

What surgeons should know about . . .

Federal commissions and advisory committees

by Adrienne Roberts, Government Affairs Associate, and Erin LaFlair, Legislative Assistant, Socioeconomic Affairs Department, Washington Office

There are literally hundreds of commissions, panels, councils, and committees in the federal government that advise both Congress and the executive agencies on policy matters. This article is intended to unveil some of the mysteries of several of the so-called federal alphabet soup groups, and to describe their roles and responsibilities in the federal health care policymaking process.

Q. What is MedPAC?

A. The Medicare Payment Advisory Commission (MedPAC) is an independent federal body that advises Congress on issues affecting the Medicare program. It was established by the Balanced Budget Act of 1997 (P.L. 105-33), which merged the former Prospective Payment Assessment Commission (the congressional advisory panel for hospital payment issues) and the Physician Payment Review Commission (which evaluated physician payment issues). In addition to assuming the responsibilities of its predecessor panels, MedPAC is charged with assessing how federal health care programs relate to the nation's overall health care delivery and financing systems.

The primary outlet for the commission's recommendations is two annual reports, required by statute to be issued in March and June. In addition to these reports, MedPAC advises Congress through other avenues, including testimony at hearings, comments on reports issued

by the Secretary of Health and Human Services (HHS), formal comments on proposed regulations, briefings for congressional staff, and a forthcoming new series of short issue briefs.

The commission, chaired by Gail R. Wilensky, PhD, a former Administrator of the Health Care Financing Administration (HCFA) and health policy advisor to President George Bush, has 17 members who bring a wide range of expertise in the financing and delivery of health care services. There are two physicians on the panel, including thoracic surgeon Floyd Loop, MD, FACS, from Cleveland, OH.

Q. When and why was the Congressional Budget Office (CBO) established?

A. The CBO was created by the Congressional Budget and Impoundment Control Act of 1974. The CBO's mission is to provide Congress with objective, timely, nonpartisan analyses needed for economic and budget decisions; it also provides the information and estimates required for the congressional budget process.

Q. What is the CBO's role in developing the federal budget plan, and how does that affect physicians?

A. A substantial part of what the CBO does is to support the work of the House and

Senate budget committees. Those committees are in charge of the process by which Congress sets its own targets for the federal budget, including the overall levels of revenue and spending, the surplus or deficit that results, and the distribution of federal spending by broad functional categories. Each spring, Congress adopts the end result of that process, the congressional budget plan. The CBO at this time “scores” the plan, determining the cost of the budget, agency by agency. Medicare, Medicaid, and other entitlement programs consume large portions of the budget. Changes in Medicare physician and hospital payment policies often result from budget-driven efforts to constrain entitlement spending growth.

Q. What is the General Accounting Office’s (GAO) relationship to Congress?

A. The GAO, organized in 1921 due to the disarray of federal financial management after World War I, is an agency that works for Congress. Commonly called the investigative arm of Congress or the congressional “watchdog,” the GAO is independent and nonpartisan. It advises Congress and the heads of executive agencies about ways to make government more effective and responsive. The GAO evaluates federal programs, audits federal expenditures, investigates allegations of illegal activities, and issues legal opinions. For example, The GAO of-

ten testifies before Congress, giving advice and opinions on the operations of the Medicare and Medicaid program, and on whether HHS and HCFA are adhering to congressional mandates to fight Medicare fraud. The GAO also recommends actions to improve the government health programs, and gives Congress a better understanding of newly emerging, long-term issues. Finally, the GAO serves as the “vetting” agency for appointments made to other congressional advisory panels such as MedPAC.

Q. How does the newly formed Medicare Coverage Advisory Committee (MCAC) function?

A. On November 24, 1998, the HHS Secretary chartered the MCAC, which advises HCFA on whether specific medical items and services are reasonable and necessary under Medicare law. This process is performed through review and discussion of specific clinical and scientific issues in an open and public forum. The MCAC is advisory in nature, with the final decision on all issues resting with HCFA.

There are six advisory panels to the MCAC, organized roughly to parallel Medicare benefit categories, to enable HCFA to obtain the most pertinent technical advice. The panels are asked to evaluate scientific evidence to assist HCFA in making coverage decisions. There are currently six Fellows serving two-year terms on two different specialty panels of the MCAC. The

Medical and Surgical Procedures Panel includes otolaryngologist and vice-chair Michael D. Maves, MD, FACS, from Washington, DC; orthopaedic surgeon (and College nominee) Angus M. McBryde, MD, FACS, from Charleston, SC; and urologist H. Logan Holtgrewe, MD, FACS, from Annapolis, MD. The Diagnostic Imaging Panel includes urologist Michael Manyak, MD, FACS, from Washington, DC; neurosurgeon Kim J. Burchiel, MD, FACS, from Portland, OR; and thoracic surgeon Steven Guyton, MD, MPH, FACS, from Seattle, WA.

Q. What is the role of the Practicing Physicians Advisory Council (PPAC)?

A. Managed by HCFA and established by the Omnibus Budget Reconciliation Act of 1990, the PPAC advises the Secretary of HHS on proposed changes in the Medicare regulations and carrier manual instructions that pertain to physician services. The council meets quarterly, and all members of the PPAC are practicing physicians. Their expertise and comments enable the Secretary to gain information and insight into the daily operation of physician offices with relation to their participation in the Medicare and Medicaid programs.

Following are several issues the council has discussed in recent meetings: Medicare fee schedule changes, rural health clinics, managed care provider protections under Medicare, nursing home quality of care initiatives, negotiated rule making for laboratories, and requirements for lead screening.

The Secretary appoints 15 council members based upon nominations submitted by medical organizations representing physicians. The council is chaired by Marie G. Kuffner, MD, an anesthesiologist from Los Angeles, CA. The College is represented by Amilu S. Rothhammer, MD, FACS, Colorado Springs, CO.

Q. What are the roles and responsibilities of the National Practitioner Data Bank (NPDB) and the Healthcare Integrity and Protection Data Bank (HIPDB)?

A. The NPDB was established through Public Law 99-660, the Health Care Quality Improvement Act of 1986. Enacted in 1986, the act authorized the HHS Secretary to establish a national data bank to ensure that unethical or incompetent physicians, dentists, and other types of health care practitioners would not be able to evade limits on their ability to practice simply by moving to a new state without disclosure or discovery of previous damaging or incompetent performance.

All information reported to the NPDB is considered confidential and is only available to state licensing boards, hospitals, and other health care entities in conducting extensive, independent investigations of the qualifications of the health care practitioners they seek to license or hire, or to whom they wish to grant clinical privileges.

In addition to the NPDB, the Secretary of HHS, acting through the Office of Inspector General, was directed by the Health Insurance Portability and Accountability Act of 1996 to create the HIPDB to combat fraud and abuse in health insurance and health care delivery. The HIPDB collects information about certain final adverse actions (excluding settlements in which no findings of liability have been made) taken against health care providers, suppliers, or practitioners.

Responsibility for the NPDB and HIPDB implementation resides in the Health Resources and Services Administration (HRSA), although it is operated by a contractor, Systems Research and Applications Corporation.

Q. What vehicle exists for public input into issues involving these data banks?

A. The NPDB Executive Committee advises HRSA and the data bank contractor on operation and policy matters for both data banks. The 30-member committee, which usually meets semi-annually with both contractor and HRSA personnel, includes representatives of various health professions, national health organizations, state professional licensing bodies, malpractice insurers, and the public. The College is represented by Norman Odyniec, MD, FACS, a thoracic surgeon from Chevy Chase, MD. General surgeon Josef E. Fischer, MD, FACS, from Cincinnati, OH, also serves on the panel.

Q. What type of information does the National Committee on Vital & Health Statistics (NCVHS) provide?

A. The Centers for Disease Control and Prevention's (CDC) National Center for Health Statistics (NCHS) provides staff support for the NCVHS and its subcommittees. The NCVHS is the official external advisory committee on health statistics to the Secretary of HHS. The committee serves as a forum for interested groups to provide input on important data issues.

The committee is composed of 16 individuals distinguished in the fields of health statistics, epidemiology, and health care services. It fulfills important review and advisory functions relative to health statistical problems of national or international interest, stimulates or conducts studies of such problems, and makes proposals for improvement of the nation's health statistics and information systems.

The NCVHS has become increasingly active over the past several years, addressing issues relating to uniform health data sets, medical classification systems, the need for improved men-

tal health statistics, data needs for minority health and the medically indigent, and state and community health data needs.


Q. Who advises the Food and Drug Administration (FDA) in assessing market applications for new medical devices?

A. Like other components of the FDA, the Center for Devices and Radiological Health has established advisory committees to provide independent, professional expertise and technical assistance on the development, safety and effectiveness, and regulation of medical devices and electronic products that produce radiation. Each committee consists of experts with recognized expertise and judgment in a specific field. Members have the training and experience necessary to evaluate information objectively and to interpret its significance.

These panelists are not regular employees of the FDA, but are paid as "special government employees" for the days they participate as members of a panel. This is time they take from their daily occupations to provide their professional skills to the FDA. The committees are advisory—they provide their expertise and recommendations—but final decisions are made by the FDA.

The center has four advisory committees, including the Medical Devices Advisory Committee, which consists of 16 panels that cover the medical specialty areas. Included in this group is the General and Plastic Surgery Devices Panel, with nine standing members. They include its chairman, Thomas V. Whalen, MD, FACS, a pediatric surgeon from the Robert Wood Johnson Medical School in New Jersey, and six other voting members, including: Benjamin O. Anderson, MD, FACS, assistant professor of sur-

gical oncology at the University of Washington School of Medicine in Seattle, WA; Phyllis Chang, MD, FACS, a plastic surgeon at the University of Iowa Hospital and Clinics in Iowa City, IA; Susan Galandiuk, MD, FACS, assistant professor of surgery and a colon-rectal surgeon at the University of Louisville (KY); and Robert L. McCauley, MD, FACS, chief of the department of plastic and reconstructive surgery at the Shriners Burn Hospital in Galveston, TX. In addition to the voting members, the panel contains one industry and one consumer representative (nonvoting). The panel also “deputizes” several expert consultants for each meeting to correspond with the panel’s agenda items. These members have temporary voting rights for the duration of that meeting.

schools of medicine and osteopathy, public and private teaching hospitals, health insurers, business, and labor. Federal representation includes the HHS Assistant Secretary for Health, the HCFA Administrator, and the Chief Medical Director of the Department of Veterans Affairs. 

Q. What is the role of the Council on Graduate Medical Education?

A. The Council on Graduate Medical Education (COGME) was authorized by Congress in 1986 to provide an ongoing assessment of physician workforce trends, training issues, and financing policies, and to recommend appropriate federal and private sector efforts to address identified needs. The legislation calls for the COGME to advise and make recommendations to the Secretary of HHS, the Senate Committee on Health, Education, Labor and Pensions, and the House Committee on Commerce. The Health Professions Education Partnerships Act of 1998 reauthorized the council through September 30, 2002.

The legislation specifies 17 members for the council. Appointed individuals are to include representatives of practicing primary care physicians, national and specialty physician organizations, international medical graduates, medical student and house staff associations,