MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

Ronald Reagan Building
International Trade Center
Horizon Ballroom
1300 13th Street, N.W.
Washington, D.C.

Thursday, April 25, 2002
10:07 a.m.

COMMISSIONERS PRESENT:

GLENN M. HACKBARTH, Chair
ROBERT D. REISCHAUER, Ph.D., Vice Chair
BEATRICE S. BRAUN, M.D.
AUTRY O.V. "PETE" DeBUSK
ALLEN FEEZOR
FLOYD D. LOOP, M.D.
RALPH W. MULLER
ALAN R. NELSON, M.D.
JOSEPH P. NEWHOUSE, Ph.D.
JANET G. NEWPORT
CAROL RAPHAEL
ALICE ROSENBLATT
DAVID A. SMITH
RAY A. STOWERS, D.O.
MARY K. WAKEFIELD, Ph.D.

AGENDA ITEM: Coverage of non-physician practitioners
-- Marian Lowe, Jack Ashby
.. Clinical pharmacists providing collaborative drug therapy management (CDTM) services
.. Marriage and family therapists, pastoral care counselors, and licensed professional counselors of mental health
.. Surgical technologists who function as first assistants

MS. LOWE: Good morning. Today we're going to continue our discussion started in March regarding Medicare coverage of certain non-physician practitioners. As you'll recall, Congress directed MedPAC in the Benefits Improvement and Protection Act to study whether the following non-physician practitioners should be allowed to independently bill Medicare for their services: surgical technologists when they're functioning as a first assistant at surgery; several mental health providers, marriage and family therapists, pastoral counselors, and licensed counselors. And finally, we had an additional request from Congress, to address whether Medicare should cover clinical pharmacists for collaborative drug therapy management services.

As is the case for so many of the issues you're addressing today, this report is due in June. With the Chair's indulgence, I'm going to present these issues in reverse order to try and knock off the easy ones first, and save a little bit of additional time for the first assistant issue.

At issue here is whether Medicare should cover clinical pharmacists who provide drug management services, essentially assisting physicians with medication management, including services ranging from patient education to ordering and interpreting medicated related laboratory tests.

In your discussion last month you talked about several basic issues, that drug management may improve quality of care, especially for beneficiaries managing complex conditions with multiple medications, that the benefit should balance physician and pharmacist roles, but that the cost of such a benefit in Medicare is largely unknown.

Several important conclusions emerged from this discussion. In short, that this was an idea worthy of exploration, that the work necessary to determine optimal strategies for implementation of drug management services should begin sooner rather than later, as this may help inform the design of an outpatient drug benefit.

That said, we have brought back the following recommendation for your consideration to encourage continuing progress on this front. That recommendation,

that the Secretary should assess models for implementing collaborative drug therapy management services.

I'm going to pause there and try and do the discussion for these, and then we'll move on to the mental health next.

MR. FEEZOR: I guess just reading this and then reading where we talk about the fact that care management services need to be covered, and yet we're talking about a program that ostensibly doesn't pay a lot for at least outpatient drugs, and we're urging study of the coordination of that.

I just wonder if it doesn't need to be offered in the broader context, as studying for ways of collaborative drug therapy management services as a part of care management services, just to raise the question.

MR. HACKBARTH: So, Allen, you're proposing just to add those additional words to the recommendation? Not everybody heard them, so would you repeat them?

MR. FEEZOR: I guess the suggestion would be that collaborative drug therapy management services, as a part of larger care management services that might be considered. But if that takes us too far off, given the time, I'll withdraw it.

MR. HACKBARTH: When we take up the afternoon discussion, one of the potential benefits that we've been discussing is some sort of a care management benefit, but it's not yet part of the program, not yet a foregone conclusion that we would recommend to make it part of the program. So introducing it here may be putting the cart before the proverbial horse.

MR. SMITH: Maybe then we should wait and revisit this recommendation. Certainly, the emphasis that we're likely to place, and was reflected in the March meeting on care management more comprehensively would suggest we're headed down that road properly, I would think. And it would seem to me maybe we should put this aside, have that conversation, and then revisit this recommendation with Allen's amendment.

DR. LOOP: This is all ambulatory or outpatient; is that correct? Because it wasn't entirely clear.

MS. LOWE: The discussion that we're considering here is basically in regard to outpatient drug benefit, management of outpatient drugs.

DR. LOOP: There's one statement that you make in the text establishing a structure for the benefit in the absence of outpatient prescription drug coverage, seems unlikely to produce the necessary integration. Aren't those two distinct issues, a drug benefit package and this collaborative management services? Do we have to tie that together in the text?

DR. ROSS: The reason we bring them together is -- they are distinct in the sense that you probably wouldn't do this in the absence of an outpatient prescription drug benefit. But if you were going to consider looking at the collaborative therapy management, that might influence the nature of the drug benefit you'd offer and how you offered it.

That was sort of the gist of why might you be looking at models for this now, so you'd have a knowledge base if and when Congress gets around to doing the drug benefit.

DR. NEWHOUSE: It's not clear to me that you'd have to be linked with an outpatient drug benefit. I didn't read it that way either in our discussion. I read it as it could be linked, but it could also stand on its own.

MR. HACKBARTH: My understanding was that was the context for the request. They asked us to evaluate this before a drug benefit had been enacted, which implies that it could be done separately.

DR. NEWHOUSE: Also in terms of the afternoon discussion, this is a separate report, as I understand it. So it's not as though this would be in the same report as the June benefit discussion.

MR. HACKBARTH: Let me just pick up on the connection, or perhaps not a connection between the two. The broader issue of care management is one of the topics we've been discussing under potential revisions in the benefit package. As we have discussed, we do not, at this point at least, plan to make specific recommendations in that report. It is an educational document, as opposed to a recommendation document, the way our March report is.

If we include language here that says the Secretary should do this in the context of a broader care management benefit, we have now said we're going to start to make recommendations about revisions of the benefit package, which takes us into an area where we said we were going to stay out of.

So that is my reservation about adding that language that you suggest, Allen. Am I misunderstanding your intent? I know you disagree with me, David. Do you want to articulate your disagreement?

MR. SMITH: I'm not sure I disagree. It would seem to me we could do precisely as you suggest and respond to Congress' request by saying the Secretary should, and then another sentence that says particular attention or the Secretary should also consider ways in which drug management programs could be, should be integrated with overall care management.

I think it's sort of goofy not to say that if we're going to make that point as clearly as I think we

intend to make it in the June report.

MR. HACKBARTH: I wouldn't have any reservation about saying that outside the bold-faced language, that if you do this it might be logical to look at it not just as drugs but in the broader context. But having bold-faced recommendation language for a care management benefit, I think goes through a door that we said we weren't going to go through.

MS. ROSENBLATT: I'm concerned about what is in the bold-face. I think we were asked to look at should there be a drug management program now, without there being outpatient drug benefits. I almost think we need two recommendations, one particularly geared to that. And I would say I don't see how you can do that when you don't have the data on drugs. So I would say no, there should not be a drug management program in the absence of outpatient drug benefits.

The second piece of the recommendation is if outpatient drugs are introduced to the program, there should be a drug management program along with the introduction of those drugs. That's how I would do it.

MR. MULLER: Though our data indicates that of the beneficiaries who have need for drugs, they use quite a bit of them and it's pretty high out-of-pocket costs. So I think an argument can be made that giving them some assistance in managing that, even though it's not a direct Medicare program right now, is a reasonable argument. And I think, in some ways, waiting for drug coverage to occur which -- like other people, we're always told it's around the corner but it may not be around the corner for quite a while.

But obviously the assistance that a segment of the beneficiaries, a sizeable proportion of beneficiaries use a lot of drugs and they need some help in that. So I do think it can be separated and would be with those people who think it doesn't necessarily have to be linked to adding prescription drugs to the program.

MR. HACKBARTH: Murray reminds me that I may be trying too hard here, and that the actual draft recommendation is one that we should assess, as opposed to an actual recommendation that we do some sort of drug therapy management benefit. If we are talking about the Secretary ought to assess it, then putting it in the context of well, assess it in the context of broader care management services may not be a problem.

We're off to a very deliberative start but probably we're not using our time wisely.

DR. NEWHOUSE: My comment was along the lines of your last comment, which is the operative sense in the text for me was at the bottom of page five, the Secretary should

start now to develop and test models, direct management models -- there's a type there -- because this might help inform the design of future benefits.

That sounded to me like we were looking toward a demonstration of a sort, as opposed to a benefit. That's what I thought I was going to vote on.

DR. REISCHAUER: In some sense that was my problem too. I had a difficult time with the word implementing because implementing is something very different from demonstrating the effectiveness and the way which this might be coordinated with a larger benefit.

I would also just say that I'm concerned about a discussion of benefits that raise serious equity issues. I would say that while they are separable, to provide a benefit like this before we've covered drugs raises a significant equity issue, because those without prescription drug coverage tend to be lower income, tend to be more vulnerable groups. Not the very poorest, because they're covered by Medicaid.

DR. NEWHOUSE: But they still use drugs.

DR. REISCHAUER: But you're talking about managing something that some people don't have an ability to access. And I think I would spend whatever marginal resources I had trying to provide the basic input, rather than the management of it.

DR. NEWHOUSE: Why can't they access it? I assumed you were providing this benefit for everybody, irrespective of whether they had insurance to cover the cost of their drugs.

MR. HACKBARTH: Potentially the people who have the fewest resources maybe are in the greatest need of help in making sure they're not taking duplicative, inappropriate drugs.

DR. REISCHAUER: They tend to take fewer drugs and more often don't take the drugs that they need. I'm just saying if I were allocating my resources, this wouldn't be higher on the list than providing the basic drug benefit itself.

MR. HACKBARTH: Before we leave, Bob, do you have specific language, Bob, that you would use to replace implementing? Models for collaborative drug --

DR. ROSS: -- assessing and implementing. Strike that.

DR. STOWERS: Mine was the same thing, not to be redundant. I was going to add something like before adding a CDTM benefit to Medicare, the Secretary should assess models. Because the way, with the word implementing, I think we were saying that it should be implemented and it should be a benefit. And what I think we need to get across here is before we would recommend adding that benefit to

Medicare there should be this assessment done, I think is much more clear in our intent.

Because from this we could say we think it should be added and we just need to pick which model. I think that's what this inferred. So I think we need this before implementing or before adding or whatever, or somehow explained if not directly in the recommendation, for sure in the text.

MR. HACKBARTH: I propose what we do is say, the Secretary should assess models for collaborative drug therapy management services. And then in the text we make Ray's point, make it clear that we're not assuming the benefit but we're looking at ways that it might be done if the benefit were added.

And then also in that text, make Allen's point that there's a broader issue here of care management services and drugs is just one facet of that bigger problem.

DR. NELSON: I know you want to end this but the basic question was whether we open a new category of practitioner to directly bill for Medicare services. Apart from whether there's a drug benefit or not, you could have a drug benefit and still say that pharmacists can't bill for patient care.

And so don't fuzz it up in the text in a way that prejudges that issue.

MR. HACKBARTH: Help me. Was there something that I was saying that would fuzz it up in an inappropriate way?

DR. NELSON: No.

MR. HACKBARTH: So the draft recommendation on the table is the Secretary should assess models for collaborative drug therapy management services. Are we ready, do you want to vote on those now or just vote on all the recommendations at the end?

DR. ROSS: Let's do it now.

MR. HACKBARTH: All opposed to the draft recommendation, raise your hand?

All in favor?

Abstain?

You had no idea, Marian, that it would take that long, did you?

MS. LOWE: Up next, Medicare coverage of non-physician mental health providers.

Once again, we were asked to assess whether or not Medicare should extend coverage and allow those providers to bill independently for their services. As we discussed at the last meeting, each of these practitioners provide viable services to their communities. However, we have some very limited data to assess the ability of whether these providers are able to fulfill unmet needs of Medicare beneficiaries in the areas in which they practice.

Second, that these providers, in some cases, are not licensed in all -- in the case of all of these providers, none of these are licensed in all 50 states, as is the case with the other non-physician providers currently able to provide mental health services under Part B.

And also, this is likely to cost additional money either by fulfilling current unmet needs or by expanding additional capacity in urban areas. One of the points of our discussion last month led to the issue that the barriers to access mental health services that cut across both urban and rural areas are both financial and cultural. Certainly the financial barriers is the area in which Medicare policy can address those issues. And that has led us to bring back the following recommendation.

That Congress should not allow marriage and family therapists, licensed professional counselors of mental health or pastoral counselors to bill Medicare independently for mental health services, noting in the text the Commission's sense that reducing beneficiary cost-sharing offers greater potential for improving access to mental health services than does covering additional providers.

DR. WAKEFIELD: I'd like to make a few comments on this recommendation, but the comments that I'll make actually derive from some of the statements in the text because the text leads us to this recommendation as its currently framed.

Let me just start off by saying I put my bias out on the table. I don't support this recommendation and how the vote goes is probably a different outcome. But I want to share why that is the case and, as I said, make a few points.

According to this text, the existence of mental health professional shortages is doubtful. We cast it carefully, saying it might exist, not sure, not a lot of precision around that conclusion. Part of the issue for me is that this is really caught up in a much bigger issue. Medicare doesn't own this problem. That is, if the problem exists, access to mental health services, it's not just unique to Medicare. That's frequently the problem that we get into, that Medicare can't solve the much bigger woes of the world. So I want to acknowledge that right up front, that the comments I'm going to make I recognize are cast in a larger context.

Nevertheless, I think it's worth noting that according to the HHS office of designations, health professional shortage designation areas, as you know, we've got designations for primary care health profession shortage areas, for dental, and for mental health. And we've got about 50 percent of our counties that, applying that definition -- which is not a perfect definition but it's the

only one that I'm aware of at the federal level for mental health.

Applying that definition, we have a lot of counties in the United States that have mental health profession shortage -- that are designated as mental health profession shortage areas. And in those counties we have about 40 million people residing. And of those 40 million people, no doubt some of them are Medicare beneficiaries.

So cast in that broad a context, and I think that my read on this chapter takes me to a slightly different place, which is a little bit too much of a caveat built around the notion of whether or not shortages exist.

When the federal office determines whether or not a health profession shortage area exists, they look at the population-to-provider ratio. They've got about five categories that they incorporate in that population-to-provider ratio. Those categories are psychiatrists, psychologists, mental health nurses, social workers, marriage and family therapists. Those are the categories that the government counts, including marriage and family therapists.

If you look at that designation, about 95 percent of Wyoming is in a mental health shortage area. When I was out with Senator Baucus and his staff about three weeks ago in Montana, I believe there is no psychiatrist, for example, east of Billings. There are some rural Medicare beneficiaries who reside east of Billings, for example.

So it's just that broader context of how we're casting this issue of access that I think I've got a slightly different take on it than how it's represented in the text.

I'd also say that in the text we talk about a lot of different barriers. And I think everyone recognizes that there isn't one single problem that drives shortage to mental health benefits. And the text does a nice job of saying there are lots of multiple barriers. But I think that even if we address some of those other barriers, like payment policy, if we've got basic fundamental access to health care provider problems it can change co-pays. And if there's isn't a provider out there to meet that need you still have a problem, I think, with access.

And I also say that on the HHS report that was cited in the text, from 2001, there are points from that report -- and I know we've got to be concise here -- but points from that HHS report that weren't cited. That report from HHS specifically speaks to access to workforce and says, just for the record, the section on workforce says -- here's the challenge: more geriatric mental health professionals and paraprofessional personnel are needed in the fields of medicine, mental health, and social services.

They state it specifically in that HHS report. Then they identify strategies. Expand the pool of mental health personnel and training opportunities, and they go on from there.

In that same HHS report, we don't pull that data into this read. But in that same report it says many older persons do not recognize their own mental health needs, don't know how to access and use the service delivery system. Older persons who live alone, are geographically isolated, frail or physically disabled have particular difficulty accessing services which tend to be in short supply.

So we've got sections of the report that I think would be useful to help frame our thinking when we're talking about this particular issue.

The last point I could make, because I could go on and on and I won't. But one of the last points I make is we've got, for example, a comment in this document -- and I didn't go back and take a look at that particular reference -- but it says non-physicians basically -- a citation from the American College of Physicians, American Society of Internal Medicine, that says you don't see non-physicians wanting to practice in underserved areas.

And yet in our next document, behind the next tab, we've got data that says use of non-physician providers, NPs and PAs are higher in rural areas. And in the Hartley study that was just done they say, in fact, you've got a higher use of social workers in rural areas than in urban areas.

So there's just lots of information here that's kind of hard to cull out. But I don't think this text goes -- I think this text could move more strongly, at least in acknowledging this broader context of problems around access, from my perspective, around access to care.

And in all honesty -- the last point, I promise, to make here -- is that the statement and text on this draft recommendation as I look at it, reducing beneficiary cost-sharing offers greater potential for improving access to mental health services. That was in our text, as well, that we reviewed. I'm not exactly sure where the evidence for positioning the first change against the second is. But what I'm fairly sure of is that there isn't one silver bullet that's going to address all of the problems with ensuring that Medicare beneficiaries get access to adequate mental health services.

I can tell you, based on CDC data released last year, when they cut their data rural versus urban, we've got a much higher rate of suicide, for example, in rural areas. And the more rural you get, the higher those suicide rates go. That's not just for Medicare beneficiaries. It's for the rural population.

So I think it's an awfully difficult problem, I think. But at the very least, I'd see reimbursement in underserved areas, in health profession shortage areas, for these providers to at least assure that level of access. I recognize cost is an issue that all of us are concerned around the table, and the cost to the Medicare program. If we're meeting unmet needs of access, it's probably going to cost something. If we're substituting a marriage and family therapist for a social worker, that substitution is probably not going to cost anything in addition.

But I recognize cost is an issue. And I think if we frame this, and we're concerned because of costs, maybe we need to state that more strongly. If we're framing this because there's really not an identified access problem, or these people provide different services, I don't think that the graph that's provided bears that out. There's a lot of overlap in the services provided.

So, I'll just stop there.

MR. HACKBARTH: How do you want to proceed? Do you want to offer an alternative to this, that you would ask people to vote on?

DR. WAKEFIELD: My alternative to this would be to at least consider health profession shortage areas for reimbursement of this category of provider.

DR. NEWHOUSE: I thought about that issue in the text too, partly because there are some data that these people are where psychiatrists aren't. But in my view, Mary stated out by saying the HPSAs were imperfect. My own view is that that's an understatement, and it's enough of an understatement that I would be reluctant to actually base policy on it, although we have precedent for that in Medicare, but I would support it.

Part of the problem is the HPSAs generally are based on counties and counties are not a natural market area. You may cross a county line and get to another provider. The no psychiatrist east of Billings is a real issue, that's not an artifact of the HPSA definition. But to then carry it into basing payment for all of these providers, if they're in HPSAs, is further than I at least am willing to go. And I don't see any step short of that. That is, I don't see any alternative to using the HPSA to address the problem.

DR. NELSON: Marian, on chapter two, page 2, you indicate that professional clinical counselors, marriage and family therapists, and pastoral counselors may bill Medicare for counseling under Medicare's incident to physician services. Is that something that is widely used? And if so, how does it work?

That is, will clients avail themselves of services on a weekly basis over a spell of time? How does it

operate?

MS. LOWE: My understanding, based on how the claims are received by Medicare, when it's a service provided incident to it's very difficult to determine who is actually providing that service. So it's hard to tell how often this mechanism is being used.

As far as the course of treatment goes, I'm really not able to speak to what that service looks like. But my understanding is conceivably it's something in a group practice where there are other non-physicians working in the same office as a psychiatrist.

DR. NELSON: Can I pursue it just a little?

MR. HACKBARTH: Yes.

DR. NELSON: Do the trade groups that represent, for example, these categories of clinicians indicate that oftentimes pastoral counselors work in conjunction with a physician and bill incident to? I mean, I don't know whether this is a way of dealing with the access, with the shortage problem or not. I don't know whether out in the areas where there aren't any psychiatrists, whether or not any other mental health clinicians are working with the family practitioners and provide services. That's the reason I'm trying to get a hold of.

MS. LOWE: I would think out in the areas where there's very limited access to psychiatrists, that the ability of a non-physician to bill incident to is likewise extremely limited. And I don't have any data to suggest how closely the non-physician mental health providers are working with primary care physicians in those areas.

MR. HACKBARTH: As I recall from our discussion last time, I think Ray was pointing out that under the incident to there's no requirement of physical proximity and being in the same practice location, is there? There simply has to be some sort of a relationship established, relationship between the physician and the non-physician provider; is that right?

So conceivably you could have a physician connected to, in some fashion, these non-physician providers of mental health services in shortage areas.

DR. STOWERS: Yes, I think that would especially be true, only be true that I know of, like in the rural health clinic thing, where they allow them not to be in the same facility in several states.

My question is not only physicians but are the other mental health workers that are paid directly, are they able to be the sponsoring individual in an incident to, or is it only for physicians? Like can a psychologist that can get direct payment work with a marriage and family therapist and still use the incident to type? Could that type of a team be used in a rural area?

MS. LOWE: It's my understanding that the incident-to policy is in reference to a physician only.

DR. REISCHAUER: One comment about something which was in the text which suggested that resources devoted to raising or lowering the coinsurance might have a bigger impact on access than this would. I'm just questioning whether we know enough to say that. Medigap policies pick up coinsurance and employer-sponsored ones do. So lots of folks out there really don't have huge coinsurance out-of-pocket costs because their supplemental is doing what Medicare isn't.

And so I'm a lot less sure of that. And if I had to just pull out of my pocket one thing that would be better, in a sense, it would be covering pharmaceuticals that are associated with mental illness, rather than changing coinsurance.

I listened to Mary and I think a lot of what she says is quite compelling, but it strikes me that these three sets of potential providers that we're talking about here are not necessarily equal in worthiness. And we're treating them in a way as if they are. You see that clinical counselors are trained in schools of education. That makes me a little uneasy. Pastoral counselors are yet a different kind of fish. And marriage and family therapist, it strikes me, are the closest to the medical model that we all cover.

So if we were going to go away from the draft recommendation, I would want to split the recommendation with respect to the providers that we're being asked to consider. Because at least I don't know enough to be comfortable that they all would deserve the same kind of access to Medicare.

MR. HACKBARTH: Here's how I'd like to proceed. First I'd like to get people's reactions to Bob's statement about the statement in the text here that -- what I hear you saying, Bob, is you're not really sure that the evidence supports the statement in text. I saw at least a couple of other heads nodding in agreement with that.

Any alternative point of view to what Bob expressed on that issue?

DR. REISCHAUER: That's just a modification in the text. It could remain and say there are other things, too.

MR. HACKBARTH: The reservation that I had about--

DR. NEWHOUSE: You can say may offer, and you can cite the drug example.

MR. HACKBARTH: I don't want the whole argument to turn on just this one point, so it can be one of several things mentioned. And I would feel comfortable with that.

DR. WAKEFIELD: On Bob's point, I don't know enough about educational background, et cetera, of each of these providers, either. And so it's hard for me to stand

in judgment of what any one of them offers that might be somewhat different.

What guided me a bit on this was it seemed to me on the table that's provided at the end of this chapter, when you look at the services that are provided by these different groups, it didn't seem like there were marked differences in terms of the services provided. So you're taking it from the educational side and what drew my attention, that left me with a little more of a leveling of the playing field, was on the services provided side.

And if I could just say, I agree with Joe on the point about health profession shortage areas. It's not an ideal formula by any stretch of the imagination. Nor are a lot of the formulas probably embedded within Medicare. They are sort of what we've got to work with, for better or worse. So I acknowledge the point but there's just nothing else.

MR. HACKBARTH: That's the second point that we need to take up, Mary, whether you want to offer alternative language to this that we would vote on.

DR. WAKEFIELD: Why not, Glenn?

MR. HACKBARTH: Now having said that, you've got to tell us the precise language that you want us to consider.

DR. WAKEFIELD: The Congress should allow marriage and family therapists, licensed professional counselors of mental health and pastoral counselors to bill Medicare independently for mental health services in federally designated health profession shortage areas.

MR. HACKBARTH: Let's have all opposed to Mary's alternative recommendation raise their hand?

All in favor?

Abstain?

Okay, now we'll proceed to the draft recommendation up on the screen.

All opposed?

All in favor?

Abstain?

And we're finished with that one.

MS. LOWE: Last but not least, the question of Medicare coverage of certified surgical technologists when functioning as first assistants.

The next slide here is just very briefly, to refresh your memory, an overview of how the Medicare program pays for first assistant surgery services at this point. I've added to there basically the surgeon who gets their surgical fee. If co-surgeons are performing a procedure, they equally divide 125 percent of the surgical fee.

The providers of first assistant services range across the board as far as their educational background as

well has how the Medicare program pays them. Physicians and other surgeons bill 16 percent of the surgical fee. The non-physician providers, physician assistant, nurse practitioner, and clinical nurse specialist bill at 85 percent of what the first assistant physician would be paid.

Residents are not paid separately by Medicare because their costs are recognized in graduate medical education payments. Surgical technologist and registered nurse first assistants, who constitute the bulk of the other folks providing this service, their costs are considered included in the facility payment bundle.

As you will recall, there's a lot of different ways that we can consider payment for first assistant services. In our discussion last month we talked about the virtues of bundling and unbundling these payments and who to include in those bundles or who to leave as independent billers of the Medicare program.

Basically, I wanted to lead us through a discussion of whether to bundle or unbundle, which will bring us down to considering either three options or two. I want to start with the issue of bundling and just go through the pros and cons very briefly and move on to unbundling and do the same.

Basically, if you bundle, there are several advantages to this approach. You eliminate inconsistencies in the current payments that, from the hospital perspective, favor the use of those first assistant service providers who are eligible to bill Medicare Part B directly.

Secondly, you encourage the recipient of the bundled payment to use the least expensive type of personnel consistent with surgical quality. And three, you certainly simplify Medicare claims administration for Medicare carriers and fiscal intermediaries.

On the disadvantages to bundling, there are several different things that can be considered here. One, redistributing the costs of first assistant service providers paid under Part B, currently that's a little less than $200 million, across all hospitals performing -- that is redistributed across all hospitals performing surgeries, regardless of who performs the first assistant service.

In that case, payment to teaching hospitals able to use residents as first assistants will see an increase in their payments without incurring any additional costs. On the other hand, community hospitals, in contrast, would get the same level of payment increase but would also incur the additional cost of paying the physician or non-physician provider who functions as a first assistant, who they had previously been not having to compensate those people because they are paid under Part B.

Second, on the disadvantages, this may reduce the

independence of surgeons to utilize a specific individual or type of practitioner as a first assistant by establishing a financial incentive for hospitals to use the lowest cost provider. And third, we're looking at potential disruption of current employment arrangements between surgeons, first assistants, and the facilities where these procedures are performed by changing how we make those payments.

Moving over to the unbundled side, that would leave you with two basic options, which is maintain current law or reconsider the list of providers eligible to bill Part B independently for first assistant services. When you look at the advantages of the system that we now have or the slightly modified system, certainly unbundling fosters maximum autonomy for the surgeons to select the most appropriate practitioner to serve as a first assistant. It allows flexibility in employment relationships for independent contractors and employees or associates of surgeons.

And third, kind of as a function of this policy, we have in place a system that promotes opportunities to learn procedures or gain experience with new technologies for new surgeons or established physicians while working as a first assistant.

The disadvantages of unbundling payments is that you have no incentive to use lower cost providers in situations where doing so would be consistent with surgical quality, that expanding eligibility to bill the program, in terms of the number of practitioners able to bill independently, may result in increased cost growth. And third, that additional providers would increase the complexity of the provider enrollment process that Medicare contractors use to verify these practitioners' qualifications, especially in the case of some surgical technologists where in all but one state -- Texas -- these are unlicensed practitioners. And so there is no state regulatory agency to fall back on to designate a scope of practice or some baseline verification qualifications.

If I could pause there and ask for some discussion of the virtues of bundling and unbundling, then we can move quickly into the remaining options, depending on which approach you take.

MR. HACKBARTH: Comments on the issue of bundling and unbundling?

DR. LOOP: The problem with bundling is whether it's the physician or the surgical technician who assists, they are often not in the employ of the principal surgeon, and that makes distribution of the payment difficult. For example, in option B, which is to bundle the payment for all non-physician first assistants with the Part A facility fee, this would mean essentially that these people would have to

be employed by the hospital. So that's the biggest problem with bundling.

MR. HACKBARTH: My personal take on this was there's some conceptual appeal to bundling; i.e., that it would create an incentive to use the lowest cost clinically appropriate provider of the services. But there needs to be a compelling reason, in my view, for requiring a reworking of employment relationships. If the payment mechanism does not match the existing way the world works, you need to have a compelling reason to say well, we're going to force the world to adapt to a new payment policy.

I'm not sure that the gains from bundling, in this case, are so great as to require the rest of the world to accommodate to this payment policy.

DR. NEWHOUSE: I'm sympathetic to that point of view but I wasn't clear as to why it required employment. That is, why couldn't the person work as an independent contractor with the hospital?

DR. LOOP: Isn't that fee-splitting then?

DR. NEWHOUSE: It would be fee-splitting with the surgeon. It's not clear it would be -- in a sense, it is fee-splitting, but bundling basically implies that.

Again, the game may not be worth the candle. I'm very sympathetic with that. But I don't think we can premise what we're doing on saying we don't want to require an employment relationship, because I don't think bundling implies an employment relationship.

MR. HACKBARTH: To me it's not that we require an employment relationship but we've got a variety of different types of relationships between the assistants and the hospitals and physicians, independent contractors. And to try to require changes in that existing institutional framework, I think is something that you do if you think there's a really compelling reason to do so. I just don't think the gains from this bundling of the payment are going to be so great as to say everybody adjust to us.

DR. NEWHOUSE: I agree but it's not clear how much adjustment is being required. That's what I'd like some discussion of anyway. Couldn't these various relationships flourish anyway?

DR. REISCHAUER: I want to know who makes the decision that an assistant is necessary, because in theory that is -- if there's bundling, it should be bundled with the decisionmaker. I don't know the answer.

DR. LOOP: The surgeon makes the decision whether they need an assistant and what type of assistant, and it varies by location. I'm sure there's fewer assistants out in far rural reaches than there are in urban areas. So you have a different -- probably in rural areas, you'd have to ask Mary this, but you'd have more physician assistants.

And in urban areas, you'd have more surgical technologists.

But it depends on the type of case. There's a huge spectrum of cases, too, that require assistants.

MR. HACKBARTH: One other issue about the bundling that's at least pointed out in the text is that, at least some of the bundling options imply a significant redistribution of payments among, for example, the hospital bundling option. Given that the residents that serve as the assistants in many of the urban hospitals are totally out of this equation, if we say we've got a new hospital-based bundling policy, there's a redistribution of dollars that occurs, as well as potential changes in the institutional relationships.

I think again, for the policy gains from bundling here, to go through redistribution and changes in institutional relationship, I just don't think it's a prudent step to take. That's my own personal view.

DR. NELSON: Just to say that I agree with you. Last month I said, all assistants are not the same, patient needs aren't all the same. In rural areas, it may well be that there's one surgeon and half a dozen general practitioners or family practitioners. And the proper kind of additional hands during a surgical procedure would suggest that the referring physician, general practitioner, may very well be the best first assistant. And bundling that fee into the surgeon's fee and requiring then a payback to the referring physician is fee-splitting.

There's just a whole host of complexities that we don't need to take on. That's the reason why I think...

MR. MULLER: I echo your thoughts as well. I think undoing this gets very complicated. I think the text covers the issues very well. The discussion has added to that. The gain to be had doesn't seem to be sufficiently there to make it worthwhile.

I think both Floyd and Alan have spoken to the varieties. Let me just mention the area I'm more specific with, they're not just residents. They're also our assistants in these big hospitals. So it's not just that it's all just a substitution effect, for the reason that Floyd has mentioned, the complexity of the cases. So until somebody articulates a reason as to the gain we would get from, this, is strikes me going back to bundling just raises a host of issues that probably are even greater than we can enumerate at this moment.

DR. REISCHAUER: It would have been nice, and maybe the data isn't available, to look at a series of procedures and the incidence of having an assistant and the type of assistant. Because my guess is that what Floyd said is right, that it varies all over the lot. And with bundling we, in a sense, create an incentive to stint where

an assistant maybe should be used. What you're doing is providing an average across -- it could work the other way. You're overpaying some and underpaying others, is the problem.

I don't know how we could have been so misguided in our discussion at the last meeting.

MR. HACKBARTH: So we've had our bundling discussion. It appears that we're unbundling.

MS. LOWE: So we would like to consider options D and E; is that what I'm hearing?

MR. HACKBARTH: Yes.

MS. LOWE: We'll flip forward to the last slide in your packet then, since we chose unbundling payment. This leaves us with two options. Option D, which is essentially to maintain current law, that we believe a list of providers eligible to bill Medicare for Part B for first assistant services should not be modified. Or option E, that Medicare should expand the list of providers eligible to bill Medicare Part B for first assistant services to include certified surgical technologists.

I'll just leave it at that and let your discussion continue.

MR. HACKBARTH: Comments on options D and E?

MR. MULLER: Not a strong feeling, but I think the argument in the text that Mary has articulated, about there being less oversight, less licensing, less education on the part of these technologists is fairly persuasive therefore for not adding them in. It just seems to me more variation than one would want to bring into the program as independent.

In the current somewhat bundled fee, the institution can make a judgment as to if they want to take the risk of taking on a person that may not be fully appropriate and so forth. But I think having an independent status for them, given the variation of licensing requirements and so forth, strikes me as not worth getting into at this point.

MR. HACKBARTH: Help me understand the decisionmaking process a little bit. To me, in this case, the principal quality control is not coming from the licensing of these people or the lack of licensing, but rather whoever chooses then to be at the operating table, whether that's the surgeon or the hospital.

MR. MULLER: The surgeon does, as Floyd indicates. But the kind of liability the institution may take on if the person is not licensed can be greater. I fully agree that the surgeon will make that judgment. The kind of quality control apparatus of the institution may say don't take on those kind of people because of something goes awry and the person is not licensed we get hit.

MR. HACKBARTH: So what I'm getting at is, if people are practicing independently, out there in the community, but my way of thinking might be a little more dependent on the licensing bodies and the certification bodies to assure the quality.

Here you've got lots of other people making sure that only appropriate people get to that operating table, and potentially liability of the wrong people get there. So I'm not all that worried about whether there's great licensure or not, in this case, as I might be in some other cases.

MS. LOWE: As far as the decision as to who serves as the first assistant in the current setup, your issues about licensing as a quality check, I think, are minimal. From the carriers' side and from the Medicare enrollment and processing and knowing who to send the check to, and being able to verify one's credentials to be able to enroll them in the program and bill independently, in a sense we may be asking the carriers to function as credential verification agencies in the absence of state licensure. And not having a defined state scope of practice, the carriers having very little guidance as to what services can and should be performed based upon one's qualifications.

DR. LOOP: This may be stretching our mandate, but although it's well stated in the text, I think we could make a plea for uniform standards and better credentialing. There's only a few states that have any standards and the licensing is a hodgepodge. And then you have, at the bottom of this, the poor orthopedic assistants that are hanging out there with little or no reimbursement. If we could tighten up standards and credentialing, licensing, whatever you want to call it, I think if we could say it, that would be doing a service.

So I am against independent billing because there are no standards and few thoughtful credentialing.

MR. HACKBARTH: Other comments?

So option D and E, we have mutually exclusive options. Why don't we choose to vote on option E, which was the question before us. Should we expand the list to include these certified surgical technologists?

All opposed to option E?

All in favor?

Abstain?

Okay. Thanks, Marian.