REPORT NUMBER THIRTY-SIX

to the

Secretary

U.S. Department of Health and Human Services

(Re: Revised Evaluation & Management Documentation Guidelines, plus updates on Risk Adjustment Profiles and Encounter Data, Advanced Beneficiary Notices, Physicians Regulatory Issues Team, Medical Audits and Reviews and other matters)

From the

Practicing Physicians Advisory Council

(PPAC)

For March 26, 2001

Attendees at the March 26, 2001 Meeting

Members of the Council:

Derrick L. Latos, MD, *Chair*
Nephrologist
Wheeling, West Virginia

Jerrold M. Aronson, MD
Pediatrician
Narberth, Pennsylvania

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

Joseph Heyman, MD
Obstetrician/Gynecologist
West Newbury, Massachusetts

Sandral Hullett, MD*
Family Practitioner
Eutaw, Alabama

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

Jerilynn S. Kaibel, DC
Chiropractor
San Bernardino, CA

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

Sandra B. Reed, MD
Obstetrician/Gynecologist
Thomasville, Georgia

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

Maisie Tam, MD*
Dermatologist
Burlington, Massachusetts

Victor Vela, MD
Family Practice
San Antonio, Texas

Kenneth M. Viste, Jr., MD
Neurologist
Oshkosh, Wisconsin

Douglas L. Wood, MD
Cardiologist
Rochester, Minnesota

* Absent

DHHS and HCFA Staff Present at the March 26, 2001, Meeting

Michael McMullan, PhD
Acting Deputy Administrator
Health Care Financing Administration

Paul Rudolf, MD, JD,
Executive Director
Practicing Physicians Advisory Council
Center for Health Plans and Providers

David C. Clark, RPH
Director
Office of Professional Relations,
Center for Health Plans and Providers

Denis Garrison
Director
Division of Consumer Protection
Center for Beneficiary Services

Hugh Hill, MD, JD
Acting Deputy Director
Program Integrity Group
Office of Financial Management

Mark Miller, PhD
Deputy Director
Center for Health Plans and Providers

Barbara Paul, MD
Director
Physicians Regulatory Issues Team (PRIT)
Center for Health Plans and Providers

Terry Kay
Director
Division of Practitioner and Ambulatory Care
Center for Health Plans and Providers

Helen Blumen, MD
Associate Medical Director*
Aspen Systems

J. Leonard Lichtenfeld, MD
Medical Director*
Aspen Systems

Ted Cron, Consultant Writer-Editor

* HCFA Contractor

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Public Witnesses:

Jack Emery, MD, Assistant Director of Federal Affairs, American Medical Association
Edward Hill, MD, American Medical Association, Board of Trustees
Ross Black, II, MD, Board of Directors, American Academy of Family Physicians
Nick Myers, Deputy Director Federal Relations, American Psychiatric Association

The March 26th Meeting: Morning Agenda

The 36th meeting of the Practicing Physicians Advisory Council was opened at 8:50 a.m. by the Council Chair, Derrick L. Latos, MD. Dr. Latos noted that he and Dr. Kaibel had returned just for this meeting; their Council Memberships had been extended because the appointments of new Members had not yet been completed. The Chair introduced Ms. Michael McMullen, Acting Deputy Administrator for HCFA. She said, "It's important for us to get timely input from you" on a variety of topics, including and especially the revised E&M documentation guidelines. After her brief remarks, Ms. McMullen left the meeting.

Can the grid be "red-lined?": Dr. Latos asked Paul Rudolf, MD, JD, PPAC's Executive Director, to review the issue grid for the Council. Dr. Latos also asked Dr. Rudolf if a "red-lined version of the grid" were possible, so that Members might see what words had been changed. Dr. Rudolf said he thought the result would be "unreadable," but he indicated he would try. Dr. Rudolf went through the grid and outlined the day's agenda. He noted in passing that HCFA would be "discussing the E&M Guidelines at the CPT Editorial Panel in May."

Clinical Examples for E&M Guidelines

Clinical records obtained and "we're on target": The Chair then welcomed back Drs. Blumen and Lichtenfeld for an update on the development of clinical examples for the new E&M guidelines. Dr. Lichtenfeld reported that his group had obtained the 2,000 clinical records that will form the basis of the draft clinical examples (the former "vignettes"). "So we're on target," he said. In the course of his presentation, Dr. Lichtenfeld suggested that "there may be some discussion ... ... as to what gets included" in the three levels of physical examination: brief, detailed, comprehensive. He also raised the issue of "counting": that is, the examining physician's need to keep track of "four bullets here and ten bullets there and three bullets here."

Six draft clinical examples presented: Dr. Helen Blumen presented the Council with six draft clinical examples from cardiology to illustrate low, medium, and high complexity decision-making. Council Members, however, quickly raised the question of whether these examples would be helpful to physicians "in general" or would they be used as line-by-line, verbatim guidance by carrier medical directors. Dr. Blumen inclined against the literalist approach and thought, rather, that physicians should "take in the gestalt of the example[s], and ... they vary." But Members cautioned that "carriers will use that wiggle room" to question physician judgments. Jack Emery, in the audience and representing the AMA, rose to warn, "If we don't involve the [carrier] medical directors ... early in this process so that there is no disagreement, we're ... headed for some trouble."

A flurry of additional issues: The Council also raised other issues, such as...

- the "studies that show physicians undercode up to 30 percent...";
- the possible need to adjust for mis-coding, the problem of general practitioners coding an encounter as complex that a specialist would code as brief (hence, the possibility that "you can get penalized for ... your specialized knowledge");

- the problem of accommodating co-morbidities (e.g., chronic disease) in the three levels of clinical examples;
- the elusiveness of the line between levels of complexity (i.e., determining the "lowest common denominator" in each level), in particular the lines above and below the middle level;
- the different level of complexity when seeing a patient for the first time as opposed to seeing that same patient for the 10th or 30th time;
- the problem of doing a complete exam and finding everything is normal (is it "brief" or "complex"?); and
- the possible need to define "normal," in order to code the encounter as moderately complex or higher (as for "the documentation of what is normal," the Council noted that "one size doesn't fit all").

The question remains, Documentation *of* what *for* what?: The Council returned a number of times to the question of the general purpose of the E&M guidelines and the particular purpose of the clinical examples. There appeared to be consensus for the notion that the taking of histories and the giving of physical exams were secondary to medical decision-making and that the documentation requirements should therefore emphasize medical management rather than the minutiae of diagnosis and treatment. (Such a shift in emphasis, it was noted, would obviously require the agreement of the CPT Editorial panel and a number of other interests as well.) But Members also observed that such an approach "gets back to the issue of work equivalence," which is not easy to resolve; in addition, there was some feeling that you still "have to give the physician the opportunity to ... code either on time or on other elements, [such as] history and the examination..." Finally, the Members reiterated their complaint that the carrier medical directors "are used to counting how many elements of the physical and how many elements of the history" are in the physician's reimbursement claim.

At this point, the Chair called for a mid-morning break.

Update on the ABN revisions

PPAC recommendations are incorporated: After the break, the Chair welcomed Mr. Denis Garrison, Director, Division of Consumer Protection, Center for Beneficiary Services, who updated the Council on the revisions of the Advance Beneficiary Notice (ABN). He reported that the ABN had been redesigned as a one-page document, as PPAC had recommended, and tests (in English) among consumers/ beneficiaries indicate a strong preference for the one-page version. A Spanish-language version of the ABN was currently being tested, also. Mr. Garrison indicated that for Form No. HCFA-R-131-G ("for general") and Form No. HCFA-R-131-L ("for laboratories") "there will be one page of instructions" and "shortly after that [we will] have instructions in the Medicare Carriers Manual." The Council recommended that HCFA drop the blank lines on the G form and instead leave a blank box for the physician to fill in, as needed. The Council asked about its recommendation for lists of the most common covered and non-covered services. HCFA is considering including the lists in question in the patient education brochure to accompany the use of ABNs. The brochure is still in the development stage. They are not on the HCFA website, although, eventually, the patient brochure including such lists might be posted on the website.

Council Members question Mr. Garrison regarding the lab form: Who is responsible? Who fills it out? Who is supposed to tell the beneficiary how much the service will cost? Mr. Garrison agreed the situation is not completely clear. He added, however, that "physicians should use prudent judgment in determining ahead of time whether something's covered or not" and then fill out the ABN themselves; he also conceded that HCFA "will accept either [an ABN] from the doctor or one from the laboratory." With respect to ABNs in emergency rooms, Mr. Garrison was of the opinion that "[you don't] have a lot of people in the emergency room [who] need stabilization getting medically unnecessary services." At this juncture, Edward Hill, MD, a member of the American Medical Association Board of Trustees, raised again the practicing physicians' concern about "carrier medical directors ... who deny payments," adding that "it would nice for them to hear this discussion."

A warm round of applause: Members asked Mr. Garrison to "take back to your colleagues the compliments and the gratitude that the Council has for the hard work that you've done." To show the depth of its appreciation, the Council took the unusual and spontaneous step of giving Mr. Garrison and his colleagues a warm round of applause.

Benefit Improvement and Protection Act (BIPA) of 2000

The next HCFA witness was Mr. Terry Kay, Director of the Division of Practitioner and Ambulatory Care in the Center for Health Plans and Providers. Mr. Kay noted that, in addition to the usual annual fee review, HCFA this year will publish in April "a separate proposal ... on the five-year review of work relative values. In June, we'll have our regular [fee] proposal." Both proposals will then be combined into "one final rule" to be published on November 1.

Key provisions of BIPA 2000: Mr. Kay outlined the following requirements of BIPA 2000:

- "Starting January 1, 2002, screening mammography will now be under the physician fee schedule," which means that HCFA "can adjust the payments for this service like we do for any other service under the physician fee schedule...";
- the law also mandates expanded coverage "for screening pap smear and pelvic exams ... the [old] law allows payment once every three years, ... the new coverage allows [payment] once every two years";
- "the next provision on the list is screening for glaucoma";
- the law also extends "colonoscopy [screening] for average-risk individuals" once every 10 years ("119 months"). "Up until now," said Mr. Kay, "coverage ... has been [reserved] for high-risk individuals," but the new law changes that, making the service available to average-risk individuals, ... meaning just about anybody";
- "nutrition therapy is another new coverage, ... effective January 1, 2002, ... for [beneficiaries] with diabetes or renal disease ... it sort of complements the benefit we have now for diabetic education";
- the last BIPA benefit expansion mentioned by Mr. Kay was for telemedicine.

Who should test for glaucoma?: The law recognizes only optometrists and ophthalmologists as qualified to test for glaucoma, but the Council objected, saying "no

payer should exclude any practitioner from providing a service for which he or she is suitably trained, has expertise, and is capable of performing the test." The Council added that HCFA's real concern ought to be "understanding ... exactly what elements would constitute appropriate screening," including multiple tests and new technologies.

Update on medical review activities

The final presentation of the morning was by Hugh Hill, MD, JD, Acting Deputy Director of the Program Integrity Group in the Office of Financial Management. Dr. Hill said *The Plain Language Document* went to the printer without any of PPAC's recommended corrections. As to the future, "the only thing I can commit to at this point," said Dr. Hill, "is a small initial printing run and a willingness to reconsider and solicit input" before the next printing occurs. Members were clearly miffed that their previous suggestions had not been used and their future ones may not be either. It was also noted that it seems to be "so difficult when Medicare makes a mistake for it to correct its own mistake," while physicians are held to a much stricter error-free standard.

Most claims go through and nobody looks: Dr. Hill next turned to the OIG-CFO's "recoupment programs," or medical audits. He confessed that it was not yet possible to produce the kinds of data PPAC has been requesting, because of computer delays, contractor limitations, and other problems. He did report, however, that, "of the tens of thousands of [complaints] that come in, ... the number of investigations or reviews that take place as a result in any given year are ... less than 100." He also said, "about one in 10,000 claims are exposed to a random review," answering a point that had been of some concern among Council Members. Dr. Hill noted that the government reviews "less than one percent of all the claims that float through ... [or] maybe 3 million claims a year," which isn't much, considering "we have 900 million claims coming in" each year. "This all reinforces the point," he concluded, that "95 to 97 percent of all claims go through the system and are paid ... without anybody looking at them." But there has been punishment for persons and institutions making wrongful claims: Dr. Hill reported that in the year 2000 there were 530 "ongoing suspensions for all providers"; however, only 162, or 31 percent, were physicians, he said.

At this point, the Chair recessed the meeting for lunch.

Update from the Physicians Regulatory Issues Team (PRIT)

Council is asked to prioritize issues: Following lunch, the Chair welcomed Barbara Paul, MD, Director, Physicians Regulatory Issues Team, Center for Health Plans and Providers, for her quarterly review of PRIT progress. Dr. Paul recalled that PRIT's role is to "identify workable issues and determine some workable improvements aiming for straightforward, well communicated policies and regulations [that] streamline the rules, [provide] fair oversight, [and] minimize paperwork." Dr. Paul presented 15 issues that required workable improvements and asked the Council's help in arranging them in priority order. The Chair suggested that the Council do that after hearing public testimony.

Top issues from AMA, AAFP: Dr. Hill, of the American Medical Association, Board of Trustees, returned to present his organization's top 12 issues. Pressed by the Council, Dr. Hill listed the AMA's top five issues as...

1. Advance Beneficiary Notice
2. Coverage of Pre-op Examinations
3. Seclusion and Restraints
4. Laboratory Services
5. Certificate of Medical Necessity.

Dr. Hill was followed by Ross Black, II, MD, a member of the Board of Directors, American Academy of Family Physicians, who presented the Academy's top issues as...

1. Advance Beneficiary Notice
2. Laboratory Services
3. Home Health Issues
4. Certificates of Medical Necessity
5. Medicare Summary Notices.

Next to speak was Mr. Nick Myers, Deputy Director of Federal Relations, American Psychiatric Association, who focused entirely on Seclusion and Restraints as the APA's top issue.

PPAC prioritizes all 15 issues: After some discussion, the Members, led by the Chair, set Dr. Paul's 15 issues into the following priority order (some received identical scores):

1. Coverage of Pre-op Evaluations
2. Coverage of Follow-up Visits for Cancer Patients
3. Advance Beneficiary Notices
4. Certificates of Medical Necessity
5. Laboratory Services
6. Carrier Bulletins
7. Seclusion and Restraints
8. Claims Re-submission
9. Medicare Summary Notices
10. Home Health Issues
11. Eligibility Determinations
12. Verbal Orders
13. Diabetics' Glucose Monitoring Supplies
14. Medical Residents and Physicians Supervision
15. Prior Hospitalization for Skilled Nursing Facility Placement.

The Council discussed each item and offered guidance to Dr. Paul on ways to approach each one.

Request for a face-to-face meeting with CMDs: Because so many of the issues seem to be generated by unsatisfactory physician-carrier relations, the Council strongly recommended carriers themselves are an issue and "we ought to tackle it right on." It was suggested that the venue be a PPAC meeting at which Members could have "direct face-to-face interaction with" carrier medical directors. The Council asked HCFA staff to plan such a meeting soon.

PPAC to work on the Sentinel Clinicians program: Dr. Paul recounted recent progress in the Sentinel Clinicians initiative. She said she envisioned it as being a "standard way" to get practicing physicians to talk about their day-to-day "bedside experience caring for patients" as well as the Medicare program itself: "Is it working for you? What about the Medicare program makes you stumble, those kinds of questions." Dr. Paul also invited the Council to establish a subcommittee to work with her in developing the Sentinel Clinicians program. The Chair, noting that "we have repeatedly emphasized that PPAC wanted to ... be instrumental in helping to plan or work with you," accepted Dr. Paul's invitation on behalf of the Council. The subcommittee is to meet (maybe once) face to face and otherwise by telephone to do fact finding, so that the full Council, at its June meeting, could advise HCFA on "how to construct that program." Drs. Paul, Rudolf and Latos were to select the subcommittee members.

Medical audits revisit: Following Dr. Paul's presentation, the Chair welcomed back Dr. Hugh Hill to provide the Council with more specific data from the OIG-CFO medical audits. Dr. Hill reported that the Department hopes to "[get] the error rate down to five percent by the year 2002." The most recent audits indicate that "improper Medicare benefit payments made during fiscal year 2000 total about $11.9 billion or about 6.8 percent of the $173-174 billion in processed fee-for-service payments." He further noted that, of all "improper payments," those made for " unsupported and medically unnecessary services are the most pervasive," accounting "for about 70 percent of the total improper payments over the last five years." While trying to reduce the error rate through improved communications with contractors, the Government, said Dr. Hill, has to confront "a conflict between simplification and clarity. We want to reduce the burden ... But we also want control, ... consistency, ... measurement, ... monitoring, and ... fairness. So how do we achieve that with contractors?" Members agreed, adding that physicians are also baffled by poorly defined terms (e.g., what does "routine" really mean?).

How many truly improper claims are there?: Members also noted that Dr. Hill's total of all cases of improper payments may not be a "clean number" because it includes cases that have not yet been adjudicated (and possibly found to have been "proper" after all). Dr. Hill agreed, but added that, according to OIG records, "90 percent of [improper payments] were correct, valid, or at least [the government] was able to get the money back." Some Members also suggested that the decline in improper payments might reflect the fact that physicians are "down-coding" their claims to avoid potential trouble. The Members asked Dr. Hill to supply them with "a spreadsheet" of the statistics he mentioned or alluded to. He was also asked for a list of "all of the initiatives that HCFA's using currently to recoup overpayments and ...all the audits" to which physicians may be subject.

Update on physician re-enrollment forms: Dr. Hugh Hill went on to describe the revisions of the physician enrollment and re-enrollment forms. He said three new versions were published as proposals in February. He reported that HCFA accepted PPAC's recommendation to eliminate the race or ethnicity question. As for an electronic (e-mail) version, Dr. Hill said it is still "way down the road ... But when we do get there, we hope it will be interactive." He also reported that enrollment contractors are being told that, "as of the 1st of July, ... they're going to have 60 days to get 90 percent of the enrollment numbers done," which deals with another frustration expressed by the Council: the length of time (as much as 18 months in some cases) for new enrollments to be completed. He also said HCFA

was taking steps to recognize individual practicing physicians as "professional corporations" in addition to being "sole proprietors." As to the use of the Medicare forms for Medicaid enrollment as well, Dr. Hill said it had not been a focus of his group thus far, but "I understand the [Council's] request to be [that] you'd like to have it work for both."

The Chair called for the mid-afternoon break, following Dr. Hill's presentation.

Risk adjustment and encounter data

Timetable and methodology presented to the Council: After the break the Chair introduced Mark Miller, PhD, Deputy Director of the Center for Health Plans and Providers, who briefed the Council on HCFA's 1998-2007 timetable for phasing in the Encounter Data and Risk Adjustment system. He reported that, in January 2000, "a model based on inpatient data ... was implemented," as required by BIPA 1997. The model is known as the "principle inpatient diagnostic cost group model ... [or] PIP- DCG." In 2004, a "Comprehensive Risk Adjustment" payment methodology, based on data collected from physicians offices and hospital outpatient departments, will begin to be phased in for managed care organizations (MCOS, M+COs); full payment to them under the program will occur in January 2007. Dr. Miller said the full story of this evolving payment system will be featured on different sections in HCFA's Website; they will provide information about diagnosis codes, diagnosis groups, and the risk adjustment scores for such groups, as well as "payment rates for MCO's in counties." Dr. Miller said that this information, combined with what the physician already knows, "should give you a good approximation of what the average risk score of the given physician's population of patients is [and] the individual patients' relative risk scores." Dr. Miller then asked the Members what they wanted from such a system.

Another fairness issue: But the Members were less than enthusiastic about Dr. Miller's system. At the heart of their response was the feeling that this was "another fairness issue" with regard to practicing physicians; that is, HCFA is "getting the [encounter] information from us and feeding it to the plans, [but] these plans don't give us any information ... And we have to negotiate [with them] from the position of not knowing." The Members insisted that "at least we should be entitled to the same information that you feed to the plans about our patients." Dr. Miller countered that HCFA must not get between plans and physicians with regard to contract negotiations; he also suggested that any physician could, on his or her own, reconstruct the data and come up with a risk adjustment factor, also. The Council dismissed that idea: "Why should we have to do all the ... calculations to come up with a number that may not even be accurate in the end, when the plan already has a number that they're receiving directly" from HCFA? Ultimately, however, the Council strongly recommended that "any information ... given about an individual beneficiary to a managed care organization should [also] go to the individual physician or provider who's providing that information."

Testing is planned: Members and Dr. Miller discussed HCFA's plans to test the comprehensive system. Dr. Miller noted, "I think that's completely fair ... because when we go public with the comprehensive risk adjustment model in 2004, we're going to have to say, we chose [this model from] among various competing models" for certain specific and demonstrable reasons.

Wrap-up and recommendations

Re-cap of major recommendations and suggestions: Dr. Latos and Dr. Rudolf reviewed the day's deliberations and noted that the Council...

1. "... clearly wants to recognize the exemplary approach that was taken by Denis [Garrison] and his crew in ... coming up with the [revised ABN] form."

2. "...[recommends] ... that a statement listing the categorical exclusions from Medicare payment be listed and distributed."

3. "... applauds Aspen for its work, and we think that this is the correct direction to create these clinical examples," but also recommended that the questions related to the clinical examples be "standardized."

4. ... concluded that "there will be a need to emphasize ... the relative weight ... of medical decision making, as well as time. [H]istory and physical examination may not necessarily carry equal weight" in the final analysis. The Council also suggested that there be "at least one" pilot test to look at the effect of "emphasiz[ing] a medical decision making model and minimizing ... history and physical examination"; the "type of an extended pilot" could possibly be "hammered out" at the June PPAC meeting. The Council also recognized that the CPT Editorial Panel would also have to be involved in "discussion about the code selections."

5. ... noted that the difficulty of "making that middle determination" in the three levels of decision-making.

6. ... indicated that some thought has to be given to "how they're going to be used by carriers..." and suggested that "whatever is provided to the carriers for their review [should be] mandatory and not just guidance for them to follow."

7. ... also recommended that the time to comment on the clinical examples be extended to 60 days, so that "unchosen specialties" [i.e., those not selected during the first cut] can also review and contribute to their development; this topic may come up again at the June PPAC meeting.

8. ... asked that "we receive and be able to review [the plain language] document prior to any final process." The Council recalled that it "had previously made specific recommendations, and we need to have those brought back ... so we can [compare them] with the new version."

1. ... repeated its request that "carrier directors or the carrier staffs ... meet with PPAC." There are two sides to this request: one, to familiarize Members with carriers and carrier operations and, two, to have "an airing of problems with the carriers."

2. ... asked Dr. Paul to return to the June meeting and report on the progress being made (1) on the "workable issues" discussed at this meeting and (2) on the Sentinel Clinicians initiative.

3. ... wished to know from HHS "the extent to which the [office that deals] with state Medicaid agencies is participating ... in the PRIT process ... to decrease the administrative hassle to physicians" in that program as well.

4. ... requested for the June meeting "the hard data and the spreadsheets from the audits as well as the payment error rates" mentioned by Dr. Hugh Hill.

5. ... asked that the question of physicians being identified as "professional corporations" be addressed on the provider enrollment form.

6. ... recommended that "the risk adjustment model should be revised or reviewed by PPAC prior to any final decision being made in 2004" in order to see if HCFA is spending all this money and all this effort ... on [a model] where the actual outcome is no different or not significantly different" from what we have now.

7. ... and very strongly recommended that "any information that's shared with the health plan on a beneficiary-by-beneficiary basis is also shared with the provider who provided the information."

Following this review of the day's work, Dr. Rudolf announced that the remaining PPAC meetings in 2001 would be on June 25 in Washington, DC (to accommodate the Department's officers for swearing in the new PPAC Members); September 17 in Baltimore, MD; and December 10 in Washington, DC. The Chair then adjourned the meeting at 4:30 p.m.

Prepared by Ted Cron
April 19, 2001

[HEADING]

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

Dear Secretary Thompson:

I am pleased to submit to you Report Number Thirty-Six of the Practicing Physicians Advisory Council (PPAC). This Report summarizes the deliberations held on March 26, 2001, in Room 800 of the Humphrey Building. Of special interest to the Council were the reports from HCFA staff and contractors regarding the revisions to the Evaluation and Management Guidelines and the presentation concerning medical reviews and audits by the Office of Financial Management. Several of the Council's recommendations, listed at the end of the enclosed report, deal specifically with these difficult matters.

The March 26th meeting was my last as both Member and Chair. Drs. Jerilynn Kaibel, Maisie Tam, and I have considered our memberships on this Council to be among our most valuable personal and professional experiences. It has been a privilege and a great pleasure for us to have worked closely with the dedicated staff of the Health Care Financing Administration as well as with many of our colleagues in the private sector, during our search for ways to make the Medicare and Medicaid programs more efficient, more effective, and more fair for both beneficiaries and providers alike. Whatever our differences and disagreements, the personnel of your Department have consistently acted from the very highest motives of public service and we commend them to you.

Although I will not be present, I do urge you to take a few moments from your busy schedule to personally greet the Council at its June 25th meeting, to swear in its new Members, and share with them your vision of the future of the Medicare and Medicaid programs. These are men and women well worth knowing, Mr. Secretary, because I believe that, during your stewardship of the Department of Health and Human Services, you will find the Practicing Physicians Advisory Council to be a useful mechanism for gaining candid insights from the Nation's dedicated medical professionals.

Please accept our very best wishes for your leadership of this important "people's Department."

Sincerely yours,

Derrick L. Latos, MD
Chair
Practicing Physicians Advisory Council

Enclosed: PPAC Report Number Thirty-Six