REPORT NUMBER FORTY-ONE

to the

Secretary

U.S. Department of Health and Human Services

(Re: Role of the CMD, Self-Administered Drug Policy,
PRIT Update, BIPA 522, LMRP Variations,
Medicaid Access, HIPAA Compliance and Privacy,
Dear Doctor Letter, Physician Fee Schedules,
MEI, SGR, GPCIs, Medicare & Prevention,
and other matters)

From the
Practicing Physicians Advisory Council
(PPAC)
For September 23-24, 2002

Draft

Attendees at the September 23-24, 2002, Meeting

Members of the Council:

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

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

Richard A. Bronfman, MD
Podiatric Physician
Little Rock, Arkansas

Ronald Castellanos, MD
Urologist
Cape Coral, Florida

Rebecca Gaughan, MD*
Otolaryngologist
Olathe, Kansas

Joseph Heyman, MD
Obstetrician/Gynecologist
West Newbury, Massachusetts

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

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

Christopher Leggett, MD
Cardiologist
Atlanta, Georgia

Dale Lervick, OD
Optometrist
Lakewood, Colorado

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

Angelyn L. Moultrie-Lizana, DO*
Family Practitioner
Artesia, California

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

Victor Vela, MD*
Family Practice
San Antonio, Texas

Douglas L. Wood, MD
Cardiologist
Rochester, Minnesota

*** Absent**

DHHS and CMS Staff Present at the September 23-24, 2002, Meeting

Thomas Grissom, Director
Center for Medicare Management (CMM)

Paul Rudolf, MD, JD,
Executive Director, PPAC, CMM

David C. Clark, RPH, Director
Office of Professional Relations, CMM

Richard Chambers, Director
Family and Children's Health Programs
Group Center for Medicaid State Operations

Melanie Combs
Acting Senior Technical Advisor
Program Integrity Group

Laurie Feinberg, MD
Medical Officer, CMM

Kathleen Fyffe, Senior Advisor
HIPAA Privacy Outreach
Office Civil Rights, DHHS

Jodi Goldstein, Attorney
Office of the General Counsel, DHHS

Catherine Gordon, RN, MBA, Director
Health Promotion & Disease Prevention

Valerie Hart, Director
Division of Provider Education and Training
Provider Communications Group, CMM

Marc Hartstein
Health Insurance Specialist
Division of Practitioner Services, CMM

Stephen Heffler, Deputy Director
National Health Statistics Group
Office of the Actuary

Hugh Hill, MD, Acting Director
Office of Program Integrity

Elizabeth Holland
HIPAA Project Staff, CMS

Terry Kay, Director
Division of Practitioner Services, CMM

Angela Mason, MS, JD
Health Insurance Specialist, CMM

William Rogers, MD
Medical Advisor to the Administrator

John Shatto, Actuary
Office of the Actuary

Don Thompson, Director
Division of Ambulatory Services, CMM

Sean Tunis, MD
Acting Chief Clinical Officer

Robert Ulikowski, Analyst
Division of Practitioner Services, CMM

Jerry Zelinger, MD, Medical Advisor
Family and Children's Health Programs
Group Center for Medicaid State Operations

Ted Cron, Rapporteur

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Public Witnesses:

Albert Bothe, MD, Association of American Medical Colleges
Larry Clark, MD, Carrier Medical Director, Trail Blazer, Inc.
Leslie B. Freed, Esq, Director, Medicare Advocacy Project, Alzheimer's Association
Myron Goldsmith, MD, medical oncologist, Huntington Beach, California
Kay Jewell, the Tara Center
Julia Pillsbury, MD, FAAP, American Academy of Pediatrics
William G. Plested III, MD, Chair-elect of the Board of Trustees, American Medical Association
Sally Trude, PhD, Senior Health Researcher, Center for Studying Health System Change
Charles A. Welch, MD, President, Massachusetts Medical Society

MORNING AGENDA FOR SEPTEMBER 23, 2002

Reminder on nominations: The 41st 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 8:40 am. He then introduced Mr. Tom Grissom, Director of the Center for Medicare Management, CMS, who reviewed the meeting's agenda and recounted some of the agency's activities since the Council's June meeting. Mr. Grissom also introduced William Rogers, MD, Medical Advisor to the CMS Administrator, who would present to the Council later in the morning. Mr. Grissom also reminded PPAC and the meeting's observers that there were four openings coming up on the Council and nominations were being received up to September 30 (two nominations may be of current Members).

The grids should go public: Dr. Paul Rudolf, the Council's Executive Director, then reviewed the updated grid, which includes topics and action items going back 18 months, rather than many years. He described the "closed list" of topics that had been discussed by PPAC in the past and were not open for discussion at the present time; however, he added that a topic may be "presented here [as] closed, although it will be recurring" on later Council agendas, such as Dear Doctor Letters, the SGR (Sustainable Growth Rate), etc. The suggestion was made that the grid cover a two-year span of interest rather than only 18 months and the document be available not only to the Council but to the public at the next and subsequent meetings. The Chair, however, urged Members to consult the PPAC Website, read meeting minutes, and in other ways stay current on CMS issues, emphasizing that "we should get an update about at least what happened at the last meeting and what has been done." It was noted that the current EMTALA proposed rule reflects PPAC recommendations, but that issue is not "closed" but will come up again at the Council's winter or spring meetings.

E&M progress "quite good": PPAC Member Douglas Wood, MD, then presented an update on his work group's progress with the E&M codes in order to "develop a system that works without guidelines." The CPT editorial panel has accepted the group's proposals thus far, he said, and is moving forward "with the aid of an initial set of clinical examples to test some working hypotheses about work equivalence." He reported that "we are on track, our progress has been quite good," and anticipates that the new CPT edition for 2004 "would have the new E&M codes and introductory paragraphs in place." Dr. Wood was not sure if PPAC could critique the work group's clinical examples before publication; that would be decided by the editorial panel.

CMD FOLLOWUP

PPAC meets with CMDs: PPAC Member Joseph Heyman, MD, reported on the carrier medical directors' (CMDs) meeting. He said "it was an excellent opportunity for us" (i.e., PPAC Members Heyman, Castellanos, and Gaughan), and that the CMDs "felt it was a pretty good opportunity for them, too," for exchanging views. (Hugh Hill, MD, Acting Director of the Office of Program Integrity, agreed with that assessment.) Dr. Rudolf added that the participants at the CMD meeting made the following recommendations:

- "that CMS should fund physician education adequately...";
- that PPAC members "on an ongoing basis or a rotating basis" go to more CMD meetings;
- that CMDs come to PPAC meetings ("someone is going to have to fund that");

· that there be "one carrier medical director per state or per X number of physicians"; and
· that local medical review policies (LMRPs) that might no longer be effective be retired.

However, Dr. Heyman said he didn't receive "a clear message ... from the carrier medical directors" on any of the recommendations.

Better CMDs, not more of them: Members debated the issue of the ratio of CMDs to MDs and generally agreed that "knowledgeable and effective" CMDs were more important than some assurance of one per state or per X number of physicians. Members also emphasized the need for CMDs to make a better effort at knowing the local physicians in their service areas. The Council wondered how CMS dealt with CMDs; Dr. Rudolf responded that the task was shared by three agency groups, "the quality people, the program integrity people, and the provider education people." The Chair suggested that it might be appropriate for a new PPAC subcommittee to focus on the role and character of the CMD.

PPAC recommends: After some discussion, the Council endorsed the following recommendations:

· That CMS expand its funding for physician education, in light of the decline in the number of CMDs and the decreases in carrier physician education budgets;
· That Members of PPAC go to more CMD meetings; that CMDs be invited to attend PPAC meetings on a rotational basis.
· That PPAC establish a subcommittee to explore ways in which physicians and CMDs can work better together on behalf of quality, cost-effective patient care.

SELF-ADMINISTERED DRUG POLICY DEBATED

"Not usually" is the new twist: The Chair next welcomed Angela Mason, MS, JD, Health Insurance Specialist, Laurie Feinberg, MD, Medical Officer, and Don Thompson, Director of the Division of Ambulatory Services, all in the Center for Medicare Management, to update PPAC on the Medicare payment policies and the agency's Program Memorandum (PM) AB02072, issued on May 15, 2002, entitled Medicare Payment for Drugs and Biologicals Furnished Incident to a Physician Service. This PM covers "drugs provided incident to a physician service and not usually self-administered by the patients who took them." (The older language of the laws referred to drugs "which cannot be self-administered.") The PM says if a drug is self-administered by more than 50 percent of Medicare beneficiaries, it is excluded from Medicare coverage. Hence, the issue is no longer simply the way a drug is labeled but how the drug is actually used (or "not usually" used) by patients and providers.

Where is the list?: CMS does not now publish a list of excluded drugs but relies on the carriers to do so; some Members thought that such reliance on CMD discretion could would lead to state-by-state differences and discrimination. Mr. Grissom indicated that CMS does intend to publish semiannually (April and October) the carriers' drug lists so that we can have "what is available out there for everyone to see and for us to manage." The Council had many questions about the drug policy, especially as it applies to patients who are not physically or mentally able to self-administer the drugs on the carriers' lists and about the administration of covered drugs in the patient's home. Dr. Feinberg reiterated that the agency's task is not to regulate patients but drugs, as instructed by the law; however, in the absence of good information, she said, "We have to have presumptions because we can't know everything [that] is happening or not happening in the patient's home" or in the physician's office.

Concern for disabled patients: The Council also expressed its concern that the methodology behind the PM eliminated large numbers and groups of patients who, because of a physical or mental impairment, will never be able to self-administer a drug that is not covered under the new law. The Council also was concerned that the effect of this PM may result in differences in drug coverage based upon region and thus discriminate against beneficiaries.

Should not be "drug-by-drug": The Chair welcomed Leslie B. Freed, Esq, Director of the Medicare Advocacy Project of the Alzheimer's Disease and Related Disorders Association, Inc. Ms. Freed said the PM in effect "instructs contractors to make coverage determinations on a drug-by-drug rather than beneficiary-by-beneficiary basis" which "clearly disadvantages persons with Alzheimer's disease and other degenerative illnesses, who — especially in advanced stages of illnesses — experience difficulty self-injecting drugs."

Cancer patients are disadvantaged: The next witness was Myron Goldsmith, MD, a medical oncologist from Huntington Beach, California. Dr. Goldsmith said that "the PM assumes — evidence to the contrary — drugs delivered by subcutaneous injection should be presumed to be self-administered by the patient and [therefore] not be covered by Medicare. This assumption, as mentioned, is blatantly erroneous and opposite the intent of HR-106-1019." Dr. Goldsmith noted that some injectable anti-cancer agents "meet patient preference for outpatient care and lower costs," but are outside the PM limits for reimbursement, according to the LMRPs of a number of states.

PPAC recommends: After considerable discussion, the Members unanimously agreed to the following recommendation:

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

MID-MORNING BREAK

PRIT UPDATE

The "Open Door" is working: After the mid-morning break, the Chair welcomed William Rogers, MD, Special Assistant to the CMS administrator and Director of the Physicians Regulatory Issues Team (PRIT), to update the Council on that program. Dr. Rogers spoke proudly of the Administrator's Open Door initiative, directed by Ruben King-Shaw. "We have 11 open doors," he reported. " We have a physician open door, we have Allied Healthcare, long-term care, and so everybody we pay in the Medicare program has an open door that they can call into monthly and air their problems, get some things solved," and get answers to their questions.

Review of the 25 issues: Dr. Rogers then turned to the list of 25 issues, developed by his predecessor, Dr. Barbara Paul:

- "We suspended the publication of the ... carrier bulletin because of lack of funds, [but it] is, of course, available on line...";
- "The provider education department has committed staff and a lot of time ..."

- "We have not been able to find any cases where people are having coverage problems ... for follow-up for cancer care...";
- He said the agency has been "working on simplifying the OASIS form," adding that "there have been recent clarifications on the homebound definition ...";
- "The program memorandum released on the 31st of July I think effectively addressed the issues that we have with the PM -- I mean, with the Medicare Summary Notices ...";
- Regarding the restraint issue, a final rule has not yet been released. Dr. Rogers said, "The major issue for providers was the one-hour face-to-face requirement, which I think — as a practicing emergency physician — is excessive, and hopefully, that ... will be solved when the final statement comes out";
- He said the agency now has a simplified form for physician enrollment, and carriers have to process 90 percent of applications within 60 days, and 99 percent have to be processed within 120 days";
- "I am not going to say anything more about E&M codes; Dr. Wood had that well in hand...";
- CMS was asked by the American Academy of Family Physicians if it would allow DME suppliers to fill in Section B of the Certificate of Medical Necessity (CMN), [but] it is written into the law that the physician or provider fill in Part B of the CMN...";
- As for concurrent care, Dr. Rogers said it was possible for a family physician to get paid for visiting a patient who had been hospitalized for care by another service, "as long as we don't have two claims filed on the same day by the same specialty ...";
- The contract funds for an assessment of the clinical environment are going to be reallocated within provider education to fund HIPPA education and other critically important outreach.
- A contract has been written to develop "a database of Local Medical Review Policies, national policies, and frequently asked questions" which will go online;
- Dr. Rogers could not comment on the proposed EMTALA regulations since the comment period has ended and they are in final approval but he did reassure the committee that the revision effectively addresses a number of concerns that providers have with the current regulations
- He noted the Administrator's concern for paying for new and expensive drugs and devices for Medicare beneficiaries;
- Dr. Rogers finished by quickly touching on a number of "high profile issues," such as documentation guidelines, the much-discussed drug benefit, quality management of physicians' practices, HIPAA, the 5.4 percent cut in the physician fee update ("The word is out there that this really is a problem with the law, not a problem with CMS"), "the falling participation rate," and the bringing on of the Program Safeguard Contractors (PSCs), "whose sole function is going to be to monitor the charges ... submitted by providers and to look for evidence of fraud ..."

How much does fraud and abuse cost?: The Council requested clarification on a number of points. For example, would the PSCs improve the fairness quotient in error rate computations? Melanie Combs, Acting Senior Technical Advisor in the Program Integrity Group, replied, noting that "moving to the PSCs isn't going to have any impact on the issues that you raised about the error rate." How much are we spending on fraud and abuse, versus how much are we getting back as a result of those investigations? Dr. Rogers said that would be hard

to answer, "because so much of it is ... preventing people from doing [wrong] things that they might do, if it weren't for the program." (One Council Member recalled that PPAC had been told several years ago that HCFA staff were "getting seven dollars back for every dollar they put into fraud and abuse, and I think that was over the spectrum of all providers...")

LMRPs, LCDs, and BIPA 522

The introduction of the LCD: The Chair then welcomed Ms. Combs to the witness table again to discuss the LMRP reconsideration process, and the upcoming LCD appeal process established by Section 522 of the Benefits Improvement and Protection Act of 2000 (BIPA 2000). The law created a new term — LCD, for local coverage determination; i.e., the reasonable and necessary portion of a Local medical Review Policy— and a new appeal process for both national coverage determinations (NCDs, done by CMS) and LCDs. A Notice of Proposed Rulemaking (NPRM) for Section 522 was published August 22; the comment period was to close October 21. Ms. Combs explained the LCD concept and the appeal for LCDs. "This is not a process for providers, this is not a process for manufacturers," she said. "This is a process ... for beneficiaries in need." She went on to explain, that most (90 percent) of LMRPs deal with "reasonable and necessary" issues; hence, will be considered LCD's.

For whose benefit?: The Council wondered if any beneficiaries would actually have the time or the money to engage in the proposed process, which is long and complicated, a point with which Ms. Combs agreed. She added that CMS itself rather hopes that beneficiaries and providers would use the simpler LMRP reconsideration process, rather than the complex and clumsy LCD appeal process. Under BIPA 522 LCD appeal process after a hearing and a decision by an administrative law judge (ALJ), an aggrieved party could then appeal through the Department of Health and Human Services and on through the federal courts. The process under the new law is long and complex; however, Ms. Combs said, Congress provided "no funding ... in BIPA 522 for anyone." With this and other comments in kind, the Council Members "could not figure out anybody for whom this [process] is going to be practical."

PPAC recommends: After a great deal of discussion, the Members approved the following recommendations with regard to the proposed appeal process:

- If there is an ALJ decision for coverage relief for a beneficiary, that the carriers should not be allowed the option of later reaffirming something that had earlier been found to be inadequate.
- That CMS eliminate the mandatory instruction to ALJs to order a stay in the proceedings, if a contractor requests one to consider new evidence.

BREAK FOR LUNCH

AFTERNOON AGENDA, SEPTEMBER 23, 2002

MEDICAID ACCESS ISSUES

Answers to four questions: After the luncheon recess the Chair welcomed Richard Chambers, the Director of Family and Children's Health Programs Group in the Center for Medicaid State Operations, and Dr. Jerry Zelinger, medical advisor in the same group. Mr. Chambers indicated

that his group was "responsible for all family and children's Medicaid issues" and, in that capacity, was responding to PPAC's four questions:

27. How does the Federal Government enforce the "equal access" provision [Section 1902 (a)(30)(A)] in the Omnibus Budget Reconciliation Act of 1989 (OBRA '89)?

Mr. Chambers replied that the 10 CMS regional offices "work with the states in a very collaborative and non-confrontational manner" to address such issues as reimbursement rates and provider participation rates "in order to meet that access requirement." He also noted that 57 percent of Medicaid beneficiaries are in managed care; those contracts, he said, require the states "to monitor that there [are] adequate networks of providers to meet the requirements of the services ... provided under those contracts." Mr. Chambers said that when states "originally agreed to participate in Medicaid and [submitted] their original state plan," they gave assurances they would meet all "federal statutory requirements." "But short of that," he admitted, "There is no oversight."

28. What current data are available regarding access to services in Medicaid?

Mr. Chambers replied that "CMS does not specifically collect data on access." However, in order to respond to PPAC's question, CMS did carry out "an informal survey of our regions," receiving responses from 6 regional offices covering 34 state Medicaid programs. Mr. Chambers reviewed those responses, noting especially the increase in managed care plans, the efforts by some states to initiate physician incentives, the general problem of health care access in rural areas, and the specific issue of beneficiaries' access not so much to primary care physicians but to such specialty providers as dentists and mental health professionals. The Council added that Medicaid-eligible children with mental health problems are frequently admitted to and "held for days in the emergency room setting because there was no psychiatric care available that could take care of those children. In the richest nation on earth, this is not acceptable."

3. and 4. What does CMS know about issues surrounding the movement from fee-for-service to managed care plans under Medicaid?

Council Members recounted experiences in their states, in which administration costs have risen from about 5 percent of total costs under fee-for-service to "probably on the order of 12 to 15 percent" under managed care. Mr. Chambers agreed that "that is something to be addressed at the local level as those contracts get renewed ... and how they have to be adjusted, if necessary." The Council felt that CMS needs better accountability from the states as to how and where the Medicaid dollar is spent. That, however, is primarily a legislative issue for the Congress.

Pediatrician testifies: The Chair then welcomed Julia Pillsbury, MD, FAAP, who spoke on behalf of the American Academy of Pediatrics (AAP). Dr. Pillsbury said, "The Medicaid reimbursement [rate] is about 64 percent of the Medicare rates, and this rate is decreasing over time. In 1993, it was 75 percent of Medicare rates." Nevertheless, she said, "pediatricians are very committed to providing care for children," noting that "89 percent of [all] pediatricians in direct patient care participate in the Medicaid program ..." However, she also said that "we are seeing a decrease in the number of pediatricians who are able to participate in Medicaid. Over half of the pediatricians reported that Medicaid fails to cover their overhead expenses." Dr. Pillsbury also said the AAP had sent a letter in March 2001 to Penny Thompson, the Acting Director of the Center for Medicaid and State Operations, giving "detailed suggestions for the enforcement of the ['equal access'] provision through measurement of provider participation, children's enrollment, continuity of care, and children's receipt of services." However, the AAP has never received a reply. Dr. Pillsbury also asked PPAC to "urge Secretary Thompson to

create a National Medicaid Payment Advisory Commission to address the many physician payment issues related to the Medicaid program."

Testimony from Mass. Medical Society: The Chair then welcomed Charles A. Welch, MD, President of the Massachusetts Medical Society, who presented his Society's data on the physician workforce in Massachusetts and how it has been adversely affected by poor Medicaid administration and declining Medicaid reimbursements. He spoke of the crisis looming with regard to the shrinking physician workforce. Dr. Welch said that physicians "are not selectively dropping out of Medicaid, they are just getting out of medicine altogether." He asserted that "it is time to fundamentally reinvent Medicaid. We do not think that it can possibly fulfill its mission in the current model." The Council asked CMS staff if the Federal Government had any authority to influence the levels of Medicaid reimbursements so that they come closer to Medicare rates. Mr. Chambers replied, "No, because ... the way the program was initially designed, [reimbursements] would be an issue the states would address ..."

PPAC recommends: After the testimony by the public witnesses, the Council drafted the following recommendations:

- To the extent possible under the law, that CMS enforce the "equal access" provision of the Social Security Act, as amended by OBRA '89.
- That HHS Secretary Tommy Thompson be urged to create a National Medicaid Payment Advisory Commission.
- That CMS work with states to accurately measure the Medicaid participation rates of private primary care physicians, pediatricians, family physicians, and obstetricians and the levels of access to these providers by Medicaid beneficiaries.
- That CMS report in a future PPAC meeting on the kinds of mechanisms they will be using in partnership with the states to measure the rates and degrees of Medicaid participation and access.
- That CMS explore whether it can request the states to publish their Medicaid reimbursement rates on an annual basis.

HIPAA COMPLIANCE UPDATE

Almost 200,000 extension requests came in: The Chair next welcomed Elizabeth Holland, of the HIPAA Project Staff in the Centers for Medicare and Medicaid Services. Ms. Holland told the Council that her office has been receiving a very high volume of application forms for one-year extensions of the October 15, 2002, deadline for compliance with the electronic and code set requirements of HIPAA. The volume of applications (made possible under the Administrative Simplification Compliance Act) has risen drastically, she said. "We have now received over 185,000 electronically and over 13,000 by paper. We ... receive over 6,500 per day on weekdays and about 1,500 per day on weekends." Ms. Holland repeated the rule that, as of October 16, 2003, "Medicare will not accept paper claims; however, there will be exceptions for small providers ... who have offices with [fewer] than 10 full-time equivalents" who file paper claims. "We have not issued those guidelines yet, [but] if you only bill by paper, there is no reason you need to file for an extension." She described her office's full-scale education effort involving meetings, roundtables, e-mails, 800-numbers, a step-by-step videotape, and other mechanisms to respond to physician inquiries. (Council Members asked for the e-mail address and 800-number, also.) As for the security aspects of HIPAA, Ms. Holland said that CMS "expects to publish a

final rule either later this year or early next year, ... so we are looking at 2005" for the final rules on security to be in place.

Cost of compliance: The Council noted that CMS asks physicians what they expect to pay in order to comply with the HIPAA requirements. The Council said, "It would be very much appreciated if the folks working on HIPAA could communicate with the folks who are working on the Sustainable Growth Rate formula to say, please include the increased financial requirements of these laws that we must comply with."

VACCINE CODES

Concern about a new HIPAA code: The Chair welcomed Kay Jewell, a former CMS staff person and now representing the Tara Center. Ms. Jewell asked the Council to recommend that HIPAA "adopt the AMA CPT codes as the standard for biologics and not create a new system .... As well, I would like to ask that you urge CMS not to implement the local codes for Hepatitis B at this time. It is contrary to the goals of HIPAA to create duplicate codes, and it is not simplification, and it does not make things easier for the other payers or providers. And also, to urge CMS that they work with the AMA CPT panel to address their concerns about the existing codes, and to work with organizations with expertise in vaccinations ..."

PPAC declines to get involved: There was no CMS staff person immediately available to discuss this request and, therefore, the Council declined to act. Later in the day, Dr. Laurie Feinberg returned to respond, but Dr. Jewell was absent and the Chair ruled that "this was a very kind of narrowly drawn issue that we weren't particularly focused on today, so given that, it would require us to do a lot more work than I think we are prepared to do on that, and we won't take any action or make any recommendation."

HIPAA PRIVACY RULE

Physicians' offices are "covered entities": The Chair next welcomed Kathleen Fyffe, the Senior Advisor for HIPAA Privacy Outreach in the Office of Civil Rights, and Jodi Goldstein, an attorney with the Office of Civil Rights and Office of the General Counsel. Ms. Fyffe reviewed the history of the privacy rule, noting that the final version was published on August 14th and is effective as of April 14, 2003, or, for smaller providers and health plans, April 14, 2004. Ms. Fyffe explained that the rule "covers three categories of covered entities: healthcare providers who transmit health information in electronic transactions ... such as claims; ...health plans and healthcare clearing houses; and 'business associates,'... agents or contractors ... hired to do the work on behalf of a covered entity..." Mss. Fyffe and Goldstein reviewed the rule's common-sense requirements with regard to safeguarding patient information in healthcare marketing and research. They proceeded to explain these other aspects as well:

- The rule's "minimum necessary standard," which permits the transmission of only the minimum patient information necessary for activities such as billing or admissions.
- As for changing a medical record at the patient's request, Members raised the issue of liability: "We are all told by our liability carriers that we don't change records." They responded that the rule "does not require anything to ever be crossed out of a record or to be written in the margins, ... or in any way destroy the integrity of the medical record." The change can be added "in the back of the record or an additional piece of paper added

to the record or an additional electronic field added to the record." (Members suggested that the Office of Civil Rights "have input from the Physician's Insurance Association of America.")

- The rule now includes language that says "state law or other applicable law would govern" in matters involving parents and minors, a specific PPAC recommendation.
- A physician "can choose not to recognize a parent as the personal representative of the minor, if [the physician is] concerned about abuse or harm to the child."
- The rule does permit disclosure of one patient's private health information, if it is necessary for the treatment of another patient: for example, informing one partner that the other partner has been diagnosed with a sexually transmitted disease.
- Members asked if they could legally give patient information to one of many national and statewide tumor registries, usually run by universities or other public institutions with National Cancer Institute funding. Ms. Fyffe was not sure and agreed to get an answer for the Council.
- The rule requires a physician's office to have a range of privacy-related services and rules: someone designated as the privacy policy person, written policies and procedures describing how protected health information — and patient complaints — will be handled, employee training, sanctions applied to employees who violate privacy policies, and so on.
- An office that does no electronic billing, does no electronic coordination of benefits, or any other electronic transactions, but only moves paper, such an office is not covered by the Privacy Rule. But if a physician "uses an agent, such as a billing company or a billing service, to do those electronic transactions for them," it is covered. Also, once you do one electronic transaction, you are covered form then on.

The Office of Civil Rights is developing educational materials dealing with these and other aspects of the final rule. They will be posted on the Web and shared with PPAC. In answer to another Council concern, Ms. Fyffe said, "There is no validation program or certification program for [privacy] consultants," adding that "you should not have to spend thousands of dollars, especially in physician practices, to implement the HIPAA Privacy Rule."

PPAC recommends: The Council agreed without discussion to make the following recommendation:

- That we support and encourage CMS to continue its efforts to provide simple and easy-to-understand guidance regarding the HIPAA privacy regulation implementation.

PHYSICIAN FEE SCHEDULE UPDATE

Issues for the MEI and the SGR: The Chair then welcomed Stephen Heffler, Deputy Director of the National Health Statistics Group in the Office of the Actuary; Marc Hartstein, Health Insurance Specialist in the Division of Practitioner Services; and John Shatto, Actuary in the Office of the Actuary. The trio briefed the Council on "two issues today specific to the June 28th Notice of Proposed Rule Making": a proposed change for the productivity adjustment in the Medicare Economic Index (MEI) and accounting for drug fee increases in the SGR. Mr. Heffler gave a brief history of the MEI and said the proposed change in the June NPRM would "still use a ten-year moving average and still use economy-wide productivity, but use a multi-factor productivity index that explicitly takes into account changes in both labor inputs as well as non-

labor inputs." The change uses only historical data but "no forecasted data of productivity." Based on these assumptions, he said, "We proposed in the proposed rule a 3.0 percent increase in the MEI ....for 2003"

Updates and Targets: Mr. Hartstein then described how the MEI is used in computing the Sustainable Growth Rate (SGR). The MEI, he said, is the first element of a formula that produces the Physician Fee Schedule Update. The Update "is either increased or decreased, based on how expenditures compare to a target. The target is sometimes referred to as the Sustainable Growth Rate." If expenditures exceed the target, he said, the Update is less than the MEI; but if expenditures are less than the target, then the Update is more than the MEI. The "target," said Mr. Hartstein, "is a cumulative target, which means that we measure expenditures over a period of time, starting in 1997. In 1997, [the law] required us to set the target equal to actual expenditures...", "later targets are equal to target expenditures in the previous year, updated by a percentage amount. That percentage amount is the sustainable growth rate." For the years 2001, 2002, and 2003, the SGR is determined by four factors:

- a weighted average of the percentage price increases of physician and laboratory fees and drug prices,
- the percentage increase in Medicare Fee for Service enrollment,
- growth in real per capita, gross domestic product, and
- any increase or decrease in expenditures that result from changes in law or regulations.

Concern about including drug prices: The Council expressed serious misgivings about the role played by drug prices. If drug prices go up, they said, but a physician's volume of service remains stable or even declines, "we could still get penalized because there was a significant increase in drug costs." Mr. Hartstein replied that "drugs are still a relatively small part of the target, even though they are growing rapidly." Including drug price growth "really has no effect on the Physician Fee Schedule Update for 2003," but he agreed that "accounting for drug price increases will have more of an effect in the future."

Drugs' "negative impact": Members pressed the matter, however, noting that more sophisticated drugs coming through the pipeline are going to be used more frequently in the interest of quality patient care and those drugs will be more expensive and "that would have a potentially negative impact on reimbursement for physician services." Mr. Shatto replied, "All things being equal, that is correct." Members decried the ethical dilemma of deciding to correctly prescribe a new and expensive drug for a patient, even though "it causes problems in the [update] formula."

Testimony from the AAMC: The Chair next welcomed Albert Bothe, MD, speaking on behalf of the Association of American Medical Colleges (AAMC). Dr. Bothe welcomed the agency's proposed increase of the MEI's professional liability insurance component by 11 percent, although "this is only a fraction of the increases in professional liability insurance costs that most physicians are seeing in this country."

PPAC recommends: Without much more deliberation, the Council approved then following recommendations:

- That CMS do everything possible to help mitigate the decrease in physician fees by actions such as, but not be limited to, removing drug pricing from the sustainable growth rate; including a factor for the increased regulatory burden imposed by HIPAA, E&M compliance, et cetera; obtaining an accurate assessment of the effects of professional liability insurance increases on physician fees, reimbursement, and expenses; correcting

the underestimate of the growth in the GDP in previous years that has resulted in reduced physician compensation; correcting and clarifying the estimate of the number of Medicare beneficiaries who move from managed care contracts back into fee-for-service; and recognizing that an increase in physician productivity is not much of an option anymore, since most physicians have about reached their productivity limits already.

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

LMRP VARIATIONS

Too many variations?: The Chair then welcomed Sean Tunis, MD, Acting Chief Clinical Officer for CMS; Larry Clark, MD, Carrier Medical Director for Trail Blazer, Inc.; and Melanie Combs. Ms. Combs began by recalling that "Congress designed the Medicare program to be decentralized in terms of most coverage decisions." Hence, the growth of Local Medical Review Policies written by carriers in response to the identification of "a significant risk to the trust fund." However, Ms. Combs said the agency has also "undertaken a number of efforts to decrease the variations in Local Medical Review Policy. We encourage our contractor medical directors to meet nationally and regionally [and] allow our CMDs to form clinical work groups, where they produce template LMRPs." Also, as of April 1999, CMS is able to initiate the development of National Coverage Decisions (NCDs), which may incorporate the best features of many carriers' LMRPs regarding a particular issue. While some Members wondered if so many different LMRPs were needed, other Members noted that "there may be some very good local medical reasons why there is one area that needs a procedure or a policy that another area doesn't need at all." Some Members also indicated that, at a minimum, it would be useful to "automatically sunset" each LMRP every four years, requiring an evaluation of their usefulness or having them immediately retired.

When is an NCD needed?: Dr. Tunis noted that "national coverage decisions (NCDs) and local coverage decisions (LCDs) are built on the reasonable and necessary language ... in the Social Security Act." "Reasonable and necessary," in turn, is assessed by "evidence-based medicine." Although many physicians would prefer more NCDs and fewer LMRPs, Dr. Tunis said they are "an extremely potent tool ... to be used judiciously and they are not appropriate for every circumstance." He agreed that NCDs might be appropriate for covering wound healing technologies or defibrillators. However, Dr. Tunis admitted that "right now, we have something of a ... haphazard mechanism for reconsidering [LMRPs]. Basically ... it is the squeaky wheels that get attention and we address those on an ad hoc basis, and it would probably make sense to think about a more formal and coherent way of looking at local and national policy."

The CMD view: Dr. Clark shared with the Council these four guidelines he has found useful for deciding whether an LMRP is worth keeping or not:

- "When you have an opportunity to simplify what you are dealing with, go through it and find out what you are no longer using, what has become accepted standards of care, which claims can go right through and which claims don't need to be audited, and get all of that waste out of the way.
- "When claims are denied, it is important to meet with people and find out why the claims are denied.

- "Whenever possible, the contractor should have consistency between Part A and Part B policies."
- Dr. Clark also urged physicians to be actively involved with their Carrier Advisory Committee and CMD, "making sure that Part A is polled in all of your states, and pointing out where the inconsistencies occur in coverage. It can really make a difference."

Going from 950 to 800: But the elimination process is still complex and costly. Dr. Clark recounted that Trail Blazer had retired 150 LMRPs — but still had 800 local policies left in eight states. Dr. Rudolf added that the Trail Blazer experience is evidence that "transitioning to national coverage would put an unbelievable burden on the system," which has close to 9,000 LMRPs in effect nationwide. Dr. Tunis responded, however, that "anyone can request a national coverage decision" and that there was "no impediment" preventing the practicing physician community from "nominating topics that ought to be considered at the national level." Members raised the issue of the difficulty of national professional organizations being able to mount strongly credible continuing medical education programs in light of the "extreme variations and the number of the LMRPs that seem to be region-to-region."

A one-stop LMRP source: Members noted that carrier Websites with their LMRPs were "a mishmash" and not terribly helpful, which prompted Ms. Combs to announce that the "Medicare coverage database ... where all the local policies will be found" will be "coming soon at a Website near you."

After a few remarks concerning Dr. Jewell's presentation on vaccine codes (see above), the first day's meeting was adjourned.

MORNING AGENDA FOR SEPTEMBER 24, 2002

PROVIDER EDUCATION FUNDING

What to do about the Bulletin: The Chair called the meeting to order at 8:45 am. He welcomed to the witness table Ms. Valerie Hart, Director of the Division of Provider Education and Training in the Provider Communications Group in CMM. Ms. Hart reported that CMS, faced with a funding shortfall for the last quarter of FY2002, told its contractors to develop but not to print and mail the fourth quarter Contractor Provider Bulletin. Printing and mailing of the Bulletin will resume in the first quarter of FY2003, however. Ms. Hart also reported the Bulletin's costs of printing and postage absorbs "a significant amount" of $44 million for provider education; hence, she said the agency is looking for ways to publish and disseminate the Bulletin other than in hard copy.

Internet or the trash?: Members suggested, again, that CMS explore partnerships with professional journals, such as JAMA, partnering with such organizations as the Medical Group Management Association, and putting an electronic version of the Bulletin on the Internet. As for the mailing costs, it was suggested that recipients be given the option of unsubscribing, since so many copies end up at the "billing service for 200 doctors, and it all goes in the trash." The Council urged CMS not to be too hasty in converting the Bulletin to an online publication, since "a lot of practitioners out there want to file paper claims, and people are stuck in their ways," so "it's going to have to be a slow transition."

CMDs and third-year residents: Members mentioned that face-to-face meetings with their CMDs is often the best way to get the latest information concerning Medicare. Ms. Hart went on to describe other activities of the Provider Communications Group established by Tom Grissom within the Center for Medicare Management. They include an upgrade of the CMS Website (with help from the AMA) and a comprehensive Medicare resident and new physician training program, including "a manual, a video, and Web-based training course [sent] out to teaching hospitals ... to third-year residents to let them know what the Medicare program is all about. And it's been rather successful."

PPAC recommends: The Council focused on the Bulletin problems and made the following recommendation:

- That CMS should continue to provide this information printed on paper, but CMD should also continue its search for publication alternatives, such as an electronic version delivered at the option of the receiving practitioner or the possible use of free or modestly priced space in professional association journals.

BENEFICIARY ACCESS TO PHYSICIAN SERVICES

Access trends are all down: The Chair next welcomed Sally Trude, PhD, Senior Health Researcher at the Center for Studying Health System Change (HSC), a private organization which conducts national surveys of households and physicians. Dr. Trude emphasized that the surveys are of a "nationally representative sample, but a clustered sample on 60 sites because the whole idea is to look at markets." Dr. Trude reported the following findings:

- "We found throughout [the most recent surveys] trends across all the measures towards poorer access." She added that the situation is worsening not only for Medicare seniors age 65 and over but also for the non-Medicare elderly (persons age 50-64) and older persons privately insured. "We also see these trends when we look at the whole Medicare population and the whole privately insured population."
- As for delays exceeding one week to get an illness appointment, "again we see [downtrends] trends that are occurring for both the private and Medicare seniors."
- "When we look at physicians accepting all new Medicare and private patients, we see declines for both populations."
- "We also looked at ... physicians' acceptance of new patients by specialty, and the sharpest decline occurred for the surgical specialists, going from 82 percent to 73 percent. It's still a higher percentage of acceptance than primary care [now down to 62 percent], but that was the sharpest decline."
- "About three out of four of the privately insured and ... elderly are waiting more than a week for an appointment" with a specialist.

Some follow-up concerns: The Council Members, in turn, raised several questions, including the following:

- They wondered how the survey numbers "balanced out." For example, if specialists are taking fewer new patients, they should be treating fewer patients and, therefore, there should be shorter wait times to get in. Dr. Trude replied that the one-week and three-week cut-offs were "fairly artificial," and that it's possible that "the ones that need to get in within a day are getting in within a day, and the ones that can be postponed are being postponed."

- Members also asked if HSC could identify the "multitude of factors in the market place" that may produce these access and practice restraints. Dr. Trude replied that HSC "can look at comparisons between private insurance and Medicare, but we're ... stuck when we [try] to explain what the causes of the capacity constraints are. So we can sort of just use our data to say there's a problem."
- The Council wondered if HSC's methodology could help the profession understand "the confounding factor of patient choice in the access issue." Dr. Trude said HSC asked people in its household survey "what they would prefer, lower cost or more provider choice, and we find people out on either extreme equally." Thus far, government policies have focused on the beneficiaries who want more choice, "but I suspect as the costs go up, they'll start focusing on the ones who would prefer lower costs."
- It was suggested that "to figure out patient access you'll need to know the physician to population ratios or the specialist to population ratios."
- Members wondered "if in your methodology you could compare the regional reimbursement variations as compared to beneficiary access."
- The Council also encouraged HSC to look "not just at the total physician number but physician work hours because ... it's decreasing, and that means fewer patients are going to be seen per physician."
- Members also emphasized that "we're still taking care of people who have an acute immediate problem. It's the sub-acute [and chronic] problems that can wait..."
- As to the cry for more physician productivity, Members countered that "there is no more room for increased production.... In previous years we could work another hour. There aren't any more hours. So we're starting to see that [physicians] are just plain full and will make room for acutely ill patients because they're professionals, and that's what they're supposed to do, or they'll manage to make room for the new patients who have the better paying insurances."

The Council had no specific recommendations for Dr. Trude.

More data on reduced access: The Chair then welcomed William G. Plested III, MD, the Chair-elect of the AMA Board of Trustees. Dr. Plested said that decreasing reimbursement rates are discouraging physicians from taking Medicare patients and, therefore, are also exacerbating the access issue. Dr. Plested referred to surveys by the AMA, the Medicare Rights Center, and the American Academy of Family Physicians showing that more physicians are opting out of Medicare service and more "Medicare beneficiaries ... are already having trouble finding a physician who accepts new Medicare patients." He also spoke of "disturbing trends in state Medicaid programs that indicate an even greater access crisis." Ranging over other matters as well, Dr Plested said the AMA "appreciated yesterday's unanimous vote by the Council urging the Secretary and CMS to exercise their authority to remove drugs from the SGR pool." He asked the Council to urge CMS to "evaluate the impact on utilization and spending resulting from all national coverage decisions issued during the last several years. " Dr. Plested also said, "It is imperative that CMS make a much higher priority of the issue of funding for physician education."

In response to Dr. Plested's remarks, it was suggested the PPAC take up the issue of budget neutrality at some future meeting.

MORE DISCUSSION OF THE SGR

What happened to our recommendations?: The Council expressed some frustration that its earlier recommendations for re-computing the SGR and in support of legislation to reverse the 5.4 percent fee decrease have not been acted on. Dr. Rudolf indicated that CMS cannot legally change the computing of the SGR and the legislation that was mentioned is no longer on the table in the House. Council Members, however, were not satisfied. They said they knew the SGR is mandated by Congress and leaves little discretion to CMS. But they repeated their belief that "the SGR is not an appropriate index the way it's put together at this time. And we want to know if CMS agrees with that and are they willing to go before Congress and .... tell them ... that this is not appropriate..." Mr. Grissom recalled the Council's requests last year and agreed that it "deserved a written response, and you didn't get it," although events in the Congress and in rulemaking had made much of the discussion moot. In this regard, Mr. Grissom was asked if the Council's recommendation that CMS drop prescription drug prices from the SGR formula was something the agency could do; he said it was.

Which productivity factor should be used?: Members also did not feel that yesterday's presentations by the actuaries dealt satisfactorily with those matters either. Still at issue was the method of factoring productivity. The question was raised, "What would be the impact if you changed the formula to show only the economy-wide gain in productivity, and what would be the impact if you changed the formula to show only the gain in physician productivity, and you eliminated the economy-wide productivity. Neither of those options were demonstrated."

A letter will go to the Administrator: At this point, Mr. Grissom suggested that the Council draft "a very short correspondence to the Administrator raising questions about double counting productivity and expressing the Council's opinion that it is being double-counted, that's inappropriate, and asking for consideration in the final rule. And that can be done in a day or two, and then in our December meeting make sure that the actuaries return. I think the rule will have been published by then, and then we can at least have an explanation of it." The Members unanimously agreed to the idea and instructed Drs. Rapp and Wood to compose such a letter.

Better data on the December agenda: Members were still interested in seeing if there were ways to more accurately estimate actual physician productivity and actual medical practice expenses and using such data for both the MEI and SGR formulas. The Council agreed that the issue was important enough to be included on the agenda of the next meeting in December with the actuaries returning to the witness table with possibly some additional comments solicited from the specialty societies.

FUTURE TRENDS AND ACTIVITIES IN PREVENTION AND HEALTH PROMOTION

The Chair next welcomed Catherine Gordon, RN, MBA, Director of the Health Promotion & Disease Prevention in CMS. Ms. Gordon listed "the four big challenges that we're worried about in this area of prevention and Medicare":

- Helping people stay well systematically and comprehensively
- Helping people live well with chronic illness
- Minimizing the rate of growth in health care costs
- Incorporating into Medicare what works in the field of health promotion and disease prevention

Ms. Gordon said that "70 percent of what happens to us as we age is attributable to lifestyle and behavior and about 30 percent is to genetics," and lifestyle behaviors can be improved. She also noted that "70 percent of all of our medical care spending goes for things that could be prevented."

Time to think about paying for it: Ms. Gordon referred to an Institute of Medicine report on prevention and health promotion that urged more attention to "interventions that stress self-efficacy and social support" and encouraged more experimentation with reimbursement and coverage to support health promotion and disease prevention. She recalled the fact that Medicare was created in 1965 primarily to pay doctor and hospital bills for America's aged and "the statute explicitly excludes prevention" from being a covered service. But the scene is changing: Ms. Gordon noted that Congress has, over the last ten years, permitted such preventive services as immunizations, mammography, Pap tests, colon cancer screening, bone densitometry, prostate cancer screening, diabetes self-management education, and glaucoma screening.

Smoking cessation works: Ms. Gordon recalled that HCFA had initiated several years ago an "evidence-based center on healthy aging staffed by geriatricians out at the Rand Corporation ... to identify what works." However, she also noted that "one of the most compelling cases for health promotion that we currently do not reimburse is smoking cessation, even though 12 percent of Medicare beneficiaries still smoke [and] 70 percent of all smoking-related deaths are in our population." As a result, she said, CMS is mounting a major demonstration this year to test the efficacy of four different smoking-cessation interventions. Her group has already had a successful demonstration in nursing homes for the use of standing orders for immunizations. She said that's why she's "been trying to push evidence-based approaches to health promotion and disease prevention." It has enabled her to "talk our colleagues into redoing the regulations that will come out next week to promote standing orders [not mandate them but allow them] in all health care facilities" for flu or pneumococcal immunizations.

Helping people change high-risk behavior: Ms. Gordon indicated that her group is also preparing "a really path-breaking demonstration ... on behavioral risk factors" in which individual Medicare beneficiaries will get feedback and support for changing high-risk behaviors and adopting preventive and health-enhancing behaviors. Ms. Gordon closed her remarks with a quote from Dr. Robert Butler, the first Director of the National Institute on Aging: "This is the first time in human history that the prospects of living a long, healthy, and productive life have become a reality. It is in our power to make it a celebration." Council comment was generally very favorable. Members did note that providers – physicians, nurses – had to be equally committed to the prevention concept for it to work. They also urged Ms. Gordon to look outside the health community for help, such as the regulations under the Clean Indoor Air Act, and not to overlook a very high-risk behavior such as violence.

Standing applause: When Ms. Gordon ended her visit and prepared to leave, the Council rose and gave her a standing round of applause, the first such accolade in the history of PPAC.

GEOGRAPHIC PRACTICE COST INDICES (GPCIs)

Different rolling averages: The Chair next welcomed Terry Kay, Director of the Division of Practitioner Services, and Robert Ulikowski, an analyst in the same division. Mr. Ulikowski reviewed the complex process by which the GPCI is computed. Members had questions regarding the differences in computations between GPCI staff (who have the discretion to choose) and the SGR staff (who are governed by statute): the GPCI staff uses a three-year rolling average for professional liability insurance, while the SGR staff uses a rolling 10-year average, and the GPCI staff uses the single latest year for rents. It was also noted that Congress has skewed the computations to favor rural practice areas among the 89 geographic areas used for the base.

A closer look at disparities and access: But the Council was most concerned about the rent figures, which are based on HUD's office-space data. A request made to look at "the disparities between apartment rents across the country compared to business-based rents across the country." Another request was to see if there was a correlation between access to certain procedures in some geographic areas and the GPCI-based reimbursements for them. Is, for example, a particular procedure "less available to our seniors in the lower payment area?"

MID-MORNING BREAK

DEAR DOCTOR LETTER

Should physicians wait to sign up?: Mr. Grissom reminded the Council that the Dear Doctor letter will go out on November 1 advising physicians of changes in the Medicare program, including the new fee schedule for 2003. "It is an opportunity," he said, "for physicians to ... complete the enrollment form or, if they choose, the dis-enrollment process." Pursuant to a PPAC recommendation last year, Mr. Grissom said, "There will be a designation on the outside of the envelope indicating [its] importance." Council Members recalled their recommendation on this matter made yesterday:

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

After some discussion, a substitute recommendation was offered (see below). The Council again debated which address would be preferable for this letter: the billing address, the practice address, or some other "preferred address." It reached no conclusion.

PPAC recommends: The Council approved the following substituted recommendation:

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

WRAP-UP AND RECOMMENDATIONS

Meeting dates for 2003: Following the break, Dr. Rudolf announced the dates for the next five PPAC meetings: December 1, 2002, and February 10, June 9, September 22, and December 15, 2003. However, the September 22 date may be changed, depending on Members' needs.

PPAC recommends: The Council next reviewed its work of the past day and a half and approved the following recommendations:

- That CMS direct the carriers to insure adequate numbers of carrier medical directors with adequate levels of support to fulfill CMS goals for physician education, to continue timely claims adjustment, to maintain adequate knowledge of the provider community, and to provide accurate and timely answers to provider and beneficiary questions.
- That every carrier medical director should have a toll-free line so that physicians can get in touch with that carrier medical director.

It was further suggested that an agenda item for the December meeting, time permitting, would focus on the criteria for evaluating CMDs.

[NOTE: All Council recommendations made during the fall meeting, September 23-24, 2002, are attached, per request of the Chair.]

Ted Cron, Rapporteur

October 21, 2002