion? All in favor?

19 [Ays]

20 Dr. Senagore: OK. Is there a—

21 ???: I want to make another proposal. I'm going to stumble through this. But the PPAC would like
22 to suggest—

23 Dr. Senagore: PPAC recommends.

24 ???: PPAC would recommend that the lower cost DME items, such as orthotics, crutches, canes,
25 cast braces be exempt from the competitive bidding process.

26 [Second]

27 Mr. Kaiser: Is that completely? Or just in the case of physicians acting as suppliers?

28 Dr. Senagore: Physicians.

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1 ?: Physicians. With physicians acting as suppliers.

2 Dr. Senagore: Could you read that back, Dana, so we can...

3 Ms. Trevas: PPAC recommends that lower cost DME items, such as orthotics, crutches, canes and
4 cast braces, be exempt from the competitive bidding process when a physician acts as a supplier for those
5 items.

6 ?: Or podiatrist.

7 Dr. Senagore: Did you think about the optometrist in this? Do they supply any of that?

8 Dr. Williams: Dr. Gustafson, you indicated earlier that your understanding was that the physicians
9 were not being involved in this process at all, so are we limiting ourselves if we just say that we're not
10 involved in the smaller cost items? Should we have a broader statement saying we're not involved,
11 physicians will not be involved in the competitive process at all, like you said initially? Did I understand
12 you correctly?

13 Dr. Gustafson: No, what I was saying was that there is no move afoot to competitively bid for
14 services of physicians.

15 Dr. William: Oh, services. Got it, thank you.

16 Dr. Senagore: You going to comment on this, Leroy? Or should we, no? Anymore comments on
17 Tye's proposal? And it was seconded, so we'll call the question. All in favor?

18 [Ays]

19 Dr. Senagore: OK. Dr. Sprang?

20 Dr. Sprang: Just consistent with what I was talking about before and it might not fit exactly in
21 here, but it's because of competitive bidding and because of the prices I'm seeing in so many of the other
22 items, I was just going to make a recommendation that PPAC requests CMS consider competitive bidding
23 for other medical supplies, like disposable equipment used in the operating room, implantable devices that
24 orthopedic surgeons use, or cardiac stints and review that as another possible way of saving overall
25 healthcare dollars.

26 Dr. Senagore: Just an aside, since that's buried in the DRG, I'm not sure there's going to be a lot
27 of motivation to alter that.

28 Dr. Sprang: But the potential cost savings—

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1 Dr. Senagore: Anybody want to second that? Do we have a second? I don't see a second. Oh, I'm
2 sorry. I didn't see the hand. OK. Any comments? Call the question? All in favor? All against? I'm not sure
3 [laughter] Was this a secret ballot here?

4 Dr. Azocar: Could you read that again?

5 Dr. Senagore: Could you read that again, Dana? Sorry.

6 Ms. Trevas: PPAC requests that CMS consider implementing a competitive bidding process for
7 other medical supplies for example disposable equipment used in the OR or implantable devices, such as
8 cardiac stints, as another opportunity to save health care dollars.

9 Dr. Ouzounian: Mr. Chairman, it's my understanding that those items are covered under DRG, so
10 it really becomes, well it wasn't on the record, so it's maybe an academic issue. It's the institution that
11 typically deals with it.

12 Dr. Sprang: But say there'd be an overall savings in health care dollars, obviously Medicare and
13 overall, so I think it's certainly worthwhile and in the best interests of patients.

14 Dr. Przyblski: I hate to go backwards with our prior recommendation, although we are a practicing
15 physician group, we didn't talk about optometrists, physical therapists, occupational therapists—is that all
16 included in that recommendation?

17 Dr. Senagore: I think what we should do is change the terminology to some effect of health care
18 providers capable of subscribing, or prescribing, I guess would be the better word. With that friendly
19 amendment, Dana, if you could just change that terminology. Back to the question at hand. Any more
20 discussion?

21 ???: Should the wording be DRG sensitive versus—

22 Dr. Senagore: Well, obviously, this is outside of DME POS, but I don't know that we need to add
23 that in effect.

24 Dr. Gustafson: Perhaps I could just provide a couple points of clarification here. Without making
25 any statement about whether or not these items are over-priced, they ones you were pointing to are
26 generally included within Part A bundled payment systems, or Part B bundled payment systems, which is
27 to say either the Inpatient Prospective Payment System where they would fall under diagnosis-related
28 groups, or the Outpatient Prospective Payment System, where they fall in APCs. We typically do not break

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1 out separate payments for catheters or what have you. Some of these are indeed very high-priced items but
2 it is up to the hospitals to determine how to best provide the overall service using whatever bundle of inputs
3 they see fit. So there already is some pressure there to move toward cost-saving innovations. How effective
4 it has been is a different question. In order to embark on competitive bidding for items of the sorts that
5 would otherwise be covered by these payment systems, it would require a change in statute, I'm pretty sure.

6 Dr. Przyblski: Although are there not add-on DRG payments that may in fact be temporary. I
7 know in orthopedic and spine that such exist in which the dollar numbers that I see with them are quite
8 impressive.

9 Dr. Gustafson: There are some temporary codes of that sort. The pricing on those is a little
10 ambiguous. Typically, we're talking about newly arrived items where there may be only one or possible
11 two suppliers. They have patent protection. That enters this entire [inaudible] a much different environment
12 to talk about a pace maker with specific characteristics which may only be approved for single
13 manufacture, may have patent protections, as opposed to a hospital bed which is pretty much a commodity
14 item that anybody can supply.

15 Dr. Sprang: Yes, an example of what you said. I paid \$50,000 for a single implantable pacemaker.
16 Person comes in, he has an outpatient pacemaker put in and the bill is \$50,000. So we're talking about huge
17 sums of money here and I guess getting the idea on the table and even starting to look at it may serve some
18 useful purpose. Because I think it really just represents the huge increase in health care dollars that
19 continuing to expand. I think somebody should just kind of bring it up and just kind of look at it.

20 Dr. Senagore: So I'll call the question again. And ask for an elevation of hands at this point. All in
21 favor, say Ay, raise your hand? Now I have a clear concept that it passed, thank you. OK, we'll move onto,
22 thank you, Mr. Kaiser for your help. We're going to move on to a less contentious item. [laughter]
23 Physician Fee Schedule. [laughter] Our next two presenters are Amy Bassano, the Director of the Division
24 of Practitioner Services, at the Centers for Medicare and Medicaid Services, and she's here to discuss the
25 Physician Fee Schedule Final Rule. Ms. Bassano is the Division of Practitioner Services responsible for the
26 Medicare and Physician Fee Schedule and until this summer, Amy was the Director of the Division of
27 Ambulatory Services at CMS. In that role, she saw the Part B payments for clinical laboratories,

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1 ambulances, rural health clinics, and federally qualified health centers. And I believe that Ms. Hambrick
2 will be joining Ms. Bassano for the presentation.

3 Physician Fee Schedule

4 Ms. Bassano: Thank you. I am pleased to be here this morning to discuss this—

5 Dr. Senagore: Excuse me, I didn't want to short shrift Dr. Hambrick for—

6 Dr. Hambrick: That's quite all right.

7 Dr. Senagore: Actually, she's double doctor with both her JD and MD.

8 Dr. Hambrick: That's quite all right. I'm just here to provide a little color. [laughter] And also
9 joining us is [Kellum Melon] the Deputy Director of the DPA.

10 Ms. Bassano: So we should be able to provide—

11 Dr. Senagore: Across the board.

12 Ms. Bassano: Any detailed technical issues. So I'm going today to talk about the 2007 Physician
13 Fee Schedule. This was a slightly different year in that we published two proposed rules. The first was in
14 June. That was the five-year review of work, which is required by law, to look at the work RVUs and to
15 reassess certain codes, and also we had a new practice expense methodology we had proposed rule. The
16 second or traditional proposed rule came out in August and that discusses the updates, the Physician Fee
17 Schedule, implemented DRE policy and various other Part B payment issues. Those two proposed rules
18 were published as a Final Rule as one single Final Rule. It went on display on November 1st of this year
19 and was published this past Friday in the *Federal Register* on December 1st, so you can find that it's quite
20 thick with lots of tables and addenda, but it is in Friday's *Federal Register*. And between those two
21 proposed rules, we had received hundreds of comments and they are all addressed in the Final Rule. Some
22 of the major provisions of the Final Rule, well first you'd say there are generally, there are no major
23 changes in policy from the proposed rule, so many things were finalized as proposed. For the five-year
24 review of work, the most of those changes, the proposals all went into effect and the largest increases come
25 from the Evaluation and Management Codes 90213 has the largest increase. That's approximately 37%
26 increase. Other specialties that increased by large amounts were infectious disease, emergency medicine,
27 endocrinology, and then family medicine, internal medicine. Because of these large increases we are
28 required by law to make a budget neutrality adjustment. The increases sum total to about \$4 billion and the

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1 budget neutrality adjustment was applied to all the work RVUs. It was about a 10% cut to the RVUs,
2 although there was no actual change in the RVUs themselves. You'll notice in Addendum B, I believe it is,
3 of the rule, we published the non-adjusted RVUs. I know that's been of great concern to physicians, so that
4 they because of other payers and for transparency purposes, so that you can what the revised RVUs are, and
5 then there's an additional cut onto those RVUs. We take and we're calculating the Medicare payment rate,
6 but the unadjusted RVUs are available to review. Then the second major policy was the change in the
7 practice expense methodology. We wanted to—this has been sort of a source of discussion for many years.
8 We wanted to create a better system that was made more sense, that was more reliable, more accurate, and
9 sort of more intuitive to the average person. We've been talking about this for a number of years. We had a
10 major town hall meeting this past February to gather ideas and listen to concerns. This new methodology is
11 a bottom up methodology that uses a code by code review of direct cost inputs. There's also the indirect
12 costs which are contained by aggregate specialty society specific cost data. There were surveys done by
13 eight specialty societies, and we have the data included from there and then the actual allocation of
14 indirects is based upon the work; the clinical labor and then the directs. The other big part of the practice
15 expense change is the elimination of the nonphysician work pool. These changes are being phased in over a
16 four-year period, 25%, 50%, 75%, then 100% in year 4. So for 2007, it's only a 25% of this new
17 methodology, and again in the Rule if you look at particular codes, you can see what the affect is for the
18 25% in the 2007. But we also have the full transition implementation for 2010 available to review.

19 The Rule also announces the 2007 update that's a requirement by law that is now at minus 5% and
20 there's extensive discussion there about the SGR and the data that's going into it to come up with the 5%.
21 Their other major provisions are implementation of the DRA provisions. The biggest issue there was on the
22 application of the imaging services. There's two major issues there. The first is that we propose and finalize
23 all 25% reduction on the multiple images on contiguous body parts in the same session. Last year we talked
24 about doing a 50% over 25% over two years, but we decided in light of the DRA outpatient cap, we would
25 limit that to 25%. The second part, as I mentioned, is the DRA provision that requires that we pay no more
26 than the Outpatient Prospective Payment rate for the service, and so we have a long discussion in the Rule
27 about the codes are subject to the cap or potentially subject to the cap. We received lots of comments
28 asking for specific services, or procedures to be exempted from the cap. We could not make any of these

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1 changes because the law is prescriptive of what is in, what is to be in the cap. Mammography is excluded.
2 However, there were certain vascular services which we did take off the list of codes, subject to the cap.
3 One note here is that there's a long list of codes that are potentially subject to the cap. Those are not
4 actually necessarily going to be hit by the cap. They're just codes that would meet the definition, and then it
5 depends upon where the Physician Fee Schedule rate and the Outpatient rate hit and it's a much smaller
6 number, I think it's something like 400 of the 1100 codes that are on the list that are actually going to be hit
7 by the cap. The other ones are not subject to the cap and we pay at the regular Physician Fee Schedule rate.
8 We also are implementing the ultra-sound screening for abdominal aortic aneurysm of the DRA provision
9 and part of the Welcome to Medicare physical. We also waived the Part B deductible for colorectal cancer
10 screening that had been another change. Then there's another several areas of issues in the Rule that sort of
11 more of discussion items and not particular policy, but have to do with expiring of legislative provisions. In
12 regard to therapy caps, we had an exceptions process for 2006 to get excepted from the therapy caps. The
13 process is ending and as of January 1, 2007, the caps will be in place. For 2007, the Rule announces that the
14 cap is at \$1,780 and so we'll be, we are ready to implement those on January 1. Also the MMA had
15 mandated 1.0 GPCI floor on and that is expiring as well, so the GPICs will go into effect January 1. There
16 was a discussion Health Information Technology and transparency, and I understand you'll be hearing a lot
17 more about that this afternoon. There was no specific proposal, more discussions, but the speakers this
18 afternoon can talk more about that.

19 There were some other non directly physician-related policies in the Rule. Independent diagnostic
20 testing facilities, supplier standards, they were finalized with several small technical changes, but this in
21 general establishes 14 supplier standards, based on the DME POS standards that must be met prior to
22 enrollment and must be maintained in order to have billing privileges revoked, so they need to come into
23 compliance with this. The average sales price for Part B drugs. There is reporting requirements there that
24 were finalized and certain expectations of what manufacturers need to be doing when they report their
25 average sales price data to CMS. There is a discussion of several ESRD issues, including the composite
26 rate, clinical lab issues, there were some conforming changes, again having to do with the addition of new
27 tests to Medicare, and really putting into regulation policies or procedures that CMS has been following in
28 terms of having a public meeting and public comment to the setting of the lab fee schedule for the new

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1 tests. Also included was the ambulance fee schedule update for 2007. Usually this is a separate rule, but it
2 was included in here, and there was also some other policy changes, based upon NPRM, that had been put
3 out earlier in the year. And the other big issue was the [unintelligible] provisions. This had garnered lots of
4 attention in many comments and it was not finalized in this Rule. I believe there's an intent to finalize it in
5 the near future, but I know people looking for this would not have found the final policies in this Rule.

6 So that's the quick overview of the major policy provisions in the '07 Fee Schedule Rule, and
7 we're happy to discuss any of them in greater detail if you have any questions.

8 Dr. Powers: I have several comments. First of all, the first thing I saw was the press release from
9 CMS about how CMS was helping physicians take care of patients by increasing the RVUs for the
10 Evaluation and Management codes and I was excited when I saw that because I thought, oh great, they
11 accepted the conversion factor for budget neutrality instead of the work adjustor, and then found out later
12 that day, when everything else was published that just the opposite was true. You giveth and you taketh
13 away. So it was sort of an, it wasn't exactly an accurate description of exactly what was happening to
14 physicians who do those types of services. This year, we've basically been hit three ways. We were hit by
15 the decision to take the budget neutrality out of the work value or to affect budget neutrality with the work
16 adjustor rather than the conversion factor. We're hit with the SGR, and I understand that CMS doesn't feel
17 they can change that. And hit a third time with a GPCIs. I understand the reasoning behind using the work
18 adjustor rather than the conversion factor that CMS puts forward, but in the end the excuse that there are
19 services that have no work value that would be affected by the change, by using the conversion factor, that
20 wouldn't be affected by using the work adjustor—that tells us that you're favoring device industry and the
21 people who make these devices, rather than the doctors who take care of the patients. And it hurts to know
22 that the decision was made and that that is the—they may not have been the intent, but that is the result. As
23 physicians, we can no longer absorb these cuts. Some of the physicians stand to lose as much as 14%
24 because of the changes in the, because of the elimination of the GPCI floor and the addition of the SGR and
25 yes there are a few, there are what, four specialties, that do stand to gain this year, by prediction. But it did,
26 that one thing, even though it was done with a certain amount of logic, it after all the physicians in the
27 country were behind using the conversion factor, it did hurt. It showed that you had not con—that we felt
28 we were working with you and it didn't happen.

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1 Dr. Senagore: If we have the lights up as well, please? Any other comments? Dr. Sprang, then Dr.
2 Ross.

3 Dr. Sprang: Obviously, we've discussed this issue repeatedly, but I think it's important enough
4 that we have to kind of continue to repeat it. Obviously the cuts in the SGR exceeding obvious that the
5 2007 cuts will be the first in a series of cuts that Medicare trustees have projected, which will yield almost
6 40% over a 9-year period of time that the 2007 cuts also follow, five years of Congressional intervention to
7 prevent cuts and establish modest updates, but none of these have really kept up with the practice cost, and
8 the payment rates for 2006 actually remain at a 2001 rate, and if the cuts go forward, we'll be back to 1997,
9 etc. There's certainly surveys and data again, repeating our concerns about the health care crisis, so I would
10 say to maintain and to avoid the looming health care access crisis, and to be fair to physicians, that PPAC
11 recommends that the Secretary of HHS and the CMS leadership work with Congress to avert Medicare or
12 physician payment cuts for 2007 and beyond and implement a positive payment update that covers
13 increases in physicians practice costs. Further CMS should work with Congress to repeal the SGR and
14 replace it with a system that adequately keeps pace with annual increases in medical practice costs.

15 Dr. Senagore: Second. Any comments?

16 Dr. Ross: I would just like to comment on the proposal and give a case scenario. Beside polling
17 doctors in my own professional building, let me just give you a real case scenario here for the record. My
18 professional building hit me with a \$400 a month increase in the rent this year for the next five years.
19 That's about \$4,000 a year. That's direct cost. That's overhead costs that are fixed. Malpractice insurance,
20 even with tort reform, increased. Materials continue to increase. Personnel, labor costs, continue to
21 increase and the reimbursement continues to go down. The bottom line is in October, I had to go to a bank
22 and get a short-term loan to cover expenses, otherwise, I was going into the red to cover my expenses to
23 keep my office going. Now, why should I be doing this every time? Why should every physician around
24 the country be dealing with a problem as state in the last meeting of keeping the lights on? And then the
25 question is how many will now start to de-select and even if they don't de-select, they just will not treat,
26 and so access will diminish, because of the costs and what we said earlier in the meeting, of selectively
27 choosing how many beneficiaries to see in a given day, week, month, or year just so that they do not go
28 into the red that week or that month. This is a serious problem. I'm facing it, I'm sure many in the Panel are

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1 facing it, from a day to day basis. And everybody around the country will be, too. And the question is, what
2 is going to happen if this is not rescinded?

3 Dr. Senagore: Any other comments? Dr. Sprang?

4 Dr. Sprang: Just going to use the example I used before, because I think it's relevant but people
5 don't kind of consider that as far as just access, there will be some physicians obviously who will continue
6 to see Medicare, unfortunately, again, some of the busiest and best physicians at doing something have
7 more patients than anybody else. As well, they should. Because all physicians are not the same and that's
8 the reality of life. And if the physicians that are the best, can more easily not see the Medicare patients
9 because they have so many other patients, it basically is saying Medicare patients are getting second tier
10 care, and not having access to the best. I think that's an important issue to look at. And even though
11 numbers may still be there, are they actually getting access to the same quality of care?

12 Dr. Williams: These cuts are disastrous to all medical subspecialists, obviously, particularly in
13 anesthesiology and in academic anesthesiology of note. We have about a 13.7% decrease given all three
14 components that were adjusted recently, just in anesthesia alone. In addition to the teaching penalty that
15 academic anesthesia programs are under, this is really the beginning of the demise, I believe, of training
16 academic physicians in anesthesiology. I didn't comment earlier on our first feedback report where it was
17 noted that the difference between surge in supervising residents and anesthesiologists supervising residents
18 has to do with the fact that the first case that a surgeon supervises ends before that surgeon then supervises
19 another case. And that is absolutely not true. But needless to say, with a 13.7% decrease on top of the
20 private insurers now following suit with CMS's decisions and on top of the teaching penalty, it's just
21 disastrous for us.

22 Dr. Senagore: Any other comments or questions? We'll call the question. All in favor?

23 [Ays]

24 Dr. Senagore: And it passes. Thank you, Ms. Bassano, Dr. Hambrick. Ms. Mullen. Thank you.
25 We'll change gears now and talk about the OPPS ASC Final Rule. I believe we have Dr. Bazell, who's the
26 Acting Director of the Division of Outpatient Care. Dr. Hambrick is going to stay as part of this.

27 OPPS/ASC Final Rule

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1 Dr. Bazell: Good afternoon. Seeing as I'm the only thing that stands between you all and lunch,
2 I'll move quickly through this. [laughter]

3 Dr. Senagore: If we get too hungry, we'll let you know. [laughter]

4 Dr. Bazell: OK. Raise your hand. Growling stomachs. I'm happy to be here to talk to the Council
5 today, to tell you a little bit about the OPSS and the ASC payment systems, both our proposals for 2007
6 and 2008 and our Final Rule in the case of the OPSS and the ASC for 2007. That rule was published on
7 November 24, 2006 and we also as part of our proposal, in August of 2006, proposed a revised ASC
8 payment system for implementation in January of 2008. That comment period closed on November 6th, and
9 we're currently actively looking at those comments with the hope that we will finalize those changes, any
10 changes for the 2008 revised system in mid-2007 for implementation on January 1st. I just listed for you a
11 number of the areas I'm going to touch on which are highlights of the OPSS payment system changes for
12 2007. Those include quality measures, payment for clinic and emergency department visits and critical
13 care, payment for device-intensive APCs, payment in situations where devices are replaced without cost or
14 with credit, drugs, biologicals and radiopharmaceuticals, drug administration services, brachytherapy
15 sources, and then the ASC payment system. We were asked to provide several questions for the Council
16 and there are a couple areas that we would be interested in input. One of the areas that we've been
17 challenged by on the OPSS is payment for pharmacy overhead. Those are essentially the associated costs of
18 preparing pharmaceuticals for administration to patients. Under the OPSS, we have typically paid for those
19 parts of the service through payment for the drugs themselves, and a lot of hospitals have argued to us that
20 their costs are very specific and very high with respect to the pharmaceutical agents. The second question
21 has to do with what we call the "inpatient list." And the Outpatient Prospective Payment System. These are
22 services that we set no prospective rates under the OPSS for them because we believe that they are
23 inpatient services. And hospitals have occasionally encountered situations where they have asked that we
24 help physicians about this list because physicians may want to perform services in the outpatient setting
25 that the OPSS provides no payment for. The last area is the question of observation services and just a more
26 general question about whether there are specific clinical conditions where observation, outpatient
27 observation is particularly appropriate and whether that practice is evolving in current times. Currently,

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1 under the Outpatient Prospective Payment System, we pay separately for observation in the cases of chest
2 pain, asthma, and congestive heart failure, and otherwise, payment for observation is packaged.

3 Next slide has just several of the key websites. Well, I'm just going to plunge ahead. I assume
4 people have hard copy. In terms of when technology fails, we'll go back to paper. In terms of background
5 is a reminder that OPSS is based on relative payment weights. The payments are calculated for groups of
6 services; that's ambulatory payment classification groups. And these groups of services, APCs, contain
7 services that are similar in terms of their clinical characteristics and resources costs. We annual update the
8 APC groups and weights, using the most recent claims data, cost reports and wage indices. For 2007, the
9 inflation update was 3.4% and our estimated impact on hospitals is a positive 3%. We project that spending
10 will increase to 32.5 billion in 2007, and that's a 9.2%. In the OPSS, we took our first step toward value-
11 based purchasing the OPSS, finalizing a policy where in 2009, hospitals that fail that meet the quality
12 measure reporting standards, based on specific reporting of specific outpatient measures, would receive the
13 OPSS update minus 2.0%. We originally proposed this as tied to reporting on inpatient side, within the
14 implementation in 2007 but had many commenters who believed that it was most appropriate to base
15 quality reporting in the OPSS on outpatient specific measures reported on hospital outpatients. And so we,
16 the time it will take at least two years to get to that period of time, that's why we finalized the policy for
17 2009. The clinic and emergency department visits and critical care services, hospitals will continue to
18 report five levels of codes. And they will be paid for the first time at five levels. In the past, they've been
19 paid at three levels, and we thought, believe that our data supported payment at five levels. We're going to
20 continue to work with national organizations and others to develop national guidelines, which currently do
21 not exist for outpatient hospital reporting. We're also going to provide payment increment, differential
22 payment for critical care that occurs with or without trauma activation, the hospital setting. And we also
23 categorized emergency departments for the first time for 2007 as either type A emergency departments or
24 type B emergency departments. Type A emergency departments are your traditional emergency
25 department, open 24 hours a day, 7 days a week. Hospitals will continue to be paid at emergency
26 department rates for those. But we finalized a set of G-Codes to describe visits to type B emergency
27 departments. Essentially, those are EDs with an EMTALA obligation that are not open full time. Those
28 hospitals to date for those types of services have been paid clinic visit rates and we're going to be collecting

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1 their data while we continue to pay them at clinic visit rates, we're going to be collecting their cost data
2 through the reporting of the G-Codes, to determine down the line where the differential payment would be
3 warranted or could be warranted in such situations.

4 For device intensive APCs, we established our payment rates for these procedures this year by
5 using only those claims that specifically contained the charge for the necessary device and excluding those
6 claims that included devices that were being replaced under recall or warranty situations. In the cases of
7 devices replaced without cost or with credit in a recaller warranty situation, in the past, at least through the
8 end of 2006, we've made a full APC payment for that, which includes payment for the procedural and
9 device costs. For 2007, we'll reduce the APC payments in these case by the amount of the estimated device
10 cost, packaged into the procedural payment rate to provide an appropriate payment on those situations.

11 In terms of payment for drugs, biologicals, and radiopharmaceuticals we finalized a packaging
12 threshold of \$55, that is drugs that cost less than \$55 per day, since it will be packaged in the procedural
13 payments. We'll pay separately for those over \$55, and we're going to be paying for those essentially at
14 ASP plus 6%, similar to the payment in the physician office setting. For drug administration services,
15 we've reconfigured our APC payments and we've changed our coding for 2007, hospitals will use only
16 CPT-Codes for 2007, and receive payments for six different levels of services, which is a change from
17 2006. With respect to brachytherapy sources, per the MMA, brachytherapy sources have been paid at
18 hospital charges converted to costs from 2004 to 2006. And we finalized a policy for 2007 to make a
19 payment based on a prospective rate related to the claims-based median cost of the source of each source.
20 So that'll provide differential payment, depending on the radio isotope and the radioactive intensity of the
21 source, and the number of sources applied. But the payment will be prospectively established, based on
22 claims data similar to the majority of other OPPS items and services.

23 So that finishes up the OPPS highlights. With respect to the ASCs, we currently may payment in
24 ASC in nine payment groups that are clinically disparate, and we pay about 2.5 billion for about 4.5 million
25 procedures performed annually in ASCs. While there are many codes on the ASC list, close to 2500 of
26 them, 150 codes account for 90% of the procedures, with cataract surgery being the highest volume
27 procedure. The Secretary currently specifies the list of procedures that are safely performed in ASCs and
28 the list is updated every two years. The payment updates are based on the CPI, although the MMA

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1 mandates a zero update through 2009. Current payment rates are at the fiscal year 2002 level. For calendar
2 year 2007, we finalized this policy for the ASCs in the November 24th Rule that was published. 19 services
3 were added to the ASC list, leaving us with 2,571 payable codes as of January 1st of 2007. This Final Rule,
4 also, will implement a section of the DRA that indicates that for 2007, no procedure would be paid more in
5 an ASC than in hospital outpatient department. And this results in a reduction in payment for 275
6 procedures. We also implemented a revised process for approval and request to change payment for new
7 technology and trocular lenses. Moving onto the proposal, which is just a proposal at this point, given the
8 recent close of the comment period for changes to the 2000 May Day ASC payment system, again as I
9 noted, we expect the Final Rule to be published mid-2007 for January 1st, 2008 implementation. This will
10 be a budget neutral per the MMA requirement, and the GAO, the time the slide was prepared, the GAO was
11 to report to the Congress on whether OPSS APCs and relative weights would be relevant for ASC services.
12 That GAO report came out actually just a few days ago on the November 30th—and in fact the GAO did
13 conclude that the OPSS provided a reasonable structure for relationship for making payments to ASCs for
14 services. In the proposed rule, we said we would include all surgical procedures except those that pose a
15 significant safety risk in ASCs, or that require an overnight stay. And we propose to add a number of
16 procedures to the list for 2008, and 2/3s of those proposed additions are actually currently performed the
17 majority of time in the office. In the proposed rule, we indicated that the OPSS relative payment weights
18 would be multiplied by an ASC conversion factor, and in subsequent years we would scale the weights so
19 the changes in the OPSS for non surgical services didn't increase or decrease aggregate ASC payments. We
20 would use the IPPS wage index in the current ASC labor non-labor ratio. And the bottom line was we
21 proposed a conversion factor of about \$39, and the payment rates, which currently in the ASC groups,
22 range from about \$300 to \$1300 would vary under the revised system from about \$3 to \$16,000. We also
23 proposed a 2-year transition with 50% of the applicable 2007 payment rate paid in 2008 plus 50% of the
24 applicable rate under the new system with full implementation in 2009. We proposed to continue the
25 current ASC packaging, but to include packaged payment for surgical implantable devices, prosthetics and
26 durable medical equipment in the ASC facility fee. Currently, those items are paid separately currently
27 when they're provide din ASC settings.

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1 That summarizes the major provisions of the 2008 ASC proposal. And I'd be happy to take any
2 comments.

3 Dr. Grimm: What do you mean by in this situation, what do you mean by "budget neutral?" If the
4 more procedures go from the hospital to the ASC center, what does that mean by budget neutral? How do
5 you determine what the budget is?

6 Dr. Bazell: I think we discussed this at length in the proposed rule and this is one of the significant
7 areas of comment to the proposed rule. We're currently evaluating all those comments. Essentially, as we
8 went over in the rule, we looked at budget neutrality two ways, considering sort of under a no migration
9 scenario and considering migration as well. And that's part of what we sought comment on that we're
10 currently considering. So we've had a lot of commenters who have had differences of opinion from our
11 proposal about the services that would be moving, under the scenario, both from the hospital outpatient
12 setting, to the ASC, the reverse direction, and from the office to the ASC and the reverse situation. And
13 we're busy assessing those to develop our final policy.

14 Dr. Przyblski: In your presentation you mentioned that you would include all surgical procedures
15 in the ASC list for 2008 other than those requiring an overnight stay. How do you decide whether they
16 require an overnight stay or not?

17 Dr. Bazell: Just to clarify, we said we would only exclude those services that require an overnight
18 stay, or that are unsafe in this setting. We've had a lot of comment in this area as well. For purposes of the
19 proposal, we proposed to define an overnight stay as a stay at midnight, essentially saying that we would
20 not based on clinical review, we would not be placing services on the list that we thought in a typical case
21 would require a recovery beyond midnight of that day. We said that we believe there's basically an
22 expectation that when you have an ASC procedure, you would go to the ASC and return on the same day.
23 It's not a hard and fast criteria saying an ASC can't keep a patient past midnight, but just in general, the
24 plan for the recovery period and the time of the surgery would generally not be expected to have a patient
25 recover past midnight in the ASC.

26 Dr. Przyblski: If I could follow up, I guess my question is in a different direction. There, I'm
27 afraid that there may be assumptions that there are types of procedures that need to stay overnight, which

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1 are inaccurate, and you may have data that suggests that they are typically done over night when there's a
2 growing volume that's not staying over night. And how do you identify those procedures?

3 Dr. Bazell: I think in terms of the proposal in identifying for procedures, we conducted the clinical
4 review based on the input from the clinicians who work in the agency as well as an assessment of the
5 medical literature and the data that we have available to us. Recognizing that we're talking about really
6 Medicare patients, specifically here, we are not establishing this list for ASC treatment of all patients. We
7 received many comments in this area about specific procedures, about the process in general, about the
8 criteria in general, and we'll be going through those. And are going through them, to assess what is a
9 reasonable place for us to be for a final policy.

10 Dr. Senagore: I guess the follow up on that is it becomes a little bit of the chicken and the egg that
11 Medicare patients will tend to lag as paradigms shift, only because the billing process gets in the way of
12 implementing that transition earlier on, so if there were maybe an easier process than simply commenting
13 on the propose rules with the different specialty societies, that would be an advantage, to take advantage of
14 these improved care processes.

15 Dr. Simon: I would also mention that the process also includes using the best data base the RUC
16 database, and communicating with those specialty societies that provide those services to help determine
17 whether care provided in ASC outpatient or inpatient setting identify where it's most appropriate for the
18 care, for the Medicare beneficiary.

19 Dr. Senagore: I just had a couple of quick questions on your presentation. The information on the
20 G-Codes—which website was that at?

21 Dr. Bazell: The G-Codes for emergency department visit? That would be the OPPS site, that's for
22 payment in the Outpatient Prospective Payment System.

23 Dr. Senagore: And there is some confusion out there of whether it'll be reporting of the current
24 inpatient quality measures, like the CEP and SKP protocols that are going to be applied to the outpatient
25 site or is it simply outpatient specific quality measures?

26 Dr. Bazell: What we said in the rule was outpatient specific quality measures. We didn't say
27 whether those would resemble or could resemble measures that are currently in use by Medicare. Would
28 seem to me reasonable and that I would think we would be looking at those measures as well, because

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1 again many of those have been developed through a lot of input from the community already and are not
2 necessarily specific to a patient's inpatient versus outpatient.

3 Dr. Senagore: Correct.

4 Dr. Bufalino: Could you just clarify again when you talked earlier about the observation beds for
5 chest pain and congestive heart failure?

6 Dr. Bazell: Right. Currently, under the Outpatient Prospective Payment System, under several
7 circumstances, we make a separate payment for observation services, as opposed to packaging it into the
8 visit and other services provided at patient. And those are patients who have chest pain, observation and
9 congestive heart failure. The advisory panel on ambulatory payment classification groups that advises us
10 technically, has recommended that we look at some other diagnoses from which to make separate payment
11 for observation. Those include syncope and dehydration and so we'll be looking specifically at that
12 information in our claims data and bringing that back to the APC Panel for their consideration at the spring
13 meeting.

14 Dr. Bufalino: Thank you.

15 Dr. Sprang: The proposals seem to kind of define various set criteria for what's safe and what's
16 not, obviously interacting with physicians, and maybe the best way of actually coming to those
17 conclusions. So I'd like to recommend that PPAC recommends that CMS establish a process to consult
18 with national medical specialty societies and the Ambulatory Surgical Community, to develop and adopt a
19 systematic and adoptable means of fairly reimbursing ASCs for all safe and appropriate services, allowing
20 for changes in technology in current practices.

21 Dr. Senagore: Did you get all that, Dana? OK. Could you read back your cheat sheet then?

22 Ms. Trevas: PPAC recommends that CMS establish a process to consult with national medical
23 specialty societies and the ambulatory surgical community to develop and adopt a systematic and adaptable
24 means of fairly reimbursing ASCs for all safe and appropriate services, allowing for changes in technology
25 and current day practices.

26 Dr. Senagore: Is there a second? Second. Any comments or questions?

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1 Dr. Gustafson: I have a question about the intent here. We are already engaged in exactly such a
2 process. We have a Notice and Comment Rulemaking procedure going forward, exactly in this area. So the
3 question is what do you see as lacking in that?

4 Dr. Sprang: I guess it's just supporting what you're doing then.

5 Dr. Gustafson: Excuse me?

6 Dr. Sprang: I said I guess it's just supporting what you're doing then, and that could be the
7 response, that's fine.

8 Dr. Senagore: I guess in the spirit of that, I guess I'll call the vote now. All in favor? It all passes.
9 I think one of your questions there is do physicians currently understand the inpatient list? It's not always
10 intuitive to the practicing physician why a specific code may or may not be and what happens on the other
11 side of the equation is things that the practicing physician in terms of terminology that we're used to using,
12 particularly writing orders, looks transparent to us, that it's the same concept, but it does put an unfair
13 burden on the institution if we say admit, versus admit to observation, and if those could be more clearly
14 articulated on what standard order sheets or what not should look like, that would be a helpful educational
15 tool, I think.

16 Dr. Sprang: Just one other comment, because obviously on the cost and where services are
17 provided, whether it's in an outpatient setting or in the hospital, I think it should always kind of be based on
18 the best interest of the patient and convenience and kind of keeping the cost even for those maybe in
19 patient's best interest. So PPAC recommends that CMS apply any payment policies uniformly to both
20 ASCs in hospital outpatient departments.

21 Dr. Senagore: I guess we'll take a second, then we'll have comments. Second? OK. Dr. Simon.

22 Dr. Simon: And I guess I would assume that that's under the guise that with the work that has
23 been done on ASCs for the prospective payment system that will be implemented in '08, the GAO as well
24 as CMS has taken into account, looking at the cost of providing those services in each different site of
25 service, recognizing that there is statutory boundaries that have been created by all of our payment systems
26 where we are prohibited to some extent in being able to assign the same payment in each site of service, but
27 I think that under the proposal that was emanated ultimately through MMA, for us to develop a new ASC
28 prospective payment system, I think the effort has been put in place to try to equalize if you will, for lack of

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1 a better term, the payment rates in each site of service, recognizing that there're different overhead costs,
2 etc., in the outpatient setting as opposed to the ASC.

3 Dr. Sprang: Of course, within legal constraints.

4 Dr. Ouzounian: I'm not sure I understand what he's trying to do. There are other payment systems
5 many of which involve us, where the cost to us as providers and therefore the reimbursement to us varies
6 by the location of service. So are you saying they should be paid exactly the same in the hospital and the
7 outpatient setting?

8 Dr. Sprang: Reasonably treated, appropriately, in the [unintelligible] take into account the costs.

9 Dr. Ouzounian: Reasonably treated appropriately and identical are very different. The reader said
10 "identical."

11 Dr. Senagore: I thought it was similar but, did I miss?

12 Dr. Sprang: Uniformly, both, just actually applying policy uniformly, so it's not asking for
13 identical at all.

14 Dr. Ouzounian: So that they apply the same principles.

15 Dr. Sprang: Same principles.

16 Dr. Ouzounian: OK.

17 Dr. Senagore: Because the cost structure may be different, depending on the site.

18 Dr. Sprang: Both treated fairly.

19 Dr. Simon: That's what I'm trying to capture, that the because of the MMA, we have different
20 payment frameworks for each of those payment systems, and recognizing that the ultimate goal is to
21 provide the most appropriate reasonable reimbursement rate for that service that's provided in that
22 appropriate site of service, in this case, we're talking about ASCs. But also we have a different payment
23 methodology for the outpatient arena. But we've used, as has been recommended by MMA, the Outpatient
24 Prospective Payment System as a model to help us design a framework for the anticipated ASC prospective
25 payment system.

26 Dr. Senagore: Dana, could we reread it just so we're clear on the wordsmithing?

27 Ms. Trevas: Did you vote on the previous recommendation?

28 Dr. Senagore: No, that's why I wanted to review it.

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1 Ms. Trevas: PPAC recommends that CMS apply any payment policies uniformly to both ASC and
2 hospital outpatient departments.

3 Dr. Senagore: As appropriate, if you'll take that as a friendly amendment, Dr. Sprang? Any other
4 comments questions? All in favor? Dr. Bazell, you kept us on mission. Thank you very much.

5 Ms. Trevas: I'm sorry, Dr. Senagore?

6 Dr. Senagore: Yes?

7 Ms. Trevas: Did you vote on the recommendation to establish a process to consult with national
8 medical specialty societies?

9 Dr. Senagore: Yes, ma'am. We approved it.

10 Ms. Trevas: Thank you.

11 Dr. Senagore: And I think we will break for lunch at this point. And reconvene at 12:45. Thank
12 you.

13 Lunch

14 Dr. Senagore: I'd like to move to a discussion of the Medicare Contractor Provider Satisfaction
15 Survey, and to help us understand the '06 survey results and what will planned for the upcoming year is
16 Mr. David Clark, Director of the Division of Provider Relations and Evaluations, in the Center for
17 Medicare Management. Mr. Clark is joined by Ms. Narayanan, close?

18 Ms. Narayanan: Very close.

19 Dr. Senagore: And Ms. Giambo of Westat and they are the directors of the survey material. In
20 addition, they are both involved, I believe, in the quality improvement organizations for CMS. So before I
21 get on with their questions, if you want to begin with your presentation, and then we can come back to the
22 questions that you have for the committee.

23 Medicare Contractor Provider Satisfaction Survey

24 Mr. Clark: Good afternoon and first of all I'd like to just thank the Council for the opportunity to
25 share with you what we've been working on over the past several years in terms of the Medicare Contractor
26 Provider Satisfaction Survey. This is a actually a very exciting project that we have here in the agency. It
27 first came up in the Medicare Modernization Act in 2003 and we have been working diligently in putting

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1 together what we think is a valid and reliable survey that we can measure provider satisfaction in the
2 Medicare Program.

3 What we would like to do today in terms of this presentation is to share with you a brief overview
4 of MCPSS to share with you the results of the 2006 survey, which was the first national implementation of
5 MCPSS, and then to talk about what we're looking forward to in 2007 in terms of the administration of the
6 survey for the second time around, and then that presentation for 2007 will be talking about some of the
7 changes that are occurring from what we've learned with 2006, as well as the expectation for survey
8 results.

9 In terms of the purpose, MCPSS is designed to garner a quantifiable objective data on provider
10 satisfaction with the performance of Medicare Fee for Service contractors. These are the contractors that
11 process the claims for the Fee for Service program as you know. Specifically, the survey enables CMS to
12 gauge provider satisfaction with the key services provided by the contractors and the processes that they
13 offer in terms of the \$280 billion that are expended in the Medicare Program. The questions from the
14 survey focus on the seven business functions of the provider contractor relationship. In conducting the
15 survey, we had three primary goals. The first goal was to satisfy the Medicare Modernization Act of 2003,
16 to measure provider satisfaction levels and particularly as we move into a Medicare administration
17 contractor, or MAC environment. Provide feedback from providers to contractors, so that they can do
18 process improvements was the second goal of the survey that, and that was the primary intent in terms of
19 providing better services for providers. And then the third goal of this survey is to establish a uniform
20 measure of provider satisfaction with contractor performance that would be used by CMS in the oversight
21 of the contractor's services.

22 Just to talk about 2006: in 2006, we administered the survey. It was available by web. Non
23 responses to the survey were followed up by telephone. We administered some 28,000 surveys to providers
24 across the country. The date of administration period for the survey began around January 3rd, and
25 concluded May 5th, 2006. For the 2007 administration, we're looking at similar activities in terms of the
26 web administration of the survey. But one of the key tasks that we have to view is validate the contact
27 information for providers and in that regard, we're doing again, 100% validation of the sample frame prior
28 to the survey, so that when we're making those initial contacts to identify the appropriate individuals within

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1 organizations to send the mail survey to, we're, if a provider wants to provide the information for the
2 survey at that time, we're collecting it on the phone. Otherwise, there will be continued with the non
3 response follow-up by phone, the screening that I just mentioned actually began November 28th, and that
4 will continue through the time that we do the actual paper and web-based administration of the survey,
5 beginning January 2nd in 2007. At this time, I'd like to turn the presentation over to Vasudha, who will be
6 talking to you in more detail about the 2006 results.

7 Ms. Narayanan: Good afternoon everyone. Thank you for being here and giving us the opportunity
8 to talk to you. The 2006 results as David said, we can't, the total sample for 2006, was 28,835 and this
9 includes all providers, provider service by carriers, FI, RHII, and DMERCs and [unintelligible] to carriers
10 and the physician sample as well. So the overall response rate was about 65% and as you'll see here, the
11 number of refusals in general, the explicit refusals in general tend to be small. We had just about 2%
12 explicit refusals, but our hunch is that the other big number you see, the other non response of 5,000, that's
13 about 17%, that includes some subtle refusal, especially when people say, Call me later, I'll do it later, call
14 me back next week. Send me a copy of the questionnaire by mail, or Can you fax me a copy of the
15 questionnaire? They're some subtle, not refusal, they're, it's just that they don't come out and say, No, I'm
16 not going to do this. So in 2007, you're going to look at ways in which we can reduce the subtle refusal.
17 Not make them explicit refusal, but convert the subtle refusals into completes. There was of course
18 variation in the response rate by contractor type. While you see the overall response rate at about 65%, the
19 response rate for the carriers was 61% and on the other extreme, the response rate for the RHHIs, for the
20 home health agencies, was close to 77%. So you have with all the way from 61 to 77, but even though the
21 carrier response rate was lower than the average, it wasn't very much lower. It was you know, just about 3,
22 little over 3 percentage points less than the average response rate. And of course if you come down to the
23 physician sample, the carrier response rate as I'd said was 61% and the physician response rate was pretty
24 good. It was at about 62%. A little over the average carrier response rate. Overall, just to give you a sense
25 of how much of the full sample came from the physicians, the physician sample contributed about 25% of
26 the total sample. That's a pretty sizable chunk for just one group of providers. And hence, their importance
27 in the overall survey, and the carrier sample is about 40% of the overall sample. So even amongst the
28 carriers, the physician sample is pretty large. And one-fourth of the overall sample is the physician group.

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1 Moving on from response rates to the actual scores and the results. I'm going to hand over the mike to my
2 colleague, Pamela Giambo to walk you through the 2006 scores and the 2007 [unintelligible]
3 administration plan.

4 Ms. Giambo: Good afternoon everybody. In terms of the scores, we've provided you with a
5 handout. That handout is a copy of the public report. That is available to anyone by logging onto the
6 MCPSS study site and at the end of this presentation, we have that website available, so if anyone who has
7 not received a copy of the public report would like a copy, you can just go to that website and download it.
8 In 2006, there were 75 survey items. And those items had a 6-point scale. The ends of the scale were
9 labeled Not at all satisfied to Completely satisfied. To get the overall score for that contractor, all of the
10 items were averaged for that survey, and that came to an overall survey score for that contractor. As I said,
11 one thing that CMS wanted to do this year was to better serve its stakeholders by presenting these scores to
12 the public. The public report that you have in your hands has benchmark scores for the four contractor
13 types, for the major provider groups, including physicians, and then it also provides overall survey scores
14 separately for each of the Fee for Service Medicare Contractors so that providers can actually see what their
15 contractor was rated, compared to other contractors.

16 The average composite satisfaction was pretty high and when you look across the four contractor
17 groups, the DMERCs which serve the DME suppliers, the carriers, which serve the Part B providers, the
18 fiscal intermediaries that serve the Part A providers, and then the RHHIs which serve the home health
19 agencies. There really isn't that much difference in the scores, in terms of how the providers are reporting
20 satisfaction. It's ranging up there from 4.7 to 5 out of 6. At least 85% of the responses we received were in
21 the 4-6 range for all the contractor types, and the average for specifically the Part B providers, was 4.52.
22 And again, that's on a 6-point scale. In terms of the carriers that did better than others, the highest was
23 Palmetto, and you'll see in the public report. It had an average rating of 4.72 and then those that had the
24 lower scores were GHI and Nuridian, where it was transitioning from BCBS regions of Utah.

25 Here we have the various provider groups, broken out, and again, you can see that in general, the
26 satisfaction that they're reporting is quite similar. Just so you know, the category up there of Other includes
27 mammography screening centers, IDTFs, and other groups. Physicians reported slightly higher satisfaction
28 rating than LPs and Labs. The physician composite score was 4.61, versus the LPs which had a composite

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1 score of 4.53. In addition to those 75 items that ask about satisfaction with very specific topics, an
2 additional question was added to asked them about just their overalls satisfaction. You know, just in
3 general, how satisfied are you with this contractor? And again, that item tracked quite closely to the
4 average for all 75 items. In the case of the physicians, the score on this one single satisfaction question was
5 a 4.72 and again, that was similar to the other provider groups.

6 Here we see the various main types of respondents versus the physicians. For the carriers, their
7 Part B providers reported most satisfaction with enrollment and with claims processing. And it's somewhat
8 similar with the physicians, with broken out from the other Part B providers, except for the medical review,
9 which again, for the respondents who reported for physician offices, it was a 4.69 out of 6, so that was a
10 little higher than the average Part B provider. And as we can see, the home health agencies which have the
11 highest response rate also tended to have report higher satisfaction. They had higher satisfaction across the
12 board than the other provider groups.

13 One thing that the team did was we wanted to see whether there were certain business functions
14 that were driving satisfaction, which is one reason why that single was added. That single item that just
15 said, hey, overall, how satisfied are you with the contractor? We used that item then to do some modeling,
16 to see what are these items that are actually driving satisfaction? What we found which probably is not
17 surprising that the two main drivers of overall satisfaction are claims and provider inquiries. The only time
18 where the relationship between those two switched slightly was when we included medical review in the
19 model. When we included medical review in the middle, the claims dropped a little in terms of its
20 prediction power of how satisfied a provider would be. And in that case, inquiries went up slightly. So
21 that's a quick summary of the 2006 scores and again the public report provides some more information on
22 that and also provides more detail on the key drivers analysis.

23 In terms of 2007, obviously, it will add another piece into the trending analysis. I can trend it with
24 an N of one, certainly. One thing that we've done in 2007 is we're trying to make some improvements to
25 the survey based on our 2006 experiences. One is trying to shorten the cycle time between the time that we
26 administer the survey and the time we report it out to the field. And we're starting data collection of the
27 web survey in January. And last year, I believe the public report went out in the very end of summer, and
28 this year the goal is to shorten that cycle time so that the providers have the information much sooner after

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1 completing the survey. Another goal is to expand outreach efforts so that we can increase awareness of the
2 survey tool, and hopefully then increase the response rates. In terms of that outreach one thing that we've
3 started is again providing this public report, which hopefully will increase both the saliency to the provider
4 community and then just also showing that CMS is committed to providing information outside of CMS. In
5 2007, some things that are changing, the sample size. Since we now have observed response rates from
6 2006, we can use that information to help build our sampling scheme for 2007. So that we can make sure
7 that we get a number of completes for each contractor that allows us some precision in our estimates. So for
8 every provider type and contractor, this year, we used the actual response rates we observed in 2006 to help
9 us determine the number of providers that should be selected in 2007. One that that we know will be
10 different this year is we will have providers who were sampled last year again in 2007 and this going to
11 happen most often for the smaller contractors. This is mainly an issue for Part A, and some of those
12 contractors have very small provider population, and so we have to take a census of everyone. In that case,
13 we'll be surveying them again, and we have responses for our interviewers to explain why this has
14 happened, and hopefully, it will not hamper response rate. Another difference in the sample in 2007 is
15 focus on certain provider types. Certainly physicians will be included again under the part B but this year
16 we will be breaking out the physicians under the DME supplier portion of the survey. Last year, they were
17 sampled, but we didn't necessarily make them a distinct sampling strata. This year they are, and we will be
18 able to report out on physicians and their experience with the DME supplier processing. Another difference
19 in 2007 is a focus on state level estimates, with a transition from to the MAC world. It's really important
20 for CMS to have state level data, and so the sampling design this year focused on jurisdiction level as well
21 as state level so we can get precise estimates for those transitioning states. And then finally, one thing that
22 we heard from contractors in CMS was a concern about providers that only had a few claims, and yet we
23 were asking them for their an assessment of their satisfaction. And so an analysis was done, and it was
24 determined that there were no statistical differences between those who had few claims and those who had
25 many, and so the decision was that we would still have a survey that was all active providers, and that we
26 wouldn't exclude someone just because they had only submitted a few claims. In 2007, we'll do a
27 reanalysis and just see where we are, to see whether anything has changed in terms of that. 2007 data
28 collection, as David had mentioned, the web survey will start at the very beginning of January, 2007. But

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1 pre-screening activities have begun to identify who the knowledgeable respondent is, because as you know,
2 generally, it's not a physician. We're sampling physician IDs or various ID numbers, they're not
3 necessarily the one who is processing the claims; they're not necessarily the one who is going to be the
4 most knowledgeable respondent. So we have a lot of screening activities to identify who that most
5 knowledgeable respondent is.

6 Other things in 2007, again as I mentioned, we're going to try to shorten that cycle times. We have
7 better procedures this year for trying to locate the respondent early on in the process. That's what we
8 started last week. And the other thing we'll be doing is more testing of interim data, so that by the time the
9 data collection closes, we can shrink the amount of time it takes us to get data up on the website.

10 Response rates in 2006 as you saw earlier varied across different provider groups. Physicians were
11 very different than home health agencies in terms of response rate, for example. And CMS and Westat have
12 considered this differential response rate and its design of the 2007 data collection. So first what we did is
13 we identified, for example, some carriers that had low response rates in 2006. These providers from these
14 carriers were given priority in the data collection, so that the telephone center, the research center will put
15 more of its energies there to make sure that we can increase those response rates and reduce that gap. Other
16 things are outreach efforts. CMS is going to be looking regionally to see if there are certain groups in
17 various regions that can help in getting the word out about the MCPSS, and whether there are certain
18 groups who's endorsement might help us increase response rates, especially with physicians. And then
19 finally, reprioritizing. That just means that at some point during data collection, probably half way, we'll
20 look to see whether certain contractors, who are lagging in response rate, if there are, we will focus some
21 resources there to again try to reduce those response rate differentials.

22 So that's it about the 2007 study design. In terms of the survey instrument design, there was a lot
23 of evaluation done in 2006 of the 2006 instrument. There were a lot of CMS subject matter experts who
24 weighed in and then cognitive testing was done with various provider groups. And the result from that
25 work is the 2007 survey instrument, which is available on CMS's MCPSS website and we have some
26 copies here if anyone would like to take a copy home. The differences in 2007: the instrument is a little
27 shorter. The reference period is now a year, since this is an annual survey, it makes sense to give folks a
28 chance to respond about their experience for the past year. Some questions were added. For example, a

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1 question on the NPI and how respondents view CMS's education and training on that, and then other
2 questions that will help CMS analyze the data. So for example, questions that were removed tended to be
3 those that the contractors really didn't have direct control over, for example how quickly you receive a
4 response to the question you asked. Since that's part of the contract between CMS and the contractors, it
5 was viewed that that wasn't something that the contractor should be evaluated on, since that's a CMS
6 direction. The same with the clarity of your contractor's instruction about Medicare billing regulations or
7 codes. Again, that was viewed as something that was prescribed by CMS and so the contractors wouldn't
8 be evaluated on it. In terms of other questions that were added, we're asking what topics they would like to
9 see more in training and education material on. To see if there's any more documentation that would be
10 helpful to providers and then some questions were reworded, just to make them a little clearer. So all that
11 evaluation work that was done in 2006.

12 2007, we'll also be doing an evaluation that's going to focus on the scales; whether these are the
13 right scales to be using, whether there are alternate scales we should be using. That will be a major focus
14 this year. In terms of the key milestones, a media kit was provided to the contractors, that includes a fact
15 sheet and documents such as that. Contractors soon will be having a hyperlink on their websites, to the
16 MCPSS website. Again data collection in terms of the web survey will begin January 2nd, the website will
17 be available, and screened respondents who have access to the Internet, will be sent an informational packet
18 that gives them their password so that they can access the survey. Data collection reports and study updates
19 will be available mid-January to the contractors and to CMS and then starting in February, we're going to
20 be asking the contractors to put messages on their IVR systems to help us with non responding providers.
21 And then data collection, right now we have closing April 28th, but hopefully sooner. Basically, we're
22 going to continue collecting data until we have a response rate that's similar to 2006 and the sooner we can
23 close the survey, the sooner we can get data out. And then again, that's why we have or sooner here, early
24 July 2007 for the on-line reporting, but hopefully that will be sooner. And that's a summary of the
25 milestones.

26 Mr. Clark: Basically the questions that we had relate to what recommendations that the Council
27 make on ways that we can further increase this survey compliance among physician practices. I think if you
28 look at the numbers with the sample frame of about 36, 38,000 providers and roughly 8 to 9,000 of those

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1 being physicians, it's a very relatively small group that we have to reach, but it's very important to us that
2 we reach them and that they respond to the survey. So we would appreciate your advice in terms of how we
3 might be able to do that. Also, how can we reduce the refusals? And then the last question was are there
4 select physician and stakeholder groups that we might try and reach whose endorsement of MCPSS may
5 help with the participation in the survey this year?

6 Dr. Senagore: Can we have the lights up? I'll go with Tye and then Peter.

7 Dr. Ouzounian: Thank you for that presentation. It was very interesting. I have a couple questions
8 though. I actually think your response rate is quite good. It's better than I think we get for surveys that we
9 send out. But some questions that I would have is what do you do with this? You collect this data and are
10 the carriers penalized? Are the physicians incentivized or what? And let me just bring out an example:
11 When we bill incorrectly, we're subject to potential audits, RAC audits, we have to pay money back, there
12 are certain situations where we under bill and we get paid more money, and if we look at the carriers'
13 report cards, one might be able to reach a conclusion. And if you take the average satisfaction, I'm looking
14 at page 9, is 4.71, if I'm reading this correctly, and from a provider standpoint, if a carrier pays all my bills,
15 I like them, and if they reject my bills, I don't like them. [laughter] And I don't know what questions are on
16 there, but you know that's going to be substantial. So a carrier that's got a higher satisfaction rating is going
17 to have more than an average score. And a carrier that has a lower than satisfactory rating is going to have a
18 lower score, and a lot of that might be based upon the ease of getting my bills paid, and I'm looking, very
19 interestingly on the last carrier on page 9, which has almost the lowest score there, and there was a
20 discussion earlier today about a local carrier coverage decision from that carrier, which was felt to be
21 inappropriate by the providers in this room, as well as several representatives from your group. And those
22 kind of coverage decisions may well reflect what that low score—and how do you then take that home and
23 counsel that carrier or correct the problem that is happening with that carrier? I'm not hearing what you're
24 doing other than collecting the data and saying, Hey we're doing a great job.

25 Mr. Clark: Let me try to address your question. The first point you made in terms of the 65%
26 response rate that that's pretty good. And we do know for most satisfaction surveys, yes, that would be
27 fairly high. However, the Office of Management and Budget is challenging us, or requires that we get to
28 80%. And that's our goal. We're striving to get to an 80% response rate for the survey. So while 65 is good,

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1 it's not quite there yet, and we will continue to push on with that. What do we do with the data? Two things
2 that we're trying to do with the data, first of all, one, it's primarily for the contractors to look at the results.
3 Item level data for each contractor is provided for all of the 75 questions and those 7 they'll get item level
4 data for their contract as well, and the intent there is that the contractor's using those data to look at their
5 systems to delve inside of some of the different processes and then use it where they scored, perhaps where
6 they were below averages, or benchmarks to use that information to do process improvements, or at least
7 target their efforts for process improvements. Right now, the survey results are not used for say monitoring
8 and oversight of the contract that the intent was that it was used more for process improvement. Secondly,
9 they were looking to the contractors, as you mentioned, incentivizing performance in that as we move into
10 a MAC environment, there are contemplated award fees for contractors and supporting contracting
11 decisions, based on performance so that we would use the results of the MCPSS as one of the elements in
12 which contractors are evaluated for that award fee. And then the last point that you raised in terms of the
13 carrier and the local carrier decision that was made. That's not, again, that's not the intent of MCPSS to
14 equate that. Surely CMS will look at the information, as it's making contracting and oversight decisions,
15 but it's not directly tied. We've gone through a pilot of the survey. We've completed one national
16 implementation. We're beginning the second national implementation and we hope to look at as Pam was
17 saying, looking at trending of the data to see if there are patterns and then that information would be used
18 with other processes that are used in terms of contracting oversight.

19 Dr. Grimm: Well, first of all. Congratulations. This is a lot of work. I know this is really tough to
20 get this survey kind of work together. And I'm interested in terms of how we use this as well and just one
21 comment about that. Since my contractor was one of the lowest persons on this list, he's going to get a nice
22 phone call from me this week to ask him why. And I think that's probably all of our obligation to do and
23 it's why. If I look at this overall, and I would take this to my kids, and say, well, you grade what you give
24 these people? Almost all of them would get a grade C. Some of them would get a B. And nobody would get
25 an A. That's how I read it, so I would say while you judge this as very high, I would say this isn't very high
26 to me. This is not what we should be communicating to our contractors that they're doing good work. I
27 think this is only average work and that they need to do much, much better than this. If I was in the
28 business and 20% of my business people weren't satisfied, I'd be out of business. Hello? [laughter] That's

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1 what we're telling you here and that's really what this survey's saying is that they should be out of business
2 if there was really competition out there. So I would say that our message from this survey should be that
3 you are doing only average work. You're not doing superb work. You should have complete satisfaction
4 for every client for your providers. That's how I see it. I don't know how you guys see it.

5 Mr. Clark: Dr. Grimm, when you see complete satisfaction, that their score would be a 6 on the 6-
6 point score?

7 Dr. Grimm: That should be, they should shoot for. They should be somewhere between a 5 and 6,
8 they should be well over 90% satisfied. What they're saying to me is that they're only satisfied 70% of the
9 time. Completely satisfied. Well, you know what happens in our practices when our patients aren't
10 satisfied, those other 30%?

11 Mr. Clark: They go somewhere else.

12 Dr. Grimm: It comes back to us. We're unhappy. That's what we here about. They're not paying
13 for us, or our businesses suffer individually, because then we have to go back and forth to recapture this
14 time and effort and everything to get reimbursed properly. That's what it's saying, that's what it's saying to
15 me. I don't know how you guys read this, but—

16 Dr. Senagore: Oh, I guess I would follow up with the question, if you're in Texas, do you get to go
17 choose that you would rather do business with BCBS of Arizona?

18 Dr. Grimm: Right.

19 Dr. Senagore: You don't. And that is the problem. So I guess what my challenge will be actually
20 my recommendation is that CMS strongly consider expediting the process of identifying best practices
21 amongst the different providers and have a process where they share that information. So I'm sure not
22 everyone scored highest in every one of your component items, but if you know, I'll pick a company,
23 BCBS of Arizona was doing something great in claims submission and Trail Blazer's was not, that
24 information should be shared to say how do you do that better than I do that? I mean that really I think
25 would be the better way to do that to try to get more rapid improvement. If you wait 4 or 5 years of survey
26 data to start to identify things, this really would not be the way a company would use this survey. You
27 would want 90% excellent satisfaction in every area, would be your goal, if you were truly using this in a
28 company.

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1 Dr. Ouzounian: Was that a PPAC recommendation?

2 Dr. Senagore: Yes, I've got to craft it here.

3 Dr. Powers: Second.

4 Dr. Senagore: Actually, I'll give you the terminology [laughter]. I'll try to put a little more
5 positive spin on for you. PPAC recommends that CMS identify actionable items based upon based practice,
6 identified by the MCPSS process to improve the provider contractor relationship.

7 [Second]

8 Dr. Senagore: Any comments, questions? Call the question—

9 Dr. Bufalino: Can I add an addendum on there?

10 Dr. Senagore: Sure.

11 Dr. Bufalino: Could we see the rest of the scores? It would be interesting to get the rest of the
12 scores from around the country. Is this every provider?

13 Ms. Narayanan: When you say around the country, you mean all contractors?

14 Dr. Bufalino: Yes.

15 Ms. Narayanan: It is in the public report that you see, if you look at Chapter Three, the report card
16 chapter, it's broken out by FIs, RHHIs, carriers and DMERCs, pages 9, 10, and 11.

17 Dr. Senagore: I was going to ask Dr. Simon after wards, but maybe at one of the upcoming
18 meetings, we could have another visit from your group and maybe talk about some of the 2, or 3, or 4
19 consistent issues you saw that were either high quality or low quality that could be transmitted to a better
20 practice opportunity. It would be helpful to us to see what you thought based on your analysis of the data,
21 what you thought would have the highest correlation and the most rapid turn around in performance. And
22 I'll ask Dr. Simon off line if we can do that.

23 Dr. Grimm: And follow up on that, do the contractors get feedback from this survey in terms of
24 what specifically that they fell down on in terms of the satisfaction?

25 Mr. Clark: They get the report, not unlike the report here where the composite scores are available.
26 But not a specific analysis of their individual operation.

27 Dr. Grimm: I think that's what you were addressing, weren't you Anthony, that he was trying to
28 get to the point where they need actually specific areas where they're falling down so that they can improve

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1 these scores. I think this is great, by the way, I don't want you to get any other impression. I think this is a
2 great start on this process, because this is where you have to, you measure, you make them accountable.
3 But then, the next step in accountability is to identify what areas of accountability they need to address.
4 And if you don't go back to the person who has the problem and don't tell them what the problem is, it'll
5 never correct. So that's why I say they need to have that feedback.

6 Dr. Senagore: It would be nice to have a report back with a little more granular detail, maybe pick
7 out three or four best performances, worst performances, and maybe try to identify the differences between
8 each of the contractor groups. I'll call the question then, all in favor?

9 [Ays]

10 Dr. Senagore: OK. Thank you. Any other questions?

11 Dr. Powers: I think it's important for us to see that, I know you do this yearly and you can't do it
12 more often, but it's important for us to see the progress made by each one of the individual companies. But
13 does this not get published in the Wall Street Journal or something like that, you know? Someplace where
14 you know it makes the companies look bad if they're not trying. And I don't think this looks good at all. I
15 don't think that's satisfactory at all. I mean I think the survey's great. But I don't think the performance by
16 the carriers is good.

17 Dr. Senagore: I think you're getting the message. There should be maybe something transmitted
18 based on '06 performance, how they're going to change behavior in '07, rather than waiting for their
19 cumulative score in '09 to decide what they're going to change, particularly for the lower providers. Great.
20 Thank you.

21 Mr. Clark: Thank you.

22 Dr. Senagore: We'll move on to Physician Quality and Cost Measures.

23 Physician Quality and Cost Measures Update

24 Dr. Senagore: Dr. Valuck is the Medical Officer and Senior Advisor for the Center for Medicare
25 Management. And he advises the Center Director and Deputy Director on clinical issues related to payment
26 policy, Pay for Performance, and as you know, he has been here several times in the past for us. He's a
27 pediatrician, a hospital executive at the University of Kansas Medical Center, and Associate at the law firm
28 of Latham and Watkins. Dr. Valuck, welcome.

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1 Dr. Valuck: Thank you, Mr. Chairman and it's a privilege to be back again, to talk about the work
2 that a number of us are doing here at CMS related to measuring physician performance. Remembering that
3 our measures aren't just limited to quality, but also include cost measures. And before, when I'd addressed
4 you, I specifically focused on the cost measures side. We thought that this would be an appropriate point in
5 time with the previous lead for our physician voluntary reporting program, who had headed up the quality
6 measures side, Trent Haywood, leaving the agency, to take another position, we thought this would be a
7 good time, now that the leadership for both the quality and cost measures is centered under my role, that it
8 would be a good time to just talk about how those two come together and that, even though you've seen a
9 lot of this material, presented in various ways at previous meetings, I don't know that we've ever really
10 talked about it as an integrated way to measure physician performance. So if you see some materials that
11 you feel like you've seen before, that is the fact, that is the case. We're going to try to think about it and
12 talk about it in a different way today. But at least the cost measures side is relatively complicated to
13 understand what we're trying to do with the episode grouper, and so I think it bears repeating, based on that
14 alone. But you know if I start to dwell on something that you feel like we've mastered already as a group
15 working together on these issues, feel free to give me the proceed a little bit more quickly signal. [laughter]
16 So the second slide gives the overview for what I'm going to be covering in this presentation.

17 First, we have to go back to quality. We have to go back to context. In the context is that this is
18 quality driven, that Pay for Performance is a way to get at improving quality, but then there's also the cost
19 side of it, and I'm going to talk about again where those intersect. And then I'm going to talk specifically
20 about the quality measures, and about the voluntary reporting program and then I'll move into a discussion
21 and an update really on the last presentation that I gave regarding physician cost of care measures and the
22 episode grouper evaluation that we have under way, and then as per usual, I like to end with a look to the
23 future and opportunities for you, your organizations and PPAC to participate in the implementation of what
24 we're doing here at CMS to measure physician performance. The third slide lays out I think the most
25 important part of the context that I want to bring to this presentation. These are the five strategies of our
26 five quality improvement roadmap. And you can see that the third strategy is actually Pay for Performance,
27 so it's pretty easy to see the tie between the strategies in the roadmap and Pay for Performance because it's
28 explicitly stated. But I think what's important to remember beyond that is that there are four other strategies

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1 that are essential for us to consider. Really they become guiding principles in a way for how we're going to
2 be implementing Pay for Performance. The first is extremely important and it's important to remember that
3 we're doing in terms of the approach for implementing Pay for Performance isn't exactly the same as a lot
4 of the other things that we implement. For example, under regulations typically. We've been working
5 through partnerships. We've been working with consensus groups; groups like the AMA Physician
6 Consortium, groups like the AQA, previously known as the Ambulatory Care Quality Alliance, now known
7 as the AKA Alliance, the National Quality Forum, various individual medical specialty societies that have
8 weighed in with directly and that's not only on the quality side, but that's also on the cost side. And you'll
9 see in the details of the presentation where some of these partnerships which have really been essential to
10 the work that we've been doing emerge throughout the presentation. Then, obviously number 2 and number
11 3 are directly related to what we're talking about in the rest of the presentation. But I do want to point out
12 in strategies four and five, and then also we could add in an update of the QI roadmap, we could add the
13 transparency initiative as point number six. So whereas we see adoption of effective health information
14 technology, promotion of innovation and building the evidence base for the appropriate use of those
15 innovative new technologies, we could also add transparency, and the idea of the benefit of quality and cost
16 information for consumers and for providers of health care to make better informed decisions about health
17 care for patients. That could be another six strategy on there. So you can see the important intersection
18 between health IT and P for P. Between innovation and P for P, and between transparency and P for P. So
19 that's another reason I think to bring this focus back to the table again, today.

20 So on the fourth slide, just very quickly because I know that I've driven this home in every
21 presentation and that it's fairly intuitive anyway, but I do want to reinforce that it's a two-part proposition,
22 that we're leading with quality, and we certainly won't be able to achieve our goals for value-based
23 purchasing tools or Pay for Performance if we can't improve quality. But it's not just about quality.
24 Because quality without attention to the cost side is unsustainable. So we have avoiding unnecessary is also
25 an integral part of what we're trying to accomplish through Pay for Performance. So moving on to the 5th
26 slide, if that's kind of conceptually where we're going and what we're trying to accomplish, how are we
27 going to get there? As they say, the devil's in the details. And these are just a few of the many categories
28 that are going to be needing to be addressed by the agency in combination with the partnerships that I spoke

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1 about. And each of these bulleted topics, with the subtopics, we could go into sub-subtopics and so on and
2 so on because the level of complexity here, is in many respects, quite daunting. And so what I'm going to
3 do for the rest of this presentation is just pull out that measures piece and talk about the quality and cost
4 measure, recognizing that we also need to be thinking about measures of patient experience, but I'm really
5 going to focus there, today. We at some point, probably should talk a bit more about data infrastructure and
6 incentive structures and the public reporting piece of this, but for right now, we're going to be focusing on
7 the measures.

8 So on the sixth slide, the first place to look at our first foray into physician quality measures,
9 would be the Voluntary Reporting Program. You'll recall that PVRP was launched in January 2006 and it
10 had a relatively modest purpose, truthfully, because we recognized that we're doing something pretty
11 momentous here in terms of beginning to engage in physician performance measurement. And so we
12 wanted to make sure that we'd covered some of the basics first. One of those being to develop and
13 implement measures for all physician specialties. Medicare is a nationwide program, primary care
14 specialties typically had a number of measures developed and so it was tempting to start there, focus there,
15 but then what about all of the other physicians? And if we were paying for performance, we knew that
16 others would want to participate as well and so that's the first point is that 2006 really has been a year of
17 quality measure development. I'm going to talk a little bit more about that as we talk about the measures
18 for 2007 PVRP.

19 The second point to design and implement a data collection infrastructure, you know we're talking
20 about a huge amount of information here. 700,000 physicians, all reporting quality measures, something
21 that we've never had experience before. We've got to get the data collection infrastructure in place and
22 figure out what works and what doesn't. We've learned a little bit about that from the 2006 PVRP. We
23 recognize we still have a lot to learn and that's why we are continuing with this program.

24 Then the third point would be to provide confidential feedback reports to physicians, so that
25 there's actually some meaningful and actionable learning that comes out of this. And then again, learning,
26 the feedback will get set up there, too. We can recognize after those reports are distributed what might be
27 more meaningful and more actionable and more fair to the physicians from their perspective after they're
28 able to see these reports. So fairly modest beginning, and the structure behind that, you see on slide seven,

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1 is that it was a voluntary program for quality data only to begin and we started, as you remember with the
2 G-Code and the CPT category 2 code reporting to minimize the burden to the extent possible. If you're in
3 fact collecting information and if there isn't a way to collect that that happens automatically, such as an
4 electronic system, there is going to be a burden. But what are ways that we could minimize that burden.
5 Well we said on the administrative claims approach, because to set up an alternative type of reporting, like
6 abstracting or something like that would be a whole other infrastructure on top of the claims reporting
7 system. So we recognize that there is a burden but the attempt was to limit that through reporting on
8 administrative claims. You'll recall and you've heard several times about the initial set of the 16 measures,
9 covered approximately 19 medical specialties. Now that's really just a planning parameter to gauge how far
10 we're able to extend the quality measures because the measures themselves are reported based on the
11 condition of the patient that's presenting to the physician. They're not based on specialties per se, and that's
12 the way the PVRP has worked from the beginning. You look at the patient, then find the measure. You
13 don't look at a specialty set of measures and then attempt to apply them to patients. So G-Codes and CPT
14 category 2 codes include exclusion codes when there are issues where the measure wouldn't apply, which
15 is a very important piece of this. And then of course we have the detail specifications for each of those sets
16 of codes and how they're supposed to be used. We also have involved the QIO Docket Project for using
17 electronic health records that are specifically set up to collect this kind of information if anybody were
18 interested in using an electronic collection system. And I think very importantly for the future, maybe the
19 near future, maybe it's a little bit further out on the horizon, but this is a concept that I know through
20 discussions that I've been have over the last six months with Hill staff, that this has gotten a lot of traction;
21 it's the idea of using clinical data bases, or something a little bit more, or maybe a lot more sophisticated
22 than a G-Code reporting system to really get at what's going on in the clinical setting, and the breadth and
23 depth of the kind of information that can be reported to a patient data registry, versus collected through a
24 G-Code reporting system, I think it's pretty obvious that that might be a direction that we might want to
25 move in to think about tying the PVRP to think about getting the electronic collection systems in place so
26 that the burden of reporting to registries and other kinds of health care data bases could be lessened.

27 So those are some of the things that we're doing around the Voluntary Reporting Program. The
28 next slide just details the 16 measures that were the initial starter set. You may remember that this starter

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1 set was culled from what was originally 66 measures that Administrator McClellan presented to one of the
2 committees of jurisdiction on the Hill, and then we pared that back to 36, and the primary care physicians
3 still felt that the 36 was very much a disproportionate burden for reporting on those particular specialties
4 and asked that it be widdled down further, and we ended up with this 16 measures set that covered
5 approximately 19 of the specialties. At least patients that those specialties typically treat. So remembering
6 that that 16 was really just a starting place for 2006, and there's been a whole lot of measure development
7 activity, and so a few slides from now, I'll be talking about PVRP 2007 and you'll see a dramatic change in
8 the potential measure set. But in the meantime, on the next slide, I do want to track the 2006 PVRP
9 reporting program. And remember it isn't just about measures and data submission, but it's also about the
10 feedback that physicians receive to sort of complete the loop on this; feedback that not only covers the
11 performance rates, which is what you'd expect out of a performance measurement system, but data
12 accuracy in reporting rates, as well. And these confidential reports, are actually being released this week to
13 the physicians who participated in calendar year 2006, April through June. So then after June of course you
14 have to have a period of time for the claims to come in, then you have to have the data analysis and
15 processing time, and then you have to actually create these reports. So that kind of lag time is pretty typical
16 in our reporting programs for turnaround of the information back to the participating individuals. So then,
17 of course, July through the next quarter and then on October through December, we'll have reports issues
18 later in calendar 2007. So what does the report look like? Well this is a draft. I believe you've seen this
19 before, but it just very simply lays out the measures on the left hand side and then three sets of columns that
20 really capture what a simply G-Code reporting system can. And of course we can't expect it to do more
21 than that. We get reporting rates in the first set of three columns, then we get the performance data, what
22 we can learn from G-Codes, and the national comparison rates for those kinds of things. And the
23 differences of course between the reporting data and the performance data has to do with whether or not
24 patients were in exclusion categories and therefore fell out of the denominators for the performance data,
25 etc. There are a lot of nuances that go along with this, but just very generally, I wanted to refresh your
26 memory about the quality reporting side, and the PVRP and the structure there and before we then move
27 into connecting this to the Cost of Care Measure side. So just to finish up on the PVRP, I wanted to talk a
28 little bit about the future. A little bit about 2007. It's only a few weeks away now.

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1 So you may recall that in October, we posted on the PVRP website a pool of potential measures
2 for 2007. And that pool was intended to reflect the measures that we might pick from for the final 2007
3 measures list. It was not intended to reflect necessarily the universe of every measure that had ever been
4 created for physician quality reporting, but that universe for various reasons, based on the selection criteria,
5 primarily, which I'm going to be talking about on the next slide, but for various reasons, that universe
6 became this pool of 86 unique measures. And the 86 measures covered 32 of 39 Medicare designated
7 medical specialties. So you see quite an advancement from 19, which the 16 covered fairly minimally by
8 the way, but now we have a more robust coverage of 32 of 39 specialties. Now this was in the pool. In the
9 pool, there were a number of measures that hadn't yet made it through the AQA adoption process or the
10 NQF endorsement process, so when you see the criteria on the next page, you'll see how the 86 then
11 becomes something closer to 45, which is what we're going to have for January 1, 2007. The last point that
12 I wanted to stress on the previous slide, was that the slide set was due so that it could be circulated to you
13 prior to a decision to not do the last point on this slide. The reason being that we felt like we were close
14 enough to January 1, 2007 than rather than do an updated pool and then the final measure list, for 2007, that
15 we would just go directly to the final measure list. We want to give you all as much notice of the new
16 measures for 2007 as possible, and we found that the pool, people confused that with the final list and we
17 wanted to avoid that. So we're not going to be doing an update pool, but what you will see later this week,
18 and this gets to what's on the next slide is the final measure set for 2007 and the way that that's been
19 selected—this is on the quality side of course—the way that that's been selected is by looking at that pool
20 of 86 and then using, applying these parameters. First of all, obviously we want to expand the scope of the
21 measure set to cover as many medical specialties as would be feasible, without unduly burdening any one
22 of the specialties vis a vis their colleagues. And then I've talked about the importance of the AQA adoption
23 and the NQF endorsement processes and we really want to stick closely with that. Let me just give you an
24 example of why that becomes so important. And I really should throw the physician consortium
25 development in here along with AQA adoption and NQF endorsement because what we get is we get
26 various medical specialties and/or non physician specialties, like therapists, and nurse practitioners, and
27 that sort of thing, physician's assistant. And then also physician non MDs, DOs, like podiatrists, and
28 chiropractors and oral surgeons and optometrists coming to us and saying OK, we've got these measures

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1 out there that have come through the physician consortium, they've come through AQA, they've come
2 through the NQF, but if you just change this code a little bit, it would really work well for us. And we say
3 well you know, that's great. But if we do that, that's a unilateral, regulatory agency activity and it totally
4 bypasses and in a way discounts all the work that all of you are doing in these consensus based processes.
5 So what we're doing is we're trying to catalog that input from all these various groups so that we don't lose
6 track of it, but feed it back to the groups that are actually the designated entities, if you will for handling
7 that kind of whether it's development, adoption, or endorsement of the various measures Because you lose
8 all of the reasons that went into that measure for in terms of coordinating among the specialties and all the
9 other things that were considered very stringent and complicated process. You would lose all of that to
10 have us step in at the last minute and say, no we're going to change it like. And it's going to be this way
11 because we need to accommodate this one group or these two groups, or something that we need that
12 maybe is not as meaningful to the physicians. So that's become a very important issue in all of this, because
13 as we move toward the expanded measure set, and there's a lot of anxiety as you know about whether
14 Congress might tie payment to quality reporting, or quality measurement in some respect, in the lame duck
15 session or early, or even later in the new Congress. You know, we get all these groups coming out and
16 saying we need to be on the list, we need to be—but we can't disrupt all of the other good work that's been
17 done. So there's a little bit of tension there and I wanted you to be aware of that. So we're really pushing
18 strongly to give preference to the AQA adopted measures and the NQF endorsed measures. This is why
19 that list of 86 potential measures gets down to about 45, because a lot of the things that are out there maybe
20 haven't completed those review processes and might be coming on line early in 2007. So also on here is
21 that we would consider relevant input from associations and stakeholders. There's nothing in statute that
22 would preclude us from doing that. We're not obligated to take everything that comes out of these
23 consensus bodies, but I just wanted to make the strong point that we're coordinating with them, and that's
24 working very well from our perspective.

25 Then the idea, too, that if the measures that are actually specked for electronic data collection,
26 given what I've said about moving toward registries and other simpler ways to decrease burden, if those are
27 out there, then of course, we would prefer those over similar measures that are not specked for electronic
28 data collection. So the last bullet here just basically saying, you know, and really it's more like in the next

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1 week, as opposed to some time in December, because we want to give as much notice as possible for the
2 2007 PVRP measures.

3 So I want to move now from the quality reporting piece, which is real in the form of the PVRP
4 program to our evaluation of Cost of Care measures. That's a very important distinction. We are still
5 evaluating on the cost side, but we may be getting to the point where we're beginning to have some things
6 that might be useful to physicians and I'll talk about what that might be in this section of the presentation.
7 So again, where I started was, this is about linking quality and cost through Pay for Performance, to get true
8 efficiency or true performance measures, again like on the quality side, CMS is not working in a vacuum
9 here. We're working with a number of different organizations that are also looking into Cost of Care
10 measure development and I have a slide on that. And then I wanted to remind you about our episode
11 grouper evaluation. The topic that I've talked about at our last two meetings. Give you both a quick
12 refresher, but primarily an update on some of the remaining issues and how we're working to address those
13 before we would be ready to actually apply Cost of Care measures to physician practice.

14 So the next slide helps to set that context of what we're talking about when we're talking about
15 cost. Cost is one of the aspects of efficiency. Efficiency is one of the IOM's key dimensions of quality. So
16 you see the tie back here to the Quality Improvement Roadmap in the quality context. Efficiency in what
17 we're talking about is taking waste out of the system, the overuse, the misuse, and the errors. We think
18 there's a lot of opportunity there, and we're not talking about arbitrary cost-cutting. So you can see on the
19 next slide, that a common definition of efficiency is where you have a similar output, in this case, being a
20 high standard of quality of care, and one type of provider can do it half the cost of the other, then you've
21 got someone who's twice as efficient. It's as simple as that. But the devil's in the details, just like on the
22 quality side. So how do you take this abstract notion and actually convert it into a Cost of Care measure?
23 Well, a typical measure which is demonstrated on the next slide, is simply the ratio of actual resource use to
24 expected resource use. Those comprising the numerator and the denominator, and I'm going to show an
25 example in here of how that ratio can then become an index of resource use, so someone who's at a 1.2 is
26 essentially 20% higher than whatever the standard is, whether it's a standard related to aggregate peer
27 performance or whether it's a standard related to cost accounting of a guideline or whatever that is, that's
28 what the index would be relative to. And then a 0.8, obviously, is 20% more efficient. Now the question

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1 would be, in the quality context, whether that under utilization is as much or more of a problem than that
2 over utilization. We have to look at both ends of the outliers in measuring cost of care. So here are a couple
3 of the basic things we want to pay attention to. Not only this link, between cost and quality, but also the
4 fairness issue. Because without appropriate adjustment, as you all know, there are relevant practice
5 differences that are not really in the control of the physician. So those become very important in developing
6 Cost of Care measures, and you'll see how our episode grouper evaluation will have that under study in
7 phase II, which is the phase of that evaluation that we're just not entering.

8 Now I said I had a slide on the coordination with external groups, which is the next slide. We're
9 working very closely with groups like MEDPAC, which is going to have another in a series of reports on
10 this topic. I shouldn't use the word "report"—they do reports to Congress. But another in a series of
11 presentations on this topic to the Commissioners on December 7th, which is this Thursday. And they are
12 sharing with us the direction that they're headed. And we're also sharing with them the outcomes from the
13 points along the way, strategic points along the way in our evaluation. The Ambulatory Care Quality
14 Alliance is looking at this from a little bit of a different perspective. That group is all about standardizing
15 inappropriate ways so that when you get reports, whether it's from Blue Cross, or Etna, or Humana or CMS
16 that you're seeing your practice portrayed in similar ways in all those reports so that you can fit that
17 together and it gives you a clear picture. As opposed to one does it this way, one does it that way, and so
18 that's where the AQA is focused, and they're doing an episode grouper evaluation as well. NCQA has been
19 looking at the groupers at the plan level for a long period of time, and they're also involved in looking at
20 grouper technology at the individual physician level, and they're actually serving in a staff roll to a certain
21 extent to the AQA. So you can see we're all working closely together here.

22 The National Qualify Forum has just launched or will be launching in January a three-part series
23 where they're going to be doing a study of efficiency measures for physicians in each of those three parts.
24 And I don't think it's just limited to physicians, but they're going to be talking about the issues that are a
25 part of all this, and then a couple of other governmental agencies, the Agency for Healthcare, Research and
26 Quality's doing a typology of physician efficiency measures, and the GAO is getting into the act and
27 they're going to do a, the Government Accountability Office is going to be doing a report that looks at Cost

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1 of Care measures used in creative ways by groups like the Government of British Columbia, etc. So lots
2 going on here, and we're coordinating with all of that. So where are we in our work?

3 Well, you'll recall in the next slide, that we initially put together a work group here at CMS to
4 respond to a MEDPAC report from March 2005. So we've been working for some period of time in terms
5 of attempting to address this particular recommendation, which is basically taking this huge Medicare
6 claims set that we have on physician providers and analyzing, developing resource use reports, and sharing
7 it confidentially with physicians to educate them about how their cost of care compares to their aggregated
8 peer performance. Well, you may remember in my previous version of this presentation, I had our initial
9 steps in that, and what we learned along the way. And what we learned along the way basically has led us
10 to the technology of the episode grouper. And I think that's where a lot of the rest of the industry is as well.
11 So I don't have to repeat all that we did with echoes for CHF. You may remember MRCT for neck pain,
12 trying to get to a standard that we could measure against, then display physician performance relative to
13 their peers. We learned a lot from that exercise, and what it told us was that we needed a more longitudinal,
14 more sophisticated look at physician resource use that something like the grouper can provide.

15 So our goals for the episode grouper evaluation are listed here on slide 20. Basically, and you'll
16 hear me repeat this because it's kind of become our mantra, but we're seeking to develop meaningful,
17 actionable, and fair Cost of Care measures to report to physicians to report to physicians in terms of
18 resource use reports. Meaningful, actionable, and fair and then of course to make that link to quality for
19 overall assessment of performance. So how are we trying to get to meaningful, actionable, and fair? Well,
20 the idea is that the episode grouper, which is introduced on the next slide, can take a more robust set of
21 information about the patients that a physician is seeing and organize those sets of information in ways
22 where you can get comparable episodes of care to make these comparisons between on practice and
23 another, ultimately with risk adjustments so that you can issue these meaningful, actionable, and fair
24 reports. So how does it work? Well, it basically uses proprietary logic, to organize claims data into these
25 comparable episodes of homogenous services that are being provided. That's a little bit opaque, but now
26 that this is the third time that you've heard this, I'm sure this is making a lot of sense. So the idea is you can
27 use both acute and chronic conditions. You can use the codes from any of our various claims set, and the
28 next slide is a graphical representation of how that particular technology works. So if the third triangle from

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1 the left is the initiating event, which could be a visit or procedure, could be an acute or chronic initiating
2 event. Maybe it's a new onset diabetes visit or maybe it's a hip fracture and it's a procedure in the OR. But
3 then you've got a look-back period, where all the services that are relevant to that initiating event are
4 brought into that episode, and then you've got subsequent services that also group to that particular
5 episode. And then at some point, it ends after either a claim period for an acute episode, or you decide for a
6 chronic episode what that time period is going to be for collection. And I think one of the most important
7 things about the episode grouper for our Medicare patients is that as you see, there are a number of services
8 there that didn't group to this particular episode. But there might be four or five other episodes open and
9 running at the same time for our patients in terms of the co-morbidities that are out there for our population.
10 So the point is that the grouper can actually collect this information in meaningful, comparable episodes
11 that give you more information than just something about echoes or something about MRs or something
12 about drug use. It gives you the whole picture, but just for that episode. And that can be compared to some
13 sort of standard, and then the index, the idea of the ratio and how that indexes to the standard gives you an
14 idea of comparable performance.

15 So on the next slide, we took that technology that you just saw demonstrated in a relatively
16 simplistic fashion and we said what do we need to know about this? What do we want to learn about this
17 before we can figure out whether it applies to Medicare patients and Medicare physicians? So we're asking
18 three basic questions: One is, how does the technology work with Medicare claims data? Now you all
19 know, because you report your claims in different ways to private payers as well as to CMS and other
20 public payers, that the data is somewhat different. And so there are unique things about our data in the
21 Medicare Program and recall that the groupers were not specifically developed for Medicare. They were
22 developed primarily for the private sector. So we've got to figure out how to overcome some issues that
23 question number one raises, which I comment on toward the end of the presentation.

24 Secondly, we want to look at the ability of the grouper technology to risk adjust, to adjust for the
25 appropriate differences among patients, such as severity of illness, present co-morbidities, you can think of
26 other things you might want to adjust for, and that goes to the fairness part of the standard.

27 And then third, can the technology actually do what we need to do with the information, which is
28 to produce these meaningful, actionable and fair reports to give to physicians. So we set up an evaluation

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1 process that's demonstrated in the next slide, basically to answer these three questions. We have an
2 evaluation contractor and we're looking at the two predominant software vendors in this field and we
3 expect that our final report is going to be due sometime in 2007. The date keeps slipping because we learn
4 new things that we need to look at along the way, and we say we've got to include that in our evaluation,
5 too, otherwise, the evaluation isn't going to be complete, so it's sort of plan, do, check, act, even in the
6 evaluation process. So as we keep adding onto the evaluation, the time line will be extended as well. But
7 the last point there is something that we're doing that as far as we know, nobody else is doing. We're going
8 to be looking at the soundness of the clinical logic. And I'll walk you through the first exercise to do that,
9 which is sort of a face validity kind of exercise. But then we're going to be investing more and looking at
10 the clinical logic in the near future as well because we found that that's really an important piece for us to
11 address. So slide 25 gets into a little deeper into phase I. This is methodology so I'm not going to spend a
12 lot of time. I'll just spend a little time. But you can see we're focusing on six conditions, basically 100% of
13 Medicare claims in four states and really just figuring out again how the grouper handles Medicare data.
14 That's phase I.

15 And then of course phase II, I mentioned, is risk adjustment, which is discussed on the next slide,
16 that each of these software technologies does have its own unique risk adjustment tool and there may be
17 some role for Medicare's other risk adjustment tools in figuring out how to take this information that the
18 grouper provides us and adjust it appropriately. So that's the second piece and we can compare how our
19 tool does versus the tool of the grouper, vendor itself.

20 So phase III on the next slide, is really just getting to those valid and reliable or meaningful,
21 actionable, and fair physician resource use reports. So I've gone fairly quickly through the methodology
22 because you've seen it before, but in slide 28, I do want to spend a little bit of time discussing each of these
23 open issues, because this is really where we're going to be answering the question, How good is good
24 enough? In other words, at what point are we going to be ready to use the episode grouper technology and
25 its product to actually do what we've been talking about, which is develop these resource use reports and
26 get them out to physicians. Well, it's going to have to do with how we ultimately come down on each of
27 these open issues. First of all, as you know, the Medicare payment systems in some of the institutional
28 settings use a prospective payment. And prospective payment typically aggregates payment information,

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1 the coding information, the procedures that were provided, the revenue codes etc., that gets entered. Let's
2 just take the instance of the hospital into a DRG grouper and then you get a DRG. Well, a DRG is a roll up
3 of a whole lot of information that of what may have gone on during that hospitalization. And in some
4 respects, although some of it is retained, a lot of information that might be helpful in parsing out how to
5 allocate the costs from a hospital stay to the various physicians who were involved in that hospital stay, that
6 gets lost in the aggregation process. So one of the things that we're asking the vendors to work with us on
7 and that we're considering with our evaluation contractor as well is how can we take that aggregated
8 information and potentially disaggregate it, or think about allocating it in ways that would make it
9 meaningful, actionable, and fair? Similarly, the attribution issues. OK, so that's related to the last issue, but
10 the idea is if you have a team of physicians who all have important input into the care of a specific patient,
11 how do you know who to either give the credit to for actually saving on costs, or who basically gets the
12 opposite of credit, however you want to define that, for a resource use that seems to be over the standard,
13 whatever the standard is. So it's how you get to the individual level when there are a team of providers
14 involved. And not just physicians, but there may be many others on the team as well.

15 The third issue, getting to relevant comparison groups. Well, we've talked about this before and
16 the context of the cardiology piece that we did on echoes for CHF, and we had cardiologist tell us you
17 know, I practice in the community, I'm not the same as that guy in the academic medical center. And the
18 cardiologist in the academic medical center said, well, you know I primarily see the outpatients in the
19 cardiology clinic. I'm not the same as that EP guy, and so you know, our practices are very different. What
20 is the relevant comparison group and how do we define that? And then as you use the episode grouper to
21 divide the data into more and more refined comparable units, you start to get into the small end problem. So
22 you get low numbers, this is all still back on the last slide. You start to get small numbers and so your
23 analysis can't be robust, as you would hope. So you have to think about dealing with that and this may be a
24 problem in some practices more than others. Defining the reporting time frame, and this gets back to the
25 small end problem too, if we would double the number of the reporting time frame, let's say we make it
26 two years, then we've got potentially twice as much data and we can overcome the small end problem. But
27 do you want to wait two years for your next report and you're going to forget that there's some
28 measurement going on in the meantime. You could have rolling roll-outs and this that and the other of

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1 various reports, but we've got to deal with that. Treatment of outliers. Often when we look at Medicare
2 statistics for various purposes, we'll cut the outliers off the ends of this for various reasons, but the
3 consideration here is that well, maybe it's the outliers that we actually want to get at, or maybe that the
4 outlier data is important and plays into this even if it does skew the results, and then impact that last
5 thought which is the stability and consistency of the resource use reports over time. Because as a physician,
6 if you get a report in one quarter, or one six-month period, and it's dramatically different from the next
7 quarter or the next six-month period, and you don't feel like you did an intervention in your practice, didn't
8 change some particular behavior, you're going to say well, what's the reliability of this? It's just all over
9 the board and so we've got to figure out how to address that issue because we sometimes see that in this
10 kind of reporting. So those are some of the open issues. You could probably think of a couple others, but I
11 think these are in some ways the priority issues that we're going to be working to address with the vendors,
12 with the evaluation contractor and with the other groups that I mentioned that we're working with
13 externally, to get to the point where we're reading to use this information with physicians. So I have two
14 remaining slides before the wrap-up slide that just review the methodology that we're using for the face
15 validity test of the clinical logic of the groupers.

16 I mentioned that as far as we know, only CMS is evaluating the clinical logic. And the real point is
17 just to get together with focus groups of physicians and say if you were to do this code mapping manually,
18 would what you set down and did for this particular patient and all these codes related to this clinical
19 scenario, would you come up with the same answer that grouper A did? And that grouper B did? Or is there
20 something different that's going on here? Is there some problem with the clinical logic? So that's the
21 simple research method that's presented on slide 30. We've actually involved, as you may know, some of
22 the medical specialty societies in this exercise and then we're going to be taking the information that they
23 gave us, these clinical scenarios and finding actual patients, then finding the claim sets to the patients, and
24 then organizing that in a way such that physicians can evaluate the performance of the groupers, basically,
25 in this focus group kind of process that I mentioned.

26 So just to end on slide 31, where are we headed in terms of performance measurement? And what
27 are kind of I don't know if tipping points is the right word, but what are some of the leading indicators that
28 you all as leaders in the profession and your colleagues, who will be hearing about our meeting today in

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1 various forms, how can we all understand together where this headed, and what we might be facing next?
2 Well, the Institute of Medicine put out a report recently that was the last of their three-part series, Pathways
3 to Quality Healthcare and it really was about the payment incentives piece of that; how the payment
4 incentives might fit in to the Pathway to Quality Healthcare. If you haven't seen that, that's a very
5 important piece of work that we're paying a lot of attention to and that I know others who are working in
6 this area are as well. Similarly, MEDPAC's work is really, we're working closely with them, we
7 understand where they're headed, both on the quality and cost side, particularly on the cost side, they're
8 coming up with a direction that I think is going to be a good kind of stepping off point for all of us into the
9 world of Cost of Care measurement and the Physician Resource Use Reports. Congress, question what's
10 going to happen in the lame duck session? But then we've got the next Congress coming up just a few
11 weeks after that. So we'll all be keeping an eye on that. Our various proposed regs give a framework for
12 where we're headed in some of the value-based purchasing initiatives, demos and pilots, similarly, there's a
13 lot going on out there in the demos and pilots that really is fascinating coming from the evaluations, but
14 also really guiding us in terms of where we're heading. On the physician side, the physician group practice
15 demo is probably the one that's to the phase of giving us the best information at this point. But we have the
16 premiere demo on the hospital side and then a number of things that are either just getting started or coming
17 on line that are going to inform the work that we do in this area.

18 The measure development as I pointed out, a priority for 2006, but it's also going to continue.
19 Measures are not static in this ever-changing environment of healthcare. They will need to evolve to
20 represent the new evidence base, so look for measures refinement to start to take the place of measure
21 development, but we will still have a lot of gaps and a lot of areas to cover in terms of measure
22 development. The transparency initiative that I mentioned is a place where a lot of this is going to be tested,
23 and so the idea of the six initial pilot sites, and the potential expansion of the transparency initiative beyond
24 those pilot sites will be something to watch. And then I mentioned our close work with the Quality
25 Alliances. And I know some of you and all of your organizations are involved in the various Quality
26 Alliances, but watch what comes out of there, and participate, because that is where we're looking for a lot
27 of partnering and even guidance in some respects from these consensus organizations.

28 So that's all I have for today, and I look forward to your questions.

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1 Dr. Senagore: Thank you. Dr. Williams?

2 Dr. Williams: Thank you, Dr. Valuck, that was a very good presentation. I'd like to go back to
3 PVRP and I've noticed over the last, this is now the third time that I've heard you speak that there's
4 definitely learning and flexibility and you're actually listening to the feedback that you're getting,
5 specifically on two different areas I'd like to just comment on. One is that where there are different
6 subspecialty groups that are asking you to modify what comes out of the consortium for their particular
7 needs, regarding the same medical issue, you're sending the people back to the consortium which I think is
8 the best way to vet everything. Secondly, changing the wording, even if it's small, may lose its clinical
9 value, that the physicians and all the different subspecialties intended. So I would like to commend CMS
10 for ensuring that all consortium developed AQA selected, and NQF endorsed measures used in PVRP
11 accurately reflect the wording and specifications as developed and endorsed by the stakeholder
12 organizations without modification by CMS, because I understand that that's been an issue.

13 Dr. Valuck: Thank you.

14 Dr. Grimm: Tom, thank you very much for that extensive presentation. There's a couple things
15 that I'm very curious about. One is the assumption you asked us to swallow right from the beginning: And
16 that is that quality without cost is unsustainable. Now that has not been established as a truth, but you asked
17 us to accept that as a truth, and everything follows from that truth. That assumption. I don't think there's
18 any evidence to show that. I think most of us believe here that we believe that quality will reduce costs in
19 itself, and my impression is what do you care about efficiency? You care about cost. If I provide a service,
20 and it takes me five minutes, and it takes him ten minutes, we get the same result, what do you care? I don't
21 care if my employees if they cost me the same. And so I don't understand a lot of this. Why, what I think
22 this is poorly labeled. And I think there should be labeled penalized for over utilization because that's what
23 this Pay for Performance agenda is about. And I think we should be honest with our physicians; that's what
24 all this is about. Because with budget neutrality and everything else we've talked about here, there's no Pay
25 for Performance. It's penalized because we've talked about before. There's no money to pay extra for
26 performance. It's going to be taken from somebody else. So let's call it what it is. Let's be honest with the
27 American physicians, that this is penalize for over utilization. All this stuff about all this stuff that you
28 talked about just now, the PVRP, the grouper evaluation, it's all about claims data and using claims data to

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1 establish utilization issues. And it's all about penalizing people for utilization and decreasing cost. So let's
2 just call it what it is. Let's stop this Pay for Performance nonsense. It's total nonsense to me. And so I'd
3 like you to explain why that assumption is made, where it came from, and why we sustain this, and why we
4 sustain this charade to all of our constituents that we have to go back to and talk to and say, What's this Pay
5 for Performance all about? And I have to go back and say you're going to get penalized if you over utilize.
6 That's what I tell them. How should I answer that.

7 Dr. Valuck: Well, let me address one of the fundamental misunderstandings. You're right, we're
8 not into instructing physicians how to make their practice more efficient. The efficiency that I'm talking
9 about here, and it has to do with your rolls in advising the Medicare Program, not in advising physicians
10 about whether to do something in five minutes or ten minutes. It's about efficiency from the programs
11 perspective. So efficiency from the programs perspective has two very important pieces, and I must take
12 great exception with your other assumption that Medicare has no interest in quality. I mean we certainly
13 have a huge interest in the quality of the care that's provided to beneficiaries and that enters into the Pay for
14 Performance equation. And then we also have a huge interest in the sustainability of the program. So when
15 I say that the kind of cost trends that we've seen, and I left out some of the slides that would have maybe
16 been better background to address this particular question, because you asking obviously very basic
17 question and a very fair question, but the idea is that when you look at the cost of care that we have, even
18 though we have increasing quality, presumably, we've seen some evidence of that. The costs are much
19 outstripping the increases in quality. So we've got a performance disconnect in terms of the ultimate value
20 for the Medicare dollar. So the idea is that with our focus on quality for beneficiaries, leading this, that
21 there are some unnecessary costs that we could take out of the system if we could begin to measure both
22 quality and cost as a part of the performance. That's the way we're defining efficiency, and that's why I
23 spent several slides going back over what we mean by efficiency. But I just, I wanted to clarify some of
24 those assumptions. So in that context, we do have a role here and we do have an interest here, and we do
25 believe that Pay for Performance is one of the tools. Pay for Performance is not a panacea. You didn't hear
26 me mention medical malpractice, you didn't hear me mention you know problems with rural and
27 underprivileged patients have access. We have other ways and will continue to have other ways to address

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1 some of the other problems in the system, but we see Pay for Performance as an important tool to get at the
2 incentives for improving quality and avoiding any unnecessary costs.

3 Dr. Grimm: But this is not Pay for Performance. You're not paying for performance. You're not
4 paying extra for performance here. Is there any notion in your mind that you are paying extra for
5 performance here? To save on some other aspect of care?

6 Dr. Valuck: I mean that—

7 Dr. Grimm: There's no mechanism—

8 Dr. Valuck: the assumption, yes.

9 Dr. Grimm: There's no mechanism that you explained to—we've listened to this for over a year
10 and a half, there's no mechanism to Pay for Performance here.

11 Dr. Valuck: Are you citing the fact that we have a voluntary program that's not tied to payment at
12 this point and that we haven't yet implemented the Cost to Care measures? Because the idea is that those
13 are the building blocks for an ultimate Pay for Performance.

14 Dr. Grimm: We have not heard, and we've heard quite the contrary that there's no plan for Pay for
15 Performance here. There's going to be no extra funds to pay for the implementation or for the executive of
16 performance of quality.

17 Dr. Valuck: So you're getting at the issue as to whether the implementation of Pay for
18 Performance will be budget neutral, versus bringing new money into the system.

19 Dr. Grimm: That's one of the issues, yes. But our contention here, my contention is that quality,
20 your issue, you've said earlier, you said that quality is not matching up with the costs are going up, but the
21 quality is not going up.

22 Dr. Valuck: No, I didn't say the quality was not going up. There's evidence out of the agency for
23 healthcare researching quality that shows quality is going up in smaller increments than inherited costs.

24 Dr. Grimm: Than costs. What that is related to, we haven't been, hasn't been completely
25 explained. Because some of its technology that has improved over the past ten years. But the point is, let's
26 just label this and describe it correctly and honestly, rather than to put these euphemistic terms that we
27 bought into a notion that this was going to be Pay for Performance from the beginning. This was going to
28 be an issue about quality. But this is moving completely to an issue about cost. Now we don't mind the

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1 cost, that's an important aspect. But we feel that by establishing quality issues, that we'll reduce costs
2 naturally. Efficiency and those other issues will occur naturally because that's our job is to do our job as
3 efficiently as we can. It's to our benefit.

4 Dr. Valuck: So we believe that setting up the quality measurement system so that when we are
5 addressing issues of cost, it's in the context of that, and we know that those quality measures are being
6 maintained, that's the connection that we're trying to make here, so that we're not doing arbitrary cost-
7 cutting. We're doing cost-cutting in the context of our improving performance.

8 Dr. Grimm: I just don't think that you've established for the American physician mindset that
9 there is a connection between cost and quality and I think that lowering cost will increase quality. I don't
10 think there's any correlation there.

11 Dr. Valuck: And again, remember the way that we're defining the cost piece of this. It's about the
12 over-use, the misuse, the errors, etc. So we do believe that by taking those out of the system we can lower
13 cost and improve quality.

14 Dr. Senagore: If I could interject. I think that as you look at where you're going, I think that
15 there's two competing methodologies. And it seems that there's two competing methodologies and it seems
16 to me that the episode grouper approach looks like the things are growing. So I would submit the
17 contention that the G-Code methodology could well be abandoned, because what you're asking therefore
18 are more expensive reporting of new data from physicians for surrogate measures that may or may not
19 clearly translate into better outcome. Where you have a good methodology I think going forward in the
20 grouper approach, to actually tie bar overall utilization. Down the road you can make a determination if it's
21 over under or appropriate utilization, based on that claims data. But I guess as I look at it, to continue to
22 pursue the G-Code submission process is burdensome right now for the practicing physician, you're using a
23 tool that really wasn't devised for that process, and you have what I think you're going towards anyway is a
24 superior approach anyway so could we not simply abandon the G-Code approach for the voluntary
25 reporting, follow where your grouper methodology will obviously take you are patterns of consumption,
26 based on similar episodes of disease and get ultimately where you need to get to is a risk-adjusted
27 formulation. Because that always is the rub in these things. If you don't have an OE ratio, it's hard to make
28 a value judgement about any isolated encounter.

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1 Dr. Valuck: So what we're suggesting in terms of taking the voluntary reporting system to the next
2 level would be something that would use more sophisticated clinical data without having an incumbent
3 burden of having every physician have to do abstracting, etc. But I don't see disconnecting the quality side
4 from the cost side, because then I think that would leave us in the situation that was just being postulated,
5 which would be that all we're looking at is cost, making risk-adjusted cost, but cost nonetheless, without
6 any attention to what's happening on the quality side as we're hopefully taking cost out of the system.

7 Dr. Senagore: Well, I'll give you an example though that has a real world exposure? DVT
8 prophylaxis. Whether I use Lovinox or Unfractionated standard Heparin has a significant cost impact.
9 There are also some quality issues. There's some reasonable data to suggest that bleeding complications are
10 higher with the fractionated, versus the unfractionated approach. So you could monitor very clearly without
11 penalizing anyone at the beginning to say that all the Medicare beneficiaries that had an abdominal
12 procedure, there was a higher transfusion rate in patients that got X versus Y, the DVT rate was the same,
13 the fatal pulmonary embolism rate was the same, have an excellent manuscript that immediately could
14 become evidence based medicine. So I think you have a very strong tool. What I'm wondering is are we
15 really going to get any value for the physician self-reporting of the interim surrogate measures when the
16 huge data repository in the untapped resource is the episode grouper approach. I guess I have a hard time
17 having done a fair bit of quality research in publications, that anecdotal reporting is going to be far less
18 valuable and from our perspective, far more expensive and onerous from where you're going to end up by
19 definition. So I would just ask the agency, in fact, I'll make a recommendation to that approach, to say that
20 why should we continue to do this when we have obviously a far more sophisticated data repository to
21 mine to come up with better definitions up front.

22 Dr. Valuck: So you're saying that we should look at the cost of care measures that are generated
23 by the episode grouper without reference to a quality context.

24 Dr. Senagore: I'm a colorectal surgeon. An easy grouper to look at would be to say look at colon
25 cancer resections, and break out node positive and node negative patients. And follow them going forward.
26 How many of the node negative patients end up with a charge for chemotherapy within 24 months of the
27 surgery? That would be a value indicator. Rather than me reporting me that I got 12 lymph nodes.

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1 Dr. Valuck: No, I certainly understand that but what the grouper could contribute to that, I don't
2 think provides that whole picture that you just describes.

3 Dr. Senagore: Sure the grouper should identify the colon cancer resection, whether it was node
4 positive or node negative because that would be DRG 148 versus 149. You could then follow it forward
5 and say was there a chemotherapy charge within a certain time frame because in a perfect world, the node
6 negative patient should be 85% chance of being cured, should never have a charge for chemotherapy. And
7 then you would have truly a quality cost measure because you'd know the cost then of chemotherapy,
8 numbers of CT scans, etc. that went with that that would dramatically increase the cost. And those are
9 things that are already reported in a standard fashion of how we all currently do business.

10 Dr. Valuck: You're using a specific situation where the coding system told you something about
11 the treatment. You know we don't always get that through the coding system. But I like where you're
12 headed, certainly be more direct and more efficient for us. The question is whether we can get the kind of
13 quality information that we would need out of the administrative claims base.

14 Dr. Senagore: Right, and I guess where I'm suggesting we think seriously about is you're asking
15 us to use a system CPT that really is never designed for this, try to put these things on a form that we're not
16 used to putting onto. It's an administrative burden for our practices, and it won't be anywhere near as
17 robust as where I think you're going with this data. So I guess I would consider the burden of that on the
18 practicing physician.

19 Dr. Valuck: Sure.

20 Dr. Azocar: I was going to, congratulations for the comprehensive presentation. And I realize you
21 are in the developing stage of identifying or determining what your reference values are going to be for the
22 different measurements that you're going to do. And as you know, different populations may have different
23 issues, which is unrelated to the physician quality or dedication. We talk about that last time. And maybe if
24 you introduce new factors, such as the zip code, for example, I have the feeling that the zip code is going to
25 give you some idea about where certain population may be and with similar demographic and
26 socioeconomic characteristics compliance related to that. Maybe if you introduce that factor into your data
27 you may obtain different values for your references. It's just an idea.

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1 Dr. Bufalino: Dr. Valuck, just to take a different spin on this. So with the physician Voluntary
2 Reporting Program that we're unfortunately hampered by the G-Code approach, so could you spend a
3 moment and talk about what are you looking at in terms of electronic reporting in connection with CMS? I
4 mean there's a lot of us that have full electronic systems with a fair amount of sophistication. Are you
5 looking at ways to begin to talk to those systems and be able to connect or have us modify the data such
6 that we could just report it electronically to—

7 Dr. Valuck: There are a couple of things at least. First of all, you heard me mention the Docket
8 Program, and that's a QIO program that's been put in place to collect electronically various measures
9 related to physician practices. Now, the QIO and their vendors have to come in and help set that up because
10 not every particular record system that's out there would be interoperable with the system that's processing
11 the information. So that's one way and any of you can talk to your QIO about the DOC IT program or DOC
12 IT program, and understand what that system is capable of, and how to integrate into that. The second thing
13 that I would say is we're having ongoing discussions with some of the better recognized clinical registries
14 or clinical databases to figure out how to import or use the information from those data bases to populate
15 measures that would satisfy reporting criteria. So if a practice or a particular physician, or in some cases a
16 whole specialty reports on their patients to a specific database, then of course, they're raising the question
17 to us, why should we also have to report [unintelligible] if we're already reporting the sophisticated clinical
18 information that can be used for a lot more things than that simple G-Code based report that you saw. So
19 we're making efforts to download if you will, or figure out how to download certain elements from those
20 databases to populate our own measures here at CMS. So at least those two ways we're looking to connect.
21 Now in the future, as the, it's not so much CMS, but as the Secretary's office, Office of the National
22 Coordinator of Health Information Technology, I think the name's been changed somewhat, but as that
23 work progresses for interoperability, we'll have a lot more options to how your system can communicate
24 with a number of other systems out there, whether it's CMS or your hospital you use, or other payers or
25 whatever, but right now, as you know, that interoperability problem hampers some of the things that we
26 would like to be able to do.

27 Dr. Bufalino: Thank you.

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1 Dr. Przyblski: Although I applaud the interest of CMS in using AQA and NCQA,
2 adoption/endorsement, rather than having it sort of a mad foray of different measures, I would suggest that
3 not everyone is necessarily happy with things that are AQA endorsed, and I think, speaking for some of the
4 surgical subspecialties, they sometimes feel that their voices are not very well heard, and obviously there's
5 been an emphasis on more medical practice measures rather than surgical practice measures, but even the
6 couple of surgical practice measures anabolic, prophylaxis, and DVT prophylaxis, there is not a lot of data
7 and I'll speak specifically for neurosurgery that supports use of either of those for many of the things that
8 we do and it's just simply been extrapolated based on its effectiveness in one particular area of medicine,
9 but not necessarily neurosurgery. So I would just caution that just becomes something's AQA adopted does
10 not necessarily mean that the specialties believes that it should be, and to please keep open dialog with
11 specialties to understand those differences.

12 Dr. Valuck: Yes, thank you. That comment sort of sums up a lot of what I've been doing over the
13 last six months. One thing that I would say is that it appears that some of that gulf between what, let's be
14 honest, started as ambulatory care quality alliance, now the AQA Alliance, and the surgeons started their
15 own quality alliance, that there's been some lessening of the gulf that existed between those quality
16 alliances. The other thing that I would say about the surgical quality alliance is because of the nature of
17 surgical practice and the relatively quick outcomes information that you can get from a surgical practice,
18 versus primary care practice that may be looking at chronic illnesses that are treated over long periods of
19 time, well, sometimes until death, unfortunately, but the idea that the surgeons may gravitate more toward
20 this data registry or this outcome, health data base outcomes type approach, which is why we want to really
21 open that opportunity up broadly because not only does it give us better information than something like G-
22 Codes, but it's different than the way a medical practice might be construed, where processes of care are
23 really what you're trying to accomplish with the patient in hopes of sustaining or improving care, whereas
24 the physician might have the outcome in hours, if not days or weeks, so we recognize that there are
25 differences there and we're trying to open avenues to the various, I would say, affinity groups of medical
26 specialties. I mean we can't have 39, there are 39 designated Medicare physician specialties. We can't have
27 39 reporting programs unless we can figure out how to do it electronically, then we'd have lots of options.

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1 But in the meantime, maybe there's some affinity groups. Maybe we start with medical and surgical and
2 have a couple different pathways and then maybe refine from there. It's a possibility.

3 Dr. Senagore: I just have a recommendation and then we can excuse Dr. Valuck. PPAC
4 recommends that CMS determine the relative benefits of pursuing a G-Code submission process in light of
5 the considerable benefits associated with the episode grouper methodology.

6 [Second]

7 Dr. Senagore: Any comments? Questions? Call the question. All in favor? Great. Well, thank Dr.
8 Valuck. We have a gap. Our next presenter will not be able to be here today, so we'll take a 15-minute
9 break here and then reconvene for the last two. Thank you.

10 Break

11 Dr. Senagore: Continuing on with our agenda, is the Recovery Audit Contract Update. Many of
12 you will recall that our next speakers have briefed us in the past, regarding this. And today we're joined—is
13 Mr. Walters here?

14 Ms. Combs: Out sick today.

15 Dr. Senagore: OK. We have Connie Leonard from the Office of Financial Management in CMS
16 and Melanie Combs, you're replacing Mr. Walters?

17 Ms. Combs: Yes, I am.

18 Dr. Senagore: Congratulations.

19 Ms. Combs: Just for today. Just for today. [laughter]

20 Dr. Senagore: OK. So we'll hear about the progress of the RAC. Thank you.

21 Recovery Audit Contract Update

22 Ms. Combs: Thank you very much for inviting us to come here today. Unfortunately, I have a
23 commitment and I'm going to have to leave early, so I'm going to start the slides and then turn it over to
24 Connie to finish the slides and take any questions. We were here probably six to 12 months ago to tell you
25 about the beginning of the Recovery Audit Contractor demonstration. Today we actually have some
26 findings to share with you. So we'll give you a quick overview about the demonstration. We'll go through
27 some of the findings, talk about a summary and some next steps. Questions for the Council. We'll be giving
28 this slide presentation numerous times to provider organizations over the next few months, so if you can

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1 come up with any recommendations about things that aren't clear in these slides, please let us know. Also,
2 all of the information in these slides today came from a report that we have produced and it's on a website.
3 You'll see the URL in a little bit. If there is data that we have not collected and we have not put in the
4 report, but we should think about putting in the report, please let us know. Or ways that perhaps we're
5 displaying the data that's a little bit confusing; ways that we can improve the data collection in the future.
6 We're open to any and all comments.

7 Quick description of the demonstration. It was mandated by § 306 of the MMA, which required
8 CMS to evaluate the use of Recovery Audit Contractors to identify underpayments and overpayments and
9 recover overpayments. And there are two different types of Recovery Audit Contractors. One are the claim
10 RACs. They do the kinds of things that most of our carriers and FIs and QIOs do regarding medical
11 necessity determinations, incorrect coding determinations, those sorts of things. Then there are the
12 Medicare secondary payer RACs that deal with identifying MSP issues. We will not be spending very
13 much time talking about the MSP RACs today. Focused mostly on the claim RACs. You can see the names
14 of the RACs in the three states where they operate in California, Florida, and New York. The RACs are
15 paid on a contingency fee basis at the top of the next slide, meaning that they get to keep a percentage of
16 what they collect in overpayment. And we have actually added a provision that was not required by the
17 statute, but heard from a lot of provider organizations that in all fairness we really should incentivize the
18 RACs to find underpayments. That was something that was not included in the statute but we found a way
19 to do it, and so the Recovery Audit Contractors are now paid the same contingency percentage, whether it's
20 an overpayment or an underpayment. It's a three-year demonstration running from March of '05 to March
21 '08, and the RACs were given four years worth of claims data and every quarter the oldest quarter falls off.
22 They can no longer touch those old claims but they're also given a new quarter's worth of data. So they
23 always have four years worth of claims data to work with. And we have created a database to exclude from
24 RAC review certain claims, and those are primarily claims that were reviewed by another contractor. If it
25 was reviewed the carrier, if it was reviewed by the FI, the QIO, CRT, if it was reviewed by any one of our
26 other contractors, then it's off limits for the RAC. We don't want multiple medical record requests coming
27 to a provider from different review entities. And of course, anything involved in a fraud investigation
28 would be off the tables for the RACs. They are not looking for fraud. They are looking for other types of

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1 overpayments. In the next slide you can see the very beginnings of our findings. The improper payments
2 that they were able to find. They found \$68.6 million that they were actually able to collect. They wrote to
3 the provider, said this is an overpayment, got the money back and it was put in the bank. You can see that
4 subtracted from that is the \$14.5 million in costs. That includes the contingency fees that we had to pay to
5 the RACS. That includes the money that we needed to pay to the carriers and FIs to process the
6 overpayments as well as some costs that CMS incurred to hire an evaluation contractor and run that
7 database I was talking about a little earlier. For a total of \$54.1 million that went back into the trust fund. In
8 addition to that \$68.6 million that we collected in overpayments, there was an additional \$2.9 million that
9 was paid back in underpayments, as well as in the Q, is what we call money has been identified by the
10 RAC, but it's in some part of the collection process. Perhaps they haven't yet issued the letter to the
11 provider to say please send the money back. Or perhaps they've issued the letter to the provider, but the
12 provider hasn't yet gotten around to sending the check back in. Or perhaps it's somewhere in between or
13 it's waiting at the fiscal intermediary or the carrier. If you add those three numbers up, the overpayments
14 collected, the underpayments paid back, and the money that's in the cue, that comes out to \$303.5 million.
15 The number that's over there on the left, we call the collected number. The number that's over there on the
16 right, we call the identified number, and you'll hear us throughout the rest of these slides talking about
17 dollars collected or dollars identified. The next slide is a pie chart that shows you the total improper
18 payments that broken down by the type of RAC. This shows the MSP RACs didn't find nearly as much as
19 the claims RACs did.

20 The next slide, which is slide number 8, is about the claim RACs only. We're going to sort of quit
21 talking about the MSP RACs. We're going to stay focused from this slide forward on the claim RACs and
22 this slide shows you overpayments versus underpayments. Lots more overpayments than underpayments.
23 Part of the reason that I will share with this group has to do with the fact that E&M claims were off the
24 table. For physician claims that's where we find most of our underpayments is in the E&M world, and
25 because E&M was off the table, Evaluation and Management, Office visit codes were off the table for the
26 RACs for this first year, that's one reason they didn't find as many underpayments as perhaps they
27 otherwise would have. The other reason that underpayments are a little bit lower than you would expect
28 from a random sample. We know this from the CRT Program, where we see that the underpayments are

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1 about 9 or 10% is that, like I said at the beginning, when the program first started, we were not paying a
2 contingency fee on the underpayment side. That did not start until about halfway through the year. Finally,
3 I would add that the Recovery Audit Contractors are all very experienced on their private side in finding
4 overpayments. But nobody has ever asked them to find underpayments. [laughter] This was a brand new
5 thing for them. They had to build the algorithms, they had to build the skill set, they had to figure out where
6 to look for these underpayments. And one final issue I would just raise is that while overpayments you
7 sometimes can find through automated review, in other words, you can find a duplicate payment without
8 even ordering up the medical record or you can find it you can't bill one of these with a one of those
9 without ordering the medical record. You can almost never find an underpayment without ordering the
10 medical record. It's just a lot more labor intensive to find them. So for a number of reasons, the
11 underpayments are significantly lower than the overpayments. I think at this point, I'm going to turn it over
12 to Connie and let her finish the slides and answer any questions and thank you all very much.

13 Dr. Senagore: Thank you for coming.

14 Ms. Leonard: Thank you, Melanie. The next slide breaks it down by state what they collected in
15 the cue and [unintelligible] identified, you can see that California and New York were both in there. \$20
16 millions for Florida, was almost a little under \$10 million. You'll see in a couple other slides, you know
17 why that is. You can see that they all have a lot in the cue, this is for some of the reasons Melanie
18 mentioned. They're someone in the process. They sent a demand letter and they're waiting to hear back
19 from the provider. It's at the fiscal intermediary, their carrier, waiting to be adjusted, so there's lots of
20 different reasons it could be in the cue. The time frame for it in the cue is anywhere from 45 days to
21 probably up to 90. We've had some backlog issues on our carrier Part B side, just because of the manual
22 nature of the adjustment. It is a manual process for the carriers to process these adjustments. There's no
23 automated fashion to complete that adjustment, so sometimes it does take them sometime to actually get the
24 adjustment to occur. I am optimistic about the \$10.4 million in total underpayments that are identified. I
25 believe just watching the data that's probably the last three to six months, which makes sense, given that
26 they had to, one, we had to change their contracts, which occurred in March of '06, and then they had to get
27 up to speed, so I do expect am very optimistic that in the future we will start to see more underpayments,
28 and then we have our total for the claim RACs, which is just under \$300 million.

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1 The next slide breaks it down for you by type. You can see that 90% are inpatient and SNF or
2 outpatient hospital. That's really where the emphasis has been. In the State of Florida, they did start with
3 some physician claims that kind of makes up the 6% and then in California, they've done a little bit of
4 DME, which is 4. The majority of the dollars, as you'll see in just a second and the majority of the claims
5 that have been reviewed have been on the inpatient side, and then next the outpatient side.

6 The next slide is the chart breaking that down by provider type. You'll see that of the total
7 identified, only \$17.9 million is of physicians. Some of that makes up ambulance, labs, or other carriers, so
8 it is not all physician services, equates to roughly a little bit more than 5% of that total \$300 million. What
9 does concern me is the lack of underpayments on the physician side. I'm sure that concerns everyone here,
10 too. One of the questions I was just recently asked by a physician is Can they refer underpayments to the
11 RAC? Well the answer to that is no, they can't refer them to the RAC, but what they can do is refer them to
12 CMS. They can refer them to myself or Melanie, and then we will take that issue to the RAC. So it is not a
13 total no you can't refer it to the RAC, but we just want you to come through CMS. What we don't want is
14 the RAC being inundated with you know, tons and boxes of medical files. We want them to come to CMS,
15 and I've talked to several providers during the demonstration have no problems. If there's ever an issue,
16 they're always very, very helpful in trying to let us know what that issue is, so the same goes for an
17 underpayment. If they know of an underpayment, if they would let us know, then we will make sure we let
18 the RAC know, so that we can get those medical records reviews and get the monies back to the physicians.

19 Other than that, I think this is pretty self-explanatory. You can see, again, we only collected the
20 \$3.2 million in from physicians in the underpayments. That's primarily all in Florida. There was maybe
21 half a million in the state of California. For the most part, even in the cue is primarily California and
22 Florida. The state of New York is just really getting into the process. We will be seeing some letters for
23 them very soon.

24 Dr. Przyblski: Before you go on, can I ask you a quick question about in the cue, what do you
25 mean by that and how many in the cue actually get translated to collected?

26 Ms. Leonard: I would probably say about 75%. Some of those may turn out to not be
27 overpayments at all.

28 Dr. Przyblski: It's a little inflated here, then.

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1 Ms. Leonard: It is, yes, because you don't really know. And that's kind of why we're always very
2 careful to make the distinction between collected and identified. Because a collection, obviously we have
3 already collected that. That is a true number we can report. The identified number, it's a little iffy from my
4 perspective because you don't know. It could end up to not be an overpayment at all. Exactly correct.

5 The next slide talks about the average overpayment per provider, and sometimes per letter. You
6 can see from a physician, we're at \$135 in the state of Florida and \$216 in the state of California.
7 Relatively low, obviously compared to the outpatient and the inpatient sides, but of course, the dollar
8 amounts of those services are much more also. As I state, in New York, there were no letters released at the
9 time of the report and that's why we do not have a number there. The next slide talks about the appeal
10 information. The future reports, as we go into '07 and then '08 status report, will have more appeal
11 information. This year we only included the numbers of appeals because really the demand letters started
12 going out last October and November, and we're really just now collecting that appeal data because of the
13 time frames allowed for an appeal. So there was 1,463 appeals for physicians in the state of Florida. It's
14 roughly 2 to 3% of the number of claim lines they actually reviewed and sent demand letters out on. In
15 California, because the number was so small, there was only 20. Now we expect next year to really be able
16 to talk about not only the numbers of appeals but the numbers that were found to be in favor of the
17 provider, also the numbers at the different levels, be it the redetermination or the QIK or the ALJ because
18 while the RAC may only be interested in the first level of appeal, the redetermination, because that
19 determines if they get paid or not, CMS is always interested in the QIK level and the ALJ level, and we
20 analyze that right now because even if something is being upheld at the redetermination level, but then
21 overturned level at the QIK level, it's something that we need to go back and maybe the RAC is doing
22 something that they should not be in their overpayment identification. So next year we believe we'll be able
23 to include a lot more data from an appeal perspective.

24 The next couple of slides gets into some examples of some the overpaid DRGs and the next slide,
25 which is some of the HCPCS-Codes. These are all inpatient and outpatient codes, so we have them here
26 just for your information. We do expect that in future reports we'll be able to also include a slide for
27 physicians. One of the reasons we weren't able to this year, well, it was only in the state of Florida. And
28 even in the state of Florida, we do have a couple of issues; a couple of problems that came up along the

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1 way that we quickly fixed, and we came about because of providers calling us, physicians calling us and
2 letting us know, calling their Florida medical association, calling their carrier, which is First Coast down
3 there, and so the data that we actually have for our physicians is so limited, you know, some of the issues
4 that they worked on in Florida was the multiple surgeries. In the state of California, it was really just
5 duplicate claims for physicians, and then they did some ambulance claims, so the data that we do have for
6 our physicians is so limited that we don't have it segmented out this year, but in future years we expect to.

7 Again, these are just some of the HCPCS-Codes. I will say some of the things we're looking at in
8 the state of New York as in these examples of the overpaid HCPCS-Codes, it's a number of units. They'll
9 look at some of the drugs in what they should be billed, and how many units are coming in or time services,
10 one of those types of things that we've seen, that they're looking at in the state of New York, though no
11 demand letters have been issued yet. So a couple of examples of what they're looking at across the board,
12 but again some of these codes fall for outpatient.

13 We're been about 16 months left of the demonstration. We think we have identified that RACs can
14 identify overpayments and underpayments, you know that was one of the main issues of the demonstration;
15 can Recovery Auditing work in Medicare? We do think it can work. I do think there's still a lot of hurdles
16 to overcome; what type of, different types of things that do work and don't work in Medicare with the
17 Medicare environment. So it certainly is by no means a perfect process. We've had some technical and
18 procedural hurdles. We think we've been fixing some of them. Some of them require system changes,
19 which everyone knows takes a long time. Some of them, we get back to provider education and it's just a
20 means of you know, how do things work and education for the RACs about how to do things in a Medicare
21 environment. But overall, we do think it has been working, at least for the little bit of time that they have
22 been doing it.

23 Some of the next steps. We released the status document. It is out there. The website will be in in a
24 future slide. Right now, we are analyzing the findings. We're working with the RACs, we're working with
25 the carriers, the QIOs and everyone involved, the central office policy experts, the regional office, to really
26 try to analyze these findings to develop a corrective action plan. And we probably are thinking about
27 coming up with different terminology. Because when we think of corrective action plan, a lot of people
28 around CMS think oh, what did the RACs do wrong? What did they have to go and fix? And really, we're

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1 talking about provider education. What do we need to go out and do so that we can pay that claim right the
2 first time? And we expect it to be very detailed and state specific. Now we do have a couple of issues that
3 we've seen in two or three of the states. Those might be things that we can handle in an MLM Matters
4 article. I think we have two or three things that we'll be able to do on a national basis with those. Some
5 other things might be working with the local carriers, the local FIs, to do some local edits on their end; to
6 fix some issues. And we're also seeing some issues where maybe CMS fixed the problem in 2004 but the
7 order claims did not go back and get adjusted, and the RACs see this and they'll find overpayments to a
8 certain point in time, and then they know that either CMS or the local carrier already fixed that problems.
9 So there's going to be some things that CMS already fixed, and there's going to be some things that CMS
10 needs to go forward and do. It could work out that we need a new edit. You know, maybe there's a need
11 and we will try to get those through. It may be a national edit. It may be a local edit and it may just be
12 different types of provider education. And that's another thing that we're always open if for different types
13 of provider education, if you ever think of something that CMS could do differently, we're certainly open
14 to hear your ideas.

15 I think the next page is our contact information; Melanie's and mine. We're always willing to hear
16 from any physician that has a problem with the RAC program. I've talked to several. I know they feel
17 comfortable in talking with their medical associations, the national AMA. We talk to all of them on a
18 regular basis. And if they ever have a problem, what we don't want is them to think that they don't have
19 anywhere to turn. We want them to contact the local associations, they can contact CMS, they can contact
20 their carrier, but their carrier might tell them to contact the RAC, and if they've already contacted the RAC
21 and they're not getting what they need, then we want to know about that. That's something that we can take
22 care of very, very quickly, and as I said before, providers, physicians have been wonderful in letting us
23 know right away when there is an issue, and we've been able to take care of it without it turning into a big
24 issue. Also if we know about these small issues, we can keep them out of the appeal process, which then,
25 we don't want the providers to have that extra cost of going through the appeal. Did you have a question or,
26 oh, I'm sorry. The next page is our website. This is where the status document can be found. We also have
27 links to the MLM Matters articles. We have three or four out there on the RAC, as well I believe we have a
28 link to the statement of work requirements of the RAC, so it is a helpful site to find a RAC information.

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1 And the last page is questions for the Council. I'm going to add one here. Again, I'll try to answer any
2 questions you may have. As Melanie stated, we're going to be using this slide presentation probably for
3 some time, so if there's anything that doesn't make any sense, please let us know. As well as with the RAC
4 status document, this was the first one we've completed for the Recovery Audit Contract demonstration, so
5 if there's a piece of data that we didn't get and I didn't mention here today, let us know. If it's too
6 complicated, are the charts with all the numbers not easy to make sense of, is there not enough? Too much
7 information in the report? Things that we want to know to make it more user friendly for everyone. One
8 idea or comment that was recently told to us was in the future when we release Fiscal Year 2007 document,
9 to update Fiscal Year 2006 document with appeal information. Certainly is an idea that we believe we can
10 do. The collected number that we reported this year did take account for any appeals that were already
11 finalized, so if the provider or physician won that first level appeal, we already subtracted that amount out,
12 so we will we plan to go back on the '07 report and update the '06, so we do have an accurate collection
13 number for 2006. And with that, I will turn it over to questions.

14 Dr. Senagore: Comments or questions?

15 Dr. Azocar: I was going to, the question is, what's the difference between this RAC and the audit
16 that has been conducted before in the previous years?

17 Ms. Leonard: Well, prior to this demonstration, all of the medical review was either completed by
18 the carriers, the FIs, a little by the CRT Program, or by our program safeguard contractor. What the RAC
19 brings to CMS is the ability to review more claims. Our carriers were limited by the number of claims they
20 could review. And the recovery auditor, because they don't necessarily receive any budget from CMS, they
21 have an at-risk contract, they only get paid by what they collect on. It's not a no-cost issue to CMS,
22 obviously, we have some administrative costs, but it's not as much as we would have to pay our FIs or
23 carriers, or another third party contractor flat fee to do this type of review. They review 100% of the claims
24 through their computer systems. Now obviously they don't do medical record review on all of those. They
25 do pick a sample of their claims, so it's just they're reviewing more claims than CMS claims, as well as
26 some older claims. A lot of times, you'll see CMS you know release edits of some sort, and we'll do it, and
27 we'll do it going forward. A lot of times that reason is because there just isn't enough budget to go
28 backwards. And we hear about this a lot of time from the OIG when they go and they do some types of

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1 investigations, and they want us to go back and sometimes we can't, so it just gives CMS the ability to
2 review more claims.

3 Dr. Azocar: And I remember when there was a proposition from the PPAC to meet the ones for
4 legal expenses that the physician has to use to take care of this audit. What's going to be returned or
5 included in that amount of money? That's one thing I remember two or three meetings ago, there was a
6 proposition that the legal costs that a physician had to, the money that the physician had to spend in the
7 legal would be included in the money to be discounted or something like that. Do you remember that?

8 Ms. Leonard: That's an interesting proposition. I don't know if I remember it off-hand, not
9 necessarily that it wasn't there. You know, we do and it may not even be just for RAC overpayment, I'm
10 sure physicians have fees for every type of overpayment, but that may be out there. Right now, we're just
11 really trying to focus on what we can find from an underpayment perspective. I'm sorry, that's the one
12 question I wanted to add. I mentioned I wanted to add a question for the Council. If you guys know of any
13 underpayments out there, please let CMS know, obviously, they must not be E&M, because the RACs are
14 not looking at E&M. There's no, I don't believe they will look at E&M through the end of the
15 demonstration, so if you know of other areas, you know if there was some way to pay physicians back for
16 their costs you know with that appeal, I'm not necessarily sure how we would work that. It's an interesting
17 proposition, though. I'm sure physicians would really appreciate that type of proposition from CMS.

18 Dr. Williams: You mentioned earlier in your presentation that the underpayments take a
19 significant amount more labor. I guess they're more labor intensive. But you pay the same percentage in
20 incentive. Why would one of the RACs want to look for underpayments if there's more work for the same
21 amount of money?

22 Ms. Leonard: Well, one of the first reasons is because there's no appeal. They don't have to worry
23 about doing all that work and then losing on that first level of appeal, and so that is an advantage to the
24 RAC, because you know once they get paid, they know that they've gotten paid. Now, I will say on the
25 inpatient side, we have had a couple of providers who have not wanted the underpayment, and we will refer
26 to that provider and we will not pay back that underpayment. Another reason is because they get a certain
27 percentage for an overpayment finding, and then depending on how CMS collects that, we may break that
28 in half, 50% depending on if we take it back by offset, or if we send a check in and that restriction is not

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1 there for an underpayment. They get that full percent for CMS paying that back. So we do that there's
2 financial incentives and I believe the RAC also believes that because we can see as they start to change
3 their algorithms and change their processes so that they can identify underpayments.

4 Dr. Bufalino: Just as a suggestion for you, looking at this, since only 6% of this is physician plus
5 ambulatory plus lab sounds to me like maybe we should stop worrying about the physicians in this little
6 project and worry about the hospitals in terms of the RAC. Since it looks like they're a pretty small piece of
7 the pie.

8 Ms. Leonard: You're exactly right. They are a small piece. And you know, we let the RACs
9 determine what they could identify. And I would suspect that the dollar amounts of the claims of the
10 physicians versus the inpatient probably have dictated why, the dollar amounts and market forces may
11 drive that suggestion in itself.

12 Dr. Ouzounian: It's the slide on page 6. You have two number listed. One is the recovery from the
13 providers. It says \$216 per provider for the fiscal year '06. Is that per provider where there was a problem
14 identified, or per provider licensed in that state?

15 Ms. Leonard: That is per provider number. So a per physician number, so that provider, the
16 average overpayment amount per provider and they may have received you know, 15 letters from the RAC
17 over the whole entire year, but the average per provider was \$216 for the state of California. Now the state
18 of Florida, I have a per letter number and it was, that's per letter, so for example, if a physician received ten
19 letters over the span of the year, the average was that \$163, I believe.

20 Dr. Ouzounian: I would submit as Dr. Bufalino has just said, that the error rate by physicians is
21 extremely small. I mean you're looking in \$200 in errors per physician and that's a pretty small number.

22 Ms. Leonard: You're exactly correct.

23 Dr. Grimm: Just one thing, in terms of your preacher presentations you might explain to
24 particularly the physician groups what the RAC is, who are these people? Are they independent or are they
25 dependent on Medicare? Are they Medicare subsidiary, how do they get paid, what are these contingency
26 fees? This seems like a business that seems really good if you get a certain percentage of \$54 million this
27 would be a pretty good business. However you realize of course pretty quickly that once you cast the net,

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1 you catch all the big fish and there's gets smaller and smaller with time. So people would be interested in
2 that kind of thing.

3 Ms. Leonard: OK, that's good to know. More information on the program and on the RACs
4 themselves. Thank you.

5 Dr. Senagore: Any other comments, questions? Thank you, Ms. Leonard, appreciate it.

6 Ms. Leonard: Thank you. Thank you for having us.

7 Dr. Senagore: OK, I believe now, we have a presentation for the AMA and then we can—I think I
8 talked to most of the Panelists—it's OK if we run the recommendations around by email again, and if
9 there's any later comments and then I'll submit them if we all agree. [off mike discussion] OK

10 Public Testimony: American Medical Association

11 Dr. Senagore: And I believe today we have Dr. Stephen Permut from the AMA to make some
12 comments to the Council. Welcome, Dr. Permut.

13 Dr. Permut: Good afternoon. Thank you. Thanks for having us. Mr. Chair and members of the
14 Council. I'm Steve Permut, a family physician practicing in Philadelphia and Chair of the AMA Council on
15 Legislation. Today, I'd like to discuss an urgent matter: Medicare Physician Payment cuts under the
16 Sustainable Growth Rate, or the SGR. Medicare will cut physician payment rates by 5% on January 1st,
17 2007 and that's not all. The Medicare trustees project almost 40% in cuts over the next 9 years, yet medical
18 practice expenses will rise by about 20% during this same time period. These cuts follow five years of
19 payment rates that lag well behind increases in medical practice expenses with payment rates in 2006,
20 about the same as they were in 2001. These cuts will be further exacerbated by several Medicare payment
21 policy changes, also slated to occur in 2007, which are discussed at length in our written statement. These
22 changes, combined with the 5% cut for 2007 mean that nearly half of physicians nationwide will face cuts
23 of between 6 to 20% in 2007. CMS could have helped alleviate the impact of these changes somewhat.
24 CMS is required to implement revisions to the work relative value units for 2007 on a budget neutral basis.
25 Despite nearly unanimous objections from the physician community, CMS is applying the budget neutrality
26 adjustment in a manner that will permanently remove about \$200 million from physician services funding,
27 and will reduce payments for most physicians by about 5.5% on top of the 5% cut as a result of the SGR.
28 We urge PPAC to recommend that CMS work with Congress to help physicians by averting the 2007 cuts

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1 and implementing a positive payment update that at least covers increases in physician practice expenses.
2 Further CMS should work with Congress to repeal the SGR and replace it with a system that adequately
3 keeps pace with annual increase in medical practice expenses. A stable payment structure is vital for
4 physician participation in quality improvement initiatives, such as the Physician Voluntary Reporting
5 Program or the PVRP. Other factors are also vital for improving the PVRP. We commend CMS for
6 working this year through the physician consortium for performance improvement to collectively develop
7 physician performance measures. This work has allowed CMS to significantly expand the measures
8 available to the PVRP, by involving practicing physicians representing the more than 100 specialty and
9 state medical societies that make up the consortium. The AMA hopes to continue this partnership. Our
10 shared efforts can improve the PVRP. We are concerned, however, with the CMS release last month of
11 proposed measures for the 2007 PVRP. In that document, many of the measures lacked specificity, and
12 other measures had incomplete descriptions. In addition, problematic 2006 PVRP measures were included
13 in the proposal. We expressed these concerns in a recent letter to CMS and are optimistic, as CMS has
14 since been open to working with the AMA and the specialties to resolve any outstanding issues. We look
15 forward to seeing a corrected list of measures from CMS and to providing additional comments at that
16 time. Further, the AMA's concerned that CMS recently directed Medicare Quality Improvement
17 Organizations, or QIOs to independently develop or facilitate measure development for the PVRP. This
18 work has already been accomplished over the last six years through the consortium in a rigorous and
19 transparent process that to date, has resulted in development of 151 measures. And work on new measures
20 will continue at a rapid pace through 2007 and beyond. The AMA urges PPAC to recommend that instead
21 of attempting to replicate the work of the consortium, CMS should further direct QIOs to pursue their
22 current complimentary responsibilities. The AMA would welcome the help of the QIOs to test measures
23 and assist physicians with PVRP implementation issues. It is our desire to work together with QIOs in a
24 collaborative fashion. Last, I would like to address issues related to Ambulatory Surgical Centers. The
25 AMA commends CMS on its efforts to implement the new ASC payment system. We have several
26 recommendations however that we urge PPAC to make to CMS for improving the system. First, CMS
27 should consult with the physician community to develop new more flexible criteria for determining
28 whether a procedure may be safely performed in an ASC. And they should be based on a physician's

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1 clinical judgment; second, CMS should adequately cover the cost of lower intensity services if performance
2 in a ASC is more appropriate than in a physician's office. Finally, CMS should apply payment policies
3 uniformly to both ASCs and hospital outpatient departments. We are pleased that CMS is moving forward
4 with adoption of a new ASC payment system, and we look forward to working with CMS to appropriately
5 refine this new system. We thank you for the opportunity to be here today.

6 Dr. Senagore: Thank, Dr. Permut. Any questions for Dr. Permut? Great. Thank you.

7 Dr. Permut: Thank you.

8 Additional Recommendations

9 Dr. Senagore: Be able to take a couple minutes for recommendations that people want to make
10 now? Dr. Powers?

11 Dr. Powers: I have three. Number one, and this is, I have two rehashed ones, and one new one.
12 PPAC recommends that CMS change the calculations to use the unadjusted work RVUs in calculating
13 indirect practice expense before implementing the 2007 Physician Fee Schedule.

14 Dr. Senagore: Second? Any questions? Comments? All in favor? Passes.

15 Dr. Power: My second one is relative to the discussion in the AMA report about the SGR. And
16 once again, PPAC recommends that CMS use its statutory authority to remove the Medicare covered drugs
17 from the SGR.

18 [Second]

19 Dr. Senagore: Comments? All in favor?

20 Dr. Power: And just in comment, we've brought that up before, but I understand that we, the legal
21 documentation is now there and maybe it wasn't there before, I'm not sure.

22 Dr. Senagore: There was a legal review, but we'll hear about I think at the next meeting.

23 Dr. Powers: Right. OK. The third one, PPAC recommends that CMS adjust the SGR to account
24 for increased spending due to national coverage decisions, just as it does for Medicare Advantage
25 payments.

26 Dr. Senagore: Second.

27 [Second]

28 Dr. Senagore: All in favor? Doing OK, there Dana? OK. Greg?

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1 Dr. Przyblski: Just one, PPAC recommends that CMS support the development of outcome
2 databases as an alternative to performance measures in the agency's quality and cost measure initiative.

3 Dr. Senagore: Second.

4 [Seconds]

5 Dr. Senagore: All in favor? Anybody else? Seeing none, I want to thank everyone for their hard
6 work today and thank all the presenters for their excellent presentations. Have a Happy Holiday Season.

7 Thank you. The next meeting will be March 15th—5th, 05.

8 Adjourn

9