CENTERS FOR MEDICARE AND MEDICAID SERVICES

PRACTICING PHYSICIANS ADVISORY COUNCIL

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

Monday, March 8, 2010
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

Jonathan D. Blum, Director
Center for Medicare Management and
Acting Director, Center for Drug and Health Plan
Choice

James Bossenmeyer, Director,
Division of Provider/Supplier Enrollment

Kim Brandt, Director
Program Integrity Group
Office of Financial Management

Kelly Buchanan
CMS Staff

Commander Marie Casey, R.N.,
Deputy Director, Division of Recovery Audit Operations

Rochelle Fiato
CMS Staff

Robin Fritter
CMS Staff

Ellen Griffith
Office of External Affairs

Edith Hambrick, M.D.,
Medical Officer,
Centers for Medicare Management

Terry Kay, Acting Director,
Performance-Based Payment Policy Staff

Connie Leonard, Director
Division of Recovery Audit Operations

George Mills, Director
Provider Compliance Group

Robin Phillips
CMS Staff

Carlene Randolph
CMS Staff

Liz Richter, Acting Director
Center for Medicare Management

William Rogers, M.D., Director
Physicians Regulatory Issues Team
Office of External Affairs

Kenneth Simon, M.D., M.B.A.
Executive Director
Practicing Physicians Advisory Council

Tony Trenkle, Director
E-Health Standards & Services

Latesha Walker, Director
Division of Medical Review & Education

and

David Hunt, M.D.
Medical Officer
Office of the National Coordinator

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MS. DANA TREVAS, Rapporteur
Magnificent Publications, Inc.

AGENDA

Open Meeting

Dr. Bufalino: Good morning. Welcome to the Practicing Physicians Advisory Council. Thank you for joining us today. This is the 71st meeting of the Council and we're here in Medicare Headquarters, back to our home, as they say. I'd like to thank all of my colleagues for taking their time out of their busy schedule to join us for today's session, and we appreciate your willingness to take the time to not only engage in these areas, but provide thoughtful commentary to the agency in these areas. Today's topics are rather robust and diverse, but they cover a number of things, including the PECOS and EHR Updates, Medical Review Update, the RAC Update, and along with some discussion on fraud and abuse and we'll have Bill Rogers today, as usual, give us our PRIT Update. I'm confident as always that you will help provide some practical insight from your day-to-day practices in an effort to provide guidance for the agency. So thank you all for being here. I'd like to begin the morning and welcome Jon Blum, who's the Director for the Center for Medicare Management and Acting Director of the Drug & Health Plan Choice. He's taken time out of his business schedule to join us. We thank you for that and ask you to open the morning.

Welcome

Mr. Blum: Great, well thank you. Thank you everybody for coming to Baltimore today. Thank you to our guests for coming out to headquarters. I just want to start off by thanking everybody for your service. This has been a very active time for the agency, for CMS, for the Medicare Program, and I really want to thank you for your leadership, taking the time out of your busy schedules to participate on PPAC and just to let you know how much your work is fully appreciated. I want to extend a very special thank you to our four PPAC members whose terms are ending and just to thank you for your service. First, Dr. Tye Ouzounian. I really want to thank you. Dr. Jeffrey Ross, I want to thank you as well, and Dr. Karen Williams, just thanks for your leadership and for your service. And I want to extend a particular thank you to Dr. Vincent Bufalino. The past two years you have served as chair of this Council and have served with distinction and with particular leadership. PPAC has been critical in the past couple years, and it's going to be more critical going forward. We are on the verge of passing health reform that's going to give the agency new authorities, new directions to think about Value-based Purchasing, to think about how we change the nature of our current payment systems to ones that promote value and quality and just want to

remind people that the agency's going to go into a very active period in the next couple years, so your time and your efforts will be that much more critical. Today's agenda, I'm very pleased, will be focusing on topics that are front and center for the agency, fraud and abuse, payment accuracy, EHRs, and so I'm looking forward to a very active discussion. And with that, I'll turn it back to Dr. Bufalino.

Dr. Bufalino: Thank you, Jon. Also want to recognize Liz Richter, who's Deputy Director of the Center for Medicare Management. We always are pleased to have you join us and spend the day with us chitchatting, as we say. So thank you for being here. So let's move into the agenda. We ask Dr. Ken Simon to begin the morning with the PPAC Update. As you know, Ken is the Executive Director of PPAC and a Medical Officer here at the Center for Medicare Management. So Ken, thank you, we look forward to your report.

PPAC Update

Dr. Simon: Morning, Councilmembers. The response report from the December 7, 2009 meeting. Agenda Item D, Physicians Regulatory Issues Team Update, commonly called the PRIT. Response 70-D-1: PPAC recommends that CMS requirement that physicians be enrolled in PECOS be delayed for 18 months. The response: Since the publication, which was published in the *Federal Register* on April 21, 2006, CMS-6002F, which pertains to the requirements for establishing and maintaining Medicare billing privileges, CMS encouraged physicians and other suppliers to update and maintain their enrollment record with the Medicare program. Physicians may enroll or update their Medicare enrollment record by completing and submitting the applicable Medicare enrollment applications, or by completing an enrollment application via Internet-based Provider Enrollment, Chain and Ownership System, commonly called the PECOS. In either case, a physician's application would be processed by Medicare contractor using PECOS. We will thoroughly address this recommendation during the PECOS presentation during today's meeting.

Agenda Item 70-D-2: PPAC recommends that CMS review the PECOS enrollment form with an independent, unbiased consultant, and make the form more user friendly. CMS response: Since the inception of the Medicare Enrollment Application in April 1996, CMS has issued several revisions to improve its usefulness and usability. In making these revisions, CMS solicited public comments via the *Federal Register* and obtained the Office of Management and Budget's approval before implementing changes to the application. Prior to developing and finalizing the April 2006 revision, CMS contracted with

the Pacific Consulting Group to review and revise the application format and instructions to make them more appealing and user friendly. In addition to incorporating revisions mandated by changes in the Social Security Act or Medicare policy, the goal of revising the Medicare Enrollment Application has been to make it easier to complete and to make the instructions more concise. In fact, in the April 2006 version of the Medicare Enrollment Application, it reflected a number of user friendly revisions including a reduction in number of pages associated with completing the CMS-855B form by 18 pages. CMS announced the release of the revised Medicare Enrollment Application and outlined the significant revisions in a MLN Matters article, SC0632, which was posted on the CMS website. Many of these revisions were based on comments received from representatives of the healthcare industry, such as the American Medical Association, the Medical Group Management Association, Medicare contractors, and providers and suppliers required to complete the form. While we are considering revising the Medicare Enrollment Application in calendar year 2010, to ease the burden and facilitate the enrollment process, it is important to note that the Internet-based PECOS enrollment process reduced the time necessary to complete a Medicare Enrollment action by a physician, provider, or supplier. It is also important to note that since the Internet-based PECOS is based on content units and is scenario-driven, applicants are only required to complete questions based on their provider or supplier type. Accordingly, a physician would not see or complete questions related to a nonphysician practitioner. The use of Internet-based PECOS reduces the application submission errors and facilitates the Medicare contractor's review and adjudication process. We will also address this recommendation during the PECOS presentation today.

Agenda Item 70-D-3: PPAC recommends that CMS table its requirement to modify the billing for date and place of service. The response: CMS originally released a change request, 6375, to address questions that have come to us from stakeholders on how to use the place of service codes and bill date of service on the Medicare claim. As a result of concerns that were raised to us by the physician and hospital community, CR6375 was rescinded, and will be replaced with another CR in the future, pending further policy clarification on date-of-service and place-of-service reporting for the interpretation of diagnostic tests that consistently addresses the full spectrum of clinical scenarios.

Agenda Item 70-D-4: PPAC recommends that CMS reevaluate its policy on paying for treatment of family members, specifically the decision not to cover services ordered. The response: Section

1862(a)11 of the Social Security Act prohibits Medicare payment under Part A or Part B for items or services when such expenses constitute charges imposed by immediate relatives of such individual or members of his household. The purpose of this section of the law is to bar Medicare payments for items and services that would ordinarily be furnished for free because of the relationship between the physician and the beneficiary, and to bar Medicare payment for medically unnecessary services that are ordered because of an immediate relative relationship. As explained in *Federal Register* volume 54, number 195, on October 11, 1989, page 41723, Congress recognized that in family situations, it is difficult to differentiate between medically necessary services and those that are furnished because of affection or concern. Thus, the exclusion was also intended to guard against potential program abuse. Since the intent of section 1862(a)11 of the Act is to bar Medicare payment for medically unnecessary services, CMS issued regulations at 42(c)FR 411.12(c)1ii in order to implement those provisions by prohibiting Medicare payment when a physician who orders or supervises incident-to services has an excluded relationship with the beneficiary. Further, under 42(c)FR, 411.12(c)2, services other than physician services are not covered by Medicare when they are provided by a group practice or partnership where one of the owners or partners has an excluded relationship. Medicare may only pay for coverage service and any changes to the current policy regarding physician payment for the treatment of family members would need to be consistent with the statute and adopted through notice and comment rulemaking. While CMS appreciates the recommendation of PPAC, the agency continues to believe that the current application of the payment exclusion is fully consistent with the statutory prohibition of Medicare payment for charges by immediate relatives of a beneficiary or members of his household and appropriately takes into consideration the unique challenges of assessing medical necessity in the context of family relationships by limiting the potential for program abuse in this area. Yet if PPAC is concerned about a particular aspect of this policy and its impact on beneficiaries, CMS will evaluate any additional information or evidence provided.

Agenda Item 70-AM-1: PPAC recommends that if hospital-acquired complications occur despite providers taking reasonable precautions to prevent them, reimbursement should not be denied. PPAC further recommends that CMS review the policy regarding reimbursement when hospital-acquired complications occur. Response: The Secretary is required by statute to select clinical conditions that are subject to the hospital-acquired conditions provision that could reasonably have been prevented through the

application of evidence-based guidelines. CMS, working with public health and infectious disease experts from the Centers for Disease Control and Prevention, identify clinical conditions that are reasonably preventable overall and not in each specific instance. CMS will continue to monitor carefully and identify the clinical conditions selected as part of the HACs provision what the Inpatient Prospective Payment System. We will continue to review our policy regarding reimbursement when HACs occur annually through notice and comment in the *Federal Register*. That evaluation process will provide valuable information for future policy making aimed at preventing HACs. This work involves a multi-year contract which will examine the following: evidence-based guidelines, state tracking of HACs, inaccuracy of coding, as well as other issues, such as readmissions due to a HAC. CMS will share information from this contract as part of future rulemaking.

Agenda Item 70-AM-2: PPAC recommends that CMS revise its 10-percent threshold multiple attribution method for resource use reports, so that providers who provide evaluation and management services to a beneficiary before or after hospitalization split no more than 20 percent of the total cost of care for that beneficiary, and so that the other 80 percent of the cost be attributed to the attending physicians and surgeons involved in the beneficiary's care. The response: CMS is carefully analyzing attribution rules for phase II of the Resource Use Reports Program. In phase I of the project, we created confidential reports using two different attribution rules. One, plurality minimum, which attributes the entire cost of a beneficiary to one physician, and two, multiple proportional, which attributes portions of a beneficiary's cost to multiple physicians, based on each physician's contribution to the total cost. Both rules require physicians to bill for a minimum threshold amount of evaluation and management services before being considered eligible for attribution of beneficiaries. Attribution of beneficiaries—the minimum threshold selected for phase I was 10 percent for both rules. We selected a lower threshold in phase I in order to be able to provide reports to more physicians, raising the threshold results in more unattributed beneficiaries, resulting in fewer reports. Attribution rules are applied to both per capita cost measures, and costs of episodes of care. CMS is reviewing the attribution rules and minimum thresholds for phase II. As part of our review of attribution methods, we will further consider PPAC's recommendation to cap attribution so that no more than 20 percent of the costs of a beneficiary's hospitalization is attributed to physicians who provide evaluation and management services to a beneficiary before or after a hospitalization. However, we

are concerned that such an approach may not support the goal of improving accountability and coordination of care for beneficiaries when that care is related to the hospitalization. Identifying beneficiaries with the hospitalization and treating the costs associated with that hospitalization differently from costs not associated with that hospitalization would require some method of episode grouping. Proposed health care reform legislation would require CMS to build its own public domain episode grouper that combines separate by clinically related items and services into an episode of care for a beneficiary. Building this grouper to perform the type of analysis PPAC suggests would be a goal of that technology.

Agenda Item 70-AM-3: PPAC recommends that CMS reconsider its presentation of numerical data in the Resource Utilization Reports to accurately reflect the statistical validity of that data. The response: CMS recognizes that statistical validity of the Resource Use Reports measurement information is important to providers. The RUR team in the Center for Medicare Management is actively consulting with colleagues in the Office of Research Development and Information on the topic of statistical validity and the importance of being able to accurately distinguish physicians from each other when measuring resource use. We are considering data presentation alternatives for phase II such as ranges and point estimates. CMS is still in the early stages of the program and we plan to consider additional approaches to this issue through our collaborations with internal and external stakeholders.

Agenda Item 70-AM-4: PPAC recommends that CMS include in the Resource Utilization Reports reporting on factors that affect the cost of patient care; in essence, patient complexity and comorbidity, local practice costs, setting of care, and similar factors. The response: CMS considers risk adjustment among the most important factors to consider when measuring resource use. In phase I, the reports took into consideration several factors that affect the cost of patient care, such as the number of physicians per capita in the county, and the median income of the physicians' practice location zip code. The measurements also include demographic factors, such as age, sex, and Medicaid status. CMS is carefully considering these and other risk adjustment factors for phase II of the program. One possible source of risk adjustment information is the Hierarchical Condition Categories model, used by the Medicare Advantage Program. CMS is consulting with HCC experts about the applicability of its model to resource use measurement in the fee-for-service program.

Agenda Item 70-AM-5: PPAC recommends that CMS propose that Congress authorize at least a 5-percent incentive payment for successful completion of Physician Quality Reporting and Initiative Reporting in 2011. The response: CMS has no current authority to pay incentives for PQRI reporting in 2011. The authority to pay a PQRI incentive and the scope of that authority would depend on congressional action.

Agenda Item 70-AM-6: PPAC recommends that CMS be required to adequately inform the provider community about the requirement to enroll in the PECOS system. The response: CMS is actively considering a number of options for further continued physician education including direct mailings and revalidations to educate those physicians who have not updated their Medicare enrollment status in more than six years.

Agenda Item 70-K-1: PPAC recommends that CMS delay for at least one year implementation of its regulatory policy that prohibits paying for consultation services, which will allow time for education about and clarification of the changes. The response: As we adopted the consultation policy through notice and comment rulemaking, effective January 1, 2010, delaying implementation of the policy will require us to issue new rulemaking. We are educating physicians about the change in policy in three main ways. First, CMS held open-door forums on November 17, 2009, December 15, 2009, and February 2, 2010, where we answered a multitude of questions from the physician community. Second, CMS released operational instructions to its Medicare contractors on December 14, 2009 and provided information about this policy change to the provider community through a Medicare Learning Network article issued on December 15, 2009, and communications with the American Medical Association and the medical specialty societies. CMS is also instructing its Medicare contractors to educate providers through various mechanisms, including their websites and listservs. Third, based on suggestions from the AMA, we will be taking more steps to educate physicians, including posting questions and answers to respond to frequently asked questions. We believe the educational materials we have provided to our contractors and the physician community resolves many of the questions we have received since the Final Rule. MLN Matters article SE1010, “Questions and Answers on Reporting Physician Consultation Services,” and the revised article, “Revisions to Consultation Services,” have been posted and are available on the CMS website.

Agenda Item 70-K-2. PPAC recommends that CMS recommend to Congress to avoid the 21-percent cut on January 2010 and advise Congress to reform the seriously flawed Sustainable Growth Rate formula. PPAC further recommends that CMS recommend that Congress provide physicians with reimbursement that keeps up with the cost of practicing medicine. The response: The President signed and CMS implemented the Department of Defense Appropriations Act of 2010. This act provides a two-month zero-percent update to the 2010 Medicare Physician Fee Schedule effective for dates of service January 1, 2010 through February 28, 2010. The President signed into law HR 4691, the Temporary Extension Act of 2010, on March second of this year. The law extends the expiration deadline for COBRA health subsidies for one month. This program was set to expire on February 28, 2010. The new law also temporarily prevents the 21-percent cut in physician payments that are scheduled to take place under the SGR and extends the Medicare physician therapy services caps exceptions process. Both are extended through March 31st of this year.

Agenda Item 70-K-3: PPAC recommends that CMS reconsider its decision to eliminate consultation codes and remain consistent with the American Medical Association's current procedural terminology guidelines and Medicare payment advisory commission recommendations. The response: In the Medicare Physician Fee Schedule, Final Rule, CMS decided to finalize its proposal to no longer make payment for consultation codes and instruct physicians to bill for their services using other visit codes. In deciding to finalize its policy, CMS considered all of the public comments, including those that were opposed to the policy but also ones from physician specialties in the Medicare Payment Advisory Commission in support of the policy. In light of recent reductions in the documentation requirements for consultation services, CMS found that the resources involved in furnishing an inpatient or office consultation are not sufficiently different from the resource required for an inpatient office visit to justify the existing differences in payment levels. The policy change for consultation codes had the effect of increasing payments for the office visit codes that are billed by most physicians and most commonly by primary care physicians. MLN Matters article SE1010, "Questions and Answers on Reporting Physician Consultation Services," and a revised article, "Revision to Consultation Services Payment Policy," have been posted and are available on the CMS website.

Agenda item 70-M-1: PPAC recommends that CMS rapidly clarify the procedures for using Evaluation & Management codes in a clinical setting, involving the appropriate use of a consultation code that is covered by an additional insurance carrier. The response: CMS will no longer recognize the CPT consultation codes for purposes of determining Medicare secondary payer payments. In Medicare secondary payer cases, providers must build an appropriate Evaluation & Management code for the services previously reported, and paid using the CPT consultation codes. If the primary payer for the service continues to recognize CPT consultation codes for payment, providers billing for those services may either, one, bill the primary payer an E&M code that is appropriate for the service and report the amount actually paid by the primary payer along with the same E&M code to Medicare for determination of whether a payment is due; or, two, bill the primary payer using a CPT consultation code that is appropriate for the service and report the amount actually paid by the primary payer along with an E&M code that is appropriate for the service to Medicare for determination of whether a payment is due.

That, Mr. Chairperson, concludes the proceedings from the December 7, 2009 PPAC meeting held in Washington, D.C.

Dr. Bufalino: Thank you, Dr. Simon. That was extensive to say the least. Let me open the panel up for questions or comments for Dr. Simon. Dr. Snow?

Dr. Snow: Dr. Simon, I appreciate your response on that last item, 70-M-1, on the consultation codes. The previous question that you had answered, I think, indicates that CMS has decided that the consultation codes are over-reimbursed, which seems like would lead to an easier way to take care of that problem—simply leave the consultation codes there and change the reimbursement levels. By unilaterally eliminating a code that is widely used by carriers, it poses an undue burden, perhaps even illegal burden, in some cases. As you've suggested in this last answer, you're suggesting that physicians illegally use a code to a primary carrier, not Medicare, so that they can be covered by a nonconsultation code if Medicare is secondary. That's not appropriate. The other way is some sort of a convoluted method of billing a consultation to a non-Medicare primary carrier and then somehow trying to file that secondarily to Medicare and somehow throwing another code in there, and how you actually do that, I don't know. So I would ask and if you like me to go ahead and make a recommendation at this point, that PPAC recommends that CMS again reconsider its deletion of consultation codes due to the problems that are

caused by billing, secondary billing Medicare as a secondary carrier, and it's for these reasons that I've stated. You can certainly reduce the reimbursement for the consultation codes. Some would argue whether that's appropriate or not, but I think simply unilaterally, without other insurance companies concurring with what you're doing, and you have your own code that interacts with other carriers, is extremely disrupting in certain circumstances.

Dr. Simon: We appreciate the input that you've provided. We think that when the proposed rule comes out that would certainly be an opportunity to share those comments again with CMS. CMS has not communicated with all of the insurance carriers throughout America, so we certainly would suggest that clinicians consult with the contractors, the medical officers for those insurance companies to find out how those companies would recommend the physicians bill those services when they provide care to a patient that has either primary or secondary coverage by that private insurer.

Dr. Bufalino: Should we take your motion—second to that?

[Second]

Dr. Bufalino: Any other discussion on the motion? You got that Dana? Thank you. All in favor?

[Ayes]

Dr. Bufalino: Thank you. Other comments, questions? Fredrica?

Dr. F. Smith: Item 70-D-4 starts on page 3, but the section that I'm looking at is on page 4 towards the bottom of that long paragraph that says that this is trying to clarify the question of paying for family members, and you say that physician services are not covered by Medicare when they're provided by group practice or partnership where one of the owners or partners has an excluded relationship. And I wanted to raise again the question that Dr. Standaert has raised the last time of how is CMS approaching, for example, the huge clinics, of which there are now a large number in the United States; you have Kaiser-Permanente in California, University of Washington, his case, MD Anderson? Does that mean that no physician family member of anybody who works for one of those entities can receive care at that entity and be paid for it? Or is it literally defined as an owner's family, the owner of Kaiser-Permanente, I assume it would actually be a CEO or something. How is CMS addressing that question of these really, really large groups or for that matter, Janis Kirsch's example of northern Iowa, where there's an affiliation of many small practices

around large number of rural towns where people are technically partners in this entity but may live 100 miles away from somebody else who's providing the care. How is CMS addressing that issue?

Dr. Simon: I think when Congress provided the statutory direction for CMS the intent was to look at individual and small group practices. I don't think that the intent was to look at institutional entities such as the MD Andersons and so forth. And I think that the further clarification through the regulations was again looking at small practices and individual practices, but we certainly can chat with our colleagues at CMS in the Office of Legislation and General Counsel to see whether the intent through their interpretation of this statute and the regulations would pertain to institutions.

Dr. R. Smith: I would support what she said, because was move toward further integration of practices, and alignment of practices, this can become an issue, both in the large clinics, like at Henry Ford's Clinic where we're 1000 docs and practices, or from the smaller ones who through the individual practice groups has had, again, to align.

Dr. Bufalino: Could you put that together in a recommendation? One of the two of you?

Dr. F. Smith: PPAC recommends that CMS clarify the definition of "group practice or partnership where one of the owners or partners has an excluded relationship" to make sure that that does not apply to large groups and entities or to widely scattered but financially connected groups or partnerships.

Dr. Bufalino: Dana got that? Second?

[Second]

Dr. Bufalino: Thank you. Discussion? Seeing none, all in favor?

[Ayes]

Dr. Bufalino: Thank you.

Dr. F. Smith: On page 8, it's item 70-AM-4, CMS is considering the risk adjustment such as the number of physicians per capita in the county, and median income of the physicians' practice location zip code. As they're looking at risk adjustment, I would urge you not to look at counties as geographical boundaries. And I'll use the example of Northern New Mexico, where there are depending on how you define it, probably three basic areas that are providing coverage for a large number of counties in the whole northern part of the state, so that if you look, for example, at Los Alamos, or Santa Fe Counties, where the median income is fairly high, and the density of physicians is extremely high, you have to take into account

that those two counties are providing care for people who live as far as four hours away in Cape Train County, Roosevelt County, Harding County, which has no physicians and a population of 670, and no income, lowest county in the state. I would urge you not to look at counties as geographic boundaries and not to look at zip codes. You have to look at service areas, and most states can tell you, the state health departments or the state Medicaid systems, can tell you from their billing systems where care is provided to people in a large number of zip codes. So if you look at Santa Fe County, you can see that they're providing care for I'm guessing 40 or 50 zip codes. I know that Los Alamos County provides care, 50 percent of its care is for people who do not live in the Los Alamos zip code. So in order to get an accurate picture, you have to look at the service area and not the county. The converse is probably true if you're in Manhattan. If you look at all of Manhattan, you get no accurate information. You have to look at Harlem versus what it's called on the Hudson, the stuff overlooking Central Park and so on. They've got to look at service areas. So I would like to propose a recommendation there that PPAC recommends that in considering risk adjustment in measuring resource use, CMS should consider not the number of physicians per capita in the county or the median income but rather the service areas that physicians or medical groups are serving.

Dr. Bufalino: Thank you. Second?

[Second]

Dr. Bufalino: Any discussion? All in favor?

[Ayes]

Dr. Bufalino: Thank you. Others. Dr. Ross?

Dr. Ross: Yes, Dr. Simon, I appreciate the comments and responses on the recommendation made on the proposed 21-percent cut that was supposed to take place on January 21st. As we all know, that extension as you mentioned was made on March 2nd, after two days of delay, which cost some practitioners a delay in filing. Recommendations were that those delays take about a week to two weeks in some specialty groups for filing, which I think could cause a hardship in some cases for some practitioners. With the fact that the delay is only for a month, to take place on March 31st, there are many physicians, practitioners, who are in a quandary whether or not to reenroll in the PECOS Program. So I would like to reiterate and make another recommendation again, after comments, as to the recommendation from CMS as

far as this sustainable growth formula, and to delay these cuts for at least six months, if not a year, that we've been dealing with as "the doc fix" for the past four years since I've been on this Panel.

Dr. Bufalino: Could you read. . .

Dr. Ross: I haven't given a motion yet. I'm just waiting for Dr. Simon's response first and then I'm going to make a recommendation.

Dr. Bufalino: Thank you.

Dr. Simon: Well, as the legislation articulates, the cuts have been rescinded until the 31st of March, and we all are awaiting to see what final decisions Congress will make in terms of how it will address both the sustainable growth rate as well as the conversion factor for physician payment.

Dr. Ross: So, with that in mind, then I would like to make a recommendation, based upon the fact that we're still dealing with these potential 21-percent cuts at this time, with only a "doc fix" reprieve of less than 30 days at this point, and with those doctors sorting sitting in limbo whether or not to reenroll. So I'm going to reiterate my earlier recommendation and that is that PPAC recommends again that CMS recommend to Congress to avoid the 21-percent cut on March 31st, and advise the Congress to reform the seriously flawed sustainable growth rate formula. Again PPAC further recommends that CMS recommend that the Congress provide physicians with reimbursement that keeps up with the cost of practicing medicine. Further, it recommends that the Provider Enrollment and, the PECOS, be delayed until the 21-percent reduction has been scheduled past March 31st and has been either decided or delayed for a period of either six months or a year to give those physicians ample opportunity to decide whether to reenroll or not.

Dr. Bufalino: I think you lost most of us, so could we break that into pieces. How about we just take the first half of that, Dana could you read back the first half, because I think that is succinct in its own right.

Ms. Trevas: PPAC again recommends that CMS recommend to Congress to avoid the 21-percent cut due to take place on March 31st, 2010, and advise Congress to avoid the seriously flawed sustainable growth rate formula.

Dr. Bufalino: Are you comfortable with that, Jeff?

Dr. Ross: Yes.

Dr. Bufalino: Thank you. Dr. Smith, amendment?

Dr. R. Smith: I want to add the word after PPAC recommends, right in between there, strongly recommends.

Dr. Bufalino: Strongly recommends. Acceptable?

Dr. Ross: Accepted.

Dr. Bufalino: Other comments on this one? All in favor?

[Ayes]

Dr. Bufalino: Part B.

Dr. Ross: The second recommendation, dealing again with the reenrollment; that PPAC recommends that the provider enrollment and chain ownership system, sorry, PECOS, be delayed until the 21-percent reduction has been scheduled past March 31st or has been decided or delayed for at least 6 months.

Dr. Bufalino: So he's asking for them to delay the PECOS enrollment beyond the 31st of March, essentially. Comments? Go ahead.

Dr. F. Smith: I've a question. Are you talking about PECOS enrollment, or are you talking participation or not participation?

Dr. Ross: I'm sorry, participation, nonparticipation.

Dr. Smith: So not PECOS.

Dr. Bufalino: So it's not PECOS, it's participation.

Dr. Ross: Participation and nonparticipation.

Dr. Bufalino: Want to take a stab at it again?

Dr. Ouzounian: Could I make a suggestion before you do?

Dr. Ross: Sure.

Dr. Ouzounian: I would suggest that you word it so that there's a time-dependent option, so that whatever that delay is, give the providers two weeks, three weeks, four weeks, so if it gets delayed another month, they get two to four weeks after that to make a decision.

Dr. Ross: I'll take a friendly amendment. That's what I was trying to figure out; how much time it should be.

Dr. Ouzounian: Two weeks ought to be fine.

Dr. Ross: Okay.

Dr. Bufalino: So the essence of this is that we're asking that participating enrollment day be delayed two weeks beyond the repair of the update.

Dr. Ross: Correct.

Dr. Bufalino: Are you okay with that? Dana's frowning. Got it? Okay. The essence. Any amendments to that? Are you okay with that? All in favor?

[Ayes]

Dr. Bufalino: Are there some opposed? Oh, that was just a weak set of ayes. [laughter] Okay, let's go, it's 9:00 we're ready to go! Good, other comments around the room for Dr. Simon. Roger?

Dr. Jordan: Dr. Simon, Dr. Ross and I had requested a revision to a recommendation that was made back in August of 2009. It was an issue that Frank Whelan had given us and had incorrectly listed podiatry and optometry as nonphysicians, and we just wanted that issue clarified, since we are recognized under Medicare as physicians, and I was with the understanding of having a correction to be done at this meeting?

Dr. Simon: Yes, and that correction is available. I did not include it in the report. I will revise this report and read that correction to the Council before the end of the meeting today.

Dr. Jordan: Okay, thank you.

Dr. Bufalino: Thank you. Anyone else? Okay, great. Thank you everyone. Moving right along. We ask Dr. Bill Rogers to join us, Director of the Physician Regulatory Issues Team and here for his usual quarterly report and waiting for the cartoons.

PRIT Update

Dr. Rogers: All right. Nice to be famous for something. Just as a clerical correction, the response to the question about care delivered by family members was actually written by the Subject Matter Expert, not by me. [laughter] Otherwise, I'm going to have Dr. Snow's hands around my throat at lunch time. And one of the reasons that I like this job so much is because I understand how difficult practicing physicians' lives are sometimes, and that was brought into sharp focus for me a couple of days ago, when I had an evening shift at Georgetown. I had a very nice young guy there who was had bipolar disease and was frankly completely psychotic and needed to be hospitalized and wouldn't volunteer so we had to go into a

commitment sort of environment. And I could have sent him to St. Elizabeth's very easily, but I found a bed at Psych Institute Washington, and unfortunately he wasn't a Medicare patient because it would have been easy from that standpoint. He was a United Healthcare patient, and I spent 45 minutes on the telephone. Ended up staying an hour and a half after my shift ended getting him approved for one day and I had to answer questions about when his socks were laundered last and what he had for supper two days ago and everything like that. And every time I'd start to push back a little bit, the woman would say, this can drop to manual review. Which at midnight is not a very appealing alternative. This seemed like as good a time as any to mention something I think very positive that the Medicare program is doing right now. The Contractor Provider Satisfaction Survey, randomly selected physicians have been invited to tell us how their contractors are doing, what kind of job their contractors are doing. And this information is important because it is one of the measures of how well the contractors are doing their job and it is data that we're going to be using for a number of purposes, including counseling and also when decisions are made to renew contracts. So please go home and tell your friends that if they got an invitation to participate in this survey, then they should do it. Because if it's not statistically valid, then we won't be able to use the numbers.

The Mandatory Fraud & Abuse Training, I think I mentioned this at the last meeting. We have a requirement that physicians who participate with MA plans have to do annual fraud and abuse training. It seemed a burdensome requirement and so we have a proposed rule proposing that since physicians have enrolled in the Medicare program, we can deem them as understanding issues of fraud and abuse, and drop the requirement. The rule is still a proposed rule. I tried to get some clarity on when that rule was going to be finalized and at this time, this information is not available. But it's out there, and I'm optimistic that it'll get approved, and that requirement will disappear.

Ordering of services by physicians not enrolled; you know, this has been an unpopular requirement, but I think in light of all of the fraudulent billing that's going on, particularly DME, it is something that absolutely has to happen. The old legacy data that we had was fatally flawed, and requiring everybody to enroll in the PECOS program is an essential step to making sure that we're only ordering services that are ordered by real doctors, who really have the authority to do it. But our original timeline was way too aggressive, and so I'm very pleased to say that the timeline's been pushed back to January 3 of

next year. This gives everybody in the United States plenty of time to submit an 855, even make a few mistakes and still get successfully enrolled by January 3, so really important for us to make sure that all of our colleagues know that if they're not currently enrolled in PECOS then they need to get the process started. It's plenty of time to get it done, but it needs to happen before January 3 because that deadline, I'm sure is not going to be pushed back again.

Date of service, place of service. This was proposal which had all the best intentions but was going to be pretty catastrophic, particularly the date of service because of the impact on things as arcane as the electronic image management systems that radiologists use and things like that, and I don't know that we were entirely aware of the challenges that implementation was going to present, but having been, having dialogue with the affected providers, it became obvious that this was not going to be an easy thing to implement and perhaps that the pain would outweigh the value, so this proposal has been tabled, essentially, and we will make sure that the provider communities are engaged if there's a thought to coming up with a new revised policy concerning this.

Legible signatures. This was sort of frightening. The Iowa Medical Society told me that they were being told that physicians whose signatures were illegible, and apparently there are two or three in Iowa, whose signatures are illegible [laughter] should change their signature to make them legible. So that an auditor could make sure that in fact the order or consultation or whatever had been delivered by the physician who was being paid for it. The identity issue is a real issue and very important. But the idea of telling somebody to change the appearance of their signature seemed like a distinctly bad idea. So we—

Dr. Bufalino: Even for Iowans?

Dr. Rogers: Particularly for folks from Iowa [laughter]. And Minnesota and North Dakota. So we actually have written a signature policy which I've looked at and I'm very pleased with. I think it's very reasonable and it does a good job of balancing the issue of administrative burden with the issue of clearly identifying which physicians are responsible for documentation on the record, and I was very pleased with the net document and I expect the document is going to be released in the very, very near future. And I think when you all see it, you will be pleased with it, too.

Travel. Just to point out if my trips are approved, I'm going to continue to do as much as I can, crisscrossing the United States and making sure that docs know that we care about their issues and that we

want to engage with them and try and fix them. A couple things, too, I mention these big issues, but there are also small issues that I'm working on all the time. One that really had a very good outcome: we did not, not all 50 state Medicaid programs were accepting automatic crossover claims from Medicare and we worked on that, and we now have 49 of the 50 states' Medicaid programs are accepting automatic crossover claims. And the holdout was South Carolina. And South Carolina last week got funding for a completely new claims processing system. It may take as long as four years to fully implement but when South Carolina has started to use the new claims processing system, all 50 states will be using automatic crossovers from Medicare to Medicaid.

So as you know, those are my phone numbers and my email address, and if there are any questions, I'll be happy to take them. Oh you can't see the entire caption on that cartoon. Can you scroll down just a little bit?

Dr. F. Smith: I have one question about, I guess it's the PECOS system again here that you're referring to here where the implementation date's been delayed 'til January. I heard complaints from a number of people in our area about trying to get into this and several members of PPAC have certainly talked about difficulties with it. We personally, in my office, have not been able to get into that system. We have tried repeatedly, and it keeps wanting a password that we don't have. And we call and try to get, my office manager calls, I don't, and tries to get information on how to do this. And you have to leave a voice mail and nobody ever returns the phone call. So we don't know how to do it. And if I don't know how to do it when I at least am hearing about it, I don't know how other people are trying to figure out what to do with it.

Dr. Rogers: And is this to access—

Dr. Smith: In order to get into it to see if you are actually enrolled in it or if you have to do something with it.

Dr. Rogers: I thought you were talking about pulling up the actual enrollment form, doing the online enrollment. You want to know whether you—

Dr. Smith: If I wanted to start 46 pages of form over again, I could probably do that, except it might create havoc with claims, as Dr. Snow has commented on a few times. But if I want simply to find

out if I am actually enrolled in it, or if I have to go through the reenrollment process, we have not successfully gotten into the system to find out.

Dr. Rogers: Right, to determine that. Okay. Mr. Bossenmeyer's going to talk right after me, and I think that is one of the challenges that we need to make sure is appropriately addressed, because if we're asking doctors to enroll if they're not enrolled, we have to make sure that they're able to tell whether or not they're enrolled.

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

Dr. Bufalino: So the next topic is PECOS, as you're well aware. This is the National Medicare enrollment system for providers. We had a number of recommendations came out of our December meeting that were addressed by Dr. Simon today. We invite Jim Bossenmeyer back again. Welcome. Jim is the Director of the Division of Provider and Supplier Enrollment at the Program Integrity Group. He has been part of Medicare for close to 20 years, had been serving for a long time as a senior technical advisor in the Hospital Ambulatory Policy Group. So Jim, welcome. Thank you for joining us.

PECOS Update

Mr. Bossenmeyer: Thank you. The PECOS system is just one part of the enrollment system. It has become analogous for provider enrollment, but it is not the enrollment process. The system can either be used by the Medicare contractor when a paper application is submitted or when an electronic application is submitted, but all applications do go through the enrollment, get placed into the National Repository of Information, and that information is then fed down to our claims processing systems. The contractors have used the PECOS system since November 2003 for physicians and other suppliers. They've used it primarily in the background when a paper application came in and they were entering data into this national repository since November 2003. In January of 2009, we deployed Internet-based PECOS, which was designed to make it easier for individuals and organizations, organizational entities came in in April of last year, to enroll through the process, that built in editing criteria so you make sure you enter all the information that's required and I can address the concern that was raised earlier in a few moments. From a background perspective, as I just mentioned, the information is sent to the Medicare contractor, whether it is a paper application or whether the application comes in through the web. The information gets verified,

and when it is verified and the approval is made, then that information then gets shared down to our claims processing systems.

Internet-based PECOS is available to all providers and suppliers except for DMEPOS suppliers. We expect DMEPOS suppliers will be able to use Internet-based PECOS later this year. The objectives of the Internet-based PECOS is to reduce the time necessary for physicians, nonphysician practitioners and other suppliers and providers to enroll in the program, to update their enrollment, or change reassignments. It streamlines the process significantly for our Medicare contractors because there's less back and forth and less developmental requests from the Medicare contractors. Frequently, the number one reason for delays in the enrollment process are related to missing documentation or information that's not included on the form and had to go back and get that information from the practitioner or most likely the billing agent or the person who's handling this process for them on their own staff. The Internet-based PECOS will allow you to review the information that you have with Medicare and it reduces the administrative burden for the contractors. On March 4, so last week, we issued a listserv announcement that outlined several things that individual practitioners could do to help facilitate their enrollment process in the Medicare program. We'll be adding that document onto our website hopefully in the next week to ten days. One of the first things that we always talk about is that physicians need to protect their privacy. And we placed the document on our website. Certainly changing your username and password. Your password is something that should be considered, especially if you're having somebody other than yourself manage your enrollment account. In February, the Medicare contractors processed more than 10,000 applications. That's initial applications, changes, and reassignments, using Internet-based PECOS. So we know that the system is being exercised. It's being utilized, and the processing times are significantly lower than the time it takes to submit a paper application in terms of the Medicare contractor's processing that enrollment application.

Before physicians can reassign benefits to a third party, a group practice or medical clinic, that group practice or medical clinic must be enrolled in the Medicare program with a valid enrollment record in our enrollment system. This is no different than if you're going to work as an employee to work with the business. The business has to be established before the employee can begin to work there. Physicians that have not updated their enrollment information since November 2003 would be required to come in as an initial enrollee or an initial application. Think of this in terms of if you're completing other software

packages, such as TurboTax, Tax Cut or something like that. The first time you go into that software package, you need to put all your information into that and then each year, whenever you make your changes, and you update that system, it has information that's propagated, and carries over from year to year, so you're becoming known to the enrollment system. You're providing a lot more information, or more information than what may have been required prior to the standardization of the enrollment application in 1996. So if a physician came in before that time, there may have been only a very limited amount of information that the carrier would have requested at that time of enrollment. So we've standardized the process and the information is used to ensure payment accuracy, and the—moving on to the next slide.

Before you get started using Internet-based PECOS, you need to make sure that you have your NPI for the individual, and that would be the user ID and password. And we would strongly recommend—and that's the user ID that you would have received when you'd gone in through NPPS, the National Plan and Provider Numeration System, and you would have established a user ID and password at that time. We strongly encourage individuals to review the getting started guide, which walks people through the steps and process. Also on our website, that same website off of Medicare Provider Supp Enroll, there's a tab on the left-hand side that talks about Internet-based PECOS, and there's a list of contacts that you can call if you have a question; you're not sure what your user ID or your password is, you can call the enumerator, you can call the EUS Help Desk, and that information is available for you in this packet. There are some limitations to PECOS. You can't change your Social Security Number or your name using Internet-based PECOS. You cannot change a business structure. That's an important thing for many physicians is that they understand their business structure as they go into establish their records. Some people think, I'm a sole proprietorship because I'm working by myself. Well, just because you're working by yourself doesn't mean that you're not incorporated and you don't have a corporate entity and that you would not need a second NPI for your corporate organization. So understanding the business structure of your company, even if for sole practitioner, are they a solely incorporated individual? And if so, then they would need a second NPI. And then the third part would be that as nonphysician practitioners can't switch from one nonphysician specialty type to another. So if you're a nurse, clinical nurse-social worker, you can't automatically change over into nurse practitioner. That's something you'd need to submit a paper

application for for those nonphysicians. We are continually working on Internet-based PECOS and we're doing enhancements. We expect to do enhancements later this spring, and then later this summer, we'll bring on the DMEPOS suppliers so we have a number of items that we've identified, and items that the public has brought to our attention. And we set those up into a queuing process and work to continue to make the system work as easily and most effectively for the public.

When you finalize your submission, you must print, sign, and date—we recommend blue ink—the certification statements. The contractor will not process your enrollment application unless they receive the signed certification statement. Signed certification statement is similar to what is in the paper application. So we would use that information—yes?

Dr. Snow: Why blue ink? I've never heard signing a legal document in blue ink. It's always supposed to have been black.

Mr. Bossenmeyer: Well, the reason there is when, we will not accept copy signatures, photo copies of pages, it has to be an original signature. It's easiest for the Medicare contractor to see blue ink versus, because there are many times when we think it's a copy, the person says it's not, so it's just a, it just facilitates the process.

If the contractor requests additional information be submitted, that information is submitted as quickly as possible and as completely as possible. That'll help facilitate the enrollment process. Medicare contractor will not process the application until they have that information. So we've had situations where people say well I have 30 days to submit, so I'm going to wait 30 days. Well, that's fine, but your application is not being processed during that time period. We're working on somebody else's application who's actually submitted the application.

Moving on the next, there are some reporting responsibilities. Physicians do have reporting responsibilities to the Medicare program. Those are outlined in regulations. Some of the reporting responsibilities are changes of reassignments, so if a physician leaves one group practice and they start to work at another group practice, that they notify us about the departure from the first group practice and the reassignment to the new group practice; that if their license is suspended or revoked, our Medicare contractors check each month whether or not there are suspensions or revocations of licenses, and if those are not reported to us within 30 days, Medicare contractor will revoke billing privileges and establish an

enrollment bar; that if there's a change in practice location. So if you have your individual practice and it's 100 Main Street and you decide to move to another location and it's 200 State Street, that should be reported to us as soon as possible. If we wind up showing up at 100 Main Street and it is no longer a physician's practice, then that leads the contractor to wonder what's going on. And also if there's a change in ownership situation, so if there's a new partner that is added or the corporate structure is changed, that should also be reported. Some phone numbers that you might find useful. The EUS Help Desk can assist physicians with a navigation or an access problem, so if you need to get your password reset, you can call the EUS Help Desk. Generally if you have questions related to systems inoperability, there's slowness, things are not working, you want to let the EUS Help Desk know. You can go to the, you can talk to the EUS Service Desk if you have other questions. Medicare policy questions should be directed to your Medicare contractor. So if there is a question such as how do I enroll or what's the requirements to enroll for nurse practitioner in a specific state? Well, that information should go to the Medicare contractor, because that's what they handle. And the final slide, I believe, or the second to last slide, is the enumerator. The NPI enumerator. This is the company that helped assign you the NPI both as an individual or as a corporation. And if you have questions about password resets, that's the company you can call. You will not, as we heard earlier, will not be able to access PECOS unless you have the correct user ID and password and that's a security feature and so that's why it's important that you maintain the integrity of your password and that you, that's not something you want to share widely and certainly we encourage that individuals routinely update that information at least once a year or perhaps after they've completed a transaction, so that they know that their information will remain secure. Finally, we continue to update the information on our website regarding enrollment issues, and the website that you have there can provide you with information. We've recently added information about advanced diagnostic imaging services and the accreditation process for those services, which will be implemented January 1, 2012. And also has information, and also has an ordering and referring list and that's a list of all the individual physicians that have an enrollment record in PECOS and you can search on it. It's a fairly lengthy document, but it does have all the individuals that are enrolled in Medicare that have a record in PECOS.

Dr. Bufalino: Thank you Mr. Bossenmeyer. Questions, comments for him today? Art?

Dr. Snow: Well, I've got a couple comments really. I unfortunately recently went through signing up with PECOS for the first time in 30 years and after three attempts, I finally got it down. I did a paper thing and I kept sending them in, and the forms are very confusing quite frankly. One of the big problems I had was when you get into the pages that you are to list the places that you serve patients, they ask for NPIs on most of those—I didn't know whose NPIs they were talking about—the facility? My NPI? And if it's mine, is it my personal? Is it my corporate? But after three or four back-and-forths with my contractor, I finally got that taken care of. A huge problem that occurs is the disruption in cash flow when you go through this process. I file claims on a pretty much daily basis, when I see patients. After two or three times of the PECOS system, I got, they accepted it, and I got a call and said they were going to accept it. I think two days later, I got about 100 denials because the system is processing everything under the new data, I'd submitted it under the old, and I'd gone through a lot with my contractor because of a problem that occurred when we changed from our old carrier to our contractor. Same thing happened then a year and a half ago. And I was very fearful of that huge disruption in cash flow. I talked to the contractor about it, they said no problem. Because there's an easy solution to it, you know? You get that thing in and then you call the provider up and you say in three weeks, we're, or a month, we're going to institute your new PECOS numbers April first, so you have enough time to lead up to that. But even though they promised at the time I submitted it, it was going to cap and it never did. So I'm currently going through the process of refiling all of those claims, using a new set of numbers. It is a huge, tremendous problem. And interestingly, the contractor, though, I talked to when I called and raised Cain with him, said, well, he had never really thought of that.

Another tremendous problem I see in my particular scenario, if it isn't going to affect all physicians. I do geriatrics. First of all I don't have an office, quite frankly. And you guys keep pushing you want an office address. I don't have one. I've got some place I bill from, I've got different nursing homes I go to, assisted living facilities I go to, hospitals I go to occasionally, an office I use maybe once a month for an hour or two, homes I go to for patients. But there is no typical office that I think CMS expects every physician to have. And that has caused a tremendous amount of problems, because you want a street address. And any of these street addresses I list, except my home address, which I don't want to list and have out there for everybody that can access the system, I may not get mail at, and typically don't get mail

at, or it goes astray because I'm not at any of these locations on a regular basis. But most importantly, it's going to limit how and where I see patients. In the past, I go primarily to one nursing home. But occasionally, the patients move to another nursing home. We have about 180 of them in the Kansas City area, and a patient may ask me to go follow them there. Well, yeah, I can do it, but then I've got to go through something with PECOS in order to get paid for visiting that patient by adding a new location. Every time I go to a new location to see one patient, as much time as it took me to do the 43 pages, or whatever, and effort, and quite frankly I don't remember how I filled those pages out. If I had to do it again, I'm sure I'd get it wrong three times, so I'm telling patients at this point, I'm not going to go to any other facilities. The ones I've listed with Medicare are where I'm going to go. I'm not going to add locations, because it is simply so difficult, I feel. You've at least taken care of the problem with home visits. Because I can list the whole state of Kansas, and I don't have to list, thank God, addresses, of where I see the patients. But I think you really need to think about these things; the disruption in cash flow, which is going to affect everybody, who enrolls in the system, and for those of us who go to multiple places of service; how we can do that. It seems like it should be easy to simply say a nursing facility in the greater Kansas City Area, rather than listing each and every single facility that person might go to.

That was a little long, but I think it's a tremendous problem, and I appreciate your listening.

Dr. F. Smith: Following up on the question I asked Dr. Rogers, and I honestly don't know which telephone number my office manager has called for help, but do you know if the number you've listed on your slide 13, if a human answers that? Because wherever she's calling, she's being asked to leave a message and the call is never returned.

Mr. Bossenmeyer: If she called, there should be a human that answers that number and also there's a person that will answer the phone if you call the enumerator, I don't know what slide's 13, that you have, but if you call the NPI enumerator, there's a person there that will answer the phone.

Dr. Jordan: In regard to the PECOS system and having the delay on it, I think this is a chance for CMS to go out and reach out to all of the associations to reiterate the importance, to check and find out if you're in it, because there are so many docs that I've talked to and they go, PECOS what? Why do I need to do it? I've been getting in the system for the last 10 years, 30 years? I've not moved, I've not changed any setup in my whole office, and so they're under the assumption that they're still getting reimbursement

and there's no need to do anything, and I think that this gives an opportunity for CMS to really get out there and stress how important it is before that January deadline, because at the date that was set there was no way that they could get all the physicians in. In regards to what Dr. Smith's talked about, I've gone into PECOS and checked, and I was listed. What I have found is an easier way to get in, and I think if I'm correct, under this website where the providers SUP enroll. If you go into that area and go under Ordering Referring, I'm assuming if you're under the ordering referring list, you're in the PECOS system, correct?

Mr. Bossenmeyer: It means that you have a record in PECOS. It does not mean that you have not been deactivated, which means you could bill for more than 12 months. So as I mentioned earlier, the PECOS has become analogous for the enrollment process. We will be doing more outreach to physicians regarding updating their enrollment information, especially those individuals who have not done so in more than 7 years, well, it's over 6 years now, and so we will be doing more outreach to those individuals. And they can do it one of two ways, either by paper or electronically, but the process would be the same. There's a verification processes and. . .

Dr. Jordan: Because I've gone into the Ordering and Referring and I am listed. It's a document of like 13,600 pages, but if you just type your NPI in then the computer can search you in a matter of a couple of minutes. And then boom you're there. So if you, if I assume that my number shows up there, it does not necessarily mean I'm in PECOS.

Mr. Bossenmeyer: Yes, you are.

Dr. Jordan: See, to me it's a much easier way to get in and find out than maybe in the PECOS system.

Mr. Bossenmeyer: What we, to assist DMEPOS suppliers, IDTFs, clinical labs, those organizations that are submitting a claim based on an order or referral, it'll assist them to make sure that the physician is known to Medicare and helps them to ensure that they'll receive payment for that service. Right now, those organizations are receiving informational messages in those circumstances where the physician is not, does not have a current enrollment record, if they've put in the wrong name, maybe put in the wrong NPI, they put in the physician's group practice number, versus the type 1 or the NPI associated with the individual practitioner.

Mr. Jordan: But I would just stress to CMS that they do a tremendous amount of outreach in the next several months to speed the process up and not have that final huge push at the end where they're going to actually delay physicians.

Dr. Ouzounian: Why don't you make that as a recommendation.

Mr. Bossenmeyer: Well, we're already doing it.

Dr. Jordan: PPAC recommends that CMS do a tremendous amount of outreach until the implementation data of January 1, 2011 to the physician community.

Dr. Ouzounian: Second.

Dr. Bufalino: Discussion? All in favor?

[Ayes]

Dr. Smith: You have to put PECOS in there, the word PECOS, otherwise—

Dr. Ross: If someone has moved addresses or if there's been an erroneous listing of address and reapplication has to take place, what's the time frame in order to get this approved and to get the "checks rolling again?"

Mr. Bossenmeyer: Well, it depends. If we conduct an onsite visit, and you're not at the place where you're located, and we are doing more onsite visits, then we would revoke the billing privileges. The physician or physician group's practice responsibility is to notify us within 30 days of any change in location. Once the contractor receives the application and depending upon whether or not the application is complete, we makes it highly dependent on how fast the Medicare contractor can get that application processed. If the contractor has to do more development and follow up, it's going to take a little bit longer. If they get a complete application and all the information is there, then I can get, in the electronic system if you use Internet-based PECOS, it can be done within about 30 days. It takes generally 45-50 if it's being done by paper.

Dr. R. Smith: Dr. Richard Smith from Michigan. Everything we do now in healthcare as physicians should, and even at this committee, should look at how do we include access, quality, and efficiency. I imagine this process that you've put in place has to do with efficiency, but what I'm hearing from other physicians is that it is not. My question to you is what sort of metrics are you going to be using to see if this is actually an efficient process?

Mr. Bossenmeyer: We're seeing that it is efficient in the sense of processing applications faster We also know that it is faster to submit an application for the individual practitioner or for the group practice, to submit that application versus filling out the paper application. Because then the Internet-based PECOS system for an individual physician, you're only going to see those screens apply to a physician. In a paper form, it's stagnant, it applies to both physicians and nonphysicians, so there's information that you're going to have to look at, review, that really doesn't apply to your situation. When you go in after the record is established, it becomes very easy to do updates. So if there's a change in reassignments or a change in practice location, you're only going to fill out those screens that are necessary to complete that specific action. Also gives you a chance to verify that the information that's been submitted on your behalf, whether it be your office manager, your clearing house, that that information is indeed correct. So we believe the matrix that we're looking at is the processing timeliness at the contractor, the accuracy in which the contractors are making a final decision, and that final decision needs to approve or to deny the enrollment application and so those are the two primary metrics that we're looking at right now.

Dr. Bufalino: I have one last question. In terms of timing and how long it takes from start to finish for those of us in large group practice, we're adding a new partner, and we've been burdened by the fact that it takes upwards of 60 days to get a new physician enrolled into our system. How long will it take now with the new Internet-based system?

Mr. Bossenmeyer: Assuming that the group practice is already established with Medicare, you can submit an application up to 30 days in advance of that physician beginning to practice at your clinic or group practice. What we're seeing right now is the application processing is less than 30 days to establish a new individual to your group. Reassignments are generally fairly straightforward and easy. It's establishing the initial record for the physician that we take, we look at, we have to look at that a little bit closer. And so that process, and the reason it goes faster is we get a more complete application when it's done through the web, or through Internet-based PECOS, because it requires you to fill out all the fields, put in the information, where in the paper application something may be missed, so our development time is cut significantly. The Medicare contractor will only begin to process that application once they receive the certification statement, so physician submits the application through the Web on a Friday, so contractor has the electronic transmission of that application, contractor gets the signed certification application by the

following Tuesday. They'll begin processing it, they'll link up the two and they'll start processing that application beginning Tuesday and that's when the Medicare contractor's processing time begins when they receive that signed certification statement.

Dr. Snow: Yes, I've got two more quick questions. Are hospitals affected at all by this PECOS move back on that deadline to January 3 of next year?

Mr. Bossenmeyer: No, we're doing some revalidations of other provider and supplier types. Where the largest group of individuals that are not updated their information in a number, more than six and a half, six years, are physicians. So we're working to get those individuals to update their enrollment records. But we are doing revalidations and revalidation is when Medicare contractor goes out and requests that the physician or the other provider supplier submit information and we'll be working with hospitals over the next several months. We've already informed them that we do revalidations on those hospitals that do not have an enrollment record in PECOS.

Dr. Snow: Second quick question. CMS is providing the downloaded file, I understand, to verify your PECOS status?

Mr. Bossenmeyer: That files shows that an individual has an enrollment record in PECOS that the DME POS supplier or other supplier, if they submit a claim, they'll know that that person does have an enrollment record with Medicare.

Dr. Snow: How often does that file updated?

Mr. Bossenmeyer: We just recently updated that file. We expect to update it every four to six weeks, but if a physician newly enrolls, they'd be able to submit a claim for them immediately, but we're updating about every four to six weeks.

Dr. Snow: Okay.

Dr. Bufalino: Any other comments, questions? Thank you, Mr. Bossenmeyer. Appreciate it. Let's take a quick 10-minute break, because we have a long presentation around electronic records that'll encompass an hour to an hour and a half. Thank you.

Break

Electronic Health Records Update

Dr. Bufalino: So we'll begin the next portion of our agenda, this is on electronic health records. We'd like to welcome Mr. Tony Trenkle, who's the director of E-Health Standards here at CMS, responsible for all the e-health initiatives, along with the HIPAA Administration's Simplification Standards, I understand, and Mr. Trenkle has overseen the coordination of the high-tech provisions of ERA and the rollout of Meaningful Use, and so we welcome you to the table along with Mr. David Hunt, who is going to provide an update around the provider support of the EHR adoption. Mr. Hunt is the Chief Medical Officer of the Office of Information Technology Adaption and the Office of the National Coordinator for Health IT. So we welcome both of you. There's actually a significant amount of interest on the part of the Council around this area, so we had plenty of discussion to get ready for you, so we're anxious to hear what you have to say. Thank you for joining us.

Mr. Trenkle: Thank you. We're trying to bring the slides into focus just as we're trying to bring the program into focus here [laughter]. So hopefully we can make it a little clearer to you as we go along. I'm Tony Trenkle as was just said, and unfortunately I have a bit of a sinus issue so if I start coughing uncontrollably, it doesn't mean I don't want to answer your question, it just means I'll turn it over to David to answer. But anyhow good morning. We're going to walk through a couple of things. Dave and I are going to kind of tag team. I'm going to talk about the Incentives Program and then David's going to talk a lot about the programs that ONC is doing that both complement and support what we're doing, the Incentives Program area. I know there's been a lot of interest in this area from all of you and look forward to hearing your questions. Some of this is probably just review for you but I think it's good to kind of go over it for a couple minutes, just to kind of level set. Of course the law passed in February 17th of 2009, and we had a very short time to pull together an incentives NPRM, which covered both the Medicare and Medicaid programs and we did publish it in January and it closes exactly a week from today, the Ides of March, so I hope everybody who hasn't submitted their comments will be putting them in this week, because it will close at close of business March the 15th.

What's in our program. NPRM is of course the definition of meaningful use, definition of a hospital-based eligible professionals, which has also gotten quite a bit of interest from a number of people, including members of Congress. The Incentive Programs, and of course, the Impact Analysis, which discusses our projections for the program over the next several years. Most of the rest here is areas that

David's going to be talking about in a few moments, so I won't spend any time with that. I think the NPRM does a number of things. What we really tried to do is harmonize the meaningful use criteria across CMS programs as much as possible, recognizing that there are real differences between the Medicare and Medicaid program, not only in practice, but also in the legislation there was distinct differences laid out in terms of how the funding was going to be provided, how the incentive payments were going to be made, and the fact that there's no penalties in the Medicaid program. Of course we worked very closely with our colleagues from the Office of National Coordinator to not only put together our regulation but also make sure it linked closely with ONC's certification and standards interim Final Rule, because that basically provides the functional requirements that we can then turn into meaningful use requirements for our program.

Got a lot of help from the HIT policy committee. One of the areas we've been very sensitive about is trying to coordinate as much as possible with the existing quality programs, and of course it provides a platform that allows for staged implementation over time.

I think you're all familiar with this. This is the payments. As you know, they are very much front-ended, and in the Medicaid/Medicare program, they end in 2016 and they start out in 2011 with the 18,000 and then quickly move down over the next several years. And of course, there's also additional incentives for the EPs practicing in the HSPA areas.

Medicaid goes to 2010 and of course it's a much flatter payment. There's also a payment in year one for implementing, adopting, or upgrading EHRs so they don't have to meet the meaningful use in—yes?

Dr. Snow: An EP is an eligible professional?

Mr. Trenkle: Yes. I'm sorry.

Dr. Snow: Thank you.

Mr. Trenkle: And the eligible professional is defined in the legislation. It's, I believe I have a slide in a few moments that talks about the difference between an EP of Medicare and Medicaid, but yes for this purpose, that's eligible professional. In the legislation, there was a coupling requirements for meaningful use, was to be determined by the Secretary. It must include quality reporting, e-prescribing, and information exchange, and we spent about six months actually a bit longer really defining the criteria for

meaningful use. We started with some hearings by our National Center of Vital Health Statistics Federal Advisory Committee last April 27th and 28th. In May of last year, the two federal advisory committees under HITECH were formed. One was a policy committee and one was a standards committee. The policy committee came out with its initial recommendations in June and then that was subjected to a public comment period for 10 days, 16th to 26th of June, where we received over 900 comments initially, and then we also had some listening sessions with providers and organizations at CMS and ONC worked together. And of course we then went through an extensive clearance process where we clear the regulations through the various components at CMS, then we go out through the department and clear it through OPS at General Counsel and the agencies who make up HHS. And then we go to the Office of Management and Budget, who, as you might expect, had a lot of interest in this particular regulation.

The conceptual approach for meaningful use is to basically build the infrastructure and then begin to tie in more advanced clinical processes and improved outcomes over the next number of years. Right now, of course, we're in stage one, which we're going to define for 2011 and 2012, and then we'll put out another regulation in two years from now to define the following two years and then a stage three. We do put some information in the NPRM about the future stages, but we've not provided a lot of specificity about later stages in this particular regulation for several reasons. One is the infrastructure's going to be built over the next several years. How quickly that's built will determine a lot of what we begin to ask for in stages two and three. And secondly, we want to see how the program is developed over the next several years and how the reaction is in the community, not only to the NPRM, but also once we begin rolling out the program. So that will help us define stage two. The HIT policy committee has done some work on stages two and three, and they'll be doing more work over the next year that provide us with some additional recommendations.

Stage one, we developed a matrix for the NPRM that really focused in five areas; each one of these areas, we defined certain objectives with measures corresponding to them, and of course these are the measures and objectives that a lot of people have specific comments on and I certainly would expect that you would have some thoughts as well as to how we've laid this out. One of the things we decided to do with Meaningful Use is develop it not only in stages in terms of the regulations, but also in terms of stages for when providers or eligible professionals and hospitals can join. And as you can see, we've laid out stage

one, so a EP or hospital could join as late as calendar year 2014 and still be on stage one and then of course they would have to move quickly to stage three in year 2015 and later.

This is what was in the NPRM, basically as much as possible we wanted to require a numerator and a denominator. Reporting period of 90 days for 2011, one year subsequently. The quality measures, 2011 in the NPRM, we asked for comments on this, that providers be required to electronically submit summary quality data to CMS in 2012, but to provide out of station in 2011 and the quality measures in the EP area were divided into two groups. We had four core measures and a subset of clinical measures by certain specialties, and the hospitals are required to report on summary quality measures for applicable cases.

These were the core quality measures that we proposed in the NPRM.

Dr. Ahaghotu: What does the NPRM stand for?

Mr. Trenkle: Notice of Proposed Rulemaking. It's a, when we draft a regulation, generally we put it out as a draft regulation, with a 60-day comment period. We then consolidate and respond to the comments and issue a final several months after that. So right now, we're in what we're calling the Public Comment Period, it's a 60-day period that ends next week.

These are the specialty measures for the EPs. I believe there's about five of them in each of the categories, and then this is the hospital measures. Hospitals only eligible for Medicare will report directly to the states, and of course—I'm sorry, for Medicaid. And Medicaid of course, the data will be collected at the state level, and also the payments will be made at the state level for Medicaid. Also, the Meaningful Use criteria is a floor in our draft regulations, states will have the ability to come in to CMS and ask for additional criteria, but it has to be approved by CMS before they can begin to apply to their specific states. These are the differences between the programs. I spoke about some of these. As you can see in the Medicare area, only physicians in Subsection D hospitals and critical access hospitals under the Medicaid, we have five types of EPs and several types of hospitals. The other thing I wanted to point out to you is that there will be fee reductions in Medicare. There won't be any in Medicaid. And the states actually have the option whether even to enter into the program or not. We expect all the states will, but they actually have do have an option not to participate.

These are some of the changes we made from the HIT policy committee. Basically we made some changes based on additional input we received internally, as well as looking at some of the changes in terms of how they could be done both operationally and policy wise made some of these changes here. And of course with each objective, we made sure they were matched to a measure and added percentage thresholds to measures where it made sense and made a few other changes as well. But in general, we did accept most of the HIT policy committee's recommendations.

The incentives time table, right now, by law, we can pay incentives to eligible professionals no sooner than January 2011. We can pay eligible hospitals no sooner than October 2010 and in Medicaid, they can potentially receive payments as early as 2010 for adopting, implementing, or upgrading. We expect that probably most of the program will begin in 2011, however. Payments will probably be made not in January of 2011, but certainly registration for the Medicare program will begin in January 2011. Potentially for the hospitals, we may pay as early as January 2011, which would require you to begin providing the information or collecting the data for out of station in October 2010.

The next steps, we did receive the HIT policy committee input last Friday. I mentioned the comment period ends, and then we'll go through a review of comments and draft a final regulation that will then go through a clearance process, and we expect the Final Rule publication to be done in late spring of this year.

So I guess we'll probably just let David go ahead and give his remarks, or do you want to, how do you want to do this, Liz?

Dr. Bufalino: Yeah, we could go back to back and then we'll come back. That would be great.

Mr. Trenkle: Okay, that works. David?

Dr. Hunt: Thanks. I'm, volume won't be a problem. It's always a content issue with me. I'll say good morning, and thank you all very much. I bring you all greetings from Dr. David Blumenthal, the National Coordinator for Health IT. I want to thank Dr. Bufalino and the committee leadership for this opportunity to update you on our work at ONC.

I was thrilled to actually speak about our plans for Health IT exactly two years ago. A lot has changed since March 2008, and for us at ONC, you know this year 2010 is a bit of a moment. For me, it feels like the morning of my first day of medical school back at Howard. It's incredibly exciting and more

than a little bit scary. But before I really get into the moment, I want to make it clear that I have no conflicts of interest about what we're about here to discuss. What's more, I hope that you're all pretty comfortable with the objectives that we maintain to hit on as far as this conversation is concerned. We're going to talk a little bit about Meaningful Use of Health IT, what it means to our practices, and one thing that I hope I'll be able to make clear is that it means an opportunity to improve the quality and safety at a systems level. And I also hope to say how our agenda over at ONC will articulate with an expansion on our national policies for quality and safety. You see, before I came to ONC, I worked here at CMS, and was fortunate enough to help lead one of the most extensive quality and safety programs for Surgical Care Improvement Project, or SCIP. So at this point, I should probably give my final disclaimer. I like to tell all of my audiences that I'm a strong believer in the adage that content without context is pretext, so to help you make an informed decision about the information I'm about to give you, you have to understand that I'm a surgeon. I know that there are a number of surgeons within the audience and whether you're a surgeon or work with one, love us or hate us, I think you're all pretty comfortable and can agree that right here Caravaggio was able to capture the essence of the entire group pretty well. Every surgeon is a direct descendent of Narcissus. We're constantly trying to find ourselves in our work, if you will, and I say this to help you understand why after looking at all the wonderful objectives that I just gave, this conversation really may just devolve into an exposition of me and my practice. You see, for all of the potential of the national scope of our work, I'm firmly convinced that the mission of the office of the national coordinator for Health IT is to help my practice, possibly by extension, yours, to provide better care. The word "tacit" is derived from the Latin *tacitus*, silent, is the past participle of *tacir*. And when tacit assumption many hold about our work at ONC is that all of it is about information technology. I know the last two words in our title actually and our learning objectives for that matter also, could be the reason that some people hold that tacit assumption; that our work is all about IT. I think right here, Barbra McClintock, one of my personal heroes, was absolutely right when she concluded that tacit assumptions are really the substance of dogma. They're a tremendous barrier to effective communication. Sure a great deal of the information and program resources I'm about to discuss have an obvious association with information technology, but a more appropriate way to describe our mandate from the President and from Congress is that Office of the National Coordinator has been given unprecedented resources and authority to effect an improvement in the value and efficiency

of healthcare services through the Meaningful Use of information technology. And likewise, when I sat down to craft this presentation, I suspected that some might make the tacit assumption that the moment of my title, health IT, and meaningful moment, speaks to a brief yet important period of time. But that's not really it. The moment I'm really here to discuss, the moment that is so precipitous is really the moment that we learned about long ago in physics. It is the moment so elegantly described by our Archimedes. Namely, that we have the capacity and the potential to cause motion about a central point or access. That central point or access is the quality and safety of healthcare services delivered in the United States. And I should point out that while our resources are profound in aggregate, they fall far short of the inertia we are attempting to overcome. That's okay. Archimedes described out with the right lever and a place to stand, you can move anything. Even if it seems to have near infinite mass. But I'm getting way ahead of myself. I have it on very good authority, my daughter always told me that I get very boring and I speak for more than five to ten minutes, I have bottom line you. I have to give you really some take home messages. And the first thing I'd like you to take home is that this moment in time, possibly more than any others, the time for clinical leadership, which is why the work of this group is really so essential. And next, while we lead, I think the essence of this group also points to the fact that we have to be the first to acknowledge that our work is a team sport. Any success we have is wholly dependent on the strength of our team, above and beyond all else we have to forge strong partnerships, which really brings me to my final point. Please rest assured that no direction beyond this point will be an easy one and while I won't only promise you blood, sweat, toil, and tears, you have to understand that the path forward, the path forward is going to require a system, tremendous resources, and no small amount of courage. And the reason for that's pretty easily understood. I showed this slide the last time that we were together, and the truth behind it hasn't changed one iota. Namely, in 1998, Cyril Chantler pointed out that years ago, medicine used to be safe, simple, and ineffective. Today, we practice in a world in which our efforts can be very effective, but also everything about that practice is more complex and potentially dangerous, and it's rather clear that the prudent use of information technology can partially mitigate some of the danger imposed by that complexity. But while we say this, we can't fall into the trap that essentially holds that the entire promise of our profession is dependent on our skilled use of a computer. I spend a lot of time managing expectations and making sure our patients and consumers understand that all won't be made right if we just make silicone valley the

epicenter of American medicine. Now, don't get me wrong, I have a firm and abiding conviction that properly applied information technology, properly applied tools can help me as a surgeon be more mindful of my patients. Learn new insights into the care I deliver and improve the quality of that care. But I think you probably better than most, can appreciate the fact that our profession is old and has seen many, many technologic advancements, and the value of each of them can only be measured against a simple scale. One patient at a time. Has the technology helped me better take care of those who put their trust in my judgment? And in the end, the healing art trumps the science because ours is a human endeavor. It's always tempered by the science, but when practiced well it's never more than one reassuring hand away from the fact that our method is ultimately dictated by our culture. So at ONC, the overarching question is can we use information technology as a vehicle to change our culture and in turn our methods in Twenty-first Century American healthcare? And the secret to using that vehicle is the one that we've always used. It's the one that transforms medical students into interns, and residents into attendings. It's work. W-o-r-k. A former chair of surgery used to paraphrase Sir William Osler when he would say that work is the philosopher's stone that would change all base metal into gold, the dull it will make bright, the bright it will make brilliant, and the brilliant it will make steady. And in short, as physicians, there is work to be done beyond using a keyboard or a mouse. We do not and cannot accept the thesis that all will be made right when the selection D on our board examinations is, is there an app for that?

Let me give you a case in point. I travel a lot and I sit in on a lot of mortality and morbidity conferences. I once listened to a presentation of a trauma case in which the lament was that computerized records couldn't get here fast enough. So my ears were obviously perked up. See the Code Yellow team was brought to the emergency room to see a gentleman that had taken a pretty bad fall off a ladder. He was bleeding excessively from some relatively minor cuts and abrasions and he had a worrisome abdominal exam. Now his coagulation profile showed an elevated INR and as luck would have it, they actually found a prescription for Coumadin in his wallet, true story. Unfortunately, he spoke no English and they had no capacity to translate. So the overriding clinical question was why was this man being anti-coagulated? Well, this was his chest x-ray. Now mind you, this chest x-ray was taken after a standard trauma evaluation. They had no translator. For those of you in the back, or if you can't make it out on the slide, I want to highlight a couple of key clinical clues. Now somebody took a stethoscope and put it two

centimeters away from a well-healed median sternotomy scar and heard tick, tick, tick instead of lub dub, lub dub, took a chest x-ray and cried to the spirits of Ostler and Halstead for the salvation of an electronic record to break an impenetrable communication barrier. Why or why was this man on Coumadin? Well, ladies and gentlemen, in reaching to grasp technology, we can't lose a grip on the basic skills and discipline that has dictated the conduct of our profession for over 2,000 years. Now if we're all agreed that all of our parents didn't send us to medical school in vein, let's discuss what we might achieve through the application of information technology.

Now, I mentioned earlier that the President and Congress gave the Secretary in our office a mandate and I think it's pretty helpful just to look briefly at the text of that mandate. And here's a section of that text and highlighted are some keywords and phrases. It starts with security, quality and trust. Further along you see that we have clear direction to facilitate the Meaningful Use of electronic records nationwide. And we see throughout that the overarching subtext is to improve the quality of care while making sure that the information remains secure and supports are institutions of public health. Now to insure, reduce, protect, facilitate, promote, that's a pretty formidable list of challenges but again, I ask you to take note that the transcending goal is not to acquire cool hardware. The point is not to have the latest software. The infrastructure is a means to an end or is nothing at all. But I'm a surgeon as I mentioned before, and a list of eleven things is no different than a list of a thousand. I need a way of describing what our office is about to do on the fingers of one hand. So moving forward, we at ONC see our job as defined by HITECH is this: We're going to define what meaningful use of an electronic health record is. And then we're going to support the medical community in meeting that definition. And we will establish public trust in a healthcare system that more effectively uses this technology. And finally, we're going to foster greater innovation in health IT. But simplifying this doesn't really make the reality of our challenge any easier. Here, you can see some of the most recent preliminary numbers regarding the use of electronic health records by physicians. These numbers are pretty sad. And I'm not one who buys the spin that a 43 percent increase from 4.4 to 6.3 EHR percentage EHR usage among the physician is anything to pop open the champagne about. And these numbers are pretty easily understood when we acknowledge that the Darwinian laws that govern our markets make a pretty compelling case that physicians aren't the business hicks that some would believe. It's quite clear that an EHR market share of 6 percent is a reflection of some pretty significant barriers.

Here we see the top six barriers to adopting electronic health record. In short, for many, it has not been worth it. Collectively, we in the clinical community, have made a very clear and compelling case that to embrace electronic health records our needs really have to be met. I guess that's probably better and a softer explanation than Darwin. Our needs, really, they have to be met. And that's the most proper description. Now, I've used this slide for some time. I use it nearly everywhere I go because it's such a wonderful construct to frame our challenge as well as our solution. This diagram is actually from the work of Abraham Maslow, who in 1943 described a theory of human motivation. In it, Maslow divided our needs into growth needs and deficiency needs. Deficiency needs are physiologic. They have to be met first. And once met, the individual seeks to satisfy the needs of growth. Well, we can apply Maslow's hierarchy to our current circumstance in health IT and in doing it, we'll assign the foundational need as privacy and security. Beyond that, moving up the needs of growth, we can see the components of usability, basic functions, a strong business case, and finally, at the top, a most fulfilling achievement; information exchange. Now let's be clear again why this is so important. The underlying proposition to all of this strikes at the heart of Cyril Chantler's observation regarding the complexity of our art, namely that Twenty-first Century information tools can help me provide better care to my patients. And in what may have been one of the most important pieces in American healthcare that's been written in the last 10 years, Michael Porter here argues that improving the quality of care is the single greatest contribution we physicians can bring to the movement or this moment of healthcare reform. I recommend this article to everyone. Regardless of what lens you see the world, physician, patient, payer, it doesn't matter, because in it, Porter clearly declares that we must all be about the business of improving outcomes. So in short, whether it's from the business end of a scalpel or stethoscope, you should understand that this whole grand endeavor is all and only about value and values.

So to that end at HHS, we're going to focus on individual and population health outcomes. We're going to focus on increasing the efficiency and transparency of healthcare, and increasing our capacity to study and improve healthcare delivery. Now, a lot of things influence our ability to realize those goals, and at ONC we're not so naïve as to believe that any one or all of them can be solved with an electronic health record alone. And here you see just a partial listing of the things that affect our nation's health status. But if we look at what can be done through the help of an EHR, the path is clearly through the meaningful use of

this tool. Now I've been at the Office of National Coordinator for a little over two years and I remember being a little bit like John the Baptist, a voice crying out in the wilderness with $60 million and a charge to save the world. It's no doubt we had good intentions. But thankfully now, we have the resources to create a set of programs that can make meaningful impact. Now if you recall my earlier slide, regarding the topics as barriers, as far as EHR adoption, financial challenges, ranging from the cost to inaccurate return on investment and the loss of productivity were at three of the top six. Clearly, the program of CMS-based incentives are meant to, in part, mitigate some of those concerns. And as you heard already those incentives will begin in 2011. And again, I try not to overlap too much with Tony's presentation but I just included this slide as a reminder of the measures that are proposed for submission by attestation in 2011.

But our programs for meaningful use are about a lot more than incentives. To be a meaningful user, you first have to become a user, which means adopting an electronic health record. In addition it's no small point that two of the statutory criteria for meaningful use involve the exchange of information. Now I'll briefly mention our program supporting exchange in a bit, but first, let's talk a little bit about adoption. To support the adoption of electronic health records we've announced the establishment of Health IT regional extension centers, and a national program of workforce training. These programs address four of the top six major concerns; the capacity to implement, transitional productivity loss, avoiding system obsolescence, and finding a system that meets a practice's needs. On February 12, we announced 32 grant awardees that were on the first round of funding for our regional extension center programs. Now these 32 awardees will cover practice locations that care for well over 50 percent of the nation's population. Their specific mandate is to provide technical assistance to providers and disseminate best practices, particularly in those practices least likely to be able to do this on their own. I'm talking about small practices, rural practices, and practices in medically under-served areas. That workforce will include of course some ubergeeks, as I like to call them, that can install and configure hardware and can set up networks and routers and software. But importantly, it also includes some folks trained in the nuance of clinical work that know how to lead practices through the steps of changing the way patients flow through offices and hospitals. Now obviously discussion of any one of these programs could easily consume an entire hour and many of them will be discussed in various forums later. But I want to talk a little bit about three major pieces of work that are designed to support health information exchange. In the largest, we're providing

over $600 million in grants to support state-based health information exchange programs. Now obviously for exchange to occur, we've got to continue to advance health IT standards and certification. And while those two domains are critical, their importance actually pales in comparison to issues of privacy, security, and confidentiality. Now I mentioned earlier that privacy is a foundational need. A physiologic need in Maslow's terms. And it's pretty easily understood. The tenets of privacy are old in our profession and the basis for the trust that patients place in us. HITECH extends and expands our collective responsibilities and as a way to meet those responsibilities, I'm very happy to announce that a few weeks ago, the Secretary appointed a chief privacy officer for our office, Joy Pritt. Now if you'd like to hear a little bit more about privacy concerns, I invite everybody that's going to be a URL at the end of this presentation. Please go there and take a look at all the things that we have around privacy and security and extensive discussion is really out of this scope. But I would like to make sure there's a clear understanding of what each of these terms means. They're often used interchangeably.

Privacy derives from the Latin *privatus*. It means belonging to ones self, not to the state. Confidentiality from *confidere* is a trust, and *securis*, the root of security is a state of being. It means free from care. And likewise, I often hear some confusion about the relationship between the proposed meaningful use objectives, certification criteria, and standards. But just as there's some uncertainty regarding these, the nuance between privacy, security, and confidentiality, in the general clinical community I've noticed that there's some confusion about what a meaningful use objective is versus a standard, versus a certification criteria. So if we had a meaningful use objective of electronic prescribing, then the certification criteria, essentially the high level functional requirement that the software programmers would have would be that the EHR has this capability. In programming terms, this actually translates in terms of standards to using the NCPDP script standard. Likewise, an objective of submitting an immunization data to a registry would mean that a certified electronic health record would possess that capability, which means using the HL7 and CVX code sets. Now again, we could get completely immersed in any one aspect of this, which wouldn't really serve the purposes for this moment. So in brief summary I hope I've been able to impart a high level view of our implementation of HITECH. Our goals are again to define and support meaningful use to establish trust and create an improvement in an environment that nurtures further innovation. In a nutshell, this is a high level overview of our major programs. Incentives

facilitating adoption and exchange all coalescing as meaningful use and throughout we're constantly looking to enhance the technology.

Now as we look forward, there are a number of milestones. None more important than the closing date for comments that Tony already mentioned. You take nothing more away from this, know this, that we desperately need and will review all comments. I emphasize that to say that we will need your help every minute of everyday because the reality of this day, of this moment, if you will, is that no country, no national enterprise as complex as the United States has fully and successfully implemented what we're attempting to deliver. I used to end my implementation presentations with a quote from Voltaire that said doubt is uncomfortable. But certainty is ridiculous. And while that's very true, as we stand just beyond the cusp of this year, I really appreciate Mr. Twain's observation even a little bit more. Namely, that we are about to understand things that could have been learned in no other way. We are willfully and purposefully grabbing this cat by the tail. And we have to keep in mind that we're learning these lessons, that we're grabbing this cat for one purpose, to improve the quality, safety, and efficiency of the care that I provide. But remember my central thesis, that while our current circumstance is not due solely to a lack of technology, it can't be solved with technology alone. This technology can be a wonderful tool, a wonderful lever to help us exchange information. It's no small matter again that two of the statutory criteria for meaningful use involve information moving, information exchange. The whole point is to provide a means to facilitate communication and the transfer of information and possibly even the transfer of knowledge. In the right hands at the right time, information can be transformative. The full complete, rapid, and regular exchange of medical information will represent a singular change in our culture and I can't think of a better way to increase the value of our services than to make their provision fully informed. And the alternative is equally remarkable to continue each of us in our silo, putting one new innovation on top of another, with no real consideration of how one piece of information informs or supports or confounds another means that we'll keep our current very haphazard and dysfunctional method of taking care of patients. It means we'll recreate the experience of babble. So I hope you understand that while necessary computers aren't the whole answer because the question is how much technology do we need? The question is how do we improve the quality of care for all patients, for all Americans, and in turn affect that elusive and that self-evident truth that among our inalienable rights, are life, liberty, and the pursuit of happiness. Now I'm

frequently accused of being hyperbolic but this is not the time, not regarding this moment. And I say that because see I've seen that the pursuit goes a little bit slower for our kids who haven't been immunized, and preventable cancers have separated far too many of our people from their right to life and the full flower of liberty is not as apparent to those that rise every moment with a disability, with Alzheimer's, or with HIV. Now a computer won't make that right. But information technology can assure that a pediatrician sees a list every morning of the patients coming that day that aren't up to date on their immunizations, as well as their brothers and sisters who will probably come in tow with mom when she arrives for the appointment. Every man and woman having an electronic record means that our best minds can really ask and answer the question. What treatments work best for a 48-year-old Latino with breast cancer? Or a 56-year-old African American with node-negative prostate cancer? And what are the full portfolio of services that they'll need to effectively implement that treatment? A computer won't rid the world of AIDS, but it will afford well-meaning people the liberty of having their care coordinated in such a way that every one of their doctors knows all of the results of all of their tests. You see, nine years ago, the Institute of Medicine got it right. Quality care is efficient, effective, safe, patient-centered, equitable, and timely. But just saying that won't make it real. And it only begins to describe what we need to do to reform healthcare. With information systems we can see the true choices and the balance that must be preserved and that balance is really highlighted in my reality as a Twenty-first-Century American surgeon. You see, in the operating room, I know that you can't be anymore efficient than you are safe. In the larger world of surgery and all of medicine for that matter, effective treatment is synonymous with timely treatment. And finally from my family and for yours, I don't see a way to provide patient-centered care without a full measure of equity. So that reality stands in immediate juxtaposition with the fact that no one has done this before, not on this scale. And in boldly moving to do something so very neat and new, we must stand on a rock, a foundation that is level, that is strong, and solid, which really brings me back again to the moment of Archimedes. The technology is one lever, one good lever, but to achieve our ends we have to remain focused and committed to making my practice and yours better for our patients. That's the foundation on which we will stand and I'm here because we really need your help to do this. We're trying to change the world. Change it with new tools and old principles. The new tools will give us leverage and working with you will have [inaudible]. You here at PPAC can actually help give us where to stand. So we can't do this without the physicians in

this room. We need clinical champions, those of you who have used or will use this lever to make your practices better. There are many tacit assumptions on either side of the truth regarding health information technology and we at ONC are asking right here, right now for you to share your wisdom and your experience with us and your colleagues as they consider electronic health records. As we attempt to carry this cat by the tail, we're all working toward the same end. Service to others. That's both our professional inheritance and our legacy. That's our collective debt. A debt we owe in equal measure to our teachers who came before us and our students who will practice after us, and at ONC, we're trying to make that debt easier to pay. But again we need your help. Now, some may take issues with parts of our approach and in doing so elect to stand on the sidelines. Please don't. Not now. Not with this moment. Physicians don't wear a cloak of complacency very well. It doesn't fit us. It's unseemly. As we at ONC again try to carry this cat by the tail there may be times when you get pretty exasperated with us. Now ill you agree with every decision or policy that we make regarding meaningful use? Maybe not, but take heart you'll not be alone. To be frank, I can't say that I've agreed with every decision that's been made in our office, but I can say that I agree completely with our intent and our focus and our commitment to work together. I know the federal government can be a hard partner at times. In that regard HHS isn't really unlike a surgeon. Just another descendant of Narcissus, but just like me and my surgical brothers and sisters, ONC is trying to do the best that we can and yes this is a journey of self-discovery. We're looking really to find the best of ourselves and like all surgeons we're looking for that best part of ourselves through the service to others. So thank you it's been an honor to speak with you and hopefully we'll have some questions.

Dr. Bufalino: Thank you. Dr. Smith?

Dr. R. Smith: First of all I want to congratulate you on an outstanding presentation. From one surgeon to another, I can say you have been well trained. I practice at a place called Henry Ford Medical Group in Detroit where we've had electronic records now for two decades. I haven't written a prescription in five years mainly because we had a program working with General Motors and Ford Motor Company in collaboration to develop this for the state of pretty much southeast Michigan, where everybody's now using e-prescribing. One thing, I get email notifications about abnormal ultrasounds and pap smears and follow up phone calls like I just got when I haven't responded to the email. So we're moving in that direction I think quite rapidly and it does improve the quality and efficiency. And as you pointed out, I view this as a

charge for the committee is to promote quality, efficiency, safety, and access. So in that regard, we are all on the same page. The one thing that's missing in one of your slides is that access to care part. And I think that's also that something that we have to be acutely aware of and that physicians are trying to provide care to patients but they're limited by a number of reasons.

In your presentation, Tony, you spoke about things such as care incentives and kind of the carrot and the stick. I would caution about the stick at this time in American history. As I mentioned, we collaborated with Ford and General Motors. Well they've had some problems in the past couple years and that's impacted quality for people throughout this country and subsequently throughout the world as we've seen, as we know the old saying.

Mr. Trenkle: Well let me just declare the stick was put in the legislation, it wasn't something—[crosstalk] I understand.

Dr. R. Smith: Because as you look around, I'm from a state now again because of that, where we've seen last year, well not even last year, ten months ago there was a 4 percent cut in Medicaid by the state, followed a few months later by an 8 percent cut in Medicaid and announced just last week, an additional eight percent cut in Medicaid, so the states are struggling. And not just Michigan. Just recently Louisiana, Oklahoma, California, Illinois, Kansas—that you can have all the quality IT in the world. If people cannot access the care, it's been an exercise. And I think we have to be very careful right now in the exercises that we do that it does not create a barrier to care, and that it will fact enhance the care, so that physicians can provide that care to their patients.

Dr. Ross: Dr. Hunt, that was the most incredible philosophical, medical lecture that I've ever heard, but I was actually enamored. I mean it was phenomenal to hear some of the things you had to say in fact, Dr. Siff and I were trying to translate your last slide of give me where to stand I will change the world. I hope that's what that meant. I would just like to comment on one particular commercial and I'm not a marketing commercial person, but if you remember during the Olympics, without mentioning which company was advertising, there was a tremendous commercial, and I think you know the commercial I'm talking about, where a physician is sitting in the well with a patient, and sitting in the amphitheatre are all these physicians and you know the story, and I think that typified—well, let me just conclude the story. The physician's trying to diagnose the condition of the patient and he comes up with one diagnosis and a doctor

up in the amphitheatre comes out and says well, we already did that test. And it came back negative. And another physician said, but we did this MRI and it came back this, and then another physician chimes in. The bottom line to the whole story, the whole philosophical story is that if you use these records, you save time, you save money, and you do improve outcomes. Just watching that commercial said a lot to me and so I thought about this and when I looked at one of your slides that said some of the major barriers to adopting electronic medical records is concern about obsolescence, investment, but what I would do is I would turn the slide around and I've seen that you've got a couple of slides that do talk about some of the improvements. But I would definitely put a slide in there and I would put into a campaign if you will, about not just positive outcomes, but saving time, saving money, maybe cutting down on payroll of employees that have to make phone calls and get MRI reports with CT scans, the time wasted for the patient to sit in a room, occupying a room while another patient is in the waiting room, waiting for that room to be vacant. I mean I go through this every single day because I don't have in my office, not the hospital record, but my private record, I don't have electronic medical records yet, but we are already starting to look at those companies that service and provide that record. I would say cost, to me, is one of the major issues. Obsolescence is going to be a major issue, but I think when I look at the outcomes, when I look at the long run and I think about that commercial, and I see what's happening in my own practice, it's just going to not only be so much easier, but much more effective for our patients' care and for those outcomes. So just a couple of possible positive comments on what you could do. And I think a campaign of that sort, not to mimic the commercial that I'm talking about, but a campaign in that sense to convince providers to go this way and what the benefits would be; how much time you're going to save, how much money you're going to save, the patients will save time. Favorite comment in my office is patients come in to the office and go do you know how much time I've been waiting here? Do you know how much time I'm spending here? I've got better things to do. And so now the patients will be happier also.

Dr. Hunt: Thank you so much just to respond briefly to that. You pretty much outlined our communications plan at ONC. So thank you, I think that it also is telling and will be getting out more and more information as the campaign unfolds that well over 90 percent of everyone who's selected or who's gone to an EHR would never go back, so it's a very, very satisfying experience once you can get over that threshold. I did like that commercial also. And I liked it for the subtlety. It was telling in a number of ways.

I'm not sure if you noticed, if you remember at the commercial, toward the end, the patient looks a little bit unsettled and asks, because it's this huge amphitheatre, and he figures he's sitting in the exam room, can I have my pants back? I thought that was a very, very appropriate because in a way, for me, and maybe I was reading too much into it, it said that we've also got to be careful.

Dr. Ross: Privacy.

Dr. Hunt: Exactly.

Dr. Ross: Yeah he was concerned about his privacy, at the same time, the physician thanked everyone and that's the whole point. He thanked them for the help.

Dr. Giaimo: Thank you both for all your hard work with this. We certainly do appreciate it and the people that we represent are all interested in very high quality care and trying to deliver that. I did have a couple of specific concerns though may I address those at this time? A few of them were about the meaningful use documentation that has come out now. And if I may just take a few moments to make three recommendations. First recommendation from PPAC: The proposed stage one criteria by CMS are too aggressive, and will deter adaptation and participation in this program. Furthermore, the use of numerator and denominator data to determine significant use would require significant manual calculations at this point done by physicians as there are no automated reporting systems and mechanisms available to get this work done. PPAC therefore urges the removal of any required numerator and denominator criteria as far as obtaining objective measurements at this time to qualify for meaningful use of the electronic health records.

Mr. Trenkle: Could you be more specific on what you would propose instead of that I mean, you recognize where you're trying to go with that, so what's your alternative?

Dr. Giaimo: Possibly a two-phase plan that we can try to stretch out the primers that we're looking at right now. Some of the information is just so difficult for us to extract. In small practices, I'm a solo practitioner, the vast majority of healthcare delivered, 80 percent of healthcare delivered in offices is by less than 3 to 5-physician groups, so it is very burdensome. I'm an early adopter of electronic health records. I was speaking with David a few moments ago about the fact that my system is now going through renovation. There's another company now that's come in to purchase the company that I bought my system from. I'm going to have to evolve into yet another system. That great creates a great burden on a practitioner. As far as the data that we can try to get to you, maybe there would be different types of criteria

that we could look at, which was things that are based on more outcome data as opposed to the specific numerator and denominator. It's very difficult for us to extract that specifically. The Physician Consortium for Performance information, they have been doing a lot of work with trying to get good dynamics for what is good quality care and maybe we can try to look at some of their protocols and try to see what would be a better form of us assessing what is a good outcome for our patients. I think that that may be a better way for us to go. Right now it's very difficult on the present system, or if we could just to delay the implementation of that numerator and denominator process.

Mr. Trenkle: There's a couple of challenges here that I think you've raised. One is of course the fact that the infrastructure is still evolving as we're trying to do a lot of this, but then you tie that in with the fact that this is a front-ended program in terms of incentive payments. So how do you get people on the, as David Blumenthal likes to say, on the escalator at the right level and then keep the escalator moving? Where you have a lot of from the political side, they put out a lot of money for this program and they want to start seeing results early on. So it's a challenge to what is the right balance between putting enough in the meaningful use criteria to make it more than just an adoption program but at the same time recognize that the realities of infrastructure development are still happy over the next several years, partly fueled by the grants that ONC is giving out to the community. So it is a challenge but we certainly welcome your comments both today and also when you comment on the, if you comment on the reg officially.

Dr. Giaimo: As another part to that, perhaps we can work some lexicon where there would be a feedback mechanism along the way, instead of just finding out at the end of a year, whether or not you qualified or not, perhaps there can be some program that would make it on a quarterly basis, or ideally a monthly basis, but at least a quarterly basis where practitioners would be able to get feedback on whether they are meeting those criteria. So whatever criteria we agree on, then those criteria would get feedback, so there'd be a two-way mechanism. So they can then go alter their practice parameters to get that.

Dr. Hunt: I guess I would ask one quick question to Ken and the group, do we have a way of making sure that these comments get put in as official comments also to the—

Dr. Giaimo: I could make the recommendation if you want on this last matter.

Dr. Bufalino: He's looking for the recommendations to go directly them by the 15th. Did I misinterpret that?

Dr. Hunt: Exactly. No I want to make sure that because I think these are good points. Oh that's right, Ken, is that out of sorts?

Mr. Trenkle: It isn't out of sorts, but it would be recommended by a federal advisory panel. I don't know how that ties into the overall public comment period.

Dr. Simon: We'll have to investigate that and talk with our general counsel. But certainly we will forward a copy of the transcripts from this meeting to both of you so that you'll at least have the content of the meeting as it pertains to this discussion.

Dr. Hunt: That's just sort of the nuts and bolts, but I think your point is very, very important and very valid, and I just tell you a little bit about what we're doing at ONC to mitigate some of that, but right now, it's going to be a little bit of time until we get to the good spot that you mentioned where you don't have to worry, do manual calculation, it would be nonsensical to have this great new EHR and then you have to get out an abacus to figure out numerators and denominators. And that will be rolled in hopefully as we move forward to our certification criteria and I'm sure that will be able to be moved in with the 2011, but I know we've heard that one comment before that anything that is requested, particularly as far as information is concerned, quality information that it can be calculated using the EHR with relatively little effort on the part of the practice, and that's clearly here, as well as and that ties right into the feedback, also that we should be able to figure out whether or not that is not a guess at the end of the reporting period whether or not you'll be a meaningful user.

Mr. Trenkle: Yes, but the problem with that is if you're, the way you calculate the percentages is looking at the percentage of use of the EHR for various—if you're using the EHR to calculate everything, obviously you're using the EHR. So that's kind of counterproductive to look at it—I understand that the problems with manual counting and manual transmission, but the part of the issue is how are you using the EHR for this? And if you don't look at the total universe of patients and, how are you going to calculate that? Then you just base it on number count, but then a number count is varies depend on the size of the practice. So if you say someone needs to do e-prescribing 17 times in a year, well that may be very easy for one practice and represent a very small percentage, whereas it might be very large for another, so the challenge is trying to define meaningful use and how we're calculating that to see how you're using the

EHR, but at the same time recognizing that some of that may require some manual calculations on your part.

Dr. Giaimo: Can I make these two as formal recommendations, then?

Dr. Bufalino: Shall we deal with this first one? You want to just reread the. . .

Ms. Trevas: The proposed stage one criteria are too aggressive and will deter adoption and participation in the program. The use of numerator and denominator data to determine meaningful use requires significant work by physicians because there is no automated method to collect these data. Therefore, PPAC recommends that CMS remove the criteria to obtain numerator and denominator data as an objective measurement to qualify for meaningful use.

Dr. Giaimo: And one last part, until those data can be readily available with electronic health record systems. So I mean in the future, I think it will be a very viable thing to do but right now with the electronic health record systems we have it would be very difficult so.

Dr. Bufalino: Second?

Dr. Snow: Second.

Dr. Bufalino: Discussion? All in favor?

[Ayes]

Dr. Bufalino: Thank you. Joe?

Dr. Giaimo: And the second part of that was going into PPAC recommends that CMS needs to develop a feedback mechanism so physicians can be assured early on in their information that it is being transmitted adequately and they are successfully meeting the criteria for successful use of electronic health record.

Dr. Bufalino: Second?

[seconds]

Dr. Bufalino: Any discussion? Meaningful feedback to the physician that they're adequately meeting criteria. All in favor?

[Ayes]

Dr. Bufalino: Thank you. Last, you have more?

Dr. Giaimo: The last one was just about on the quality issues with it. PPAC recommends that we believe that measures for quality should come from consensus organizations, such as the Ambulatory Quality Alliance, the Surgical Quality Alliance, and the Physician Consortium for Performance, to help facilitate good evidence-based medicine. And these criteria should be included in electronic health records as their criteria for meeting quality.

Dr. Bufalino: Second?

Dr. Snow: Second.

Dr. Bufalino: Any discussion about that?

Dr. Smith: One brief thing. Make sure that it's not exclusive.

Dr. Giaimo: No, not exclusive, but these should be considered in inclusion with other criteria that they're using now, but use some of the consensus organizations that have significant feedback from physicians and providers.

Dr. R. Smith: And also with specialty groups, they usually use their evidence-based guidelines as well.

Dr. Giaimo: That's where the Physician Consortium for Performance is, that's where a lot of the specialty groups sort of meet in at, but certainly other groups. This wouldn't be an inclusive list, this would be just that these types of groups would be included.

Dr. Williams: What do you mean exclusive? I don't understand what that means, Francesca?

Dr. Bufalino: She just doesn't want you to exclude any specialty groups from that list? He just wanted to have it include those but not exclude all the others. Correct? I'm sorry.

Dr. R. Smith: The old mammogram controversy, you know, you have different groups recommending different things now.

Dr. Giaimo: But just try to get consensus and that's why these were groups that all represented consensus with a fair amount of physician input with quality assurance related to, with evidence-based medicine. Those types of criteria.

Dr. Bufalino: All in favor?

[Ayes]

Dr. Bufalino: Thank you. Karen?

Dr. Williams: I want to thank you both also for your presentation, and for the efforts that you're making to bring us forward with this, a very complex issue. I'm a practicing anesthesiologist here in the, well, in George Washington University, in DC. And so therefore would be considered a hospital-based physician, according the criteria that's outlined in the proposed rule.

Mr. Trenkle: Right.

Dr. Williams: However, in general, anesthesiologists don't only practice in hospital bases anymore. They practice in surgery centers, they practice in physicians' offices. There are a number of different practice settings that anesthesiologists, critical care, etc. And pain specialists. Depending on how you ran numbers, I think in the proposed rule, you stated that the first nine months of 2009, about 27 percent of Medicare eligible physicians would be considered to be hospital-based, and therefore not eligible to receive any incentive payments. When you ran those numbers, did you break them down by provider type, i.e., specialty type?

Mr. Trenkle: Yes, we did.

Dr. Williams: Because it appears as though when we run the numbers for the hospital-based codes for all anesthesiologists that submitted claims for 2008, which was what we had the complete data for, it doesn't come near the 90 percent that you're requiring and so we're trying to find out what's hospital-based going to be? And maybe there's some other details that need to go into that figure before you decide who's eligible and who's not eligible.

Mr. Trenkle: Right, well one of the things. Well, there's two things. Of course you know there's legislation pending that may change that, but secondly, we did talk about in the NPRM that there were a number of organizations who spoke with us and it talked about some changes they felt need to be made and one of the things that we asked for in the NPRM was for comments and changes to be recommended accompanied by data, so if you do have some data that would back up some of the concerns that you have, that would be very helpful if you could submit that as part of your public comment.

Dr. Williams: Okay. And then the legislation that you talk about that's pending is related to the Ambulatory Surgical Centers I presume. And obviously, a lot of us work in Ambulatory Surgical Centers also. And if that is approved and removed, that will further add weight to the fact that a number of anesthesiologists are not hospital-based anymore. However, the flip side to that coin is the people who are

working in hospitals generally rely on the hospital systems in order to, for instance they buy our anesthesia machines, etc., so therefore they may buy our information systems. But I don't know that there's any incentive right now for the hospitals to work with us as far as the meaningful use things that apply for instance to anesthesia or emergency medicine, I think. Where's my emergency medicine colleague up there? And the radiologists already have the PAC systems, etc., but anesthesiologists in general across the country, don't have those same meaningful use things that the hospital may find it's worth their while to incentivize us to do jointly.

Mr. Trenkle: Right. And actually one of the things that we've looked at is how do we define the meaningful use criteria in later years to begin to take into account some of that. Because it's one thing to change the way we do payments and assign more to the eligible professionals as nonhospital-based if the legislation changes or if some other change in regulation occurs, but it's the other thing is make sure we put into the criteria for the hospitals that they do begin to provide the infrastructure [inaudible/cough] support the ambulatory areas and others.

Dr. Williams: And how do you combine if a physician works in a hospital, like a surgeon, and also in his private office? How do you combine those two so that the physician in particular is not utilizing two different systems [inaudible]. How can you make that transition easier for that one person who works in multiple locations?

Mr. Trenkle: That's a difficult question. Obviously the way we based the hospital base was on point of service and we have, that's something we would have to take a look at. There's always going to be an issue with different types of different groups that may fall into certain categories that don't neatly fit into a definition, and we have two problems with that. One is how do you maintain consistency across payment programs within CMS? And secondly, is operationally, how do you make these types of things work? So we understand your concerns. It's how do we do that balance between all these different policies and operational decisions we have to make.

Dr. Williams: Thank you very much. I have three recommendations, I can wait till the end if you'd like.

Dr. Bufalino: Well, let's just have the conversation. We can wait till the end, yes.

Dr. Williams: I can wait till the end.

Dr. Standaert: Couple of comments. A couple for Mr. Trenkle, and a comment for Mr. Hunt. Mr. Trenkle, I'm confused about a few things. I don't mean it as a criticism, but when I went through your talk to prepare for this, I didn't have the Diviner [unintelligible] of the acronym gods to help me with what you're talking about. I had no idea what these things were. So an EP, I just didn't know what they were. So for helping us prepare for what you're going to say, it really a little guide, a cue or something? Anyway, I'm not sure I totally get this. Is a measure your acquiring the same as a PQRI? Is that the same thing? Or are these different measures now? You're saying quality measures that have to go in this record, right? Is that PQRI?

Mr. Trenkle: Right. We're looking for consistency with the PQRI program. It's not the PQRI program.

Dr. Standaert: So it's a whole 'nother set of measures on top of all of the PQRI measures?

Mr. Trenkle: They will be consistent with the PQRI measures. If you look at the, part of that, I understand your need for acronyms but I understand you should also do some research looking at the legislation, looking at the regulation, what we put in there, because we laid out specifically in the regulation how it relates to the PQRI and RAC programs. And also how it related to the NQF endorsed measures as well. So it's all specifically in the regulation.

Dr. Standaert: Right. I have not read the regulation, I would have to admit. It was readily accessible, obviously. Maybe I should do that. So that was one question. Other question, you have to assign a specialty. Specialty quality measures—select one of the following specialties. A number of specialties aren't in there. My specialty isn't there. Her specialty isn't there. The emergency physicians aren't there. A number of us who aren't on this list. So does that mean we don't do this or does that mean we don't pick a specialty or does it mean we pick the closest one we can think of.

Mr. Trenkle: It means you comment and then say that you need for your specialty to be included, or you self-select another specialty that would be the measure that would be closest to your specialty. I mean that's the way it's laid out now. But certainly there's room for you to comment to say that the specialty measures that are applicable to you are not there.

Dr. Standaert: I'll stop with that one on the questioning. My other comment, Mr. Hunt, as brought up earlier, and one of the problems I had with the adoption of electronic health records is the expense and

efficiency drag. I use, I'm a big hospital system. I'm in a huge multispecialty group and we have two different hospitals. We have two or three different systems throughout our, so it's actually very confusing. They don't communicate very well all the time. But it's very inefficient. And it slows me down to actually use an electronic health record in my day-to-day practice compared to when I was just using a paper chart before. And there's these two issues. One, the issue of sort of the benefit of the record, if it's there. There are some articles that sort of look at cost effectiveness and analysis of the financial benefit of doing electronic health record that really argue that it actually isn't very effective for most big systems even, because of the cost of upgrading and maintaining and all the sort of staff you need, and everybody else to sort of keep all that up to speed and keep it running. The infrastructure costs are pretty high. But even with that, it's a system benefit. The system is what gets the benefit. Not the individual provider. When you have most provider, most care being provided by small groups, they're not getting the benefit of the system. It's the system wide benefit you're looking for. It's avoiding writing down the test, avoiding all this other stuff, which I agree is better for the patient. I wouldn't argue with you at all. But to the individual provider, it's a problem, and hence the need for financial incentives and all that sort of things. But you have to make sure they stay in line. Because otherwise, you're not going to get adoption. Because out of the goodness of their heart, physicians I'm sure would like to do this for better care, but if it kills their practice financially, they're going to have trouble doing it. And I also want to point out when we talked about this example of that commercial with the guy sitting on the stage with all these people around them. As I recall, that was a commercial for a particular healthcare service, company.

Mr. Trenkle: It was GE, I believe.

Dr. Standaert: And I think when you look at this stuff, we have commercials for Group Health. Group Health is out in Seattle. And Group Health is a company and you have this philosophical conflict here between what you're talking about, which is sort of we all need to go together and put this information out there and get there, and the marketplace driven incentives of our practice, where things are proprietary. And we have Group Health commercials saying we have electronic health records and so we can do this and we'll know all about you. If you come here, we'll know all about you and record it. But they're not going to want to share that with the guy who's sitting right next door with a solo practice, because they just lose their competitive advantage of they give their whole record system away to somebody else. And

there's a big gap here that has to bridged somehow. You have philosophically competing demands of sort of this global ethical, we need to take care—again, I'm a physician. I don't argue with you at all, we need to take care of this system. It would be more efficient, it would be better for patients. But that isn't the way the marketplace and the financial incentives are set up. And so there's a conflict I think you're going to run into as we go through.

Mr. Hunt: I can appreciate a lot of what you said. The first thing, in terms of there is not going to hit every specialist, and every specialty isn't going to find the easiest way on the path forward, and there's going to be a bit of a transition, but having said that, I'm really surprised that you're in a large group. Groups over 11 docs in general, have found the efficiencies far outweigh the productivity lost so I would be surprised—

Dr. Standaert: From a group perspective, it is more, from the hospital perspective of storing medical records, record retrieval, there aren't people running around with carts with little charts anymore, from that perspective—from the ability for me to see a patient, it is slower. I see less patients in a day because I can't get through their record as fast. And maybe that's a system problem with our system, but from me standing in the trench, seeing my patients, it is slower.

Mr. Hunt: And that could be a number of reasons. We're not going, I'm not going to tout any one particular piece of software. There are some that are good, some that aren't. I know that when I speak to folks in large groups though when they take call, and they're able to in the middle of the night at 2:00 in the morning, they call for a colleague's patient. They have no idea about to be able to click click, oh Mrs. Jones, I see that you are on this and that is a world of difference rather basically reaching in the dark, so in and of itself it's the total productivity, I would say, but as far as one thing that we're trying to do, or two things, to help address some of the efficiency issues. One, the Health IT regional extension centers. Those are going to be experts that are going to try to help—we're definitely going to get 100,000 physicians up to meaningful use but not just 100,000. We're going to hopefully have them as a resource to help all practices and specialties in some way, perhaps through Internet base resources to help figure out and show you how to better use your system. Not only that, but one of the things that have really dragged the health IT market down is that we didn't have the robust competition that you might see in other areas of technology, where people—take cell phones for example. People are trying to one up one another virtually every minute, even

sometimes are trying to up themselves, actually. One-up themselves. So I would have every expectation that the productivity drags that you see now won't necessarily be the productivity drags that we see later, and part of what we're doing with the Health IT, I didn't mention it because there's just so many things that we're doing. It's the research resource center, it's to help identify improvements and innovations that can be made at the system at the software level, and the RECs, the regional extension centers are going to work and try to identify ways that we can help practices become a lot more efficient. Now the last question that you had as far as working through two different systems. That's a huge concern that a lot of people have. I go to this hospital, is this one, how can I, I'm in private practice, how can I share my information with hospital A and hospital B when they're using two different systems and that really speaks to the issue of interoperability and that's one of the things that we're actively working on and that's what some of the first meaningful criteria help actually dissuade. And interoperability isn't the huge bucket of interoperability that we all hope and eventually will see. We're talking about getting a clinical summary, getting medications, allergies, problem lists to be able to be exchanged in a meaningful way, so I think what we'll see as particularly as this market begins to become a real market with market share well above the 6 percent that we see, that you're going to see innovation and providers will begin to compete on the basis of value rather than a particular system of proprietary information. So to that extent, for the hospitals you go to, I would say to that they're not going to be able to be really meaningful users in some way if they're not able to exchange information very well. So we actually have recognized and have built into a lot of the work by statute and by way of our implementation to knock down some of those barriers. But to be honest, the technical barriers. That's really small potatoes, even though they are pretty formidable. The real barrier is to really get to the CEOs in the executive suite to let them understand that particularly in institutions that it is in their best interest and in their patients' best interest to exchange information with that hospital that's right across the street and then compete really on the value of healthcare services. Again, we've seen this time and time again in other technology domains. The best example again, is cell phones. We're not competing where every cell phone, you can only use one carrier cell phone to reach another cell phone within that, you compete not on the standards themselves, but you compete on the value. So I can use a AT&T phone to contact Sprint, okay, a Sprint customer.

Dr. Standaert: But you're only getting iPhone on AT&T at the moment. So that's the problem—

Mr. Hunt: And that's a great example and that's exactly why other companies are coming in to bear to try to beat back that market. So hopefully we will see the market begin to respond. But is it going to be perfect? No. Are there going to be problems that you're going to encounter? Yes. Every time when I walk into an OR locker room is somebody going to grab me and say you know, this is great for everybody else but it's not working for me. Yes, I expect that.

Dr. R. Smith: I just was going to say that we found it's a competitive advantage to share the information to bring more physicians into to when they're caring for patients as referral based. That's how we did that. I was going to say that the next step in this has got to be user friendly where these systems can begin to connect. In Michigan, our state's Michigan State Medical Society, we've had what's call MSMS Connect, where a there's a single portal the physicians can sign into and go from system to system in order to get information to provide care to their patients. And so there's been some movement on that, and I would appreciate maybe if you can look and see if there can be some incentives built in so we can encourage more participation in networks for the exchange of information. I think AMA is also on that, again with the same philosophy, we're in this for quality and safety and access to care for patients.

Dr. Siff: First I want to thank you both for coming and presenting today. I don't want to get too far away from Dr. Williams, I know she has some things to present. But you mention interoperability. And there are three barriers to interoperability. One is technologic, which in many ways are the easiest to solve. And I spend half my time as a, doing health IT. There's the business issues, which you just touched on briefly, convincing the two hospitals across the street that it's in their benefit. It's not a competitive disadvantage to share information. That patient's siloed and stuck in that hospital because all their records are there. But the third one and I bring this up because in the last three months, we've been trying to share information with another hospital in the city, which is Cleveland. There's a big hospital there some of you may have heard of [laughter] not who I work for though, who shares the same electronic health record as my hospital and that health record has a system that allows hospitals to share information very easily. The technological barrier doesn't exist there. What we have found is the privacy barrier is preventing this from happening. And it goes back to the commercial that was mentioned. We have no idea, nor does this large institution which has plenty of lawyers and money to figure this out, how state and federal law surrounding privacy interact with the sharing of information. Do I have to have a release every time? Can the standard

consent allow me to view the information that a hospital's database? CMS really needs to help providers and help organizations understand this because we have three people involved in this plan. One has dropped out because of this issue. The other two, we're trying to slog through it and hopefully can get something done. But until there's guidance, until both patients and providers understand what they're allowed to do, when they're allowed to do it, and what paperwork is necessary, this is a huge barrier. And again, a small group, or a small hospital, may not have the resources to figure this out. And may just say we're not sharing it. And you have a grand vision of improving care, being able to do research across huge areas. Without this sharing that can't happen, and without clarity here, sharing isn't going to happen.

Dr. Ahaghotu: I'd like to thank both of the presenters. Wonderful presentations of and particular Dr. Hunt, as an academic surgeon at Howard University, I can really proud to know that we have someone of your caliber working on this very, very important initiative. I just want to kind of touch on what Dr. Smith mentioned, and that's the access issue, going back to it, just a little bit. Because I think it's very important for us to appreciate the fact that this is a potential opportunity to grow the entire healthcare population in terms of providing services to and accessing individual who may not be getting quality care right now, but it also on the flip side, could work to the detriment to the underserved population. And I can see a situation where you have providers who become overwhelmed by all of these initiatives, both the EHR, they're dealing with this SGR issue, this PECOS issue, so you could easily see how a provider could pretty much be forced out of CMS, and I think it's going to be very important to adopt a philosophy of inclusion and partnership as opposed to the philosophy that this is legislation and therefore you have to do it or you're out. Because you may not give some of these providers opportunities to be part of this very important initiative. So something to think about.

Mr. Trenkle: I totally agree with you. There is a lot that's being put on your plate and of course much of it is legislatively mandated. The program itself is a voluntary program. Of course there will be a penalty right now, and legislation that kicks in and but I understand what you're saying. I think that makes a lot of sense that we do need to work closely with you to make sure that this is something that works for you as well as something that's a legislative mandate for us to implement.

Mr. Hunt: Just briefly from our standpoint, from our office, one thing that I've been impressed with, in our office everyone knows I'm rather independent voice, but I've been very impressed with the

single focus that the national coordinator, Dr. Blumenthal, has had on issues of access and disparities. And decreasing the digital divide. He has constantly and regularly gotten back to us and asked well, what will this do in this sphere and how can we make this better? So I can say honestly that I feel very comfortable that we will do everything we can to make sure that digital divide grows smaller and that this really is a rising tide that raises all boats. He has had a very refreshing singular focus on that.

Dr. Bufalino: One last comment before we take some recommendations. So Mr. Trenkle, could I ask you, those of us that are struggling through the 700 pages on the Meaningful Use document, trying to interpret what you really mean and we're hoping this gets translated down to something that we can practically use. I run a 50-man practice. We've been electronic for over a decade, we do PQRI and earn it all, we e-prescribe, we do it all. We're struggling with trying to understand what's it going to take for us to meet the Meaningful Use. Could you speak to who's going to be excluded, those of us in private practice, and yes, we have hospital-based work, but much of our work is on the private-sector side. Could you talk to the folks that are going to be not meeting the criteria?

Mr. Trenkle: Well, there's two answers to your question. There's the one where some aren't eligible for the program and that was specifically laid out in the legislation that we had to specifically include or exclude certain groups, the second was the—

Dr. Bufalino: Which are?

Mr. Trenkle: Well, I had the one slide here under that talked about under Medicare physicians Subsection D hospitals and critical access hospitals. Under Medicaid, there's five types of EPs, which includes the nurse practitioners, the dentists, and there's a couple other ones that are mentioned in three types of hospitals. So that's specifically laid out. There's not a whole lot we can do with that one. The—

Dr. Bufalino: So I'm sorry because you got to translate that for a moment. So who is that? When you say physicians in subsection D for hospitals. Who would that be?

Mr. Trenkle: No, I said physicians, comma, subsection D hospitals in critical, Liz you want to help me out here?

Dr. Richter: This is going to be awkward as we keep passing the mike. So he hasn't gotten to the hospital-based definition yet. But I think the point here is there are only certain types of hospitals, and then the eligible professional definition basically follows the definition of physician in the Medicare statute, so

there are a number of providers and suppliers who may participate in Medicare but aren't eligible for the incentives; DME suppliers for instance, aren't eligible.

Dr. Bufalino: But do you anticipate a group of practicing physicians that will be ineligible? So let's take the DME folks, and the nursing homes and all those folks off the table. So if you're just talking to folks sitting at the table here, so who would you anticipate might be excluded on the practicing physician side?

Dr. Richter: I should say this is Terry Kaye, who's Senior Technical Advisor in the Center for Medicare Management, and helped work on that part of the regulation. In the proposal, the main exclusions would be people who aren't meaningful users, and then physicians who meet the proposed hospital-based definition, which I suspect is where you're looking for a little more…

Dr. Bufalino: Clarity.

Dr. Richter: Clarity, so Terry, I don't know if you want to walk through the…

Mr. Kaye: There's one other I would mention. In Medicare, the payment is based on fee schedule allowed charges, so if a physician does services, let's say primarily in a rural health clinic, rural health center, then there's no fee schedule charges generated, so in that case, there would be no eligibility. But hospital-based, I mean our proposal was reasonably straightforward. If 90 percent of the services are performed in a hospital, and we defined hospital very specifically inpatient, outpatient, and emergency department. So.

Dr. Bufalino: If 90 percent of your work is hospital-based, on the procedural side or the E&M side, then that means that you're not qualified.

Mr. Kaye: Right. And we proposed to do that based on services provided, so in the proposed rule, we talked about an alternative we looked at was using 90 percent of allowed charges, but it didn't make much difference and the proposal is 90 percent of services. So you just basically would look at the services you provide, where you do it, if you do it, and inpatient hospital, outpatient hospital, or emergency room, if that's 90 percent or more, then you're hospital-based.

Dr. Bufalino: I'm sorry to be detailed. So is it by number of services, or by individual encounters? So will it be counted by patient encounters or if you have three or four services on an individual bill for an individual patient? Will that all add up?

Mr. Kaye: Yes, it will be number of services. So on a claim if you had five line items, each line item would count.

Dr. Bufalino: Counts. Got it. Thank you.

Dr. Kirsch: Yes, I would like just a little clarification on the hospital-based. My organization in north Iowa, I'm a hospital-owned practice, and every patient that we see, they're coming and being registered through the hospital as we get to get a little bit of the fee for doing that. So you're saying that because we do the provider-based and everybody comes in and is registered through the hospital then we are not eligible for the bonus? And in turn, does that mean that we also are not eligible for the penalty, too?

Mr. Trenkle: Yes, that would be correct. You're not eligible for the bonus, you won't be eligible for the penalty, so.

Dr. Kirsh: Okay.

Mr. Kaye: Under the proposal that was consistent with how we determine how much to pay the physician for the service, so in this case, the physician gets paid and the hospital receives a payment, too.

Mr. Trenkle: I think it's important to note that these policies as they were put into the regulation really fall into three buckets. Either they were statutorily mandated, they were policy-consistent with the current payment policies, and then third was their operational feasibility there, and that's how we tried to develop them based around that triangle of three different things. Now if there's nuances within that that we need to look at for the final reg, we recognize the hospital-based one, for example, but if there's other ones, certainly be helpful to get your comments as we go through that, but we do have to face the reality if we can't operationally implement something, particularly on a national scale, it becomes very hard for us to do it even though it would be something that might benefit certain groups.

Dr. Bufalino: Just along those lines, I think it might be helpful for a number of folks, for this to have a way of clarifying. So if you take Karen's issues of does she meet the 90 percent number, I mean would there be a way for individual groups, practitioners, etc., to be able to request of CMS do I make it, don't I make it so that there's no mystery about I'm trying and then I get disappointed because I thought I was eligible but I really wasn't. And I don't know if that feedback loop's in there but I think obviously on a practical basis would be helpful to folks to be able to say I made it or you can't, or you can't qualify, based on what you described in terms of the number of encounters.

Mr. Kay: Well, couple things. When we make that actual determination, we won't know who does or doesn't meet the criteria 'til we have the claims data. I think the easiest way to do this right now is the criteria like I said is pretty straightforward, and it literally, if you look at the claims that you submit, there's a place of service code. And if one of those place of service codes is 21, 22, or 23, then that's under the proposal that was a hospital-based, that would be added to the hospital based calculation. And if the place of service is something else, then it doesn't count, so I think earlier, you had asked or mentioned Ambulatory Surgical Centers, and that is not one of the hospital-based place of services, so—

Dr. Williams: Well it depends. Some hospitals actually own the Ambulatory Surgical Centers and some of them don't, so you know.

Mr. Kay: But ownership doesn't matter. It's a matter of whether the place where the service is being performed meets the criteria for the specific place of service code. So ASC is not considered hospital-based.

Dr. Williams: Just for my naïve brain can you explain why is it advantageous to exclude certain professionals since the whole goal is to get all of us to work more efficiently, safely, blah blah blah. I mean is there some feedback that we're supposed to get from the hospital because they're getting a certain bonus and benefit from their electronic participation?

Mr. Trenkle: Yes, that's, I think you've hit it right on the head. The money provided to the hospitals is supposed to support the hospital systems, and if you're listed as a hospital-based eligible professional, you should be part of the group that benefits from that. I think the problem comes in is where you deal with the clinics and some of these out areas that don't fall neatly into a specific definition and tend to be the last ones to get some of the upgrades and other system improvements that come to the hospitals as a whole. So that's where you run into that problem, and then of course the problem is if the definition does get changed, does that change the problem anyway? So it's also an issue that seems to be somewhat different for a hospital system as well. Some hospital systems are very much engaged in including their clinics and other outpatient areas in their systems. Others are much farther behind. So as I said from an operation of policy standpoint, we're trying to be as inclusive as possible, but it's very difficult to set a policy that on a national scale is totally fair to everybody. I guess for want of a better word.

Dr. Williams: But is there a way to incentivize the hospital to make sure that I am on a quality and safety level, doing what the program is trying to do?

Mr. Trenkle: Yes, as I said earlier, that's one of the things we need to look at from a meaningful use criteria, how broadly we make that definition. And that would certainly be a way to kind of get the hospitals more engaged at looking at it from enterprise perspective.

Dr. Bufalino: Sounds like you need to get GW to share their check with you. [laughter] Good luck with that. Yes, Janis?

Dr. Kirsch: I just have one more question of clarification. I can certainly understand with the hospital-based exclusion, with the hospital systems really being the supporters of this. I just want to make sure that these issues are not pertinent to PQRI. These are exclusive to just the electronic health record.

Mr. Kay: Right. This hospital-based criteria is for the IT incentive payments. Not affecting other parts of payment.

Mr. Trenkle: Right. That was specific language put in the legislation that talked about hospital-based eligible professionals. So.

Dr. Bufalino: Any recommendations, please wrap up.

Dr. Williams: I have three and they're all written down. If you'd like for me to give them to you. Okay. PPAC recommends that given CMS's proposal to utilize prior years claims data, to determine whether a professional is deemed a "hospital-based eligible professional, or an eligible professional" for the purpose of determining incentive payment eligibility for meaningfully using electronic health records, that CMS inform professionals of their eligibility status prior to the start of each year in which the incentive payments or penalties are determined and make publicly available in deidentified summary form, the number of professionals who are deemed "hospital-based," and the number deemed "eligible professionals" by specialty designation.

Dr. Bufalino: Second?

Dr. Snow: Snow.

Dr. Bufalino: Any questions?

Dr. Standaert: Two different things in there, right?

Dr. Bufalino: It was one really big one.

Dr. Williams: It's a run-on sentence.

Dr. Bufalino: But the concept was probably—

Dr. Standaert: You have the individual notification and then you have the publish the list, deidentified list somewhere by specialty which are totally different things, right?

Dr. Williams: Yes. That's true.

Dr. Bufalino: How about an A and a B to that? So the concept was there with an A and a B recommendation. We'll do that.

Dr. Williams: All right.

Dr. Bufalino: All in favor?

[Ayes]

Dr. Bufalino: Thank you.

Dr. Williams: PPAC recommends that as part of the meaningful use objectives and measures for eligible hospitals, CMS include requirements that will encourage investment in EHR technology in all clinical areas of the hospitals, including inpatient and outpatient operating rooms, Ambulatory Surgical Centers, and emergency departments in which the hospital has financial stake, to allow the hospital-based physicians as well as other eligible professionals who frequently practice in the hospitals a meaningful way to practice their subspecialty.

Dr. Bufalino: Do you want to make that two sentences? [laughter]

Dr. Williams: I'll give it to her to get two sentences, yes.

Dr. Bufalino: We'll clean that up?

Dr. Williams: Okay, we'll clean it up.

Dr. Bufalino: Thank you. Second?

[Second]

Dr. Bufalino: Discussion? All in favor?

[Ayes]

Dr. Bufalino: Thank you.

Dr. Williams: And then finally, PPAC recommends that CMS develop modified meaningful use standards to allow traditionally hospital-based professionals the opportunity to meaningfully use EHRs,

receive incentive payments, or avoid penalties set to begin in 2015. If they demonstrate that they have purchased and are meaningfully using a certified EHR system in their primary practice location, or they discover that due to providing more than 10 percent of their services in multiple locations, they do not meet the 90 percent threshold to be considered a hospital-based eligible professional.

Dr. Bufalino: You lost me.

Dr. Williams: It's too long?

Dr. Bufalino: What's the concept? What are you trying to get at? That you get an opportunity to earn the bonus?

Dr. Williams: We get an opportunity to earn, to participate in the system.

Mr. Kaye: If you're more than 10 percent non-hospital.

Dr. Williams: Right.

Mr. Kaye: So you're saying it's a separate—you're saying get rid of the threshold, or make a separate category or make the threshold not apply to certain physicians?

Mr. Trenkle: Well it would be more than 10 percent non-hospital you would be eligible.

Mr. Kaye: Right, that's what I'm asking. Is she trying to change the, are you trying to change the threshold or are you saying the threshold shouldn't apply?

Dr. Williams: Let me think about that one.

Dr. Bufalino: Okay. We'll do it at the end.

Mr. Trenkle: If you're trying to get it more inclusive, is that basically, you're trying to get a larger number of…

Dr. Williams: I think we're trying to get it more inclusive, but let me rewrite it.

Dr. Bufalino: Other recommendations? Art?

Dr. Snow: I'd like to ask a quick question first. Does HIT Policy and Standards Committee, who is on that? What is that comprised of?

Mr. Trenkle: That was a federal advisory committees that were put into law as part of the HITECH statute, and in the law it actually gave certain authorities to Congress to the national coordinator and to others to select certain members. I don't have in front of me how it was but GAO for example got to, General Accounting Office got to pick a number of them, and it was laid out specifically in the legislation

how many members could be picked by certain organizations and I guess the bottom line with that is it's a cross-section of a variety of constituencies. You have provider groups, you have payers. You have consumer groups. You have privacy advocates. You have a hospital representative. It's a kind of a cross-section of different interest groups who were chosen by different organizations as put in legislation—and David did you have something more you wanted to—

Mr. Hunt: Yes I was just going to say if I can sound like an infomercial. I want all of you to go to HealthIT.HHS.gov and there's a link for the different councils. All as one word, healthit.hhs.gov, no www in the front, and you'll be able to, this is the link on the last slide that I have, you'll be able to see specifically who was in the policy council and the standards council.

Dr. Snow: Let me ask the question if you can tell me who represents—because you've asked the question here about small and rural providers in that group. Do you have such a representative?

Mr. Hunt: We have a few.

Mr. Trenkle: Yes we do.

Mr. Hunt: Neal is always the one that. . .

Mr. Trenkle: [off mike] Neal Cashman.

Dr. Snow: Neal Cashman, is he a provider then is what you're telling me?

[crosstalk]

Dr. Snow: From New York City, representing small, rural providers? [laughter]

Mr. Trenkle: I think what Dave is saying is go out and look at the list. They tried to make it as much of a cross-section as possible.

Dr. Snow: Thank you.

Dr. Bufalino: We're losing control here. We're definitely losing control. Any recommendations? Dr. Snow.

Dr. Snow: No sir, not at this time.

Dr. Bufalino: Thank you. Anyone else with a recommendation before lunch? Please.

Dr. Kirsch: I'd just like to [crosstalk close mike] Dr. Siff's comments. PPAC recommends CMS clarify its rules for EMR information sharing between various organizations in order to maintain HIPAA and other privacy compliance. And also recommends that this information be disseminated.

[Second]

Dr. Bufalino: Discussion? All in favor?

[Ayes]

Dr. Bufalino: Thank you. Karen.

Dr. Williams: I think I've cleaned up—just took out the last sentence. So the last one should go to be inclusive. PPAC recommends that CMS develop modified meaningful use standards to allow traditionally hospital-based professionals the opportunity to meaningfully use EHRs, receive incentive payments and avoid penalties set to begin 2015, if they demonstrate that they have purchased and are meaningfully using a certified EHR system in their primary practice location.

Mr. Trenkle: All right well they can only go one way or the other. If they qualify then they're covered by the penalty, as well. Did you say they would be subject to the penalty?

Dr. Williams: I said "or avoid."

Mr. Trenkle: Oh avoid, right, because if they don't—if they qualify for the program, they're going to get qualified for the penalty as well.

Dr. Bufalino: Any issue with that? All in favor?

[Ayes]

Dr. Bufalino: Thank you. Anyone else? Gentlemen thank you for this meaningful conversation. We appreciate it. Not to pun it. We will break for lunch. We'll be back at one promptly.

Lunch Break

Dr. Bufalino: All right, Dr. Simon's here, we can start. Thank you. We, Kim Brandt hasn't joined us yet, so we will begin the presentation and ask Mr. George Mills, who's the Director of Provider Compliance and Latesha Walker, Director of the Division of Medical Review and Education in the Compliance Group to provide us an update on medical review and so we'll start with them and then hope that Ms. Brandt will join us to follow. Thank you. Welcome.

Medical Review

Mr. Mills: Okay. Hello everybody. My name's George Mills, I'm the Director of the Provider Compliance Group in the Office of Financial Management. We're here to talk about what my group does, because to a large extent everything we do touches on the function of medical review. So there's my name,

George Mills, Director of Compliance Group. This is Latesha Walker. She's the Director of the Division of Medical Review and Education. The first slide is an organizational chart that talks about the organizational structure of our group. As I said, the Provider Compliance Group is within the Office of Financial Management. And within our group, we have four divisions. And I try to use a, being a football fan as you can see from my lanyard here, I always try to use a football analogy to describe our group. The first group that I'm going to talk about are the referees, which is the Division of Error Rate Measurement, DERM. They're the referees because they keep score. And what I mean they keep score, they are the ones that produce the Comprehensive Error Rate Testing Program, the Error Rate for Fee-for-Service Medicare, as well as the PERM rate, the Payment Error Rate Measurement program, which measure the rate of error in the Medicaid Program. So they are the referees, and the Division of Data Analysis is my special teams unit, which does special projects, related to data, looking for trends, trying to identify issues that might need some analysis or further research by our group. And then I have my Division of Medical Review and Education, which is our offense to prevent improper payments made by Medicare. And then our defense is the Recovery Audit Contractor Operation Division. So I'm going to go through each division and give more fulsome description of each one, before we get into some issues that are going on.

Division of DDA, as I said, they conduct data analysis of suspected vulnerabilities. Either they identify them through their own work. We get referrals from contractors, from program integrity, contractors like ZPCKs or PSCs. They look at the issues. We do data analysis reports. We work collaboratively within and outside of CMS to identify issues and potentially implement or monitor corrective actions. And they're spending a lot of time on a project that you might have heard about, which is called OnePI, which is an integrated repository of Medicare data, as well as eventually other kinds of data like Part D and C & D. So they use that do analysis of emerging issues.

The Division of Error Rate Measurement, as I said, they are responsible for the CERT program and the PERM program. From these programs, contractors and states are asked to produce corrective action plans when there's vulnerabilities identified and to take those corrective actions which can be edits, education, outreach, changes in law, regulations, things like that. So that's the Division of Error Rate Measurement.

The Division of Medical Review and Education, which Latesha runs, they're responsible for the daily operations of the MACs in terms of medical review. So they oversee and coordinate the development of contractor policy review, in terms of the claims operation. The actual policies are handled by OCSQ in terms of the LCDs. So we don't make the rules. They do. We are just the operational implementers of those rules. And we provide support and direction to contractors in terms of how to review the claims and we ensure that they're reviewing consistent with our rules and procedures.

The last division is the Division of Recovery Audit Operations. I know my staff has come and talked to you several times about the RACs and what is happening with the RAC program. We're in every state right now. We did over 140 outreach events across the country. They were doing tons of meetings. I went and did some of them myself around the country. Every RAC is up and running. There at are various points in terms of what they're identifying. Right now, the focus is on automated reviews. And when I say automated reviews, that means that they're doing analysis of data that on the face of the claim without a medical record, they can make a determination that there's an overpayment. And the two RACs that are probably further ahead than the other ones are ACI, which is the western part of the country, and Connelly, which is in the southeast and the south of the country. The entities were in the regular RAC program in the demo RAC program, so they're a little bit ahead. The other two parts of the country, what we call region A and region B, and the RAC regions correspond to the DME MAC regions, they're up and running, but they're not as far along as HDI. So they've actually recovered some money, and as of the last report, it was just a little under $6 million that the RACs so far have recovered. But the next step in terms of the RACs is a lot of them will be doing DRG validations for inpatient hospital claims. As it stands now, in terms of complex medical review, there's no issues that have been approved by what we called New Issue Review Board team. The deal with physician claims where their medical records would be collected. That might change in the future, but as they're approved they get posted to the RACs' website, but right now, there's none. There might be automated situations that come up, but none that require complex require.

In addition to those divisions, there's three other people that report to me directly that I wanted to mention. Because they have a major role in the group. One is Dr. Jesse Polansky, who's our Medical Officer and serves as an advisor throughout the group on medical issues, especially clinical judgment training, where one of his major functions has been to go and train not only the RACs, but the MACs on

exercising clinical judgment in terms of medical review activities. The second area is Melanie Combs who's a technical advisor and she's been really involved in a lot of the HITECH stuff, which is the first bullet point there. This is becoming a major issue for us. We have responsibility for down the road, auditing payments to noninstitutional providers to ensure that the people receiving the HITECH incentive payments and subsidy payments meet the conditions. So Mel is leading that effort. But the bigger issue is actually ensuring the Medicare can receive electronic health records from providers and establishing our gateway to the various networks to be able to receive that. So that's a major project in terms of ensuring that we're making payments, for people to implement it we have to be sure that the agency and our contractors can receive it and use it for part of our medical review process as well as the RACs.

The second bullet point up there that you'll see is the Auto-edit project and what this is is because the RACs are finding so many things on an automated basis, on the back end, our goal is to try to reduce that and to implement a project where we would implement additional edits to prevent mistaken payments in the first place. This is a project that we're just starting and it's just going forward. One of the things that we stressed is to people is these are going to be black box edits or something like that that are top secret or proprietary. When these edits are installed beyond the current edits, they will be public so people will know what they are as compared to some proprietary thing, which is a black box because transparency's a very important function here. So we have the Auto-edit project.

The last item there in the fourth bullet is a thing called the PEPPER project, which some people may now or may not know about. But it is basically a comparative billing report that we sent to hospitals and we're looking at potentially expanding beyond inpatient hospitals into other areas to provide comparative information for purposes of compliance and understanding how you or other kinds of providers appear compared to their peer groups. So for example on the PEPPER report for inpatient, like one-day stays, the hospital would be able to see how they compare to the people in the state, in the contractor jurisdiction, how they compare nationally for looking at whether they're doing the right things in terms of admissions and where they stand, just because they're an outlier doesn't necessarily mean you're doing anything wrong. You could just be the major provider of the service. But it's information that we think is helpful for people in terms of analyzing the way they're doing their billing.

Another thing that's not on there because it's sort of breaking news is there's been a lot of I hate to use the word "controversy," but when the OIG reviewed this CERT contractors, they called errors on CERT, because when they looked at the records the signatures of the physician or the ordering professional was legible. And so we felt like we needed to address that because it seems silly at times to be denying claims based on penmanship, so what we decided to do, and we issued a CR that'll be effective shortly, which allows where we can't read the signature, to allow for an attestation rather than to deny the claim. This is sort of the middle ground before compared to where the IG wants us to be, in terms of denying the claim, or compared to completely accepting anything. So that CR was just issued on Friday and will take effecting a month, I believe. So it was sort of the middle ground. It was like that or nothing. In terms of missing signatures. If it's on a order, there would be a denial in terms of that, but in terms of illegible, which seems to be the biggest problem is we've analyzed CERT, we're going to allow an attestation. There won't be a form to start, but we'll ask people to send in some language saying yeah, that's my signature. I attest that it's accurate. So we think that'll help rather than have people file appeals and things like that, as an interim step. It doesn't happen a lot, I mean there was a lot to do about it, but when we looked at it, it was, we didn't find any errors in a sample we pulled out of the CERT data. We didn't find any inpatient errors on that. We found over a few for other institutional providers. There was virtually none on DME. The problem really was part B claims. That's where the issue was showing up more than anything. But the majority of it, probably about 90 percent was illegible as opposed to missing, so we think this will help the cause, and it's not a perfect solution but we believe it's one that we need to address.

We have other issues, I mean for people that saw the Error Rate report. A lot of the major problematic areas are in DME, and the big issues in DME is documentation to support the medical necessity of the claim, or supporting the legislative or regulatory requirements. A good example of problems we're having is with power mobility devices. The kind of situation we're seeing when it comes to power mobility is that the face-to-face interview will present a patient that is desperately in need of a wheelchair, meets all the conditions, but then when we check the historical medical record, there's nothing that's even close to what's going on with the patient. And it's one of those things that a lot of people have come to us and say we just want a checkbox form, where we just check. Our argument is even if we had that, we'd still go and validate against the historical medical record and the people in OCSQ, they've

developed a policy, like Dr. Miller, Susan Miller, who's a physiatrist would say, the stuff that's missing you would normally expect it to be there and to have present in a face-to-face somebody that's so fragile or inability to walk or have no problems breathing or whatever, this doesn't just come out of the blue except in certain really severe cases. So we have that problem, and also in DME for pressure support services. We have people going immediately from nothing to the highest price item. So there is like no progression that you would normally expect to see. And I'm not talking about somebody who just became eligible for Medicare, and we don't have a record. These are generally older people and they go from nothing to boom, the most expensive item in terms of the pressure support services. So documentation continues to be an issue. We're going to be working, we've got these open, I hate to use the word "open door," but we're going to be doing these education outreach events where we're going to talk about specific areas that are coming up either in CERT or the RACs or relate to the OIG reports. The areas that have been recently sort of hot again are PMDs, pressure support, negative wound pressure, oxygen, these are big issues when it comes to DME. And what we get from the suppliers is that they argue that it's unfair that they be held liable when the doctors are not documenting right, and that they argue that the doctors hate them worse than they do us. So that might be true, but at the end of the day, these are like a lot of times, like thousands of dollars for items that are going to be paid by Medicare and we're just trying to seek documentation to support the medical necessity of the item.

In terms of other areas that we saw in CERT that were problematic; chiropractic claims seems to have a number of issues, continued maintenance, therapy, as it continues to be an issue. The IG did a report on chiropractic recently. So a lot of the issues are familiar themes. One area that the IG, I believe has done 15 reports on is Place of Service, when there's a service provided by physician when the person's getting an outpatient or an ASC, that they're being billed for an office visit as opposed to a facility visit. So there's another report on that. So these are the kinds of things that are coming up in here in terms of medical review.

In terms of inpatient, probably the big issue is whether a person needed the level of care, the severe level of care that they were getting. And the example is for example maintenance on an implantable device and what we're seeing is we're not saying that the person didn't need maintenance, it's just that they didn't need to be inpatient. We have records which show scheduled the maintenance for this day because

the patient's daughter is flying in from Detroit, which isn't necessarily an emergent situation and that really based on the medical record that it didn't need to be done on an inpatient. One-day stays continues to be a big issue. The CERT error rate's very high for one-day stays. There was just an article in the Baltimore Sun about one-day stays and about Maryland being the highest, but so those are the kinds of trends we see across medical review. Long-term care hospitals we're doing a study as part of the MISA Section 114 Law, requires us to do a sample on that so there'll be more information on that, so probably the biggest issue again turns out to be documentation. And for us, we're looking at it and when we ask for the documentation, the first time we ask, we get some documentation, and then we deny and then at the appeal level stuff appears that wasn't sent to us at the first step. So I don't know if we need to do a better job, or whether the people responding to these things are just haphazard in their response, but it's probably the number one issue more than anything else is just documentation of medical necessity. So Latesha, did I forget any big area that you want to add?

Ms. Walker: I could add one thing. In terms of the appeals, what we're seeing is a lot of the appeals are being overturned at the ALJ level and I don't know if you—

??: What's ALJ?

Ms. Walker: The Administrative Law Judge level. And that's the highest level of appeal and so when people are coming to speak with us from the outside, they use that almost as a tool to try and get us to change our rules, but one of the things that we have to emphasize is the fact that the ALJs are not bound by our regulations, our manuals, or our LCDs or NCDs. I think they're bound by our NCDs but not our LCDs and so what in fact happens is there is a disconnect between what policies our contractors are denying against, versus what the ALJs are denying against.

Mr. Mills: It's like an apples and oranges comparison. Because if you don't have to use the same rules to make your decision, no wonder they're coming up to a different conclusion. So that's an issue we keep looking at, but at the lower levels, the first two levels of appeal, the MACs and the RACs are upheld at very high levels, so and then when you get to the ALJ. Now the thing Latesha, very few cases go to ALJ. It's a very small percentage of the thing but it's an issue that we're looking at in terms of making sure our rules are clear and educating people on that. So but I turn it open to the floor or. . .

Dr. Bufalino: Question for Ms. Walker, Mr. Mills?

Dr. R. Smith: I would say just to say again starting out with quality, efficiency, safety, and access, it may be easy for a company to say that the physicians are not playing by the rules, but I think most physicians are acting on behalf of the patient and making sure they have access to the equipment that they need. And it's not the physician who's advertising, as we talked about earlier, about these expensive devices and creating the demand up here and the potential for perhaps abuse on the other side, so I think as we look at that, I'm sure you're looking at the data on the physicians who perhaps have a high threshold on this. But I'd be very careful just to put the blame, or shift the blame to the physicians.

Mr. Mills: Boy, I understand that completely. Our issue is if you're a supplier and you have your normal physicians that you're dealing with, don't you have an affirmative responsibility to help them understand what they should be documenting and what should be there if you see a problem? It's not just us. We try, we do the best we can. But it's a two-way street. That's just their way of dealing with it, but I appreciate the point.

Dr. Smith: You commented that you have done a lot of outreach to physicians and so on, and I consider myself pretty much aware of these kinds of things, and I haven't heard one single word about any outreach on any of this. And I certainly haven't been aware that you've come to Los Alamos, New Mexico or even Santa Fe, New Mexico, to talk to anybody and as we were talking about a little bit at the mid-day break, there is no way for physicians or even office managers to spend a lot of time paging through the Medicare website to see what new stuff has shown up this week. I mean it's just not technically feasible. There aren't enough hours in the day. And so I would urge you to consider what we talked about this as a broad issue, but to consider doing something like a bullet point thing that shows up in a major medical journal or on the CMS website, or preferably both, and do it every month, the first Monday of every month is going to have an update on the new important things that we need to know, and maybe target some things through the state medical societies that reach a lot of private practitioners. They don't reach academic practitioners who aren't always members of the state medical society. But whatever your outreach is, it isn't reaching.

Mr. Mills: Okay. Well, those are good point, we'll try to be. I know we were in every single state, at least for the RACs. I couldn't necessarily be in every single town. But I know we were in New Mexico. Probably was Albuquerque, but we have our MLN Matters articles and things like that, so but those are

good suggestions and we'll take them back and see what we can do. It's one of the things, if you look at the GAO report on outreach and education. They're kind of skeptical of the practice, because they're saying it's hard to define ROI. I disagree because people need to know what the rules are and I'd like to be able to produce customizable things where we look through the billings and potentially say okay, this person's billing these codes the most. Let's make sure they have what the rules are for those ten, so they really know what they are. So rather than say yeah, this was in a bulletin three years ago and why didn't you know about it, so we're trying to produce more customizable things and that's potentially one of the things we'll think about down the road.

Dr. Bufalino: Another side suggestion we talked about is maybe using access to the specialty societies, since they touch the docs maybe more than some of the other things and it might be a good opportunity for you to use them as a vehicle for communication.

Mr. Mills: Several have approached us in terms of the RACs about understanding their practice area and those have worked out well, it's just how to handle it because there's so many.

Dr. Bufalino: Yes, there's a lot. It's a difficult task.

Mr. Mills: Those are good suggestions and part of what we're trying to do is look for where the biggest problems are and sort of chunk it up into smaller piece and sort of deal from biggest to smallest, because if you try to address everything, you're probably not going to address nothing, so we're going to look at the areas that seem to be the most problematic and then start from there and start whittling our way down on the vulnerability list. I always say it's like eating an elephant, you need to do it a piece at a time. So whereas if we tried to eat the elephant at one big gulp we couldn't do it. So that's our goal and you'll see some stuff coming out in regards of to the Executive Order from the President on improper payments, which talks about things like that, breaking it down in smaller chunks and trying to have goals and corrective action plans and things like that.

Ms. Walker: And then also I can add each of our contractors, our Fee-for-Service contractors have provider outreach and education areas specifically within them as an intent to try and educate, so when there's an issue that arise, yes, they try and attack that person or educate that person on the particular issues that are the problems, but also they have a wealth of information on their website, so that is a resource that's available.

Dr. Ouzounian: I'm an orthopedist and there's a problem with this wheelchair, and probably isn't as big from my perspective as it is from yours, but as a provider, there's a burden on us. We're expected to ration the care and the burden falls to us I think unfairly, so a patient of mine's got spina bifida, she can't walk. We get a call, will you do a mobility exam? And it's not generally something I would go out looking to do but she's a patient of mine so I say sure. So she comes in with two family members, this multipage form which is unintelligible, but I can read English, and we spend quite a while of time marking this whole thing up, getting all the right answers, verifying that the answers are right. We get to the last page and I said well, okay, you qualify for a scooter. And we verify all the answers and I sign the form and I give her the form. Well the next day, the vendor is at my front desk, yelling and screaming that he wants this torn up and fill out the new one correctly because he wants to give her an electric wheelchair. I assume there's a higher profit margin. We refused to do that and I lost the patient. So here you are. It's a very difficult system. We're expected to enforce it, when you refuse to do so, they still get the device because I'm sure it went to another provider who will sign it, and in a certain sense, I came out the loser, because the patient's now mad at me for doing the right thing.

Mr. Mills: The whole influence of advertising and family is an issue. But I appreciate that. To me, you're doing the right thing. The facts were that she didn't need it and unfortunately by, it's like no good deed goes unpunished kind of thing. But to me, you're doing the right thing and if somebody else is certifying that they need a power wheelchair when they really don't, that's of concern there in terms of that and potentially when Kim gets up, she can talk about that. But that potentially could cause other problems, so to me you're doing the right thing. Unfortunately you're suffering for it, but if everybody did the right thing, see then everybody would get the right services and we wouldn't be in this problem. [crosstalk] I'm sure you get the same thing with, not for DME but I'm sure you get it for prescription drugs, too, with all the advertising on TV.

Dr. R. Smith: The other thing that happens is that patients didn't learn that if the vendor tells the patient well if you told her she had A, B, C, and D, she goes to another doctor and says, well I have A, B, C, D, and E and then he's doing the right thing because he's giving the right answers.

Mr. Mills: But we'll go back and look at the historical medical record and if it's not there then we deny the claims so that's why we do the validation and the face-to-face so that we have an historical,

longitudinal record over a period of time to show that these problems are developing that you need this high-priced item. So you might get somebody to fill out the face-to-face that way, but the historical record should stand on its own and not reflect medical necessity.

Dr. Ahaghotu: Yes, I wanted to ask the question but I chose not to and Tye brought it up. Let's restrict the DME question to the power mobility devices. Does not CMS require a specific face-to-face exam for that? I mean the basis of filling out those nine questions on the form. So there's a code for that.

Mr. Mills: Yes, there's a special payment for that.

Dr. Ahaghotu: So do you mine your data to see whether the person has had a couple of such codes filed for them at some point before, I mean how do you pick the people to go [crosstalk]

Mr. Mill: --if the person didn't order the chair, they might have billed it under another code. That would only be picked up if we actually did the complex medical review. I mean that's something we would look for is like are they doctor shopping and if there's multiple there of those codes, that would indicate exactly the situation you were describing, but that's something we would look for.

Dr. Ahaghotu: I just asked because we do that kind of a modified functional capability evaluation that fits the nine questions and we bill for that, having nothing to do with whether we get the device or not. We give our best information, and we get what Tye referenced, we get the pushback from the companies, saying well, I want you to change this, I want you to change that. In fact, I barred one of your top companies from my office because they wanted me to change things on the record. And I've documented what I found. I mean they don't even know what they're asking me to do. There's a legal term for it. And I won't further mention them, because you got them to give you back $29 or $50 million a number of years ago, and they've not changed their habits. They just paid you and walked on away smiling. And are still doing the same thing, but not in my office. We have about four or five DME providers who provide power mobility devices so we don't have to discriminate for or against any of them. When we barred them, it was never an issue because they had been harassing some of our patients and the kind of harassed us when they suggested that we needed to fill number 3 and number 1 in a certain way. That documentation's in my record. I don't even remember whether the person got a device or not, but I do remember their doing this. But it seems to me that if you require a particular exam on a code, that any time any of us do that, and then

later a similar code pops up, that that's almost prima facie evidence for checking the permanent record, particularly in the latter instance, or maybe in both.

Mr. Mills: Yes, that might be something more to have Kim address because what you're really bringing up is the [crosstalk] more complex issue than medical review. So.

Dr. Bufalino: I promise, Dr. Ross, 60 seconds.

Dr. Ross: 60 seconds. I've asked this question in the past. And I think it's worth one repeat question again. Do you have an actual breakdown on the fraud and abuse by the DME supplier, versus the physician providers that you can at least give us some type of tangible evidence where this fraud and abuse is coming from, whether it's the DME suppliers or if it's the providers themselves.

Mr. Mills: Yes, we can—Kim and I were there. The real issue is we don't have a fraud rate, and Kim can go into this, earlier, I can tell you what the rate of error is and the rate of error in DME was very high. It was above 50 percent and for part B services, it was more like 10 percent, but it doesn't go into the error rate. Now if you talk to Malcolm Sparrow, he believes it's like 30 percent fraud across the board. Now Kim and I were at a conference with Dr. Sparrow and we kind of disagreed with that, because in our view, fraud is a very legal term and that can only be designated by the OIG or DOJ, so our error rate programs, we measure the rate of error, which to put it easy way is claims that don't comply with our rules. And the problem is, things might not comply with the rules, but actually the person needed it but they didn't comply with the rules, because like even in the case of wheelchairs, we had examples we've seen recently where it's pretty clear the person needs the wheelchair but instead of a signed form by the doc, there's a stamp and so the claim gets denied, and so then the supplier says ah, you're, this person, they go to Congress and say oh my god this person has no legs, and only one arm and Medicare's denying claims, but you stamped it, you didn't sign it. We can't take a prescription with a stamp. So that's the problem. I think I'll let Kim address it further, but our CERT error rate just measures noncompliance with our rules as opposed to the rate of fraud. We don't know of anybody that's ever created a fraud rate because it's not static that you can measure it like an error, because it's willful, knowing, intent, so.

Dr. Ross: Well there was one particular case in point that I need to bring up that you did a reference as an example, and that is going from a nonsupport situation to a total high paying situation. In our particular case, as I think Dr. Ouzounian and I can agree on this, we have diabetic patients, who for

many years have no complaints, no problems, have no need for insoles or shoes whatsoever and then one day, a Charcot arthropathy develops and a collapse of the foot occurs and guess what? Now they're in need of a major AFO. So that's a perfect case in point of going from nothing to something is really implied, so with that I think that you need to reconsider, at least look at, under those circumstances. Again, with documentation, I'm sure.

Mr. Mills: Right and the issue is there where there's no documentation to support it going from nothing to the second level. Clearly there might be situations or even like a wheelchair, somebody might have been going to a doctor for a many years and there's nothing and then they develop ALS and just the progression is real quick and they need the most expensive wheelchair with all these accessories, so that's not what we're talking about. We're talking about like people that do not appear to have any of these things or that they're minor and they're going from nothing to boom, the most expensive thing. And that's not what we'd expect. There's always the real bad case. And don't get me wrong. We're not trying to slam wheelchair providers because it's a covered service. We have nothing against the benefit. It is what it is. Our issue is we want people to comply with the rules. Because we're trying to be good stewards. I think this is a good lead-in for Kim, so I'll let her, turn it over to her. Thank you very much.

Dr. Bufalino: Thank you. Ms. Brandt, welcome. Glad to have you. She's the Director of the Program Integrity Group. Been at CMS for a bit and comes to us from the OIG, where she's had an extensive background and is actually the author of the paper on compliance program guidance for physicians. So we're glad to have you. Thank you for being here. Please.

Fraud and Abuse Update

Ms. Brandt: No problem. Thank you for having me. I have some slides and in the interest of time, I think I'm going to pick the most pertinent ones because I want to get to the gentleman's question. And I think this was something you all had charged me from my last visit here to go back and do some digging to try and be able to find some statistics, if you will. So what I wanted to do was actually give you some examples, comparatively, going to George's point about the fact that it is difficult for us to be able to exactly answer your question because there is no fraud rate, but I think I can give you a sense of at least in the areas where we have high fraud, what the percentage of physician fraud is as compared to the percentage of DME supplier, home health agency owner, or infusion clinic owner types of fraud because

those are the three areas that we see the most types of fraud that involve tangentially physicians and where we have seen the biggest action from the government. So with that, what I wanted to do was just quickly give you an overview. These are the types of fraud instances in which we most often interact with physicians in a non, they didn't bill correctly. It's the billing for services not rendered. There is no proof that a service was actually ever provided. There's deliberate intent to upcode or to unbundle to try and maximize revenue or to be able to get more payments from Medicare. They're billing for medically unnecessary services. We see this a lot with our infusion fraud examples, where there's billing for services that beneficiaries don't need and in some cases, we actually had quality of care issues with that, because what happened is that they were actually being provided saline solution instead of the clinically appropriate, medically appropriate mix of solution. So that's certainly a problem, because Medicare was being billed for it and in those instances, the patients were obviously getting something that was not even appropriate. Where it is that they are receiving or being paid kickbacks, which is the most common example that I'm going to go through. The physicians are on retainer, if you will for anywhere from $5,000 on up a month in some of these areas just to let their number or their information be used. They are not providing services, they are simply complicit. And they they're signing orders for unnecessary lab and diagnostic tests, therapy, DME, home health, or hospice care. Again, the big things that we have seen and have been the biggest focus for us over the past two to three years have really been in the areas of durable medical equipment, home health, and the infusion therapy. It's been primarily focused in Florida, California, and Texas. There are other areas of the country that are certainly pulling, but that's really where we're seeing this. And so we've done a lot of things to really crack down on this, and some of the things, just to again give you an overview before I get into the numbers is that we've really been looking hard at whether or not everyone is appropriately licensed. What we have seen is that many instances we had physicians, particularly some of these physicians who were on retainer, if you will, where their license had been revoked, it hadn't been appropriately updated at the contractor, things like that. So we're doing monthly state licensure reviews to make sure that we know that these people are indeed licensed and that they do have the appropriate certification to be able to provide Medicare services. We're deactivating unused Medicare billing numbers. So if people retire, if they die, if there's any other reason why they are not practicing we're deactivating their numbers so their numbers can't be compromised. Because another

part of the fraud that we see is that unfortunately if a Medicare number is not used that frequently, or if the criminal elements are reading the paper and see that a physician has passed away, they may try and obtain their billing number and use that to submit bills. We've very active now and we call it this jokingly, but we have sort of a find-a-felon-Friday, if you will, which is that we go through and actually look at the convictions on line, all the press releases to be able to revoke owners, physicians, and nonphysicians, who we find have felony convictions. These felony convictions are not necessarily for healthcare related things in all instances. It could be for drug issues. We have a number of marijuana related felony convictions. We have also a number of convictions related to tax liability. We have felony convictions related to other things that are completely separate and apart from anything to do with Medicare so those are the types of things where if there's a felony conviction, that gives us the ability to make sure that those folks [unintelligible] because again, unfortunately, some of those folks are the ones who again have ties to being the bad actors that have committed some of this. And we've been doing a lot more on-site inspections to make sure that practice locations are operational, particularly for these clinics, the infusion clinics and other outpatient lab clinics. What we've found is there's much more of an effort, these days to bill as though those types of part B outpatient services allegedly sometimes under physician supervision are being provided from UPS store locations, or other types of sham storefront operations, which we could not tell because the address looks legitimate, everything looks legitimate until you actually send someone on site and verify. It's not a real physician, it's not a real facility. And then we've also been trying to make sure that we're making sure in general that we have the most accurate information on all the physicians that are participating in Medicare, which is one of the reasons we've been doing a such aggressive revalidation effort. And that's why many of you and your colleagues have probably received notice from Medicare about please update your Medicare information. Please make sure your practice location and all of your information is correct and accurate and a big push of that is we had a large percentage of physicians who had entered the Medicare program prior to 2003, 2004 which is when we really started to update our enrollment database, and most of those physicians we did not have current and accurate information on them. So we have been very aggressive in working to get updated information on them. To make sure that we have good information and know that these are legitimate practicing physicians. So let me now talk particularly about a couple of areas and give you some numbers, because that's what you asked me for.

One of the areas that has been a real area of focus for us has been durable medical equipment. You had quite an extension back and forth with George about the power wheelchairs and the scooters and a lot of the issues that we have. That is a huge problem for us, particularly in the seven states where we have the highest billings for durable medical equipment. There are seven states, which I'll go through in a minute, which focuses on the highest area of DME suppliers, where we have the highest number of them, where we have the highest number of ordering physicians, where we have the highest billing for DME equipment and where we have the highest utilizing beneficiaries. So those are kind of the four prongs of the plan that we focused on in this stop gap plan.

Dr. Bufalino: Question—does highest ordering physicians, highest ordering of DME?

Ms. Brandt: Highest ordering of DME, yes. So highest ordering physicians is the highest dollar, so it would be for instance in the seven states, we have over 100 physicians in each of those states, who routinely refer over $100,000 or more in excess of DME on some cases a monthly basis. So it's a very high number and so we look to that as an indicator of where it is that there's potential issues. Sometimes it's legitimate. But sometimes that's an indicator of fraud. I won't go through all of this because you've got all of the slides, but one of the things that we're really looking at is in the seven states and I thought they were listed in here, but they aren't, so let me list them for you. It's not surprising, it's New York, North Carolina, Florida, Michigan, Texas, Illinois, and California are the seven states. So I don't think there's with the exception of North Carolina, which might be a little bit of a surprise but that's because of the high number of retirees that are now settling there, so it goes to both the beni volume and there is a much higher volume of DME suppliers opening up there because of the higher number of beneficiaries. Those are the seven areas. As a result of this project, which has been in place since October 1, so these are results just from October 1 of last year through December 31, we have thus far, and this goes to your numbers, sir, gone ahead and revoked 265 suppliers, so we've actually taken 265 durable medical equipment suppliers out of the program, because we've been able to ascertain that they were not providing legitimate services or they were conducting things that were not appropriate. We have placed 539 durable medical equipment suppliers on pre-payment review. We placed 2,191 beneficiaries on pre-payment review, which means that we are monitoring their billings to ensure that they're accurate. And of those, we have only placed 37 physicians on prepayment review. So again, comparatively speaking, it's probably certainly less than 10

percent of the total number, probably more like around 5 percent that is actually tied to physicians. And just because we placed them on prepayment review doesn't mean that that's fraud, it just means that there's something about it that we want to verify the legitimacy of the services before we look in. All totaled, just in that three-month period of time, we've been able to stop over $5.4 million of inappropriate billings from going out the door. Just through those efforts, just in that three-month period of time. So again, comparatively speaking the bulk of the truly bad acts, we've been able to tie primarily to the DME supplier themselves. We haven't had any physicians that we have taken action against. But ancillary with that, this project was supposed to supplement the larger action of the HEAT, which is the Secretary's Healthcare Enforcement and Prevention Action Team, which you've probably heard some of the press about. And that has a big focus on DME as well. The bulk of the convictions and indictments that they have had on the HEAT initiative of the 250 plus indictments that they've had, thus far, only about 20 are specific to physicians. So again, to just give it some comparative numbers, it's still probably a fairly small, and that's primarily, the physicians in those cases were ones who were accepting kickbacks, they were ones who were allowing their numbers to be used and be put on the ordering and referring field on the claim form when they actually hadn't seen the beneficiary, they hadn't done any of the in-person examinations or any of that and so they were sort of complicit in it. I can't speak to all 20 of them, but I can tell you that one of them in particular, just got sentenced to one of the longest sentences yet which was 264 months in jail for allowing their number to be used inappropriately. And it was going to be a less sentence, but the judge did not feel the physician had been appropriately contrite about their complicitness in this and gave them a longer sentence. And so we've had instances like that where it's really been, but these are people who are truly bad actors. I mean these are people who are knowingly deliberately with intent going and allowing their information to be used, so that's the type of thing we've looking at thus far.

In general, just going on to some of our other things, we've been focusing on the whole issue of ordering and referring physicians because of what we've seen with this stop gap plan and because of what we've been seeing as part of project HEAT. One of our goals has been to get more accurate information and to be able to have more information on the claim form about those physicians who are ordering and referring. It has been a goal of CMS's to try and get more information about them so that we can help go back to them in instances where we have the DME supplier that we're going after, but we also want to

make sure that we know that it is an actual physician who is appropriately licensed and everything who's providing that service. Right now, oftentimes what happens is just a dummy NPI number is put in the ordering and referring field because it's not actually checked as part of the claims system, so we've really been focusing on that and we had a instruction that many of you were aware of that went out where we were going to have this effective this spring, we would actually start to require that number to be up in the field at all time and everyone would have to have an NPI. That caused a bit of confusion and the messaging on that was not as good as we wanted, especially as we went through the process last fall, and so as you'll see, one of the things that we're doing and actually this should be January 2011, not 2010 anymore, is that effective in January 2011, we are going to start having it so that if we don't have the ordering and referring number on the claim then it will be something that we will not be able to pay because we will be verifying the legitimacy of that ordering and referring number to make sure it's an actual physician number, effective in January 2011. But what we're going to be doing between now and then is working with Dr. Rogers and our outreach folks and we've been in discussions with the American Medical Association, Medical Group Management Association, and others to really be able to message and explain to people why we're doing this and the importance of this, and why that's the direction that we're heading in. So in terms of other things just to finish up here. I talked a little bit about the HEAT, but I want to focus a little more on that because I think it's really important to know that in the HEAT, it really has been a big focus on not only the enforcement piece, you know this really particularly bad doctors, but the other piece at CMS is going to be focusing even more so on is going to be the prevention piece of it and one of the things that we have been doing is having a lot of discussions recently as I'll talk about in a minute, with our outside groups with the AMA, the MGMA and a lot of the physician specialty groups about how we can do a better job of messaging more on the prevention side. How we can do a better job of working on education, particularly when we find things through the HEAT or through some of these other initiatives that we can share that information, I think someone raised it earlier, you might not always be at the right open door forum or you might not always be at the right meeting to hear about this, how can we get that information out to you all in a more timely and accurate manner. And that's one of the things that we're really hoping as part of the HEAT to take it, continue certainly the enforcement focus but really take the prevention, the pea that's not in the acronym up there, and really make it a little more of a focal point so that we can have more

interaction to help it so that we can have it so that we continue to have a relatively small number of physicians who are actually impacted in this. The people who are really bad are going to continue to do their thing, but we don't want it so that the innocent physicians or the people who are trying to do the right thing get caught in the crosshairs of this which is one of the reasons that we're so focused on the prevention piece going forward.

So again there's some good information in here that you can take about what the strike force activities are and all, but I want to end on some of the things that we're doing in terms of prevention and then just give you some general numbers in terms of what we've been seeing in terms of some of our outreach efforts in some of the things we've been doing and what a difference that's made in terms of physicians. We've really been working hard to try and make sure that we're continuing to do enhancements to the Internet-based PECOS. We've heard a lot of concerns from people about the fact that the system freezes up and locks you out and a few other things. So we've been addressing that. We have a new release that's going to be going into affect at the end of this month which should help with that. We basically are trying to do more advance notification to make sure that people know if there's a risk that their billing privileges might be deactivated because they didn't get their information in the system. We want to try to give them as much advance notice as possible that we can work with them. If it's just that it got lost in the mail or they didn't realize that they had to reenroll, we don't want them to get deactivated without at least trying to make multiple attempts to notify them. We've really tried to work to make sure that everyone's updating their enrollment information per the discussion I talked about at the beginning to really make sure we have as accurate as information as possible on the physicians participating in the program. We are doing more regular provider open door forums. The last one we did we had 3100 lines or 3100 callers participate. So that's a huge number of people that participated where we spoke to them about all of these things and talked to them about how important it is to have accurate and updated information. We're continuing to do those. We'll do another one in May and we are continuing to update at the website that you have on here, information about the enrollment process and what people need to do in terms of enrollment on our website, particularly on the issues that have been most hot lately, which are the advanced diagnostic imaging accreditation, which is sort of the process that CMS is moving forward to accredit entities or to

deem entities to do accreditation for advanced diagnostic imaging and with respect to the issues I just talked about with the ordering and referring physicians and some of the changes we've made there.

So to conclude before I open it up for questions, one of the things that I think is really unique not only beside some of the brief statistics that I gave you about particularly with DME and infusion and the HEAT in terms of the number of physicians is that in general what we have found is that when we've gone ahead, particularly where we see these high usage. I talked about how the DME stop gap states we had a high number of high ordering physicians, physicians that seemed to have a high number of billings submitted for ordering and referring. What we've been doing is sending out letters to those top physicians. So in each a of the states we'll send out letters, what we found is that in 90+ percent of the instances, once we send out the letters that list all the billings that are allegedly tied to the physician's name, that what we find is that less than a handful, five or six of those 100 physicians, because we usually do it to 100 physicians in each of the states, call in and say that's not mine, I would never bill for that, that's not something that I would ever do. What can I do? My number's been compromised. With the remainder of the 90 percent or so that don't call us, we see a fall off a cliff drop in terms of what they're actually submitting and so one of the things that we've decided to be more aggressive on is to start doing more of that and we've been talking with the AMA and we certainly would welcome information from the PPAC about how we can do that for not just the folks that seem like they might be perhaps participating in something with the DME suppliers who are more complicit in this but how we could do that for legitimate doctors so that they can also verify that their billings are correct and that they can look and see if there might potentially be an issue with their billings and so that's something that I have had recent discussions with the American Medical Association on where looking into to some various options that we have to try and figure out how we can broaden that to make it so that we could have it so that more people could take a look at those types of things. But I do think that the fact that it's literally five or six physicians in each of the areas that are calling to say hey, these aren't my billings shows that of the really high, the outliers, the really aberrant people, the bulk of those are the people who it seems like are either somehow complicit or somehow involved in this whereas the rest are people who are really just trying to do the right thing and that's where we want to continue to focus our efforts. So hopefully those statistics and some of those numbers helped give you a sense. From our sense the amount of physician fraud is very small in the

comparative scheme. It's really the DME suppliers, the home health agencies, the infusion clinics, it's the companies where people can come in as nominee owners with little to no clinical expertise. There's very little barrier to entry for the most part, although it's much higher now with DME since October, when we started requiring surety bonds and accreditation. But for the rest of them, there really is not that higher of a barrier to entry and what happens is that folks come in particularly in those high fraud areas of the country, California, Texas, Florida and a few of the others and really try and manipulate the system and it's really only a very, very small percentage of physicians who are sort of complicit in this and who are the ones who are legitimately almost partners in crime with the ones who are doing that. I think we are not seeing this as a widespread issue with physicians, certainly not nationally, but it really is sort of something that seems tied to those three areas of services and those three areas of the country. So with that I'll open it up to questions.

Dr. Bufalino: Let me begin, and just kind of focus on what she just raised, because I think you asked what you could do in terms of education. I think obviously here there's a sensitivity, and there's probably a sensitivity nationally, that when they talk about medical fraud and abuse, the gun is pointed at the physician. And so I did the math here and I got 20 physicians indicted on 600,000 nationwide, and that's .003 percent of the total physicians in the United States involved in medical fraud. That message to me needs to be tailored out and sent out with the rest of the messages that it isn't the physician and not that there's not bad actors, and those guys, I don't know if you noticed, across the room everybody's going wow, oh my god, I can't believe people would be involved in that, so we just want that message portrayed out there that this percentage is a tiny amount of folks and that the average everyday guy gets up everyday trying to do a good job.

Ms. Brandt: And just to clarify, the 20 convictions is just in the HEAT states so far, but still your point is well taken. It's a very small percentage.

Dr. Bufalino: We would just hope that as part of the promotion that that word gets spread, because the media picks up that end of the conversation and I think in this time of healthcare reform, important that the facts get played out. Thank you.

Dr. F. Smith: I was actually going to ask you if you could somehow devise a 60-second sound bite which seems to be the length of time that most people listen to things, to convey those proportions, that 20

physicians out of whatever, and I do understand that it's only in certain states and in a certain time frame, but the concept is the numbers are incredibly small. I think one of the, well back up, I think all of us agree that catching these bad actors is incredibly important. It costs the system a lot of money and very selfishly, we want that money available to taking care of our patients, whether it's physicians, hospitals, physical therapists, good DME suppliers, etc. But I think one of the problems with the way this is being pursued at the moment as it is perceived in the press, which is probably not an accurate perception, is that a lot of physicians are apprehensive about whether they want to continue to take care of Medicare patients because of this. And it applies to the RAC as well, to direct my comments to that presentation. But as physicians feel more and more as if they're being hassled, accused of fraud, when they're really not committing fraud, if they make an error, it's usually literally an error. If they order something, they don't order it because it's medically unnecessary, they order it because they consider it medically necessary, and so for somebody to come back later and say, it was unnecessary is I guess I'll call it offensive. They really feel as if somebody's picking on them, and then when the choice comes, do I see a Medicare patient or do I see somebody else? You see somebody else. And we're just seeing that all over the place. And I think it's important to change the public perception of that. I think it's important to convey to physicians that you're trying to change the public perception of that because I think it has a major impact on access to care. Finances have an issue on access to care, too, but the mere thought of being audited by the RAC or having the suppliers thing somehow spin off to you because you tried to do the right thing is very intimidating and what we're seeing in our area is that fewer and fewer people are taking Medicare patients. It's really a major impact on access to care and these bureaucratic legal hassles are, it's both, it's both bureaucratic and legal are a major issue. I'm going to expound a little bit on the access to care issue in our area, but one, for example in Farmington, there's one physician. In Santa Fe, two physicians, in Los Alamos, zero physicians are taking new primary care Medicare patients. Golden, Colorado, a patient who moved up there moved back because she can't find a physician. Somebody who just moved to Missoula, Montana, a physician, said there are no primary care physicians in the city of Missoula who are taking new Medicare patients. This is huge, and if somebody doesn't [inaudible/cough] to address these issues and make it less of a hassle and less of a constant feeling of somebody's picking on me, when I'm trying to do the right thing, I think that's going to get worse and not better.

Ms. Brandt: Okay.

Dr. Bufalino: Start with Dr. Ross, then Joe.

Dr. Ross: Kim, you mentioned three groups, the DME suppliers, was it home health suppliers or providers?

Ms. Brandt: Home health providers, home health agencies, yes.

Dr. Ross: And the infusion suppliers. Did you have any more on that list?

Ms. Brandt: Those are, I mean we also have—those are the top three. It really depends on, it kind of ebbs and flows on the other, but any low capitalization type of entity like an independent diagnostic facility, things like that are always potentially up there.

Dr. Ross: I would just like to add to Dr. Bufalino's suggestion of trying to change the perception, again, with the public announcement or public broadcast, whatever, that you list these; that you let them know it's not the physicians but rather these are the bad eggs and these are the folks that really are committing the greater number of fraud cases. At least let the public know that, and just to add to Dr. Smith's sentiments, I can't agree more by the fact that we're practicing enough defensive medicine as it is when it comes to medical malpractice, but now when you look at DME and for me to reapply or if I were reapplying or starting to supply DME in my practice and worrying about what Mr. Mills said a minute ago about justifying a type of DME that I might supply, that if it's appropriate, that I document, what happens if, again, as Dr. Smith said, an error was made, or I didn't document properly, here comes the audit and before I know it, I'm begin charged with fraud. So we're practicing defensive medicine as it is, now we're going to be practicing fraud abuse medicine as well.

Dr. Ahaghotu: Thank you very much for a very comprehensive assessment of what's going out there, particularly emphasizing the fact that it appears that the physicians do not seem to be the primary culprit in a lot of this activity and it's very important for us to understand and for the public, but I'd like to dovetail on something that Dr. Smith was alluding to, and that is public perception. I think that probably an even more important message is to those individuals who are interfacing with the physicians during the investigative process, because I think that what happens is at your level, at the executive level, you may certainly understand that this is not something that needs to be a punitive process, that we're just trying to get to the truth, but by the time it trickles down to the field workers and the people at that level, who are

actually investigating the physicians, that's where you get into that situation where it's like, okay, you've done something wrong. And you've got to prove to me that you didn't do something wrong. And that is clearly what we don't want to have. I mentioned earlier that between the RAC activity, Fraud and Abuse, SGR, EHR, all of these things are going to at some point reach a critical point where many physicians, particularly solo practitioners, physicians who don't have maybe the resources to deal with this are just going to have to back away from utilizing, from being CMS providers, and I don't think that's what we want. The people who really suffer at the end of the day are going to be those patients in the underserved population, who really don't have any alternative, and then they just won't get care. So if there's some way of as part of the training of these individuals in the field and education to look, lets go in this without a punitive philosophy. And we're going to get to the bottom of it, and if these people are bad people, we'll deal with them. I think that may be very helpful.

Ms. Brandt: That's a fair point. And I'll certainly take that back particularly to my law enforcement colleagues who are the ones who primarily have the agents who are out dealing with this. We have regular meetings of the HEAT and that is a good point that I will certainly raise at the next operations meeting.

Dr. Ahaghotu: Thank you.

Mr. Mills: But in terms of the level of review, what do people think the level is? Because we know what the level is and it's incredibly small, and so I keep hearing like there's all this review, but our numbers don't show it's even close to 1 percent, so. . .

Dr. Bufalino: Review of physicians or review of claims or—

Mr. Mills: I mean across the board, we know our level of review, complex review is less than, way less than 1 percent, so and sitting here and hearing these comments sound like it's like 10 percent.

Dr. Bufalino: I think it's probably, it's just as much and I'll let everybody speak, but it's probably just as much a perception issue on our side. I mean obviously this has been a very sensitive topic, and you can ask when we're sitting alone, we'll stir that topic up because there's that concern that is it coming at us? So we probably have just minimal anecdotes at this juncture.

Mr. Mills: And that's all I wanted to raise is there's a perception that doctors are doing this and there's a perception that we're doing all this review, and our issue and Connie can talk to this later, when

we go out to talk to people about the RACs, you got all these consultants scaring people to death about the RAC is going to get you and then they're going to turn you in to the OIG, and we know where the RACs are going after money, and we know what the total level of review is, even with the RACs, and it's really, really small. Now, when they find a problem, it's usually like if you made the mistake once, you might have made it 100 times kind of thing but the overall level of review is really low and I think maybe going back to your point about perceptions is that we're really not doing a gigantic amount of review, which actually people have been criticizing us for in Congress about the level of review we've been doing, so I just wanted to throw that out there.

Dr. Bufalino: An opportunity for you to inform Congress that again, .003 percent of the indictments are physicians, and so again, I think the Congress is just as guilty as we are, as the public is, is that it's everybody's perception is it's doctors that are causing Medicare fraud and that's to me where we're banging on that issue—

Mr. Mills: and I think the issue as Kim would acknowledge the cases that get taken and they get publicized are the worst of the worst and so I think that might give the impression that everybody's doing that and so I think those are fair points. I just wanted to emphasize to you all the level of review that we know that people are doing is way under 1 percent, so just FYI.

Dr. Bufalino: That's great. Chris? Art?

Dr. Standaert: I think what people just said is fair. It comes under a fear issue for the doctor, that one, there's fear that our reputation is everything. You've been in practice for a while, you need your reputation. If that gets threatened, you're in trouble. Threatening to take away a medical license is 20 years of work down the drain, reinvent your life, it's a big threat. And even when you said medical review, it's a small number of people but you know we've said before when the RAC thing came up and how many records you want and all this sort of stuff, in a typical small physician office, every 10 or 20 minutes of your day matters, you're scheduled every second of every day while you're there, there's something on your schedule, for the most part for most of us, so you start saying well, we'll just take 10 records of 100 records or 50 records, when you're a small practice, that's a big threat. And you say, well just take a week to go through it. A week? I mean if you lose all productivity for a week, that's a big disaster. I mean most doctors really the margins aren't that tremendous. And so that's where it comes from. Nobody likes the

perception that the physicians are the crooks, I think it's very reassuring for all of us here that by the way that probably isn't the big driver in DME fraud is not the physicians. But also the idea that when you set up the review processes and we go through the RAC stuff the burden of what has to happen if you get reviewed can be rapidly overwhelming for a small practice. They're not made for the administrative demands that CMS has or that a large practice has, and a lawyer, $300 an hour is not very accessible to most doctors. So that's where the problems are.

Mr. Mill: Yes and those are the perceptions because the other perception, I hear this all the time, is I, to fight a RAC audit, I got to hire a lawyer. I mean our appeals people would be terrified by that, because they don't believe the appeal system is set up. And a lot of times you'll hear people say, well this is why I did this and this is why and you'll hear them, and that's all you need is on a piece of paper. You don't need to hire a lawyer, and what our fear is is that there's people out there sort of fearmongering so that you hire them where a lot of these things can be either it's documentation or whatever, so I think it's just more good to have these kind of dialogues and discuss these things, because we have a different perception of what we do and but part of it is pandering to people to try to make money. And that's one of the things I say in the speeches is be careful about these consultants because they're trying to scare you so that you hire them and a lot of them aren't telling you anything different than you'd get from a MAC or Kim or I when we go out and give a talk, so.

Dr. Snow: I think your use of the degree you have medically complex reviews though is not the comparison you want, because I think to get to that level, many physicians just don't push the issue. They get, for instance, a CERT review, if they decide to argue the point, they may sit down with a nurse. I would welcome to have a physician review the charts on the one or two that I've gone through because I'm sure the physician would agree 90 percent of the time, whereas the nurse is coming to a subjective decision of what the decision decided was a medically necessary endeavor. And based on the results of that, quite frankly, doesn't want to spend the time to go through the appeal process if the physician is doing it himself, in small practices, which is typically what they're doing. They're not sending an administrator down to argue these points. So I think that factor weighs heavily against many physicians, but it doesn't show up in your medically complex review because it's just not pushed to that level.

Dr. Kirsch: I just want to comment on some of the things that the state of Iowa went through in the late 1990s. The number one agenda issue for the Iowa Medical Society at that time were issues of fraud and abuse, and I speak to trying to educate our congressmen. Because at that time, Senator Tom Harkin was given some information about the amount of medical fraud there was in this country and he said, oh my god, we got to get into this, and the state of Iowa became made an example. It was like every other TV commercial was go call this number and report any fraud or anything on your bill. It was crazy. And you know what? They didn't find a single thing. And Senator Harkin, afterwards, couldn't really quite bow out of it. He'd already put his foot in his mouth and the whole subject just got really pushed too far. And a lot of it was he was acting on misinformation. Our legislators need to have good information before they go out and attacking folks, and know what they're really talking about.

Ms. Brandt: We would agree with you. That's certainly, I mean it's even with the dollar amount of fraud. There's a lot of varying degrees and varying numbers out there, none of which are substantiated. So it is something that I think it's important for everyone to be able to be working off of accurate information.

Mr. Mills: Take our Dr. Sparrow for example. He's got no quantitative background on this and he'll be on news shows and he'll talk about 20, 30 percent, and a lot of times his definition goes beyond what we believe is fraud includes like medical malpractice, preventive medicine to stop malpractice, all those kind of things. So we, that was one of the issues that came up at this conference is like we got to be careful about these numbers and what they mean and what they are, and to say one out of five doctors claims is fraud, I don't think anyone in this room would say it's even close to that, especially given the numbers we just talked about.

Dr. F. Smith: I have come back to somehow figure out that 60-second sound bite you can get out in front of the public and the Congress, repeatedly. But I think part of what happens with physicians is that essentially every one of us knows somebody who went through a RAC audit or one of your, I don't know what the official term is, but—

Ms. Brandt: The anti-fraud contractors, yes.

Dr. F. Smith: Yes, the durable medical equipment information audits and so on and to echo Chris's comment, they're enormously time-consuming. You talk to a colleague who's been through that and they've invested hundreds of hours in trying to defend themselves, and even if they ultimately win,

they say, I'm just not going to risk going through this again and that gets passed on to numerous other physicians and it again becomes an issue of access to care. They decide they just can't face doing this, so they stop seeing patients, or greatly decrease the number of patients they're seeing within the Medicare system, which increases the burden for everyone else. So somehow, there needs to be a mechanism to get more accurate information to everybody, public and press, and Congress and physicians, for that matter, and to somehow remove that process of by definition, every single one of you is guilty. If we have time we'll prove some of you are innocent, which is really I think the perception that a lot of people have right now.

Dr. Ross: I have a recommendation, Mr. Chairman.

??: Can you speak in the microphone please?

Dr. Ross: Of course. I'd like to recommend that PPAC recommends that CMS recommend to the Program Integrity Group that public announcements, including informing Congress, be made showing that physicians represent an extreme minority in regards to fraud and abuse.

[seconds]

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

[Ayes]

Dr. Ross: A second recommendation would be that the auditors for the Program Integrity Group should consider matters of fraud and abuse without a punitive philosophy, in regards to physician reviews.

Dr. Bufalino: Discussion? All in favor?

[Ayes]

Dr. Bufalino: Thank you. Thank you both for being here. We appreciate it. Sorry to keep you late. Thank you for your time and very informative conversation. We'll wrap up the presentations and ask Commander Casey to join us again and Connie Leonard for joining her to talk today about the Recovery Audit Contractors Update. Both of these folks have been with us many a time, and we welcome you back again. Thank you for joining us and we welcome your comments.

RAC Update

Ms. Leonard: Yes, thank you for having us back. I am Connie Leonard. It's been a little while since I've been here. I've been sending Marie, and some of my other staff members, but I am happy to be

back today. And we're going to try to provide you with a short update, and then we'll take your questions. So today we just want to talk about what's new in the program. It's been a little while. The last time we came, I believe we brought the contractor medical directors from the RACs and introduced them. So that was really all that we were able to do for our time slot, so it's been a little while. That was probably about six months ago. I don't believe we were here last quarter. So and we'll talk about what's new. We'll talk about the additional documentation limits that we hope to have for physicians. We really don't have any out there now. So we can talk about that a little bit and then talk about some sample new issues. There's been a little bit of work that the RAC have done for physicians. Mostly it's been DME and the hospitals. But we have a couple of issues that we can share with you that the RACs have started to do.

The RAC Program is operational in all 50 states and when we say operational, we mean that we provided outreach in the various states and the RACs have the data. That does not mean that every single state has received a RAC demand letter because that is not true. In fact, all four of the states have issued demand letters, but again, a physician in that various region may not have received a demand letter. For example, I know that up in Region A, which is our northeast, there have been no physician demand letters. I think there's been a few in the other regions, but again, primarily it's been focused on DME. We've done a lot of DME in regions C and D, which is basically the south and the west of the country, and then all four of the RACs are now starting to do some DRG validations. So again, that's more focusing on the inpatient, the hospital stay, and not the physician side of the house. And all four of the RACs have what we call a Claim Status website. And what the Claims Status website is, is a mechanism where providers can go into a web portal and check the status of if they have any requests that are outstanding they can update their contact information. We allow the ability for a physician to say I want to have the letters come directly to me. We know they get lots of mail, and it may all go into a pile by the office manager. But maybe they want to have one person in their office have receipt of all the correspondence from a RAC. So we allow the ability for a provider to say this is my particular point of contact, or to have it sent to another address. If you're a larger organization, you may want to, again, have it all go to one particular place. And that's working most of the regions. In region D, it's not working quite yet for Part B, but we are working with them to get that up into place. The point behind that Claims Status website is to make sure providers can find out where the review is in the process, but it's also to help that provider or that physician, who is

worried that they missed a letter from the RAC. They are concerned that it got lost in the mail or it ended up on somebody else's desk or for some reason it's somewhere. And we do hear that a lot. We heard that a lot during the demonstration. Providers and physicians who were just worried that it got misrouted, oh my gosh, I know the RAC has started and I haven't gotten anything yet. Well, that's actually not unusual, but they get worried. That fear factor that you guys were just talking about with George and Kim. We see that everyday and George was talking about the consultants. And I know the consultants are out there telling physicians, oh my gosh, the RAC is coming, they're going to put you out of business. We really don't think that's going to happen at all. If you look back, historically, and you guys have seen the evaluation reports from demonstration. It was a very small percentage of the whole entire overpayments collected that was actually physician directed. But we want that physician to be able to log on to a system to say, oh, okay. I'm okay. There are no requests that I just didn't see. And that's the part that's missing in region D right now. If you've got a request the RAC in region D, a medical record request, additional documentation request, you can actually log on and figure that out. Of course that's only been for hospitals. That doesn't help that physician who's worried that he's just missing something. So that's what we're working with, the region D RAC right now to fix. At all of the other regions it is up and working and a physician would be able to go on and say, okay, I don't have anything that I just missed. So I think that's important myself, because I know that they are out there worried. I know they hear these things. They'll hear press releases or they'll hear news reports or their consultants, or they'll go to all the conferences or they'll hear from their friend down the street, oh my gosh. And then they'll start to wonder where my request is. So we really wanted that ability for physicians to go in and see, okay, I'm okay, I don't have any issues. Same goes with demand letters. Because we did see in the demonstration a lot of the part B reviews were what we would call an automated review, meaning it didn't need to have review of a medical record, and again, they can go in that system and they can check to see if there's any demand letter out there that again, got misrouted, that they didn't get or something else.

I'll turn it over to Marie now, she'll talk about it—Oh, I think we just went a couple slides ahead. That's okay, I know I'm talking all over the place. The additional documentation limits. I know this has been a big issue and we've gotten some recommendations from you or actually, we've gone out with some fiscal year 2010 additional documentation limits for hospitals and some of the other types of providers. We

have not really sent any for physicians yet. And one of the reasons we haven't is because we've been working with the AMA to try to establish something that is, we want to obviously have something that's fair. We went, our first stab at it I guess you could say, is kind of mirrored off we did for the hospitals is we have a percentage goal. The reason we wanted to do a percent was we thought it was fair if we did one percent up to a maximum then you didn't have a small facility getting hit the same number as a larger facility because of the maximum number or something else. So that was why we were geared towards the use of a percentage. We would like to eventually get there on the physician side, with the use of a percentage. Again, we're trying to be fair, across the board, not hit the small provider the same as a medium or larger physician's office. The AMA was very worried about the ability and the time it takes obviously for a physician's office to be able to calculate that limit, because we obviously, there is some onus on the provider to be able to calculate their limit at least from the perspective of they think the RAC has gone too high they need to be able to disagree with the RAC and have that discussion, so what we planned to go back to the AMA with was a set number for a smaller physician, a sole proprietorship or someone with less than five physicians in their office and then we'd like to in the larger groups begin the use of a percentage. Again, we like to work with the AMA and PPAC obviously, so this is not necessarily, this is still in draft form. It's not public yet from the perspective that it's done on our website and it's not something that we're going to be using. And until we do get something out, obviously the flip side to that there won't be any complex medical reviews or additional documentation limits or records requested from physicians. So while we're still in this discussion period, there'll still be some automated reviews, and that's what physicians have been seeing, those that have seen anything at all. But again, we want to try to get something that's fair. Again, I know that PPAC has requested three, the number that we use. We're a little concerned that three might be too small. We'd like to stick with our 10, again, that allows you if you have a percentage, someone really could be three. And that would be adequate obviously. And I think that there's a perception out there, that if we have a limit and that every single physician or every single provider is going to get that limit every 45 days and that is not a realistic perception. I know sometimes that might be what they are fed by the consultants and some of the others, but even if you look back at the demonstration data, and this was hospital data, but I just think it probably even more so on the physician side, over 50 percent of the hospitals in the state of New York were never contacted by the RAC. I think if I

tried to do that for the physician side, I bet it would be even higher. So we expect the same type of analysis from the national program when we really get into it in a couple of years, we believe there's still going to be a large number of physicians that have never heard from a RAC, so that's why we wanted to have some of these other things like that Claims Status website I talked about in place, to calm the fears and help squash that fear factor that I think, understandably that they have. Because I think that it's going to happen again. You are going to see a number of physicians who just don't get contacted by the RAC.

Historically speaking, again, going back to the demonstration data, there's actually very little complex medical review completed by the RACs in the demonstration for physicians. And quantify that, for physicians, because there is a lot done for some of the hospitals. I know there was some done in the state of California. Now I don't know if that will hold true in the national program. Now that CMS is approving on new issues, it is possible that some of the things that were done on an automated basis on the demonstration, CMS may require some complex review. We're still kind of very early on in that process, but again I still think if you looked at the ratio, the ratio from a complex medical review perspective is going to be much higher on the hospital side than it's going to be for physicians. I could end up being wrong, and two years down the road when we have hard data to look at, it might be a different theory, but just again, using that historical knowledge from the demonstration, we expect the majority of the complex review to be completed on the Part A hospital side, and then a lot of them are automated reviews to happen on the physician and that's what Ross was seeing on the DME side.

We are hoping that the RACs also use complex medical review on the DME side, just to talk about some of the issues you guys were previously discussing with George and Kim, that aren't quite fraudulent, don't necessarily meet the requirements to fall into their category but maybe are still improper and are some things that should happen out there. The RACs again, might be able to review some of those types of things. With that, I'll go ahead and turn it over to Marie. She's going to talk about a couple of sampling issues that we're starting to see and then we'll take your guys' comments and questions.

Commander Casey: Thank you, Connie. Good afternoon everyone. I'm glad to be here again. And today I just wanted to talk to you a little bit about the RACs websites and to let you know what information we actually have posted in terms of the audit ideas that have been approved for each of the RACs to review. And first of all, just a little bit about the RACs websites. At the very minimum, all the RACs have the name

of the issue that they're reviewing, or the audit idea that they're reviewing. They also have included a description of the issue and they've identified what the provider types are that are being affected by that particular audit. Additionally, all the RACs identify what states are affected by the audit, as well as where they can find additional Medicare references regarding the issue under review. And this again, was an attempt to the responses that we got from the provider community, regarding our need to be more transparent and actually what the agency is looking at in terms of new issues. So I am very happy to announce that all our RACs do have websites. We've had pretty good response from most of the provider community on the websites. We do know that going forward in the future, we plan to enhance the websites and enhance the ability to do some search features on the websites, but we do think this is a very good start to the national program. With that, I just wanted to tell you a little bit about the issues to date that we have posted. Basically, our region A RAC, DCS, they have not proposed to CMS to review or have been approved for any physicians issues to review yet, however, our Region B, C, and D RAC all have come in to CMS and have received approval for some new issues to review that will impact physicians, and those issues are listed there on the slide for you. They all primarily deal with the number of units. In other words, the code the provider may have used was actually correct, it's just they billed too many units. The code could only be used once for the number regardless of the number of units that were transfused to the patient, but they still should have only billed one, but they billed four because they gave four units of blood. It's more of a coding thing. We call that an incorrect coding thing and the RACs, the provider was paid too much for the claim, so the RACs can receive a contingency fee for collection on that particular issue. And again, the same thing goes with IV hydration; the code for IV hydration, the provider should not have been billing multiple units for that particular code. They should have only billed one unit, and again, the RAC gets payment or gets a contingency fee on the difference. So in other words, a provider still would have gotten paid for the one unit, not the four units. The RAC will get the difference between the one and four units in payment. And with that, I'd like to go on to the next slide, which identifies for you our RAC website, again. This is where CMS posts all of its very valuable information regarding changes to the program. We had the escalation strategy posted and we've just recently gone through and done some updates to the website, so I did want to encourage you to continue to look at that website for updates on the RAC program. And then lastly, Connie and I have listed our contact information, if you should have any

questions of concerns, we have both our emails and our phone numbers to contact us. And with that, I think we'll take questions.

Dr. Bufalino: Thank you. Questions. Start at that end, Karen?

Dr. Williams: It's been brought to my attention that there's been posted notice for Region D, for anesthesia care package E&M services, where I suppose if there was an automated review that took place by HDI with the intent of looking for instances where the provider not only billed for the anesthesia service, which includes the pre-op and post operative care as a bundled service, but also maybe were billing a separate E&M code for the post-operative service that's appropriate to look for in its inappropriate coding. However, because it was an automated review, there was another group of appropriately billed services that should not have been bundled in the anesthesia care itself, for instance, placing and following a peripheral nerve catheter, postoperatively for pain. So that usually is coded separately with an E&M code that is separate from the intraoperative service but because of the automated review, it was all captured as one thing, and so people started getting notices that they were billing incorrectly, when in fact, they were billing correctly. There was discussion that took place between HDI and the Anesthesia Society. HDI has agreed to look into it a little further, but notices that were in the pipeline that they realized were probably incorrect, were still going to be sent out requesting payment and then I guess they're somehow going to adjust things on the backend.

The second thing that happened was—so anyway to conclude that, it might have been in that particular instance maybe a complex review may have picked up that nuance in that particular case.

The other thing apparently with that same group, HDI, was that there was a delay in notifications for instance, where the demand letters were dated January 14, of this year, 2010, they weren't postmarked though until February 9th of 2010, so people didn't actually receive the letters until February 16th or later. And so obviously the rebuttal period of 15 days had lapsed. Recoupment had already begun, when the providers didn't have a chance to go ahead and go through the rebuttal process as they normally should. So I guess based on that, I have two short recommendations. You want to comment on any of that?

Commander Casey: Well, I can comment on the anesthesia codes. We are looking into that and perhaps, that's one of the benefits of the program, is we'll know in the future that an automated isn't appropriate for every circumstance. And this is one thing that we are looking into and if need be, we'll

certainly refund the provider, or the anesthesiologist the money that he's owed if the audit is not capturing everything correctly. But thank you for bringing that. And I was aware of that. I just got word last week about that and I think HDI has been in talks with the anesthesia community on that particular issue, so I believe in regards to that they've been taking the appropriate steps in trying to resolve the issue. Connie, I don't know if you have anything further.

Ms. Leonard: I'll just say that one of the reasons why we're trying to slowly roll out the RAC program is so that we can not have any large process issues. And we have had some process issues out in Region D between the DME claims processor contractor Noridian and HDI in just the sharing of files back and forth. And it has resulted in some demand letters that were sent later and the providers were not getting notification, so we were working with both of them to make sure they fine tune their processes and see where it broke down and make sure they have the right internal controls that this doesn't happen in the future. One very similar type of audits with all of our other contractors to make sure this doesn't happen anywhere else, because we certainly we want that provider to get all the notification they're supposed to have regarding the rebuttal or the opportunity for discussion period for the RAC or anything else.

Dr. Williams: I think that timing issue has been brought up before when we were doing the demonstration projects.

Ms. Leonard: It has. There was some issues in the demonstration especially with some of the MAC transitions, we definitely had some issues. We're trying to fix that now with both working with Noridian and HDI together to say okay where was the breakdown in the process and how can we make sure this doesn't happen in the future.

Dr. Williams: Thank you. Can I make two recommendations?

Dr. Bufalino: Please.

Dr. Williams: PPAC recommends that CMS investigate methodology a RAC intends to use for a potential target area such that the implementation of focus appropriately captures miscoding.

[seconds]

Dr. Bufalino: Second, conversation? All in favor—

Dr. Ouzounian: Oh I'm sorry, I have a comment. It kind of brings up another thing, and maybe it's the right time. But you talked about units of service and your screen picks up that it should only have billed

once, and you know admittedly maybe the physician made a mistake the first time and billed two or three units by mistake. But your computer should have caught it the first time. There is no reason that it should have got by you the first time. And we could debate all day who's responsibility that is, but let's just assume the physician billed it in error the first time. You should have caught it the first time and is the physician being penalized, did he try and game the system where he should be penalized? But what is the explanation that you didn't do it right the first time?

Ms. Leonard: Well now you are correct. That one would think, it is common sense that CMS's systems would catch things like that, that are specially our policies are very clear. So sometimes we do have the same question as you. And that's one of the reasons why we're trying to work with the areas in CMS that do oversee the systems and do implement the system edits to say okay, you know what, this is what we're finding the RAC program. How can we work to make sure that these don't happen again? Because from the RAC program's perspective, we view most of these—that's exactly what happened. The person put it in hit the wrong number. They went to hit the one, but their finger slid off and hit the two and they didn't realize or something to that fashion. Or they may have been done so quickly that they just, these are human mistakes, so we're in agreement with you there. If we see something different, then we pass it on to the appropriate to Kim and George or to Kim from a fraud perspective. So we're actually working with those particular areas within CMS to say this is what we're finding. How can we correct these so they don't happen in the future? And since that process from a nationwide perspective takes a little long for CMS, we actually monthly calls with the claims processing contractors, too, so they can see what we're finding, see if it's relevant in their particular jurisdiction so they can maybe install a local edit or something or they begin looking for it too, because you're right, we want to pay these claims right the first time.

Commander Casey: And sometimes with the codes, things change so rapidly it almost isn't wise for us to put an edit in if it's going to be something that's going to change in the near future. So again at the end of the day, the provider was paid incorrectly for that service and certainly we should take that back, but certainly then, there's no negative action from CMS part of that provider, we would consider that provider abusive or anything like that. They made a simple coding mistake.

Dr. Williams: You want to vote on that first recommendation?

Dr. Bufalino: Let's vote on the first one, I'm sorry. All in favor?

[Ayes]

Dr. Bufalino: Thank you.

Dr. Williams: The second one is PPAC recommends that RAC notification letters be sent in a manner consistent with reasonable and timely reply expectations for providers.

Dr. Bufalino: Second?

[Second]

Dr. Bufalino: Any issues? All in favor? Did you have an issue I'm sorry?

Dr. Ouzounian: Yes, where's the 15 days response? Is that in the law someplace?

Ms. Leonard: Well, the 15 day response to the rebuttal. It's in a regulation but it's not to the RACs discussion here it is more to a provider's right to submit that they don't want recoupment to occur on day 41. And the provider has 15 days to come and say don't stop recoupment, and then I believe the regulation says CMS has 15 days to get back to the provider, thereby it would all have been before the 41 days.

Dr. Ouzounian: So that's calendar days or business days?

Ms. Leonard: I believe it does not specific, and I believe that when that happens it's usually calendar days but I'd have to regulation. I was just reading the regulation today.

Dr. Ouzounian: Frequently there's a several day delay between the date on the letter and the postmark on the envelope.

Ms. Leonard: And from a performance metric standpoint, CMS would clearly find that the RAC did not meet—we do have performance metrics in place that we are holding the RACs do. We're doing the on a monthly basis and a lot of the, well in all of the regions, the reviews just occurred, so they just started the end of the calendar year, so we're just doing some of those reviews. But we're certainly looking closely at what the RAC's doing and making sure they're following all of our guidelines that we have put in the statement of work to ensure that they're meeting all of those compliance areas.

Dr. Bufalino: Other discussion on this motion?

Dr. F. Smith: I don't know if it's within your purview to change that 15 days, but I would strongly urge you to do that. I don't know what's happening elsewhere in the country but I can tell you in New Mexico, we're getting first class mail postmarked December 7th, delivered January 8th, and I got something recently that was postmarked January 13th delivered February 19th. There's no way that one can respond

within 15 days, and it's because the post office's budget problem, they're just telling their carriers not to sort through mail. But then all the sudden your payments are being withheld and you didn't even get the letter, or, to make it worse, you are lucky enough as the solo practitioner to take a two-week vacation, and that letter which already took a month to get there, arrived the day you left, so now you're six weeks out and that is happening very commonly at least in the state of New Mexico, for people to not get mail for three or four weeks after it's been postmarked.

Dr. Ross: And just to add, there were many occasions where doctors' mail goes to other doctors' offices. This happens in my building. I'm in a 27-story building and the mail goes to other offices and we don't get that mail or our checks sometimes for a long period of time, so there may be a delay with that as well. But I just wanted to ask one more question concerning Dr. Ouzounian's point. Would it not make more sense for you to try to save money by making these corrections, particularly on coding changes early and in the beginning rather than sending it to the RAC where then it takes time, you're having to spend money, split the money for those RAC investigations? It would make most sense to correct the problem up front immediately from your end, rather than sending it out.

Ms. Leonard: You're correct, obviously, from the agency's standpoint we need to be preventing these and paying the claim right the first time. And I do think that is a direction that we're trying to go. Sometimes I think when they instill the edits they don't necessarily know everything that's going to occur until after the fact; I mean we see certain situations where the number of units where in some strange situations, it might be applicable to pay, and I think in those types of cases, they can't necessarily have an all or nothing edit, but we're certainly working with those appropriate units to say okay, what can we do and what can we do in a timely manner? What edits can we get them to put in place then? I think the agency's done a good job over the last couple of years trying to put a lot of those into place.

Commander Casey: Well I just think in general, we are trying, and definitely it's a priority of both Connie's and mine to ensure that we're sharing these vulnerabilities and really making that a priority to share the vulnerabilities, not only with the provider community, but to share them internally with all the components within CMS, in addition to, as Connie said, we'll publish our top 10 findings in the annual report to Congress. We're also providing tracking and internal emails to the appropriate components to ensure that the information is being shared.

Dr. Bufalino: Okay, vote on that motion. All in favor?

[Ays]

Dr. Bufalino: Thank you. Chris, Fredrica.

Dr. Standaert: So one quick thing—two questions for you, one quick one. I assume in what Dr. Williams said, there's no penalty on the RAC for actually collecting money back from the people who billed correctly. Like two different coding scenarios got caught up in their coding web. And so they put out the notices and they pulled money back from people and I assume they paid no penalty, but people they put money back from incorrectly then had to go back and find that money back and pay to get their money back, correct?

Ms. Leonard: Well, the RAC does not receive the contingency fee, so in the event—

Dr. Standaert: But there's no penalty, there's no disincentive on them to collect inappropriately and then have to pay it back?

Ms. Leonard: There's no financial disincentive. The only disincentive would be that again, these are option year contract, so CMS could at any particular year if there were issues in particular regions stop activity in that region with that contractor and determine to recompete or something else. But you're right there's no financial incentive.

Dr. Standaert: But there is on the physician. It'll go back in my next question. You also said that when you were talking about record limit, you're saying there's a record limit for physicians. The physician actually has to go calculate what their number is so they know what percentage is being pulled from them. And it seems that CMS readily knows how many Medicare patients I have billed in the past year and everybody in this room has, and should be able to calculate that rapidly. And my point is sort of what we talked about before; the burden on physicians. And I know every time I bring up something RAC, they say well this is calculated as part of the RVU and this is what you're supposed to do, but these are new contingencies being put on and they weren't in the RVU calculations for work. And these things are reversed, so the physician has to calculate how many patients they've seen to know if they're getting too many record requests and the physician who got inappropriately caught up for doing appropriate billing has to go out of the way to pay to get it back, whereas there's no financial penalty or disincentive to the RAC to do that and CMS has no obligation to sort of tell us how many patients they saw and what their percentage

is, your doing what we've been talking about with all this other stuff. This constant shifting of burden of workload back to physician is not a good thing. It's a strong disincentive to play the system with CMS. The more and more you do this, the more unfair it seems to us.

Ms. Leonard: Well, the RAC will calculate the limit, the physician does not have to calculate the limit. I guess the comment was made that I would imagine that physicians will want to verify the limit. So if physicians want to verify the limit, they obviously need to be able to determine their—

Dr. Standaert: But CMS would be able to objectively do that. If the physician—

Ms. Leonard: Oh absolutely.

Dr. Standaert: If we can't trust, if we think the RAC is not trustworthy in the limit they give us, and we just don't believe them, I mean it's easy for CMS to do. You have the data, we don't, you don't. It's easy. So why put it on us. That's my point. It's a bigger point, not that individual thing—it's the bigger point of shifting all the workload to us.

Ms. Leonard: No I do understand. And I guess in our view we're putting it on the RAC to do, we're not putting it on the physician. But we can certainly again understand that the physician may not believe the RAC.

Dr. Standaert: Imagine that.

Ms. Leonard: And we understand that. We certainly understand that the physician's not going to just the auditor's word for it and I guess that's what we were saying. We certainly can, what'll happen in the first request, if a physician gets a additional documentation letter, in that first letter, it'll say we've calculated your additional documentation limit to be blank. Again, this is if there was the use of a percentage. We can certainly expand that to say you know this was calculated because in calendar year 2009, this many claims were paid by Medicare and that's how we—so we can actually expand that to provide a little bit more information.

Dr. Standaert: But if it comes from CMS, or if CMS has a place a physician can go to find that number, that's much different than its coming from the RAC asking for the records. A physician wants to verify that somewhere and they should be able to do it without going through all their records, and how many people from Medicare did we bill last year? Go find the billing and pull the numbers out and run the numbers and—

Ms. Leonard: No I totally, I would imagine that would be very difficult for a physician. A physician is not going to know off the top of their head how many claims they submitted to Medicare. I wouldn't expect them to. I do not know if there is a one-stop shop in CMS that providers can go, but I can certainly look into it and see. I know we have the data obviously, and we've given all the data to the RACs in one large data dump, but if there's a place where providers can go, I'm just not sure, but we can find out.

Dr. Standaert: It's part of my bigger point.

Ms. Leonard: It's a good point. I understand it.

Dr. Standaert: One last comment. On the letter thing, isn't it easy, can't you record date of receipt of the letter so you know when the physician's office actually got it and then start the clock there, rather than when it was dated by the RAC?

Ms. Leonard: I'm trying to think back and see I know that in the last, I don't know if that's in regulation, but I know they were only given a five-day US mail time, which really wouldn't help some of the other types of issues—and I don't think you're alone. I think in some of the other rural areas, we are starting to hear these are different things we didn't have during the demonstration, but I've been around Medicare for a long time with some of the other claim processing contractors, but I don't know if it's in regulation, and I'd have to double-check if that five days is in some of the legislation. I don't know off the top of my head but you make a valid point.

Dr. F. Smith: I was going to make a recommendation, addressing that issue, that PPAC recommends that CMS change from 15 days to 45 days the period for appealing a RAC withholding of payments, in order to reflect the realities of mail delivery and physician schedules.

Ms. Richter: Can I just ask Connie and Marie to see if that language is right? Because I remember before we got into an issue where I think you were talking about the document review period, but because you used "appeal" in the recommendation we ended up all of our responses talked what the statutory appeals times frames are, so I just want to make sure you've got the right words for your recommendation.

Dr. F. Smith: There's something in the letter that says if you don't file an appeal or whatever the correct term is, in 15 days, then they will start withholding.

Ms. Leonard: Well the withholding occurs on day 41, and you're right, Liz, I mean—

Dr. F. Smith: But you have to notify them within 15 days.

Ms. Leonard: If you want to discuss the issue or if you want a rebuttal. And I think rebuttal is the proper term to use in the recommendation because if it's an appeal, you actually have 120 days to file the appeal, of course recoupment may have already occurred. So I think rebuttal would be the correct term so that you don't get something back that's. . .

Dr. F. Smith: So change from 15 to 45 days the period allowed for rebuttal before [crosstalk] are withheld or recouped—

Dr. Standaert: Recoupment is initiated.

[chat]

Dr. F. Smith: . . . to reflect mail delivery and physician schedules.

Commander Casey: And I guess that would be a recommendation both for a RAC review claim or a regular Medicare claims processing contractor, because a RAC actually follows the same process as the MACs. So you might want to keep that in your recommendation. Because the rebuttal period is 15 days for a MAC reviewed claims as well as a RAC review claim from the time of the demand letter.

Ms. Leonard: Right, it's not just a RAC.

Commander Casey: Right, this isn't something new we invented for the RAC program.

Dr. F. Smith: I'm happy to expand it. I'm serious to make it more—

Commander Casey: We try to be very consistent with the MAC process in as many ways as possible, so I think whenever we can align up the recommendation to match the MACs.

Dr. F. Smith: So that becomes then that CMS change from 15 to 45 days, the period for rebuttal to MAC or RAC requests before recoupment payments begin. And that change the reflects the realities of mail delivery and physician schedules.

Dr. Bufalino: Second?

[Second]

Dr. Bufalino: Discussion? All in favor? Thank you. Anyone else? Thank you ladies for being with us. We appreciate it. We will actually finish the meeting and maybe ask Dana to work on the recommendations and then take a break and then those that can stay, we can review the recommendations before we leave so that they're in place for the next meeting.

<u>Wrap up and Review of Recommendations</u>

Dr. Bufalino: So let me wrap up by asking Liz Richter to make a few closing comments for today's meeting.

Dr. Simon: Excuse me, Dr. Bufalino. Before Ms. Richter makes a few closing comments, during the, as part of the, this will go as an addendum to the response report. During the August 31, 2009 meeting of the Practicing Physicians Advisory Council, there was an incorrect response in the response report. Agenda Item 67-0-1, PPAC recommends to CMS that physicians and licensed healthcare providers not be subject to costly and burdensome durable medical equipment, prosthetics, orthotics, and supplies, accreditation requirements, as they are already licensed and trained to provide durable medical equipment supplies to patients. The corrected response: We note that most nonphysician practitioners e.g. podiatrists, optometrists, etc., are exempt from the bottom requirement as outlined in Medicare regulations, since Section 1861® of the Social Security Act includes podiatrists and optometrists within its definition of physician, we're clarifying our previous response that podiatrists and optometrists are considered physicians, nonphysicians practitioners.

Dr. Ross: May I ask Dana to include that in the recommendations? Just so that it's written out and shows also as an addendum for the next meeting.

Dr. Simon: Well, it'll be an addendum to the response report that I gave today.

Dr. Ross: Okay.

Dr. Bufalino: Okay others? That's good. Ken you're done? Thank you.

Ms. Richter: All right. I'll just say thank you to everybody, but a special thank you to Tye, to Karen, to Jeffrey, and to Vince for your great work, and we've really appreciated having you as members and I hope that we see you in other circumstances and that you continue your interest in helping us to improve the Medicare program. So thank you to everybody. [applause]

Dr. Bufalino: Thank you. And let me wrap up by saying thank you to all of you. We have had a good year and we thank you all for your participation. I'd like to thank my colleagues who are officially ending today, Tye, and Karen, and Jeff, and I. I'd like to thank all of you for the cooperation that you've offered me as chair over this last two years, and ease at which we've been able to get this group to work in a cohesive focused manner around providing commentary to the agency. So thank all of you for that. And with that, unless someone has a comment or concern, Janice?

Dr. Kirsch: I guess I had two kind of extra recommendations to make.

Dr. Bufalino: Please.

Dr. Kirsch: First of all, I would like to just do a follow up on our presentation on PQRI last time. I was experiencing some questions and concerns about using the Preventive Care Panel and ran into some issues where when you are doing a panel of patients, you're doing 30 consecutive patients all over age 50. So not all of these patients are on Medicare. A good number of these people are coming in for regular physicals, and are given regular physical codes. The problem with that is your panels are only supposed to show the recognized denominators, and physical codes are not recognized, so you're excluding all these people in which you're addressing their mammograms and their osteoporosis and all these issues, and but you exclude them because you didn't use the right code. So my recommendation goes: PPAC recommends CMS review the list of recognized denominators utilized in PQRI, particularly physical codes in the Preventive Care Panels.

Dr. Bufalino: Okay. Second?

[Second]

Dr. Snow: You mean physical exam codes.

Dr. Kirsch: Perfect.

Dr. Bufalino: All in favor?

[Ayes]

Dr. Bufalino: Thank you. Another one?

Dr. Kirsch: And then, I hope you'll consider this pertinent, because there's going to be an open forum tomorrow. This is on rural health, open door forum, and the issue that has come up is physician supervision in the outpatient setting. And there have been some new rules that basically, in a rural medical, critical access hospital setting, that if you're not actually present at let's say you send a patient for just an outpatient blood transfusion or for IV fluid infusion, but your office is in a different site, and you send them over to the critical access hospital, and you're not present, you cannot bill for it. But you have to have the physician supervision right there. This also goes for ancillary services, and I think there's going to be a lot of testimony on this subject, but I just want to put out this recommendation. PPAC recommends CMS

revise the rules regarding physician supervision of outpatient services at critical access hospitals and report the outcome of the rural health open door forum to be held March 9, 2010.

Dr. Bufalino: Second?

[Second]

Dr. Bufalino: Issues? All in favor?

[Ayes]

Dr. Bufalino: Thank you. Any other recommendations? Please.

Dr. Snow: PPAC recommends that CMS revise its implementation of the PECOS revalidation system to furnish providers a date certain, i.e., six weeks in the future, when the new application information will become effective (in order to stop disruption of cash flow after this process).

[seconds]

Dr. Bufalino: Issues? All in favor?

[Ayes]

Dr. Bufalino: Thank you. Anyone else?

Dr. Snow: Got one more.

Dr. Bufalino: Please.

Dr. Snow: PPAC recommends that CMS limit its payment restrictions for services to immediate relatives to only the physician with an excluded relationship. And the reason for this has to do with the two rationales given in our update report today. Number one, that ordinarily furnished services would be free to family members or those of partners, etc. Well that certainly contrary to CMS policy at this point and is considered fraudulent, I think in most cases, in this day and age. And number two, that the ordering of these tests are medically unnecessary because they may be due to affection or concern to the individual. And I think that's an idiotic statement to make for a physician ordering a particular service. So I think it's appropriate per regulation that these apply to family members. I mean I think that's a good halfway ground, but it certainly shouldn't apply to other partners or members of the organization, especially in some of these large organizations we've talked about today.

Dr. Bufalino: A second to the undue concern amendment.

[Second]

Dr. Bufalino: Any discussion? All in favor?

[Ayes]

Dr. Bufalino: Thank you. Anyone else?

Dr. Snow: Last, but not least for me, anyway. PPAC recommends that CMS add two additional representatives to its HITPAC, namely physicians representing rural practices and a physician representing a small, i.e., less than five provider, practice. And just quickly comment, I did after my discussion, I looked at that website. None of the members of that HITPAC have M.D. after their name. They're none of them physicians. There's hospital people and there's Cerner people and public people, but apparently no physicians at all on that group, and since one of the questions he's asked is he'd like to have concerns by providers in these two particular areas, I think they need to have a physician representative for those areas, AAFP I'm sure, could provide one, and there's probably other groups that could do it, but I think that's essential if we're going to get input from the 80 percent of physicians who practice in small and rural areas.

Dr. Ouzounian: Didn't he tell us there were physicians on that panel?

Dr. Snow: They indicated somebody from New York City, but I couldn't find—

[off mike discussion]

Dr. Standaert: Well, the MBA from New York really sort of looks after the rural interests.

Dr. Bufalino: All in favor?

[Ays]

Dr. Bufalino: Anyone else? Great, so what we'll do is ask Dana to write that up. We have three announcements. One, next meeting is Monday, June 7th. Two, there's a shuttle van taking everyone to the airport leaving at 3:30. Three, we'd ask you all to join that portion of the wall for a picture of the whole group, since Jeff's got a camera today. Thank you, and we ask Ken and Liz to join us for a quick photo. Thank you. And thank you to all the CMS staff, Robin, Kelly, Dana, and John, thank you, we appreciate it all. Thank you and have a good day.

Adjournment