

J U N E 2 0 0 2

REPORT TO THE CONGRESS

Medicare Coverage of Nonphysician Practitioners

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MEDPAC Medicare
Payment Advisory
Commission

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Executive summary

Executive summary

Medicare Part B pays for services provided by physicians and certain nonphysician practitioners, such as psychologists and nurse practitioners. Other categories of nonphysician practitioners are not recognized as Medicare providers and thus are not able to bill the program independently for their services, although in some cases payment for their services is made to the facility or as incident to the professional services of a physician. In the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000, the Congress required MedPAC to assess providing Medicare Part B coverage for services rendered by surgical technologists, marriage and family therapists, pastoral counselors, and licensed professional counselors of mental health (licensed counselors). A separate congressional request asked MedPAC to consider coverage for clinical pharmacists providing drug therapy management. In this report, we make three recommendations regarding whether these nonphysician providers should be included as recognized practitioners under Medicare and permitted to bill the program independently for their services.

Surgical technologists

Each year, Medicare pays for more than 70 million surgical procedures. Medicare allows payment under Part B for a first assistant at surgery during complex procedures when a second set of skilled hands may be necessary. This additional payment is made for less than 2 percent of surgical procedures. First assistant payments cover physicians and certain nonphysician practitioners, and total payments for first assistant services have fallen since the physician fee schedule was implemented more than 10 years ago. Payment for first assistant at surgery services performed by other providers, including certified surgical technologists and registered nurse first assistants, is covered as part of the prospective payment to the facility (usually the hospital). We see no compelling reason to change how Medicare pays for first assistant at surgery services performed by surgical technologists, a group of providers licensed in only one state. Accordingly, the Commission recommends that the Congress should not expand the list of providers eligible to bill Medicare Part B for first assistant services to include surgical technologists.

Marriage and family therapists, pastoral counselors, and licensed professional counselors of mental health

There has been concern that Medicare beneficiaries lack adequate access to mental health services—particularly in rural areas—and it has been suggested that this could be addressed by allowing additional nonphysician providers to bill Medicare directly. Beneficiaries' access to mental health services in both urban and rural areas is hindered by many barriers such as high copayments and lifetime limits on inpatient psychiatric care. Addressing the barriers to mental health services embedded in Medicare payment and coverage policies may have greater potential to improve mental health services for the largest number of beneficiaries than would expanding the list of recognized providers. Expanding the list of covered providers would likely increase costs to the Medicare program without improving access proportionately in problem areas. On this basis, the Commission concludes that the 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.

Clinical pharmacists

Evidence suggests that drug management programs may decrease the likelihood of medication errors and improve medication regimen adherence, which could improve the quality of care for a subset of Medicare beneficiaries managing chronic conditions or taking multiple medications. The Commission sees potential for a Medicare drug therapy management benefit to facilitate access to an important health care service for some beneficiaries. As the Congress contemplates Medicare coverage of outpatient drugs, including drug management services with that benefit may provide a mechanism to optimize medication therapy. Establishing a structure for drug management in the absence of coverage for outpatient prescription drugs, however, may not produce the necessary integration of providers, services, and products to achieve significant quality of care improvements for beneficiaries. The Commission is concerned that limited Medicare dollars should not be used managing a treatment that Medicare does not yet cover and that defining coverage and payment policy for clinical pharmacists may constrain future consideration of prescription drug coverage options. Nevertheless, assessing drug management models now could help inform the design of an outpatient drug benefit. Therefore, the Commission recommends that the Secretary assess models for collaborative drug therapy management services.

CHAPTER 1

**Medicare coverage of surgical
technologists when functioning as
first surgical assistants**

R E C O M M E N D A T I O N

The Congress should not expand the list of providers eligible to bill Medicare for first assistant services to include certified surgical technologists.

***YES: 14 • NO: 0 • NOT VOTING: 0 • ABSENT: 3**

***COMMISSIONERS' VOTING RESULTS**

Medicare Part B covers physicians and certain types of nonphysician practitioners when functioning as the first assistant in surgery. Payment for first assistant at surgery services performed by other types of providers, including surgical technologists and registered nurse first assistants, is covered as part of the prospective payment to the facility (usually the hospital). Surgical technologists and registered nurse first assistants (or their employers) have sought statutory authority to bill Medicare separately under Part B for their services when acting as the first assistant to the surgeon, although MedPAC was asked to address this issue only for surgical technologists. The Commission does not believe any modifications are necessary to Medicare’s payment policy for certified surgical technologists who provide first assistant at surgery services.

Background

Each year, Medicare pays for more than 70 million surgical procedures. Medicare allows payment for a first assistant at surgery during complex procedures when a second set of skilled hands may be necessary—this is an additional payment the program makes for less than 2 percent of surgical procedures. First assistants participate in surgical operations and actively assist the surgeon as part of a working team by providing aid in exposure, hemostasis, and other technical functions, helping the surgeon carry out a safe operation. The role varies considerably with the surgical operation, specialty area, and type of hospital (ACS 1997).

Prior to 1986, only physicians could bill Medicare independently for serving as first assistants. As part of the 1986 Omnibus Budget Reconciliation Act, the Congress authorized Medicare Part B coverage of physician assistants as first assistants at surgery on a discounted fee basis—65 percent of what a physician would have received—and specified that payment would go to their employers on an assignment basis. Nurse practitioners were added as first assistant providers in rural areas through the Social Security Amendments Act of 1994. Shortly thereafter, the Balanced Budget Act of 1997 expanded coverage for first assisting to include nurse practitioners and clinical nurse specialists in all settings, and raised the payment rates for the three nonphysician groups to 85 percent of the physicians’ first assist fee. Residents—the primary providers of first assistant services in teaching hospitals—are ineligible to bill for Part B payment for first assisting. Payment for their services is covered through Medicare’s graduate medical education payments (Table 1-1).

**TABLE
1-1**

Payment for surgical services: current law

Provider	Payment
Surgeon	100 percent of surgical fee
Co-surgeons	125 percent of surgical fee, equally divided
First assistants	
Physician	16 percent of surgical fee
PA/NP/CNS	85 percent of physician first assistant fee
Resident	Not paid separately by Medicare
Registered nurse first assistant	Included in facility payment bundle
Surgical technologist	Included in facility payment bundle

Note: PA (physician assistant), NP (nurse practitioner), CNS (clinical nurse specialist).

Source: Centers for Medicare & Medicaid Services.

The Physician Payment Review Commission (PPRC) examined payments to assistants at surgery in 1991. At that time, only physicians and physician assistants were paid on a fee-for-service basis for this service. With respect to nonphysician providers, PPRC identified two alternatives to then-current policy:

- pay for assistant-at-surgery services provided by all qualified practitioners on a fee-for-service basis, or
- return to the approach of covering the costs of nonphysician assistants through Medicare hospital payments or physician surgical fees.

After considering these alternative policies, the PPRC decided to make no recommendation for changing Medicare's payment.

Should Medicare change how it pays for first assistant services?

Of the practitioners who provide first assistant services, Medicare pays physicians, physician assistants, nurse practitioners, and clinical nurse specialists on a fee-for-service basis. Surgical technologists and registered nurse first assistants are not paid separately; their wages are part of the hospital's inpatient or outpatient prospective payment.¹

Current policy for first assistant services essentially unbundles the wages of physicians and certain nonphysician practitioners from the facility payment for surgery. Although first assistant services are generally billed in connection with surgical procedures performed in hospitals, payment is linked to the current procedural terminology (CPT) code for the procedure, not the facility payment. First assistants at surgery also are paid for surgical procedures performed in other settings, such as ambulatory surgical centers.

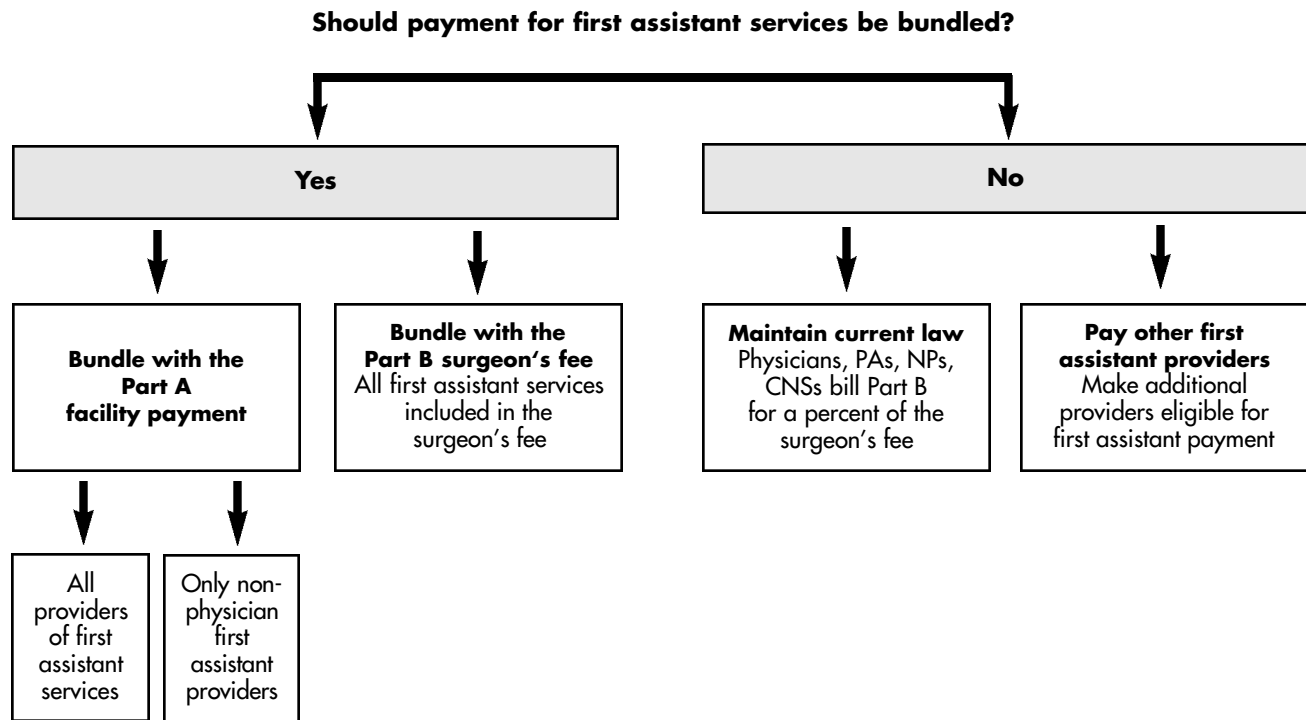
Current policy creates a financial incentive for hospitals to use first assistant providers who are eligible for separate payment under Part B instead of employing technologists or registered nurse first assistants. Because the diagnosis related group (DRG) payment remains fixed, and because hospitals benefit financially when they do not incur costs for first assistants, surgical technologists and other categories of nonphysician first assistants who cannot bill Part B directly are at a competitive disadvantage. In addition, physicians and other providers who are eligible for Part B payments may be used in situations in which their level of training exceeds that necessary for the surgical procedure, thus resulting in higher costs to Medicare than necessary to maintain surgical quality. Of course, in some facilities where the volume of surgeries is low the use of more skilled practitioners may be necessary if adequately trained hospital personnel are not available to provide first assistant services.

Several options exist for structuring payment for first assistant services, each with advantages and disadvantages. The overarching issue is whether to bundle the payment for these services, and if so, whether to bundle it with the facility payment or with the surgeon's payment (Figure 1-1).

¹ For illustrative purposes we refer to first assisting services for surgical procedures performed on an inpatient basis in hospitals and the corresponding inpatient prospective payment system payments. Any changes made to payments for first assisting services would need to be applied across all settings in which surgical procedures are performed.

**FIGURE
1-1**

Options for paying first assistants at surgery



Note: PA (physician assistant), NP (nurse practitioner), CNS (clinical nurse specialist).

Bundled payments

Bundling payment for first assistant services raises several important considerations. The advantages of such a payment structure include:

- eliminating inconsistencies in current payment policy that, from the hospital perspective, favor use of those first assistant providers who may bill Medicare Part B directly;
- encouraging the recipient of the bundled payment to use the least expensive type of personnel consistent with acceptable surgical quality; and
- simplifying claims administration for Medicare carriers and fiscal intermediaries.

Disadvantages associated with bundling payment for first assistant services include:

- redistributing the cost of first assistant services paid under Part B across all hospitals performing surgery, regardless of who performs the first assisting service. Teaching hospitals that can use residents as first assistants would see an increase in payments without incurring any additional costs. Community hospitals, in contrast, would get the same payment increase but also would incur the additional costs of paying the physician or nonphysician practitioner who functions as a first assistant;

- reducing the independence of surgeons to utilize a specific individual or type of practitioner as a first assistant by establishing financial incentives for hospitals to use the lowest cost provider; and
- disrupting current employment arrangements among surgeons, first assistants, and the facilities where procedures are performed (in some cases, the hospital would become the payer for first assistant services, instead of Part B of the Medicare program).

Most of these advantages and disadvantages assume bundling first assistant and facility payments, but payments for nonphysician practitioners who provide first assisting services also could be bundled with physician surgical fees. As with facilities that employ surgical first assistants, physician employers would have a financial incentive to control and monitor the cost and volume of services provided by these nonphysician practitioners. Bundling with physician payments would encourage conscientious use of resources and may reduce or control costs.

Bundling payments could create potential problems, however. Moving the costs of first assistant services to the prospective payment for hospitals would partially uncouple the financial incentive to use the most efficient providers from the surgeon's professional judgement. This would not be an issue if payments were bundled with the surgeon's fee. Bundling payment in the facility fee also complicates the relationship between the surgeon and the facility, because fees for first assistants not employed by the facility—which generally are paid directly to the practitioner now—would have to be negotiated with the hospital and paid out of the prospective payment to the facility. In a recent study, the Department of Health and Human Services Office of Inspector General (OIG) found that only 19 percent of hospitals compensate surgeons who bring their own staff to assist a surgical procedure (OIG 2002). Thus, this course of action could create an environment viewed by surgeons as more adversarial and disrupt current practice arrangements.

Medicare pays about \$200 million each year for first assistant services billed under Part B. Because residents provide the majority of first assistant services in teaching hospitals, the Part B payments are generally made for surgical procedures performed in community hospitals. Accounting for the costs of first assistant services in the inpatient prospective payment would redistribute the pool of money for first assistants across surgeries performed in all hospitals, which would generally lead to underpayment for surgeries in community hospitals. It is in these facilities, where surgical volume is low and highly skilled hospital personnel may be unavailable, that using a physician first assistant is necessary to ensure high-quality surgical care. Teaching hospitals would benefit under this policy by receiving higher payments for facility services in addition to the payment they receive for training residents. A similar change in the distribution of payments would occur if the first assistant payment were bundled with the surgeon's fee.

One variation of bundling payments to facilities for first assistant services would be to exclude physicians working as first assistants and continue to pay them separately. This option would encourage the use of physicians as first assistants because they would continue to be paid under Part B. If physicians were substituted for nonphysician providers, this policy might increase overall costs to the Medicare program, compared with a policy that included costs for physician first assistants in the bundled payment. Reducing the payment rates for physician first assistants would address the issue of costs to Medicare but might reduce the pool of physicians willing to perform first assistant duties.

Unbundled payments

Arguments exist both for and against Medicare's current practice of paying first assistant providers outside the prospective facility payment or the surgeon's fee.

Advantages of unbundled payment for first assistant services include:

- fostering maximum autonomy for surgeons to select the most appropriate practitioner to serve as a first assistant in surgery,
- allowing flexibility in employment relationships for independent contractors and employees or associates of surgeons, and
- promoting opportunities for new surgeons or established physicians to learn procedures or gain experience with technologies while working as first assistants to surgeons.

Disadvantages of this approach include:

- failing to create an incentive to use lower-cost providers in situations when doing so would be consistent with quality surgical care,
- expanding eligibility to bill the program could result in increased cost growth, and
- covering additional providers would increase the complexity of the provider enrollment process for Medicare that carriers use to verify these practitioners' qualifications (especially when providers are unlicensed).

The rationale for the current inconsistency in the payment structure is unclear, but it is probably rooted in the evolving roles, state licensure, and employment status of different nonphysician provider groups. Physician assistants and advanced practice nurses generally are employed by surgeons or companies providing first assistants, or they function as independent contractors. By contrast, most surgical technologists and about half of registered nurse first assistants tend to be hospital employees (although as state laws have been expanded to provide direct payment by private insurers and Medicaid to registered nurse first assistants there appears to be a trend toward these providers working as independent contractors as well) (AORN 1996). Employment relationships between providers of first assistant services and the facilities in which they work vary considerably.

Financial incentives to choose a particular type of first assistant could be eliminated if Part B payments were extended to all nonphysician practitioners who function as first assistants, but this approach has disadvantages. Increasing the number of fee-for-service providers could encourage overuse of services, increasing Medicare's costs. In addition, the volume of billings that CMS must process would increase if additional nonphysician practitioners became eligible for Part B payments, which would tend to increase the administrative costs of the Medicare program.

On balance, we see no compelling reason to change how Medicare pays for first assistant at surgery services. Overall program payments for first assistant services have fallen since the physician fee schedule was implemented more than 10 years ago. In addition, since nonphysician providers became eligible for direct payment of first assistant services, the proportion of surgeries assisted by physicians has declined to about 80 percent. The financial incentives embedded in the current payment system do not appear to have encouraged inappropriate use of first assistants.

Should Medicare change who it pays directly for first assistant services?

In addition to there being no indication that Medicare’s payment method for first assistant services warrants any change, it is likewise not clear that a change in the law to allow certified surgical technologists to bill Medicare directly is appropriate.

RECOMMENDATION

The Congress should not expand the list of providers eligible to bill Medicare for first assistant services to include certified surgical technologists.

The types of nonphysician practitioners who perform first assistant services vary in their education and training requirements. For example, clinical nurse specialists are licensed registered nurses with a master’s degree. Although some physician assistants are graduates of certificate or associate degree programs, most states require recent trainees to have a bachelor’s degree for licensure. In contrast, surgical technologists may have nine months to two years of additional education after high school; in order to be certified, they must document two years of first assisting experience (or complete a first assistant program) and at least 350 cases. In addition, the duties and scope of practice of first assistants vary and are dictated in part by the surgeon, the type of surgery, the hospital, and state law or regulations. This lack of a consistently defined list of duties and skills complicates Medicare’s job of determining qualified providers.

For licensed providers, carriers can rely on state licensing and regulatory agencies to maintain and enforce standards for most practitioners. For surgical technologists, Medicare cannot defer to the states to fulfill this function, as only one state licenses these providers. To add surgical technologists as eligible providers would require carriers to verify providers’ credentials with previous employers and educational institutions—a role more appropriate for state licensing and regulatory agencies.

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CHAPTER

2

**Medicare coverage of nonphysician
providers of mental health services**

R E C O M M E N D A T I O N

The Congress should not allow marriage and family therapists, licensed professional counselors, and pastoral counselors to bill Medicare independently for mental health services.

***YES: 12 • NO: 2 • NOT VOTING: 0 • ABSENT: 3**

***COMMISSIONERS' VOTING RESULTS**

Medicare Part B currently allows psychiatrists and certain nonphysician practitioners such as psychologists and social workers with the equivalent of a master's degree in psychotherapy to bill independently for mental health services. Although marriage and family therapists (MFTs), licensed professional clinical counselors (LCs), and pastoral counselors (PCs) may bill Medicare for counseling under Medicare's so-called "incident to" physician service provision, Congress asked MedPAC to assess whether these providers should be able to bill Medicare Part B directly for the mental health services they provide, including psychiatric diagnostic evaluation and psychotherapy.¹

Background

Medicare currently pays for both inpatient and outpatient mental health services, but with different cost sharing limits than for other inpatient or outpatient care. Medicare Part A covers 100 percent of the payment for inpatient psychiatric services, subject to a deductible and a 190-day lifetime limit in a psychiatric hospital. Under Part B, beneficiaries receiving outpatient psychotherapy must pay a 50 percent copayment. Part B covers a variety of mental health services, including psychiatric diagnostic evaluations and psychotherapy, which are the focus of this paper.² Other covered services include hypnotherapy, electroconvulsive therapy, narcosynthesis, and medication management. The nonphysician providers recognized by Medicare receive different payment rates for their services. For example, psychologists are paid at 100 percent of the physician fee schedule, whereas social workers receive 75 percent of the physician rate.

To qualify for coverage under Medicare Part B, mental health services (like other services) must be reasonable and necessary for the diagnosis or treatment of an illness or injury or to improve the functioning of a malformed body member. Services provided by nonphysician mental health professionals must be delivered by Medicare-recognized practitioners who are legally authorized to perform them under state law, and must be otherwise covered if performed by a physician. Currently, Medicare makes direct payments only to psychologists, licensed clinical social workers, nurse practitioners with the equivalent of a master's in psychotherapy, and clinical psychiatric nurse specialists as nonphysician providers of mental health services. The current policy raises three questions:

- Do Medicare beneficiaries have difficulty getting access to mental health services, including psychiatric diagnostic evaluations and psychotherapy?
- Which categories of nonphysician practitioners have the appropriate education and licensure to provide psychiatric diagnostic evaluations and psychotherapy?
- What would be the cost implications of recognizing additional mental health providers in the Medicare program?

1 Services provided by nonphysician providers may be reimbursed at 100 percent of the physician fee schedule if they are billed by the physician as "incident to" services. Such services must meet the following requirements: (1) the services must be provided by employees of a physician and under the physician's direct supervision; (2) the physician must be in the office suite while the service is being provided and immediately available to provide assistance and direction; and (3) the physician also must have initiated the course of treatment and must furnish subsequent services at a frequency consistent with active management of the course of treatment.

2 The American Medical Association current procedural terminology defines psychotherapy as "the treatment for mental illness and behavioral disturbances in which the clinician establishes a professional contract with the patient and, through definitive therapeutic communication, attempts to alleviate the emotional disturbances, reverse or change maladaptive patterns of behavior, and encourage personality growth and development." In addition, it states that psychiatric diagnostic evaluations include a history, mental status exam, and a disposition, and may include communication with family or other sources, and ordering and medical interpretation of laboratory or other medical diagnostic studies (AMA 2001).

Do Medicare beneficiaries have difficulty getting access to psychiatric diagnostic evaluations and psychotherapy?

Medicare beneficiaries face many barriers that may prevent or discourage them from seeking mental health services. Often, beneficiaries do not use mental health services because of cultural traditions or geographic barriers while others do not get treatment because of limitations resulting from Medicare payment and coverage policies.

Cultural traditions and geographic barriers to mental health services are not unique to the Medicare program, nor are they confined to a particular population or geographic area. Some of the barriers facing older Americans identified by the Administration on Aging include the lack of affordable transportation to services, denial of psychiatric problems, and the cost of mental health treatment—especially prescription drugs (DHHS 2001a). Research also has documented that certain geographic locations—particularly rural areas—have a shortage of mental health providers and therefore pose an access problem (DHHS 1997). However, even in areas where practitioners are present, some Medicare beneficiaries who may benefit from psychotherapy may not seek services because of a perceived stigma attached to mental illness (DHHS 2001a).

Financial barriers raise additional concerns about Medicare beneficiaries' access to mental health services. Unlike other Medicare-covered services, for which copayments are limited to 20 percent, beneficiaries who use outpatient psychotherapy services face a 50 percent cost-sharing requirement. Medicare also limits treatment in freestanding psychiatric hospitals to 190 days in a patient's lifetime, creating coverage shortfalls for beneficiaries whose mental illnesses may require them to be hospitalized at various points in their lives. This arbitrary limit does not exist for medical treatment in hospitals.

In addition, a recent report by the U.S. Department of Health and Human Services' Office of Inspector General (OIG) found that more than 8 percent of reviewed medical records suggested that beneficiaries may not have received needed mental health services. According to many of these records, patients who were receiving psychotherapy services should have been evaluated for psychotropic medication. On the other hand, 22 percent of the reviewed medical records revealed that Medicare beneficiaries received mental health services beyond what was medically indicated or necessary (OIG 2001a). In these cases, the medical record did not justify the duration or frequency of psychotherapy services.

Previously, the Congress has used Medicare payment policy in an attempt to bridge gaps in access to primary care health professionals in rural and underserved communities—a potential benefit both to Medicare beneficiaries and to the entire population of the area served by these providers. A primary motivation behind Medicare's earlier policies for certain nonphysician providers, such as nurse practitioners, was to entice them to provide services in areas that suffered a shortage of physicians. When nonphysician providers were present in a community this change in payment policy may have improved beneficiaries' access to services. However, in communities where practitioners were not present, many nonphysician providers were reluctant to relocate their practices to underserved areas—citing reasons such as quality of life and proximity to the amenities of urban areas, the same reasons that physicians gave (ACP-ASIM 2000). Moreover, some researchers suggest that telepsychiatry also may address certain access problems in health professional shortage areas (Summer 2001).

Which categories of nonphysician practitioners have the appropriate education and licensure to bill independently for psychiatric diagnostic evaluations and psychotherapy?

All the providers Medicare currently allows to bill independently for treating beneficiaries' mental health must hold at least a master's degree, but the program does not permit direct payment for all such providers. Marriage and family therapists, licensed counselors, and pastoral counselors assert that their training is at least as comprehensive and rigorous as that of some of the practitioner groups Medicare already allows to bill independently, and therefore, that Medicare should give equal recognition to them. Although these providers appear to have qualifications similar to the currently recognized Medicare practitioners, differences in the focus of their education and training may explain or justify current Medicare policy.

Marriage and family therapists

MFTs are mental health professionals trained in psychotherapy and family systems, and they diagnose and treat mental and emotional disorders within the context of marriage, couples' relationships, and family systems (DHHS 2001b). These providers normally have a master's or doctoral degree in marital and family therapy, and at least two years of supervised clinical experience. Forty-four states currently license or certify MFTs, and the U.S. Department of Health and Human Services recognizes them as a core mental health provider in areas designated as mental health professional shortage areas.³ The federal CHAMPUS/TRICARE programs and the Indian Health Service also recognize MFTs as mental health providers.

Licensed professional clinical counselors or licensed mental health counselors

LCs have a master's or doctoral degree in counseling and at least two years (or 3,000 hours) of supervised clinical counseling. Historically, licensed professional counselors have received their degrees through a university's education department and worked in a variety of settings, including schools and colleges, community and government agencies, businesses, and private practice. While LCs are similar to other mental health providers, their counseling can be distinguished by its developmental and preventive orientation as well as its focus on the individual within an environmental context (DHHS 2001b). LCs are licensed or certified in 45 states and the District of Columbia. They also are covered by the CHAMPUS/TRICARE program.

Pastoral counselors

Pastoral counseling integrates behavioral science with the spiritual aspects of mental health. PCs are ordained clergy—or are otherwise recognized and endorsed by a religious denomination—who are also mental health professionals. Some PCs have master's degrees in a related counseling discipline, such as marriage and family therapy or psychology. Others have completed graduate coursework, but the focus may be in divinity, theology, or philosophy rather than in a counseling discipline. In the latter group, courses in clinical counseling and related subjects are required for certification. The American Association of Pastoral Counselors is seeking direct billing rights only for those PCs recognized through certification as "fellows"—a designation requiring at least a master's degree.

Only 6 states now have licensure or certification for PCs, but 37 states license them under another counseling discipline (for example, pastoral counseling preparation can meet the criteria for licensure as an MFT or LC). PCs are recognized providers for CHAMPUS/TRICARE and for federal employees in certain underserved

³ As defined by the Health Resources and Services Administration, core mental health professionals include: psychiatrists, clinical psychologists, clinical social workers, psychiatric nurse specialists, and marriage and family therapists. In designating mental health professional shortage areas, states can use either a population-to-psychiatrist ratio or a ratio of population-to-core mental health professionals (HRSA 1995).

areas. Because spirituality and religion may be beneficial in preventing and healing disease and because elderly individuals may be more comfortable and apt to seek counseling from a mental health practitioner who will respect their faith and beliefs, PCs believe that expanding Medicare coverage would improve access to mental health services (AAPC 2001).

State law and regulation

State scope of practice laws and administrative code indicate the types of services that certain categories of mental health providers may furnish. Researchers analyzing state laws have found that in 40 states with significant rural areas (where access to mental health services is thought to be problematic) there is variation in whether state laws and regulations expressly address the provision of psychiatric diagnostic evaluations and psychotherapy when delineating the roles of nonphysician mental health providers (Hartley et al. 2002). In the absence of any reference to these services in the statute or administrative code, state regulators were found to have varying interpretations of whether these services were permissible.

Although Medicare defers to the states to define scopes of practice, the carriers responsible for claims payment must interpret these vague state laws to determine whether providers are eligible for payment based on their scope of practice. Current Medicare policy explicitly states that services (for example, the diagnosis and treatment of mental illness) will only be covered if practitioners (such as social workers) are legally authorized to perform them under state law or regulations. In a recent study of Medicare coverage of nonphysician practitioner services, the OIG likewise found that state scopes of practice are “broad and as a result provide little guidance that carriers can use to process claims.” Moreover, the OIG discovered that “most scopes of practice contain only a general statement about the responsibilities, educational requirements, and a non-specific list of allowed duties and do not explicitly identify services that are complex and/or beyond their scope.” OIG concluded that current state scopes of practice “create potential vulnerabilities, both from payment and quality of care standpoints” (OIG 2001b). Thus, state licensure laws may not provide sufficient or appropriate guidance to Medicare for coverage decisions about additional groups of providers of mental health services.

What would be the cost implications of recognizing additional mental health providers in the Medicare program?

Approaches to improving Medicare beneficiaries’ access to necessary mental health services cover a wide range of policy options with varying cost implications. Increased costs should be anticipated and are appropriate in areas where recognition of additional mental health providers fulfills unmet demand. The combination of costs associated with fulfilling unmet needs and the costs associated with creating additional capacity for outpatient mental health services is likely to negate any program savings that may accrue as a result of provider substitution or decreases in the incidence of inappropriate physician or emergency room visits.

Some studies have found conflicting evidence of the impact on costs to government and private payers for nonphysician practitioners with newly expanded service and payment prerogatives (OIG 2001b, Hartley et al. 2002). In a report examining payments for the services of physician assistants, nurse practitioners, and clinical nurse specialists whose billing rights were expanded by the Balanced Budget Act of 1997, OIG determined that billings rose rapidly after geographic restrictions on payments to these providers were lifted (OIG 2001b). However, OIG acknowledged that because some of these services otherwise

would have been billed as incident to a physician service prior to the change in law, it was unable to determine how much of the increase was due to real growth in services and how much was due to simple changes in billing practices. In seeking guidance on when it is appropriate to pay nonphysician providers for certain services, the OIG found that controls on billings, such as state-mandated scopes of practice, had limited effect because the administrative rules governing practitioners' services were too vague to clearly delineate what was beyond a provider's scope of practice and should not be reimbursed.

Expanding the pool of mental health providers to include MFTs, LCs, and PCs would probably increase Medicare costs. On a case-by-case basis, paying a nonphysician mental health provider a lower rate than what the program would pay a psychiatrist could save Medicare money. However, expansion of the number and type of practitioners who can independently bill the Medicare program is likely to result in increased use of mental health services. For example, increasing the number of eligible mental health providers in rural areas may lead to higher costs by fulfilling previously unmet needs—an appropriate cost—as services for this population were previously unavailable. Moreover, use in other areas also may expand with additional capacity.

Some nonphysician providers assert that judicious use of mental health services may actually decrease Medicare costs. They argue that by effectively treating such mental disorders as depression and anxiety, the number of inappropriate physician or emergency room visits may be reduced. Although this may be true for some beneficiaries, it is likely that the resulting savings would be more than offset by increased volume of psychotherapy services billed to the program.

Other barriers take precedence

Although additional Medicare providers may help alleviate mental health professional shortages in some areas, a multidimensional approach is needed to address the cultural traditions, geographic and economic barriers that prevent beneficiaries from accessing mental health services. Addressing the many financial barriers to mental health services embedded in Medicare payment and coverage policy may have greater potential to improve mental health services for the largest number of beneficiaries.

RECOMMENDATION

The Congress should not allow marriage and family therapists, licensed professional counselors, and pastoral counselors to bill Medicare independently for mental health services.

Although Medicare beneficiaries in certain areas may benefit by allowing additional providers to bill Medicare, this change would not address other important barriers to mental health services in both urban and rural areas. Across the board, beneficiaries seeking mental health care face significant cost-sharing requirements, and those with serious mental illness face lifetime caps on inpatient psychiatric care. Further limiting use of services are practical barriers such as limited transportation to health care providers. Stigmas associated with mental health problems keep individuals of all ages and races from seeking treatment, and present a challenge to providing beneficiaries with needed care that cannot be addressed through Medicare policy alone.

Although each type of nonphysician mental health professional the Commission addressed provides valuable services to their communities, the data to assess their ability to fulfill unmet needs of beneficiaries are extremely limited. Incentives could be targeted to pay only those nonphysician providers who practice in rural and underserved communities. However, because many states assess mental health professional shortages by identifying the location of psychiatrists, there is a paucity of data available to determine whether marriage and family therapists, licensed counselors, and pastoral counselors are present in areas where there is a shortage of Medicare-recognized mental health practitioners providing services to beneficiaries.

Given the uncertainty associated with the many factors affecting Medicare beneficiaries' access to mental health services, the Commission concluded that the additional costs that would almost certainly result from expanding the list of eligible providers would not represent the best use of finite resources for meeting beneficiaries' mental health needs.

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CHAPTER

3

**Medicare coverage of
clinical pharmacists' services**

R E C O M M E N D A T I O N

The Secretary should assess models for collaborative drug therapy management services in outpatient settings.

***YES: 15 • NO: 0 • NOT VOTING: 0 • ABSENT: 2**

***COMMISSIONERS' VOTING RESULTS**

Physicians are responsible for managing patients' care, including drug therapies, but mounting evidence suggests that involving clinical pharmacists in managing drug treatment may reduce costs and improve the quality of care. Medicare does not currently cover collaborative drug therapy management (drug management) services provided by clinical pharmacists. MedPAC was asked to assess whether to provide Medicare Part B coverage for services rendered by clinical pharmacists under drug management agreements with physicians. The Commission agrees that such services show promise and warrant further study.

Background

Medication use by people 65 and older is an important part of their health care regimen. Although people in this age group represent only 13 percent of the population, they consume 35 percent of all prescription medications in the United States—an average of 1.5 to 2.2 prescription medications daily. Prescription drug therapy is expected to increase, making the proper use of medications imperative to maximize benefits and minimize risks. A recent study suggests that inappropriate drug use is a common problem among the elderly (Hanlon et al. 2002). Drug management is one approach to addressing this problem.

Medicare Part B does not currently cover drug management services provided by pharmacists. Drug management is an evolving approach to care in which drug therapy decisions are coordinated collaboratively by physicians, pharmacists, and other health professionals together with the patient. Thirty-three states currently permit physicians and pharmacists to enter into voluntary written agreements to manage the drug therapy of patients or groups of patients. Although the specific terms are dictated by the parties and limited by state law, drug management arrangements may allow pharmacists to:

- assist physicians to improve medication management and continuity of care,
- select, initiate, modify, continue, discontinue, and monitor patients' drug therapy,
- order, perform, and interpret medication-related laboratory tests,
- assess patients' responses to therapy,
- counsel and educate patients on medications, and
- administer medications.

In practice, drug management focuses largely on managing the drug therapy treatment of high-risk patients, those taking a wide array of medications, or those with specific diseases, such as asthma, diabetes, heart attack, or hypertension. A primary role of clinical pharmacists is to develop and/or implement drug treatment protocols for specific medical conditions. State Medicaid demonstration projects in Iowa, Mississippi, Wisconsin, and Washington are currently testing this approach, but no data are yet available.

Drug management services may improve the quality of care

Drug management has the potential to improve the quality of care for Medicare beneficiaries by:

- reducing the incidence of adverse drug effects,
- improving patient outcomes, and
- improving patient compliance with drug therapy.

Adverse drug events can increase the morbidity or mortality of a medical condition. These incidents also may increase the length of inpatient stays for hospitalized patients or lead to increased emergency room or office visits or even hospitalizations for outpatients. Many adverse events are preventable with careful drug selection and monitoring of drug therapy. In some studies, involving pharmacists in patient care has resulted in reduced drug errors and associated morbidities, improved patient outcomes, and reduced costs (Chiquette et al. 1998, Leape et al. 1999). In addition, pharmacist participation in a multidisciplinary patient care team may improve clinical outcomes (Gattis et al. 1999).

Pharmacists also may play a valuable role in reinforcing drug dosing schedules and educating patients about their medications. As a result, patient compliance with complicated drug regimens and follow-up visits may improve—potentially leading to better treatment outcomes.

Benefit design should balance physician and pharmacist roles

In general, physicians support the concept of collaborative drug management but believe that the practice of medicine and the responsibility for overall patient care should remain in their control. This is consistent with current models of pharmacist involvement in patient care that range from patient education and hospital rounds to prescribing privileges for pharmacists under established protocols. The American College of Clinical Pharmacy (ACCP) holds that in the model drug management relationship, the physician would diagnose the patient and make the initial treatment decision and subsequently authorize the pharmacist to “select, monitor, modify, and discontinue medications as necessary to achieve favorable patient outcomes” (ACCP 1997). Under this arrangement, the association asserts that the physician and pharmacist would share the risk and responsibility for patient outcomes. The physician’s ongoing involvement in the patient’s care also would need to be clearly defined.

Costs unknown

While drug management may improve the quality of care for Medicare beneficiaries, the cost of widespread implementation of this service has not been ascertained. Some studies suggest that involving clinical pharmacists in the medical therapy of patients may produce savings for the Medicare program by reducing adverse drug events and improving patient compliance with medical therapy. These changes may result in better clinical outcomes, which could decrease the number of physician visits or hospitalizations. Although these studies describe positive financial benefits from more direct participation of clinical pharmacists in patient care, they have been criticized for not including the additional costs of providing pharmacist services (Schumock et al. 1996). Moreover, they generally have focused on pharmacists’ involvement in patient care for specific subsets of patients. A key question is whether savings for a subset of Medicare beneficiaries would be offset by widespread additional payments for clinical pharmacists.

The ACCP has estimated that the annual cost of drug management under Part B of the Medicare program would be between \$500 million and \$1.7 billion, depending on the structure and use of the benefit. The lower figure assumes 2 outpatient visits per year for 8 million beneficiaries, and the higher number is based on 4 visits per year for 12 million patients. These estimates assume an hourly payment rate for pharmacists of \$60, with 65 percent of visits lasting 15 minutes, 25 percent lasting 30 minutes, and 10 percent lasting 60 minutes (ACCP2002). More recently, the results of a cost analysis of proposed legislation (S. 974/H.R. 2799) conducted for several pharmacy-related organizations suggest that paying pharmacists

to provide drug management services would cost \$13 billion over the next ten years (Moran et al. 2002). Following CBO scoring rules, this analysis does not take into consideration any offsets for the likely savings that may accrue from improved medication use. In addition, Medicaid demonstrations currently in progress will provide some information on the cost of providing drug management services in a public program.

A promising idea

The Commission sees potential for a Medicare drug therapy management benefit to facilitate access to an important health care service for some beneficiaries. Drug therapies for hospital inpatients are currently monitored by physicians and pharmacists working collaboratively within a facility, with inpatient drugs covered under Medicare's hospital benefit. In outpatient settings, there is neither a parallel to this collaborative relationship nor payment for medications for beneficiaries who take a variety of drugs to treat diseases or manage complex conditions.

As the Congress contemplates creating a Medicare drug benefit, including a drug management benefit may provide a mechanism to optimize drug therapy for a subset of Medicare beneficiaries who have complex drug regimens. Establishing a structure for drug management in the absence of coverage for outpatient prescription drugs, however, seems unlikely to produce the necessary integration of providers, services, and products to achieve significant quality of care improvements and may ultimately limit the effective design and implementation of a prescription drug benefit. The Secretary should start to assess drug management models, as this work might help inform the design of a future outpatient drug benefit.

RECOMMENDATION

The Secretary should assess models for collaborative drug therapy management services in outpatient settings.

Many options are available for designing and carrying out drug management services in concert with implementation of a Medicare drug benefit. The Congress may seek to include drug management as a service provided that pharmacy benefit managers, the potential private sector administrators of a drug benefit, are required to provide to certain Medicare beneficiaries. They also may choose to establish this benefit through the physician fee schedule and pay providers accordingly. Or, as part of multi-faceted program reforms, the Congress could consider drug management services together with comprehensive care coordination for Medicare beneficiaries. Embedded in each of these options is the need to clearly define the roles and responsibilities of pharmacists, physicians, and other providers on the patient care team.

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A P P E N D I X

**Commissioners' voting
on recommendations**

Commissioners' voting on recommendations

In the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA), the Congress required MedPAC to call for individual Commissioner votes on recommendations, and to document the voting record in its reports. The information below satisfies that mandate.

Chapter 1: Medicare coverage of surgical technologists when functioning as first surgical assistants

The Congress should not expand the list of providers eligible to bill Medicare for first assistant services to include certified surgical technologists.

Yes: Braun, DeBusk, Feezor, Hackbarth, Loop, Muller, Nelson, Newhouse, Newport, Raphael, Reischauer, Smith, Stowers, Wakefield

Absent: Burke, Rosenblatt, Rowe

Chapter 2: Medicare coverage of nonphysician providers of mental health services

The Congress should not allow marriage and family therapists, licensed professional counselors, and pastoral counselors to bill Medicare independently for mental health services.

Yes: Braun, Feezor, Hackbarth, Loop, Muller, Nelson, Newhouse, Newport, Raphael, Reischauer, Smith, Stowers

No: DeBusk, Wakefield

Absent: Burke, Rosenblatt, Rowe

Chapter 3: Medicare coverage of clinical pharmacists' services

The Secretary should assess models for collaborative drug therapy management services in outpatient settings.

Yes: Braun, DeBusk, Feezor, Hackbarth, Loop, Muller, Nelson, Newhouse, Newport, Raphael, Reischauer, Rosenblatt, Smith, Stowers, Wakefield

Absent: Burke, Rowe

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