REPORT NUMBER FORTY

to the

SECRETARY

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

(Re: Patient Access, Medicaid, EMTALA, HIPAA Standards,

E&M Documentation Guidelines, PRIT, GPCI,

ABNs, Reimbursement for "Shared Visits,"

and other matters)

From the
Practicing Physicians Advisory Council
(PPAC)
For June 3, 2002

PPAC Members at the June 3, 2002, Meeting

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

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

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Amilu S. Rothammer, MD
General Surgery
Colorado Springs, Colorado

Victor Vela, MD
Family Practice
San Antonio, Texas

Douglas L. Wood, MD
Cardiologist
Rochester, Minnesota

CMS Staff at the June 3, 2002, Meeting

Thomas A. Scully
Administrator, CMS

Thomas R. Barker, Esq.
Office of the Administrator, CMS

Tom Grissom, Director
Center for Medicare Management, CMS

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

David C. Clark, RPH, Director
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Denis Garrison, Director
Division of Consumer Protection
Center for Beneficiary Services

Elizabeth Holland
HIPAA Project Staff
Office of Operations Management

Renee Mentnech, Director
Division of Beneficiary Research

Dennis Smith, Director
Center for Medicaid State Operations

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

Frank Eppig, Deputy Director
Information and Methods Group
Office of Research, Development, and Information

Dana Trevas, Rapporteur

Public Witness:

Albert Bothe Jr., MD, Chair of the Association of American Medical Colleges' Faculty Practice Steering Committee's Subcommittee on Legislative and Regulatory Issues.

Morning Agenda of the Meeting of June 3, 2002

The meeting of the Practicing Physicians Advisory Council (PPAC) was held at the CMS headquarters in Baltimore, MD. The Chair, Dr. Michael T. Rapp, called the meeting to order at 8:41 AM, Monday, June 3. Dr. Rapp thanked the Members of the Council for their participation and advice and thanked the CMS staff for their ongoing efforts. He then introduced Mr. Thomas Grissom, Director of the Center for Medicare Management, who outlined the agenda for the day.

Nominations for Council Membership: Mr. Grissom noted that four Council positions will be available for 2003; of those four Members, two are eligible for reappointment. In September, DHHS will be accepting nominations for Members submitted by other Members or by the public. Dr. Paul Rudolf, Executive Director for PPAC, added that a notice about nominations would be published in the *Federal Register* this summer. Before the next meeting, the staff hopes to develop a comprehensive package of background and orientation materials for new Members.

March meeting moved to February: Dr. Rudolf also advised the Council that its first meeting of 2003 was moved to February to allow more time for the Council to make recommendations and changes to proposed reimbursement rules for 2004 before they are released for public comment.

FOLLOW-UP ON PREVIOUS ISSUES

"Boutique" medical practices: Dr. Rudolf said a guidance document regarding "boutique" medical practices was sent to the regional administrative offices in March to enable those offices to handle inquiries. (The American Medical Association is also addressing the issue.) Mr. Grissom also noted that the information regarding boutique practices was extrapolated from a general survey of beneficiaries, which was presented to the Council at the last meeting.

HIPAA privacy rule: A final rule on the privacy requirements of the Health Insurance Portability and Accountability Act (HIPAA) of 1996 is expected to be published this summer. The staff is presently organizing the more than 10,000 comments it received on the issue and will update the Council in September.

Reimbursement decreases: The CMS staff is still working with Secretary Thompson on a reply to the Council regarding the Council's December 2001 recommendations for preventing reimbursement cuts to Medicare providers. Dr. Rudolf noted there have been significant changes to the Federal budget since those recommendations were made.

PRIT update: Because Dr. Barbara Paul has moved from the Physicians Regulatory Issues Team (PRIT) to another position at CMS, some items on the PRIT agenda have not yet been finalized: e.g., supplies for home glucose testing. Mr. Bill Rogers, Dr. Paul's successor, will update the Council in September on the various PRIT initiatives.

Cancer denials?: Dr. Rudolf noted that the PRIT staff, as a priority matter, is investigating allegations that individuals with a personal history of cancer are being denied Medicare services. Thus far, a survey of carriers has yielded no evidence of a policy of such denials. Mr. Rogers will continue to evaluate the situation. Dr. Rudolf asked Council Members and others with knowledge of services inappropriately denied for cancer patients to contact the CMS staff with those specific examples. However, he said, "The evidence just doesn't show a widespread problem." He also said CMS staff is leery of sending out a guidance document on the matter, because such documents sometimes can create more problems than they resolve.

Members to Attend Carriers Meeting: Dr. Rudolf pointed out that local medical review policies (LMRPs) and variability in coverage among carriers were not on the agenda for this meeting but would be included on the agenda for September. He reminded Members that carrier medical directors (CMDs) would be meeting in August and had set aside 2 hours for meeting with PPAC Members. Dr. Rapp will appoint those Members who will go to the August CMD meeting with an agenda of PPAC concerns. All Members should communicate with their local CMDs, he suggested, and pass their concerns on to those who will be attending the August meeting.

MEASURING PATIENT ACCESS TO MEDICARE PROVIDERS

Focus on patient access to care: Dan Waldo and Frank Eppig, Director and Deputy Director, respectively, of the Information and Methods Group of the CMS Office of Research Development and Information, described how their office is tracking beneficiaries' access to physicians, particularly in the wake of reduced physician reimbursements. In response to questions raised by the Council at the March meeting, the Medicare Current Beneficiary Survey (MCBS) was revised to address some more specific concerns, such as the most common barriers to access.

Case loads, density, etc.: Other efforts of the Information and Methods Group include measuring the following, calculated on the basis of billing data currently available for 1995 through 2000:

- The number of physicians per county who bill Medicare
- The patient case load per physician (using fee-for-service claims data)
- Physician density: i.e., the number of billing physicians per 1,000 Medicare fee-for-service beneficiaries, by county
- Dollar volume: i.e., payments per billing physician and per fee-for-service beneficiary.

National trends from local data: With the aid of an accelerated data input process, Mr. Waldo and his colleagues hope to have 2001 data available this summer and data from the first 6 months of 2002 by September. Their goal is to produce semi-annual and annual reports and to spot national trends in access by looking closely at local problems. Currently they are gathering such information not only at the national level but from counties as well. They are also using focus groups and other techniques to identify areas for more targeted surveys. In addition, a toll-free number is available for beneficiaries to relay complaints or problems related to access; these are then tracked by the staff. Renee Mentnech, Director of the Division of Beneficiary Research, said her staff hopes that the rising volume of calls – plus the collaboration of regional offices, beneficiary groups, and others – may help point the way to more targeted surveys in the future. Meanwhile, the staff hopes to produce reports on access in specific regions.

What about access to specialties?: The Council complained that the CMS surveys only look at access to physicians in general and do not identify specialties, sub-specialties, or specific services to which access may be dwindling, even though some data on access to specific services are already available on a statewide basis. Members said the situation was becoming serious, especially with regard to such specialties as thoracic and cardiac surgeons. Mr. Waldo agreed that the MCBS does not now address specific specialties, but he hopes the targeted surveys planned for the future will do so. Ms. Mentnech added that the scope of the survey effort is

being expanded to look at services provided at the county level. The assessments by regional offices should also help identify specific access problems at the local level, she said.

Access to quality is the issue: But the Council Members pressed the staff on the question of patients having access not just to anybody but "having access to people whom I think are the best." The CMS surveys, they said, do not deal with the quality issue at all. Members also noted that in routine practice situations, patients may have access but only to lower-level services (and a lower level of quality) at the hands of non-physician providers within the group. The Council also suggested that CMS take the next step and attempt to understand (perhaps through the MCBS) how beneficiaries respond when they do not have access: that is, to whom do they turn for help finding a physician or getting care. Despite these criticisms, the Council in general indicated its support for the agency's efforts to survey beneficiaries regarding access to providers and care.

Recommendations:

- The toll-free phone number and Website address for Medicare information and complaints should be included on all beneficiaries' identification/plan information cards.
- In future surveys of beneficiaries regarding access, the surveyors ought to look at access to services by specialty to determine if barriers exist between or within specific specialties.
- The Information and Methods Group responsible for surveying beneficiaries should partner with medical specialty societies, physician groups, and other state organizations as appropriate to gather more specific data as to precisely who provides care through Medicare, as presented by Dr. Wood in his report from the Secretary's Advisory Committee.

ADMINISTRATOR SEEKS COUNCIL'S VIEWS ON ACCESS

Additional thoughts on access: Thomas A. Scully, Administrator of CMS, joined the meeting and asked for Members' thoughts on whether Medicare has a significant physician access problem. Council Members cited their difficulties trying to help patients find primary care physicians who will take Medicare. They also reported that some private groups are even recommending that physicians not only limit the number of Medicare patients they accept but also refer to hospitals those Medicare patients who need chemotherapy. It was felt that oncology might soon be an area with major access problems.

Drug costs and physician fees: Mr. Scully pointed out that Medicare has a history of overpaying for drugs and underpaying for other services. The Council wondered if maybe physicians are being punished for high pharmaceutical costs through the current reimbursement formula. Mr. Scully responded that prescription drugs, use of laboratories, etc., are essentially physician-driven; hence, Congress felt the only way to control those costs was to include them in the computations for physician reimbursement. He also noted that the Bush administration wants to provide benefits for the uninsured and prescription drug coverage for Medicare beneficiaries.

Fee cuts and budget "neutrality": Mr. Scully said he and the Secretary are seeking ways to improve the Department's reimbursement record, agreeing that the physician payment formula requires revision. If the Council believes there should be change, it should make specific recommendations for the Secretary's consideration. The Council raised the "budget neutrality"

issue, arguing that it was unreasonable to reduce physician fees in order to achieve budget neutrality in the midst of rising medical costs. But the system is not truly "neutral," Mr. Scully replied, pointing out that the 5.4 percent cut in physician reimbursement about to take effect is actually a correction to years of overpayment that occurred because of a "massive inadvertent error compounded by some quirky statutory language." Mr. Scully said his agency was "spending $260 billion of taxpayer dollars, and we should be giving people the absolute best care," although he did acknowledge that the government may be guilty of "not spending enough in the right places, and ... spending too much in the wrong places."

Variations among states: Members also noted that the fee cuts were especially hard on physicians in poorer states. Mr. Scully agreed on the need to update the geographic practice cost index (GPCI) and reported that some states are complaining that they're being penalized for efficiency: that is, they provide better care with fewer surgeries and, as a result, receive less money. Here again, Mr. Scully asked the Council to make specific recommendations for changes to the Secretary.

EMTALA REFORMS AND PROPOSED CLARIFICATIONS

Common-sense solutions: After the departure of the Administrator, the Chair welcomed Thomas R. Barker, Esq., of the Office of the Administrator, to explain the proposed reforms to the Emergency Medical Treatment and Active Labor Act (EMTALA) of 1986. These reforms, Mr. Barker said, were made in an effort to provide common-sense solutions to the confusion and antagonism surrounding the application of EMTALA regulations. He also noted that the regulations apply not only to hospital emergency departments but also to clinics that provide urgent or emergency care. Mr. Barker noted, for example, that many managed care plans require preauthorization for a patient to be admitted to the hospital, even though such a requirement is not permitted under current EMTALA regulations. He said he believed the new language would also help providers and carriers understand specifically when EMTALA does *not* apply, and he described several of those situations. The Council commended Mr. Barker and his colleagues for the proposed changes to the EMTALA regulations.

Rules for on-call physicians and multiple casualties: However, some Members were still concerned about the effect of the regulations upon physicians on call. They noted certain areas of confusion that may lead to significant access barriers. For example, is it acceptable for an on-call physician to see patients in his or her office or perform surgery while on call? And may a physician be on call at only one hospital at a time? Mr. Barker promised that an interpretation of these and other issues will be addressed in the guidance that accompanies the reform regulations. He said that EMTALA provisions applying to psychiatric patients were not addressed in these revisions, but may be addressed later. The Council also urged that further thought be given to the application of EMTALA rules in the event of an accident involving multiple casualties. It was noted that the Centers for Disease Control and Prevention will soon provide guidelines for hospitals caring for victims of bioterrorism, but the Council was less concerned with that than with multiple-car accidents. Members felt that issue should be addressed in future revisions of the regulations.

EMTALA and peer review: Dr. Wood reported that the Secretary's Advisory Committee recommended modifying enforcement procedures for EMTALA by making peer review mandatory early in the process and less open to discovery later. But Mr. Barker

responded that some cases might bypass CMS completely and the plaintiffs could have access to peer review proceedings anyway. Mr. Barker agreed the recommendation was helpful, and the Council asked Dr. Wood to provide more information on the matter at the September meeting.

What does "stabilized" mean? What is "property"? The Council discussed proposed language that would require a hospital to contact the patient's managed care plan once the patient is "stabilized." Mr. Barker agreed that "stabilized" carries a meaning different in the law than in medicine. After much discussion, the Council agreed that because the new language is related to payment and not to patient care, it should be deleted from the proposed reforms. Dr. Wood also reported that the Secretary's Advisory Committee recommended that CMS clearly define the phrase "come to the emergency department" and the term "hospital property." Mr. Barker thought his office would need to consider the issue further because there is such a wide range of interpretations. He closed his presentation by noting that comments on the proposed reforms will be accepted until July 8, 2002. The new regulations will be published on August 1, 2002, and will take effect on October 1, 2002.

Recommendations:

· The following language should be added to the proposed revisions to the on-call EMTALA regulations: "Physicians are not required to restrict their activity while on call solely to cover their on-call responsibility. EMTALA does not prohibit, for example, doctors being in the operating room while on call, being on call simultaneously at more than one hospital, or tending to other responsibilities of their practice while on call."

· The statement on Medicare+Choice should be deleted from the proposed revisions to the regulations for EMTALA (item [6] on page 31507 of the *Federal Register*, vol. 67, no. 90, May 9, 2002), as it relates to reimbursement and not treatment.

· The following language should be added to the current proposed revisions to the regulations for EMTALA: "EMTALA does not apply to patients coming to the emergency department to obtain previously scheduled or follow-up care." (This recommendation is intended to obviate the need for someone in the emergency department to screen patients coming in for scheduled or follow-up care in order to determine that such patients do not have an emergency condition.)

· The Council supports the recommendation of the Secretary's Advisory Committee (as presented by Dr. Wood) that the current proposed revisions to the EMTALA regulations limit the term "hospital property" to mean the emergency department or a clinic that holds itself forth to the public as a place to obtain emergency care.

· The Council supports the recommendation of the Secretary's Advisory Committee to create an Emergency Services Cooperative Project to address such issues as reimbursement mechanisms for EMTALA-related services for uninsured patients.

· Regarding the Secretary's Advisory Committee's recommendation to modify enforcement procedures for EMTALA by making peer review mandatory early in the process, the Council asks that Dr. Wood provide more information on models of enforcement at an upcoming meeting. However, the Council also recommends that the EMTALA regulations include a mechanism to insulate peer review from later discoverability in the context of EMTALA.

· The EMTALA regulations should be further revised in the future to include the following concept: Compliance with preestablished community protocols for triage, treatment, and distribution of patients during a declared multi-casualty incident (as predefined by community needs) does not violate EMTALA. The Council agreed to consider how best to word such a statement to prevent hospitals from misusing the regulation to avoid treating Medicare patients.

EVALUATION & MANAGEMENT WORK GROUP UPDATE
Dr. Wood, who chairs the AMA's CPT (Current Procedural Terminology) Task Force, provided an update on the progress of the work group addressing evaluation and management (E&M) codes. The work group expects to have recommendations for the AMA's CPT editorial panel in August. Dr. Wood believes the recommendations will satisfactorily address concerns raised by CMS (as well as physicians).

UPDATE ON ADVANCE BENEFICIARY NOTICES
Awaiting the nod from OMB: Denis Garrison, Director of the Division of Consumer Protection in the Center for Beneficiary Services, gave a brief update on the status of Advance Beneficiary Notices (ABNs). He said the ABN-X form, which listed exclusions, was withdrawn and replaced by a document available online. The American Dental Association worked with the CMS staff to develop a version of the ABN-X applicable to dentistry. Mr. Garrison suggested that Council Members might consider whether their own specialties had unique exclusions that should be clarified as well. Mr. Garrison further noted that existing guidelines will be revised, and he welcomed any further suggestions. Meanwhile, he reported that CMS is awaiting approval from the Office of Management and Budget on the ABN general form, the ABN laboratory form, and the instructions for beneficiaries. The instructions for providers have been approved. Hence, CMS hopes to implement the revised ABNs as of October 1, 2002. Members complimented Mr. Garrison for his and his staff's cooperation in revising the ABNs.

PRESENTATION BY AAMC
Comments on documentation guidelines: The Chair welcomed Albert Bothe Jr., MD, Chair of the Association of American Medical Colleges' Faculty Practice Steering Committee's Subcommittee on Legislative and Regulatory Issues. Dr. Bothe referred to the recommendation of the Regulatory Reform Committee to eliminate the documentation guidelines that clarify how E&M codes should be applied. While opposing the elimination of the guidelines, he also said, "(I) can't overstate the importance of having a common understanding of whatever new rules or regulations might emerge (among) the CMS staff who interpret the law, the program integrity group, ... (the) OIG staff who perform the audits, and the physicians who are held accountable for following those rules, whether they're clear or not." He asked that all relevant CMS personnel review the revisions to the E&M codes. "Physicians actually code on a somewhat intuitive basis or code by their gut, but it would be unsettling if auditors audited on their gut," said Dr. Bothe.

UPDATE ON HIPAA'S NATIONAL STANDARDS
Help available by phone and online: Elizabeth Holland, of the HIPAA Project Staff in the Office of Operations Management, spoke about the mandate to establish national standards for

Electronic Health Care Transactions and Code Sets. Organizations are required to comply with the standards by October 16, 2002. Over 12,000 compliance plans have already been submitted. Ms. Holland believes many organizations are applying for 1-year extensions because they're concerned they may be excluded from Medicare if they don't comply. After October 16, 2003, CMS will not accept paper reimbursement claims, except from small provider groups. Ms. Holland said that applications for extensions and more information on compliance are available online and on videotape; her office is also establishing a telephone hot-line to answer compliance questions. CMS is seeking suggestions on how to enforce the law without creating burdens on providers or raising new barriers to care for patients.

Questions about exemptions: The Council felt that it should be made clear that small provider groups that are exempt from compliance with the mandates do not need to file requests for extensions. Members also asked whether doctors who are independent contractors but whose billing and other paperwork is managed by a hospital or group practice are exempt from submitting compliance plans. Ms. Holland said "it depends..."; however, if several independent doctors are covered under one compliance plan with one individual overseeing the implementation of the plan, it may only be necessary to submit one plan or one request for an extension. Also unclear is whether small provider groups are exempt from compliance between October 16, 2002, and October 16, 2003.

Recommendation:

· Although the Secretary has the authority to exclude from the Medicare program anyone who does not either comply with the new HIPAA standards by October 16, 2002, or file a formal request for extension by that time, the Secretary should *not exclude* from the Medicare program *anyone who would not be required to comply with the standards in the first place.*

UPDATE ON BILLING RULES

Concerns raised about "shared visits": Terry Kay, Director of the Division of Practitioner and Ambulatory Care, addressed the issue of reimbursement for "split visits" or "shared visits": i.e., E&M services provided jointly by a physician and non-physician, such as a physician assistant. Currently, each provider bills separately in a hospital setting, but both bill jointly in an office setting. To streamline billing procedures, CMS has proposed language that would allow one provider to bill for a split visit. If a physician sees the patient in person during an E&M split visit, either provider may bill for both; but if the physician does *not* see the patient, the visit must be billed by the non-physician. Dr. Rudolf pointed out the revision applies only to E&M visits and not to clinical care. In response to Council questions regarding rules for E&M billing in nursing homes, Mr. Kay said that nursing homes have different coding and billing rules. However, he promised to study the matter to determine if further clarification were needed in the proposed language. Mr. Kay also noted that the proposed changes in the physician fee schedule would be published soon, to be followed by a 60-day comment period. The final rule will be published in November, to take effect in January 2003.

Recommendation:

· The Council endorsed the language proposed by Mr. Kay to revise the rules regarding reimbursements for split or shared evaluation and management (E&M) visits.

REVIEW OF THE GPCI

Differences between relative and actual, urban and rural: The Council returned to the matter of the geographic practice cost index, or GPCI, and asked Mr. Kay to explain how it was calculated. He said the GPCI reflects relative differences in the cost of providing care among areas, while the Medicare economic index, or MEI, reflects the actual costs of care. Mr. Kay reported that urban providers complain that the GPCI does not take into sufficient account their higher costs of providing care, while rural providers complain that physician practice expenses, for example, are similar everywhere and, therefore, all physicians should receive equal increases in reimbursement. The current method of calculation is an attempt at compromise. Mr. Kay believes, however, that the GPCI formula will be revised in 2004 anyway, if updated census data are available.

Concern about state differences: The Council raised several questions with regard to intrastate matters. For example, could a state possibly have different GPCIs for different regions as opposed to using one GPCI for the whole state? Mr. Kay suggested that a state medical society and other state medical groups propose an answer for CMS to study. Members also complained that the agency's formula for physician work punishes providers in poorer states with lower fees and salaries. Mr. Kay said his office "did sort of a comprehensive review of every possible data source we could think of to try to find any kind of national level data that would be available in all the different localities that we could use to reflect the cost of physician practice. And frankly there was nothing. We couldn't find any." The Council was nevertheless unhappy with the way the GPCI formula accounts for physician work and also how variations in costs are calculated (such as differences in rent and overhead expenses). The Members asked Mr. Kay to provide more details in time for the September meeting, if possible.

Recommendation:

· The appropriate CMS staff should evaluate the GPCI in order to 1) determine what the impact would be of using a formula of 0.75 of the national index instead of 0.25, and 2) consider how to revise the index to include costs more specific to medical practice.

MEDICAID: BLOSSOMING OR BELEAGUERED?

"Federal dollars follow state dollars": The Chair next welcomed Dennis Smith, Director of the Center for Medicaid State Operations, who gave an overview of the program. Mr. Smith explained that each state decides how much it wants to pay for various services and goods; it must then commit its funds in order to be eligible for Federal matching funds. Hence, "Federal dollars follow state dollars," he said. The Medicaid program is always growing, he noted, and constraints on the program are aimed at slowing that rate of growth, not eliminating services. Mr. Smith also reported on new developments in state administrations of Medicaid:

· For example, many states are updating their Medicaid information systems.
· More Medicaid programs now allow families to apply online or over the phone.
· A number of states presume eligibility to speed up processing.

- Many states no longer base eligibility solely on income.
- To decrease paperwork, Virginia reduced its 16-page application to two pages.

Different views on physician participation: Mr. Smith indicated that in states with barriers to access to Medicaid providers, there are barriers to access to providers for the general population, also; hence, the problem of access is not always specific to Medicaid. However, his Center does monitor access carefully, he said. But Council Members took exception with his generally positive picture of physician participation. Several felt Medicaid programs were unresponsive to providers and reimbursed them poorly. As a result, they saw physician participation as extremely low (only 3 of 31 pediatricians in one community; only one urologist in a five-county area, etc.).

Members raise a range of issues: Mr. Smith agreed that Medicaid does not sufficiently support primary and preventive care to counter the costs of hospitalization, but he said his office is working on the issue. Members, however, went on to raise the following issues as well:

- Young uninsured adult men were not covered by Medicaid, which is "unconscionable." (Mr. Smith said the administration is encouraging states to expand Medicaid programs to cover the uninsured.)
- Medicaid patients were more likely even than uninsured patients to use a hospital emergency department as their usual source of care.
- Budget increases for Medicaid do not yield increases in physician reimbursements but rather pay for higher administrative costs. Members requested a national breakdown of costs and payments to show where the money is going and who is profiting.
- The government was not adequately enforcing the provisions in the 1989 Medicaid amendments that call for equal access to providers across all ethnic, geographic, and socioeconomic populations.

To be continued: Mr. Smith had to leave the meeting but agreed to come to another meeting to discuss Medicaid further; the Council agreed that it would like to continue to review the Medicaid program. Mr. Grissom said he would review the Council's charter to see if and how the Council can comment on Medicaid issues. Meanwhile, Mr. David Clark, RPh, Director of the Office of Professional Relations, said CMS is working with the Department's Health Resources and Services Administration (HRSA) to schedule an open meeting on patient access under Medicaid. He will notify the Council when the meeting is scheduled in case any Members want to attend.

Recommendations:

- The Council feels that Medicaid beneficiaries face significant access problems, and it would like to explore the issue in more detail. The Council asks that more information be provided on the following areas of particular interest and that Mr. Dennis Smith or another representative of the Medicaid program speak about them at the September meeting:
  - Federal government's methods and tools to enforce the law on access within states (the equal access provision of the 1989 Omnibus act)
  - Current available data on access to Medicaid

- Current available data on fee-for-service vs. managed care plans under Medicaid
- The financial impact on Medicaid of moving from fee-for-service to managed care.

FINAL WRAP-UP

Mr. Grissom agreed to a Council request that the issue grid sent to Members before meetings include updates on issues discussed by the Council in the previous 6 months. Mr. Grissom also reported that the Medicare program was forced to reduce its provider education budget and may therefore put one of its quarterly bulletins online. (Two Members said they had already been affected by such education cuts.) Mr. Grissom agreed to discuss the matter at the next Council meeting, September 23-24, 2002 (in Baltimore or Washington, DC).

Respectfully submitted,
Dana Trevas
Rapporteur

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 Forty of the Practicing Physicians Advisory Council (PPAC). This Report summarizes the deliberations held on June 3, 2002, at the Baltimore CMS headquarters. Administrator Tom Scully was able to meet with us for a short while and we found his information to be very helpful. He also reiterated his and your interest in improving the methodology for computing physician reimbursement rates. Please be assured that our Council stands ready to help in any way we can to resolve the inequities in the current system.

We discussed many issues of great concern to physicians. However, most of our deliberative time was spent on the patient-centered issue of access to care, which we believe is a paramount issue for Medicare and Medicaid beneficiaries. We urged the CMS staff to generate more specific data about this issue, so that we and the Department might work together to resolve some of the problems related to access to care. We understand that the President and the Administration are as concerned as we are with making progress on this issue, and we fully support any efforts made in this regard.

Again, 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 Forty