REPORT NUMBER THIRTY-NINE

to the
Secretary
U.S. Department of Health and Human Services

**(Re: Beneficiary access, FACA, HIPAA, PRIT,
contractor operations and accountability,
physician fees, sustainable growth rates,
LMRPs, and other matters)**

From the
Practicing Physicians Advisory Council
(PPAC)
For March 25-26, 2002

PPAC Members at the March 25-26, 2002, Meeting

Michael T. Rapp, MD, JD, *Chair*
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Arlington, Virginia

James R. (Ronnie) Bergeron, MD
Dermatologist
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General Surgery
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Victor Vela, MD
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San Antonio, Texas

Douglas L. Wood, MD
Cardiologist
Rochester, Minnesota

DHHS and CMS Staff Present at the March 25-26, 2002, Meeting

Claude Allen
Deputy Secretary, DHHS

Tom Grissom, Director
Center for Medicare Management, CMS

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, Deputy Director
Division of Medical Review

Jeff Davis, Chief
Administrative Law Branch
Office of the General Counsel, DHHS

Ken Frank, Health Insurance Specialist
Committee Management Office
Office of Communications and Operations Support

Kathleen Fyfe, Senior Advisor
CMS Privacy Outreach Program

Jody Goldstein
Civil Rights Division
Office of General Counsel

Anita Heygster, Director
Division of Practitioner Claims Processing
Provider Billing and Education Group

Bill McQueeney, Executive Producer
Medicare Learning Network, CMS

Barbara Paul, MD, Director
Physicians Regulatory Issues Team (PRIT)
Center for Medicare Management

John Shatto, Actuary
Office of the Actuary

Paula M. Stannard
Counselor to the General Counsel, DHHS

Dan Waldo, Director
Information and Methods Group
Office of Research, Development, and Information

Latesha Walker, Health Insurance Specialist
Purchasing Policy Group

Ted Cron, Consultant Writer-Editor

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Public Witnesses:

Pat Boardley, Provider Education Coordinator, Trailblazer Health Enterprises, LLC
Laurance Clark, MD, Medical Director, Trailblazer Health Enterprises, LLC
Ron Davis, MD, member of the Board of Trustees of the American Medical Association
Karen Nichols, DO, member of the Board of Trustees of the American Osteopathic Association
Albert Bothe, Jr., MD, Chair of the Association of American Medical College's Faculty Practice Steering Committee's Subcommittee on Legislative and Regulatory Issues.

March 25-26, 2002, Meeting: Morning Agenda of Day One

Four new Members on the Council: The 39th meeting of the Practicing Physicians Advisory Council was held at the Hubert H. Humphrey Building in Washington, D.C. The meeting was opened at 8:40 AM, Monday, March 25, by the Chair, Dr. Michael T. Rapp. Dr. Rapp introduced Mr. Tom Grissom, Director of the Center for Medicare Management, who in turn welcomed the four new Members of the Council: Drs. Barbara McAneny, Chris Leggett, Ronald Castellanos, and Rebecca Gaughan. Mr. Grissom also previewed the agenda items for the two-day meeting. Dr. Rapp then asked all Members to introduce themselves and indicate their particular concerns. The four new Members emphasized the following: patient access, inadequate physician fees, HMOs, prescription drug costs, unfunded mandates, and the difficulty of providing quality care for minorities and the elderly.

Review of Pending Matters on the Grid

Paul Rudolf, MD, JD, Executive Director of PPAC, went over the following items on the PPAC grid:

The ABN revision: This has been "a three- or four-year journey"; the ABN is still being revised, but Dr. Rudolf promised "some kind of follow up at the June meeting."

Guidelines for teaching physicians: A new set will soon be released, designed to "minimize the requirements for teaching physician documentation." However, as to the primary care exception, Dr. Rudolf said it is still being discussed internally, but "it's not likely that anything is going to happen" to change the current rule. He suggested that PPAC might want to discuss the guidelines again at the June meeting.

HIPAA compliance: The Council had asked for a delay in the deadline, but Dr. Rudolf noted that the law clearly precludes that. He again reviewed the timetable that requires compliance by all providers by April 16, 2003. He reported that a model compliance form (required by law to be published by March 31, 2002) has been developed by the Workgroup for Electronic Data Interchange (WEDI). The form has been favorably received by the provider community, and the Secretary "is further refining [it] to minimize the burden on providers." The Council ruefully noted that physicians would have to bear the additional costs of getting help to fill out the new form.

The 5.4% fee reduction: At its December meeting, the Council had asked Secretary Thompson to oppose the scheduled 5.4 percent reduction in physician fees and to support legislation to that effect. The Council's resolution "was received by both the Administrator and the Secretary, ... a response is in the clearance process [and] will be sent back to PPAC." In any case, "the Department is sticking with the President's budget, which leaves in place the ... minus 5.4 percent update." As to the legislation, Mr. Grissom said, "Those bills [S1707 and HR3351] are going through the normal process, and we are not lobbying for them."

Council Members repeated their deep concerns about the effects of the fee cutback. They reported that many physicians' practices were "on the brink [and] a major concern is that we will lose [them]." If that should happen, said the Council, we will have "lost the infrastructure for providing healthcare across the country." The Council predicted, "It may take us years to ... rebuild the access for patients." Members indicated that the patients most to suffer will be those covered by Medicaid. In that connection, the Council asked that time be set

aside on the June agenda to discuss Medicaid, specifically the "discrepancies" that seem to exist between Medicaid and Medicare rules and fees.

Patient Access and the Medicare Current Beneficiary Survey (MCBS)

Annual personal survey: The Chair then welcomed Mr. Dan Waldo, Director of the Information and Methods Group within the CMS Office of Research, Development, and Information. Mr. Waldo described the MCBS as "a longitudinal survey of the ... social, economic and demographic characteristics ... of [about 16,000] Medicare enrollees." Questions are designed to yield information about enrollees' financing and their use of care, access to care, and satisfaction with the care they receive. Mr Waldo offered this sample of results:

- "Six-tenths of a percent of the sample respondents reported that they didn't receive care
- or they didn't seek care because they couldn't get an appointment soon enough.
- "About 0.3 percent reported that the doctor charged more than Medicare would pay.
- "And 0.2 percent reported that they couldn't find a doctor who would accept Medicaid."

What is the "confidence level?": Council Members asked if this level of MCBS response (1.1%) is statistically significant. They also asked what the "statistical confidence" level was for the question as to whether Medicare beneficiaries can or cannot get in to see physicians. Mr. Waldo said he hadn't done that computation; the Members suggested that CMS "put a big disclaimer on this, saying these data do not allow you to make any statistically valid conclusions about ... why people may or may not go to their doctors." Mr. Waldo agreed that "that's a very valid point," but said CMS achieved the highest "statistical power" possible with a survey budget of $12 million. He later admitted that "the material that I've given you this morning should not be construed, and I did not intend it to be, a report on access to care in the Medicare population."

"Loss of hearing or a runny nose?": Members also criticized the survey for not distinguishing among persons seeking medical help for "an urgent problem, an emergent problem, or just a routine problem." Those differences "really matter" in the physician's decision to see someone right away or not. One Member noted, "If you ... have a sudden sense of real hearing loss, you're in [my office] that day. [But if] you have a ... runny nose, it might be weeks." Mr. Waldo agreed that the data analyses "involve all of these other correlates and the other variables that are involved" so that "the cell sizes become very small very quickly at the national level." This prompted an already skeptical Council to ask, "Then ... what is the data good for?" Mr. Waldo allowed that "you can't draw anything statistically reliable at all, but," he insisted the survey could be used "as an indication" of existing problems that might require further study. After reviewing the data once more, the Members noted that, after a decade of use at a cost of "probably a hundred million dollars," no significant statistical changes occur year to year regarding physician access and patient satisfaction. Mr. Waldo agreed, but noted that the survey is also used for other purposes by CMS actuaries and other staff.

Not enough about the chronically ill: The Council also wondered if too many of the respondents were "the healthy Winnebago seniors who come in once a year [for] their physical." They suggested that patients who don't use the medical system very much tend to be pleased with it, but the chronically ill – "diabetics with multi-system disease, heart patients, cancer patients, et cetera" – those who use it often are far less satisfied. The Council indicated that the survey seems to capture a statistically insignificant sample (all told, about 1.1%) of user-beneficiaries who were unhappy with the system; hence, the survey does not yield any

worthwhile information about how the system might better serve these especially needy persons. Mr. Waldo repeated that the MCBS is a survey of "people who are eligible for Medicare ... We don't have any information on them other than their age."

Three weakness of the survey: The Council concluded that the MCBS survey was weak in three significant ways: It did not focus clearly enough on the needs and satisfactions of people who actually used the system for serious health needs; it did not reveal any serious problems at the county or local level, where care is actually delivered; and it did not take into account the impact that the pending 5.4% cut in physician fees may well have upon access and physician availability. An additional question was raised with regard to Medicaid. Although 10%-12% of Medicare beneficiaries are also eligible for Medicaid, Council Members noted that the MCBS does not clarify the role of Medicaid per se. Mr. Waldo said no separate Medicaid survey was contemplated, mainly because "it would probably [take] $15 to $20 million to do a comparable survey of the Medicaid population." To this and other responses, the Council offered the general sentiment that CMS ought to "spend [its] money on something we need to find out." The Council also strongly recommended that CMS try to establish partnerships with other surveying organizations, such as state medical societies and the Medical Group Management Association, in order to get the provider's view of these same issues.

More on access in the next round: Responding to the Council's clear interest in access, Mr. Waldo suggested that the next MCBS iteration, due out in the fall of 2002, might well contain a question targeted to the access issue. Since the fall 2002 questions will be finalized in July, PPAC might want to offer items and review suggested items at its June meeting. But getting the Council's suggestions prior to June, said Mr. Waldo, would be even more helpful.

The Chair called for a mid-morning break at this point.

New Members Sworn In

Members lauded for their "national service": Following the break, Deputy HHS Secretary Claude Allen arrived and told the Council that "the Secretary and the President ... value your input greatly." He said the Department was concerned about such matters as the "continued disparities" between care for minorities and others and the continuing problem of obesity among women. Mr. Allen also noted that the President has asked "all Americans to give some time in national service." Speaking directly to the Council Members, Mr. Allen added, "We look at this as your national service." Following these remarks, Mr. Allen swore in the four new Members.

The FACA Rules of Advisory Council Conduct

"The most public of public proceedings": The Chair next welcomed Mr. Jeff Davis, Chief of the Administrative Law Branch in the Office of the HHS General Counsel, and Mr. Ken Frank of the Committee Management Office. Mr. Davis briefed Council Members on the requirements of the Federal Advisory Committee Act. He reminded Members that they are "in the most public of public proceedings." Mr. Davis also emphasized, among other things, that, when speaking to the media or to any group, Members speak only as individuals or "industry representatives," but not as spokespersons for PPAC itself. Mr. Frank reviewed all six advisory committees serving CMS. He also noted that the original PPAC charter has been broadened to include Medicaid as well as Medicare. Members asked about rules governing e-mail and

teleconferencing and other sub-group consultations. Mr. Davis replied, “To the extent that you are [only] gathering information, doing research, or collecting data that you will [later] bring before the full committee, ... there are no restrictions.”

HIPAA Privacy Rule Discussed

Nine revisions to the Privacy Rule: The Chair next welcomed Ms. Paula Stannard, Counselor to the HHS General Counsel, and Ms. Kathleen Fyfe, Senior Advisor in the CMS Privacy Outreach Program, to discuss the Privacy Rule in the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Ms. Stannard emphasized that the Privacy Rule, which has been drafted by the Office of Civil Rights, is meant to assure “that privacy rights of individuals were protected, but [not] at the expense of the efficient and effective provision of medical care.” The rule went into effect April 14, 2001; however, “compliance... is required by April 14, 2003, unless you’re a small health plan. In that case,” Ms. Fyfe said, “you’ll have an additional year [to April 2004] for compliance.” CMS was to publish proposed modifications to the rule on the Wednesday following the PPAC meeting and accept public comments for the next 30 days. Ms. Fyfe described the implications of HIPAA’s subtitle “F,” Administrative Simplification, which was written to encourage “the increased use of [electronic] automation for healthcare business transactions, [or] ‘paperless processing.’” Ms. Fyfe then reviewed the Department’s nine proposed revisions of the Privacy Rule.

Privacy protection – on balance: Ms. Fyfe explained the kind of “balancing act” that has been employed in the revisions. For example, physicians must provide insurers with all the patient records they request, said Ms. Fyfe, but the insurers are “only permitted to use the minimum [information] necessary for their purposes.” Again, “at the same time that the proposed revision says that [patient] consent is no longer mandatory, ... the rule [requires] that covered entities use a good-faith effort to have the patients acknowledge receipt of the notice, such as a signature.”

Private data for public marketing: During the ensuing dialogue, Council Members expressed deep concerns about the porous nature of the patient privacy rules. They noted that pharmacies, insurers, and health plans all share information about patients’ prescription drug usage and other data that has marketing value, and some private health care matters are sent by fax from pharmacies to environments that are not secure at all. They also voiced concerns over direct marketing efforts to patients themselves. The most egregious examples cited are those by drug companies that market their products directly to patients known to have diabetes, heart conditions, or psychiatric conditions. The Council was assured, however, that physicians, “as covered entities, were not required to police the activities of ... business associates,” such as pharmacies or laboratories, each of which should have its own approved compliance plan. Some Members nevertheless wondered if, for their own protection, they would have to insert privacy protection clauses into contracts or agreements they have with business associates

Privacy rights of minors: Another proposed revision says, in effect, that “disclosure to parents will be permitted when this is permitted or required by a state law, [but] ... would not be allowed if the state law prohibited it. Lastly, if the state law is silent or unclear, the provider could act within his or her discretion under state law to give or deny parents access to the medical records of minors.” Members expressed some concern that the proposed revision might actually weaken current privacy protections for victims of spouse abuse or child abuse.

Patient data for research: The proposed rule would also reduce from three to one the number of patient authorizations for the use of personal medical information in research. The

suggestion was made to change the patient authorization from "yes, you can use my data" to "no, you can't use my data," on the theory that many patients don't bother signing. Hence, with the change, more data would be available (by default). Mss. Stannard and Fyfe found the argument of interest, but could not commit to changing the language of the regulation from positive ("I give permission...") to negative ("I refuse permission...). Members also noted that the ability to "de-identify" patient data (that is, unlink the data from the person) presents serious problems to research mechanisms such as the Tumor Registry and the Surveillance, Epidemiology, and End Result (SEER) record for cancers.

Technical assistance is in the works: Members asked if CMS could provide the Council with side-by-side comparisons of the current and proposed Privacy Rule. This was something of a problem, since the rule runs to 200 printed pages. Ms. Fyfe indicated that she was " in charge of ... preparing technical assistance documents for physicians, hospitals, other covered entities." She thought they would be ready in "a few months." Meanwhile, copies of the 200-page rule were to be prepared for Members to review overnight and discuss the following morning. At that the Chair called a recess for lunch.

PRIT

Dr. Paul to move on: The Chair then welcomed Barbara Paul, MD, Director of the Physicians Regulatory Issues Team (PRIT). Dr. Paul explained that, after "a couple of years" as the first Director of PRIT, she was leaving to assume a new position in the CMS Center for Beneficiary Services. She then presented awards to CMS personnel who have been helpful to her and her team since PRIT's inception. Dr. Paul, in turn, was called "an inspiration to all of us" by her colleagues. Dr. Paul told the Council, "Dr. Bill Rogers, an emergency physician who has been advising [CMS Administrator] Tom Scully for the last six months, ... is going to be coming on full time as of May 1, and will be ... directing the PRIT." She then brought the Council up to date on the following outstanding PRIT issues:

- *ABNs.* A table has been prepared to explain modifiers; the Inspector General is also looking at ABNs, not as an audit but for policy implications.
- *Carrier bulletins.* The Division of Provider Education and Training is looking into "nationalizing certain aspects of best practices."
- *Certificates of Medical Necessity.* Program Integrity is running a pilot, in which they are asking, "Are CMNs necessary?" Another pilot is being conducted to "review the efficiency and effectiveness of CMNs for durable medical equipment (DMEs).
- *Claims re-submission.* That was next on the PPAC agenda.
- *Coverage and payment for follow-up visits for cancer patients.* "We are meeting later this week to try to get this one off of my list ... before I move on."
- *Diabetic glucose monitoring supplies.* "We have a final instruction in clearance... Not only does the renewal frequency go from 6 to 12 months, but also the requirements of physician charting are much more simplified."
- *Medicare summary notices.* "We are going to be removing some of the phrasing ... that talks about fraud and turning the crooks in. ...and leave in the constructive, helpful language."
- *Documentation requirements for teaching physicians.* "We are in the final clearance stages of some new instructions to the carriers regarding what teaching physicians have to write when they supervise residents."
- *Clinical Environment Appraisal Program (CEAP).* The team is trying to develop "an

easy way to check in with practicing physicians from time to time. This is moving along slowly." Dr. Paul noted that a Website was in the offing, as well as a permission paper to "tell the world that we're going to ask for information, and we [want] the world tell us whether they think this is okay.....We will be working with one of our carriers, probably Trailblazer, [for] logistical reasons."

- *"Medicare Resident Training Manual."* CMS now has "a very nice revision" that is available on the Web. Dr. Paul suggested "it might be nice to bring copies of that at the next PPAC meeting." Again, the language has been edited to eliminate the "blunt instrument fraud message" and "talks about paying claims accurately, and good business practices, and things like that." The Council again asked that CMS staff revise the *Pay it right* pamphlet and eliminate the fraud and abuse language there as well.
- *Carrier medical directors.* Dr. Paul asked CMDs to invite a resident PPAC member to visit their offices, "so we have given them your names ... you're certainly welcome to ... contact them yourselves. But they should be contacting you and inviting you to come and visit." Dr. Rudolf suggested that PPAC Members might want to report on their visits; therefore, ":maybe it should be an agenda item either for the June or September meeting."

Contractor Billing and Operations

The switch to electronic claims processing: The Chair next welcomed Ms. Anita Heygster, Director of the Division of Practitioner Claims Processing within the Billing and Education group, CMM; Ms. Melanie Combs, Deputy Director of the Division of Medical Review; and Bill McQueeney, Executive Producer of the Medicare Learning Network. Ms. Heygster told the Council that 25% of Medicare claims are now submitted on paper, while 75% are electronic. (As it is, all claims made today are already processed electronically, regardless of the medium in which they've been submitted.) Medicare's 20 carriers "process claims using one of three standard claims processing systems," she said. However, "Those three standard systems are not identical. Over the next few years, Medicare is reducing the number of standards systems so that, eventually,"Ms. Heygster said, "all claims will be processed by one standard system that will be used by all Medicare carriers." When HIPAA goes fully into effect in October 2003, "there will be a new format, the X12 and 837P, under which all electronic claims will have to be submitted to Medicare," she said. Asked whether physicians will need to upgrade or re-program their computers for this, Ms. Heygster said, in effect, that will "depend on ... what your particular circumstances are."

Level III codes to be phased out: Ms. Heygster then explained in great detail the features of a "payable claim," which, "in general, represents a service or item that we cover, rendered under the circumstances for which we cover it." She went on to present "the life cycle of a claim." She also reviewed the nature of the three-level Healthcare Common Procedure Coding System (HCPCS), the "uniform method for healthcare providers and medical suppliers to report professional services, procedures, and supplies." Level III codes, however, "created by individual carriers [since 1989] with respect to unique circumstances and services," are being phased out and will no longer be recognized after October 2003. Council Members and Ms. Heygster raked the claims information issue back and forth, citing personal experiences and raising new questions. Ms. Combs described the three levels of medical review: automated review (no person involved) and routine manual review and complex manual review (human beings involved).

Payment error rate now 6.3%: Ms. Combs then went on to discuss the payment error rate, which, she said, is often spoken of the "fraud rate, [but] it really has very little to do with

fraud." She recalled that in 1996, when the program was started by the Inspector General, "the payment error rate was 14 %, and ... it has declined every year... The payment error rate is now at 6.3 % ... a 55 % decrease." The program's success, said Ms. Combs, is based on three things: "better oversight by CMS, better compliance by providers ..., and better enforcement of the rules by the contractors." Ms. Combs said her group is "developing contractor specific error rates." In addition, the agency's Comprehensive Error Rate Testing (CERT) Program "will really help us ... to see which contractors are able to get the error rate down and which ones are not," she said. Council Members, however, offered the opinion that the lowered error rate may also be a function of physician undercoding to avoid trouble (the "fear factor").

Three parts of a "covered service": The foundation of the claims process is the "covered service," a term that has three parts to it, Ms. Combs said. "It's important for providers to understand what the coverage rules are [in order] to help ... decrease that hassle factor," she said. First, a covered service must be a Medicare benefit or in a benefit category. Second, the item or service cannot be "statutorily excluded": e.g., cosmetic surgery, eyeglasses, or hearing aides. Third, it must be "reasonable and necessary. Medicare only pays for things that are reasonable and necessary." The actual, specific rules governing "covered services" are found in three different places (or "buckets," as Ms. Combs called them):

- There are about 300 National Coverage Decisions (NCDs) published by CMS in the *Coverage Issues Manual*, after going through the rule-making process. The NCDs are binding at all levels of appeal.
- Coverage provisions are also found in CMS interpretive manuals, such as the *Medicare Carrier Manual,* or the *Medicare Intermediary Manual,* or sometimes through a program memorandum. These are also national in their effect.
- Finally, there are about 9,000 Local Medical Review Policies (LMRPs) which have been developed by Medicare's contract carriers. Each carrier's LMRPs apply only to that contractor's geographic jurisdiction or, in the case of multi-state carriers, to a subset of its jurisdiction. They are not nationally binding.

The nature of the LMRP: In 2000, HCFA instructed contractors to "have a more open LMRP development process," as a way to reduce rancor and confusion among providers, patients, and other healthcare stake-holders. They are now able to play a more active role in the process. Ms. Combs agreed that there may be wide variations in LMRPs from carrier to carrier and suggested Council Members go to www.lmrp.net and type in any key word to see the actual variations in LMRPs across the country. (It was noted, for example, that Minnesota had 100 LMRPs, while Wisconsin had 220.) Nevertheless, she said, CMS has very little to do with LMRPs, unless they actually conflict with national policy.

The undercoding issue: Ms. Combs also noted that carriers have been instructed to tell physicians if they've undercoded and are being underpaid. Members hadn't heard of such a thing and asked Ms. Combs to report further on that part of the system at the June meeting. Ms. Combs suggested that underpayments present the physician with a problem, however: the physician, receiving a larger 80 % fee, has to bill the beneficiary a larger sum for the remaining 20 %. But the Council disagreed, suggesting that CMS should give as much time to undercoding as it now gives to overcoding, since they have "the exact same hassle in both directions," with regard to collection and repayment. "Thank you for educating me," said Ms. Combs. "I will try to get that fixed."

New drugs, old codes: Members indicated confusion as to what would be the outcome if a physician (e.g., an oncologist) appropriately uses a new drug or a new diagnostic procedure that has not yet been vetted by the carrier. Dr. Rudolf, a former CMD in Maryland, suggested

that there be weekly interactions between CMDs and specialists who are on the frontiers of medical practice. The same confusion was voiced over ICD-9 codes; how many obsolete codes, the Council asked, are still on the books of Medicare's contract carriers? Dr. Rudolf suggested that a CMS staff person ("a woman named Pat Brooks") might be able to clarify that.

How do carriers self-correct?: Members asked what system was in place to assure that the contractors themselves correct their own errors. Ms. Combs replied that, if the carrier's edits are "generating denials that all get overturned on appeal, [the carrier needs] to go back and make adjustments ... in their edits or maybe in the underlying policy. ... [That] is a very important piece of a 'progressive corrective action,'" she said. Ms. Combs recounted a number of improvements in the assignments CMS has made to its contractors to rationalize and expedite the claims review process. One outcome should be a more effective but less punitive relationship with physicians. For example, each contractor must make sure physicians are clear about the pre-appeal rebuttal process, "by which the provider can send to the contractor information to say why [a particular] determination was incorrect."

PET projects: Ms. Combs also spoke of a greater emphasis on Provider Education and Training (PET). Contractors have two budgeted PET programs: Program Management (PM-PET) and Medicare Integrity Program (MIP-PET). These will receive more attention and possibly more funding in 2003. Also on tap for 2003 is the full roll-out of the Program Safeguard Contractor (PSC) Strategy. "Program Safeguard Contractors ... have a special contract with us to do certain MIP-related activities, [such as] certain medical reviews, or fraud and abuse, or cost report audit activities." Under this program, said Ms. Combs, all carriers will focus on reducing the payment error rate, but the PSCs will also handle fraud and abuse and other program integrity matters.

Appeals processes for NCDs and LMRPs: CMS will also instruct carriers to "formalize the LMRP reconsideration process." "Right now," said Ms. Combs, "it's an informal process by which providers share with the contractor their thoughts or ideas [for changing an LMRP]. We will be making that a more formalized process [and] require contractors to consider those ideas and recommendations that come from providers." Ms. Combs ended her presentation by noting that CMS will put in place the NCD and LMRP appeals processes mandated by Section 522 of the Benefits Improvement Protection Act (BIPA) of 2000. "This is not an appeal process for claims," she noted, but a process for appealing the substance of the NCDs and LMRPs. Section 521, on the other hand, mandates a timetable for handling claims appeals. Unfortunately, the law requires a timetable that, thus far, seems unworkable, and the agency is pondering what to do about it.

Contractor Accountability

The CMS schoolhouse: The Chair then welcomed Mr. Bill McQueeney, Executive Producer of the CMS-sponsored Medicare Learning Network, an activity of the Division of Provider Education and Training. Mr. McQueeney noted the accelerated pace of change in the Medicare program and the fact that CMS will issue over 400 instructions to carriers this year, considerably increasing the complexity of the task of maintaining carrier accountability. He then recounted the number of ways CMS informs and trains contractors to, in turn, educate, train, and inform providers: e.g., the Medicare Learning Network, the Best Practices Website, toll-free telephone calls, face-to-face trainer sessions for major initiatives, Internet and satellite training broadcasts, the development of protocols for contractor performance evaluation (beneficiary service, provider service, etc.), plus a library of videotapes, audio tapes, and CD

ROMS.

Is Medicare the standard?: In these and other respects, Mr. McQueeney repeated the notion that Medicare sets the standard for the insurance industry and for medical care in general. But Council Members questioned that, noting that some carriers look to Medicare for "the absolute bottom for [physician] reimbursement" and use it as an easy cover "to follow that same pattern." If indeed Medicare is the "standard,"said the Council, it should strive to "err on the side of fairness, ... on the side of completeness, ... on the side of hearing the issues that impact physicians disproportionately, [and on side of] access..." Medicare's role as the "standard" of coverage and care was further questioned by the Council, which asked, "If Medicare is the standard, why is Medicaid so different...?" If Medicare, with all its faults, was the latter's standard, also, "it would improve Medicaid dramatically."

A model contract carrier: The final presentation of Day One was by made by Ms. Pat Boardley, Provider Education Coordinator, and Laurence Clark, MD, Medical Director of Trailblazer Health Enterprises LLC, the Medicare contract carrier in Maryland. Dr. Clark began by emphasizing the role of Medicare in setting the pace for all insurers, including private insurance carriers. Ms. Boardley then described the Trailblazer's extensive physician education program, which includes seminars, teleconferences, workshops, newsletters, individual letters, face-to-face meetings, Web-based materials, customer service representatives (who deal directly with providers), as well as its MIP-PET responsibilities. Dr. Clark then returned to explain his carrier's approach to developing LMRPs.

More on LMRPs: Council Members were unanimous in their praise for the Trailblazer program and agreed that it was exceptional, not the norm for carrier conduct. But Members still questioned the wide variations in LMRPs, even within the Trailblazer family, which covers not only Maryland but also Delaware, the District of Columbia, Virginia, Texas, and Colorado. They contended that there was a relationship between LMRPs and the questions of access to and delivery of quality medical care. For example, some LMRPs may conflict with generally recognized national medical practices. (Echocardiography was specifically mentioned.) Dr. Clark agreed with the Council that carriers had to keep up with new technologies, new medications, and new procedures in order to deal fairly with both providers and beneficiaries. He cited the help of the specialty societies, his own carrier advisory committee (CAC), and the compelling nature of evidence-based medical practice itself.

Are 9,000 LMRPs too many?: The Council asked if CMS could possibly reduce the 9,000 LMRPs to manageable size, by concentrating on the ones "that really make a difference and where there are true reasons that there should be a regional variation." Such a massive undertaking didn't seem necessary, said Ms. Combs, because "once an LMRP has done its job in terms of changing the behavior of providers who are billing incorrectly, the contractor usually shuts down [that policy] and just keeps it on the books so that new providers ... or folks who want to try to abuse the system will know what the rules are and will have been put on notice." ("Those are terrible words," said the Chair.) As to the possibility of CMS converting some LMRPs into national coverage decisions, Dr. Rudolf reminded the Council that "the national coverage process is a voluntary process; [that is,] people voluntarily come to us and ask for a [national] coverage decision." He said that CMS does not now intend "to self-generate lots of national coverage decisions."

After some further dialogue, the Chair recessed the meeting at 6:00 PM, to be re-convened at 8:30 AM the following morning.

Day Two: The Morning Agenda

Report of the E&M code Work Group: Dr. Michael T. Rapp, the PPAC Chair, re-convened the Council at 8:34 AM on Tuesday, March 26, 2002, in the Humphrey Building. The first piece of business was a report from Dr. Wood, PPAC's representative on the Chair of the E&M Work Group, which is a subcommittee of the CPT Editorial Panel. In addition to Dr. Wood (who Chairs the Work Group) the membership includes representatives from the Editorial Panel, the CPT Advisory Committee, CMS, subspecialty members, carrier medical directors, and others.

Mission and principles: Dr. Wood reported that, after extensive discussions and sharing of wide-ranging views, the Work Group agreed on a "very succinct mission statement" that says the Group is committed to "develop [an E&M] coding system that physicians can use to report their services while practicing medicine according to the needs of the patient." The Work Group also agreed on the following principles to underlie a new set of E&M codes:

- The codes "should be easy to understand and [easy to use] by physicians and beneficiaries;
- the [code] definitions should be clinically meaningful and describe clearly differentiated services;
- there should be consistency between [and among] code families;
- the choice of a code should be simple and reflect the physician's total work;
- the system should allow physicians maximum flexibility in demonstrating the level of work involved in the service;
- physicians should not suffer a reduction in reimbursement [because of the] implementation of an improved and simplified [E&M] coding system;
- and the new codes should reflect contemporary medical practice."

First the system, then the guidelines: Dr. Wood indicated that the Work Group would meet again in May, complete its work, and send its conclusions to the parent CPT Editorial Panel. The Panel will then hold a public meeting, probably in August, to discuss the Work Group's conclusions. Additional study will take place before the Panel meets again in November for a final determination on the matter. In any case, said Dr. Wood, "technically, they could go to February and still meet" their deadlines. Responding to Members' questions, Dr. Wood explained that the Work Group is not focusing on the documentation guidelines but rather on the code descriptors, which are "very prescriptive." He said the group wants to "modify the code descriptors so they are less proscriptive. [Hence, the] issue is the coding system [itself]. The documentation guidelines will follow." The Work Group has also "been asked to look at medical decision making and time as two major areas" for study as well.

Physician Fee Schedules

The May to November timetable: The Chair then welcomed Ms. Latesha Walker, Health Insurance Specialist in the CMS Purchasing Policy Group, who reviewed the process by which the annual regulation governing physician fees is drafted and finalized. The process has a tight timeframe, she noted, beginning with the publication of a Notice of Proposed Rulemaking (NPRM) on May 31, a 60-day comment period that ends on July 31, a three-month period for review and revision, the publication of the final rule on November 1, and an effective date of January 1 of the next year.

How to get PPAC's views considered: Mr. Grissom and Drs. Rapp and Rudolf thought

"it might be advantageous to have PPAC participate [in the rulemaking] in a more concrete way." But, Mr. Grissom noted, the law requires that on March 1st the Secretary of HHS must report to the Medicare Payment Advisory Commission (MedPAC) on his or her estimation of the Physician Fee Schedule Update. Dr. Rudolf observed that "PPAC meets in March, and by then most of the decisions about what is going to be included or not included in the [NPRM] have already been made." Therefore, in order to get PPAC's participation, said Dr. Rudolf, "we would need to move [up] the PPAC [March] meeting to early February or mid February ... at the latest."

The March meeting is moved up to February 10: Members wondered why the 60-day comment period wasn't adequate, and Dr. Rudolf explained that the rule regarding physician fees also includes new approaches to "all of the major physician concerns and policy issues ... that we think will improve the functioning of the Physician Fee Schedule, improve the distribution of payment, and things like that. And once we publish those proposals, any individual [or] organization has 60 days ... to tell us what they think. ... However, ... no new issues can be raised by anybody." Dr. Rudolf said it would be very helpful to him, as PPAC's spokesperson within CMS, to have a clear and early statement from the Council regarding fees and other relevant matters that may be incorporated into the annual NPRM on fees. After a brief discussion the Council unanimously approved Monday, February 10, as their first quarterly meeting date in 2003.

Sustainable Growth Rate 2003

The SGR to constrain physician spending: The Chair then welcomed Tom Gustafson, Director of the Purchasing Policy Group within the Center for Medicare Management. He said his group "writes the payment regulations that govern the acute care portion of the Medicare Program, hospitals and physicians, largely." (The Chronic Care Policy Group writes the payment regulations for the skilled nursing facilities, home health, etc.) Mr. Gustafson proceeded to recount "everything you wanted to know but were afraid to ask about how to do physician updates." The key factor in the annual computation is the sustainable growth rate (SGR), which, Mr. Gustafson said, "was designed to ... very explicitly constrain the rate of growth in Medicare physician spending." The SGR, he said, "takes into account physician control over the volume and intensity of services delivered to Medicare beneficiaries."

Physician fees linked to the GDP: The original Medicare law recognized physician fees as being whatever physicians deemed were "reasonable and customary." But between 1970 and 1992, the average annual growth in physician spending was what Mr. Gustafson termed an "eye-catching" 14.5%. Hence, in 1992, a new congressionally mandated Physician Fee Schedule law took effect. That law, as amended over the years, stipulates a number of factors that must go into the government's annual computation update, such as physician-influenced medical costs (lab fees, drug costs, DME rentals, etc.) as found in the Medicare Economic Index (MEI), fee-for-service rates, and the health sector's overall growth factor, which is affected by the nation's Gross Domestic Product (GDP).

"Reasonable and necessary" replaced by SGR: In addition, the "reasonable and customary" approach was scrapped and Medicare was instructed to establish dollar figures for reimbursing services for some 7,000 payment codes. Each code has relative value units (RVUs); a single conversion factor is used as multiplicand for all RVUs; the result is the dollar reimbursement figure for each code. In the aggregate, these dollars multiplied by the codes equals the money that ought to be available for physician reimbursement. However, the system

is no longer open-ended and singularly physician-driven. In its latest adjustment in 1999, said Mr. Gustafson, Congress specifically linked "physician spending in the Medicare program to the overall size of the economy, and as that economy changed, advanced, grew, then physician spending would grow and stay at, roughly, a constant fraction." That, roughly, is the profile of the Sustainable Growth Rate which is used to arrive at the physician fee update each year.

Dollars can also be moved between fiscal years: But there's a further complication, as explained by Mr. John Shatto, the CMS actuarian. Sometimes the projected spending for physician fees may exceed the year's target because of changes in any or all of four factors: fees, beneficiary enrollments, law and regulation, and the GDP. However, in 2001, said Mr. Shatto, the growth in actual Medicare expenditures was "somewhere around 13.5% ... [but there was] virtually no growth in the economy." The two figures were no longer synchronous. When that kind of situation arises, the law allows a "performance adjustment," which permits Medicare to, in effect, borrow forward, reclaiming those overspent physician-fee dollars by cutting back the next year's or subsequent years' funding for physician reimbursements. Today, therefore, Medicare is required to borrow forward in order to make up the asynchronous difference between the 2001 fees and the GDP. The result is the 5.4% reduction in physician fees for 2002. Mr. Shatto added, "We expect the GDP growth in 2002 to be very poor again, and actual [Medicare] expenditures to go up again, so we are projecting the 2003 physician fee update to be ... a negative 5.7%." CMS has also projected a -5.7% in 2004, -2.8% in 2005, and -0.1% in 2006, for a total of 19.7% in compounded decreases over 5 years.

Physician behavior drives expenditures: Mr. Gustafson explained that the computations do reflect "the substantially independent behavior of physicians in their ability to control the allocation of resources throughout the entire system." The Members were especially troubled by the fact that their methods of practice and patient care (writing prescriptions, applying new technologies, calling for lab tests, etc.) are interpreted as the cause of the rise in Medicare expenditures and consequently lead the CMS actuarian to compute a reduction in physician fees. They vigorously objected to the notion that there might be a penalty for directing "patients to the best technology and the best available therapies in medicine today." In other words, delivering quality care would become, to more and more physicians, "not worth the effort."

Is "bedside rationing" the answer?: Members argued that the government would surely not want physicians "deciding whether or not they are going to triage differently to people ... because it might negatively impact their [income]." Members stated flatly that "it would be unethical for us, as physicians ... functioning as [our] patient's advocate, to do the bedside rationing that it would require ... to control that level of volume and, therefore, increase our fees." Mr. Gustafson responded, "I am certainly not going to tell you that this system demands rationing. [But] I would ask you to ... acknowledge that there are some gray areas in terms of some of the services you provide or are asked to provide." Mr. Gustafson then pointed out that the system is designed "to create incentives to perhaps reduce [those] gray areas, and frankly, it is ... explicitly designed to constrain overall physician spending. Whether constraint equals rationing is something I will leave for other parties to say."

Physicians have options, too: The Members asked Mr. Gustafson, as an economist, how he thought physicians might respond when they see "their reimbursements go down and their costs go up." Mr. Gustafson replied, "Standard economic theory says, 'You pay people less, they supply less.' However, ... physicians are not mobile pieces of labor. ... You cannot simply decide with complete freedom to go and choose another career." Members thought that "a lot of very good physicians are going to take a hit on this" and responded that physicians do

have two options that have serious national repercussions: refuse to take more – or any – Medicare patients or leave medicine altogether. In addition, the current system tends to convince young people that the enormous education debt they would incur to become a physician would simply not be worth it. Each of these outcomes, they argued, has a serious negative impact on patient access and the quality of patient care.

Public Testimony

Dr. Davis of the AMA: The Chair then welcomed Ronald M. Davis, MD, of the Board of Trustees of the American Medical Association, who began his remarks with criticism of the "flawed Medicare physician payment update formula." Dr. Davis indicated that CMS's own figures show that, "under the current update system, additional [physician fee] cuts will continue to a total of roughly 20% over four years, and this number is almost 30% in real payment reductions when adjusted for medical inflation. In fact, Medicare payments to physicians will be lower in 2005 than they were in 1993." Noting that "two-thirds of all physician offices are small businesses [which] cannot be sustained [if they] operate at a loss," Dr. Davis said some of the physician-small businesses options would be to lay off staff, stop providing some medical services, stop seeing new Medicare patients, limit or discontinue investments in new technology, move the practice somewhere else, or leave the practice of medicine altogether.

Urge support for the Thomas-Johnson letter to CMS: Dr. Davis then referred to a letter sent on March 21 to CMS Administrator Thomas Scully from Bill Thomas, Chair of the House Ways and Means Committee, and Nancy Johnson, Chair of the Ways and Means Health Subcommittee. The letter urged CMS to take six measures to roll back the current update process:

- Change the measure of physician productivity
- Revise assumed behavioral response of physicians to rate decreases
- Account for other factors affecting physician income, like tax changes
- Adjust for professional liability insurance cost increases
- Account for costs of new benefits
- Correct errors in target expenditures in 1998 and 1999.

The Council asked for copies of the Thomas-Johnson letter for study.

Dr. Nichols of the AOA: The Chair then welcomed Karen Nichols, DO, of the Board of Trustees of the American Osteopathic Association, who said, "Physicians are laying off staff, taking no new Medicare patients, retiring early, and dropping Medicare," as a result of the fee schedule, which, since 1991, she said, has averaged out "to a 1.1% increase in physician's reimbursement per year." She said she was "having increasing difficulties getting my patients in to a subspecialist," a result of low fees that are "making access more and more critical for even my good Medicare paying patients." Despite the evidence presented by CMS thus far, said Dr. Nichols, she declared that "the size of the economy does not have a bearing on my cost of providing patient care. My practice does not buy houses, my practice does not buy cars, my practice does not buy groceries. ... I have been in practice for 17 years. My labor costs have increased over 300 percent, [while] my reimbursement has continued to go down. The gross domestic product is not related to my practice." On behalf of the AOA, Dr. Nichols also asked PPAC to support the recommendations in the Thomas-Johnson letter.

Dr. Bothe of the AAMC: The Chair then welcomed Albert Bothe, Jr., MD, Chair of the Association of American Medical College's Faculty Practice Steering Committee's

Subcommittee on Legislative and Regulatory Issues. Dr. Bothe said the AAMC "supports the replacement of the SGR with a methodology that ensures adequate payment and stable updates for physicians who participate in Medicare." He stated further the "growing disparity between the cost [of providing care to Medicare beneficiaries] and reimbursement will make it increasingly difficult for medical schools and teaching hospitals to maintain their missions of patient care, education, research, and community service." Dr. Bothe added that the issue is "not trivial," since "Medicare reimbursements to academic physicians represent up to one-third of the revenues in academic centers."

After Dr. Bothe's statement, the Chair called for a brief mid-morning break.

What is "physician productivity"?

No way to measure physician productivity: Dr. Rudolf noted that the first recommendation in the Thomas-Johnson letter referred to "physician productivity," a term which had not yet been discussed or defined. He suggested that this be done before the Council moves ahead on recommendations. The Chair agreed and invited Messrs. Gustafson and Shatto back to the witness table. Mr. Shatto began by admitting that "there is no physician productivity measure anywhere that exists, so we are trying to come up with a measure to proxy physician productivity." In order to compute the overall physician update each year, he said, "We currently use labor productivity as a proxy applied to the labor share of the Medicare Expenditure Index [MEI], and the recommendation has been to change to multi-factor productivity."

Do lower fees equal more work?: After further discussion about the relationship between current productivity measures and physician fees, Mr. Shatto admitted that the operating theory in CMS is that "an increase in productivity causes the fee schedule to go down because there will be more services done." He referred to "several studies that have been done [showing] that if prices for physician services are reduced, there will be more volume and intensity of those services ... In other words, if the price is decreased by 1 percent, we are saying 30 percent of that is going to be made up through additional volume or intensity of services." Council Members reacted sharply to that theory, observing that it "clearly cannot go on infinitely ... Your assumption that if you decrease the price, that we will increase our productivity to compensate for that cannot go on for multiple years. There is a limit to how much increase in productivity it is humanly possible to do." The Council indicated that physicians had reached that limit already. Special concern was voiced about the problem in rural areas, where there are few – and each day fewer – physicians in practice to serve minorities and the elderly on Medicare. The reductions in physician fees and the increases in their costs of medical practice, said the Council, raise the possibility of the nation "losing the infrastructure that delivers health care to our elderly patients."

Recommendations of the Council

The following recommendations were proposed and approved by PPAC at the close of its meeting, March 26, 2002:

BENEFICIARY SURVEY (MCBS): The MCBS, as currently devised, does not get at answers to questions that are of major concern. The cost of the survey is high ($12.5 million); hence, PPAC recommends that, instead of further expansion of the survey, the current instrument should focus on indicators of trouble, rather than on broad questions that are answered in similar

fashion year in and year out. As a way of doing this without further costs, CMS should consider partnering with states, counties, professional associations, and others who are also doing surveys and focusing on key issues of access, chronicity, sociocultural factors, etc., in order to generate results with more significance for responding to current needs.

PPAC further recommends that CMS use timely and effective survey research methods to study beneficiary access to care and other service functions. CMS should also partner with specialty medical societies, state departments of health, and other interested agencies and parties who undertake methodologies to survey providers and beneficiaries to study access to care.

HIPAA: PPAC recommends that the proposed HIPAA privacy rules protect minors seeking services related to domestic violence, contraception, and sexually transmitted diseases; that the HIPAA privacy regulations eliminate the business associate provisions that regulate contracts between physician practices and their business associates or, at the very least, limit physician liability as precisely as possible; and that HIPAA privacy regulations be written as narrowly and specifically as possible to limit physician liability to the giving of appropriate notice to patients. (PPAC also notes that the costs of carrying out the HIPAA provisions will be costs added to the Medicare Expenditure Index.)

PHYSICIAN FEES: PPAC recommends with the strongest possible emphasis that CMS support legislation that would

- immediately halt the 5.4% Medicare payment cuts;
- repeal the sustainable growth rate (SGR) system;
- replace the SGR formula with a new system that appropriately reflects increases in practice costs, including changes in patient need for services, changes in technology, and other relevant factors as MedPAC recommends.

PPAC further recommends that CMS accept and adopt the AMA's recommendations to...

- ...use its administrative authority to change the measure of productivity instead of waiting for a directive from Congress;
- ...adjust payments to reflect the recent sharp increases in professional liability insurance premiums;
- ...account for the costs of new covered benefits, including new outpatient drugs covered by Medicare;
- ...correct the errors in the SGR targets for 1998 and 1999, which have already siphoned off $20 billion in Medicare funding for physician services; and
- ...abandon its assumption that volume growth will accelerate if the SGR is repealed.

PPAC also strongly recommends that CMS adopt recommendations from the House Committee on Ways & Means:

- Change the measure of physician productivity.
- Revise the assumed behavioral response of physicians to rate increases.
- Account for other factors affecting physician income, like tax changes.
- Adjust for increases in the costs of professional liability insurance.
- Account for the costs of new benefits.
- Correct the errors in the target expenditures in 1998 and 1999.

PRIT: PPAC recommends that CMS give the Council a timetable for completing action on PRIT's 25 priority issues.

CARRIER RELATIONS: PPAC appreciates the efforts by CMS to strengthen relations between physicians and carriers and recommends that such efforts continue with the active participation of individual PPAC members, such as attendance at the national CMD meeting in August and visits by PPAC members to their own CMDs.

CLAIMS PROCESSING: PPAC recommends that CMS study where, when, and how to reduce variability in claims processing.

MEDICAID: PPAC recommends that a PPAC agenda item be developed to deal productively with Medicaid issues. (Mr. Grissom announced that Dennis Smith, Director of the Medicaid Program and State Operations, is to make a full presentation at the June meeting.)

Further discussion and clarification

Re: HIPAA. Ms. Jody Goldstein of the Civil Rights Division in the Office of General Counsel returned to the witness table to clarify the privacy rule coverage of business associate relationships. "The privacy rule," said Ms. Goldstein, "requires that covered entities, in this case physicians, would have a ... business associate contract with people who are providing services on their behalf and using health information. [The] business associate would provide assurances to the covered entity [i.e., the physician] that [it] will not use the information in a way that would violate the privacy rule [but] would protect the privacy of that information." Ms. Goldstein also indicated that the proposed rule includes "model business associate ... provisions that could be included in a contract ... for covered entities." Council Members were not happy with the rule, however, since it places physicians in the role of "regulating other businesses. If you want to regulate them," said the Members to the Department, "do so, but don't ask me to."

Re: MCBS. Mr. Grissom indicated that the MCBS survey was not designed to deal specifically with the issue of access, but the staff is looking to see how it could be done. Furthermore, he said, "The ratio of doctors to beneficiaries ... has risen every year for the last five years ... from 14 to 16 [physicians] per thousand beneficiaries." Mr. Grissom added that the number of physicians who submit bills to Medicare "has risen from 469,000 five years ago to 489,000 in the last year for which we have data," although he added that "in the last two years, there has been a decline in the total number of doctors enrolled. I don't have an explanation for that, but it has gone down."

Mr. Grissom closed his remarks with gracious words of thanks for the work done by the Members of PPAC. The Chair then adjourned the meeting at noon. The date and place of the next meeting is June 3rd, 2002, in the Baltimore headquarters of CMS.

Possible agenda items for June

During the course of the March 25-26 meeting, the following suggestions were made for topics to be included on the agenda of the forthcoming June 3rd meeting in Baltimore:

- Dr. Rudolf promised "some kind of follow up at the June meeting" regarding the revisions of the ABN.
- Dr. Rudolf suggested that PPAC might want to discuss the guidelines for teaching physician documentation at the June meeting.
- The Council asked that time be set aside on the June agenda to discuss Medicaid in general and "discrepancies" between Medicaid and Medicare rules and fees in particular. Dennis Smith, Director of the Medicaid Program and State Operations, is to make a full presentation at the June meeting.
- Since the questions for the next (fall 2002) MCBS iteration will be finalized in July, PPAC might want to offer questions and/or review suggested questions, particularly regarding the issue of access, at its June meeting.
- Carrier medical directors have been asked to invite PPAC members to visit their offices. Dr. Rudolf suggested that Members might want to report on their visits either at the June or September meeting.
- Carriers have been instructed to tell physicians if they've undercoded and are being underpaid. Members asked for more information about this instruction at the June meeting.

Respectfully submitted,
Ted Cron, Rapporteur

[HEADING]

The Honorable Tommy Thompson
Secretary
Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

Dear Secretary Thompson:

I am pleased to submit to you Report Number Thirty-Nine of the Practicing Physicians Advisory Council (PPAC). This Report summarizes the deliberations held on March 25-26, 2002, in Room 800 of the Humphrey Building. We were joined at this meeting by four new Members, who immediately made important contributions to the Council's deliberations.

We had a packed agenda of topics and issues to discuss, but I believe we spent the most time and intellectual energy on the issue of the 5.4% reduction in physician fees this year and the continued reductions that CMS has estimated for Calendar Years 2003, 2004, 2005, and 2006. Such reductions will result in nearly 20% in physician fee decreases over the 5-year period. Council Members were especially disturbed to hear that increased physician productivity will actually help bring about these lowered fees. In addition, the mathematical formulae used by CMS lead one to conclude that physician fees can be raised only if physicians engage in "bedside rationing" of therapies and services, a concept that flies in the face of the ethics of the medical profession. We respectfully urge you to review this extraordinary situation to see if physicians and Medicare beneficiaries alike can be shielded from such punitive calculations.

Despite the attention given to this matter, let me assure you that the Council remains totally committed to working with you and the personnel of the Department to attain the most equitable, efficient, and cost-effective Medicare program possible for America's most vulnerable citizens.

Sincerely yours,

Michael T. Rapp, MD
Chair
Practicing Physicians Advisory Council

Enclosed: PPAC Report Number Thirty-Nine