REPORT NUMBER FORTY-TWO

to the

Secretary

U.S. Department of Health and Human Services

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(Re: Physicians Regulatory Issues Team [PRIT], Physician Fee Schedule, Doctor's Office Quality [DOQ] Project, Fecal Occult Blood Testing, Customer Service Survey, and other matters)

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From the

Practicing Physicians Advisory Council

(PPAC)

Hubert H. Humphrey Building

Washington, D.C.

December 16, 2002

SUMMARY OF THE DECEMBER 16, 2002, MEETING

Improving the PPAC Process

The meeting of the Practicing Physicians Advisory Council (PPAC) was held at the Hubert H. Humphrey Building in Washington, DC, on Monday, December 16, 2002. The chair, Dr. Michael T. Rapp, called the meeting to order and announced that various changes were being implemented to improve the process through which PPAC provides recommendations to the Secretary. In addition to the agenda, PPAC members will receive a reference manual that contains minutes of past PPAC meetings, the PPAC charter, a CMS organizational chart, biographic and contact information of PPAC members, and contact information for supporting staff at CMS. Mr. Tom Grissom, director of the Center for Medicare Management, noted that CMS was reviewing the nominations it had received for four positions on PPAC that will be available in 2003.

Old Business

Agenda Item C - Status and Update on PPAC Recommendations from September 2002

Response by CMS and DHHS to PPAC Recommendations made at the September 2002 meeting (Report Number 41)

(***Key:*** *Numeric and Alpha organization refer to the following: 41 refers to the meeting number; A, B, etc. refers to agenda item; and 1, 2…refers to number of recommendation under each agenda item.)*

41-A: Concerning Physician Education and Contractor Medical Directors (CMDs)

41-A-1: PPAC recommends that CMS expand its funding for physician education, in light of the decline in the number of CMDs and the decreases in carrier physician education budgets.

ADOPTED, pending passage of the federal 2003 budget.

41-A-2: PPAC recommends that Council members go to more CMD meetings and that CMDs be invited to attend PPAC meetings on a rotational basis.

ADOPTED, pending passage of the federal 2003 budget.

41-A-3: PPAC recommends that the Council establish a subcommittee to explore ways in which physicians and CMDs can work together better on behalf of quality, cost-effective patient care.

ADOPTED, with the specification that the PPAC chair will appoint the members of the subcommittee.

41-A-4: PPAC recommends that CMS direct carriers to ensure adequate numbers of carrier medical directors with adequate levels of support to fulfill CMS goals for physician education, to continue timely claims adjustments, to maintain adequate knowledge of the provider community, and to provide accurate and timely answers to provider and beneficiary questions.

NOT ADOPTED on the basis that the current strategy for funding contractors does not specify the number or type of employees contractors use to accomplish tasks.

41-A-5: PPAC recommends that every carrier medical director should have a toll-free [telephone] line so that physicians can get in touch with that carrier medical director.

NOT ADOPTED on the basis that all contractors already have toll-free telephone numbers through which they can be contacted.

41-B: Concerning Self-Administered Drug Policy

41-B: PPAC recommends that CMS reissue its Program Memorandum to determine the coverage criteria of self-administerable drugs patient by patient, rather than drug by drug: that is, rather than publish a blanket statement that this drug will be covered and that drug will not, that the physician be able to look at a Medicare beneficiary's circumstances and specific clinical criteria to determine whether in this specific clinical situation the patient is able to self-administer or not, so that the patients who cannot self-administer are still able to get the same coverage.

NOT ADOPTED on the basis that CMS has no evidence that the Congress intended that the same drug provided incident to a physician's service would be covered for a certain class of beneficiaries and excluded from coverage of other beneficiaries. The insertion of the phrase "by the patient" was intended to distinguish the patient from a spouse or caregivers when determining if a drug is usually self-administered by Medicare beneficiaries as a whole.

41-C: Concerning Administrative Law Judge (ALJ) Decisions

41-C-1: PPAC recommends that, if there is an ALJ decision for coverage relief for a beneficiary, the carriers should not be allowed the option of later reaffirming something that had earlier been found to be inadequate.

UNDER CONSIDERATION. The recommendation was included in a comment letter sent to regulatory staff. The final rule is expected to be released after July 2003.

41-C-2: PPAC recommends that CMS eliminate the mandatory instruction to ALJs to order a stay in the proceedings, if a contractor requests one to consider new evidence.

UNDER CONSIDERATION. The recommendation was included in a comment letter sent to regulatory staff. The final rule is expected to be released after July 2003.

41-D: Medicaid Access

41-D-1: PPAC recommends that, to the extent possible under the law, CMS enforce the "equal access" provision of the Social Security Act, as amended by OBRA 1989.

NOT ADOPTED.

41-D-2: PPAC recommends that HHS Secretary Thompson be urged to create a National Medicaid Payment Advisory Commission.

NOT ADOPTED.

41-D-3: PPAC recommends that CMS work with states to accurately measure the Medicaid participation rates of private primary care physicians, pediatricians, family physicians, and obstetricians and the levels of access to these providers by Medicaid beneficiaries.

NOT ADOPTED.

41-D-4: PPAC recommends that CMS report in a future PPAC meeting on the kinds of mechanisms [the agency] will be using in partnership with the states to measure the rates and degrees of Medicaid participation and access.

NOT ADOPTED.

41-D-5: PPAC recommends that CMS explore whether it can request the states to publish their Medicaid reimbursement rates on an annual basis.

NOT ADOPTED.

41-E: HIPAA Compliance

41-E: PPAC supports and encourages CMS to continue its efforts to provide simple and easy-to-understand guidance regarding the HIPAA privacy regulation implementation.

ADOPTED. CMS is currently sending more information to providers, using various methods of distribution.

41-F: Physician Fee Schedule

41-F-1: PPAC recommends that CMS do everything possible to help mitigate the decrease in physician fees by actions such as, but not limited to, removing drug pricing from the sustainable growth rate; including a factor for the increased regulatory burden imposed by HIPAA, E&M compliance, etc.; obtaining an accurate assessment of the effects of professional liability insurance increases on physician fees, reimbursement, and expenses; correcting the underestimate of the growth in the GDP in previous years that has resulted in reduced physician compensation; correcting and clarifying the estimate of the number of Medicare beneficiaries who move from managed care contracts back into fee-for-service; and recognizing that an increase in physician productivity is not much of an option anymore, since most physicians have about reached their productivity limits already.

UNDER CONSIDERATION. These issues will be addressed when the final rule is published.

41-F-2: PPAC recommends that CMS delay signing up physicians for Medicare past December, to give physicians time to see if the computation of the update is going to change through regulation or legislation and then decide whether or not to participate.

ADOPTED, pending timing and dates of publication. It is expected that physicians will have 45 days to decide whether to continue their participation once the schedule is published.

41-G: Provider Education Funding

41-G: PPAC recommends that CMS should continue to provide [the Contractor Provider Bulletin] printed on paper, but CMS should also continue its search for publication alternatives, such as an electronic version delivered at the option of the receiving practitioner or the possible use of free or modestly priced space in professional association journals.

ADOPTED. CMS will continue looking for more effective ways to distribute information.

41-H: Dear Doctor Letter

41-H: PPAC recommends that, if a legislative or regulatory action occurs so late in the year or early in 2003 that reasonable people couldn't make decisions based on [the action] by December 31 [2002], then CMS should extend or somehow adjust the enrollment period to give physicians a chance to act on the basis of that new information.

ADOPTED. Physicians will have 45 days to decide whether to continue their participation in the Medicare program once the new fee schedule and other changes have been published.

New Business

Agenda Item D - Physician Regulatory Issues Team (PRIT) Update

Dr. William Rogers, MD, Medical Advisor in the Office of the Administrator, updated the Council on the work of the PRIT (see Appendix 1). He reported that the open-door program has been very successful. The PRIT is currently considering concerns raised about the following areas: Restraint and seclusion; the 1-hour rule; reimbursement for administration of medications brought to the office by the patient; Universal Physician Identifier Numbers (UPINs); Medicare coverage database; and reimbursement for anesthesia providers in specific cases.

Agenda Item E - February PPAC Meeting and Physician Fee Schedule

Terry Kay, director of the Division of Practitioner Services, reminded Council members that the proposed rules for the fee schedule apply only to fee-for-service providers (see Appendix 2). Mr. Kay provided background on the process of developing proposals. It was noted that national policies supersede local rules.

When determining issues for the PPAC agenda, Mr. Kay suggested members consider whether other committees (such as the Office of Clinical Standards and Quality, the Office of Financial Management, American Medical Association's CPT Editorial Panel, the Relative Value Update Committee, or the Practice Expense Advisory Committee) would be a more appropriate venue for a given topic. The Council should also consider whether the issue might be better addressed at the local level; what costs to beneficiaries, providers, and the agency may be involved; and what unintended consequences could result from proposed changes. Mr. Kay also asked that any specialty societies that have issues that they would like PPAC to consider for the next NPRM are encouraged to submit them to CMS staff (Diana Motsiopoulos at dmostiopoulos@cms.hhs.gov) by January 24.

42 E: Physician Fees

42-E-1: For its future meetings, PPAC recommends the agenda include, under new business items, the outcomes of research on the costs of reestablishing practices that were lost (i.e., no longer participating in Medicare) due to decreases in the physician fee schedule.

42-E-2: PPAC recommends that it get updates from the appropriate entity on the assumption that physicians can accommodate an annual 30% increase in productivity ad infinitum.

Agenda Item F - Doctor's Office Quality (DOQ) Project

Barbara Fleming, MD, of the Division of Plan Improvement & Quality at the Center for Beneficiary Choices, described in detail the DOQ project, called "a physician level measurement and improvement initiative." The DOQ project is a three-state pilot project that has enrolled 300 physicians and will explore how to measure quality of care in the context of a physician or physician group's practice (see Appendix 3). The project will also assess what incentives motivate physicians to participate in quality improvement initiatives and what motivates or impedes offering the best possible quality of care. Public testimony was given by Yank D. Coble, Jr., MD, of the American Medical Association (see Appendix 4). Written testimony was submitted by the American College of Physicians and the American Society of Internal Medicine (see Appendix 5). The Council indicated its support for the DOQ project and offered the following recommendations.

42-F: Doctors Office Quality Project

42-E-1: PPAC recommends that the DOQ project take steps to minimize the paperwork and time required by participating physicians in order to avoid creating a financial disincentive to participation.

42-F-2: PPAC recommends that CMS explore future demonstration projects on the use of financial incentives to achieve quality improvement goals.

42-F-3: PPAC recommends that CMS use the AMA Physician Consortium for Performance Improvement's evidence-based performance measures and any resulting data for quality improvement purposes only.

42-F-4: PPAC recommends that CMS continue to work with the AMA and the Consortium to ensure the appropriate development and implementation of evidence-based clinical performance measures that enhance the quality of patient care and advance the science of clinical performance measurement and improvement.

42-F-5: PPAC recommends that CMS use information gleaned from implementing the measures in the pilot tests of the DOQ project to further refine the measures, if necessary, in collaboration with the Consortium, and the Consortium should be involved in future implementation efforts.

42-F-6: PPAC recommends that CMS recognize the state-of-the-art of physician performance measurement, which supports the use of measurement to promote continuous quality improvement; existing methodologies do not warrant the use of measures for purposes of individual accountability, comparison, or choice.

42-F-7: PPAC recommends that CMS acknowledge the serious limitations in using performance measurement to assess physician competence and to work with the AMA and the Consortium to ensure that data from the DOQ project are used to improve the overall quality of patient care and not to assess individual physician performance.

42-F-8: PPAC recommends that CMS consider the burden of data collection; consider the use of electronic medical systems to collect and process data; and agree to collect data for the DOQ project prospectively only.

42-F-9: PPAC recommends that CMS involve the national medical specialty societies and boards in addressing what constitutes the appropriate specialty-specific variance in clinical practice.

42-F-10: PPAC recommends that CMS indicate physician participation only as the sole criterion for public recognition by the DOQ project.

42-F-11: PPAC recommends that the DOQ project measure physician productivity within the context of the current study.

42-F-12: PPAC recommends that specialist physicians be included in the DOQ project.

Agenda Item G - Immunoassay Fecal Occult Blood Testing (FOBT)

Steve Phurrough, MD, MPA, Director of the Division of Medical & Surgical Services' Coverage and Analysis Group, explained that under current CMS rules, only guaiac-based FOBT for the purpose of screening for colorectal cancer is covered by Medicare (see Appendix 6). A newer immunoassay for FOBT is available and may be a better alternative, but the agency may not consider covering it until the current rule specifying guaiac-based FOBT is revised. Public testimony was given by Richard C. Wender, MD, of the Jefferson Medical College of Thomas Jefferson University (see Appendix 7). Background information was submitted by the College of American Pathologists (see Appendix 8).

42-G: Immunoassay Fecal Occult Blood Testing (FOBT)

42-G: PPAC recommends that the existing rule related to coverage of guaiac-based fecal occult blood tests for screening for colorectal cancer be changed to allow other types of fecal occult blood tests to be considered for coverage.

Agenda Item H - Program Integrity Customer Service Survey

Melanie Combs, Acting Senior Technical Advisor of the Program Integrity Group, and Ellen McNeil, Director of Operations for Pacific Consulting Group, described survey results from physicians and office staff on the issues of provider enrollment, prepay medical reviews, and postpay medical reviews (see Appendix 9). On the basis of these results, various improvement initiatives are underway, including a Medicare coverage database, available online in late December 2002. In addition, contractors will provide, on request, a comparative billing report that compares an individual with other local providers or others in the same specialty.

42-H: Customer Service Survey

42-H-1: PPAC recommends that when a comparative billing report on an individual is requested, that the request does not trigger an investigation of the individual.

42-H-2: PPAC recommends that CMS publish the results of the Program Integrity Customer Service Initiative survey and the resulting workplan and that CMS use those vehicles available through specialty and other medical societies to widely distribute the survey results and work plan.

42-H-3: PPAC commends the Program Integrity Customer Service Initiative for efforts to make the project more understandable.

42-H-4: PPAC recommends that Program Integrity Staff continue efforts to have contractors make their articles on coverage and coding policies and frequently asked questions available for the Medicare coverage database and searchable.

Report from the Administrator

Mr. Tom Scully, CMS Administrator, announced that the 2003 fee schedule would include a 4.4% cut as a result of a legislative error he hopes will be fixed. The final rule, which will take effect sometime between February 16 and March 1, 2003, had not yet been released as of December 16, 2002. The Administrator also told the Council that CMS has successfully instituted programs for quality measurement for nursing homes and home health providers and is beginning to devise such a program for hospitals. CMS eventually hopes to have measures of quality for individual physicians. Mr. Scully also reported that no decisions had so far been made on how to provide prescription drug coverage for the publicly insured.

After a review of all the motions adopted, Dr. Rapp adjourned the meeting.

Report Prepared and Submitted By
Dana Trevas, Rapporteur

PPAC Members at the December 16, 2002, Meeting

Michael T. Rapp, MD, JD, *Chair*
Emergency Room Physician
Arlington, Virginia

James R. (Ronnie) Bergeron, MD
Dermatologist
Shreveport, Louisiana

Richard Bronfman, DPM - Absent
Podiatrist
Little Rock, Arkansas

Ronald Castellanos, MD
Urologist
Cape Coral, Florida

Rebecca Gaughan, MD
Otolaryngologist
Olathe, Kansas

Joseph Heyman, MD
Obstetrician/Gynecologist
West Newbury, Massachusetts

Stephen A. Imbeau, MD - Absent
Internal Medicine/Allergist
Florence, South Carolina

Joe W. Johnson, DC
Doctor of Chiropractic
Paxton, Florida

Christopher Leggett, MD
Cardiologist
Atlanta, Georgia

Dale Levrick, OD
Optometrist
Lakewood, Colorado

Barbara L. McAneny , MD
Clinical Oncologist
Albuquerque, New Mexico

Angelyn L. Moultrie-Lizana, DO
Family Practitioner
Bellflower, California

Amilu Rothhammer, MD – Absent
General Surgeon
Colorado Springs, Colorado

Victor Vela, MD
Family Practice
San Antonio, Texas

Douglas Wood, MD - Absent
Cardiologist
Rochester, Minnesota

CMS Staff Present:

Tom Scully
CMS Administrator

Tom Grissom, Director
Center for Medicare Management, CMS

William Rogers, MD
Medical Advisor
Office of the Administrator
Centers for Medicare and Medicaid Services

Paul Rudolf, MD, JD
Executive Director, PPAC
Center for Medicare Management

David C. Clark, RPH, Director
Office of Professional Relations,
Center for Medicare Management

Melanie Combs, Acting Senior Technical Advisor Program Integrity Group

Barbara Fleming, MD, PhD
Division of Plan Improvement & Quality
Center for Beneficiary Choices

Terry Kay, Director
Division of Practitioner Services
Center for Medicare Management

Ellen McNeil, Director of Operations
Pacific Consulting Group

Steve Phurrough, MD, MPA, Director
Coverage and Analysis Group
Division of Medical & Surgical Services

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Dana Trevas, Rapporteur

Public Witnesses:

Richard C. Wender, MD, Jefferson Medical College, Thomas Jefferson University
Yank D. Coble, Jr., MD, for the American Medical Association

APPENDICES

Appendix A: Meeting Agenda

The following documents are recommendations:
Appendix B: Recommendation list from the December 2002 meeting
Appendix C: EMTALA recommendations from the June 2002 meeting

The following documents were presented at the PPAC meeting on December 16, 2002, and are appended here for the record:
Appendix 1: Update on Provider Outreach, Physicians Regulatory Issues Team
Appendix 2: Educational Preparation: February PPAC Meeting Regarding Physician Fee Schedule
Appendix 3: Doctor's Office Quality Project: A Physician Level Measurement and Improvement Initiative
Appendix 4: Statement of the American Medical Association to the Practicing Physicians Advisory Council Re: Doctor's Office Quality (DOQ) Project: A Physician Level Measurement and Improvement Initiative
Appendix 5: American College of Physicians–American Society of Internal Medicine Testimony to the Practicing Physicians Advisory Council
Appendix 6: Immunoassay Fecal Occult Blood Testing
Appendix 7: Testimony of Richard C. Wender, MD, to the Practicing Physicians Advisory Council
Appendix 8: Fecal Occult Blood Testing as a Screening for Colorectal Cancer, from the College of American Pathologists
Appendix 9: Medicare Program Integrity Customer Service Survey