CENTERS FOR MEDICARE AND MEDICAID SERVICES

PRACTICING PHYSICIANS ADVISORY COUNCIL

Hubert H. Humphrey Building
Room 505A
Centers for Medicare & Medicaid Services
200 Independence Avenue
Washington, D.C. 20201

Monday, December 7, 2009
8:30 a.m.

Council Members in Attendance

DR. VINCENT BUFALINO, *CHAIRMAN*
DR. CHILEDUM A. AHAGHOTU
DR. JOHN E. ARRADONDO
DR. JOSEPH GIAIMO
DR. ROGER L. JORDAN
DR. JANICE A. KIRSCH
DR. TYE J. OUZOUNIAN
DR. JEFFERY A. ROSS
DR. JONATHAN E. SIFF
DR. FREDERICA SMITH
DR. RICHARD E. SMITH
DR. ARTHUR D. SNOW
DR. CHRISTOPHER J. STANDAERT
DR. KAREN S. WILLIAMS

CMS Representatives

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Kenneth Simon, M.D., M.B.A.
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Barry Straube, M.D.,
Chief Medical Officer,
Director, Office of Clinical Standards & Quality

Public Witnesses

AMA
[via written document]

MS. DANA TREVAS, Rapporteur
Magnificent Publications, Inc.

AGENDA

Open Meeting

Dr. Bufalino: Good morning and welcome to the Practicing Physicians Advisory Council. My name is Vince Bufalino. I'm the chairperson of the Council, and would like to welcome you to the 70th meeting of the Council and that we're looking forward to a meaningful dialog today. I'd like to begin the morning by introducing two new council members to the organization, Dr. Chi Ahaghotu—I'm not close.

Dr. Ahaghotu: Ahaghotu.

Dr. Bufalino: Ahaghotu. We'll keep practicing. Welcome. Chi is the Chief of Urology at Howard University here in Washington, and we're glad to have you. Thank you for joining. And then we have Dr. Richard Smith, OB/GYN from Detroit, Michigan. He's the Chief of Obstetrics at the Women's Health Center at Henry Ford Hospital. We're pleased to have you join us. Thank you for being here today. We look forward to this opportunity. We hope to give you a chance to get comfortable with the presentations and conversations. Please be comfortable to ask questions and provide feedback as you're comfortable with. This afternoon, Charlene Frizzera, who is the Acting Administrator, will be swearing both of you in after lunch, and so we look forward to your smiles in the pictures. As always, I thank all the council members for taking time out of your busy schedules and willing to travel here to Washington to provide some guidance around the issues that CMS is facing and hopefully to take your practical day-to-day experience from your practices and provide candid observations about some of the projects that are being planned. Today's agenda is quite full, as you know, we have a number of topics, ranging from the 2010 PQRI, and E-prescribing Update to an awaited update on Physician Resource Use Measurement, along with the Quality Improvement Suite, the 10th Scope of Work, the Final Rule on the Medicare Fee Schedule, along with an update on OPPS and the Ambulatory Surgical Center Fee Schedule. We are going to postpone the Fraud & Abuse presentation today. That will be on the March schedule. As always, we are glad to have our presenters from CMS, and welcome you to the program today. Before I begin, anybody have any questions or concerns before we start the morning? Having none, let me begin with mentioning that Mr. John Blum, who's Director for the Center for Medicare Management, is traveling this week, and so we're missing him, so we have the delightful pleasure of having Liz Richter make some comments. We always try to get Liz to make some comments. But Liz is the Deputy Director of the Center for Medicare

Management and we're thrilled to have her, and joining her today is Dr. Barry Straube, who is the equivalent of the Chief Medical Officer and I'm never good with the titles, but I'm learning, and so we're glad to have you with us as many of your folks will be presenting here this morning. So without further ado, Liz?

Welcome and Opening Remarks

Ms. Richter: Good morning, everybody. I promised that I would say more than my one sentence, since John's not here, but it's not going to be much more than two. Just to say thank you for coming and one of the reasons I always try to keep my remarks brief is that what we really get out of this and what makes this really valuable for us is hearing from all of you, and I think we've got a good varied agenda today, the usual sort of updates and then basically spending the morning on a lot of different facets of the quality agenda. Barry is the Director of the Office of Clinical Standards & Quality, as well as being the agency's Chief Medical Officer. He and his folks and some of ours are going to talk about various aspects of that, including the Quality Improvement Agenda, Quality Measurement, and also an update on the Resource Use Measurement project that you last heard about, I think, two meetings ago, was the most recent presentation on that, and we'll be updating all of that. And this afternoon, focusing on the two Final Rules that had a lot of provisions, that I am sure, based on the presentation on the proposed rule are of great interest to you and we're really looking forward to hearing your input on where the policies for 2010 ended up being. So I would just again, like to say thank you. We really do find these useful. And they're at the most useful, the more we hear from you. And with that, Barry, I don't know if you want to say anything to start?

Dr. Straube: Well, just my greetings to all of you also. I've met a number of you, although not everybody in this room. I think this is especially appropriate time to be having a PPAC meeting, as just literally several blocks from here, there's intense discussion that's going to affect the physician community as well as other stakeholder communities. And although we'll be talking about specific updates and initiatives that are ongoing right now, I think that the comments from this commission are always very helpful insofar as we have some areas of discretion in interpreting legislation and statute that gets presented to us. So even though we don't know what healthcare reform will entail, I think some of the comments that

you'll make today will be helpful to us as we decide and determine how that legislation, whatever it is, is implemented going on. I might add, too, that everybody's focused on healthcare reform legislation, but there's a whole series of statutes which have passed in the last several years that we're still implementing here, too. You'll hear about some of those activities in presentations today. But again, we need help input on those. And I might just give you a teaser that the High Tech American Recovery and Reinvestment Act of 2009, which is largely related to incentives for adoption of electronic health records in physician offices as well as hospitals, that we will be having a proposed rule coming out soon, and that's something people ought to keep their eyes open for and certainly provide comment when it does come out. So again welcome from my standpoint. If I can do anything for you, please contact me, not just at this meeting, but any time, and I'll send it back.

Dr. Bufalino: Thank you, Dr. Straube. Appreciate the comments and glad to have you join us this morning. I just want to take a moment as a special thank you to Liz, who without fail, makes every one of the meetings in all the time I've been here, she has been at every session. So we're thrilled to have you involved in this process. Thank you for being here. So moving forward, we'll move on to the next agenda item, which is the PPAC Update, and we ask Dr. Ken Simon, who's the Executive Director of the Practicing Physicians Advisory Council and Medical Officer here at the Center, to present his remarks. Ken?

PPAC Update

Dr. Simon: Good morning, Council. Recapping the events from the August 31, 2009 meeting, Agenda Item H: Physician Fee Schedule Notice of Proposed Rulemaking. 69H-1. PPAC recommends that CMS fully implement the data from the American Medical Association's Physician Practice Information Survey to more accurately calculate practice expense relative value units, and more fairly calculate reimbursement for all medical specialties. The data should be fully implemented in 2010. The response: The response to this recommendation is outlined in the Medicare Physician Fee Schedule Final Rule, published in the *Federal Register* notice on October 30, 2009. We will thoroughly address this recommendation during the Medicare Physician Fee Schedule presentation at today's meeting.

69H-2. PPAC recommends that CMS review the AMA Survey Extrapolation of Geographic Data when it becomes available. The CMS response: The Physician Practice Information Survey was not designed to capture geographic cost differences. It was designed to collect national practice expense data that could be used for the allocation of direct and indirect practice costs. CMS purchased certain specialty level aggregate cost survey data from the AMA under a separate contract. To the extent the AMA would consider making geographic cost data available to CMS, it would be reviewed and considered along with any other information provided.

Agenda Item 69H-3: PPAC recommends that if CMS decides to form a supervisory body to oversee the AMA Relative Value Scale Update Committee, PPAC be considered as the appropriate group to perform that role. The response: The response to this recommendation is outlined in the Medicare Physician Fee Schedule Final Rule, published in the *Federal Register* notice on October 30, 2009. We also will thoroughly address this recommendation during the Medicare Physician Fee Schedule final presentation at today's meeting.

69H-4: Any move to decrease compensation for consultative services will adversely affect access to these services and severely affect the quality of care for beneficiaries, therefore PPAC recommends that CMS reevaluate studies that determine the actual cost of providing consultative care and provide the findings to PPAC. As previously noted, the response to this recommendation is outlined in the Medicare Physician Fee Schedule Final Rule published in the *Federal Register* notice on October 30, 2009. We will also address this recommendation during the Medicare Physician Fee Schedule presentation at today's meeting.

69H-5: PPAC believes 1) recent CMS statements questioning the quality of current academic anesthesiology practice are unfounded, and 2) that the intent of section 139 of the Medicare Improvements for Patients and Providers Act of 2008 commonly called MIPPA, was simply to restore full payment to academic payment anesthesiology training programs, based on current practice. Therefore, PPAC recommends that CMS implement section 139 of MIPPA without the additional criteria requiring that only one individual teaching anesthesiologist, the one who initially started the case, be present during all of the key and critical portions of the anesthesia procedure. The response to this recommendation is outlined in

the Medicare Physician Fee Schedule Final Rule published in the *Federal Register* notice on October 30, 2009. We will also address this recommendation during the Physician Fee Schedule Final Rule presentation at today's meeting.

Agenda Item K: Fraud & Abuse Update and Recovery Audit Contractor Update, 69K-1: PPAC recommends that CMS provide to PPAC at the next meeting statistics on fraud and abuse involving physicians in the Medicare program. The response: When CMS or its contractors have reason to believe that potential fraud exists, the agency refers such instances to the OIG to further investigate and determine if fraud has occurred. CMS cannot make a determination of fraud but can only ascertain if there is potential fraud and then refer cases to the OIG and the Department of Justice, the DOJ, for a final determination and further action. Potential fraud with physicians has not been a significant issue for CMS. CMS does not maintain data or statistics specific to physicians pertaining to fraud and abuse. Our fraud investigations have been focused primarily on the type of service rather than the type of provider.

69K-2: PPAC recommends that CMS provide PPAC information on its mechanism for oversight of investigations by RACs and the guidelines for when investigations should be terminated when no problems are found. The response: The RAC statement of work included many changes that CMS will use to monitor a RAC's performance. The RACs typically do not complete investigations, but when necessary provide their findings to the program integrity group for their consideration and determination of next steps. The RACs review claims data to determine the probability of an improper payment. Sometimes, this can be completed without medical record review and sometimes additional documentation is necessary. The RACs must have all new issues approved by CMS prior to review. Part of the approval process is the review of the edit parameters being used by the RAC. CMS agrees with PPAC that a review should not continue or even begin if improper payments are not probable. At this time, there are no set limitations on the RACs regarding when a review should cease. Since the RACs are paid on a contingency basis, it is not cost-effective for the RAC to continue to request documentation on claims that do not have a high probability of an improper payment. In addition, CMS believes that the medical record requests limits prohibiting the RAC from reviewing a large percentage of a physician's records. However, as the program

expands nationwide, CMS will monitor the impact of complex medical review on physicians, to determine if other limits need to be put into place.

Agenda Item 69K-3: PPAC recommends that CMS establish a neutral arbitrator at CMS outside of the RACs to whom physicians or other providers can appeal for assistance when a RAC investigation seems unreasonable. The response: If a provider disagrees with the RAC claim determination, the provider should contact the RAC. The RAC information can be found in the URL addresses listed in the report. And it's also posted on the CMS website. If the provider wishes to speak directly with the RAC contractor medical director, the RACs are required to ensure that the RAC medical director is available to speak with the provider. Providers may also utilize the RAC discussion period, which affords the provider the opportunity to refute the initial claim determination prior to funds being recouped. If the provider is unable to resolve the issue by speaking with the RAC staff, the RAC CMD, or through utilizing the discussion period, a provider can contact the appropriate CMS RAC project officer. The chart indicated in the response report provides the contact information for the RAC project officers. In the event the provider feels that a neutral arbitrator is needed, CMS would recommend that the physician appeal the improper payment determination through the administrative appeals process. Information related to the administrative appeals process can be found on the CMS website. The Medicare Administrative Appeals Process is independent from the identification of the improper payment.

Agenda Item M: Wrap-up. 69M-1: PPAC recommends that CMS explain its use for a 10% threshold for attribution of care in its resource utility reports, instead of the 25 to 30% recommended by the Leap Frog Group and the National Committee for Quality Assurance, and the 35% threshold that the Medicare Advisory Commission employed in its analysis. The response: In developing and testing physician resource use reports, CMS is considering a variety of ways to attribute resource use to physicians. We agree that there is currently no consensus on what methodology should be used. For example, as PPAC indicates, MedPac previously published studies using 35% of E&M services as a minimum threshold. However, more specifically, MedPac used a single attribution method with 35% threshold of E&M dollars. That is, if a physician was responsible for at least 35% of the E&M dollars in a given episode, MedPac contributed that episode and all its cost to that physician. MedPac cautioned that

policy makers should not interpret their use of a 35% threshold of E&M dollars as a recommendation. In contrast for the phase I reports, where CMS used a 10% threshold, CMS used a multiple attribution method, in which the total costs were attributed to each physician responsible for the care provided, based on the percentage of E&M services that each physician furnished to the patient. For phase I reports, we chose to test the multiple attribution approach, because it recognizes that treating physicians frequently have incomplete control over treatment by specialists and other physicians. We believe our program compliments the earlier work by MedPac. As we further refine the Physician Resource Use Measure and Reporting Program, we intend to further explore these methodological issues and welcome further suggestions from PPAC, MedPac, and others.

Agenda Item 69M-2: PPAC recommends that CMS provide data on the number of appeals and percentage of overturned cases of RAC determinations by RAC and if possible by the site of the appellant's practice, at least annually. The response: CMS is required to provide an annual report to Congress; the number of appeals by RAC, the number of appeals by MAC jurisdiction, and the percentage of RAC determinations that are overturned will be included in the annual report. CMS may be able to provide information related to the number of appeals and percentages based on the state of the appellant's practice. CMS will explore the feasibility of reviewing the site of service information.

69M-3: PPAC recommends that CMS provide data from the Validation Contractor Reports for each of the RACs at least annually. The response: The Validation Contractor is required to complete an accuracy score for each RAC. The accuracy score will be based on a sample of improper payments identified by the RAC and the accuracy of the determination. CMS will include the accuracy scores, which will be an annual percentage in the annual report to Congress. The fiscal year 2009 Report to Congress will be mostly narrative, focusing on implementation activities. The first accuracy scores will be reported in the 2010 Report to Congress. The report is posted annual to the CMS website after the beginning of the calendar year.

That, Mr. Chairperson, concludes the recommendations and the responses from the August 31, 2009 PPAC meeting.

Dr. Bufalino: Thank you, Dr. Simon. And let me open this for comments and conversation, Council. Janice?

Dr. Kirsch: On item 69H-2, about the AMA extrapolation of the geographic data, I had the AMA report on that. I don't know if you've gotten a copy of it? I can certainly provide that for you. I noticed the comment is made that CMS contracted with the AMA to come up with the report and imagine that in order to interpret that data, you'd probably need more than just a final report. Probably need to petition the AMA to provide all the data that was applied to that for your review, if you are interested in reviewing it further?

Dr. Simon: In our conversations with the AMA, as it pertains to this report, we learned that there was no geographic distribution of the data reviewed by the contractors for the purpose of the report. And so for that reason, that information was not provided to CMS. We indicated that if the data were going to be analyzed, looking at the geographic distribution and also looking at the cost differences geographically, that the agency certainly would be interested in that information so that it could review it in relationship to the information that the agency already has, pertaining to GPCIs. And so when CMS purchased the information pertaining to the survey data from the AMA, none of that type of information was incorporated into the information that was submitted to CMS.

Dr. Kirsch: Okay. Well I do have their analysis reported if you'd be interested.

Dr. Simon: Okay, thank you, and we will share that with the appropriate people in the payment policy section of the agency. Thank you.

Dr. Bufalino: Other comments? Dr. Ross?

Dr. Ross: Dr. Simon, on 69K-1, the recommendation that was made at the last meeting about trying to provide to PPAC at the next meeting the statistics on fraud and abuse involving physicians, I think the intent, the demeanor of that was to try to find the difference between the material fraud and abuse that's occurring out there, versus the physician abuse and fraud that's taking place. Those that are keeping those statistics that have shown us those statistics with various graphs and generalities, have told us that physician abuse is basically about one percent. But we'd like to get more detail on that fraud and abuse that's taking place to the physician, so at least we can demonstrate that it's not the physician fraud and abuse that's occurring, but rather those other individuals, whether it was the hospitals that was shown, or

whether it was the material companies that was shown, and rather than the physicians. So if there's any way that we can get those statistics, I know that they must have them, if we can be presented with that information that might clarify and at least show that the physicians are really not the culprits.

Dr. Simon: As I mentioned in my report, in the conversations I had with the members of the Program Integrity staff, CMS does not store data pertaining to physician activity. When it explores the vulnerabilities for the potential for fraud, it looks at the clinical activities and all of the individuals that are involved. But it does not focus on any specific provider group. It focuses on the type of service that is vulnerable, as opposed to the provider itself.

Dr. Ross: Is there any way that we can get that information reported by the group who's keeping that information in statistics to one of our next meetings?

Dr. Simon: There is no data pertaining to type of provider, as I mentioned in the report. It's the type of services that may be vulnerable that where the Program Integrity group looks at that entire service, and all of the individuals or clinicians that are involved in that service, where it's vulnerable are then reviewed. But it does not store or keep data pertaining to type of provider.

Ms. Richter: I have to admit I've always wondered on this if what's happening is we're talking past each other a little bit. And whether what you're interested in is actually the information that's more around the medical review area than the actual criminal fraud area, and we've been talking, because the words "fraud and abuse" have been used, we've been talking to the folks who work on fraud. But if this is a much broader inquiry, where you're looking at just payment issues, where recoveries are made without a determination of sort of whether it was just a mistaken effort or something else is going on, we can broaden the inquiry and see if they have statistics that sort of reflect more broadly for recoveries whatever the cause, what provider types they're coming from. And that may be something that we've got more information about that we could report back to you next time.

Dr. Bufalino: See one of the sensitivities is unfortunately, whether we like it or not, in the media is this popular notion of fraud and abuse and it quickly gets pointed at the physician, and so in an effort to try to clarify the data to say that they're not the usual culprits and if it's a percentage or low number or something to be able to clarify it, because we're hearing it from the Congress, we're hearing it in the media,

and Mr. Blum outlined the same concern in his opening remarks when he first came to the agency, so I guess from our perspective, there's some sensitivity to at least provide some definition as to, it's one thing to question whether or not the coding was right, it's another thing to have active fraud and abuse.

Ms. Richter: Understood. Maybe what we can try and do for next time, what Ken and I will try and do for next time is have both the medical review area and the more fraud oriented area co-present, so that you can hear sort of the broad picture of what's going on with mistaken payments of whatever cause. And then from there maybe that'll refine the questions and help everybody sort of move past this. Because we don't like telling you that we don't have the information that you keep asking for, either, so maybe a broader discussion like that will get us to the point where we can get closer to where you want to be.

Dr. Bufalino: Great. Thank you.

Ms. Richter: So we'll aim for that for March.

Dr. Bufalino: Other comments about the PPAC report? Thank you, Dr. Simon. We'll move on to the next agenda item. We welcome Dr. Bill Rogers, who's the Director of the Physician Regulatory Issues Team. Dr. Rogers reports quarterly at this meeting. We're glad to have him. This time for a change, we actually have a few meaty issues, so we're glad to have you come and chat with us. Welcome.

PRIT Update

Dr. Rogers: I appreciate the invitation. Thank you, Dr. Bufalino. Oh no. My cartoon got taken off? Oh thank goodness. One of my favorites, too. A little commentary on everybody's waiting room reading material. First real slide. A couple of the issues that we've been working on. This is one of the issues that makes my kids' eyes glaze over. When I talk to them about what I do for the federal government with coding and helping them make the transaction more efficient, they just think it's the most boring thing on the planet. And when I tell them a billion transactions save ten cents a transaction, you're talking real money, it doesn't take the glaze off of their eyes, so, but for me this is really exciting. Medicaid obviously is not a generous payer in most cases, and believe it or not, not all state Medicaid programs accepted automatic crossover from Medicare, and so with a lot of support from the HBMA and MGMA and others, we sought to find out which Medicaid programs were not doing automatic crossover, and three states seem to have had problems; New York, New Jersey, and South Carolina. And New York is now fixed. They are

now accepting automatic crossover claims. New Jersey's fixed, and we're still leaning on South Carolina. But that was really nice to see that happen, because obviously, with a Medicaid crossover claim for a physician, once you draw up the paper, any money that you might have made has been consumed by the administrative costs.

Mandatory fraud and abuse training. This was a complaint that I'd heard from a number of physicians. The MA plans were sending out letters to physicians saying they had to take annual training in fraud and abuse. It seemed like a lot of work and with not very much obvious benefit to be derived, and I'm pleased to say that the proposed MA rules for next year propose that for physicians, enrollment in Medicare be considered as deeming that they have been adequately trained. So if not too many people complain about that change, then presumably the proposed rule will go through and that'll disappear as a requirement for next year. So that was great news.

Treatment of family members. This was, I know Art will be pleased. This was his medical society that brought this issue up. The local carrier had been overly rigorous in interpretation of our instructions, and we were able to clarify for them that when a practice treats a patient who is related to one of the members of the practice, the physician who treats the patient, who is not related to the patient, can be paid for the service. And so their interpretation was that nothing could be paid for. The physician can be paid. However, our interpretation is that no other services can be paid for. And this might be burdensome, particularly in rural areas, where there might be one orthopedic practice, and in other words, that practice cannot be paid for doing an x-ray on a patient because the patient was related to one of members of the orthopedic practice. Not a big deal issue but on the other hand, it doesn't really make sense that there be a prohibition against that, to a lot of physicians, so that's why it's an issue to us. So we fixed the problem as much as we can fix it without changing our rule.

This has been a big issue. AAMC was particularly exercised about this. This is a new policy, a sensible policy in terms of reducing the amount of fraudulent billing that's going on, but a difficult policy on the part of the practicing physicians and on the part of people trying to get paid for these services. We have instructed physicians and those who sell services that physicians order, that initially as of January, we would not pay any claims for services or items unless the physician was enrolled in PECOS, and because it

seemed the deadline was a bit too aggressive, we recently rolled that deadline back to April 24. But it's a hard deadline now and so physicians need to make sure that they're enrolled in PECOS, that the carriers are sending out warning—well, I'm not supposed to call them warning notices—educational notices, when an order comes from a physician who's not in PECOS, which is great, because it warns, it educates the physician that there's going to be a problem come April 24 and we are working to populate PECOS with NPIs to the extent that we can to try and reduce the likelihood that a claim will be denied. And we're developing an online list that will allow vendors and x-ray suppliers and lab suppliers to check and see if doctors who are ordering things are enrolled in PECOS, so it would be up to them to verify that. We're hoping that all physicians who order x-rays, labs, DME, any of those things will either revalidate or enroll, if they're not currently enrolled before April.

I'm continuing to travel a lot. Saw Greg Przyblski at the Spine Society Meeting, Hip & Knee Surgeons, and I've got a bunch of meetings coming up and I think that this kind of outreach is very helpful. It sure is helpful for me, because a lot of times I learn things when I'm talking to physicians in places other than Washington, D.C. Some of the issues, too, that haven't made the PRIT list but that we're working on: We've recently changed the definition of "place of service" and "date of service." And that is going to present some challenges, particularly for radiologists and pathologists, and we also as you know, have recently changed our policy towards consultations, and so I've been trying to help make sure that physicians and everybody else understand what our new policy is about that, and I had the distinct honor of being able to help one of the PPAC members with an individual problem. And that was a delight that that person called me recognizing that I wanted to be of assistance.

And so my last slide, my phone number and my email address.

Dr. Bufalino: Thank you. A bunch of arms go up quickly! Let's start on the right for a change, Dr. Snow?

Dr. Snow: Bill, I want to thank you very much for what you've done so far on that issue, treatment by family members, because I think that at least, is a help for the rural area. 80% of the patients across our state of Kansas are rural physicians, are rural patients that have very few physicians in the area where they are being treated. So I think at least the physicians' partners for treating a family member can get paid. But

it still poses a problem. And you kind of mentioned that CMS would have to change their rules in order to get other payments made; for instance, x-rays, lab, potential hospitalizations, I presume, if these other family members had to be put in the hospital, which seems to be a real problem for the rural hospitals that are in a real money crunch anyway. Is there any chance of CMS doing something more internally to get that process further looked at?

Dr. Rogers: I don't think hospitalization would be a problem. But there would be a problem with x-rays, and labs, and DME, that that practice could not be paid for providing any of those things to a patient who is related to any member of the practice.

Dr. Snow: But if they send it to the hospital to have it done, the hospital could get paid for those services?

Dr. Rogers: Yes.

Dr. Snow: Okay, thank you. One other quick one I've got: How many doctors are not enrolled in PECOS across the country?

Dr. Rogers: We have one here. The total—[off mike remarks]

Dr. Snow: Never heard of this rule, in this group, as we've discussed it. But I'm just wondering how many are you going to have to enroll by April 24? Do we have any idea?

Dr. Rogers: I'm sure there are people that do have an idea and I'll try and find out the number for you.

Dr. Ouzounian: If I can interrupt you. Yes, from the AMA letter, it's around 200, 300,000.

Dr. Snow: I'd like to hear CMS confirm that, if that's true.

Dr. Ouzounian: I have some comments on PECOS. I'm a solo private practice provider in California. I'm a small provider, I deal on paper and there has been no notification of me, I consider myself to be reasonably well-informed, based upon the stuff that I participate in, and there has been no notification on my EOBs. I've got two recent letters; one from CMS and one from my carrier. One is dated November 11, 2009, and received on November 23rd, 2009, one is undated and received on December 2, 2009. There is no comment about my need to enroll in PECOS in any of this. So as a provider, I have not been notified. The only way I found out is through information I received from this organization and others. So if you're

telling us that you're informing the providers that there was this deadline, you're not doing your job. So the concept of rolling this back to April is not realistic. Additionally, you guys have all our data. We've been billing you. I've been enrolled for 20 years. I send in my bills. I get my checks. You have all my data, you have all my information. You know my NPI number. I don't believe there should be a requirement for us to enroll in PECOS. You can transfer the data; you can take care of it. It should not be a burden placed on providers.

Dr. Rogers: I would say my understanding is that the databases that were maintained by the carriers, which have been around for a long time, had become gradually less and less reliable and so the idea of bringing everybody into a centralized database makes a lot of sense and the idea of making the process rigorous makes a lot of sense. But there obviously are issues with our ability to communicate particularly with smaller practitioners, and there's obviously issues about whether it would be reasonable that people like you would be able to enroll by April, even with the PECOS web available, because it can sometimes take longer than 30 or 40 days to enroll.

Dr. Bufalino: Are the things on PECOS—let's just limit the conversation to that for the moment. Go ahead Art, and then Frederica.

Dr. Snow: I'd like to make some comments. I got a letter from my contractor, personally, mid-October, regarding my need to revalidate, which I've been enrolled with them since 1989, and quite frankly I don't think I've ever done anything since then. So I went to the website, pulled off this 34-page form that is totally unintelligible to me, quite frankly. It's taken me 3 weeks to try to get it filled out and I'm still not sure it was done right; multiple phone calls to my contractor person who supposedly helped me with this, but I'd ask her a question about do I need to fill out this line? And she'd say you can fill it out or not fill it out, it doesn't make any difference. I didn't get much help. I was without payments for three months when I switched to an NPI number. I quite frankly foresee that's going to happen with this change. Even though it may be a good idea to have everybody in a computer in the sky, for physicians that, I think we've already heard this morning, there is no essential criminal fraud and abuse that exists, I'm not sure what we accomplish by physicians. Quite frankly, I know it's going to change the way I practice medicine. I see geriatric patients, primarily in a nursing home. So I list the nursing home on one of the pages in this form. I

list the hospital on one page of the form. I make home visits. Initially, it looked like I was going to have to put down the zip code of every home I went to in the Kansas City area. There's a hell of a lot of zip codes. But it turns out I can put the whole state of Kansas, so I did that. So I asked this lady I was talking to at the contractor, I said, but every now and then, one of my patients transfers to another nursing home, and one of the hospital goes to a nursing home, and I, they ask me to go see them, and I do. How am I going to do that, because I don't even know which one it is, and I'm not going to list 200 nursing homes that are in the Kansas City area. And she says well, you have 30 days to change it. I am not going to change that form again. So I feel my practice is going to be restricted markedly and I'm just going to have to tell all these patients I'm sorry, the government won't let me go there because I didn't list it on the form.

Dr. Rogers: Well, I think that's a misinterpretation. You don't have to enroll at each of the nursing homes. You just have to enroll your practice location.

Dr. Snow: I'm told that those are the, any location that I put on a claim form has to be listed with them or they will not pay. The address goes on the bottom of the form. That's what they told me. With the information I've gotten from them, I can't be sure that that's 100% correct, Bill, but it's going to be devastating I think, for those of us that have multiple, multiple practice locations, some of which we only go to on a sporadic basis. So it's a real problem.

Dr. Rogers: Yeah, well, we'll get some clarification for you, but my understanding is the address is basically your office location, and if you do work a shift in an emergency department or something like that, then you can get paid for it. But I'll verify that.

Dr. Snow: Okay.

Dr. Bufalino: Dr. Smith?

Dr. F Smith: I have concerns also about the enrollment issue. I mean I honestly had never heard anything about this until it came up with PPAC and like Dr. Ouzounian, I consider myself fairly active in keeping up with this kind of thing. I still haven't received any notification; either a general letter, check to see if you are enrolled, or a personal letter saying you're not enrolled, do something. And I'm presuming that if I haven't gotten it, neither has anyone else. And I don't know of any practice that at this point has somebody who can sit there and look at the Medicare website everyday to see what the latest thing is.

Nobody has time to do that kind of stuff. So that's a concern. The other thing is, everybody keeps saying, when I do hear about this, go to the website and look it up. I don't even know what the website is. Is it a CMS website? Do I type in PECOS, in which case I'm going to get PECOS, New Mexico, PECOS bill, PECOS River, New Mexico, PECOS National Wilderness, I don't know what I'm looking for and I don't know if I go on to Medicare what do I look for? So I think that there's been zero communication with the physicians on the issue at this point, and expecting us to do a 34-page form and get it in on time, particularly if you miss one box and it is rejected and 90 days later they notify you of that, it's going to be a disaster.

Dr. Rogers: Did you enroll since 2003?

Dr. F Smith: I enrolled in 1975.

Dr. Rogers: Because these educational notices are supposed to be going out every time you order a service.

Dr. F Smith: 1975 is when I enrolled. And the NPI transition for us took 14 months. We had 14 months before we got paid with the NPI conversion, and 14 months with no payment is going to put me under. And I'm not alone. I mean that's the reason I'm raising it. If nobody else in my area has heard of it, and in Tye's area, people aren't getting notified of it, I have to believe it's nationwide.

Dr. Jordan: Our office is in PECOS, because I checked, and we have actually applied 3 times in the last five years or revalidated I should say, which I also, last month did it again, and I've got 5 docs, so I have to go through that form for 5 doctors, plus I've got the DME form, I've got to reenroll when I do make changes. And every time I am required to make a change because of situations changing office. I just dread the thought of having to fill out this form, knowing one thing is I'm going to have a delay of payments for at least three to four months minimum, and then the backlog of those claims possibly being rejected for different reasons on top of the new claims that will then be submitted during this whole time, just becomes a nightmare for staff. The form, when I went through it, and filled out, I went through it, let it sit for a few days, went back through it again to make sure I did not miss anything, let it sit for a few days, went through it one more time. Then I had one of the other docs go through it, and he actually found areas that I had missed the first three times. Then we had a staff person go through and actually found a couple

more items that the two of us had already missed. And it's like no matter how many times you go through it, there are so many areas that you can just miss a check mark, misinterpret what they're trying to ask for, that it becomes just a nightmare. When you think about what is going to be happening with, and like I say, I know what's going on for the most part, too, because of my involvement on this committee and my other associations, federal relations committee, that the average physician provider in this country, has no idea about PECOS and to have them have to go through and fill out these forms, be it on the internet and website, and/or on paper, is just going to be such a huge burden on CMS, that the people that are trying to get in as a new provider is going to extend those time frames as far as getting paid and even the approval process is going to have to be extended. There's no way 200,000 physicians can be revalidated and in a timely manner, especially at the deadline they're looking at. Now, I also went on the actual website, to actually look at enrolling on the website. What I read was it could take possibly upwards of 20 minutes. Well then I thought, okay, I've got five docs. Twenty minutes, first of all, it's the first time through it, so that means it's going to take me longer than 20 minutes. Then I was concerned that if I did miss something during that first few times, then clicked submit, I'm already in trouble. So I said nope, I'm going to do it on paper. So that's kind of what I've gone through, and I get to do this probably once a year for the next three years, because of situations going to be changing in my office. So I just am dreading and hold off to the last minute to do anything as far as revalidation and enrolling.

Dr. Bufalino: Thank you. Other comments?

Dr. Snow: Different issue?

Dr. Bufalino: Please.

Dr. Snow: Well, you mentioned the data service, place of service problem that is coming up with when I guess the radiologist, pathologist bill for their services on specimens, readings, etc. That's a problem that we, in primary care, have had for the past three to five years on care plan oversight, where a patient is in the hospital or nursing home, we order let's say, Home Health. The date that we can bill for that service is the date we sign the form, which can be anywhere from a few days to three months or so after the patient leaves the facility, and even though that's a bit of a headache, the biggest problem I find is the patients you don't get paid on, because they've died in that three-month interim, say, because there's no

way you're going to get Medicare to, there's no excuse for billing after a patient's death, and that's probably going to be an increasing problem with the sicker folks that are in the hospital, for instance, so it's a tremendous problem. It's an idiotic rule.

Dr. Rogers: Yes, it's different than this Date of Service, Place of Service change. That won't be impacted by this. This has to do with the technical, services that have a technical component and a professional component.

Dr. Snow: But I understand they're reading the date of billing as the date for instance, a pathologist reads the slide, which may be a day or two for preparation after the surgery, and perhaps the patient died on the table. You're going to have the same situation.

Dr. Rogers: I hadn't even thought about that. That's another issue.

Dr. Bufalino: Okay. Was there another comment? Was there any recommendation? Sure, we're glad to entertain them now.

Dr. Ouzounian: PPAC recommends that the requirement for physicians to enroll in PECOS be permanently delayed.

Dr. Snow: Second.

Dr. Bufalino: Okay.

Dr. Ouzounian: I'll take a friendly amendment.

Dr. Bufalino: Would you accept a 12-month delay in the present roll out?

Dr. Ouzounian: Twenty-four.

Dr. Bufalino: Eighteen.

Dr. Ouzounian: You know, look at what happened with NPI.

Dr. Bufalino: I guess we would look at NPI and say how long did the NPI roll out take in its entirety? Twenty-four months?

Dr. Ouzounian: And there was better education. There's been no education.

Dr. Bufalino: Okay. Eighteen month?

Dr. Ouzounian: Eighteen months.

Dr. Bufalino: Okay, is there a second to eighteen month?

[Second]

Dr. Bufalino: Second, thank you. Any discussion? So please.

Dr. Jordan: One other comment, too, I almost forgot that was made. Was that the contractors, it was talking about their computer records being not kept up to date over the past several years or decades, whatever. It's like then all of a sudden why are we the providers being penalized for ill-kept records?

Dr. Rogers: Well, there's just no other way, it wasn't that they weren't kept up to date, but people died and it was missed, or keystroke errors creep in and things like that, and because the data base was disseminated across the contractors, it was much harder to keep it pristine. So hopefully PECOS is going to be pristine, but I don't know how you do it besides get the physicians to enroll in PECOS. And eventually it's reasonable that it should happen. I know how hard the 855 is because I just did one myself because I'm changing hospitals. And it's not all that straightforward, although most of the pages are instructions rather than actual information.

Dr. Bufalino: So it's PPAC recommends that CMS delay the rollout of PECOS enrollment for 18 months. Any other conversation? All in favor?

[Ayes]

Dr. Bufalino: Any opposed. Thank you. Other recommendations? Jon?

Dr. Siff: I wanted to go back and kind of real quick on the date of service issue. I have two concerns about that, one being clinical. For instance, imagine being an intensive care physician. Every day you look at a chest x-ray on the intubated patient. Now instead of seeing that in your system as the date it was done, you may see it as the date it was billed, depending on how your systems are set up. And most [unintelligible] and the issues in the computer system are significant. But now you're trying to remember, okay, did the radiologist read this a day later, two days later? Three days later? Which day's x-ray am I really looking at? And I think that poses some clinical concerns that really CMS should think about before they approve this change.

Dr. Bufalino: Thank you. Frederica?

Dr. F Smith: I'm trying to formulate this recommendation about the PECOS system, but what I'm after is basically trying to make sure that somebody sits down and looks at that form with a fresh eye and

sees if they can figure out how to make it understandable. So PPAC recommends that CMS conduct a review of the PECOS enrollment form and review it with an outside, independent, unbiased person who can determine whether there's a way to make it more user friendly.

Dr. Bufalino: Second?

Dr. Ouzounian: I second that, but that they make it more user friendly.

Dr. F Smith: Okay, I'm okay with that.

Dr. Bufalino: Okay. Any other conversation? Dana do you have that?

Ms. Trevas: Can I ask, do you still want to include the part about the outside reviewer?

Dr. F Smith: Yes, I mean what I'd like them to do is to take, I don't know, take somebody like Chi, who is brand new on this committee, not involved, may or may not have actually done the form, you know, a physician, but not somebody who's been immersed in it before, and help him fill it out and discover that doggonit it doesn't make any sense here, here, here, and here. How can we rephrase it and rework it so that it can be done?

Dr. Bufalino: Okay. All in favor.

[Ayes]

Dr. Bufalino: Thank you. Other recommendations?

Dr. Ouzounian: Back to the comment about the date of service, place of service. PPAC recommends that the consideration for a modification of the present system be tabled and that the prior system be utilized.

Dr. Bufalino: Second?

[Second]

Dr. Bufalino: Thank you.

Dr. F. Smith: My other comment on that issue is that I think it's going to be very confusing for patients who get EOBs. I mean I had some patients who actually look at their EOBs, in fact they keep graphs of their EOBs, you can guess what their professions might be [laughter] and they're not going to understand why they suddenly have six x-ray charges on one day, when grandma died three weeks before.

They aren't going to understand it, and that's going to take more of our physician time explaining it to them, whether it's mine or the x-ray department's or whatever.

Dr. Giaimo: And besides just the administrative problems with that, I mean you have the problems of patient care going back to what Jon had said, from the emergency room. I mean when you look up pathology. I do a bronchoscopy and I'm looking up a date that I did the bronchoscopy. Well, I don't know when the, I know the pathologist has probably interpreted that within 72 hours, but am I searching different days if there were different procedures done, maybe they had a lump biopsy and then they had an open biopsy after that, and other things that create a lot of difficulty and it's going to lead to errors and patient errors and it's going to be, there's no purpose for it.

Dr. Bufalino: So we have a recommendation on the table. Could you reread that?

Ms. Trevas: PPAC recommends that CMS table its proposal to modify the changes to date of service and place of service. I don't have a lot more clarity on that.

Dr. Bufalino: Another other modifications to that?

Dr. F. Smith: I think what that really means is modify its new requirement for billing, with respect to date of service and place of service.

Dr. Ouzounian: Well, they're making it a requirement. They don't need to make the requirement, just leave it the way it was.

Dr. F. Smith: No, but my point is just saying date of service and place of service doesn't tell us what we're concerned about. We're concerned about the change of the requirement for billing, redefining billing date of service and place of service.

Dr. Bufalino: Others? All in favor?

[Ayes]

Dr. Bufalino: Any opposed? Thank you. Any other last recommendations for this arena? Janice?

Dr. Kirsch: Yes, I do want to make one about the family members. Because the more I think about it, this issue is more complicated than it might initially seem. For instance, my group is affiliated with North Iowa Mercy Medical Center and we have 100 physicians scattered all the way across North Iowa, and one way of looking at it, each individual center is a practice, and another way of looking at it is all 100

of us are a group practice. So how do you define the group, and the family members and such. And so I am going to propose that CMS reevaluate its policy about treatment of patients whose family members are physicians, let's see, maybe I need to write this out, but basically for CMS to reevaluate its policy regarding nonpayment of the nonprofessional services.

Dr. Bufalino: Okay. CMS reevaluate its—

Dr. Kirsch: Yes.

Ms. Trevas: What you haven't specified is what part of that policy you want to reevaluate.

Dr. Kirsch: The decision to not cover the nonprofessional services.

Dr. Giaimo: Yes, because what you're going to do is just encourage people to send those people to the hospital. It's going to be much more costly to get a CAT scan in a hospital or a plain chest x-ray than it would be in a physician's office or a clinic's office, so it's really sort of counterproductive to the interest in cost and savings in time. Plus, you don't know when you're going to look for the x-ray report because they're not going to have it that same day. It's going to be a couple of days [laughter]

Dr. Kirsch: Yes, or that blood count where you have to send them 30 miles away to the hospital when you could just do a quick little finger stick hemoglobin in the office. I mean they're just, it's very nitpicky.

Dr. Bufalino: Second for that motion, I'm sorry.

[Second]

Dr. Bufalino: Thank you. Please.

Dr. Ouzounian: There's other situations in an orthopedic practice where it just makes no sense. You know, grandma shows up with a broken wrist. You're not going to send them down the street to the radiologist to get an x-ray, bring her back to your office, restrict the wrist, and send her back down the street. The orthopedist has an x-ray machine in his office and the standard of care is that you provide that service in the office, because it's not practical to send a patient with a broken wrist back and down the street twice to get an x-ray. I mean it just doesn't work.

Dr. Standaert: Or it's a broken neck or [off mike 01:33 1003]

Dr. Ouzounian: Well, they get paralyzed on their way, it could…

Dr. Standaert: But the thing is, they have to stick them in an ambulance to transfer them for, I mean you can't, you know?

Dr. Bufalino: Any other discussion? Please?

Dr. F. Smith: I'm thinking, I mean, I understand that it can take three hours to go 30 miles down the street in Los Angeles, but I'm also thinking of very rural areas like in New Mexico, and Reserve New Mexico, there's one physician. And he probably has three or four employees who have 87 family members, all right, so if you can't treat any of those people in your office, and you want them to drive to the next nearest town, which is 75 miles, that's really not appropriate. Even if you argue that he can treat them, what about things like giving them flu vaccine. I mean you're not going to ask somebody to take a half day off of work to drive to Silver City to get a flu vaccine and drive back, and if I heard you correctly, he can't get paid if he gives the flu vaccine in that setting. I don't think they've thought through the implications of this when there isn't somebody next door to whom the person could go for care. And if you're trying to do things like make care accessible to people in very rural areas—what about Alaska? Where you may have to fly three miles to the next nearest physician. Well, you're not going to do that to get a flu vaccine. So I think they need to reassess the implications of that. I understand the intent; you don't want people billing for a lot of services that aren't necessary just to make money and doing it on family members, but they're actually having a major restriction on access to care.

Dr. Rogers: It's not a new policy.

Dr. Bufalino: Dr. Smith?

Dr. F. Smith: Well, I understand that, so they need to look at it.

Dr. Rogers: Because nobody knows that it's the policy and because we have no way of enforcing it. It hasn't presented a huge number of problems, but it is a policy.

Dr. F. Smith: Right, but it needs to be addressed, because of the recognition, or there should be the recognition that there are many areas of the country where there is no access to care with any reasonable time frame or distance or perhaps literally none.

Dr. R. Smith: I was going to say yes, I think that represents an unnecessary barrier to care, which is a barrier that we don't need to have right now. The point I wanted to make, I think there needs to be a

more specific definition of group practices. Because as you pointed out, you have a 100-member physician group, you're going to take care of family members within that group. If you have a 1000-member physician group, what do you do? Don't take care of anyone?

Dr. Standaert: Yes, I was just thinking about that and what Janice said about the group thing. I mean I'm in the urban setting, so is Seattle. But in University of Washington Physicians. There are thousands of us. But that's multiple hospitals, it's the cancer center, it's every major sort of academic facility in the entire sort of western part of the state, so if saying any family member, anybody in that group, can't actually be cared for, there's no other choice. I mean you have to go, it's in that urban setting, it's not like you have to go miles and miles to find another provider, but there are thousands of us in the same group, so it's totally unworkable, if you look at it that way.

Dr. Bufalino: Do we have a pending motion, I'm sorry. Can we vote on that motion because the hour's late. All in favor?

[Ayes]

Dr. Bufalino: Good. Thank you. Any opposed? Any burning issues because we're already 10 minutes behind, so others? Hearing none, thank you. Thank you, Dr. Rogers, thank you for being here.

Dr. Rogers: Thank you for inviting me.

Dr. Bufalino: Let me introduce the next talk. One of our favorite topics here is PQRI, and E-prescribing. We welcome Dr. Michael Rapp back. Mike is Director of Quality Measurement and Health Assessment Group in the Center. As you know, E-prescribing is being implementing through the PQRI infrastructure, so these two topics are tied together. So we're glad to have you with us, Mike. As you know, Dr. Rapp is an emergency room physician at George Washington and on the faculty there, so we're glad to have him. We're going to actually kind of tailor to, if I have this correct, we're going to tailor two talks back to back. So the second talk is going to follow this PQRI presentation. Dr. Sheila Roman and Colleen Bruce are going to join us and talk about Physician Resource Use Management and Dr. Roman's an endocrinologist and an officer in the Hospital and Ambulatory Policy Group, here. She works at Johns Hopkins and is part of, her position here is at the HAPG, which is the Hospital Ambulatory Policy Group. So we're glad to have everyone join us. Colleen Bruce, who is also an insurance specialist in the agency

will be also part of this presentation. So we're going to do these back to back and then take questions after everyone's done. Thank you, Mike?

2010 PQRI and E-prescribing Update

Dr. Rapp: Well good morning. Again, I'm Michael Rapp. I'm the Director of the Quality Measurement and Health Assessment group and share some leadership responsibilities with regard to PQRI. I'm going to cover a number of things. At the last meeting, I know, you heard about the proposed program for 2010. At that stage it was proposed. Since then, it has been finalized, so I'm going to tell you where we ended up with the PQRI Final Rule but also since that time, we've also made the payments for 2008 PQRI, and the 2007 Rerun. So I'm going to talk about those results. We frequently talk about it from the physician perspective, but I want to also raise a few points with regard to the beneficiary perspective, and I do note that you're ready to give us a lot of helpful suggestions, so I encourage you to do the same thing with regard to the PQRI program. Just in terms of the background, we deal with several years at once in PQRI. We're dealing with the 2007 rerun and the payment we just recently did. The 2008 program as well, 2009 the reporting period is currently going on. We're preparing for 2010, and Congress is looking toward 2011, so it's a very dynamic environment, but just to refresh your recollection on what the differences for 2008 were, at the end of 2007 Congress in the MMSEA legislation made a few modifications. First of all, it did authorize payment of a 1.5% incentive payment based upon Part B Physician Fee Schedule estimated total allowed charges. It maintained the 80% reporting requirement for individual measures not reported by a registry, and it added two alternatives; alternative reporting periods, and alternative criteria for satisfactory reporting for groups of measures—so, different than individual measures—and reporting via participation in clinical data registry.

So with regard to the 2008 implementation, I think as you recall, we did an extensive analysis based upon 2007, to see what we could do to deal with some of the issues that were raised to us. We did find a number of claims reporting analytic modifications we could make, and we expected by doing that that we would increase the portion of quality data codes that were validly submitted for 2008 and based upon that, we also as an agency committed to do a rerun of 2007 and apply those same analytic modifications as well, and that is the reason that the payments came out a bit later this year than they

otherwise would have to give us time to implement those analytic fixes. And we had a few specific goals in mind as we entered 2008. We were interested in working to see what we could do to increase the valid submission of quality data codes through the claims process. We wanted to see what we could do to help increase the participation and also increase the numbers of professionals qualifying for an incentive, and part of that would be to effectively implement the registry-based reporting that MMSEA required.

There were a number of reasons for invalid quality data code submissions, so basically to refresh your recollection as to how PQRI works, there is a denominator population and if a patient falls in that denominator population, there's a quality data code that would be appropriate for reporting under PQRI, with respect to that particular patient. If the patient doesn't fall in the population and the quality data code is submitted, then it's not an appropriate submission. Or if the patient does fall in the population, but there's no quality data code reported, then that wouldn't be satisfactory reporting for that particular patient. So basically, there's several categories for invalid QDC submission; one general category is adhering to the measure specifications, another is dealing with these technical business rules that again we found there are ways that we could address that, and third was no NPI on the claim. That was a requirement under PQRI, the NPI, although it was being newly implemented at that point, was the only effective way that we could identify the individual doctor, which was a necessary part of the PQRI.

So here are some—I'm not going to go through in detail about what we did to address these, but one of them was education and outreach, which has been quite extensive. It's involved regional medical officers. We also have a monthly national provider call that we've maintained through the entire year of 2008 and continue in 2009, except we did take August off. But otherwise, we've had these calls and they're very well-attended and we address every kind of issue that you can imagine. We did put the modifications for analysis into place and the NPI issue was fixed by a rule that basically, effective March 2008, no claims for payment would be accepted unless the NPI was present. So previously, the NPI, if it wasn't there, they were paid and the doctors, it didn't really come to their attention that they wouldn't be considered as validly reporting under PQRI.

So I just want to tell you the impact of the modifications of the analytics. This, and that's best indicated I think, by the 2007 rerun. The valid QDCs increased from 51.5% to about 68.5%, which is a

33%, now again, these are the same claims, this is the same thing we did for 2007, except that we added these modifications in the analytics. We brought split claims back together, even though that was something that in many instances was something that the software through which the claims were submitted resulted, and it wasn't a "fault of CMS," but nevertheless, we sought to see what we could do. We also dealt with this diagnosis pointer issue, where we looked at all the diagnoses on the claim. But the impact of that again, was to increase the valid QDCs by 33%. Now, of course that doesn't make all the quality data codes valid, because of the fact that you still have to submit the code for appropriate patient. So if it's the wrong age, the wrong gender, the wrong diagnosis and encounter code, that QDC would still be invalid. But as far as the analytic fixes, this was, I believe, fairly successful and that would have helped for 2008 as well. So I want to give you the overall results here that the agency has put out a press release on. You have some of this information already. But again, getting back to one of, what we were interested in trying to achieve, increased participation, increased successful reporting. And you'll see in 2007, there were 692,000 more or less eligible professionals, for whom one of the measures applied with respect to at least one of the patients that they treated. So that's quite a big number. But you'll see for 2008, we increased the number of measures from 74 to 119, so we covered quite a few more eligible professionals. Almost a million eligible professionals could have reported in this program, based upon the services they rendered to Medicare beneficiaries, which is a 39% increase. As far as those who attempted participation, in 2007, we had 109,000 and in 2008, we had 162,000, which is nearly a 50% increase, so that I think was quite a success. I'll define it for you now and I'll define it for you again, what participation means; it's a very liberal definition: Any eligible professional that submitted even one quality data code, even if it wasn't a valid QDC, in other words, it wasn't for the right patient, we counted them as participating. And the reason I want to raise that is because people look at it as well, there are a lot that participated that didn't qualify. It's because we have a very liberal definition of what participation is. I think the assumption is made that participation means that the doctors every month submitted, and continued to do it and attempted to participate. That's not our definition. So we have a broad category. Now as far as the incentive eligible, again, about 51%, if you just look at the original 2007 analysis, but with the additional rerun another 3600 or so doctors and other eligible professionals qualified, bringing that to 60,000, so again, if we just look at

the number of eligible professionals who qualified for an incentive, even adding the rerun, we have 40% more which I think you would agree would be a success here. As far as incentive payments, that is nothing that we can really change particularly, at least in terms of the rate. That's 1.5%. For the first year, 2007, it was for 6-month reporting period; for 2008 it was for the full year, or six months reporting period we had both, but the amount of the payments overall, reached almost a hundred million dollars, which was 2.5% or so increase from 2008. And if we just look at the claims submissions, the figures don't include all of the eligible professionals, but even for the claims, just looking at that alone, the claims submission process, we're up to about 40% or so, and 30% in terms of incentive eligible, and almost 40% in those participating, and you see the figures as far as the incentive payments. So there are two basic ways that you can report in PQRI for 2008; one is through the claims submission process, and the other is through registries. And you'll see that here how that worked out, most of the people still participated in claims, you see almost 75,000 submitted that way. Some or substantial number participated via registries, 11,000, and then the measures groups was another concept that MMSEA introduced. We had relatively few participate in that and you see how the numbers in terms of the incentive payments worked out.

And here, what I've tried to display is how "successful" the doctors and other eligible professionals were in submitting these various modalities. So the claims, about half who participated, again, even submitting a single data code counting as participation, about half of those qualified. The registries, on the other hand, 96% who sought to submit or had data submitted by a registry, to us, there were 31 different registries, qualified. Now what's the difference between claims and registries? Well, first of all, the claims is an ongoing process. You need to put the codes on the claims. The claim system was never really designed for quality reporting. The doctors have to do it contemporaneously. They can't go back and redo it, and so forth, so it does require significant early commitment to do this process and to keep at it. Registries on the other hand, you don't necessarily need to report or convey the information to a registry 'til after the entire reporting period is over, and then the registries will see what you sent, and they'll say wait a second, you didn't give us enough information. Give us some more information, and that sort of thing. Each registry's different. But you can see how the back and forth that can occur in a registry

process would lead to a success. Nevertheless, some didn't succeed. We did ask the registries to give us a report on all of the individuals who participated with them, rather than just the ones that were successful.

And then we had the measures groups. Now the measures groups, I'll get to that. That's I think an excellent concept because it deals with a multitude of measures with regard to a particular clinical problem, like diabetes or pneumonia. We have a whole array of measures groups. For this first go around, you could do it via registries or you could do it via claims, and as we looked at it, I think we understand why it was so hard via claims, and it was because of our criteria. Doctors and professionals only had to report on 15 patients, but they had to be 15 consecutive patients. That we determined was quite a burden, when you're going—it's consecutive patients to whom that particular measure applies. It's not just any patient. So if it's diabetes, it's 15 consecutive diabetic patients, so you can miss one. And then you of course didn't meet the criteria. It sounds easier than it is. And we modified that for 2010, which I'll get to in a minute. So here's what was; we only had four measures groups in 2008, so when we look at this, it's sort of like going back in history, the 2009 program's almost finished, and we're about to enter 2010, so we learn from this, but it's not really the way things are right now. For 2010, what we did is in the proposed rule, we eliminated the requirement that the patients be consecutive patients. The requirements for 2010 for measure groups, if you report for the entire year, require 30 patients, without regard to whether they're consecutive. They have to be patients that fit in the measures group, or if you do it for half of a year, it only has to be 15 patients. So we think that will be actually a fairly convenient way to report, now that you don't have to keep track of the consecutive part of it.

I do want to get back to this issue of okay, only half of the doctors in the claims submission process qualify. I know the AMA raised that in some of their, in their statement here to the PPAC, so I think it's important to look at that, because yes, we want doctors who participate to be successful. But when we looked at it, one of the things we found out, I think it's assumed again, that when we talk about participation, we would be talking about people that sent in claims every month and codes every month, but we found when we looked at it that actually a large portion of the ones we categorized as participating submitted measures during less than 10 months. And since you have an 80% reporting requirement, you have to kind of, even if actually quite a few of the measures only pertain, you only have to report on the

patient once per year, so conceivably, if you're seeing them multiple times, you can start late or near, but nevertheless you have to get started at the beginning of the year for the most part. And we did not have anything other for individual measures than the whole year reporting period. So a large portion of those who participated didn't really start until later in the year. Now one of the ways we dealt with this for 2010, and this was a suggestion we got from the Professional Associations, was to have a six-month reporting period for individual measures. So for 2010, if you don't get started in January, February, March, or you can start in July and participate in a second reporting period that's only 6 months long, and the incentive will only apply for that second six months, but you can start then. So I think that will help both with participation and with people that say well I really didn't get around to it the first six months or I didn't do everything that I needed to do. And this gives you the kind of breakout for those who submitted quality data codes during a less than a 10-month period. So 13, almost 14% of those who we categorize as participating, only submitted quality data codes during one month. So if you think about that, you can't really expect to qualify for the incentive and submit quality data codes only for one month. About 5% submitted quality data codes using the claims system only 2 months, again. So and we go all the way up to 9 months here. If you add those up, that's about half of those who did not qualify who, when they submitted, they submitted during less than 10 months their quality data codes. So let's say all of those, if we just define participation as those who submitted quality data codes during 10, 11, or 12 months of the year, you would have the rate of success up to 75 or 80%. So it's how you define your participation that also determines how the success is. So hopefully that's somewhat helpful for you.

The next slide we also thought well, maybe the 80% threshold is too high. Maybe it should be 50%, at 50% reporting rate. Well because of for the reasons that I just went through, the doctors are frequently sending in codes and we did encourage that. Even in 2008, we said, well if you haven't participated in 2008, you might try it out at the end of the year and that way you'll be ready to go for 2009 and we encourage doctors to do that. It does sort of distort our success rate. So that's why I'm going through this, but if let's say we reduced the requirement for success, satisfactory reporting to be instead of 80% of all cases, which is what was set by Congress in the beginning, to down to 50%, what would happen? Eighty percent would qualify for one measure, but one measure's not sufficient. You have to do it

for three measures, and so we estimate that if the reporting threshold were 50%, if that had been the rule for 2008, about 66 of those who "participated" would have been incentive eligible. So you'd have to go down pretty far and not get that much farther on it, so I think that the explanation here is basically, on the claims-based process, you have to participate during the entire year, because it is a contemporary in this process.

Feedback reports were another issue, and I saw in the AMA statement that they were suggesting that we have an appeals process. There was concern last year about feedback reports for several reasons. One of them they didn't give enough information; second, it was hard to get the feedback report, and three, there was nobody to argue with about it. So we sought to address all three of those. We redid the feedback report, with involvement and suggestions by professional organizations that the AMA helped convene. We had what we call a focus group on the telephone. The focus group's usually supposed to be a few people, but this telephone call was so well attended, I couldn't call in myself, because all the lines were taken up. So we did get a lot of input on the feedback report and we think it is a lot better. We're interested in more suggestions, but we do think it goes into significant detail. In terms of how you get the report, we had some difficulties because when you go into a CMS computer system, we have to make sure we know who you are, and you're not in there rummaging around from some outer space trying to modify our computer programs with some Trojan horse or something like that, so it is, there are security requirements. So we looked to see if we could have a different way of giving the doctors the feedback reports, and as I want to make sure you're aware of this, because we've had a little trouble getting pick up on this; the first way is if you're a group, you go through the process we had last year and that again does take some time to get the security requirements done. If you did it last year as a group, you should be able to do it this year. Some people found that their password and so forth was timed out because they hadn't used it. There's ways to fix that by just going into the computer. You don't have to call anybody, you can just use the self-help mechanisms for that. But as an individual doctor, regardless of how big a group you practice in, you individually can call up your carrier, and identify who you are and this takes a few minutes, but not that many minutes, and they will then get an email address from you and they will email you your individual report. So if you're a solo practitioner, or if you're one of a million-doctor practice, you as an individual can call up and it will give you your own individual report, including the Physician Fee Schedule charges

that applied to you and how much incentive was paid because of the reporting by you or in your behalf. So I think that's an important thing I want you to all be aware of and spread the word if you hear people saying, I can't get my report. Say you can call up your carriers as an individual and you can get your report. Then about the, I want to have somebody to talk to about this and maybe argue with about and quasi appeal it. We set up a Help Desk for that. And it will handle things all the way from I don't know the first thing about PQRI, but I'd like to get started, they'll help you with that. I don't understand this feedback report, I want somebody to walk me through it. They will help you with that. I disagree with this feedback report, I should have gotten X amount of money and I only got such and such amount of money. They will help you with that and in fact, if it requires in effect, not an appeal, but a review, to try to understand better why it was, in effect a quasi appeal, you can use this Help Desk and inquiry process for that. So again, I encourage you and encourage you to spread the word, and others to do that to the doctors that participate in PQRI, because that Help Desk, I think, would be very helpful.

And so I just went through this process with you again, to get the individual feedback report, you can go to, you just call up your carrier MAC and you can get it emailed to you. You do not have to get an IX account, you do not have to log into any CMS computer system, and it will be emailed to you.

From the beneficiary perspective, we do frequently and naturally look at it from a doctor perspective, who's participating. I wanted to give you a sense of how it looked from the beneficiary's perspective. The number of beneficiaries to whom the measures applied was almost $30 million, excuse me, 30 million beneficiaries. I'm not sure how many overall Medicare beneficiaries there are, I think it's 40 some million. It may be about 10 of those are in Medicare Advantage, I'm not sure about that. But something like that and then there are a number of beneficiaries who never go to the doctor in the Fee for Service, but 30 million patients, I think this is to whom the measures apply. So a doctor could have reported a measure with respect to that beneficiary. The numbers for whom there was a measure reported was about 6 million, which is substantial, which is about 22% of that overall population, so it's a bit higher than the percentage of doctors who participated. So I think that's interesting. It's something we always want to keep in mind. And we looked at the different measures themselves. They varied in terms of the beneficiaries to whom that measure applied. What percentage of beneficiaries had that measure reported for

them? We would look for the future to try to see what we could do to change this because what this is about is not the mechanics of what we spend a lot of time on, especially the claims, but what this is about is understanding the quality of care being rendered to Medicare beneficiaries across the country.

The 2010 PQRI, we went through the proposed proposal last year, excuse me, last meeting with you, so I won't go through that all again. I just want to point out the highlights. We did finalize the EHR Reporting for PQRI, for a number of vendors, a limited set of vendors that volunteered early last year to go through a testing process. We did finalize that, assuming those, the testing gets completed. Those vendors would be able to submit on behalf of the doctors from the electronic health record, which I think is an advance and ties to the interest in electronic health records. We will be reporting the names of eligible professionals and group practices for 2010 that successfully or satisfactorily report as required in MIPPA. We have a variety of reporting options. I mentioned to you before that we have a six-month reporting period for individual measures, which is new. We revised the reporting for the measure group, so that consecutive patients are not required which I mentioned before, and we have the EHR reporting, which I mentioned. 2010 Measures Groups, we expanded those substantially. And one of the things we've been asked to do is get the specifications for the claims-based reporting up early and the first year, for 2008, we didn't get them up until December 31, 2007, which doesn't give doctors a chance to prepare. We have the claims reporting specifications via claims up on the website now. So you can go to them and prepare for 2010. You don't have to—now we did reserve the right to make some technical modifications if that becomes necessary. We don't think that will be necessary, so we think that the specifications that are up there now are the ones that you will use during 2010. We have the Physician Group Practice Reporting option. I believe we went through that with you significantly last time, so I won't duplicate that discussion, but this was something that was required under the MMSEA legislation that we provide a mechanism to do it. What we did is basically adopt the method that is used in the Physician Group Practice demonstration. So it's something unlike, when we had to start PQRI where we just, they just said go and we had to implement it without any chance to test it out, the Physician Group Practice reporting option has been tested, used significantly, and we believe this will work well. And just some more information about. In this case, the groups will get a tool, where they populate the information on that tool, so there won't be the

technical issues that come with claims-based reporting. I do want to point out that those group practices that want to participate in this have to volunteer or have to make it known to us by the end of January that they want to do this.

Couple of proposals we did not finalize. The proposal to require public reporting of performance information for the Group Practice Reporting option. We got a lot of comments pro and con. The pro tended to be from consumer groups; the con tended to be from professional groups who thought it was too quick, too soon, and we should think about that some more. So we decided not to, or the Secretary decided not to finalize that proposal, and so we will not, for those who do the group practice reporting, we will not publicly report the performance information from that. And then the proposal to require a minimum number of cases to qualify for the incentive. We did propose that to qualify for the incentive you had to report at least 15 cases, that does sound like a reasonable number. But when we looked at the data in more detail, we found that would have left out a lot of eligible professionals who otherwise qualified or would have qualified in 2008, so we decided not to finalize that proposal, but we'll look more into that. There should be a minimum number, but currently up to today, there hasn't been and we didn't finalize this proposal.

Here it just gives you kind of a general graph showing what we've done. PQRI has, you have different ways to report now, that have expanded over the years, and we have more professionals reporting in these different ways. The electronic prescribing reporting, we did finalize our proposal to change the criteria from 50% of all the patients that you saw, report whether or not you electronically prescribed. That was what Congress had originally required, but gave us the authority to change that. So we did propose changing it, and we finalized that so that now doctors, to qualify for 2010 electronic prescribing program, don't have to report on 50% of all their patients in the denominator, but they do have to report that they electronically prescribed 25 times. But I do want to put this caveat on it, it's 25 times for the patients that fit in the denominator of the measure. So be careful not to say, woops, I did 25 E-prescribing events, and reported that. That's not sufficient. It's got to be 25 E-prescribing events for the patients that fit in the denominator of the measure, which are, generally speaking, office-based measures and they are basically CPT codes. There are no specific diagnoses, so it's any diagnosis but it wouldn't be for a patient that you're

doing surgery in a hospital for example. That code's not in the denominator. We did add home health codes. That was something that we were asked to do last year, and we did do that this year, so it's a fairly broad denominator. But if you put in a code that I E-prescribed and it's for a patient not in the denominator, it won't count. But once you report 25 times for those that are in the denominator, you're done for the year. If you do that in the first month, that'd be sufficient to qualify for electronic prescribing incentive, which is 2% for 2010. That was very broadly favored by the comments that we got back.

So really I'm done with the presentation. I would be definitely interested in feedback that you have, suggestions, and I know we're going to move to Sheila and Colleen now, but here's the questions that you might consider, and you may have others: The claims-based reporting and criteria for satisfactory reporting, the Secretary for 2011 or future, does have the authority to modify the criteria for PQRI and electronic prescribing incentive programs, so for the PQRI, as you saw, we did that for E-prescribing but it's still 80%. Based upon the data I showed you, I'm not sure that it would make much difference if the doctor's not reporting regularly during the year, but it's something to consider. Also, we don't have any current requirement to report on any specific measures. If we look at this as being from the perspective of the beneficiaries, we want to have as broad a coverage of the beneficiary as we can for the measures that are reported. Maybe measures groups should be required more than individual measures. So those are thoughts that we've had and you may have some views on that. Continuation of the claims-based reporting option, as you have no doubt heard, people criticize PQRI for how people do using the claims-reporting option. We did suggest in the proposed rule that maybe we should do away with that. We got a lot of feedback that you shouldn't do away with it. That claims-based reporting option is really important to have, but you may have some views on that. And then the group practice reporting option, I think there's a lot of people who have actively favored that. We limited that to large groups, 200 or more, so for the future, should we bring that number down? We didn't feel that for the first go around we wanted to take on too big a job because we might not successfully implement it. But as we get more experienced, now, going from 12 in the Physician Group Practice demo to I don't know, it could be 100 or 200 large groups like that, we may feel that it's important to reduce that number. You may have some views on that. So with that, I'll stop and I'll turn it over to Sheila.

Dr. Bufalino: Dr. Roman and Ms. Bruce, welcome. Glad to have you.

Physician Resource Use Measurement and Reporting Program Update

Dr. Roman: Thank you very much, Dr. Bufalino. I would like to introduce Colleen Bruce, who's been Program Manager for this program that you'll be hearing about for the past year. I'm new to the program and haven't actually yet celebrated my month's anniversary with the program, so Colleen will lead off in our presentation.

Ms. Bruce: Thanks, Dr. Roman. Just to review the statutory authority, I know you heard a presentation by Tom Valuck and Lisa Grabert on this back in March, I believe it was. So I'm going to try to not walk all the way back through that, but refresh everyone's memory of what was discussed in Phase I and talk about where we think we're going to go for Phase II. So our statutory authority for this program was from the Medicare Improvements for Patients and Providers Act, called MIPPA, in 131(c). Just want to draw your attention to a couple things in here. We have the authority to provide confidential reports. That's all this is so far. That's all we've been doing. That's all we plan to do in the near future. And we have the authority to report to both individuals and groups of physicians and to use cost information and quality information in the reports. As I'm sure you're all well aware, measuring resource use and trying to figure out how much stuff costs is of great concern to everybody in the medical community. MedPac has done work on it. They've released several reports that contain information on cost measurement. They've done work on episode groupers, which is an issue subset of what we're covering here. GAO has also studied this issue. They just released a report on the use of per capita measurement to measure resource use and also CMS internally, has several different contracts underway. Our Office of Research Development Information, ORDI, runs several contracts where we're trying to examine these from a more research perspective, to find out what their uses might be in the future. This is just to refresh everyone's memory of what was done in Phase I. Phase I is complete. We're now moving on to Phase II. So the Phase I reports included both per capita and episode based measurement. The two commercially available products that we used were the Megs and the ETGs, but no one report contained information from both groupers, but we did want to include information from both and study the impacts of using both. The per capita data is calculated from all parts A and B claims data. We chose to focus as the statutory authority indicates on high-cost,

high-volume conditions, and there's a slide that follows that outlines exactly which conditions we chose, but there's four acute, and four chronic conditions. As part of our Phase I report distribution, we conducted one-on-one interviews with about 66 different physicians, in which we actually went out to their practice sites, where they practiced, and handed them their report and asked them a series of questions, spent about an hour with them, asked them a series of questions about what they thought about the report in general, the look and feel of the report, what information did you understand, what didn't you understand, to try to get good physician feedback on how we can better design these reports into the future. And then in totality, for Phase I, we distributed Resource Use Reports to about 310 physicians. So not huge. We wanted to start small, we're trying to implement this in phases and learn as we go.

The next slide just talks about the regulation cycle we've been on for this. It's a little bit tricky. MIPPA was passed in July. We had to have the program operational by the next January, so the only option we had for issuing a regulation was in a Final Rule so we had to propose and then finalize on an interim basis our Phase I program parameters. So we outlined those in the, it's actually the Final Rule, but they're proposals, I know it's confusing, we named the geographic sites we wanted to use. We named the focal conditions, we mentioned that we were going to use per capita and episode methodologies, and so then when the 2010 Final Rule, which is the one that was just published, we didn't get any comments on any of the interim final program parameters, so we went ahead and finalized all of them. So they were final on an interim basis, now they're final on a permanent basis.

This one is the one that outlines our focal conditions. So for the acute conditions, we focused on community-acquired pneumonia, urinary tract infection, hip fracture, colisystitis, and then for the chronic conditions: congestive heart failure, chronic obstructive pulmonary disease COPD, prostate cancer, coronary artery disease with acute myocardial infarction. In Phase I, we did use these two commercially available episode groupers. We, they're not designed to run on Medicare data, so it involves some preprocessing of the Medicare data to get the groupers to actually run optimally and produce good results. So this is just the process that we use when we actually do use these episode groupers. We have to pre-process the claims, kind of get them to match up with the parameters of the software. Like I mentioned, we only use one grouper per report design. The Phase I reports went out in two waves. Phase I, wave I was the

MEGs, and wave II, I always get those confused, wave II was the ETGs. We took the information we got from the episode groupers and we then applied some certain policy decisions, like benchmarking and attribution, and figured out relative costs and tried to show physicians where they fell compared to their peers, and it's important to note that we did use two commercially available groupers. We understand that there are more commercially available groupers. We chose these two to focus on and we are not trying to endorse one grouper over the other. That was not the intent. We have no basis to decide which one is better, so that's where we used both.

This is actually a screenshot from the report. It shows per episode cost for a certain physician. This is an actual, this is actual data. This is a physician, he's unidentified, obviously in the report, but for example, if you follow through on the first line, for congestive heart failure, it shows the number of episodes that were attributed to this doctor, his average per episode costs, and then it compares him to other physicians in his state. That's what the other two, he's compared within his own specialty, other general internal medicine physicians, and then also all other physicians who happen to be attributed this type of episode. If you follow the graph down, for example, the prostate cancer, that line's blank because this doctor didn't get attributed enough of that kind of episode to produce valid data, so we just left it blank. We didn't want to start providing data that might not be either actionable or fair.

Per capita measurement. That's much more straightforward than using a grouper. It just provides a different picture of what the cost of care is for a beneficiary. Like I mentioned, we used all parts A and B claims, we use one total calendar year of data, so January 1 to December 31, everything that happened to that beneficiary, and it just gives a better total picture of the cost for the beneficiary. Then on the next page is, here's another screenshot from the report. This shows this doctor, where he falls, compared to his peers, on average per capita cost. You can see we would classify this doctor as a high-cost outlier. The lines on the graphs are the 10^{th}, 50^{th}, and 90^{th} percentile, and demarks where those dollar lines fall and then shows where the physician is, compared to his peers.

Phase I was our obviously first shot through this and we learned a lot of lessons. A lot of this comes from the formative testing that we did and we also received a lot of passive feedback, is what we called it. We left a phone line and email address open that was checked on a daily basis for physicians to

just submit whatever comments or questions they had and we were responsive to all of those comments and questions throughout the whole process. The first take away, that to me is the most important, is that when you hand a doctor this report, the first thing they say is, This is really long. The report itself is about 50 pages, inclusive of the glossary and the methodology section and trying to make sure everybody understands what's in this report. But then when you probe them and you walk them through the report and ask them what they would remove, there's nothing they would remove. So it's a little bit of a challenge for us to figure out what to do with that feedback. We're trying to figure out—we're in the process right now of testing Phase II, and we're asking people the question, where we are forcing, well, trying to, force them to remove something. If you had to remove something, what would it be? So we're trying to work on the length of the reports. In Phase I, the only information that was included was cost information. Probably the second most prevalent comment was, This information is not meaningful to me until you tell me how high the quality or low the quality is of the patients I'm treating. So that's what we're again trying to move towards in Phase II. And that physicians are generally concerned, and I'm sure you guys are all aware of these issues, attribution, risk adjustment, I think it's pretty generally accepted that there is no silver bullet for this stuff yet. We're working through it and doing the best with what we have.

So then moving on to Phase II, I already alluded to a couple things we're working on in Phase II. We decided to exercise our statutory authority to include quality measures and to also report to groups of physicians and measure them at the aggregate group level and provide feedback to the group itself. We also decided to add diabetes as a focal condition. Some of the other feedback we got was that that's a pretty high cost, high volume condition in Medicare, so including that would cause you to be able to reach more providers, so we are going to do that this time. We got good comments on all that stuff. No one disagreed with our use of quality measures of reporting to groups or adding diabetes, so we finalized all of those proposals.

So then for Phase II, the quality measures that we're going to use—we're limited by the data we have, unfortunately. I'm sure everyone would agree that we'd like to have more data. The Physician Quality Reporting Initiative measures that we're going to look at using and then there's also the, we call it the GEM project, Generating Medicare Physician Quality Performance Measurement. And this was, for

those of you who are unfamiliar, it was an effort undertaken by OCSQ, so Dr. Rapp can probably answer much more technical questions that I can. But it's a set of 12 claims-based measures. They require no additional information from doctors to actually calculate it. So it was a project undertaken to see what could we do if we don't ask doctors to submit any more information. So we're looking at the use of those measures as well. They're obviously a more limited set. It's of arguably limited usefulness, given the fact that they don't actually have to submit any more information than just the claims themselves. As I've mentioned before, the public comment, when we mentioned this in our regulation, was overwhelmingly supportive of it, including quality measures.

To report to groups of physicians, again we're still in the process of figuring out how we're going to do this, so we tried to keep the definition as broad as possible. If you look up the rule itself, it actually defines the group as more than one physician. So the types of groups that we are looking at as including in the program are either single or multi-specialty group practices, physicians practicing within a defined geographic region, or physicians practicing in larger facilities or systems of care. So we want to look at all of those different options as well as any others that we may come across to see how we can again reach the most physicians. The public comment is supportive of reporting to groups. Many commenters suggested that when you provide a group level report to a group, the person who's probably going to be reading that report is a practice administrator or a quality improvement person in that organization. And that, it would be most useful if that group report could actually drill down to physician level data. And so we're again exploring how exactly we could do that, given the data we have with our time parameters.

So in the Phase II process, we're following a similar process that we did in Phase I. We're conducting one-on-one interviews. We're conducting a few more than we did in Phase I. As of November 30, we had conducted 80 and we actually have about 30 more interviews planned for next week. This time around, because we're including new information, we're reporting to groups, we're trying to get a broader range of actual interview respondents. We are also at this time going to talk to practice administrators. So someone at a group practice would read this. We're also talking to people at state level medical societies, to ask them questions about the concept of measuring at a geographic level. As I mentioned, we're testing the concepts of reporting quality data, we're testing the concept of reporting to groups, we are including both

per capita and episode measurement in these reports that we're testing and so for Phase II, we end up, we anticipate that we will end up distributing reports on a larger scale than we did in Phase I. The exact number is still under consideration because we're trying to figure out exactly how many groups and exactly how many individuals we have data for. And we're also going to be piggybacking off of the report distribution mechanism that Dr. Rapp mentioned, where the groups will go through IOCS and individuals will call their carriers to get their reports. And I'm going to turn it over to Sheila to cover the last couple slides because they're much more medically related.

Dr. Roman: Thanks Colleen. Obviously through Phase I and now as we start to move into Phase II, the methodology considerations are very important and we've strived in Phase I, and would appreciate input from the committee for Phase II, to lead our decisions on these methodology challenges and end up with both reliable and actionable results in the end. Obviously, we want to be able to include as many providers as possible. And to some extent, we take that into consideration when we think about some of these methodology considerations. The methodology considerations that were very seriously considered under the first phase, and as we move into the second phase, we have additional challenges, include benchmarking, which for the first stage, since it was at the individual provider level, had first focus on medical specialty and geographic location as well as comparators to national, state, or local service areas. As referenced by Dr. Simon, for attribution, we went with a multiple attribution model in attributing a physician and assigning cost to a physician. And as was related, MedPac, in their recommendation was looking at a different attribution model, and I think one thing we would be looking for in feedback from you, is now that we're moving to include groups as well as individual providers, how different attribution models might play or whether we should be really moving forward with a single attribution model.

Finally, risk adjustment. There's obviously from a physician's perspective no perfect answer from the perspective of trying to risk adjust a population of patients and make the patient population absolutely comparable from a physician population to physician population. We did in the first phase take into consideration demographic risk factors, clinical risk factors, and socioeconomic risk factors, and we would appreciate input from the committee as to defining these factors further as well as whether all of these

factors should be retained in our risk adjustment of the data in order to be able to actually look at variations between population.

Finally, looking at minimum case size, how many episodes does a physician need to treat in order to get a valid result is something that we've looked at very carefully for Phase I and now will be reevaluating for Phase II. And finally, price standardization. We've wanted to be looking at the actual costs to deliver this service independent of such things as geographic adjustment and other adjustments that Medicare may make to their payments to physicians. So we wanted to remove policy considerations to payment.

Throughout Phase I and I think as Colleen has described to you, in Phase II, we've been very interested in outreach and coordination in hearing from the physician population itself, how they respond to this material and how this material could be improved so it does become actionable for them within their practices, and now as we move to groups, within the group's practice. There's been multiple presentations to stakeholder groups, to providers, including the report recipients themselves as Colleen has described, to consensus based organizations. We hear, obviously, from consumers and payers in comments to our rules and clearly they're looking at very defined populations in general when they do submit their comments to us, and we've been interested in purchasers' accreditation and standard organizations and over the past year, certainly, Tom Valuck has done a lot of presentations to these multiple stakeholder groups.

And finally, we've had a public domain episode grouper listening session, I think as Colleen alluded to, we are currently using two episode groupers to get at episodes related to specific conditions in our resource use reports, and that we've chosen two proprietary groupers, but that CMS, I think with this listening session, has clearly stated that they are looking to build an episode grouper that is more specific to a Medicare population, or in other words, a population who is very complex with multiple co-morbidities, where chronic disease and acute on chronic disease is really the problem that we're challenged within the grouper. That was held on November 10th. There was a public episode grouper requirement included in proposed health reform legislation and during that session, we solicited and received a lot of good advice on approaches for defining an open and transparent logic for creating episodes for a complex population such as the Medicare population.

And finally, if you would like to look through one of these Resource Use Reports, there's an example posted at this website. It is a PDF file that you can import, and as Colleen said, it's quite long, but I think just looking through the glossary and methodology sections themselves, would be very useful. And next slide, please, finally gives our contact information, and we'd be glad to hear from you and answer any questions going forward. Thank you.

Dr. Bufalino: Thank you. Let me begin the discussion and ask Dr. Rapp a couple questions about PQRI. So in light of the fact that we still are only successful in about 10% of the total eligible physicians across the network, if I did the math right, about 85,000 actually received an incentive payment out of the 960,000 that were eligible, what kinds of things are we doing over this time to try to change that? I mean for my practice setting, we earned better than 90% of the bonus. We have 5,000 E-prescriptions going out a week. It isn't a problem in an electronic format, but for others, it seems like it continues to be a problem, and whether someone's taking the time to report for four or five or six months, they took that time and then got frustrated, or it cost them too much, I guess the summary of this is is there a consideration that changes the incentive? Because for a lot of folks, that $1,000 is probably not enough to get them interested in this program, since you're not paying out all the funds that were appropriated for PQRI on an annual basis, is there consideration to moving the incentive payment to 5% so that we could begin to make it worthwhile for the physicians around the country to take on the burden?

Dr. Rapp: I think you properly raise two different issues; one is the mechanics of reporting, and being successful in terms of meeting the requirements, but the other is is the incentive sufficient that doctors will want to do this? Although there were about 16% or so of those who could have participated who chose to do that and that I think is largely driven by the amount of incentive that's available to them, or at least that's just my sense. So that would be of course up to Congress. We can't modify that. The Secretary's given quite a bit of authority to fashion the program in terms of criteria and that sort of thing, so we've done what we can to make it easy. We have now, again, three different ways that you can report. In 2008 we had just introduced registries. We were able to get 31 registries up but people didn't know who those registries would be until August of that year so now we have 74 registries that were used during 2009 and we expect, and now that doctors for 2010 know what those registries are, so they can contact those

registries right now and be able to do that. So that's very secure and the American Board of Family Medicine, for example, is a registry. So I think that's really the vehicle for the future, along with electronic health record reporting. The claims are what we had to use to begin with, but inevitably, this system was not designed for quality reporting. As far as the incentive itself goes, the Secretary has the authority to pay an incentive through 2010. There is no, it's a permanent program, but there's no current authority to pay an incentive beyond 2010. So that has to be dealt with by Congress and I'm aware that there are considerations both in the House side and the Senate, have a couple of different ways of approaching that in terms of the 5%, 10%, whatever percent it is, that's not anything that we control. That will be up to Congress so—

Dr. Bufalino: Part B to that, so with the change in the six-month reporting period where now you can be eligible for six months, will there be an acceleration of the payment system since it took eight or nine months to get 2008 money this year? Will we see an opportunity to actually earn the incentive quicker?

Dr. Rapp: When will you get the money? Yes. So the reason it was not 'til October, November, this year was because of the need to put these analytic changes in. So that's been done, there's no new analytic changes to be made. So yes, we would expect it to be similar to 2007, the original payment came out in July of 2008, so we would expect that type of timeframe. Not toward the end of the year, but toward the middle of the year.

Dr. Bufalino: But the six month reporting won't accelerate it?

Dr. Rapp: No, because we, see the doctors can report on claims through February of the following year, so it doesn't end December 31st, they still put their claims in through February, so it's, so between February and July, all the work has to be done. That's about what, four months.

Dr. Bufalino: So let's move around, Dr. Ross, Janice.

Dr. Ross: So the question is if you were to report for the January 1st to December 31st, you're going to get the 2% incentive, correct?

Dr. Rapp: Two percent for the claims that patients treated during that period of time.

Dr. Ross: Exactly, but if you then choose to opt for the July first, to the December 31st, is it going to be half or will it still be 2%?

Dr. Rapp: It's 2% for that six-month period.

Dr. Ross: Well what's the incentive of doing it for the six-month versus the twelve-month?

Dr. Rapp: Well, there's not a financial incentive, but if you haven't been doing it the first six months, it gives you an opportunity to start later in the year. Previously they didn't have it, there was no such opportunity.

Dr. Ross: So you think that's going to deter a lot of people from responding until July versus starting on January the first?

Dr. Rapp: No, I don't think so. But there still will, again as Dr. Bufalino mentioned, there's only about 16% of a total possible eligible professionals that could participate. So there's still a lot that they sort of think about it and it's a gradual uptake. But it was something that really came from the professional societies that suggested this, and we took them up on it.

Dr. Bufalino: Janice?

Dr. Kirsch: [off mike] three things. The Help Line, some questions about the measures group, and then a clarification about reporting through the year. First of all, the Help Line. I've been through that CMS website, I didn't see anything labeled "Help Line" or particularly helpful. Where is it on the website?

Dr. Rapp: It's the slide that I didn't get to, right after the questions for considerations, key websites, you've got the PQRI website, which is CMS.HHS.GOV—and then you've got a Help Desk number, 1-866-288-8912.

Dr. Kirsch: So it's in there, okay.

Dr. Rapp: Open from 7 am to 7 pm central time and there's an email address if you don't want to actually call them, QNETsupport@SDPS.org.

Dr. Kirsch: Okay, I find that very helpful because I'm trying, after last time, Dr. Green was the presenter, and he described this as PQRI for dummies, and I'm still struggling with it, so I don't know what that says about me, but among the concerns is when you do put in your patients into the registry, the denominators, and I'm going to, I've got my patients all set to go into the preventive care measures group. I've got probably a good 30 patients in a row, and I see women all day, so it took me two and a half days to get 30 patients over age 50, but I'm concerned about the denominators. In that group of 30, only 2 of them

happen to be Medicare, but I'm concerned about what if there's someone who has private insurance and they're in for a physical? The physical code is not a recognized denominator. Is that okay to use? I'm working through the DocSite.com registry. The person there doesn't know the answer to that question. Are those, I mean it's preventative care and they're there for their physical. Do I put them in or don't I put them in? I'm totally confused about who qualifies.

Dr. Rapp: Your registry, if you're working through a registry, they should be able to help you. If they can't help you—

Dr. Kirsch: They can't.

Dr. Rapp: Then they can call us and we can clarify it for them. So the good thing about the registry is you probably don't have to do quite as much and they have regular calls with Dr. Green who handles this registry, so we can clarify that for them.

Dr. Kirsch: Except I can tell you that the gal that I talked to at DocSite.com said that she tried to call her CMS person, and that person never returned the call and never answered the question.

Dr. Rapp: Okay, well why don't you have them email me or something and we'll take care of it.

Dr. Kirsch: Okay. And thirdly, you mentioned you want people to report throughout the year. I'm going to be doing 30 patients in a row over two and a half days and I collect my data in November. Is that an issue to get the 2% for the year?

Dr. Rapp: No, it's not, as long as you meet the criteria. What I was mentioning is that for those who submit using the claims-based system for individual measures, that it will be a challenge sometime to meet the requirements if you don't do it during the course of the year. But we do have the measures groups, which again, don't require an 80%, and that's why we put those in. We're not too successful in 2008 getting pickup on that. You saw the relative low use of it, but it is, I think an easy way to report, compared to 80% of individual measures. So no, it's once you meet the criteria, in 2008, we had nine different ways you could qualify and some of those statistics I showed you, some doctors qualified several different ways, and whichever is the most favorable in terms of the incentive, that's the one we use.

Dr. F. Smith: I pulled off a summary of an article which I've seen in several different places, but this I brought with me and it talks about the QI Program cost of doing this in primary care. This is from an

Annals of Family Practice and it was referring to the 2007 data, but the statement, it was a University of North Carolina study, and the cost of implementation for PQRI for the Medicare system ranged, per clinician, ranged from $368 to $11,100. Now if you're looking at getting a $1,000 payment from Medicare, it's probably not even worth investing $368 for your time, much less investing $11,000, which is a $10,000 loss. I'm very concerned, at that kind of information, which kind of parallels what I was hearing from everybody I was talking to. I invested $1,000 in this and I didn't earn 50 hours of time at $20 an hour, and I didn't get paid anything. I heard that from a lot of people and it was certainly my personal experience, as I've mentioned to you before, but if it gets to the point where it's a mandatory thing or you see payment cuts, it's going to have a major negative effect on people's willingness to see Medicare patients. It's going to become another issue of access to care. If it costs money to do it, far more money than you get, you're not going to be willing to invest that. So I think that that's a significant issue.

The second thing, and it relates to the 2007, is that I have a feeling that because that 2007 one overlapped what I will call a "mess" with the NPI implementation, that may have had some significant impact on the number of people who qualified, even though you've reworked some of your numbers. I mean again, using a personal example, I invested a good 50 hours in entering, got nothing. Our NPI mess didn't get straightened out until April of 2008, so I don't know if that's the reason or not the reason. I understand that there is a way to try to figure out why you didn't qualify, but I've never been able to figure out even how to find the way to figure out how to qualify. And if I can't figure it out easily and quickly, it's not worth my time, which is money, takes me half an hour, that's one or two patients. So I think somehow the data need to be much more accessible to physicians. Somehow there needs to be some kind of system where you can figure out during the course of the year whether you're doing it correctly so that you know whether it's worth proceeding. My guess is that's why a lot of people gave up. They had no clue, they heard partway through the year that they weren't getting anything for last year's time investment, why bother? So I think there needs to be a feedback mechanism that can somehow be very clear, very easily accessible to people.

I have a question also about the E-prescribing. Do you want me to mention that?

Dr. Bufalino: Go ahead.

Dr. F. Smith: Okay. And that is you're saying that you have to prescribe for 25 patients in the measures denominator. What is a measure denominator? I don't know where it is, where it's written down, how to tell my colleagues to look up and see what a measures—I don't know what it means, and I certainly don't know how to tell anybody else how to find what it means.

Dr. Rapp: Okay, so the cost versus the incentive. There are, we have made an effort to try to have criteria that are not overly burdensome, and particularly with the measures groups, as was mentioned, you could do 30 consecutive patients for 2010, they won't have to be consecutive. That would hopefully be a fairly easy way to qualify. So we've sought to do that. You've cited some statistics, but on the other hand, we had calls that the American College of Physicians, and the American College of Family Physicians also participated, and with those, some people pointed out that they only had to report on, for example, their diabetic patients, but they got their incentive on all of their patients. So the actual reporting is only on a subset of your patients, but the incentives, 2% of all of your Part B Physician Fee Schedule charges. So I think there's different cost versus incentive comparisons but that's something to bear in mind. As far as 2007, with regard to the NPI, that has been fixed, and I think we tracked that for 2008. It was not a substantial problem in 2008, just because of the requirement to use the NPI. And I will point out again, compared to 2007 and 2008, 50% more eligible professional participated. Fifty percent more earned the incentive through claims plus the registry. As far as what is a denominator? A measure goes like this: The percentage of patients who, boom. That's the denominator. Are a diabetic, are this, are that, or the other thing. Percentage of patients who whatever it is, whatever the parameter is, that's the denominator. We define that denominator in terms of codes. For the electronic prescribing, there's no diagnosis code in the denominator, so that's not an issue. Anybody you e-prescribe on, it doesn't matter what the diagnosis is. but it does matter what the encounter code is, the billing code. So what's in the denominator, if you look at the specifications which you can get on our PQRI website, under the specifications for the measures, so it would be, for example, and I'd be happy to send that to you so you don't have to go track it down, but the e-prescribing measure is basically office visits, also home health visits, so any of those normal things that you would bill the level 1 through 5 services, would be, don't hold me to that, because I don't want to off the top of my head tell you what's in the denominator, but if you look at those codes, every time if you bill

that encounter code on your claim form, then you can put in, and you e-prescribed on that patient, you put that in, that would count as one of the 25. But I'll send that to you through Dr. Simon, if that's okay with you, so you'll have that. And then finally, let me see. I thought I got all of your questions. Oh, during the course of the year, you can't figure out what's going on. Well if one deals with registries, that's not so much of a problem and again, we, the claims system is not really constructed for quality reporting, so we never, it was never designed that way and we don't claim that it will be the way of the future. It is a current way that many doctors can report, but we would encourage you to look at the registry piece of it. I know that the American Board of Family Medicine does serve as a registry and in that context, they would do this for you if you participate in that. Some people participate in the NCQA recognition program, the diabetes recognition program. That qualifies as a registry. So we're looking for ways that there's overlap. I know that the American College of Physicians, for example, is interested in potentially serving as a registry too. So there are ways that you can overlap with the things that you already do. Yes, we wish that claims-based system had worked better, but I don't think that's really the future of PQRI. It's more registry-based submission, continuing the claims-based while it still seems to be useful, but also the electronic health record submissions, which will likely be the prime way in the future of reporting.

Dr. F. Smith: Did I understand that your registry options for 2010 include everything that was previously a registry option and you've added some more, is that what you said? Or did you eliminate some?

Dr. Rapp: We'll have more registries. You can go to our website and see what registries there are as far as how you can report. You have more measures groups that you can report. You have more measures that you can report. So I would say we have more options in general, rather than less.

Dr. Bufalino: The last two comments, because we're about a half an hour behind.

Dr. R. Smith: I'm Dr. Rick Smith. I practice in Michigan at the Henry Ford Medical Group. As you know, we're one of the early adopters of e-prescribing as a quality initiative with General Motors and Ford Motors in collaboration, and it's been a very successful program that we've had here as a result throughout Michigan, large physician groups, physician organizations also, we've instituted a statewide

portal where doctors can get in. My question to you is do you see any more opportunities for groups, either real or virtual groups, to participate in this for further enhancements?

Dr. Rapp: For E-prescribing as a group? Well for 2010, you can do that if you also participate in the Physician Group Practice type option for reporting. So if you report under PQRI as a group, the way we have it set up for 2010, you can also report for E-prescribing as a group.

Dr. R. Smith: But for individual, like smaller practices, if they were in let's say a virtual group, electronically, can they participate in those sort of incentives also?

Dr. Rapp: Not so far. But that would be something to consider for the future.

Dr. Standaert: For the second time [off mike] keep your eye on, I had a couple comments, but I don't want to let go away from the REOR thing. I talked when Tom Valuck was here, I went through this before. I still have a lot of problems with how you present the statistics in these things. And what they're going to do, and you said several times, with nice little qualifiers that these are for direct use with the physician. But that's not going to be what happens with these things if they go bigger, and we know that and everybody else knows that. The idea is to get them out as a public measure, I would assume, at some point in time. That isn't the idea, that's probably what's going to happen and we have no reason to think that won't happen. The way you present the statistics, you say, This doctor had a cost down to the single-digit dollar. And there are so many problems with how these are statistically done that that is not remotely statistically accurate. And your reports have no indication of statistical range. They have no indication of statistical reliability. There's no marker of complexity. There's no marker of local practice cost. There's no marker of geographic distribution of cost. City versus urban versus whatever is academic versus non, that from a statistical standpoint, those are essentially meaningless numbers. But there's no indication of that. And if these go to somebody that doesn't understand statistics, it's completely deceiving and completely misrepresenting of what you're trying to find, and I think that needs to be addressed, and it hasn't been addressed. This is the exact same presentation, or format, we saw 6 months ago, and you guys aren't addressing those problems remotely. So that'll be my comment.

Dr. Roman: I think, I hear your comment and I think you bring it up at a good time. We're right in the throes of making decisions for the second phase and we'll get back to you on our next presentation on some of these issues.

Dr. Ahaghotu: Just a quick comment, again on this same issue of the Resource Use Initiative. Looking at the per capita measures, when you're looking at that figure, that total cost, are you attributing the cost to those activities that that individual provider is generating, or are these costs for the entire beneficiary? Because if they're costs for the entire beneficiary, for example, in the case of like prostate cancer, if a family physician identifies a patient with prostate cancer and then refers that patient for consultation, some of the charges generated downstream now become no longer under the control of that provider, and I'm just wondering whether or not that could also have impact in trying to interpret where that provider falls in terms of their costs for treating that patient. Comments on that?

Ms. Bruce: Sure. For the attribution rule that we're using is called Multiple Proportional. If you look up the report itself on the website, there's actually a visual diagram of how the rule works. I'll attempt to summarize it. It's all based on E&M dollars, so if you create any E&M dollars in the course of treating that beneficiary for the year, you're included in the possibility of getting attributed costs. The total E&M dollars are added up for the whole year and then divided across the doctors in proportion to the E&M dollars they created, so if there's 10 E&M dollars, and you caused 2 of them, you get 20% of the costs. Does that make a little bit of sense? I don't want to try to get into the super nitty gritty details.

Dr. Ahaghotu: I did go on line to look at it and it was a very robust document [laughter] so it was hard to kind of get through it, but yes, that does help to understand how you attribute cost to a—

Ms. Bruce: There are other attribution rules that exist out there. For example, there's an attribution rule that was examined and never used, where just the first doctor who touches a patient gets all the costs. And that's appropriate for some services, and in some situations and not others. We're kind of …the state of the art of attribution right now is indicating that different attribution rules work differently, work better in different situations. For a hip surgery, it's a lot more possible to attribute the entire cost of a hip surgery to that surgeon than it is for a primary care doctor to be attributed the entire cost of a beneficiary for a whole year. So it's a policy decision, is really what it is.

Dr. Bufalino: I hesitate to cut off conversation but we are wildly behind. So thank you, the discussion was great. Thank you for the comments and we welcome you back the next time for a follow up. Thank you again for being here. We will reconvene at 10 after 11:00, so it's a quick run to the bathroom, because we are wildly behind.

[Break]

Dr. Bufalino: Moving on to the next presentation, we have the opportunity to have Dr. Straube, who is, as I said earlier, the Chief Medical Officer here at the Center for Medicare and Medicaid Services, and Director of the Office of Clinical Standards. Many of the folks that we heard from this morning report to Dr. Straube. We are glad to have you on board and to present the Quality Improvement Initiative, so please begin, thank you.

Quality Improvement Initiative

Dr. Straube: Thanks very much. And good morning again to all of you here. You have heard from some of my office directors and staff so far. You'll be hearing more after me, but what I wanted to do during the period of time we have here and we'll try to catch up on a little bit of time and get back on schedule, hopefully, was to give you a pretty high-level overview of what the agency's strategies at the moment are for trying to improve healthcare quality and value. Although this is a changing by the minute on any given day, fluid situation, so as we go forward, especially in this uncertain healthcare reform debate situation, waiting to see what comes out of the Senate and the House, there is an opportunity for us to paint this high-level picture and perhaps get some input, which I've teed up at the end of my presentation from you all to help guide us as we're able to use our discretion in some of these programs and in their design.

You should have in front of you again, the updated presentation. For some reason, they sent out a very truncated version earlier. That was not at all intended to be the presentation today. So let me just walk you through this. So the first slide, or actually slide number two, and if you have three per page, it'll be the second on the first page, I have to list the healthcare quality challenges that we all face, but we have to think about every single day here at CMS, and very quickly, we spend more per capita on healthcare in the United States than any other country in the world. In spite of that, if you look at any number of metrics, we are usually no better than and frequently inferior to other health developed nations. And if you look and this

is frustrating to me as a physician, as well as to all of you, in spite of evidence-based guidelines, in a substantial number of cases, the quality of care and the type of care being delivered is not in conformance with national consensus derived guidelines. So this is a huge problem. In addition, there's tremendous variation, as you know, in not only the quality of care in different parts of the country, somewhat puzzling, given the communication we have, Internet-based opportunities to look at practice guidelines and what the most up-to-date care that's recommended is given, but not only the quality varies immensely across the country, the costs vary immensely. And I know there was some discussion earlier on in terms of some of the costs and the cost reports, but it's interesting in that light, that there's increasing evidence, I believe, and many other folks involved in quality improvement and value improvement work, that there may be an inverse relationship between the amount of cost that people are incurring, versus the quality. Namely, it's increasingly being shown that efficient providers of care, who in fact provide care at lower costs than competitors or other benchmarks, in fact have higher quality outcomes. So the amount of money being spent does not guarantee that the quality improves, based on higher expenditures.

We obviously have a very large and growing number of beneficiaries, just on the Medicare, Medicaid, and CHP Programs, and simultaneously, the trust fund is dwindling which the next slide will show, and our economy has been in a poor strait for the last year or two, at least. So in collaboration with you all and everybody else in the healthcare sector, we need to address these issues. And I'm going to outline for you the various ways we intend to do so. I did put at the bottom here, though, because I get very frustrated myself. This is arguably not your opinion, but the minute people go, whether it's at policy level, out in the provider community or anywhere, it's assumed that payment reform is mandatory to address all of the issues that I've outlined here. And while I would say that payment reform is absolutely essential, I would also posit that it's insufficient by itself to address the problems that I've alluded to here. And we'll get into that in a second.

This is the Medicare Trust Fund Report, came out in March of 2009. There will be another one coming out in March of 2010. And what the trust fund basically showed, and this is something again we have to come to work every day thinking about, since we're charged with protecting the trust fund among other duties, is that the trust fund for the hospital Part A trust fund, will be depleted by 2016 if nothing is

done to address this. The most notable points on this slide are the one bullet with three sub bullets, that over the next 75 years, not only will we run out of money in the Medicare Part A trust fund, but we'll incur a deficit of $13.4 trillion over the next 75 years, and although most of us, maybe all of us perhaps in the room won't be here in 75 years, the fact is that we'll leave that there and although it would take a long period of time for that deficit to occur, in order to assure that deficit does not occur, we would have to immediately either increase payroll taxes by 134%, that's not 34%, that's 134%, or we would have to reduce Medicare benefits by 53% or we'd have to combine both. So the clock keeps ticking. My guess is the trust funds will be depleted sooner than the 2016 in the March report coming up in 2010. We'll wait and see. And this is above and beyond Medicare Part B, Medicare Part C, Medicare Part D, which have equal challenges to funding.

The next slide just graphically shows again, under total expenditures, that HI deficit just shows you how it's going to grow in comparison to the darker shaded areas which are revenues the fund accumulates. On the next slide, you'll see on the left, the varying years of projection to the Medicare Trust Fund running out, and you'll see that it varies over a period of time. I think the bad news is, you can see over the last 6, 7, 8 years there's been a tremendous shortening of the time to trust fund diminution and obviously there are a number of factors that have contributed to that. And we're down to again, 7 years away from insolvency. But the good news may be that if you look back to 1997, we were four years away from insolvency, if you remember back then, and because of a better economy, mostly, we did extend that insolvency period. So we can hope that all of the things being done right now may have some effect on this.

This slide just shows our three primary functions. Provider payment, which you've talked about a lot this morning. We have a whole host of beneficiary focused activities, which not only include benefit education, but increasingly, education about health promotion and disease management as well as our functioning as a beneficiary protection agency. But the last and third bullet is what I spend a good deal of my time on, although not all of my time, and the agency's increasingly spending more and more time on, and that is to develop and focus on strategies to improve the quality, the efficiency, and the value of healthcare. And it's that which we'll talk about at a very high level for the rest of this presentation.

The next slide lists for you what I consider to be the core CMS strategies to try to improve quality and improve value of healthcare, within our programs, but because we are such a large agency, and everything that we decide influences the private sector as well, and the commercial insurance company sector, I think we have to keep in mind that fact, and recognize that anything we do will affect the entire healthcare system, which places a great responsibility and duty on us I believe, because if we get it wrong, we're going to affect more than just our own programs, which are large enough in and of themselves.

So the strategies which we'll talk about have to do with what I call "traditional quality improvement," and it's quite interesting in the discussion this morning, we talked for some time about quality reporting schemes, but we really haven't talked about so what? Other than we start collecting more data than we already have. How does that lead to better care for patients and better delivery of care from the provider community, especially in this context, with physicians. The second bucket, or the second strategy, is transparency. And this is both public reporting of data, so that patients, beneficiaries, their families, as well as other payers and policy makers, can use that data to either choose where they're going to seek their care and use the marketplace as a lever if you will, by going to the better providers of care and perhaps putting pressure on those who aren't so good to improve the quality of their care or potentially go out of business. But I think the transparency, and we'll talk about this, has been expanding, as we speak, for us as an agency, and not only will it involve public reporting, but it will involve making available CMS data and hopefully in conjunction with private sector commercial data and share that data with folks so they can use it at a local level more than they have previously.

The third area, third strategy for improving quality and value, are incentives, primarily financial incentives. And we'll spend the bulk of our time on that subsequently. But there's additional vehicles or strategies that we have that we're using to try to improve quality of care, which include certain regulatory vehicles, the conditions of participation for healthcare facilities, the Survey and Certification process, and myriad policy decisions, including benefit category determinations, fraud and abuse oversight, and others I could have listed, that we are able to focus in on particular problems in the healthcare delivery system, and hopefully do something that will lead to improvement in that problem. Arguably a difficult problem sometimes and inarguably something that we know we have to do better and better.

And then finally, we have demonstrations, pilots and research that we do to try to inform our decisions in improving quality and value. And then lastly, I'll allude to, we have national and local coverage decisions which can be utilized to motivate quality improvement. So if go to the next slide, what I'm going to do is just run through very quickly and give you some examples of what the agency is involved with with each of those strategies and what I'm going to do is to some extent, use as an example of one of the problems that we have to address, healthcare acquired conditions, or healthcare acquired infections, as one example, and each one of you could easily pick out a topic that the agency needs to focus on. I think the point I'm trying to make is that the strategies would apply to whatever problem area we believe we need to address.

So if you think about traditional quality improvement, this is where one measures the process measure, or an outcomes measure identifies an area that needs improvement, uses hopefully evidence-based interventions, not opinion-based interventions, puts in place and implements that quality improvement efforts, remeasures, reassesses and then decides whether there are additional tactics and interventions that need to be done or hopefully the problem is solved and you move on to something else. And we do this through any number of multiple collaboratives at the national, regional, and local level, and we will be continuing to do this. And if you look at some of the national collaboratives we've worked with, I've listed just a few for you here. There are many, many more, not only CMS, but the rest of the Department of Health & Human Services, work on these and to varying extents, we get involved with regional, and in some cases, even local collaboratives. I think the only point I'd like to make here is that in addition to continuing these national collaboratives and increasingly regional collaboratives, we believe that local interventions are increasingly important, and that community-based interventions are something that we have not done as much as we would have liked to, I think in retrospect. So look to us in the future and Dr. McGann may talk a little bit about this in our QIO Program overview, to us getting more involved with trying to promote the other federal agency and community-based initiatives that will be focused on the intricacies of local specific healthcare problems.

If you go to the next slide, what our most and best funded method for trying to work with traditional quality improvement is the Quality Improvement Organization program. We've talked about that

a bit before in more detail. Dr. McGann will go into plans for the future. We've made some radical changes in this program over the last several years, and currently have in place, the so-call Ninth Statement of Work, and as you can see, to give you a little bit of an idea of the topics, which we'll be focused on both now and over the next three to six years, include patient safety, prevention, care transitions, with a focus on reducing readmissions to the hospital, and again, focused on beneficiary focus care, which we currently call "beneficiary protection." But it'll be patient focused patient centered care, increasingly. You'll see that we have three cross-cutting themes, that go across all of these issues: Health Information Technology Adoption and Use, and that's going to be something that will hit big time when we release our high tech notice of proposed rulemaking soon, we have chosen to focus on health disparities, something that I believe personally has been largely neglected while we've been focused on many other priorities, and then finally, value in health care, which we've been talking about throughout this presentation.

The next slide shows that in addition to the QIO program, which works across the board with our 17 plus different types of providers, we have End Stage Renal Disease networks in case you don't know, I happen to be a nephrologist, and a transplant physician by training and practice background, and we take care of the bulk of the end stage renal disease patients in the United States, so we have a series of ESRD networks who are like the QIOs, involved with traditional quality improvement, and I've listed for you, some of the focus that they have right now.

And in addition to these two major funded programs at CMS, we have again, as I mentioned any number of other collaboratives that we are doing in concert with other Health & Human Services agencies as well as the private sector.

So if you go back, and look in fact at some of our traditional, but I've thrown in one here that actually has incentive, it's already overlapping into the incentive strategy, too, I think with the discussions that you had with Dr. Rapp about PQRI earlier, one of the main problems that we have in this country is that various provider types have not been used to providing data, certainly on a national level, let alone, even on a local level, to be used for any of these strategies that I mentioned for improving quality of care and value, so our biggest first hurdle is just getting people to report data. And you heard some of the problems, technical problems, administrative problems, with PQRI. That's not just with CMS, but it's also

at the provider submission level that there are problems. Practices are not geared up to do this. It's expensive business. It takes time. There's burden. It interferes with patient care. So this is just an example though of how incentives, if done at the right level, can work and back in early 2000s, there was the beginning of a national voluntary hospital reporting initiative with the organizations that I've listed here, trying to get voluntary reporting done. This eventually led to the Hospital Quality Alliance, which is present today, and after several years of voluntary cajoling and pleading, begging, etc., it turned out that there were only 10% of hospitals in the United States that were voluntarily reporting one or more of the ten potential hospital quality metrics that we , CMS, had developed by that time. So Congress started to get frustrated, and they had the Medicare Modernization Act of 2003, Section 501(b) and they put in place a financial incentive of only 0.4%, such that if hospitals didn't report to CMS, they would have 0.4% less of their annual payment update per year. So if you go to the next slide, you'll see that this rather small percentage in the hospital setting took voluntary participation from 10% of hospitals recording one or more of 10 measures, to over 95% reporting all 10, and this incentive, Congress saw that it worked, and I'm not sure of all of the details on why they decided to increase it, but they did and hospitals currently have 2% of their annual payment update subjected to just reporting of quality data. There's 96% of hospitals that qualified in the last year. We're up to 44 measures that they have to report from this. Many of these are chart-extracted measures, so it's burdensome and involves some resource use etc. We're trying to address those areas of burden, but my point is that in spite of that burden, and in spite of what some people might say is a small percentage, hospitals, 96% of them, have chosen to participate. So in this case, we got some … in Congress, in its authorization legislation … seemed to get it right, so they seemed to have picked a number that for hospitals, seems to be enough that it gets hospitals to report to us. But as you discussed earlier, I don't think we've got it right yet on the physicians' side, and in all the other areas to come, I think it's arguable as to what the appropriate percentage is. And that's something, I think again, that the specialty societies, you all, the physician community, we need to do some more work to try to figure out what is an appropriate amount of reimbursement to catch people's interest for at least reporting, let alone for quality improvement work. And again, here Pay for Reporting does work. It's better than volunteerism, and I think what it says is Congress has basically said to all of us that they recognize voluntary reporting doesn't seem

to work. Pay for Reporting does. We have to get the Pay for Reporting right first and then we go on to Pay for Performance and actual Value-based Purchasing.

So if you go to the next slide, you'll see the second strategy category and that's transparency. And we have a whole host of Compare websites that are in place. If you haven't ever gone to the Medicare.gov website, I'd encourage you to do so because each one of these is somewhat different in terms of the presentation, the metrics involved, perhaps the audience for those metrics in terms of the usefulness, etc. But I think we've made incredible progress over the last several years. And over the next several years, I think our challenge will be to improve on each and every one of these websites to try to get them better aligned, because care obviously occurs across all of these spectrums, not just in any one area and as you can see on the third yellowish bullet from the bottom, we've talked for a couple of years—I came here a year, year and a half ago—with thoughts about a Physician Compare website. So that's something I'll tee up for the end for discussion also.

In addition to publishing publicly on our websites, and making information, there are many other healthcare websites that use our quality data, and publish on their own websites, I wanted to announce what I think is a very exciting difference in trend since President Obama and his administration came to the White House and came to the Executive branch. We've been working, many of us, Liz, myself and others, at a senior level here at CMS, along with White House representatives, the Office of Management & Budget, and other parts of the department, to try to prioritize the concept that the Department of Health & Human Services, most notably CMS, needs to make as much, preferably all of its data available to the American public in a much more facile way than we have traditionally. We have tons of data. It's available, but it often is available with jumping through many hoops, and then even when you jump through the hoops and have the data available, it's sometimes difficult to interpret. So there are major efforts going on. If you go to another website, www.data.gov, this is something that we've already contributed CMS, Medicare and Medicaid and CHP data, expanded the amount of data that's publically available on that website, and like our Compare websites, this data is downloadable and is in the public domain. But there's other data that gets down individually identifiable data, etc., that can be used for a variety of purposes, but has to be carefully protected. It's our goal to try to make more of that available to the broadest group of

appropriate people in the United States. And I think if you remember back to my slide where I had three functions for CMS, payment, beneficiary focused activities, and quality, I think the data is going to be a fourth core competency that the agency will achieve soon. The next slide, we get into the main area where people are talking about and I think were the most focused perhaps with healthcare reform debates right now, and regardless of what comes out in this round of legislation, I think the area of change that will occur over the next several years that will affect physicians, hospitals, and other provider sites most profoundly, and that's tying incentives for better quality and value of care to the payment structure, whatever that may be.

I've listed our alphabet soup of the worst acronyms in the United States up on top: P for R is Pay for Reporting, RHQDAPU is the Reporting Hospital Quality Data for Annual Payment Update, that's the hospital data submission I alluded to previously. I apologize, I have not updated this slide. The HOPDRAPU is HOQDRP, which is the Hospital Outpatient Quality Data Reporting Program, PQRI, you're familiar with. That's relatively benign, although difficult, I think, to figure out what that stands for. But these are all Pay for Reporting initiatives, that I've alluded to earlier, which are in place, and which clearly Congress has signaled to us are the foundation, not necessarily a foundation that won't be changed. In other words, if it's cinderblocks that have built the foundation, and they're in a certain pattern, I'm not sure that those cinderblocks may not be extracted and replaced by different ones, but at least it's the basic foundation that Congress sees as growing into a true Value-based Purchasing system. And as we get other programs that such as the next bullet, Era and High Tech, when you see Congress's intent in its legislation, it adds other incentive programs. In this case, these incentive programs, Era and High Tech are to promote the adoption and use of electronic health records, which will be used for quality and value promotion. Congress envisions that all of these somehow will merge and come together, as opposed to starting from scratch on all of these. We'll see how well all of this merging and alignment works, but that's our intent and what we're working hard on. And eventually, it leads to true Value-based Purchasing, as you've heard here before and you will hear more thoroughly going forward, we've submitted a major Value-based Purchasing report to Congress in November of 2007 for hospital Value-based Purchasing. And that's being used very extensively in the Healthcare Reform debate, and undoubtedly for future legislation beyond the

current legislation being debated. We are due, and Liz and her team, but all of us in the agency contribute to a physician Value-based Purchasing report to Congress, which is due in May of 2010. Very complicated, lots of input needed, and again, you will be hearing more about this as we get closer to that date.

You heard I'm a nephrologist. We're in the process right now of implementing the first true Value-based Purchasing program that CMS has administered. And that's the End Stage Renal Disease Quality Incentive program. This has to be implemented by January 1, 2012 for payment of dialysis facilities. So that's the first, coming out of the gate, and we have plans or at least have been thinking about, every other setting of care, because it's clear that the Congress will be progressively mandating some sort of Value-based Purchasing programs for all healthcare provider settings going forward. Hopefully, we'll know a little bit more about that direction and you can infer by reading the current drafts of Healthcare Reform legislation. And on the next slide, if there's any question about whether we're going to have Value-based Purchasing in this country, I've listed for you here all those things that point to this and say it's happening; the president's budget has included this, even before President Obama came into office, there's been Congressional interest dating back to the 1990s. I've listed for you a bunch of alphabet soup legislation, but all of these have Value-based Purchasing either preparatory elements or frank foundation pieces that will go forward. MedPac has talked about Pay for Performance for years. The Institute of Medicine has been instituting reports in this regard ever since the late 1990s, and states in the private sector of course are implementing Value-based Purchasing dramatically in a progressive manner. So I think our challenge is, not that it won't happen, but how can we make this happen? How can we get alignment between the various programs that are out there? And how can we put together programs that will be fair, valid, and lead to uses which actually improve quality and value in the United States?

So as part of the incentive program here, I presented this one to you the last time I was here. There was some updated data since that time, but this is, the next slide is the premiere hospital demonstration, and this has gone on for six years now. You see the five major domains of care here, with a total of 34 quality metrics. The next slide shows how the scoring has been, and this gave a two percent bonus for those providers in the top decile; one percent in the second top decile, and if you go to the next slide, you'll see that for all five domains, there was steady improvement in this Pay for Performance model that we had a

demonstration. It's just come to a conclusion. And again, it's only one demonstration, one study, but it is suggestive that Pay for Performance is linked to quality improvement. And if you go to the next slide, you'll see an article that was published in the *New England Journal*, I guess we're going on a year and a half, or almost two years, you'll see Dr. Roman, who reported to you earlier, is one of the co-authors on this. And if you go to the next slide, this just shows in brief what this study did, was to compare two groups of hospitals that were comparable. One group that participated in the public reporting effort that I mentioned to you earlier, that was driven by CMS, and the RHQDAPU program, and as you can see over a period of time, this is a composite of all 10 measures in that initial data submission reporting. The slide looks the same whether you use individual measures of just composite, but you'll see that over a period of time there was steady improvement in the performance rates for this composite of 10 measures. But if you compare this to the performance of a matched group of hospitals that participated in the Pay for Performance methodology of the premiere hospital demonstration, you'll see that the rate of improvement was actually greater than just with public reporting alone, so perhaps, although arguably, some evidence among other studies we could also talk about some other time, suggests that Pay for Performance can lead to in some instances, improvement of quality of care outcomes.

The next slide, again, does get into hospital-acquired conditions. And I wanted to highlight these. This is just a slide that outlines the problems you are all are very, very much aware that hospital-acquired conditions lead to medical errors, lead to unnecessary costs, lead to unnecessary complications. I won't go through each of these, and if you go to the next slide, slide 23, you'll see that the Deficit Reduction Act, section 5001(c) authorized CMS to implement the following approach. First, on October 1 of 2007, the Inpatient Prospective Payment System hospitals were required to actually submit data on their claims, so another claims-based quality program, if you will, in which they were required to indicate whether or not the diagnoses that we came up with were identified as hospital-acquired conditions, were present on admission or not. Then beginning a little over a year ago, October 1, 2008, we stopped assigning cases to a higher DRG in the hospital, based on the occurrence of one of the selected conditions. If the condition was acquired during the hospitalization. So what happens in the hospital is they're paid a base DRG. If they develop certain hospital-acquired conditions, they're given an outlier payment on top of that base DRG,

i.e., we've been paying for complications up until this law required us to change our payment structure. And starting a year ago, if they had that condition develop during the hospital, we would no longer pay that extra add-on outlier payment. We still pay for the basic DRG payment. Again, another model of possible Value-based Purchasing. And if you go to the next slide, this just shows what I just said about the outlier payment. And we are currently just starting to evaluate the first year's experience of this. So unfortunately, I'm not able to give you any experience right now. But hopefully, at some future session, we can go into this in some detail. Now in addition to this payment policy, which Congress authorized and was done again under the hospital-acquired condition and Medicare Part A payment system, we also added and we have the authority to add certain payment restrictions, under our coverage policy, via national coverage decisions. So we did this simultaneous with the implementation of this Congressional mandated situation and what we did was created a list of so-called "never events;" surgery on the wrong body part, surgery on the wrong patient, and two other conditions, and we said we would not pay at all. This went way beyond just an outlier add-on payment. These, I think everybody can agree, should never happen. These so-called "never events," and the difference if we do this by national coverage decisions, is that not only does it apply to Part A, hospital payments, and hospital Part A payments in their entirety, but it also pertains to Medicare Part B, which means physicians, clinicians, suppliers and others who are paid under that payment scheme. So this is another incentive or perhaps you could say a disincentive program that is a legitimate strategy, although I would guess that because never events they're so few you can identify, that should never ever happen, for which there should not be payment, I don't know how much we will be using this particular approach going forward.

To go to the next slide, this simply lists for you the hospital-acquired conditions, how these were chosen. If you go to the next three slides, it just runs through the list of hospital-acquired conditions, and this is just for the add-on payment. This is not for the national coverage decision, total nonpayment policy.

So if you then go to slide, up to 29, this is the additional strategies that we have available, which for our 17 provider types, we write and I have another group that reports to me, that writes the Conditions of Participation and Conditions for Coverage that set certain basic standards for all provider types in the United States. It's incumbent upon providers meeting these conditions; if they don't, they're not eligible for

Medicare payments and if they're not eligible for Medicare payments, they sometimes are not eligible for private sector commercial payment. So it's a very powerful tool. It sets a bare minimum standard. It does not set necessarily the highest of standards, but it is a tool that we can put into condition certain quality expectations and expect folks to meet those conditions or else they won't be eligible for Medicare payment at all. You will remember that physicians do not have a Condition of Participation per se. So we don't have regulations that govern physician offices, but participation in Medicare, there are some restrictions, but it's not under this rulemaking, this particular rulemaking process. And in addition to setting the standards, we then have our Survey & Certification functions, which go out and survey facilities to evaluate whether they've complied with these or not. So that's an additional strategy. The last bullet here, and the three bullets on the next page are just additional strategies, but with the time limitations we have, I won't go into those with any formal remarks.

So I'd like to end up with my section in terms of talking about just some observations that I think tees up some questions, feedback, input for you folks. In terms of the traditional quality improvement for physician offices that I mentioned, I think I could have listed hundreds of pages of issues, I think, but I just listed a few here for your consideration. One is that it's all well said and good that we expect traditional quality improvement to be done and in fact, I think that all of us as physicians in our practices have done this since we got out of medical school, and we did it in medical school, and we did it back before then. So the question though is how complicated is that. How much does it cost to do that? Where is the funding for some of this going to come from? Should it be expected to come out of the base payment? Whatever healthcare reform we have? Or should we be factoring this in in some other manner, and if so how? Is this an expected part of medical delivery? If you take your car in to have car service done and the car dealer doesn't do it well, is that something you expect them to do for the money you pay, or is it something we should pay extra for? So I think of a lot of questions, but important ones as we go talking about payment reform. What about technical assistance? Even if the money is there, we don't always know the best way to identify and improve on a particular product, so how do we provide technical assistance? Is it something that the QIO program should do? Is it something that independent contractors should do? Is it something that we should leave up to individual providers to contract with folks themselves? A lot of questions. And

then of course the whole issue of metrics, which you started to get into with PQRI. What are the metrics to be used and how valid are they? And so forth. The same questions really apply to public reporting. One of the questions is should we publicly report specifically at the physician level, and I think that the consensus of most stakeholders, even among some physicians, is that that would be a good thing. But not everybody agrees with that. If it is done, what format? What are the metrics? What's, should it be the group or the individual level? Who's the audience for those metrics? How do you target how it's publically reported? How about the data validation? Can it be reviewed by the individuals who you're going to report on? Is there an appeals process per se and on and on and on in terms of other important questions.

The next slide gets into Value-based Purchasing, and again, I'll make the same point I did at the outset. I think it's an incredibly important strategy, but I don't think it's the only strategy, and I think by itself, it's not going to change the needle as far as we need to change the needle on improving quality of care and addressing the imperatives I had at the beginning of my comments. I think there are many, many administrative and clinical issues that need improvement, but the payment structure can't possibly attend to. We all know that a patient comes in and sees us in an office. In the first minute or two of sitting there with a patient, we've done a number, we've asked questions, they've given up information, we may have been putting our hands or blood pressure cuffs or stethoscopes on them, in a matter of minutes, have gathered an incredible number of metrics. But how can a Pay for Performance scheme address all of those metrics that we literally have accumulated in a very, very brief period of time? And may or may not have documented in the chart. Volunteerism doesn't work, so volunteer, we've already talked about that. But when we get into Value-based Purchasing on the next slide, there's clearly multiple models, and again, you've heard about a few of them in this presentation and other comments here today, and other times, but I've listed a few here. There's incentives with bonuses, there's disincentives, where you withhold or have negative penalties for not meeting certain benchmarks. There's combinations of incentives and disincentives, there's reward to top performers, versus rewards to anyone who achieves improvement from wherever they started. How much reimbursement is appropriate? How complex is it to collect and report the data? And to put in place an appeals process and a review process? What about the data accuracy and validity? It goes on and on and on. And on the next slide, how do we pick which metrics we're going to

focus on? There's already, National Quality Forum has at least 500 metrics that they've endorsed publicly and there's thousands in the cue. There's literally thousands out there that haven't been endorsed nationally. Which ones do we use? Which ones do we use across settings? Competitive bidding, with quality benchmarks, is another form of incentive program if you will, or a financial way of dealing with things. And then how do we evaluate these Value-based Purchasing programs once we put them into place, as to whether they work or not?

The next slide, and the last slide, is there a business case for quality improvement, irrespective of Value-based Purchasing? I would posit the premiere hospital demonstration that I mentioned to you quickly is a possible demonstration of this point; namely the premiere hospital chain, reimbursed under the DRG system, found in fact that they shortened hospital stays, they reduced readmissions to the hospital, and they reduced the total cost during a hospital stay. If we pay them a certain amount of money, they have a better profit margin if you will, or they have money left over at the end, so whether there's a Value-based Purchasing, Pay for Performance incentive there or not, they have an incentive to prove care to cut their costs and to improve quality of care. So there may be a business case, in at least some settings, and/or in a setting depending on how we devise Value-based Purchasing. And then I've also listed here, the second bullet, there are some surveys that have been done. If you look at beneficiaries and patients, and ask them should we pay extra for better quality of care, many American patients say hell no, we're already paying a lot. We expect the highest quality of care. Why should we pay more for that? So there is a school of thought that will fight all of us for paying extra for quality care and then I've listed some other barriers and issues that are there also.

So Dr. Bufalino, this is the end of my formal comments, and we can do whatever you would like at this point.

Dr. Bufalino: Well, why don't we have some conversation before we move over to Dr. McGann. So please.

Dr. Ahaghotu: First of all that was a great overview on where the agency's going in this particular area. Can you just comment a little bit about the healthcare disparities issue and where you see the agency moving forward and sort of trying to get into that arena.

Dr. Straube: That's, I'm really glad you asked that question. And it would probably take me an hour and a half to even begin to skim the surface, but let me try in a two-minute response. First of all, I think that with all of these strategies, which involve all sections of the agency, and frankly, of the department, that we have to ask in every activity that we do, and I implemented this in the Office of Clinical Standards & Quality, and many other parts of the agency are doing this also, it's we have to say when we're writing a regulation or a coverage decision or doing PQRI, or thinking about a Value-based Purchasing program, before we finish with a draft even, we have to figure out what did we contribute in this project that would in some way shape or form, address health disparities in this country. And although health disparities of course are first and foremost I think in most of our minds, ethnic, racial, and language disparities, I would remind folks that disparities include age, gender, socioeconomic issues, geographic differences, conditions where some people with some conditions are not treated the same as other people with other conditions, like substance abuse, alcohol abuse, chronic disabilities, they don't get treated the same way as someone with heart disease, and of course, there's other disparities, including sexual preference, and so on and so forth. So we have to ask that question with every activity we do and challenge ourselves to include in every piece of bit of work we do in the agency to include a focus on health disparities. As an example of doing that, a second point would be in our Quality Improvement Organization program, we have across all of those four themes, prevention, patient safety, care transitions, which includes readmissions to the hospital, and beneficiary-focused care, we have required a certain, and in some cases a major part of that task that we assign to the QIO program and that we now require the QIOs to meet certain predefined metrics. If they don't meet those, we can pull their contract from them, so they have a strong incentive to meet metrics, and some of those metrics are focused on issues to reduce healthcare disparities. And I think the third area is, and so that's, I could give you a whole long laundry list of specific projects. We have a subtheme there on focused disparities efforts. We had six of our QIOs who specifically bid on and were awarded contracts, where they are focused on deliverables that are addressed at the community level, doing diabetes self-management in ethnic minorities in six different states. And we just recently expanded this with a different stream of funding to the entire state of Mississippi, so it's dealing, and that's in conjunction with other HHS agencies. So what we're doing there is going out to the

community, using community-based resources in addition to our own to instruct and use community health workers to teach ethnic minority patients who are being seen under Medicare program, on how to do diabetes self-management, following them up and looking at specific outcomes metrics and process of care metrics, such as hemoglobin A1C testing, hemoglobin A1C results, amputations, any number of other metrics, too. We hope to expand that in the next statement of work nationwide.

Dr. Ahaghotu: Is reimbursement linked to that activity?

Dr. Straube. Yes, yes. And then the final thing is we're working now, I think there's been a tremendous change with this administration to try and get all of the HHS agencies and the rest of the federal government to try to work together. So that one process that I mentioned of community-based resources, we have partnered with the Department of Housing and Urban Development. And they have centers or places for the aging, where they provide housing. And what we're trying to do is take those community-based resources, go into aging housing developments, and provide diabetes self-management classes right there in the housing development locally, so that's another example, and if you're interested you can hear about it some other time.

Dr. Ross: Dr. Straube, I'm glad you brought up that point in reference to the evidence that has occurred in this disparity among states. There was a recent study, in fact, I've presented on that looking at Louisiana, Mississippi, versus Utah on amputation rate. And that study was very, very important, because it showed how many more lower extremity amputations of diabetics took place because of a lack of access to care versus the other states, where they had better access. And I think when you're looking at prevention, and I think I brought this up four years ago, when I first started on this council, how we can save money and keep these people active without losing a limb with just prevention, screenings, education, and I think that's really important that we start to focus on that if you're looking at CMS guidelines. But also for physicians to be available to try to do these screenings and to give that access to these patients in the future. That was the first point. Now the second point I was going to bring up, a little bit of a contention here. Dr. Pam Howard brought this up on the last occasion, and that was the hospital-acquired complications. There are two areas that I'd like to comment on and the first area would be the area of infections. Particularly the infections that we see as part of surgery, whether it's orthopedic surgery, whether it's vascular surgery, in

that infections are a part of surgery. They occur. We try to prevent them. In fact, in the orthopedic literature, we're prescribing perennially, prophylactic antibiotics prior to these hip and knee surgeries and foot and ankle surgeries or shoulder, whatever. But that the infections still occur. That's not a "hospital-acquired complication due to negligence." It just happens. So now you're penalizing the physician, and in this case, maybe even the hospital, because of something that just happens, even though preventative measures were taken. The second area is DVT. I'm sure many physicians have seen this happen both after surgery, prolonged immobilization, and again, even though prophylactic DVT prevention has been made, I've still seen DVT occur. And you've pointed out just for knee surgery, for total hip and total knee, but it can happen in shoulder surgery, it can happen in foot and ankle surgery and any other part of the body, or as I mentioned before, it can happen in an OB/GYN case, where somebody has been prolonged in bed for a long period of time and develops DVT. So again, even with prophylactic DVT, whether it's Lovenox or Coumadin or whatever, again, these things happen. It's a complication. But again, we're being penalized in the situation or the hospital is and now we have to take care of the complication but we're not going to be reimbursed. So I'd like to hear your comments on that as well.

Dr. Straube: I'll try to be brief, because I'd like to hear as much from others, too, as possible. Thank you for those comments. We've heard some of those before and are trying to address some of them. On the access issue, obviously Congress is trying to achieve access to health insurance, generally, on a much broader level, but I think your point is very well taken in terms of there are other ways of providing access to these services through community-based resources, etc., which do have other funding streams through other HHS entities sometimes. So that's one focus on what we're talking about as a department. The second piece is, you may or may not be aware, but under the Medicare Improvements for Patients and Providers Act of 2008, that passed a little over a year ago, MIPPA, section 101 of that authorized CMS to add preventive service benefits under Medicare, without waiting for Congress to legislate it, those additional benefits. They have to ironically be grade A or B from the US Preventive Services Task Force, but if they grade a preventive service as A or B level, and it's not currently a benefit under Medicare, we have the authority to open up a national coverage decision and potentially add additional preventive service benefits. So we've done that already. We just finalized a national coverage decision for HIV screening,

which is actually more prevalent than people realize, in the Medicare population. We're about to open one, or we have opened one on smoking cessation counseling, to broaden smoking cessation counseling and the payment therefore, and we're going to go down a long laundry list, so that will improve access in Medicare also. Then down to your hospital-acquired conditions; one, remember that under the statutory program that we were mandated to implement, there were certain, first of all criteria that the statute required us to use and they are reasonably preventable, is the language in the statute. It doesn't say 100% preventable, so I think the challenge is going to be, and this is true of all of the healthcare acquired infections approach and preventable readmissions and anything. We're not going to likely be able to get to a 100% elimination with most conditions, although arguably some we could. We're going to have to figure out a way as to what, rather than going down to zero, is there some other number, although right now, Congress mandates that it has to be reasonably preventable and it doesn't give us any leeway with current legislation to change that. There have been many, many centers though, particularly on the infection side, that have dramatically and in some cases virtually eliminated certain kinds of infection in the hospital. So I think our challenge, lots of folks say, well we have a different patient mix, well we use risk-adjusted measures to some extent, and I think we're going to have to have an ongoing dialog as to what that ultimate expectation should be, but right now we have to work with what we have under this legislation.

Dr. Ross: That is one of the recommendations that I'll make later that I think this should be made for further review and I'll present that in a proposal later. Thank you very much.

Dr. Kirsch: I get a lot of questions on when to expect the Physician Compare site. What is the time frame on that and where is that moving?

Dr. Straube: There is no specific time frame right now other than several of these pieces of legislation have required CMS to post participation in the PQRI program. We actually posted that deep in the bowels of our CMS website, not the hospital, or excuse me, not the Compare website places. That was posted a year ago. We're required to increasingly post the names of physicians and/or hospitals, not only for data reporting, but for the EHR compliance under the High Tech rule. But in terms of actually reporting results of the metrics on a Physician Compare website, as I've said here before and say in other places, we're not ready yet in terms of we have to be certain that the metrics are good, that the data's valid and

accurate and that it doesn't literally destroy somebody's practice potentially in an unfair manner, so we're not there yet.

Dr. R. Smith: I just wanted to make a comment about what you said about, they're already paying for the care, but in many circumstances, they don't, because the patients are on Medicaid. Medicaid doesn't pay for it. It doesn't cover the cost of a physician doing it, and every month it goes down and down. States like Michigan, we have thousands of patients every month going on Medicaid rolls and what this does, those who provide care, they have to allocate costs from other areas, and it begins to erode, or make it difficult in certain geographic areas to provide the type of care that we would like to. Also, it impacts upon physician shortages as well in wide regions where you don't have primary care physicians, or you have obstetricians providing care to seniors as primary care physicians, providing the Medicaid base. There has to be a means to improve Medicaid funding to the states and it has to be a way so that the physicians who are providing that frontline care can provide that type of care. Because otherwise, they do come in with very difficult problems, and they do come in and develop other infections while they're in the hospitals, and other complications which if you could prevent that on the front end, through it. We've got to fix Medicaid.

Dr. Straube. Yes I thank you for the comments. As we often have to say, a lot of that change that's needed, we don't have the authority to implement directly at CMS in terms of Medicaid Program. As you know it's a state-federal partnership, and to a large extent, whether states participate, to what extent they participate, and ergo the number of beneficiaries that are covered under Medicaid and ergo how much money gets allocated across the board for that number of patients differs from state to state. What I think I would like to say as positive news is that there's again a refocus on can we get the Medicare and Medicaid programs better aligned, and that starts off I think with, from a quality standpoint, can we align and get the metrics similar, if not identical? Can we talk about payment structures that will perhaps be similar? And therefore more easy to implement for us as well as to be implemented by individual providers, particularly if they take care of Medicare and Medicaid patients? So trying to get those two programs aligned is something that again over the last 8 or 9 months we've been talking a lot more about within the agency. The funding stream is a major part of the health reform debate and we have to keep working on that.

Dr. R. Smith: Just as a follow up, because you can have someone enrolled, but that doesn't mean the cost is, it's like have your grant—oh yes, we approve your grant, but you're not funding it. You've done nothing in order to really address that problem, so you'll just lose providers and lose that quality of care that we all wish to obtain.

Dr. Straube: But we don't set the individual Medicaid state reimbursement rates.

Dr. R. Smith: I understand. I know.

Dr. Straube: But I'm not disagreeing with your point.

Dr. Standaert: Just a philosophical comment on what you've described in the whole value agenda, that you use a hospital model for things and say it worked in hospitals and more reported. Physicians are not hospitals. Hospitals are administrative entities. Physicians are trained in and like to deliver patient care. That's what we're taught to do. That's what we like so that's why we do this. So when you increase regulatory administrative burdens, that's disincentives to physicians. We are not regulatory administrative things. And I think when those models parallel, I think that explains part of the issue with the PQRI stuff. Fine, you have 175 measures of things to go figure out. The more you get, the harder it is for the doctor to do, the less likely they are to do it. That's not what we're good at. That's not what we do. And I think as you go through your models, you're trying, in some of these things, you're trying to fundamentally change the definition of what a physician is, or what the purpose of a physician patient interaction is. And you look at the cost with that, and you look at the education with that and you go all the way back to sort of fundamental medical education on what a doctor is and does with some of the things you're after. I think you have to think about that as you go through that. And I think when there's an economic burden, putting that burden for that degree of change on the physician community is inappropriate. That's not what we're trained to do. And I think you just have to think about those things as you look at this data, because I think that's what the data tells you or what you've seen.

Dr. Straube: You raise a whole number of very good and interesting points. I guess I'll limit my response to we're trying our darndest. Mike went through a whole litany of things, and again, it may not be enough yet, but we are very cognizant of the burden it places on people and trying our darndest to see if we could reduce that burden. I think that again, eventually our end game with all of these is that electronic

submission, which hopefully will come out of a process of medical record that already has it there is our end game, and so hopefully the burden will be massively reduced, but getting from here to there is a tremendous challenge, let alone a burden particularly to small offices, and we recognize that.

Dr. Bufalino: Thank you, Dr. Straube, I understand that Dr. McGann has agreed to join us after lunch, so thank you for that indulgence. And we have with us Ms. Charlene Frizzera, who's the Acting Administrator for the Center of Medicare/Medicaid, and we are excited to have you here today and as you know, we she was appointed Acting Administrator earlier this year and has a variety of leadership roles. She has kind of done most of the jobs in the shop, as they say, but was a prime mover in the whole Part D Medicare roll out along with her jobs as Deputy Director and Regional Administrator, and she's won a whole bunch of awards and we're glad to have you join us, and it's your job to enroll our new members, so thank you for being here.

Swearing-In Ceremony

Ms. Frizzera: Well thank you. Thank you for letting me come and enroll your new members. Just to tell you a little bit, they said how about 60 days. You just need 60 days. You need a little Acting Administrator. Think that might sound like a good job for you? I said, oh that sounds kind of fun. Sixty first days, so now we're close to a year. January 11 with be a year as the Acting Administrator at CMS and I will tell you, it has been an awesome experience. I mean you think you know what it takes to run the organization, and we sit in meetings with the Administrator—for 10 years I've been sitting at them, and you kind of think you know the job. You really don't 'til you do the job. So it's really been an awesome experience where really I think doing yeoman's work at CMS, trying to balance, keeping all of the trains running while health reform is swirling literally around us, so we're glad you came here today. Your issues are important to us and I know there's always cynicism when we keep saying we're trying and we're working hard and I hope what you'll find—it's been very interesting for the new folks coming in that lots of people come in and think they know CMS, just like I thought I knew an administrator. It looks a little bit different when you're here and you really see how we function and operate. So thank you all for coming today. I can't stress enough how much we rely on the input that you give us. So this Council is really very critical to CMS. Jon Blum and Liz Richter run the Center for CMM and they really depend on the

information you give us and while we may not move fast enough for you, we do listen, so I can guarantee you we do listen to what you have to say. We don't always, we're not able to fix them as quickly as you'd like, and sometimes we don't even have the power to fix them, but we do continue to repeat the issues when they aren't within our purview, to others, to make sure that they know what the issues are and hopefully they can help you move your agenda as well as we can.

So thank you so much for today. I know everybody wants to go eat lunch, so why don't we do the honors of swearing in.

Ms. Richter: So Dr. Ahaghotu and Dr. Smith.

Ms. Frizzera: Well, Dr. Smith is easy. He's right here. So why don't we do Dr. Smith first, do we have a place to stand Liz?

Ms. Richter: They probably want you in front of the flag, so [crosstalk/chat]

Ms. Frizzera: Please raise your right hand and put your left hand on the Bible, and repeat after me: I,

Dr. R. Smith: I, Richard Smith.

Ms. Frizzera: Do solemnly swear.

Dr. R. Smith: Do solemnly swear,

Ms. Frizzera: Or affirm

Dr. R. Smith: Or affirm.

Ms. Frizzera: That I will support and defend the Constitution.

Dr. R. Smith: That I will support and defend the Constitution

Ms. Frizzera: Of the United States.

Dr. R. Smith: Of the United States of America.

Ms. Frizzera: Against all enemies, foreign and domestic.

Dr. R. Smith: Against all enemies, foreign and domestic;

Ms. Frizzera: That I will bear true faith and allegiance to the same.

Dr. R. Smith: That I will bear true faith and allegiance to the same.

Ms. Frizzera: That I take this obligation freely

Dr. R. Smith: That I take this obligation freely.

Ms. Frizzera: Without any mental reservation

Dr. R. Smith: Without any mental reservation.

Ms. Frizzera: Or purpose of evasion.

Dr. R. Smith: Or purpose of evasion.

Ms. Frizzera: And that I will well and faithfully discharge

Dr. R. Smith: And that I will well and faithfully discharge

Ms. Frizzera: The duties

Dr. R. Smith: The duties

Ms. Frizzera: Of the office on which I am about to enter

Dr. R. Smith: Of the office that I am about to enter.

Ms. Frizzera: So help me, God.

Dr. R. Smith: So help me, God.

Ms. Frizzera: Congratulations.

Dr. R. Smith: Thank you very much.

[applause]

Ms. Frizzera: I have to remember I'm reading it. Sorry, I thought I was trying to go slow. I can read it so that was pretty easy for me. Okay, same spot. Ready? I'll take it easy. Raise your right hand and put your left hand on the Bible. I,

Dr. Ahaghotu: I, Chiledum Ahaghotu,

Ms. Frizzera: Do solemnly swear

Dr. Ahaghotu: Do solemnly swear

Ms. Frizzera: Or affirm.

Dr. Ahaghotu: Or affirm

Ms. Frizzera: That I will support and defend

Dr. Ahaghotu: That I will support and defend

Ms. Frizzera: the Constitution of the United States

Dr. Ahaghotu: The Constitution of the United States

Ms. Frizzera: against all enemies

Dr. Ahaghotu: Against all enemies

Ms. Frizzera: Foreign and domestic

Dr. Ahaghotu: Foreign and domestic

Ms. Frizzera: That I will bear true faith

Dr. Ahaghotu: That I will bear true faith

Ms. Frizzera: And allegiance to the same.

Dr. Ahaghotu: And allegiance to the same.

Ms. Frizzera: That I will take the obligation freely

Dr. Ahaghotu: That I will take this obligation freely

Ms. Frizzera: Without any mental reservation

Dr. Ahaghotu: Without any mental reservation

Ms. Frizzera: Or purpose of evasion

Dr. Ahaghotu: Or purpose of evasion

Ms. Frizzera: And that I will well

Dr. Ahaghotu: And that I will well

Ms. Frizzera: And faithfully discharge

Dr. Ahaghotu: and faithfully discharge

Ms. Frizzera: duties

Dr. Ahaghotu: duties

Ms. Frizzera: of the office

Dr. Ahaghotu: of the office

Ms. Frizzera: on which I am about to enter

Dr. Ahaghotu: on which I am about to enter

Ms. Frizzera: So help me, God.

Dr. Ahaghotu: So help me, God.

Ms. Frizzera: Congratulations.

Dr. Ahaghotu: Thank you.

[applause]

Dr. Bufalino: Ms. Frizzera, while we have you here, would you mind giving us—

Ms. Frizzera: Oh! Gotta go! [laughter]

Dr. Bufalino: Giving us your reflection on where you think the direction of health care reform is going to take us from CMS's perspective. Obviously, we know you don't have any answers, and it's in the state of flux, but we're curious as to your read from inside Washington as to what's going to happen.

Ms. Frizzera: Well, I can tell you how we're managing it. I mean I think the way we're looking at it, health reform, we're putting it into two buckets, really. There's running the program and of the 2100 pages, a lot of it is our normal program, Medicare Medicaid program functioning. So changes to payment rates, changes to eligibility in Medicaid, then there are the new ideas; the public plan option, the insurance reform, the exchange. So we're looking at those in terms of these are bigger decisions that have to be made and not necessarily within CMS. These are department, government-wide. And then there are those smaller provisions we're called CMS owned sections where we are in charge of, so I think it's fair to say everyone believes reform will pass. What it will look like, is obviously the big debate, and nobody knows what this is, but I think it's general agreement, reform has to happen. We have to change the program, even if we just change the program as it current operates. If you read the trust fund, we're running out of money, so it's really not a question of politics as much as the system has to change. We don't have enough money to run it, it's not being run very efficiently, those are common goals. How that happens is really what's up for debate, so we're managing it as two buckets; what we in CMS will have to do that really just belongs to our programs, and then what are the other big pieces that are being debated more politically.

Dr. Bufalino: So on the regulatory side, at least as far as CMS is concerned, do you see big changes to the agency as part of that?

Ms. Frizzera: I see the same thing you see. I mean what passes, I don't have any idea. I mean really, we honestly don't sit down and even guess what we think is going to pass, especially as the weekend, no matter what channel you turn to you get the two sides of the story. So I think, I've been doing

this job long enough that I've learned even if I think something's going to pass, I wouldn't say it, because you don't really know until it's passed. And this certainly there's no prediction on what's going to happen here. But I will say CMS, we are actually excited about reform. I think we are ready. Everybody talks about who's going to do it, and who's going to run it and I think CMS is very proud that we're the agency that we think have a lot of the expertise, a lot of the knowledge, and more importantly, relationships with the external stakeholders to make this happen, making sure that they get included in moving any of the plans we have forward. So I think we're excited about the changes that are coming. We're waiting for the final vote to happen, so we can really start working on doing some implementation plans.

Dr. Bufalino: Thank you. We didn't mean to put you on the spot but it was a rare opportunity to get you here, so thank you for that.

Ms. Frizzera: Thank you. So do you have any quick questions? I'm happy to take any questions if you have any before I leave? No. Okay.

Dr. Bufalino: It's rare that we're without comment, so.

Ms. Frizzera: Well, I guess they'll save them for Paul and Barry and Liz and Ken, who actually come out to answer your questions.

Dr. R. Smith: Just help the primary care docs out.

Ms. Frizzera: We are. We are. We are, we get that. We are. Thank you so much and welcome to our two new members.

Dr. Bufalino: Pleasure, thanks. While we have everybody here, since we have actually about 15 or 20 minutes, so I guess the question is, Dr. McGann is that enough time to get this done or should we just make some recommendations? What's the pleasure of the Council?

Dr. Simon: Make recommendations.

Dr. Bufalino: Fine. Let's do that. Why don't we go around the room and make some recommendations around the areas that have been covered, both PQRI, E-prescribing, Resource Use, and the QIO area. So Jeff, you want to begin?

Dr. Ross: Mr. Chairman, I'd like to propose in reference to the quality initiatives and with the HACs, that PPAC recommends to CMS that if reasonable precautions have been taken to prevent hospital-

acquired complications and complications do indeed occur, that reimbursement should not be denied. Further review of this policy is recommended.

[second]

Dr. Bufalino: Second, thank you. Any comments? Additions subtractions? Hearing none, motion for approval. All in favor?

[Ayes]

Dr. Bufalino: Anyone opposed? Thank you. Other recommendations, Dr. Snow?

Dr. Snow: I'd like to make one on the Resource Utilization Reports and it has to do with this attribution issue. I didn't get a chance to comment because of our time, but let me point out quickly, my real concern as a primary care physician, who sees many patients in the nursing facility who come in after acute care in the hospital, hips, open hearts, knees, a variety of surgical procedures, quite frankly, my four or five E&M visits in the nursing facility can equal in dollar value what perhaps the ER physician put in and probably the hospitalist that saw them during a short hospitalization. So I as a primary care physician have the possibility of getting charged with, if you will, one-third of the total cost of multiple surgical procedures, which sometimes are very expensive, and I don't think that's appropriate. This 10% threshold for the multi-attribution that CMS is proposing to use, I don't think gets at the issue. So I am going to suggest that PPAC recommends that CMS revise its 10% threshold multiple attribution method for the resource utilization reports, so that providers with E&M services before or after a hospitalization split only 20% of the total cost of care involved in that particular patient. And the other 80% is attributed to the attending physician and/or surgeons involved in the care.

Dr. Bufalino: Second?

[I'll second that]

Dr. Kirsch: Art, could you restate that?

Dr. Snow: You really want me to, huh?

Dr. Kirsch: I'm sorry.

Dr. Snow: That's fine. PPAC recommends that CMS revise its current method of attribution, the 10% threshold with multiple attribution method, so that those providers with E&M services before or after

a hospitalization, split only 20% of the total cost of care for that patient and the other 80% is attributed to the attending physicians, surgeons, caregivers during the hospitalization.

Dr. Bufalino: Comments, questions, Joe?

Dr. Giaimo: Can I make an amendment to that?

Dr. Bufalino: Please.

Dr. Giaimo: What do you say, up to 20%? Do you want to make it 20% across the board or do you want to say up to 20%?

Dr. Snow: Well, right now they're going to split 100% of it is the way they're going to do it. If I see a patient for 40% of their E&M visits when I've seen them 4, 5, 6 times in the nursing facility, I'll get 40% of the full care which includes that open heart procedure. And I don't think that's appropriate. So I'm suggesting, and there's certainly some responsibility for the physicians caring for it at the end and I don't know, 20% is what I came with. I think that perhaps could be looked at. Maybe there's something to indicate it should be a different number.

Dr. Giamio: I'm saying maybe less, if you want to say that that is a maximum of it, no more than 20%, instead of saying 20% as the number?

Dr. Snow: In other words, I'm saying split among those physicians, 20% of the total cost. Let's say the open heart's $10,000 total care. So the E&M physicians that took care of him before and after hospitalization would split up $2,000 somewhere.

Dr. F. Smith: Which may be more than your share, so you wanted no more than 20%

Dr. Snow: No more than, okay, I've got no problem with that.

Dr. Bufalino: Okay. Other comments, Tye?

Dr. Ouzounian: Well, it's a question. I'm not sure I understood from the presentation. I thought they said they would divide up the E&M services, but what you're talking about is the surgical service, which is not an E&M service, so are they lumping that surgical service in with the E&M? Which is not what they said? They said E&M.

Dr. Snow: See this is the—

Dr. Ouzounian: E&M is different than surgical services.

Dr. Snow: That's right. That's all they count, so in a way, the surgeons get off scot free because they hardly have any—

Dr. Ouzounian: That's right. I didn't do any E&M.

Dr. Snow: E&M services, so you don't get attributed anything.

Dr. Ouzounian: That's right. It's all bundled. So I don't know if they made the presentation improperly, if the metric doesn't work right, I don't really know.

Dr. Snow: We questioned her afterwards and what they do is they add up all the E&M services, the total dollar value of those E&M services provided before the hospitalization, during the hospitalization, post op care. Again, surgeons don't have E&M service or charges post op, it's all bundled. So they divide that out; if I've seen the patient for $300 of that, my $300 is a certain percentage of the total E&M services. I mean that's all they look at, as far as who gets attributed the total cost of that care. Surgeons don't get a thing. Well, yeah, they had an office visit, but it probably wasn't 10% of the total E&M charges. It's a very faulty method that they're using now.

Dr. Bufalino: In the end, doesn't it, isn't it just all about how do you compare to the guy next to you? So put the formula aside for a minute, and it's all the guys that look and work like you that matter, just like it's all the guys that look and work like orthopedic surgeons. So it isn't about your absolute numbers. Maybe I'm missing this, but I thought it's really about how do I compare to the other orthopedic surgeons in my region in my state.

Dr. Snow: Perhaps. I mean that's one way, that's a rational way to look at it, no question about it. Is the public going to look at that, Dr Snow—

Dr. Bufalino: You're suggesting it may not be rational?

Dr. Snow: Well, yes. I mean you're looking at big numbers for care for the patients attributed to people who don't really contribute to those costs.

Dr. Bufalino: who are not in control of those costs, understood. Yes, I just thought part of it, and maybe Dr. Straube or Dr. Rapp have a comment there. I know neither of you, obviously, covered that, but

Dr. Straube: I think you're correct in terms of the intent of these resource reports, and I have a hunch that you're thinking ahead and that's not unwarranted; what about the next step? But I think all I can

respond is we're thinking about those next steps too, and I don't think that there's a logical follow-the-breadcrumb in a straight line necessarily with this. The intent originally with these is simply to try to come up at the local level with some comparative resource use report that hopefully would be of benefit on a policy side, but more importantly to me, would be for that traditional quality improvement, where somebody can look at a report and ask the question, should I be doing something in my practice differently than I am? That's the stated intent, but…

Dr. Snow: Theoretically, that is a fantastic way to look at it, but there is going to be more than that involved, and I understand CMS is looking at the attribution problems and they're concerned about it, too, and I'm just throwing out a proposal that I think we may be interested in hearing feedback from, what CMS thinks about that as a possible change to the way they're proposing to do it now.

Dr. Straube: Just remember, there's different resource use reporting schemes. So we haven't even decided what's the best reporting of resource uses, let alone linking it to payment.

Dr. Bufalino: So we have a motion and a second on the floor. Any other discussion? All those in favor?

[Ayes]

Dr. Bufalino: Opposed? Thank you. Chris?

Dr. Standaert: I have three of them, actually. Two on resource utilization reports. First, PPAC recommends that CMS reconsider the presentation of numerical data in resource utilization reports to accurately reflect the statistical validity of that information.

Dr. Snow: Second.

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

[Ayes]

Dr. Bufalino: Opposed? Thank you.

Dr. Standaert: Second one. PPAC recommends that CMS include reporting for factors affecting cost for patient care in resource utilization reports, including patient complexity and co-morbidity, local practice costs, setting of care, and similar factors.

Dr. Snow: Very good.

Dr. Bufalino: Any other discussion?

[crosstalk]

Dr. Arradondo: …to the fact that we've done this three times before—

Dr. Standaert: I know. We're asking again.

Dr. Arradondo: … we've been picked up and a little bit differently and massaged differently, and get a different response.

Dr. Standaert: We're looking for a different response, yes. [laughter]

Dr. Bufalino: Well said, thank you. All those in favor?

[Ayes]

Dr. Bufalino: Any opposed? Thank you.

Dr. Standaert: Third one, there may be some discussion on this one. PPAC recommends that CMS propose that Congress authorize a 5% incentive payment for successful completion of PQRI reporting in 2011, can be 10, can be 20, I don't care. Should be more than two. I'm open to suggestions.

Dr. Snow: Second.

Dr. Bufalino: How about at least 5?

Dr. Standaert: At least five. Okay, propose that Congress authorize at least a 5% incentive payment.

Dr. Kirsch: I love the idea behind it, but my feeling has been that right now, we're getting incentivized and the intent in the future is to start penalizing us for not participating.

Dr. Standaert: Right, and I think in some ways, when CMS talks to us, they give us this viewpoint that well this is what Congress tells us. So I'm sort of asking that CMS be more proactive and say we think for this to work, you have to do this. The other way around. I don't know if they can do that or not. We'll find out. I'm sure we'll see it in their answer that they may not be able to do this, but throw it out there.

Dr. Bufalino: But Janice, your insinuation is the penalty may become excessive?

Dr. Kirsch: [Yes]

Dr. Standaert: Oh yes.

[second]

Dr. Bufalino: Second, thank you.

Dr. Ross: Incentives work, that was your testimony.

Dr. Standaert: Right.

Dr. Straube: Actually there is an interesting science that's evolving, that disincentives may be more powerful than plus incentives [laughter]

Dr. Bufalino: Well on the hospital side, obviously, your incentive program has gotten you from a few folks participating to 96 or 98% on board, so it's shown there. The difference is that unfortunately they have an infrastructure of people to be able to administer it and most of the rest of us don't. So that's where the devil's in the details, again. Any other comments about that? Are you comfortable? All in favor?

[Ayes]

Dr. Bufalino: Any opposed? Thank you. Other recommendations around the room?

Dr. Ouzounian: It's back to the PECOS issue, but sorry [laughter] PPAC recommends that CMS be required to adequately inform the provider community about the requirement for enrollment in PECOS.

[Seconds]

Dr. Bufalino: Second, thank you. Any discussion?

Dr. Arradondo: I started to say this earlier, but this is as good a time as any. You know, when McDonald's is going to roll out a dollar burger, when they've been selling them at $2.99, there's this whole thing. All kinds of ads and stuff, you know, you could say PECOS is coming, you could say whatever is going to happen and people notice. Our emails are available, our faxes are available, our post office address is available, we're in the hospital, we're in the office, we're in the neighborhoods, just a little ad campaign aimed at just less than a million physicians, could just probably double compliance for a few dollars, and while we are fussing about what we want, rightly so, there are some other things. So I wish the Acting Administrator were here. She gave all the good bubbly good, we ain't going to do anything we don't know about yet, but we're going to work hard with what we have kind of attitude. That's kind of positive if you really look at the presentation we've had over the last few years, so there are things that could be done, and just a note in the bowels of an email is not the only way to get our attention. There are just lots of ways.

Dr. Bufalino: Exactly. Any other comments about the motion? All in favor?

[Ayes]

Dr. Bufalino: Any opposed? Thank you. It's been a unanimous morning. Any other motions before we break? Jump right in Dr. Straube, we'd be glad to have another recommendation.

Dr. Straube: I don't think I'm allowed to make a motion, but I do want to respond to Tye and to John that one of the advantages of these meetings, in addition the formal motions that you make, you've got any number of senior leadership here and staff who listen. And so regarding the PECOS thing, there's several issues about that that you don't need the Acting Administrator sitting up there. There'll be some discussion about some of the issues made and we don't have to wait for the motion. So. Thank you for the comments.

Dr. Bufalino: Great, thank you for that comment. Well we'll take a break. We'll ask Dr. McGann to join us at 1:30, so we'll be back here beginning at 1:30 for the presentation that we skipped. Thank you.

[Lunch Break]

Dr. Bufalino: We'll get started, and thank you for joining us. Dr. Paul McGann is Deputy Chief Medical Officer at CMS and he's a full time member of the Quality Improvement Group and we're glad to have you here to talk about the 10th Scope of Work. And thank you for that. You're following right behind Dr. Straube's introduction around quality. So thank you.

10th Scope of Work Update

Dr. Paul McGann: Thank you very much, and thank all of you for your service to CMS and the country by the very important work that you do. Let me tell you a little bit about myself, so you see where I'm coming from. I'm board certified in Internal Medicine and Geriatric Medicine. I practiced medicine at the frontline in academic medical centers for about 25 years. I trained about 35 board certified geriatricians. My last stint was at Wake Forest University, where I was the clinical director of a 128-bed inpatient facility that catered to all levels of care, including acute rehabilitation for geriatric patients. I spent most of the last seven years of practice in hospital medicine, but I worked a substantial fraction of the time in long-term care facilities and home health agencies as well. What got me into quality improvement, actually, was the introduction of electronic health records, in the geriatric practice at Wake Forest, which I led. It took us about three years to get the program in and it's telling that in the five or six years before that, as clinical

director of the aging unit, I'd had hundreds of meetings with both medical school and hospital personnel about the financial health of not only the hospital but the aging unit. And over that period of time, there was not one single meeting about the quality of care we delivered. All of the physicians in my group practice, which was about eight in geriatrics, assumed we were delivering the best possible care. I'd won several awards, I was residency program director, everybody had told me that I did nothing but spectacular care, and I'll never forget the day when I programmed our EHR in the clinic to ask two simple questions; what percent of my diabetic patients were receiving recommended care, like hemoglobin A1C, eye exams and foot exams, and what percent of my hypertensive geriatric patients had their hypertension actually controlled? And the answer to both of those questions in my clinic, myself and seven other physicians, was less than 50% and that moment changed my life in medicine, because I did all the Kübler-Ross stages of dying. I said this can't possibly be right. We bought the wrong EHR, the data is wrong. And you can go through that, and I did, for several weeks, until you finally realize that even if it's 60% or 70%, you're not delivering the care that you thought you were. And a sequence of events happened that led to a job offer from CMS and I started with the agency and the Quality Improvement group in about 2002. And I spearheaded the agency's effort to get the QIO's involved in long-term care in the nursing home field. Since then, my portfolio has broadened, and I hope today in just a few minutes, I'm going to radically shorten my presentation to try to get back on time, to give you some idea of a friendly part of the agency, the QIO program.

The QIOs are required by law, and they exist in every state and territory. They are physician-sponsored or physician access organizations by law, and they are meant to help physicians in the local community improve the quality of care. The original QIO program was called the PSRO, or PSRO Program first and then the PRO program, and in 2000, the name was changed to QIO to more adequately reflect the focus on improving quality of care. The QIO program operates from four basic principles. The first is that we understand from the IOM measurements in many studies over the last ten years that the quality of care in this country is far from perfect. My experience in my clinic turns out not to be atypical. Almost any healthcare system, if it measures its quality, will find serious problems in one or more quality measures. We've also learned in the last 10 years that the best quality delivered in the United States of America is not

always, but very often, I'd say more than half of the time, the best quality care is actually less expensive than the worst quality care. And we also assume in the QIO program that all physicians are in medicine to help people and to do a good job and that all physicians really do want to help their patients and the QIOs exist to capitalize on that noble principle of the profession. But the other thing that formal studies of quality improvement in the last ten years have taught us is that high quality care, meeting basic guidelines in diabetes, meeting basic guidelines for hypertension care, meeting basic guidelines for VTE prophylaxis as was discussed earlier. Meeting basic guidelines to prevent infections in a hospital or surgical environment. These things do not happen just because we're good doctors. They only happen, and we've got data now from hundreds of medical centers, they only happen when an organized system of quality is embedded into the protocols and processes of care, and they only happen when physicians get involved in those processes and lead them. If you don't have meetings about quality, and don't talk about your quality performance, I can guarantee you you're not providing high quality care. The data are overwhelming in support of that right now. The QIO program really exists then to help physicians, hospitals, and other providers, who don't currently have these systems and my system, just in the last 10 years, down in an academic medical center in North Carolina, did not have any of these systems. It's very common that these systems are still lacking, even in 2009 in this country. Our program exists to help physicians who want to lead the way, and there are examples of leadership physicians in the country, who've done this, to try to measure and then achieve much higher quality care than we currently deliver. So I'm going to do, there's about 25-content related slides in this deck. You've got the slides here, since the title is the 10th Scope of Work, I know Jean Moody Williams, the Director of our Quality Improvement Group was here to see you, I think back in March, so I'm going to tear through the first half of these slides, because that forms the foundation and the background to the statutory authority and how the QIO program operates, and I'm going to spend most of my time on the last 10 or 12 slides, which gives you an idea of what our strategic planning process has developed as an outlook for the 10th Statement of Work.

The QIO program operates in three-year contract cycles, and so the 10th Statement of Work would begin on August 1, 2011, and that's really what the focus of today is. And then at the end, we'll provide

you with an opportunity both now and later, to give us feedback in case there are other dimensions that you would like to comment on, or other areas that you feel are also important.

So the first slide there really just underscores the importance that CMS has as a payer of healthcare services in this country. We currently have 80 million people enrolled in one of our three programs; Medicare, Medicaid, or the Children's Health Insurance Plan. And those of you who have studied geriatrics, or even if you look at the age of the patients in your clinic, unless you're in pediatrics, you will notice that the population's getting older. And 20 years from now, there will be twice as many old people as there are now. So many physicians have a practice that's about 30% Medicare payer right now. I ran for years 100% Medicare practice, with the average age of my patients over age 85, so I'm very familiar with the unique problems of this population. But they're only going to get more common as we go on. The next slide outlines what we use as the definition of quality in our quality program. This comes directly from the Institute of Medicine, Crossing the Quality Chasm Series. If you haven't looked at that, it's been about 10 years now, since it was published, I highly recommend you go back and read the data there, because it's quite well done and supports some of the statements I made at the beginning. But we have six dimensions of quality and now I'm happy to say, unlike 10 years ago, we have fairly reasonable measures for each of these dimensions of quality. The gentlemen over here were talking about health care disparities which has become a major thrust of our program and that's the very last one there, the measures of equity in healthcare. And I'm happy to say we're much more sophisticated at doing that now. I'm going to refer to that in a few minutes. And we're just going to tear through these—the QIO characteristics and functions. It shows you where they are. It quotes the Social Security Act, at sections 1152 to 1154 that gives us our statutory authority and our funding. It identifies the main statutory mission of the problem at the bottom of that slide. The next slide goes over QIO operations. I've already told you we operate in 3-year contract cycles. Each QIO, which is housed in each state, is usually run by physicians. Many of the CEOs are physicians. So they're very physician-centric and physician-oriented. I'm hoping many of you here know the QIO in your state. They each have a different name. Actually I'm curious to find out, how many of you know the QIO in the state that you practice in? So not very many of you. So I'd urge you to look that up. There's some websites at the end of this presentation where you can look it up and at least

find out who they are, each of them has their own website. You can look up the board of directors. I think you can see, based on the presentations earlier today, that quality improvement and technical assistance for quality improvement is going to become much, much, more important as Pay for Performance, Pay for Reporting, and Value-based Purchasing legislation is passed, and as healthcare reform comes on line. So at the very least, I would say that all practicing physicians should be aware that there is a QIO resource because it is there for you and your institutions.

Next slide is the outline of the 9th statement of work. Dr. Straube went over most of that with you and I know Jean Moody Williams did as well, earlier this year, so I'm not going to belabor it, but the 9th Scope of Work structure around its different projects is contained on that slide that you see there. I think it's slide 6 in your deck.

At CMS we have a very unusual combination of interest in medical work and quality measurement, payment of course, but as you know, most of the major projects, and the QIO program is no exception, at CMS are handled through contractors. QIOs are CMS contractors, but when Dr. Straube took over leadership of this program a few years ago, he was correct to analyze that our management, CMS's management that is, of the contractors was not optimal. About a year after Dr. Straube figured that out, the Institute of Medicine published a separate book that was 500 pages long about the QIO program and confirmed a lot of these findings, and we set about redesigning the program. The map that you have there on slide 7 shows you the result of that redesign, where we introduced, despite the law, which prohibits more than one QIO from operating in any state, we found ways contractually to increase competition. So if you look closely, I don't know if your handouts are in color, probably not, but the three orange states up there, Georgia, New York, and you can't see it, it's so small, Rhode Island, were 3 of the states that won by a competitive procurement mechanism, the most safety and quality projects in their states. And the other colors represent other combinations of those projects. So the QIO program is changing fundamentally from a procurement and CMS management perspective, we report to OMB every six months about the performance measures and how each of the states are doing, and we're happy to report that one year into the 9th Scope of Work, this better contract management is starting to pay results.

So when we went from the last Scope of Work of work, the 8th, to the current 9th Scope of Work, we started to examine patterns within the work we did. Before the work was exclusively oriented around settings of care. So we had projects for hospitals, projects for nursing homes, projects for physician office and home health agencies. We tried in the 9th, we haven't been fully successful yet, to break down the silos of care and quality and a project such as the Reduction of Rehospitalization project is an excellent example of that. I organized some projects in pressure ulcers that worked both across the nursing home setting and the hospital setting. So we tried to work in themes rather than silos of care. We also insisted that every project that every QIO did even though there's a different contractor in every state, every project had to be based on evidence-based intervention. And that single change alone in the QIO program, we feel is responsible for a lot of the improved outcomes in this current statement of work.

The other thing that the IOM and others criticized us for is that we allowed, and this is almost a paradigm for healthcare reform, as we go on in the country, and as I listen to your comments this morning, physicians, and I include myself in that group, are naturally reluctant to get on board with excessive regulation and control of what they do. The QIOs by their statutory origin have always had incredible autonomy, much more autonomy than any other CMS contractor. With the 9th Scope of Work, the current contract, we took some of that autonomy away and insisted on evidenced-based interventions and standardized evaluation metrics. The physicians in those organizations found that difficult, but when we compare the outcome results from the last three-year contract to the outcome results we're seeing this contract, the difference is like night and day, so some standardization is required, if one aspires to very high quality. Other systems of human endeavor have seen this exact same pattern. The last one to go through this in the seventies and eighties was the aircraft and aviation industry, where standardization of pilots and checklists, although fought by them as independent professionals, clearly and unequivocally have reduced the number of fatal and near fatal aircraft accidents in this country over the last 20 years. It's now in the science of safety and quality recognized that in order to achieve the highest levels of safety and quality some relinquishing of independent autonomy is required, because without that there is no standardization. We've certainly done that with the QIOs. We now choose the providers that they work with because we

want to invest the limited resources we have in the providers that have the most need for improvement, and so we are now directing where these resources are deployed.

A big part of the QIO program that often is not understood or appreciated by physicians is that the QIOs represent the contractors that process all complaints that come from Medicare beneficiaries and their families, and in recognition of the disparities effort, we recognize that our complaint system is not attuned to what many Medicare beneficiaries would like to tell us about the Medicare program. And so we are currently undergoing a complete redesign of our beneficiary complaint program and attention to healthcare disparities is at the top of the list for the new system.

The second theme is one of patient safety, and the bullets on this slide just outline the current projects that we're involved in. I'm going to move on to the 10th Scope of Work here in a minute. The next slide and the couple after that show you the three prevention realms that we're working on. The first is core prevention in physician offices. This is an extension of the DOQIT project, for those of you who knew about that in the 8th Scope of Work. We decided to focus on those prevention measures that have the highest return on our investment. We're kind of running the QIO program now like a business. So you see the two cancer screenings, and the two adult immunization measures that we have up there. We're running parallel measurement systems in the 9th Scope of Work; one based on claims in the traditional way, but also a new one that's based on reporting from a physician office from EHRs. Obviously, for the burden discussion that we had, and also for the accuracy questions that are brought up, we would very much like to move in the 10th Scope of Work to an EHR reporting system. As of this moment, the EHRs are not quite up to the task, but the QIOs are working with about 1500 physician offices to fine tune their EHRs in order to enable this to happen more easily.

We also have several other prevention projects that Jean Moody Williams told you about before. We have one that's aimed at chronic kidney disease and that's in the ten states listed at the top of this slide and then this slide, slide 12 is a brief description, and we'd be happy to come back and describe to you in more detail when time permits of our focused disparities programs. In addition to the focused disparities program on slide 12, we've also required the QIO contractors to calculate healthcare disparities by race and ethnicity for all the other projects that I've described here, so in addition to the global measures of

healthcare quality that we traditionally did in the QIO program, we now have program by race and ethnicity for all the other projects and themes that I've talked about here. So we're really putting a lot more emphasis and energy into identifying healthcare disparities. And I have to say wherever we've looked for healthcare disparity, no matter what the specialty, what the measure, what the subject, what the state, we've always found healthcare disparity. Healthcare disparities are pandemic around the United States. The focused disparities project, which is on this slide, Dr. Straube already told you about, where we deliver diabetes self-management training to about 11,000 Medicare beneficiaries or members of minority groups in the six states that are shown at the bottom of the slide. That's part of the core QIO contract. The project was so promising and attracted so much attention that Dr. John Ruffin at the National Institutes of Health asked us to expand it. We didn't have the budget to do it but he, Dr. Ruffin, made an inter-agency agreement with CMS and we've now been able to expand this project into the states of Tennessee and Mississippi as well. We launched the Mississippi project on October 29th in Jackson.

The Care Transitions is probably the penultimate example of where medicine and the interests of CMS as a health insurer overlap. Those of you who haven't seen it, I highly recommend that you go to the April 2nd issue of the *New England Journal of Medicine*, where Steve Jenks, Eric Coleman, and Mark Williams, the latter two being geriatricians, published a landmark paper on 12 million annual hospitalizations of Medicare beneficiaries that we pay for and calculated the rate after discharge in an index hospitalization of readmission of the hospital of a Medicare beneficiary within 30 days after discharge. Anybody want to hazard a guess as to what the rate is in the United States? It varies from place to place, but it's 20 to 30%. So in some places it's higher than that. So in some places in the United States, one out of every three Medicare patients who have been discharged from the hospital, end up back in the hospital, within 30 days. It happened to my own mother about three weeks ago in California. And if we look at these rehospitalizations, it reminds me of what the gentleman was asking in the corner there, we find that the rehospitalization rate of course cannot be zero percent. But we have very good evidence to suggest it should not be anywhere near 30 percent. And many, many, probably more than half of these rehospitalizations if the discharge had been conducted properly and the 20 or 30 medications that the patients were prescribed at discharge, and the primary care arrangements had been worked out, the

readmission to hospital could have been avoided. And that's what this part of the 9th Scope of Work is all about. We use a community-specific model, with evidence-based interventions in those ten states, sorry, 14 states, that are organized within a community, so although the hospital's the center of it, we recruit physicians to join us, nursing homes, home health agencies, even in some communities, an ambulance service to interact with the physicians and providers there to ensure that when discharges of frail elderly people happen, they happen according to the well-described principles of geriatrics and we have evidence now, that if that is followed, the rehospitalization rate at 30 days and 60 days and 90 days for that matter is dramatically reduced. So this has, this project has drawn a lot of attention from OMB, from MedPac, from the Congressional Budget Office, and in the 10th Scope of Work we're planning to expand this particular care transition rehospitalization project nationally.

So that's sort of the process we went through. The title of the talk you saw at the beginning was Strategic Planning. We really went back to first principles and we asked ourselves over the next three to five years, what are we trying to achieve, and what measures and interventions can we work on that will achieve the maximum value, not only in quality for patients, but value for the agency as well. So we asked how can we improve the effectiveness of our program, because we recognize that the QIO program wasn't managed optimally and wasn't achieving the most efficiency for the resources spent and we put a lot of energy and work into thinking about innovative methods of contractor management to improve that efficiency. We've also started to branch out with partnerships, and we'd love to talk to you and the NMA at some point about the partnerships that we've worked out in this new project, just last month in October, in the State of Mississippi, because we've worked, as Dr. Straube said, both with Housing and Urban Development, HRSA, the Administration on Aging, and other federal partners, but also a rich array of partners at the local level in the state of Mississippi and we think this could be a model that we'd like to engage in in the future and we could use your advice as to how to do that and tap into local trusted sources.

Most of all, we want to take the principles of continuous quality improvement, which for years the QIOs have talked to physicians about and apply them to our own program, and so we have formal mechanisms of monitoring and contractor management that incorporate the principles that for years we kind of went out and preached about, but didn't really do ourselves.

So to finish this off, you've got the basic foundation now and what I want to do is just outline project by project, how we made the decisions for the first ideas of the 10th Scope of Work. The 10th Scope of Work development, a lot of people don't understand, is a process. There are many, many, many people that weigh in on this, from the QIO contractor community, to the other components at CMS, to all the way through the Department of Health and Human Services and the Office of Management and Budget. We're just at the very beginning of that process, which all together takes more than six months. These are the objectives of the program. I'm not going to—they echo what I've already said. I'm not going to review them one by one.

But we did notice when we reviewed the content this time that if you look at all the recent publications by the Institute of Medicine, the National Quality Forum, the National Commission for Quality Assurance, and then the various quality alliances, the AQA, the HQA, the National Priorities Partnership, which is a very big national quality initiative, and others like our sister agency's quality reports, the National Quality Report and the National Healthcare Disparities Report from AHRQ, and several recent MedPac studies, we realize that in the 9th Scope of Work that for the four themes that Dr. Straube and I have told you about, we actually picked the ones that are most important, not only to these groups, but to the new administration and the new president. So we're keeping these four themes the same, that is, we're going to pay attention to prevention, to patient safety issues, to care transitions, and then to the beneficiary complaint system. So the basic structure of the 10th Scope of Work will be the same.

We have added, however, some crosscutting themes. And crosscutting themes are themes we try to do in every theme in every project. I've already told you and referred to the disparities project for the 9th scope, the health information technology and Dr. Straube told you about value driven healthcare. But for the 10th scope, we see an increased emphasis on healthcare-acquired infections, there's already been some discussion this morning about the importance of healthcare associated infections, and we certainly agree with your observations about that. I think if you look at the recent literature, a lot of it coming from Peter Pronovost in the Michigan studies, called the CUS program, what we're starting to find when we actually measure healthcare infections, using CDC and other resources, is that for example, take one project led by Peter Pronovost in Michigan. Central line associated bloodstream infections can be dramatically reduced by

renewed attention to adherence to guidelines. I know we all feel we're adhering to guidelines but when Peter Pronovost, who's a professor at Hopkins, went to Michigan and several hospitals and measured adherence to guidelines there, he found that adherence to guidelines was under 40% and just putting that message out to physicians who want to do a good job making it easy for them to do it, and removing barriers for that, resulted in an 80% reduction of central line associated bloodstream infections in the ICUs in those hospitals in Michigan, and those results were published in the *New England Journal of Medicine*. So there is a lot of room for improvement and there are things we can do that are very simple and straightforward, and the QIOs are there to help hospitals and physicians achieve that type of quality improvement. You'll see the other crosscutting theme we've added is attention, which is something that's important to me as a geriatrician, attention to symptom control and pain relief at the end of life, which of course, as the population ages is a very, very important priority for anyone who provides care to extremely frail, elderly people.

In our prevention efforts, we're going to try to pay more attention and these suggestions really came from our CMM group in terms of marrying this quality improvement activity in the QIO program with some of our simple claims abilities. I hope all of you are aware of the initial preventive physical examination benefit that was approved a few years ago, otherwise known as the Welcome to Medicare examination. When we reviewed those claims data from the last couple of years, we realize that it's a tremendously underused benefit in Medicare. And so the QIOs and the 10th statement of work are going to pay more attention to that. It's very well reimbursed and it has many different preventive items that are important to elderly people already embedded in it, so that's something we'd be happy to talk to you about more if you'd like to learn more about it. We'd also like to pay more attention to care management, utilizing NEHR, as I referred to earlier. In the CKD project, we're going to take it from the subnational project in 10 states to a national project, but we're also, we've also found with the Fistula First initiative, that even though a lot of nephrologists are doing better at putting fistulas in prior to dialysis, the fistula might be in, but often unfortunately, the very first episode of dialysis is done with a central line or a catheter, and so to the Fistula First initiative, we're adding Catheter Last initiatives, and those of you who work with dialysis patients will be familiar with this discussion in the nephrology community.

For our Focus Disparity project we're going to call it now Prevention in Priority Populations. So far, the very small effort that we're doing now in six or eight states depending on how you count it, really has only focused on African American and Latino or Hispanic populations, and we're going to make a concerted effort now as we roll this out to a national project to include other groups that are often subject to disparate care. I've just named two of them here because the complete list fills up the slide, but often overlooked are Native Americans and Medicare beneficiaries living in rural areas. So that's going to be part of the expansion of our healthcare disparities efforts. We're also going to try to increase awareness of the diabetes self-management training. It is a Medicare benefit that providers can get paid for. Again, it's grossly underutilized. It's utilized only in less than 3% of the times that it could be used around the country. So we're going to pay more attention to that. It has, in an evidence-based way, dramatic impacts on the care of people with diabetes as you give them more health literacy, particularly in minority populations. And we've discussed earlier, the shockingly high rate of lower extremity amputations in diabetics both in Louisiana and New Orleans, and Mississippi. This has been well-documented. We actually have the QIO in Louisiana doing a special project so that we can fine tune our measures on this and we agree with your observations completely, that this is a type of disparity that would be easy to overcome. And we intend to launch that nationally in the 10th Scope of Work.

Our patient safety efforts are probably the most complex and we don't have time to go into them all now. I just want to reiterate that we have decided to pay enhanced attention to the prevention of hospital-acquired infections, following the work of Peter Pronovost at Hopkins, where there's very good evidence on how to do that now. We already have collaborated in the 9th Scope of Work with the CDC to use their NHSN network. I hope all of you are familiar with the NHSN network run by CDC to monitor infections in hospitals in the United States. The 9th Scope of Work has a MRSA project in hospitals for that. We're going to carry that on to the 10th scope plus we're going to hop on to the MDRM module of NHSN network, and launch projects in cost treating [unintelligible] and we're hoping central line associated bloodstream infections, again, following in the evidence that's been generated by Peter Pronovost and others. We've got Warfarin medication safety projects, with the new Part D benefit. We have a lot better database over the last three years and we're going to capitalize on that by launching projects on medication

safety. I've already gone on at length about the care transitions project, otherwise known as the reduction of rehospitalization. This is exactly the right combination of medicine, cross cutting care, and value to beneficiaries in the agency that we're looking for. And this is a high value, high return type project where everybody wins. It is best measured from the claims data and we have probably the most sophisticated readmission measuring system in the world today, and it's highly applicable to the frail, elderly population. So this is a real winner and we're planning to expand that considerably. And I've talked to you already the beneficiary protection system, or the beneficiary complaint system is going to have a complete redesign for the 10th Scope of Work. We don't have time to go into it today. It's almost an hour discussion in itself, because it is a complex system, but for those of you who believe that patient complaints and beneficiary complaints are useful in learning what's wrong with our system, especially in the area of disparities, in feeding that information back into quality improvement, you'll appreciate why this is such an important part of our system and why we have to do better than we're doing now at it.

In addition to all of that medically oriented stuff I just want to remind you that we do operate through contractors and so we have a lot of nonmedical stuff and this is the kind of information I had to learn as a new physician to CMS back in 2002. But we have to learn even more than we have now, how to manage contractors more efficiently, we have to learn how to design incentives for higher efficiency and better procurement. We have a serious problem at CMS particularly with our claims-based measures of data lag and we have to learn how to do better with that and there are many innovative ideas coming down, particularly with health information technology that I think will help us make breakthroughs on that in the next three years, coupled with the high tech incentives that are already in law and then we have to get better, I think, at interacting with other components of our agency than we do now. We aren't a regulatory or Survey & Certification system, but I think it would make sense if we worked with them, and we have to do better at that. The Value-based Purchasing you've already heard about should be a big part of this and the QIO should be perceived by the physician community as a go-to resource to help you with these terribly complicated measurements and performance systems and we'd like to do a better job at outreaching to you on that. Data monitoring with policy development is kind of a longer term thing, but Dr. Straube is one of the country's biggest experts on that. We'd like to use our data system and Dr. Straube is fond of saying

that in the quality side of CMS, we process about 250 terabytes of data, which is an equivalent amount of data that exists on the claims processing side. So we have an enormous amount of data that could help us build a better and smarter and safer healthcare system and we'd like to get better at doing it.

And then finally as healthcare reform comes down the road, I think the QIOs could be a very valuable and a much more impactful set of resources for the physician and hospital community and we'd like to do a better job of aligning with the rest of CMS. We'd like to leverage even more of the potential of HIT as a care management tool in learning how to coordinate care better. We're committed to using this program to reduce healthcare disparities because we are by statute allowed to use our resources in those populations and areas of the country that need it the most and that's what we're going to do. And we'd like to focus more work at the patient level like we're doing in the project in Mississippi and the Medicare diabetics in Mississippi.

So just to finish up, here's a few websites. They're all in your package here, except for one, which I only had constructed last week at our annual conference. These are in your package. So there's the Quality Net website that gives you all the resources that the QIOs use in their quality improvement work, there's QIO Synergy, which is our new effort to outreach for partnerships and then there's a Quality Center on the CMS website which is the last bullet on this slide. The next slide has this is the one that isn't in your package so you might want to write this down. We'll have however many minutes the chairman allows us for questions now but if you have further comments about anything that I've talked about or Dr. Straube has talked about, please feel free to use this box, because of the timelines involved in clearance and OGC type issues, we have a deadline of December 14th to receive comments on the QIO 10th Scope of Work. It's not the last time we'll go public with it, but after that, it goes into clearance, so the email address to do that, if you'd like to, is OCSQBox, all one word, @CMS.HHS.GOV and that's on their computer so if somebody isn't clear about it, you could contact Dr. Straube or me or get it from the people here. And the final two people that you should know about with the QIO program is first of all and most important, the Director of the Quality Improvement Group, Jean Moody Williams, a nurse with many years' experience in the QIO Program and Quality Improvement and has done just an excellent job in all of this contractor reform and in getting the QIO program focused. And myself, who provides the medical backup and

direction as we move on into the future. So thanks very much for your attention and Mr. Chairman, I'll hand it back to you and you can tell us how long if any we have for any more discussion.

Dr. Bufalino: The hour is tight, as you insinuated. But we're also here for conversation. Janice?

Dr. Kirsch: Thank you for your conciseness. I have to make a comment about the Welcome to Medicare examination. There's a reason it's underutilized. And that is it's not perceived as having high value. It's a very rigid evaluation. I'm sure that you have some experience with it, if you've had strong Medicare practices. If you miss one element, you can't bill the entire exam, there's no flexibility—

Dr. McGann: Just like a level 5 office visit.

Dr. Kirsch: I know, I mean thank goodness they did raise the reimbursement on it, but it just seems like the efforts could be used much more productively. Sixty-five year old ladies do not like being asked about their toileting function. I mean things along those lines make it a difficult exam. I will put out the point that one of the big obstacles I run into is the G0101 exam, which Medicare only pays for every two years. They pay for mammograms every year, but they will only pay for the breast and pelvic exam every two years, which is somewhat ridiculous and you have to talk people into having to pay for the exam on the off year. So if there is something that was going to improve preventative care services, I would encourage you to look at that.

Dr. McGann: Thanks for that.

Dr. Bufalino: Others? Karen?

Dr. Williams: Speaking of mammograms, what is your position on [inaudible 35:21 1008] publication of [inaudible] the firestorm around pro, con mammogram?

Dr. McGann: Well first of all, I don't have a position [laughter] There are just facts and what is reimbursed is reimbursed, and we tried as much as possible, including the pelvic exam, to follow the recommendations of the US Preventative Services Task Force. So those recommendations are based on the published evidence that there is. We recognize and have observed the reaction in the press, but the coverage that we have in Medicare actually goes beyond those recommendations for mammography, so my observation under the Quality program isn't having a big effect on Medicare right now, but we understand that there's a lot of concern out there. Barry, you might have more to add on it.

Dr. Straube: Yes, thank you for the question because it's come up a lot recently, but in terms of the Medicare Coverage Program, coverage also falls into the Office of Clinical Standards and Quality. CMS and the Medicare Program was given most of the preventative service coverage by statute after the program had started in successive years, and mammography screening is one of those, and the current coverage is very different from what the US Preventative Services Task Force recommended. For us to change that, the Secretary would have to go to the Director of the National Institutes of Health, who would have to make a determination that based on the guidelines that they elicited our coverage wasn't appropriate given those guidelines. Since there are so many other guidelines by reputable guideline producers in this area, I think it's open for discussion still as to whose is the best, so we can't and we wouldn't change our coverage right now. It would have to be done through federal rulemaking also at that point, not through a National Coverage Decision process. I think we're very interested. The answer, we're very interested in the recommendations. I think a lot of folks, because we've made recommendations before, too, and been vilified in the press. And it turns out that a lot of folks haven't even read the recommendations to be able to logically make an opinion about it. So I think we're in the process of we're looking through those guidelines, but putting it into the context of the many other guidelines, that are out there, in the short, intermediate term there is no change in Medicare coverage for…

Dr. Williams: It seemed like the Secretary was sort of back pedaling on making any changes when she made her comments.

Dr. Straube: Oh yes, she was trying to stress what we had suggested she stress, that there was no intent—some people were out there saying we had to change our coverage because of this. That's not true. We're, it's left up to discretion. In that particular coverage, too, I think regardless of what each of us individually may feel about the proper indications for mammography screening, it is very broad and probably covers more than mammography screening. I think the comment that Janice made earlier, it's in some ways, you look at anybody's guidelines, it's a bit on the broad side. But I think it's done so, one, because it came out of statute, and two, the feeling is strongly that this is something when it's not black and white, that really the physician involved and the patient involved should examine in that particular instance,

what the best things to do are, make a decision—we believe our coverage policy, as it is now, gives complete flexibility to do that.

Dr. R. Smith: I just wanted to add the American College of OB/GYN still recommends at age 40 mammogram.

Dr. Straube: Age 40?

Dr. R. Smith: Age 40.

Dr. Straube: Yes, and we pay for, starting at age 40, up to one year.

Dr. Bufalino: Other comments? Thank you very much for your presentation. We appreciate it. We are up for the next presentation, which, as many of you know is the Physician Fee Schedule Final Rule, and although this is appropriated for 30 minutes, it's likely to engender the most discussion of the day, and so we'd ask you to tighten down on your presentation if you wouldn't mind, because I know that there's a fair amount of emotion in the room on this topic, so let me introduce Ms. Cassandra Black, who's Director of the Division of Practitioner Services, here at the Center for Medicare Management. She's responsible for the publication of the Final Rule, and along with her Mr. Hartstein, who is Deputy Director of the Hospital Ambulatory Policy group. Both of them were here last time, and we are once again glad to have both of you back and look forward to this conversation. Thank you. Good afternoon.

Medicare Physician Fee Schedule Final Rule

Mr. Hartstein: Okay. Well thank you very much, Dr. Bufalino. I appreciate being here. As you indicated, I'm Marc Hartstein, I'm the Deputy Director of the Hospital and Ambulatory Policy Group, in the Center for Medicare Management, and we're, Cassie and I are going to go through what was in the Physician Fee Schedule Final Rule, and we'll try to go through it rapidly to leave enough time for questions and discussions.

Dr. Bufalino: Thank you.

Mr. Hartstein: As you indicated, there's probably a lot of interest in our topic. If you'd rather discuss mammograms with us, I'd be happy to take that offer [laughter]. So these are really just very quickly some of the issues that we covered in the Physician Fee Schedule Final Rule. There's a number of provisions of the Medicare Improvements for Patients and Providers Act of 2008. Cassie's going to discuss

some of the ones that are more relevant to this Panel. We discussed a number of Part B drug issues, End Stage Renal Disease, then we made some durable medical equipment related items, some more provisions of MIPPA, and then we covered a number of Practice Expense Relative Value Unit proposals, Malpractice Relative Value Units, some specific coding proposals related to misvalued and over-valued procedures and then the Physician Fee Schedule update.

Probably the most popular issue in the Physician Fee Schedule Final Rule had to do with the Physician Fee Schedule update. I want to spend a lot of time on this one because this is the one that's really popular. [laughter] Unfortunately, it doesn't start out with a popular bullet point about the conversion factor going down 21.5%. However, as all of you know, the sustainable growth rate is a target for the rate of increase in expenditures, and its accumulative target of spending is over that target in a prior year. Not only do we have to return future spending to the rate of target, we also have to reduce, update, or recoup the overage in prior years' spending. Congress has precluded the Physician Fee Schedule update from going down a number of times, however. In doing that they did not allow the target to grow to accommodate that increase in expenditures from the increased update. As a result, we've been now forecasting very, very large negative updates going forward into the future. We've been asked a number of times to take injectable drugs; Part B drugs, out of the target, because those drugs are not subject to the update, and they have been growing very rapidly. We did propose to remove those drugs retrospectively to the 1996-1997 base year, because they've been growing far more rapidly than all other Physician Fee Schedule services that are included in the Sustainable Growth Rate. It actually does have a very, very significant benefit. It doesn't affect the update in 2010 but it does improve the prospects for an increase in the update in future years. It gets into some very technical concerns as to why that is but suffice it to say, it does have benefit and it does improve the likelihood that you'll see a positive Physician Fee Schedule update in future years. It also will have effects on whatever Congressional actions they may take to avoid the 21.2% update in the Final Rule. These, it was almost universal, it was universal in fact, that everybody who commented on this proposal had suggested that we should finalize it and we did so.

The next proposal had to do with Medicare's proposal to no longer—are we on consults? [off mike conversation] The next slide has to do with Practice Expense Proposal, related to the Practice Expense

Information Survey. This is a Practice Expense Survey that was done by the American Medical Association, two or three years ago. A number of specialty societies came to us and asked us to partner with organized medicine to conduct this survey, and to financially contribute to it, and use it to update the practice expense piece of our Physician Fee Schedule payments.

Ms. Black: I think in hard copy, you've got the re-ordered slides, so do you prefer that we follow the hard copy slides that you have or the ones on the screen?

Dr. Bufalino: Yes, hard copy.

Ms. Black: [discussion with Mr. Hartstein]

Mr. Hartstein: Sorry about that. We had some late consultations.

Dr. Bufalino: We're on page six, the consultations.

Mr. Hartstein: Consultations. Okay, so, no pun intended [laughter] [chat] The NPRM proposal, so the coding proposal related to consultations, I mean one of the things that we were looking at in this year's proposed rule was we've had some issues with consultations over a number of years and we proposed to eliminate the consultation codes and instructed, and indicated in the proposed rule that instead of providers billing for a consultation, they would bill for an initial hospital care or initial nursing facility care, and we explained the proposal about our concern that the requirements to build a consultation had gone down over the years and there had been significant controversy over the years as to what constitutes a transfer of care for a physician to be able to bill a consultation and that because the requirements for a consult had gone down over time, our concern was that it made a consult and an office visit or a hospital visit less distinguishable since a great variety of services will take place in that physician encounter. So we got a number of comments on that proposal, we considered those comments very, very carefully before deciding whether or not to finalize the proposal and we did decide to finalize the proposal effective January 1 of this year. One thing that I think is really important to note is the consults proposal is not a savings proposal. Even though we're proposing not to pay any longer for consults, we did say that physicians will be able to bill other E&M services in its place, most commonly an inpatient hospital visit, or an office visit and we forecast, we made some assumptions as to how often the office visits, the new patient, established patient office visits would be billed in place of the office consults and how often the inpatient hospital visits would

be billed in place of the inpatient consults, and we distributed the money that we estimated we would pay in 2010 for consult over the office visits and hospital visits, increasing the payments for those services. So we were paying everybody more for inpatient hospital visits and office visits, at the same time that we're not paying for consultations and we structured the changes in payment such that there would be no increase in spending or savings to the Medicare program from this proposal. As I indicated before, one of the proposals we had in the proposed rule was to use the Physician Practice Expense Information Survey. It was conducted by the AMA with support from a number of physician specialties. This proposal was also redistributive in that it was budget neutral, increased payments for a number of specialties and decreased payments for a number of other services affecting other specialties. The use of the survey updates the indirect practice expense data for almost all of the specialties. We were continuing to use supplemental data for independent diagnostic testing facilities and independent laboratories. These groups had done their own supplemental survey, and they were incorporated in the Physician Practice Expense Information Survey that was done by the American Medical Association. So we didn't have any data to use for those groups who do bill for Physician Fee Schedule services. We did get a number of comments on those proposals. Again, as we always do, we carefully considered all of those public comments. We respond to each and every one of them and in some cases, we did make some modifications in the Final Rule in response to those comments. We did decide to use the PPIS data with a 4-year transition period. We also are continuing to use the supplemental survey data for independent diagnostic treatment facilities and independent labs, and then we also decided to use supplemental data for oncologists. The oncologists had brought to our attention that there was a statutory provision in the Medicare Modernization Act of 2003 that required us to use a supplemental survey that the American Society for Clinical Oncology had done related to their drug administration services and after reviewing that public comment and the statutory provision, we agreed with that comment and we decided to continue to use the oncology supplemental survey. So with that, I'm going to turn it over to Cassie, who's going to take you through some of the other proposals.

Ms. Black: Okay. The first issue I'm going to talk to you about is equipment utilization. In the NPRM, we had proposed to increase the equipment utilization percentage from 50% to 90% for extensive equipment, priced over $1 million. We finalized this proposal in the Final Rule but only for expensive

diagnostic equipment. We did not finalize it for expensive therapeutic equipment. In response to comments, we are implementing this change with a four-year transition.

The next issue has to do with the Malpractice RVU update. In the NPRM, we updated the malpractice data to implement the second five-year review of the malpractice RVUs. And we had proposed to use the medical physicist data as a proxy for the malpractice cost paid by technical component suppliers, such as IDTS. In the Final Rule, we implemented the new data; however, commenters gave us a source of data on the malpractice cost paid by IDTS, so we were able to verify that data, so we used that in the Final Rule.

The next issue has to do with the IPPE. I know that was discussed a few minutes ago. It's known as the Welcome to Medicare visit. It was created in 2003 by the MMA. We implemented some changes to this benefit last year, but at the time we did not increase the valuation of the service. We sought comment on whether it needed to be revalued, and commenters told us that it did. So in the proposed rule, we proposed increasing it to a stage 4 office visit. Commenters were overwhelmingly favorable and we implemented this change in the Final Rule.

The next issue has to do with some of the MIPPA provisions that Marc talked about a few minutes. The first one is some changes that MIPPA made to payments for teaching anesthesiologists and CRNAs. These changes are going to be effective January 1 of 2010. The first issue has to do with a special payment rule and in the Final Rule, we implemented our proposal to implement this rule by paying the teaching anesthesiologist the full fee for involvement in either a single case with a resident or two concurrent cases with a resident, or a resident case concurrent to another case, such as an anesthesiologist assistant or a CRNA, and those are paid under the Medical Direction Rules.

The next issue has to do with anesthesia hand-offs. And in the NPRM, we had proposed to implement another part of the Special Payment Rule and saying that the teaching anesthesiologist must be present with the resident during all critical or key portions of a procedure and that another teaching anesthesiologist or the teaching anesthesiologist themselves must be available during the noncritical or key portions. We also solicited comments on how to maintain quality during anesthesia hand-offs. And in the Final Rule, in response to the comments we received, we implemented an alternate proposal that we had

also discussed in the NPRM, which is to allow members of the same anesthesia group to serve as the teaching anesthesiologist during key or critical portions of a procedure. We did not finalize any proposals related to quality but we said we might revisit this issue in future rulemaking.

The final anesthesia related provision has to do with payment for CRNAs. In the Final Rule, we finalized our proposal to pay a CRNA at the regular rate for their involvement in up to two concurrent cases.

Next I'm going to discuss the MIPPA provisions related to cardiac rehab. Effective January 1, 2010, MIPPA creates a statutory cardiac rehab program and intensive rehab cardiac program. In the past, we had covered cardiac rehab, but that was based on an NCD, the statute requires that a cardiac rehab or intensive program must include physician prescribed exercise, cardiac risk factor modification, psycho-social assessment, and an outcomes assessment. It can be provided in a physician hospital, or outpatient office setting and it requires direct physician supervision.

In the NPRM, we proposed to continue paying for cardiac rehab, using the current codes and in the Final Rule, we finalized our payment proposal. We'll pay a maximum of two one-hour sessions a day. We'll pay up to 36 sessions over 18 weeks; with contractor approval, an additional 36 sessions can be provided. In the Final Rule, we also clarified the physician supervision requirement and the hospital outpatient department and we clarified that the physician must be immediately available at all times that cardiac rehab services are being offered.

For cardiac rehab, we created two G codes to pay for intensive cardiac rehab; one is for cardiac rehab with exercise, and one is without. By statute, payment for intensive cardiac rehab on the Physician Fee Schedule is based on the Outpatient Prospective Payment System amount, and in the Final Rule, we finalized our proposal to pay a maximum of six one-hour sessions and up to 72 sessions over 18 weeks. Physician Fee Schedule payments will be adjusted by the appropriate locality.

Coverage of intensive cardiac rehab is similar to cardiac rehab except in order for an intensive cardiac rehab program to be covered, it must demonstrate through peer reviewed literature positive outcomes. In the Final Rule, we clarified the process that this happens through the NCD process.

MIPPA 144 also creates pulmonary rehab benefits. A pulmonary rehab program must include physician-prescribed exercise, education or training, a psycho-social assessment, and an outcomes assessment, and it must include an individual treatment plan. Pulmonary rehab is also covered in a physician office or outpatient hospital setting, and direct physician supervision is required. And in the Final Rule, we finalized our proposal to pay for 36 one-hour sessions with an additional 36 sessions at contractor discretion; we limited payment to two a day. We also expanded coverage to include patients with chronic obstructive pulmonary disease. We finalized two G codes to pay for this service, and we adjusted payment based on comments.

MIPPA 152 provides coverage of kidney disease education services. In the NPRM, we proposed to cover patients with stage four chronic kidney disease. We defined a qualified person as a physician, nurse practitioner, clinical nurse specialist, and in a rural area, it can also be a hospital, critical access hospital, skilled nursing facility, comprehensive outpatient rehab facility, home health agency, or hospice. We finalized these provisions as proposed. And in the Final Rule, we finalized our proposal to pay up to 6 60-minute sessions. We adjusted payment based on comments.

There were some other issues in the rule. The first is we summarized some information we received on our request for comments on a panel of experts to assist CMS in reviewing relative value units. We also talked about our work on a process to update the cost of high-cost supplies, and finally, we said that we were examining whether to expand the multiple procedure payment reduction. And then your slides close with the websites, for more information on the rule and my contact information. Thank you. Do you have any questions? [laughter]

Dr. Bufalino: Thank you both for the speed and alacrity you presented that with. So let me open the conversation. Who would like to begin? Janice?

Dr. Kirsch: I just want to comment on the Physician Practice Information Survey. At one of the last AMA meetings, there was a resolution that went through for us to extrapolate geographic data out of that survey and there is a Final Rule from the AMA on that and interestingly, there isn't geographic variation in practice expenses and there are a number of issues that probably pertain to that, including concerns that I brought up before that on the practice expense GPSI, there's a 26% weight on rent expense,

when a number of studies suggested that that number probably is closer to 10%. The use of the HUD information, which is not exactly reliable. In the State of Iowa, you have these little towns where the rents are extremely low, the head rates are very low, but you don't have the practices in those little towns, so it floats everything downward. And we hear time and time again, that we just don't have easy information to tap into and I just want to point out that yes, I think there is some information that points to, that the degree of discrepancy in payments throughout this country really should be narrowed.

Dr. Hartstein: Okay, well thank you for that comment. I mean the Practice Expense Information Survey was not designed to measure geographic differences in the cost of operating the practice. It really was intended to measure the differences in the cost of practices operated by different specialties. We do have a statutory obligation to adjust Physician Fee Schedule payment rates by the geographic practice cost index, and we've also contracted with Acumen to look at the physician payment localities within the last two years, and I know there's a lot of interest on Capitol Hill in geographic differences in payment and if there is a statutory change that would require us to adjust payments differently than currently required by the law in the geographic practice cost index, we certainly will implement those provisions of the law. Thank you.

Dr. Giamio: I had a couple of things actually, is it best I do one at a time, or—

Dr. Bufalino: Please.

Dr. Giamio: First of all thank you very much for the SGR and IV medications. That's very much appreciated by the physicians in helping us with some of these long-term things. One question of clarity was regarding rehabilitative services. When they say "supervision," is it direct supervision within the facility? That's how it's defined. Okay. And now I was going to go over, if I may, over to the fee schedule. There's a number of areas that we needed some clarity as a group of physicians, and this has been what's been the topic of most of our conversation in our sidebar meetings. One of them is the implementation of this proposed plan with such short notice for physicians. And a number of the problems that may instill as far as access to care and being able to clarify our billing purposes. There is one of the caveats was about having a modifier for the admitting physician or the primary physician of case. That modifier's not available as far as I'm aware at this time. The ability to be able to if there is really not a lot of crosstalk

between the agency, CMS, and secondary insurers, how will be able to bill as a consultant for a plan, and then if Medicare is a secondary, how will that then be affected? Will that be kicked out if we're billing as a consultive code? On one issue? I can stop right there because I know there's a number of other people who want to have the floor, but I'd like maybe some answers to those two questions about the modifier, and about if Medicare is a secondary, how will that be handled in this proposed legislation or proposed ruling?

Mr. Hartstein: Okay. Well I guess the first thing to say is when we proposed the policy, we did propose it effective January 1, we did allow for a 60-day public comment period. The Final Rule was put on public display on October 30, so there's another 60-day delay between the time that the rule went on public display and the time that the rule goes into effect. We did receive a number of public comments about the proposal, some of which we did our best to try to answer in responses to those public comments. And we don't have authority to say to a private insurer whether or not they can or can't use the consultations. They certainly can, however, if they do use the consults codes, it will be inconsistent with the Medicare policy. Medicare will not be using the consult codes, we will be using other codes in place of the consult codes. So if a consult is billed to Medicare then that service, beginning January 1, won't be used. So the issues with secondary payers are really within, they really have to make some determinations on their own as to whether or not they're going to have policies that are consistent with Medicare or not. Again, we offered, in response to some of the public comments in the rule, we offered up what the potential options are for those private insurers, but we don't have the authority to make them select a particular policy. I think the likelihood is that for Medicare patients, we would expect that they would adopt Medicare's policy, just for administrative ease, but again, we can't require that. With respect to the modifier, when we put out a policy like this, or any policy in the Physician Fee Schedule Final Rule, what we typically do is we do an instruction to our contractors, and then we'll do a MedLearn Matters article, a Medicare education article for providers. The consults proposal has raised a number of questions and concerns. As these questions and concerns have been coming to us, we've been trying to do our best to answer them. We want to try to put out a single Medicare education article to inform physicians of how the new policy's going to work, as soon as possible time, and we're hopeful that that will go out shortly. As questions come to us, we've been revising that article so it's delayed by some number of days. The time

until it's released—but we're very close to putting out a change request to our contractors and that will follow up this Medicare education article.

Dr. Giamio: Can I have a follow up question if you don't mind? Thank you for that input but in the light of a proposed 21% downturn for physicians in practice, and the possible delays to claims and processing that will be initiated with all this, do you think maybe this is not a good time to introduce this policy?

Mr. Hartstein: Well, the policy was adopted through Notice and Comment Rulemaking, so we certainly put the Congress on notice, I'm sorry, we put the public on notice, that we were planning on doing this policy. We are aware that there is statutory reduction of 21% in Physician Fee Schedule rates and that Congress at several points in the past has averted that reduction. Right now, we're at the point where we really have no choice other than implement the requirements of the law, which will require this 21% reduction in payments. If Congress were to change the 21% reduction in payments, we will work as quickly as possible to get out the corrected rates, which don't include that reduction in payment rates. And we will, again, also educate our contractors and try to communicate as best we can with physicians. We have had a number of times where the Physician Fee Schedule update, the large reduction has been averted. So we are gaining more experience with this process and I'm optimistic that if Congress were to act again to change the reduction in the update, we would have correct information out to our contractors at the soonest possible time.

Dr. Bufalino: So just to go back to the budget neutrality aspect of the consultation; some of us with a back of the napkin kind of analysis are struggling with trying to understand how the crosswalk works here, when you remove level 4, level 5 consultations on both the inpatient side and the outpatient side, how moving to level 3 initial hospital encounters and follow up visits is going to translate a spreading of the money back into the pot. So could you help us with that a little bit? Because we are just trying to understand how you wipe out the highest paying codes and make it all still work?

Mr. Hartstein: Well, what we did was we made some assumptions. Obviously, we don't have any data on how those services are going to be billed in the future, because they haven't been billed yet, so we have to make some assumptions as to how the volume of consults will be billed as inpatient hospital visits

and office visits and that's what we did, and we did put a crosswalk out on the CMS website. The crosswalk is to identify how we were going to distribute the payments for consults over the hospital visits and office visits. It's not a crosswalk that's intended to be used by physicians, when billing those services. It was just our best guess as to how we think those services will be billed in the future. So like the level 4, level 5, those high-level consults, we made an assumption about how those would be billed as office visits, and we allocated the money based on those assumptions.

Dr. Bufalino: And it all washes?

Mr. Hartstein: Whenever we do anything with budget neutrality, we always use utilization data from a past year, so in this case, we're setting the rates for 2010, using 2008 utilization data. So what we did is we took the billing of those consults in the 2008 utilization data. We also looked at the billing of office visits and inpatient hospital visits in the 2008 utilization data. We added sufficient number of RVUs to the codes that are still billable to replace the exact volume and relative value units for the codes that will no longer be billable.

Dr. Bufalino: So when will you relook at this again, assuming that now we're alive and it's into 2010 and we know how it gets billed? When will you relook at it to decide whether or not you've appropriate proportioned the increased RVUs for the other codes?

Mr. Hartstein: When we make these budget neutrality adjustments, we're doing it based on assumptions. We can evaluate how well, we can certainly evaluate the billing of consults, I'm sorry, the billing in place of consults in 2010 sometimes in 2011, when we're doing the 2012 rule.

Dr. Bufalino: And so if it doesn't calculate out, then there will be a possibility of an adjustment in the RVU calculations?

Mr. Hartstein: That's to be determined. [laughter] I'll leave it at that.

Dr. Ahaghotu: Just a quick question. When do you anticipate that this education article will be available?

Mr. Hartstein: We're trying to get it released as soon as possible, and I think our hope is that it will be later this week.

Dr. Ahaghotu: So prior to implementation?

Mr. Hartstein: Oh, absolutely. We want to give physicians as much lead time as possible before January 1 in knowing how to address these issues. Yes, yes, yes, I see you looking at your watch. I know what date it is. [laughter] Stop asking us questions and we'll get it out.

Dr. Williams: Thank you for the change in ruling that was published in the Final Rule regarding teaching anesthesiologists. You mentioned in your verbal report that we will get full coverage for teaching two concurrent residents. Is that what you meant to say?

Ms. Black: Yes.

Dr. William: Because it was different in your book.

Ms. Black: Oh, well, it's two concurrent residents.

Dr. William: Okay, and the other question I guess I had was my understanding is that nurse anesthetists that supervise two student nurse anesthetists get paid 100% for concurrent supervision, but anesthesiologists, physicians, do not. They still get paid the 50% for supervising two student nurse anesthetists, is that right?

Ms. Black: Right, under medical direction.

Dr. Williams: And can you tell me why that is?

Ms. Black: Well, MIPPA didn't make any changes to the medical direction rule.

Dr. Williams: But you did make a change to the CRNA supervising the two student CRNAs, right?

Ms. Black: Right, because there was a provision in MIPPA that addressed that CRNA payment. There was a special payment rule for CRNAs included in the legislation.

Dr. Williams: Is there, outside of the law, is there a rationale behind that that you can explain to me, so I can…

Ms. Black: Well, we were implementing the law. Congress created some provisions that dealt with teaching anesthesiologists, and they created this provision that dealt with teaching CRNAs and we implemented both.

Dr. Williams: Thank you.

Dr. Standaert: I just want to be clear, I know you're going to send an article out, somewhere around the Christmas holidays regarding this, but as of January 1, if somebody bills a consult code, does that have an RVU of zero, so it doesn't get paid, does that code get bounced and sent back to you to be rebilled, or what exactly happens with that? And if you have a patient who has dual insurance, can you bill a consult and their insurance will take the consult code, can you bill that primary insurance and Medicare separately with different visit codes, or is that a problem?

Mr. Hartstein: There are codes in the HCPCS, in the CPT and the HCPCS, that have what's called a Proc Stat, or a procedure status of I, which means that another code is used to determine payment for that service, so the code is returned to the physician to use the other code that describes that service, and that's what will happen with consultation services.

Dr. Standaert: So it won't get dropped to be value to zero, it'll get bounced back to the doctor.

Mr. Hartstein: No, correct. So be billed with a code that's currently active and paid under the Physician Fee Schedule.

Dr. Standaert: All right.

Dr. Ouzounian: He only answered half the question.

Dr. Standaert: Yes, the other half of the question. Can you bill separate, can you bill a consult code—

Mr. Hartstein: I want to talk to you afterward. [laughter]

Dr. Standaert: Got lost in the I thing, threw me. Too many acronyms once again.

Mr. Hartstein: This is really the question. I mean, that I was asked earlier. Medicare is not accepting the consultation codes, so if a consultation code is billed to Medicare, that claim will be returned for correct billing. The interaction with, and we had indicated that a private payer either has the option of continuing to use the consultation codes, which would be inconsistent with Medicare's policy, or it could not use the consultation codes, which would be consistent with Medicare's policy, which would certainly facilitate billing and payment of claims where the patient has two insurers.

Dr. Standaert: But again, what happens if you had—so when you bill that, can you bill, say the insurance pays a consultation code, so you bill that to primary insurance. For you to bill Medicare, to get reimbursed for the Medicare portion of that visit, you have to bill a whole different code.

Mr. Hartstein: That's correct.

Dr. Standaert: And is that legal? Can you bill two different codes for the same visit to two different insurers? Medicare and somebody else?

Mr. Hartstein: I can't answer the question as to whether, I mean presumably it is legal. I, we have had, this is not a particularly unusual situation. We've had situations before where Medicare will not recognize a code in the HCPCS, and we will put this indicator that I described before, a procedure status code indicator of I. Typically, our understanding is what private insurers do is they adopt Medicare's policy when there's a patient involved who has Medicare insurance and private insurance, but they're not required to, because we don't have authority over the private insurer.

Dr. F. Smith: The question is not when the patient has Medicare primary and another insurer, that's easy. It's the reverse.

Dr. Standaert: Right, it's the reverse. Do you bill twice with two different codes?

Dr. F. Smith: And we know in many areas, national carriers in our area are going to continue to honor the consult codes. They've said that. So if we bill Medicare secondary, do we change the code to bill it to Medicare with the ELB from the primary that then has a different code?

Mr. Hartstein: This is one of the issues that we'll need to address in our change request in our MedLearn Matter article. Yes.

Dr. Bufalino: Another question. As far as the PPIS, it appears that there's some inconsistency in terms of some groups are being treated by the survey data and other groups are being treated by the supplemental survey and we know there's a number of specialties that have asked to be treated by the supplemental data. Could you talk about that inconsistency in the fact that some groups are treated one way and others are not?

Mr. Hartstein: Yes, as I indicated in the presentation, IDTFs and independent laboratories were not represented in the PPIS survey. There really was no other data to use except for the supplemental survey

data. Oncologists had done a supplemental survey data and have a special statutory provision that requires us to use the supplemental data. Other than that, we did not use the supplemental data for any specialty that completed one.

Dr. Bufalino: And the fact that that's inconsistent in terms of, I mean there are plenty of people who have questioned survey data and wonder whether or not the supplemental survey data was better than the data in the PPIS.

Mr. Hartstein: Yes, well we evaluated the PPIS data. We evaluated the supplemental survey data and we felt that the best option was to use a single source for all physician specialties, where it was possible to use that survey information. Like I said before, in the case of independent labs, and IDTFs there was really no other survey data to use, so we couldn't use the PPIS survey, because of the special oncology statutory provision, we had to use it. Otherwise, our feeling was that we should use a single data source to value practice expense for all specialties.

Dr. F. Smith: I had to leave briefly because colds cause trouble, but anyway, and I hope I'm not duplicating something you clarified earlier, but on your slide number six, where you're talking about the consultation services, you say you're eliminating the consultation codes in all settings except telehealth and then it says, "Instead, providers bill initial hospital care or initial nursing facility care." My understanding was that if it was an office visit, we billed an initial office.

Mr. Hartstein: That's correct.

Dr. F Smith: So this is incorrect?

Mr. Hartstein: It's not complete.

Dr. F. Smith: It's not complete. Okay.

Dr. Bufalino: Recommendations? Joe.

Dr. Giamio: PPAC recommends that CMS delay the implementation of the regulatory policy that prohibits payment for consultative services for a minimum of one year. This will allow further time for education and clarification of the possible implications of these changes.

[Second]

Dr. Bufalino: Discussion? All in favor?

[Ayes]

Dr. Bufalino: Any opposed. Thank you. Others. Jeff?

Dr. Simon: Point of clarification.

Dr. Bufalino: Please.

Dr. Simon: With the elimination for non recognition of the consult codes for 2010, physicians are instructed to use the initial inpatient hospital codes for those patients that are inpatient and to use the initial nursing care home codes for those patients that are in the nursing homes. To complete the sentence that you were asking, if those patients are seen in the outpatient setting, then you use either the new or the established E&M codes for those services.

Dr. F. Smith: Yes, I just wanted to make sure, because this made it sound the opposite

Dr. Simon: That's why the point of clarification.

Dr. Bufalino: Others? Dr. Ross?

Dr. Ross: Yes, Dr. Hartstein, in terms of your discussion on the SGR, I'd just like to point out some facts, number one that all physicians are facing an extreme, steep cut as you well know, this 21.2% on January the first. This so-called, as you described, the Congressional fix, as they call it the Doc Fix, maybe one way to eliminate that problem, but as you well know, the cost of living expenses, malpractice, rent, payroll, other expenses, materials, continue to go up and if you want to stay neutral, you're really not staying neutral, so given this in the current economic climate, physicians will be confronted with a, I would describe, a dire situation that will preclude many of these physicians from accepted Medicare beneficiaries as patients, thus hurting these seniors' to access to care. At this particular time, how ironic it is, that our nation has an historic opportunity for health reform, and fixing the Medicare payment formula once and for all, averting this 21.2% physician payment cut. And this can be a cornerstone of this effort. Therefore, I would like to recommend at this time, that PPAC recommends that CMS reform this seriously flawed SGR formula, and provide physicians with reimbursement that keeps up with the cost of practicing medicine. I think this is something that needs to be done once and for all, and to recommend that CMS advise the Congress to do so. We appreciate that.

[Second]

[Third]

Dr. Bufalino: Discussions? All in favor?

[Ayes]

Dr. Bufalino: Any opposed? Other recommendations, Dana, I'm sorry?

Ms. Trevas: [inaudible]

Dr. Bufalino: Yes, there was. Voted in, unanimously. Other recommendations?

Dr. Ouzounian: PPAC recommends that CMS reconsider their decision to eliminate the consult codes and instead remain consistent with the definition as per the— [interruption]

Ms. Trevas: [inaudible]

Dr. Ouzounian: PPAC recommends that CMS reconsider their decision to eliminate the consult codes, and remain consistent with the AMA CPT guidelines.

Dr. Bufalino: Second?

Dr. Ross: I would also add an amendment to that?

Dr. Bufalino: How about a second first?

Dr. Ross: Sorry.

Dr. Bufalino: Thank you.

[Second]

Dr. Bufalino: Sorry, amendment?

Dr. Ross: And to his, a friendly amendment to where he described the AMA, also the Medicare payment advisory commission, which also recommended to Congress administration, just say, and to add MedPac to AMA.

Dr. Bufalino: Comfortable?

Dr. Ouzounian: Sure.

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

[Ayes]

Dr. Bufalino: Anybody opposed? Thank you. Any other recommendations? Thank you both for joining us. Have a good afternoon. We will try to keep this going since we are going to begin losing

Council members, so let's try to get to the next conversation. We welcome Carrie Bullock, who's the Acting Deputy Director of the Division of Outpatient Care. She has been in a variety of different settings, and then has been involved with CMS since 2007. We are here to talk about OPPS and the Ambulatory Surgical Center fee schedule Final Rules. Thank you for joining us.

OPPS/ASC Fee Schedule Final Rule

Ms. Bullock: Thank you for having me. Okay, I've been informed my files are corrupt, so I believe they did some quick maneuvering and we have a PDF, a file up on the screen, but if that becomes too cumbersome, we'll just run through your handouts very quickly. And I've been informed I also need to go quickly as it is, because I should have finished 15 minutes ago.

So at the same time the Physician Fee Schedule Final Rule went on display, the Outpatient Prospective Payment System and ASC Final Rule also went on display. I'll note that we will accept comments on some designated provisions through December 29th.

In your handout, you'll see an outline of the topics we'll cover, and again, we're going to go through this really quickly. By way of background, we pay for groups of services under the OPPS that are similar clinically and in terms of resource utilization, and we annually update those groups' weights, and also the services that are assigned to individual groups, using the most recent claims data and cost reports from hospitals, and also the most up-to-date weight indices.

Drugs and biologicals, under the OPPS, always an area that gets lots of attention. We pay for the less expensive drugs and biologicals through their associated procedure payments and we provide separate payments for the more expensive drugs and biologicals separately. In 2009, we're paying at ASP plus 4% for drugs that are over $60 per day. And I think we're losing some slides. [looking through presentation] It looks like we're losing some slides, so I am just going to refer you to the handouts. So on slide number 7, you'll see that in 2010, we implemented a policy to continue paying at ASP plus 4% for separately payable drugs and biologicals. These are drugs that are over $65 per day.

And moving on to drug administration, on slide 8, we're going to continue using a 5-level APC structure for those procedures that we established in 2009. Slide 9, radiopharmaceuticals, we recognize therapeutic radiopharmaceutical and diagnostic radiopharmaceuticals, under the OPPS. For the therapeutic

radiopharmaceuticals, we have been mandated by law through the end of this year to pay at charges adjusted to cost. That is expiring. And we implemented a policy to begin treating them like drugs, beginning in 2010, so we'll pay based on ASP plus 4%. This is the first time we're asking manufacturers to voluntarily submit ASP data to us. And we'll continue our policy of packaging payment for diagnostic radiopharmaceuticals into the nuclear medicine procedures with which they are used.

On slide 10, brachytherapy sources, also statutory provisions that provide special payment for them that charges adjusted to cost will be expiring and we implementing a policy for 2010 to pay based on their median cost from our claims data. Slide number 11, physician supervision. This was an area where we received lots of attention this year. The law authorizes OPPS payments for hospital services that are provided incident to physician services, rendered to outpatients. And in the 2009 Final Rule, we restated and clarified our requirements for physician supervision of outpatient diagnostic and therapeutic services. And on slide 12, you can see what those are. We stated our expectation that all therapeutic hospital outpatient services, including those in CAHS, would be furnished under the direct supervision of a physician in the hospital and in all provider-based departments of the hospital, both on campus and off campus. And for provider-based departments, we specifically stated that direct supervision means the physician must be present and on the premises of the location and immediately available to furnish assistance and direction. I'll also note that our current policy through 2009 is that nonphysician practitioners may not provide supervision in a provider-based department.

So moving on to slide number 13, the polices that we implemented for 2010 with respect to the supervision of therapeutic services. First, we implemented a policy by which nonphysician practitioners, including nurse practitioners, clinical nurse specialists, certified nurse midwives, and licensed clinical social workers, may supervise all therapeutic services that they may, themselves, perform, within their state cope of practice, and hospital-granted privileges. Would also note that all other provisions in the law related to the collaboration between these nonphysician practitioners and physicians still continue to apply, and also that the exception to nonphysician practitioners being able to supervise outpatient therapeutic services is for cardiac rehabilitation, intensive cardiac rehabilitation, and pulmonary rehabilitation. As

Cassie mentioned in the last presentation, the law requires that only physicians may directly supervise those services in hospital outpatient departments.

We also said in the 2010 Final Rule that the definition of direct supervision means for on-campus services, means that the physician or nonphysician practitioner must be present on the same campus and immediately available to furnish assistance and direction throughout the procedure and that applies not just to provider-based departments for which we had specified that in the past but also other locations in the hospital or off campus. And then on slide 14 we talk about the diagnostic services and our policy for physician supervision there. Under current policy, for provider-based departments specifically, Medicare pays for the diagnostic services that are furnished at the appropriate level of supervision that's listed in the Physician Fee Schedule relative value file, and again, that's specified for provider-based departments in particular.

And so in the Final Rule for 2010, on slide 15, we broaden that to specify that for all hospital outpatient diagnostic services that are furnished directly or under arrangement, whether they're provided in the hospital provider-based department or nonhospital location, that the Physician Fee Schedule supervision requirements should be followed. And we'll also note that direct supervision has the same definition here as for therapeutic services that the physician must be present on the campus and immediately available to furnish assistance throughout the procedure.

On slide 16, first of our slides talking about some special MIPPA benefits that begin on January 1, 2010. Kidney disease education will be provided for people with stage 4 kidney disease, when they're furnished by a qualified person, which includes a physician, physician assistant, nurse practitioner, or certified nurse specialist, and hospitals come into play here, because the law also will pay for rural providers of services and those would include hospitals, CAHS, SNFs, home health agencies, rehabilitation facilities and hospice programs, again, but only when those are located in specific rural areas. And on slide 17, you'll see our references to the payment and coverage provisions. The rural providers will bill G codes in order to receive payment for these services.

On slide 18, pulmonary and cardiac rehabilitation, additional new MIPPA provided benefits. In the Physician Fee Schedule their payment and coverage are discussed. Under the OPPS, as you see, on

slide 19, we'll continue to pay for cardiac rehabilitation at the rate of $38. This is something we have covered under the OPPS in the past. We'll also pay for the intensive cardiac rehabilitation at the same rate for 2010, but we're implementing G codes, so we can collect some specific data for the intensive cardiac rehab programs and consider whether to adjust that payment in the future.

On slide 20, we outline payment for Type B ED visits under the OPPS. The Type B EDs are those that are not open 24 hours a day, 7 days a week, but which have, and incur an EMTALA obligation, and we have special codes that hospitals use under the OPPS to report their costs for those services, and receive payment and in 2010, we're going to be providing 5 specific levels for the type B ED visits.

Slide 21, partial hospitalization program. We have PHP services are paid when provided by hospital outpatient departments, and also when they're provided in community mental health centers under the OPPS. There are two payment rates; one for service, three services and one for four or more services provided in a day.

On slide 22, we mention quality reporting and how that relates to the OPPS and in 2010 hospitals that failed to report the existing quality measures in CY 2009 will receive a 2% payment reduction. We also said in the OPPS Final Rule that we'll continue to require those in 2010. We also outlined a new validation requirement. It won't affect payment at this time, but hospitals should become familiar with it for the future and we also established in the rule, some procedures to make quality data publicly available as early as June of next year.

ASC payment on slide 24, as I think everyone here is familiar, back in 2008 we implemented a revised system that uses the OPPS payment weights and payment policies, and for the first time in 2010, we're authorized by law to implement an update factor to the ASC rates, that's 1.2%. And we'll make almost $3.4 billion in payments to approximately 5,000 ASCs projected for 2010. As you see on slide 25, 2010 is year three of a four-year transition. This means that the rates will be based on 25/75 blend of the 2007 ASC rates, and the 2010 rates calculated according the revised payment methodology. We added 26 surgical procedures to the list of procedures that may be covered in an ASC, and we also newly designated six procedures as office-based, an additional 16 as temporarily office-based, and payment for those will be made at the lesser of the Physician Fee Schedule rate or the ASC rate.

On 26, key websites, and 27, questions, slide 28, you have my contact information.

Dr. Bufalino: Thank you. That was quick. We appreciate that. Take a breath. Comments, questions for Ms. Bullock? You've caught them at a moment of fatigue, to your benefit.

Dr. Standaert: I want to get in a recommendation on a prior subject—I may have to leave before the end of the next presenter, so when she's done I'd like to come back to that.

Dr. Bufalino: Well thank you for joining us. Thank you for the information. We appreciate it. So we have the Fraud & Abuse update has been postponed 'til March. So we're not doing that. The only written testimony we have is the AMA written statement testimony which you have with you for any review or comment. And then I thought we could wrap up sort of round A of the recommendations, take a break, have Dana kind of put them together, and then who's left, we can kind of go around and take a look at those and approve them before we leave. So another round of recommendations. Chris, you want to start please?

Wrap Up and Recommendations

Dr. Standaert: Yes. PPAC recommends that CMS rapidly clarify the process for utilizing E&M codes in a clinical setting involving the appropriate use of a consultation code that is covered by an additional insurance carrier.

Dr. Bufalino: Second?

Dr. Ouzounian: Second!

Dr. Bufalino: Thank you.

Dr. Standaert: It's what we were getting at, just put it in writing.

Ms. Trevas: I'm sorry. Could you repeat it?

Dr. Standaert: PPAC recommends that CMS rapidly clarify the process for utilizing E&M codes in a clinical setting involving the appropriate use of a consultation code that is covered by an additional insurance carrier.

Dr. Bufalino: Okay, second we got. Any discussion? All in favor?

[Ayes]

Dr. Bufalino: Thank you. Anybody against? Others? Okay. Well, go ahead, I'm sorry.

Dr. R. Smith: This has nothing to do, just for consideration, for the March meeting, is the week after the AMA's National Advocacy meeting, I didn't know if anyone was going to participate, I just wanted to hear recommendation, maybe to move the meeting up one week, to the first?

??: We can't do it.

Dr. R. Smith: Can't do it? I just thought I'd ask.

Dr. Bufalino: We have a better chance of Mr. Obama visiting us today than [laughter]

Dr. Kirsch: …comment that last year, this meeting was held just right at the time, and it was very convenient and I just stayed in town and went to the AMA Advocacy, and if there's any way to match them up for next year, that would be nice.

Dr. Standaert: For our next meeting, could we make suggestions? We did not hear from RAC. I know we had a ton on there, but as we get into RAC roll out, it would be nice to hear from them again, come March, just as a suggestion.

Dr. Bufalino: Great. All right, well, let's take a break, and we'll let Dana get the recommendations together for everyone's review and then we'll finish this off. Thank you.

[Break]

Dr. Bufalino: Here's the recommendations, anybody that's here. The recommendations are all here so if you all just want to take a look at them so that we can wrap this up and get everybody off to the airport. Anyone have suggestions? Anyone uncomfortable with the recommendations? Dr. Ross?

Dr. Ross: I just want to probably after the statement to reform the—

Dr. Bufalino: What number are you on?

Dr. Ross: 70K-2. Avoid the 21% cut in reimbursement on January 1st, 2010, and then to advise Congress to reform the seriously flawed sustainable growth formula.

Ms. Trevas: Could you restate it for me please?

Dr. Ross: PPAC recommends that CMS recommend to avoid the cut of 21% on January 1, 2010 and advise Congress, and that same statement, to avoid the 21% cut on January 1, 2010.

Ms. Trevas: Do you want me to break that into two?

Dr. Ross: You can. Thank you.

Dr. Bufalino: Any issues with that? Great. Anyone else? Okay, so we'll leave these as is. We'll send them out to everybody for review for those that missed and wrap up the meeting, and let me close by just thanking everybody for being here and I want to take a moment to thank the CMS staff, Bob and Kelly for all the arrangements and making it comfortable for us to be here in Washington. We appreciate that. Thank you, John and Dana, for your support today and thank you, Ken, for dinner last night. It was an enjoyable evening. So thank you all for being here. We will see you on March the 8th, next time. And for four of us, that'll be the last meeting. All right? Have a good day.

Adjournment