Choices, Centers for Medicare & Medicaid Services, 7500 Security Boulevard, Mail stop S2–23–05, Baltimore, MD 21244–1850, (410) 786–0090. Please refer to the CMS Advisory Committees' Information Line (1–877–449–5659 toll free)/(410–786–9379 local) or the Internet (*http://www.cms.hhs.gov/faca/apme/default.asp*) for additional information and updates on committee activities, or contact Ms. Johnson via e-mail at ljohnson3@cms.hhs.gov.

Press inquiries are handled through the CMS Press Office at (202) 690–6145.

SUPPLEMENTARY INFORMATION: Section 222 of the Public Health Service Act (42 U.S.C. 217a), as amended, grants to the Secretary of the Department of Health and Human Services (the Secretary) the authority to establish an advisory panel if the Secretary finds the panel necessary and in the public interest. The Secretary signed the charter establishing the Advisory Panel on Medicare Education (the Panel) on January 21, 1999 and approved the renewal of the charter on January 14, 2005. The Panel advises and makes recommendations to the Secretary and the Administrator of the Centers for Medicare & Medicaid Services (CMS) on opportunities to enhance the effectiveness of consumer education strategies concerning the Medicare program.

The goals of the Panel are as follows:

- To develop and implement a national Medicare education program that describes the options for selecting a health plan under Medicare.
- To enhance the Federal government's effectiveness in informing the Medicare consumer, including the appropriate use of public-private partnerships.
- To expand outreach to vulnerable and underserved communities, including racial and ethnic minorities, in the context of a national Medicare education program.
- To assemble an information base of best practices for helping consumers evaluate health plan options and build a community infrastructure for information, counseling, and assistance.

The current members of the Panel are: Dr. Drew E. Altman, President and Chief Executive Officer, Henry J. Kaiser Family Foundation; James L. Bildner, Chairman and Chief Executive Officer, New Horizons Partners, LLC; Dr. Jane Delgado, Chief Executive Officer, National Alliance For Hispanic Health; Clayton Fong, President and Chief Executive Officer, National Asian Pacific Center on Aging; Thomas Hall, Chairman and Chief Executive Officer, Cardio-Kinetics, Inc.; Bobby Jindal; David Knutson, Director, Health System Studies, Park Nicollet Institute for Research and Education; Dr. David Lansky, Director, Health Program, Markle Foundation; Donald J. Lott, Executive Director, Indian Family Health Clinic; Dr. Frank I. Luntz, President and Chief Executive Officer, Luntz Research Companies; Dr. Daniel Lyons, Senior Vice President, Government Programs, Independence Blue Cross; Katherine Metzger, Director, Medicare and Medicaid Programs, Fallon Community Health Plan; Dr. Keith Mueller, Professor and Section Head, Health Services Research and Rural Health Policy, University of Nebraska; David Null, Financial Advisor, Merrill Lynch; Lee Partridge, Senior Health Policy Advisor, National Partnership for Women and Families; Dr. Marlon Priest, Professor of Emergency Medicine, University of Alabama at Birmingham; Susan O. Raetzman, Associate Director, Public Policy Institute, AARP; Catherine Valenti, Chairperson and Chief Executive Officer, Caring Voice Coalition; and Grant Wedner, Senior Director, New Services Department, WebMD.

The agenda for the February 24, 2005 meeting will include the following:

- Recap of the previous (November 30, 2004) meeting.
- Centers for Medicare & Medicaid Services update.
- Medicare Modernization Act: education and outreach strategies.
- Public comment.
- Listening session with CMS leadership.
- Next steps.

Individuals or organizations that wish to make a 5-minute oral presentation on an agenda topic should submit a written copy of the oral presentation to Lynne Johnson, Health Insurance Specialist, Division of Partnership Development, Center for Beneficiary Choices, Centers for Medicare & Medicaid Services, 7500 Security Boulevard, Mail stop S2–23–05, Baltimore, MD 21244–1850 or by e-mail at *ljohnson3@cms.hhs.gov* no later than 12 noon, e.s.t., February 17, 2005. The number of oral presentations may be limited by the time available. Individuals not wishing to make a presentation may submit written comments to Ms. Johnson by 12 noon, e.s.t., February 17, 2005. The meeting is open to the public, but attendance is limited to the space available.

Special Accommodation: Individuals requiring sign language interpretation or other special accommodations should contact Ms. Johnson at least 15 days before the meeting.

Authority: Sec. 222 of the Public Health Service Act (42 U.S.C. 217a) and sec. 10(a) of Pub. L. 92–463 (5 U.S.C. App. 2, sec. 10(a) and 41 CFR 102–3).

(Catalog of Federal Domestic Assistance Program No. 93.733, Medicare—Hospital Insurance Program; and Program No. 93.774, Medicare—Supplementary Medical Insurance Program)

Dated: January 19, 2005.

Mark B. McClellan,

Administrator, Centers for Medicare & Medicaid Services.

[FR Doc. 05–1504 Filed 1–27–05; 8:45 am]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS–5037–N]

Medicare Program; Demonstration of Coverage of Chiropractic Services Under Medicare

AGENCY: Centers for Medicare & Medicaid Services (CMS), HHS.

ACTION: Notice.

SUMMARY: This notice announces the implementation of a demonstration mandated under Section 651 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) (Pub. L. 108–173), which will expand coverage of chiropractic services under Medicare beyond the current coverage for manipulation to correct a neuromusculoskeletal condition. Chiropractors will be permitted to bill Medicare for diagnostic and other services that a chiropractor is legally authorized to perform by the State or jurisdiction in which such treatment is provided. The demonstration will be conducted in four sites, two urban and two rural; one site in each area type must be a health professional shortage area (HPSA).

Any chiropractor that provides services in these geographic areas will be able to participate in the demonstration. Any beneficiary enrolled under Medicare Part B, and served by chiropractors practicing in these sites would be eligible to receive services. Physician approval would not be required for these services. The statute requires that the demonstration be budget neutral. We anticipate that the demonstration will begin in April 2005 and operate for two years.

ADDRESSES:

1. *By Mail:* Written inquiries regarding this demonstration must be submitted by mail to the following address:

Centers for Medicare & Medicaid Services, Attn: Sidney Trieger, Division of Health Promotion and Disease Prevention Demonstrations, Office of Research, Development, and Information, Centers for Medicare & Medicaid Services, S3–02–01, 7500 Security Boulevard, Baltimore, Maryland 21244–1850.

Please allow sufficient time for mailed information to be received in a timely manner in the event of delivery delays.

2. *E-mail:* Inquiries may be sent to the following e-mail address: *MMA_section_651@cms.hhs.gov.*

FOR FURTHER INFORMATION CONTACT: Julie Jones, (410) 786–3039 or Sidney Trieger, (410) 786–6613.

SUPPLEMENTARY INFORMATION:

I. Background

Section 651 of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA) (Pub. L. 108–173) provides for a two-year demonstration to evaluate the feasibility and advisability of covering chiropractic services under Medicare. These services extend beyond the current coverage for manipulation to correct neuromusculoskeletal conditions typical among eligible beneficiaries, and would cover diagnostic and other services that a chiropractor is legally authorized to perform by the State or jurisdiction in which the treatment is provided. Physician approval would not be required for these services. The demonstration must be budget neutral and will be conducted in four sites, two rural and two urban; one site of each area type must be a health professional shortage area (HPSA).

Current Medicare coverage for chiropractic care is limited to manual manipulation of the spine to correct a subluxation, which chiropractors define as a malfunction of the spine. The three currently covered CPT codes are 98940 (manipulative treatment, 1–2 regions of the spine), 98941 (manipulative treatment, 3–4 regions of the spine), and 98942 (manipulative treatment, 5 regions of the spine).

Treatment must be provided for an active subluxation and not for prevention or maintenance. Treatment of the subluxation must be related to a neuromusculoskeletal condition where there is a reasonable expectation of recovery or functional improvement. Chiropractors are required to document the patient's complaint and establish a treatment plan, which includes the expected duration and frequency of treatment, specific goals and measures of effectiveness. This information must be maintained in the medical record and made available to Medicare upon request. Patients do not need a medical physician referral for treatment by a chiropractor under fee-for-service; some Medicare Advantage (MA) plans may require an enrollee to obtain a referral before seeing a chiropractor. In addition, some MA plans do not have chiropractors in their networks and allow osteopaths to provide manipulative services.

II. Provisions of the Notice

A. Covered Services

To determine which services will be covered, we conducted a literature review of the evidence of the effectiveness of chiropractor services. We held discussions with the American Chiropractic Association (ACA) and also reviewed the current coverage of chiropractor services with the Department of Defense and the Veterans Administration. In addition, we convened an Open Door Forum in November 2004 to invite comments on our proposed design for the demonstration. Based on these discussions, the evidence for effectiveness of chiropractic care, and current Medicare policy, the following guidelines for the demonstration were developed:

1. Services must be related to active treatment, not maintenance or prevention. This follows current Medicare coverage for similar services, such as physical therapy. Medicare does not authorize payment for maintenance therapies for other providers. We will require that all claims under the demonstration will have the active therapy (AT) modifier.

2. The demonstration will expand the services chiropractors are allowed to provide in the demonstration only to treatment of neuromusculoskeletal conditions, but not to other conditions. We have found no literature that provides conclusive evidence that chiropractic services are effective for treatment of other diagnoses.

3. Under the demonstration chiropractors can provide plain x-rays, electromyography (EMG) tests and nerve conduction studies; order magnetic resonance imaging (MRI) scans and computed tomography (CT) scans; as well as order or provide laboratory tests (where the applicable State practice act permits chiropractors to provide these services). These diagnostic services are related to the diagnosis and treatment of neuromusculoskeletal conditions. No limits will be imposed on chiropractors for providing diagnostic services, unless limits exist for other providers delivering these services.

4. The demonstration will cover CPT code 98943 for extraspinal manipulation, as it is a recognized procedure for treating neuromusculoskeletal conditions. It will also expand coverage to include other services chiropractors are legally allowed to provide and Medicare currently covers. These procedures include electrotherapy, ultrasound, transcutaneous electrical nerve stimulation (TENS) therapy, and other services that are medically necessary for the treatment of neuromusculoskeletal conditions. Chiropractors delivering these services will be subject to the same payment policies as other Medicare clinicians currently delivering these services. These requirements can be found in the Medicare Benefit Policy Manual 100–2 in Chapter 15, Sections 220 and 230 and the Medicare Claims Processing Manual 100–4 in Chapter 4, Section 20 and other manual sections. For example, physical and occupational therapy services must be identified through the use of modifiers GP and GO respectively. Chiropractors will also be allowed to make referrals for these therapy services.

5. Chiropractors would also be reimbursed for evaluation and management (E&M) services delivered for neuromusculoskeletal conditions.

Under the demonstration, chiropractors would be allowed to bill Medicare for treatment in addition to an E&M visit on the same day the first time they assess a patient, and thereafter only when they assess a patient for a new, separate problem not currently being treated. The current E&M CPT codes will apply.

We will require chiropractors to submit claims for demonstration services separately from claims for currently covered services (CPT codes 98940, 98941, and 98942). Chiropractors will have to add demonstration code 45 to all demonstration claims in order to be reimbursed for demonstration services.

B. Managed Care Plans

The legislation requires that the same demonstration benefits be offered under MA plans as for Medicare fee for service beneficiaries. Because participation of managed care plans is voluntary, we cannot require plans to participate in the demonstration. We therefore plan to approach MA plans in the demonstration site areas to determine if they would offer demonstration services to beneficiaries, but we will not change the MA plan rates since the demonstration is required to be budget neutral.

C. Payment Rates

The payment rates for demonstration services will be the same as under the physician fee schedule.

D. Budget Neutrality

The statute requires the Secretary to ensure that the aggregate payments made under the Medicare program do not exceed the amount that would have been paid under the Medicare program in the absence of this demonstration.

Ensuring budget neutrality requires that the Secretary develop a strategy for recouping funds should the demonstration result in costs higher than would occur in the absence of the demonstration. We will first determine over the two-year demonstration whether the demonstration was budget neutral. If the demonstration is not budget neutral, we plan to meet the legislative requirements by making adjustments in the national chiropractor fee schedule to recover the costs of the demonstration in excess of the amount estimated to yield budget neutrality. We will assess budget neutrality by determining the change in costs based on a pre-post comparison of costs and the rate of change for specific diagnoses that are treated by chiropractors and physicians in the demonstration sites and control sites. We will not limit our analysis to reviewing only chiropractor claims because the costs of the expanded chiropractor services may have an impact on other Medicare costs.

A CMS evaluation contractor will conduct the analysis of claims and budget neutrality. Since it will take approximately two years to complete the claims analysis, we anticipate that any necessary reduction will be made in the 2010 and 2011 fee schedules. If we determine that the adjustment for budget neutrality would be greater than two percent of the chiropractor fee schedule, we will implement the adjustment over a two-year period. However, if the adjustment is less than two percent of the chiropractor fee schedule, we will implement the adjustment over a one-year period. We will include the detailed analysis of budget neutrality and the proposed offset in the 2009 **Federal Register** publication of the physician fee schedule.

We invite comments regarding the appropriate methodology for determining budget neutrality. Written materials may be submitted by mail or e-mail to the addresses listed in the **ADDRESSES** section of this notice.

E. Site Selection

The statute requires that this demonstration be conducted in four sites—two rural and two urban; one site in each type of area must be a health professional shortage area (HPSA). We have selected:

- 26 northern counties in Illinois which includes Cook, Dekalb, DuPage, Grundy, Kane, Kendall, McHenry, Will, Boone, Bureau, Carroll, Henry, JoDaviess, Kankakee, Lake, LaSalle, Lee, Marshall, Mercer, Ogle, Putnam, Rock Island, Stark, Stephenson, Whiteside, and Winnebago, and Scott county in Iowa (urban);
- 17 central HPSA counties in Richmond, Charlottesville, Lynchburg, and Danville MSAs in Virginia (urban HPSA)—the Virginia counties include Pittsylvania, Campbell, Appomattox, Nelson, Buckingham, Fluvanna, Louisa, Caroline, Hanover, New Kent, Henrico, Richmond City, Goochland, Cumberland, Powhatan, Amelia and Danville City;
- New Mexico (rural HPSA); and
- Maine (rural).

We first grouped States by Medicare carriers, because we determined it was important that control and experimental sites should have the same carriers (since some carriers impose limits on chiropractor claims they approve). We then determined appropriate sites based on the following criteria:

- Exclude States with restrictive practice regulations.
- Exclude States that will not have transitioned to the MCS system in time for the demonstration.
- Exclude States that are ranked in the top or bottom 5 values for two or more of the following six statistics:

—Medicare per capita claims costs
—Medicare per capita chiropractic costs
—Per user (patient) chiropractic costs based on carrier data
—Chiropractic service users as a percentage of Part B beneficiaries
—Chiropractors per 10,000 State population
—Chiropractors per 1,000 Part B beneficiaries

- Exclude States among those remaining that are served by a unique carrier and, thus, would lack a potential comparison site.
- Each carrier group was assessed to determine its ability to support treatment and comparison groups for one or more types of sites.
- Data was then used to estimate the number of beneficiaries residing in Urban/Rural and HPSA/non HPSA areas and determine which of the remaining States could support a demonstration site or sites.

Few States had enough beneficiaries residing in HPSAs to be considered for one of the HPSA demonstration sites.

III. Collection of Information Requirements

This document does not impose information collection and record-keeping requirements. Consequently, it does not need to be reviewed by the Office of Management and Budget under the authority of the Paperwork Reduction Act of 1995.

Authority: Section 651 of the Medicare Prescription Drug Improvement and Modernization Act of 2003 (Pub. L. 108–173).

(Catalog of Federal Domestic Assistance Program No. 93.778 and No. 93.774, Medicare—Supplementary Medical Insurance Program)

Dated: December 17, 2004.

Mark B. McClellan,

Administrator, Centers for Medicare & Medicaid Services.

[FR Doc. 05–1505 Filed 1–27–05; 8:45 am]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS–5033–N2]

Medicare Program; Meeting of the Advisory Board on the Demonstration of a Bundled Case-Mix Adjusted Payment System for End-Stage Renal Disease Services

AGENCY: Centers for Medicare & Medicaid Services (CMS), HHS.

ACTION: Notice.

SUMMARY: This notice announces the first public meeting of the Advisory Board on the Demonstration of a Bundled Case-Mix Adjusted Payment System for End-Stage Renal Disease (ESRD) Services. Notice of this meeting is required by the Federal Advisory Committee Act (5 U.S.C. App. 2, section 10(a)(1) and (a)(2)). The Advisory Board will provide advice and recommendations with respect to the establishment and operation of the demonstration mandated by section 623(e) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003. This notice also announces the appointment of eleven individuals to serve as members of the Advisory Board, including one individual to serve as co-chairperson, and one additional co-chairperson, who is employed by CMS.

DATES: The meeting is on February 16, 2005 from 9 a.m. to 5 p.m., eastern standard time.

Special Accomodations: Persons attending the meeting, who are hearing