Performance Reporting

Voice: (301) 871.0010 Fax: (301) 871.0020
Toll Free: (877) 871.0010

WHITE HOUSE COMMISSION
on
COMPLEMENTARY and ALTERNATIVE MEDICINE POLICY

+ + +

Meeting Topic I:
CAM: Understanding Coverage and Reimbursement

and

Meeting Topic II:
CAM: Research Challenges

+ + +

Volume II

+ + +

Tuesday, May 15, 2001

8:10 a.m.

Academy for Educational Development
1825 Connecticut Avenue, N.W.
Academy Hall, 8th Floor
Washington, D.C.

PERFORMANCE REPORTING
Phone: 301.871.0010 Toll Free: 877.871.0010

PARTICIPANTS:

Chairperson

James S. Gordon, M.D., Director
The Center for Mind-Body Medicine

Commission Members

George M. Bernier, Jr., M.D.
Vice President for Education
University of Texas Medical Branch

Thomas Chappell
Co-Founder and President
Tom's of Maine, Inc.

Effie Poy Yew Chow, Ph.D., R.N., DiplAc (NCCA)
Qigong Grandmaster
President, East-West Academy of Healing Arts

George T. DeVries, III
Chairman, CEO, American Specialty Health Plans

William R. Fair, M.D.
Attending Surgeon, Urology (Emeritus)
Memorial Sloan-Kettering Cancer Center
Chairman, Clinical Advisory Board of Health, LLC

Joseph J. Fins, M.D., F.A.C.P.
Associate Professor of Medicine,
Weill Medical College of Cornell University
Director of Medical Ethics,
New York Presbyterian Hospital-Cornell Campus

Veronica Gutierrez, D.C.
Gutierrez Family Chiropractic

Wayne B. Jonas, M.D.
Department of Family Medicine
Uniformed Services University of the Health Sciences
F. Edward Herbert School of Medicine

Charlotte Kerr, R.S.M.
Traditional Acupuncture Institute, Inc.

Linnea Signe Larson, LCSW, LMFT
Associate Director
West Suburban Health Care
Center for Integrative Medicine

PARTICIPANTS (continued):

Commission Members

Tieraona Low Dog, M.D., A.H.G.
(Private Practice)

Dean Ornish, M.D.
President/Director
Preventive Medicine Research Institute
Clinical Professor of Medicine
University of California, San Francisco

Conchita M. Paz, M.D.
(Private Practice)

Joseph E. Pizzorno, Jr., N.D.
Co-Founder/Founding President, Bastyr University

Buford L. Rolin
Poarch Band of Creek Indians

Julia R. Scott
President
National Black Women's Health Project

Xiaoming Tian, M.D., LAc
Director, Wildwood Acupuncture Center
Academy of Acupuncture & Chinese Medicine

Donald W. Warren, D.D.S.
Diplomate of the American Board of
Head, Neck & Facial Pain

Commission Members Not Present

David Bresler, Ph.D., LAc, OME
Dipl.Ac.(NCCAOM)
Founder and Executive Director
The Bresler Center, Inc.

PARTICIPANTS (continued)

Executive Staff

Stephen C. Groft, Pharm.D.
Executive Director

Michele M. Chang, C.M.F., M.P.H.
Executive Secretary

Joseph M. Kaczmarczyk, D.O., M.P.H.
Senior Medical Advisor

Corinne Axelrod, M.P.H.
Senior Program Analyst

Geraldine B. Pollen, M.A.
Senior Program Analyst

Joan Albrecht
Program Assistant

Doris A. Kingsbury
Program Assistant

Consultant Staff

Kenneth D. Fisher, Ph.D.
Senior Scientific Advisor

Maureen Miller, R.N., M.P.H.
Senior Policy Advisor

James Swyers
Writer/Editor

C O N T E N T S

CONTENTS (continued)

P R O C E E D I N G S

[8:10 a.m.]

MS. CHANG: Good morning. Welcome to the second day of the meeting, the first agenda topic on Understanding Coverage and Reimbursement.

If we could have the first panel come up. We are going to do a little bit of an opening, but we will have you ready to go since we are running already a little bit behind schedule:

Melinna Gianninni from Alternative Link, Inc. and Linda Bedell-Logan from Solutions in Integrative Medicine and Wayne Sickels, a massage therapist.

DR. GORDON: We customarily just sit for a moment to get ourselves centered and present here. If we could do that.

[Moment of silence observed.]

DR. GORDON: Okay, thank you.

Yesterday, we had a very full and fruitful day, and today we have a very challenging agenda. So let's begin with our first speaker, Melinna Gianninni.

Panel Session VII: Issues and Ideas

Presenter: Melinna Giannini

MS. GIANNINNI: Perfect. Congratulations.

Good morning Honorable Commissioners. I appreciate the opportunity to talk to you today. A special thanks to the staff for getting me here so efficiently and helping me get my presentation together.

What if every licensed CAM provider could bill any insurance company and spend no more than five minutes on paperwork?

What if every insurance company knew within a nanosecond that the CAM provider billing the service was allowed by state scope of practice laws to file the service being billed?

What if the CAM provider and the insurance company could negotiate fees for all CAM services by agreeing on one number, and that resulting fee structure was legally defensible?

What if the insurance company could instantly compare CAM treatments for any disease or health problem to the average cost of conventional medical treatments?

What if allopathic physicians and CAM providers knew exactly how to cooperate with each other and build the appropriate care paths for patient treatment?

What if CAM providers could be paid within three days of filing a claim and the money automatically went into their bank account?

What if Medicaid plans could report CAM services to HCFA?

What if all this were possible without one new piece of software?

I am here today to tell you about a coding system that makes all of these things not only possible, but they are being used today.

Before I explain how and why this coding system was created, I would like to provide the Commission with a brief background on coding. Coding is not mysterious. Actually, the first codes were developed by the Chilton's Car Manual people because automobiles were very complicated and had a lot of parts to track. By the use of numbers on auto parts, things could be looked up easily, fees could be attached to each piece, and the services also had codes.

So, what Detroit started learning from using coded information was which automobile parts lasted the longest, which services got the car fixed the quickest,

and they also learned that if a fuel pump went out and somebody purchased it too many times, maybe they needed to redesign the fuel pump.

So, coding is not mysterious, but it is very powerful even though it is kind of boring for the average human being to think about. It is a very powerful tool, and it can be used to do a lot of chores.

Codes allow us to measure patient outcomes. They can also be used to measure costs. Health insurance coding also represents the fee attached to the code for the service or supply. Codes must convey as much detail as is needed to make sure that the right payment is made for the service or supply being billed for.

Insurance companies constantly review coded data from claims to learn what premium to charge for health care policies. Health insurance software used to pay claims to doctors is also used to capture treatment patterns and outcomes information from the standard forms like your HCFA 1500 or the one used in hospitals, the UB 92.

These paper standards are now becoming electronic standards because of HIPAA, Health Insurance

Portability and Accountability Act. In 1996, HIPAA mandated that no longer could insurance companies create internal private code sets, but national code set standards had to be identified to support all licensed health care practitioners.

This process has been ongoing since that date, and we have been participating in that process, telling the federal government about the code set that we have developed that contains over 4,000 procedures, supply items, and descriptions of things that CAM providers need to bill insurance companies.

We also have relative value units, not developed by us, but developed by a company that you all may know of, Relative Studies, Inc., created relative values for physicians, and it is used quite a bit throughout the health insurance industry.

When you attach a relative value unit with a code, that allows that negotiation of going out with one conversion factor that is adjustable by any region in the country to negotiate fees for all of the services in the system, in a coding system, and that is standard operating procedure with conventional medicine and CPT

codes.

They all have relative value units whether they are relative values for physicians or the Medicare/Medicaid RB/RBS system. That is developed, so that we can negotiate fees without having to go in and negotiate for each service individually.

So, with one number, you multiply the relative value unit, and now you have a rate for any area of the country. That number is adjustable, the relative value units stay the same.

Does everybody understand that?

Having relative value units allows comparative analysis across state boundaries and economic districts. The reason is you can always go back to the relative value unit and take out the conversion factor, and now you can compare apples to apples where you never could before because now you have a pooling of values on this side and a pooling of values on this side, and you can find out what the cost comparisons were.

So, when I said before that insurance companies could instantly compare the costs, this is true because of relative value units.

CAM codes are necessary to create usable claims data that, in turn, is monitored to measure patient outcomes and costs, and also to help develop premiums for CAM services. We heard a lot yesterday about why insurance companies are having trouble handling CAM services. The biggest reason, and I think the one that you will agree with me on, is that there is no cost outcomes to look at. So, having cost comparisons is key to driving CAM services.

My company started out to track who was allowed to do what, in which state, because we thought that would be really key to appropriate reimbursement for CAM. We tried to work with existing coding systems, and we couldn't do it because they just weren't specific enough.

So, in addition to committing to develop a database to describe who was allowed to do what, we had to take several steps backwards and go back to the code level and describe the services from that level.

We have been in the process of working through the government standardization process as it was outlined in HIPAA to develop a standard code set to support all alternative practitioners and also conventional

practitioners, like registered nurses that have advance degrees, there is five levels of nurses that have advance degrees that in some states bill separately from physicians, and can be in private practice, but they weren't supported by coding either.

The work that we have done has resulted in the inclusion of the code set in the UMLS, which is the Unified Medical Language System at the National Library of Medicine. We were invited to testify before the National Committee on Vital and Health Statistics two years ago as they were looking at the standard code sets.

We were mentioned in the Final Rule as a potential standard that came out in August of 2000, and we have since been following a process that has been outlined by the government to make exceptions to the standards that were already listed.

This was complicated by the fact that they chose a version of an X12 standard, which is the electronic message format standards for health care messages. It was an earlier version than the one we were voted into in 1999, so what we are doing now is asking to be included in the updates.

The ABC codes support all alternative practitioners that hold a state license. I am going to collapse the rest of my testimony and ask that the Commissioners support insurance reimbursement to CAM by asking the Secretary of the Department of Health and Human Services to name this code set of standard for CAM services.

Thank you.

DR. GORDON: Thank you very much, and I am sure the Commissioners will have questions more about how the coding system works as we get into the questions.

Next is Linda Bedell-Logan.

Presenter: Linda L. Bedell-Logan

MS. BEDELL-LOGAN: Good morning. Thank you.

Medicine in the United States was at one time as diverse as the cultures that came here to build new lives. There was an integration of Native American medicine, Eastern and European medical philosophies and techniques.

By the mid-1800s, biomedicine began to dominate with the discovery that bacteria was believed to be the cause of disease and therefore, vaccines and antitoxins

became the complete focus of research in the United States.

Similar to the balancing act between offensive action and defensive action in war, medicine in the United States became focused on offensive medical practices, in other words, good bacteria and cells are being killed in the movement towards killing bad bacteria and cells.

Within the past 30 years, medical research has refocused on defense or preventive techniques used in the past, as well as new non-pharmaceutically-based research that has transformed to other countries, both from the standpoint of prevention, as well as disease intervention. This evolution has proven to reduce the cost of overall health care in other countries, as well as increase the quality of care delivered.

First, the Office of Alternative Medicine, and now the National Centers for Complementary and Alternative Medicine, are convinced through pointed research, botanical medicine, mind-body interventions, manual healing techniques, diet and nutrition, and Eastern medical techniques and philosophies will play an

important role in disease intervention in the future.

This exciting and promising research is extremely important to the future of medicine in the United States, however, long before organized research began in this field, consumers were being treated by alternative medicine providers.

Once a number of excellent national surveys were published and the use of alternative medicine was realized, conventional physicians all over the country began to ask their patients if they used alternative medicine and began to realize they were actually sharing patients with providers they knew nothing about.

Conventional physicians found their hands tied in treating chronic diseases, such as chronic fatigue syndrome, migraine headaches, and multiple sclerosis. These physicians started to do literature searches based on the alternative medicines their patients were using.

These physicians found that there was, in fact, sufficient efficacy information on many of the techniques that were considered outside of mainstream medicine. Many of these providers not only began to support their patients' use of these therapies, but also added

alternative medicine providers to their practices.

This mutual respect of diverse medical practices led to what we now called integrative medicine. Currently, there are hundreds of integrative medical practices in this country that range from private, free-standing clinics to hospital-based centers, to academic health centers that have integrative clinics as a focus on health services research.

The current system in the United States used to objectify medical procedures and encounters is CPT or Current Procedural Terminology developed by the American Medical Association. This system of coding is an excellent way to provide a tool for billing insurance carriers for medical procedures. These codes can also be of great use when researching utilization data.

The challenge for the integrative practices that are already treating patients is to find the proper codes within this system to objectify services in an effort to obtain insurance reimbursement. The AMA has come a long way in creating codes for this purpose, but fall short in providing a comprehensive system of coding for the integrative or alternative practice.

The AMA must find a way to code integrative and alternative services with the help of research entities like NCCAM and provide accessibility to these practices or this huge gap in medicine will continue to hinder health care reform in this country.

The AMA has created acupuncture, massage, hypnosis, biofeedback, and nutritional counseling codes. These few codes are not comprehensive and fail to capture many services being frequently delivered by properly licensed health care providers.

Much work needs to be done to expand CPT in an expedited process to include these frequently rendered services. This process, however, should be done with the input of a panel of CPT experts, as well as the practitioners, providing these services in an effort to appropriately capture the service rendered in a coding scheme.

Much of this work has already been done by professionals outside of the AMA, and until both administrative sides of health care integrate their knowledge and systems, the delivery side will never truly be able to thrive and the American consumer will be left

to pay out of pocket for choice.

Medicine that is potentially cost saving to the insurers will continue to be accessible only to the wealthy. If your disposable income is not sufficient to support both an insurance premium, as well as an out-of-pocket expense, your only option is to accept the limited set of options covered by your insurance carrier at the very moment when your life is threatened and choice is essential.

In my experience over 12 years of providing billing and practice management services to integrative and alternative practitioners, I have seen firsthand the cost offsets and efficacy apparent in alternative techniques. Many integrative clinics are creating cutting edge programs for patients suffering from chronic disease and negotiating with managed care companies to reimburse these cost-saving programs.

The U.S. Public Health Service estimates that 70 percent of the health care budget is spent on 20 percent of the population, that segment of the population which suffers from chronic diseases.

The recommendations that follow are intended

for health care as it exists today, for the urgent needs of patients without choice, providers without the right to make clinical decisions, and payers without answers.

The origin of CPT was created by the desire to obtain utilization data for conventional medicine techniques and procedures. The role of CPT in the eyes of the AMA was to categorize conventional medical services in an effort to objectify services rendered in the physician's office. The license to use these codes is then purchased by the insurer and the CPT code books are sold to physician offices.

This mass distribution of CPT resulted in the creation of a standard language used to submit information to insurance carriers.

There are three main factors that have attributed to the demise of the clinical usage of CPT, the administrative paper war associated with CPT, and the crash of managed care systems because of the misuse of CPT.

First, the clinical usage of CPT in the physician's office was severely misused and abused in the seventies and eighties. The crackdown by Medicare's

Fraud and Investigation Unit discovered huge abuses in the way services were reported and began to create guidelines around how long a physician could spend with a patient with a given disease and how that service needed to be coded in order to be paid.

Once the commercial insurers caught on to this same kind of abuse, meetings began to take place with the large insurance companies in the country and Health Maintenance Organizations, and the advent of managed care resulted.

The second factor of the demise of the administrative side of health care was when the simple use of CPT, used to track utilization and cost data, became the tool for measuring best practices in managed care. Actuarial firms all over the country purchased large quantities of CPT data from many sources, and from those data decided what were the best practices in medicine.

Then, these firms sold the analyses of their data to managed care and insurance companies who started to create software that would kick out claims if the diagnosis did not match best practices analysis generated

from the CPT data previously collected.

Picture this - if every physician decided to treat terminal cancer patients by significantly changing their diet, given the way we make best practices decisions today, chemotherapy might cease to be considered best practice. Just because the data indicate a treatment is most widely used, it does not prove the efficacy of that treatment.

CPT data should be used only as it was intended to be used - for utilization review and not the determination of best clinical practices. In making these data best-practice guidelines, we have increased the cost of health care significantly by giving many patients the wrong treatments for them because it was the only thing the insurer would cover.

Using CPT to provide best practices guidelines assumes we are all the same. This is an assumption that will continue to increase health care costs in this country until we stop and realize that the way we capture data must change.

Finally, we must record some objective measurement of patient outcomes and/or progress at the

encounter level to assist the payers with controlling over-utilization. A potential example of how we might do this is as follows:

The provider submits a protocol with an estimated number of treatments and specific objective goals;

For each subsequent claim, the patient indicates, for instance, on a scale of 1 to 10, his or her perceived rating of the current status of the presenting problem and progress towards treatment goals;

The provider enters this patient rating on one of the open fields on the current HCFA 1500 form;

That we begin the coding of innovative treatments by starting with HCFA and the HCPCS level and then adopt codes into CPT as their meaning and utilization are studied.

This gives the insurers time to update their systems and provide for education in the use of these new codes and speeds up the amount of time it will take to get these new codes accepted by CPT or the American Medical Association.

I believe we should not try to replace CPT, but

instead to enhance its use and provide a bridge for consumers to access therapies that cannot be coded legally today.

If no progress is being made or no improvement is shown, which is patient-reported, then the patient would be switched to a new treatment plan. This approach allows all of us to choose the kinds of treatments we want to receive, patients and providers to collaborate on treatment options, providers to responsibly innovate in the treatments they offer patients, and payers to control costs; all better than we are now.

Waste is minimized, and administrative costs are slashed because providers no longer must generate huge volumes of paperwork to convince payers to consider coverage for innovative treatments.

Health services research at the patient encounter level provides a valuable real-world corroboration of the results of randomized controlled trials.

It measures the appropriateness and the outcome of treatment plans to which both the patient and the provider have agreed, with which both can willingly

comply and which improves the odds of a positive outcome.

Best practices are only best for those patients who respond best to them. The rigidity with which we are now managing care puts physicians into ethical quandaries and puts patients into the predicament where they are receiving the wrong treatment plan for them because that is what their insurance company covers.

Thank you.

DR. GORDON: Thank you very much.

Wayne Sickels.

Presenter: Wayne O. Sickels, M.T.S., M.Div.

MR. SICKELS: Members of the Commission, thank you, first of all, for inviting me to come to speak with you today. This morning I am not trying to represent any group or organization. I offer only my personal viewpoint and experience, a view from below, in the trenches of a fast-growing, young, and ancient profession, after 16 years of practice and teaching in the field of therapeutic massage and bodywork.

My primary concerns focus on what may be lost in the complete absorption of manual/manipulative therapies, somatic or body-oriented education and

facilitation methods, into the belly of modern medicine and the mainstream health care payment and delivery system. I also find myself questioning some assumptions about, and motivation for, getting into the health care payment and delivery system.

When I teach massage therapists, I teach that there are two kinds of touch, procedural touch and expressive touch. Many of my own clients implicitly know this difference and come to me precisely because I am very conscious of the difference and I am skilled at doing both.

Professional therapeutic massage, when most effectively and ethically applied, marries the two. The health care payment and delivery system only recognizes the procedural form and application.

I have come to recognize that much of the potency and value of what I do comes from the fact that I work with people, and not on them or pieces of their anatomy, and that this is true no matter the technique used or outcome sought. I believe that this is precisely the alternative that the lions' share of people who seek our services find so complementary with or without

reimbursement.

I worked in a doctor's Physical Medicine and Rehabilitation office alongside a physical therapist early in my practice. Cases involving auto accidents, falls, cervical strains, herniated discs, and chronic pain would be sent to me to work on the neuromuscular and myofascial components of their painful and guarded conditions.

When I left the doctor's practice for my own, the physical therapist wanted desperately to know what was it that I had been doing to the patients that I had seen, what techniques was it that I was using, so that she could perhaps go and learn them, too.

I had to honestly say to myself and to this colleague that if there was anything consistent and identifiable about the time that I spent with these people, that it was not the application of a particular manual protocol or technique, rather, it was the quality of the time that I spent with them, listening carefully to their stories and experience both with my ears and with my hands, validating and supporting them in their process of letting go gradually of their holding,

guarding, and fear.

I helped them become aware of what they were doing and choices that they might have. Various massage and neuromuscular protocols, which were always carefully recorded for tracking patient progress and keeping the treatment record, were the platform and excuse for them to receive safe, responsive, intelligent, caring touch.

These skills cannot be learned from books, published studies, and the hard sciences. These are the softer arts, and they, like expressive-type touching and exquisite sensitivity to boundaries, are mostly set aside in the mainstream health care service industry to make room for the efficiency of procedures.

It has also been my experience that perhaps a majority of persons in our culture have largely and sometimes exclusively experienced touch that communicates primarily one of three things: expectation, demand, or threat.

This includes much of the touch that passes between persons in private and intimate relationships, as well as the typically procedural type touch provided in medical exams and rehab intervention. I tell my students

that for some of their first-time massage clients in particular, it may be the first time in their life in which they experience a quality of touch that does not only express and communicate some form of expectation, demand, or threat.

Keep in mind that most procedural touch is focused primarily on the desired outcome but not the person. It breaks, loses or never even establishes real contact with the person, but instead emphasizes the separation, difference, distance, power differential, and, of course, the outcome or goal that is being focused upon.

This is quite naturally and often received as a subtle aggression, from a position of power-less-ness and vulnerability - doing something to someone to make them other than they are in that moment.

It has been my role, and I suspect the role of numerous other alternative health care professionals to, in Bevis Nathan's terms, "counteract the level of vulnerability conferred upon the patient by the curative processes and associated technical administrations."

The demands of the health care system as it is

currently structured and oriented will lend even more momentum to a tendency I already see within my profession as it grows and seeks mainstream legitimacy.

That is to focus primarily, and often exclusively, on techniques and theory for the application of those tools in fixing and curing presenting problems, just like the physical therapist whose entire focus and only question was what technique had I used, what had I been doing to the patients that we had both been seeing.

With the theory comes research justification sought and framed within a mechanistic medical model, expressed only in the language of physiology. Meanwhile, contact with the interpersonal, expressive, and phenomenological qualities of the interaction and skill development in observing and relating in this regard, fall to the back of the curriculum, or off of it entirely.

So, we learn techniques to help and fix, things we do to someone for them, with less focus given to teaching or developing the skills of presence, attention, listening to, being with and educating.

Techniques are then strung together into

protocols and procedures used on anatomy, no longer persons, by health care providers, including massage therapists.

Nathan points out that, "Holding, rocking, rubbing and stroking touches are procedurised versions of expressive touch forms."

While we ascribe physiological rationales to our techniques in an attempt to become or remain scientifically acceptable and to gain access to the mainstream medical reimbursement system, we must continue to recognize, as Nathan puts it, that our "therapeutic pedigree is rooted in primitive and instinctive healing behavior of the expressive touch variety."

We cannot expect all our answers and justifications to come from the language of anatomy and physiology. Nathan suggests that in fact, "We may have become over-reliant upon a small physiology section of a very large library of the human constitution. An answer may instead arise in terms of the meaning of a caress, rather than the physics of it. The meaning of a touch to an individual is a far subtler notion than is the mere stimulation of a postural reflex pattern."

How do we quantify, control, and/or reimburse for the meaning someone makes of an interaction during a carefully and ethically contained therapeutic session?

I support and encourage integration, coverage, and reimbursement for the minority of persons who really need alternative and adjunctive services such as massage therapy, and cannot afford to pay for them. But my experience is that this is only the case for a small minority of persons who actually seek and use our services.

The most common application and use of massage therapy does not meet the "medically necessary" criterion for coverage. This is not to deny the validity and value of forms of medical massage, some of which I am trained in, for those who truly need it, provided for and reimbursed by the system.

What is more in question is the limiting definition and control of these and other alternative care services through integration, in a way that compromises some of their essential ingredients and redirects some of their most creative focus and gifts, in effect limiting both quality and access.

These essentials for massage therapy and somatic education lie in the area of expressive contact and presence, strategic, responsive, interpersonal interaction focused on the whole person. They also lie in exquisite attention given to boundaries and to a person's physical and emotional responses to the caregiver's presence, pace, contact, and intervention strategy.

It has also been my observation that quick and uncritical allegiance to the "benefits of access" to the health care payment and delivery system has often had more to do with the profession's and professional's access to, and control of, market share, than the real interests and needs of patients and clients in their pursuit of resources for health and healing.

Many therapists are sold on the idea of becoming a "preferred provider" and gaining (the assumption and packaging says) easier access to more clients as referrals are provided you through the network.

Meanwhile, many have little awareness of the implications to their practice, time and attention, and

their possible dependency upon and costs of securing this effortless marketing and referral source.

I look forward to learning more from the perspectives and understanding of many of those, and many of you here, who have a different view and experience. These are interesting times in the world of alternative and complementary care.

I once again thank you for this opportunity to offer my simple and personal perspective.

Thank you.

DR. GORDON: Thank you very much and especially for the articulation of much of the spirit of the work that all of us do.

Panel Discussion

DR. GORDON: I would like to ask the first question while the commissioners collect their thoughts, maybe to set the stage, as well.

Given the kind of the spirit of care that Wayne Sickels was talking about, what are each of your best recommendations, Melinna and Linda, both of you working on coding in different ways, what kind of recommendations would you make to us to recommend for making the kinds of

changes that will accommodate a truly integrative practice and this kind of spirit of care?

MS. GIANNINNI: I think that one of the things that can happen to make this process so -- right now it is very time-consuming and it is taking up 51 days average for practitioners who are filing paper claims to insurance companies to get paid at a cost of over $20 a claim.

I think that if you can take the paperwork burdens down, for instance, if Wayne was given a super bill that he could just check off the services that he had just done at the end of his session, that would make his life easier and maybe wouldn't focus his attention on his reimbursement to the point that he couldn't focus on the patient.

I think that reducing paperwork burdens is incredibly necessary if CAM providers are going to participate in insurance reimbursement, and accurate descriptions of what was actually done are very necessary to receive the appropriate reimbursement.

So, I think a very large terminology of massage therapy services needs to be available to Wayne to choose

from, so that it is an effortless process on his part to just check off what he has just done.

DR. GORDON: But what recommendation should we make? We are a body working at the federal level. What and to whom?

MS. GIANNINNI: The "to whom" is the Secretary of the Department of Health and Human Services, Tommy Thompson, and the "what" is the appropriate language terminology and code set for filing those services.

DR. GORDON: Linda.

MS. BEDELL-LOGAN: I think that to a large degree, from owning a billing company for 12 years that does nothing but file claims for alternative practitioners and integrative medicine centers, I don't think we are ever really going to capture the spirit of what happens in a patient encounter in a code. I think that that is not going to happen.

But I think that what we can do is we can look at the therapeutic benefit of that. When the RB/RBS system was created, it took into consideration the level of liability, the level of overhead, and the level of expertise that it takes to provide any given service, so

we have a code for massage in the CPT code book, and so massage therapists go to that book, and if it is not strictly massage that they are doing, we also have a manual therapy's code, which is the code that includes manual lymphatic drainage and other important manual therapy techniques.

Although we can't always capture the spirit of that in those codes, what we can do is -- and this is where the stick happens -- is were those codes put in the CPT code book for the purposes of physical therapists using them, or were those codes put in the CPT code book for any provider who is appropriately trained to perform those services to use them.

What happened in the State of Maine, which was sort of a precedent-setting process, is that the Worker's Comp Board said, in 1992, we are going to pay alternative therapists half of the RB/RBS system that has been attached to the CPT codes in the CPT code book.

We went to them as a group, and I put a very large report in to the Attorney General's Office, and I said this has already been taken into consideration in the RB/RBS system, why is it that a massage therapist

performing massage is taking on any less liability or less expertise than a physician who is performing massage. Those are things already taken into consideration.

So, the answer from the Attorney General's Office was to go back to the Worker's Comp insurance companies and make them pay back all the 50 percent that they had withheld from those providers over a two and a half year period.

So, I think that that is a very important part to remember, is that it is not only the fact that we do have a lot of these codes available to us, it is who can use them that has become the problem, and that is because those codes were developed by the American Medical Association, and they don't always embrace some of the outside therapies.

I think that what is happening is that expanded use of those CPT codes for other providers is going to allow us to today get people care who need alternative care as long as those codes are being accepted by insurance companies, which they are, and we wouldn't be alive today if we weren't getting reimbursed.

DR. GORDON: Again, that would be a recommendation to the Secretary of Health and Human Services?

MS. BEDELL-LOGAN: To expand CPT, not only from a coding perspective, but who is allowed to use those codes.

DR. GORDON: Wayne, do you have any thoughts?

MR. SICKELS: I first want to just thank you, Linda, for some other perspective that you are offering. As I said at the very beginning, my perspective here is much more personal just from my own time in practice, all of which has been outside the system of medical health care and reimbursement, so there is a lot that I can learn and need to learn in terms of how the system might work that can be to our benefit.

So, I don't really have a solution on that level of, you know, from the top down. I can only say what it is that I do personally to address the issue of access for people who cannot afford services that I provide, and that is twofold, one thing that many people do, which is pro bono work. The other is I always keep a fair percentage of my practice in sliding scale, so if

somebody does come to see me looking for resources, and they find that what I do is particularly helpful, they need it, they want it, and they are motivated to learn and do what they can, then, I will slide my scale to whatever their budget can afford. I do that consistently and persistently, but obviously, that does not address the system and how to organize the system. That just has been my personal choice.

So, in some sense, I need to be hearing and learning more from people, such as Linda, who have access to more of the technical components of how the system works and how it might work better.

DR. GORDON: Also, I would say I appreciate, speaking from the practitioner's point of view, in a sense what you are saying is even though you have concerns about it, it may be possible, and in certain instances does make sense, for you to be included in the system, if the system can't capture the spirit, but perhaps can accommodate the spirit.

MR. SICKELS: Yes.

MS. GIANNINNI: Could I respond again, too, please. There are so many levels of training of massage

therapists, for instance, 500 hours is a minimum usually in any state to get a massage therapist license, up to 2,500 hours for the practitioners who are trained to do Rolfing structural integration and Feldenkrais.

What was needed in my opinion was a tie to the training by code level to show that payment needs to be higher for the people with more education, so this coding system allows for that difference in training to that level of specificity.

DR. GORDON: Thank you. Tom and Joe and Don.

MR. CHAPPELL: Thank you all so much. It was an enlightening presentation.

Wayne, could I ask you whether the patient requires more time or more services for your intent with expressive touch versus procedural touch?

MR. SICKELS: A very good question. Nobody has studied me in that regard except for myself.

MR. CHAPPELL: Well, let's assume I am the third-party payer here, and I want to know.

MR. SICKELS: I guess the only context in which I can really kind of accurately relate to that question is the period of time that I worked in the physician's

office where the time was time limited, and people would move across the hall from the PT to me or from me to the PT, and the period was limited by how long they were going to get coverage for their medical treatment.

In that context, what I certainly can say is that the physical therapist and the doctor were surprised by what was -- it was the reason why the physical therapist was asking me what is it that you are doing with these people.

So, even within that rather limited container, actually quite limited because I do a good bit more in my own private practice, there was effective space for that quality of contact. What there wasn't was the language. That is why I had to respond to that physical therapist's question the way I did. There was not a technique or protocol that I could consistently say was what it was.

So, that is part of the issue is how can we, as we integrate, find ways to hold and contain and value that way of defining space with someone and interacting with someone that isn't purely technique protocol oriented, because it simply can't contain it. But in terms of time, certainly, I can do an enormous amount in

the 20 minutes to half an hour that I might have with somebody, and the patients experience that because they were attended to in a very different way when they crossed the hall to do their exercise protocol and ultrasound.

MR. CHAPPELL: So, you are differentiating your service from another provider, you are not differentiating the amount of time.

MR. SICKELS: I would say that is true.

MR. CHAPPELL: And you are differentiating the result as a more holistic result, but for the reimburser, the minimum baseline result is achieved.

MR. SICKELS: I would expect, yes.

MR. CHAPPELL: So, I don't see why integration isn't possible.

MR. SICKELS: Oh, I don't know that it is not possible. I just have a lot of concerns about the nature of it.

MR. CHAPPELL: I am thinking to myself, I am asking myself, so it seems to me it is doable rather than your staying outside the system. Thank you.

DR. GORDON: Joe.

DR. PIZZORNO: Wayne, thank you for your eloquent and inspirational presentation, very much appreciated.

Forgive me, Jim, I have to ask two questions. This is for Melinna and Linda.

One is, Melinna, when I first heard about your system, what you were doing, I was very supportive of it, but when I started talking to practitioners, I got a very negative response from the practitioners, and that is, they were afraid that if their procedures were differentiated from conventional medical procedures, they would be ghettoized and that they would see a progressive eroding on their reimbursement system.

So, I would like to ask both of you to respond to that concern.

The second question is you both seem to have a somewhat different approach, but what we are wondering is if there is some way of combining what you are doing together to get something that will be even more effective, so I would appreciate it if you would both comment on both of those questions.

MS. BEDELL-LOGAN: My feeling about Melinna's

work is that it would be an absolute crime to see it not used in the enhancement of CPT, HCPCS codes, whatever we do. I have seen her work, and it is absolutely impeccable.

However, from a billing company standpoint, if I am sending out HCFA 1500 forms with Melinna's codes on them, no insurance company will look at them or pay them, and so I can't use them, but that does not mean they don't have incredible value to what could be an expansion that would allow us to collect better data and to objectify services on a more personal level to the provider.

So, what we have is we have, you know, a massage code, a manual therapies code, but there is no code that says this is being delivered by a Feldenkrais practitioner or this is Rolfing or this is this other thing, and truthfully, I don't know that that is necessary.

I truly believe that the patient encounter is the most important thing here, and if what we are trying to do is show the insurance company that manual therapy is being done, then, manual therapy is being done, and I

think that if the patient and the provider have the ability to sit down and corroborate on that plan of care, this is the way Worker's Comp works.

It is interesting, really being adopted very much in managed care. In the State of Maine, we have had an incredible cost savings in Worker's Comp since they were able to pay for acupuncture, massage therapy, biofeedback, mind-body interventions, and they are doing beautifully at getting people back to work much sooner than taking them through the pharmaceutical, take feostat, take all of these other drugs, that then they end up in rehab because they are addicted to those drugs.

So, what we are looking for is just some more tools to put ourselves in a position where we can code more articulately, and I believe that is where Melinna has an incredibly valuable thing that we could use as a growth into integrative medicine, but taking CPT away, there has been billions of dollars spent on the building of the CPT code book, and I feel very uncomfortable with saying swipe it away and let's do it something else. To me, that is creating a cavern and not a bridge.

DR. GORDON: Joe, let me interrupt for a

second. Could you clarify what the practitioners were so concerned about?

DR. PIZZORNO: The concern of the practitioners is that if they provide a service that is coded separately from what is provided by conventional practitioners, then, they will see an erosion of reimbursement, because they will be set into a lesser category, you know, the same service, but differentiated differently, paid less.

DR. GORDON: Thank you.

DR. PIZZORNO: And you didn't answer that part of the question.

MS. BEDELL-LOGAN: What I was talking about earlier, about the RB/RBS system already being set up to look at those three indicators, which are the level of expertise, the level of overhead, and the level of liability, the RB/RBS system, as it exists and is attached to the CPT coding system, works beautifully for alternative medicine providers.

That is what we use to bill, we use the RB/RBS system in any given state that we bill in, and it works beautifully, and that is how those practitioners are

paid, whether it is an M.D. performing the service, a licensed acupuncturist.

I have had many M.D. acupuncturists come to me and say I should be making $200 an hour because I am an M.D. doing acupuncture, but why should that mean a licensed acupuncturist, who went to school for six years, should not also be making $200 an hour, because it is the same level of liability and the same level of expertise and the same level of overhead.

So, it is important to remember that that RB/RBS system has already taken those things into consideration, and that therefore, they are usable across the board.

MS. GIANNINNI: I agree that the RB/RBS system is the most broadly used pricing mechanism out there, and these codes have RB/RBS values attached to them under the same theory of costing that conventional medical codes from CPT have.

Dr. Pizzorno, I have heard the pain of the practitioners, and I really do believe that talking about coding and reimbursement is as much fun for most practitioners as chewing on kitty litter, so it has

always been a challenge to get them to understand that this is not something that they need to be afraid of.

We have gone to the American Medical Association at least three times, maybe four, asking to cooperate with them to add these terms into the CPT system, and that has not resulted in anything happening.

The HCPCS from the federal government that are controlled by HCFA have been much more open to this coding system, and realize that there are many code sets out there to support health care.

There is dental codes for dentists, there is drug codes for drugs, there is HCPCS Level 2 codes that are used by the federal government to support things that are inside of shots, J codes are used to describe things that are distributed to people as medications, so there is more than one code set out there.

The American Medical Association having control of alternative medicine, in my opinion humbly, is like giving Ford control of GM parts and services. There is only four codes for chiropractic after 20 years of chiropractic visits being paid for by insurance companies, two for acupuncture, and the two acupuncture

codes are acupuncture and electrical acupuncture, which is like saying surgery and minor surgery. You cannot put a price on either of those codes, therefore, there is no data.

The other thing about having a parallel coding system with a different structure is when you merge all of that data together in CPT, you cannot call out which provider is giving you the service. When you get into meta data, it is all thrown into a big pot together, how do you call out who is giving you the best results for carpal tunnel syndrome.

With a unique coding system that also describes the practitioner filing the service as either an acupuncturist or a massage therapist, this coding system is a little bit unique because the modifier tells the computer who is filing the service.

It fits onto the HCFA 1500, it is business as usual, but this coding system calls out who is filing the service, and it is not going to be discriminated against the provider price-wise because in order for that to happen, the payer would have to redesign his payment system, and he would also have to go to battle with the

practitioners over the RB/RBS system.

I hope that answered the questions.

DR. GORDON: Thank you. I would like to ask Linda for any of the cost savings data that you have, and, Melinna, if you could provide us with your coding system, so we can try to understand it.

MS. GIANNINNI: I left that with the Commission, and I will make sure as many books are given out as are needed. Just tell me afterwards who would like to review them.

DR. GORDON: We would all like it. I don't think we have a copy of it. Do we? Okay, great. Thank you very much.

Don, you are next.

DR. WARREN: Melinna, you talked about ABC codes supporting state licensure. Dentists doing TMJ cross code a lot. They go from dental to medical to physical therapy.

Do you see in this cross-coding and everything, do you see code stacking to increase the payments?

MS. GIANNINNI: I think that there is logic to payment systems that will prohibit practitioners from

abusing the system, such as if a practitioner starts exceeding an hourly rate that is kind of standard in the industry for, let's say, an acupuncturist is usually making $135 an hour -- this is picking a number out of the air -- but if they are billing starts exceeding that hourly rate, I think that there is checks and balances inside of payment systems that would catch that if it was going on a lot. So, I don't see that as a problem.

As to the state, can you help me with your question on the state scope of practice?

DR. WARREN: This new coding, would it preclude a dentist from doing physical therapy?

MS. GIANNINNI: Not if he was trained. The thing is if you will get procedures down on a code level very specific, such as reflexology, it doesn't matter if you are an acupuncturist or a massage therapist or a dentist doing reflexology, because there is a training standard in this coding system attached to each one of those codes.

So, all you have to do when you are paying for a service is if the provider is in a managed care network, you look for that training, you look for the

certification, and then the code should sail through.

DR. WARREN: One of the things that bothers me, Linda, about a massage is a massage is a massage, is that it is not true.

MS. BEDELL-LOGAN: No.

DR. WARREN: And a physical therapy treatment is a physical therapy treatment, it is not true.

MS. BEDELL-LOGAN: No.

DR. WARREN: You have various gradations of expertise. To say a massage therapist that is sensitive to the patient, that works with the patient, they are out there. They get paid the same as somebody that comes in there as a mechanic, you know. I would rather have somebody work with me than work on me, and there has to be a differential in coding for that.

To obtain that essence with the CPT codes, it looks like you have to stack. To get it with this, at least you say all Feldenkrais reps are all Feldenkrais or all Rolfers are Rolfers, and all Feldenkrais are Feldenkrais. Then, it gives you a differentiation as to at least the level, and I think we need to incorporate that somewhere in that coding.

MS. BEDELL-LOGAN: Right. Right now the way that we use the CPT codes in providing -- because you have to remember that my purpose for being here is that we are dealing with a situation right this minute, every single day, where providers are seeing patients in an alternative medicine world, and we provide the license number of the provider performing the service in Box 24(k) of the HCFA form, so that when the service goes out, whether it is in an integrative model or as a private practice, in Box 24(k) is the state license number of the person performing the service.

So, at least you know, you know, when that claim comes through, that the person who is providing the service is licensed to do so. As I said in my testimony, I believe that the AMA has fallen very short of giving us a comprehensive coding package, and I really believe that they need to be working more closely with Melinna.

It is just that there is a lot of ownership issues. There is a huge amount of money in the sale of CPT to insurance companies and to providers, it is a huge, huge revenue stream, and a lot of this is about that.

DR. WARREN: That is the way the ADA keeps making money, they keep changing the code every three or four years.

MS. BEDELL-LOGAN: That is exactly right.

DR. GORDON: Tieraona, Charlotte, and Wayne, and then we have to move along a little bit because we are running some over time.

DR. LOW DOG: I want to thank you all for your presentations. As somebody who runs an integrative medical center, I can tell you I am very sensitive to these CPT codes.

Wayne brought up some interesting points that we have heard previously in this commission about a lot of CAM providers not really wanting to opt into the system, and actually a lot of Western providers wanting to opt out of the system that they themselves see as somewhat restrictive.

I am struck by the need to have both, so that these services that actually have been proven efficacious are available to people who are underinsured, uninsured, or Medicare and Medicaid, who actually can benefit from massage and many of these other therapies.

I am somewhat dumbfounded, though, by the concept that somehow we can code for quality, because I don't think you can code for quality, and I don't think that quality or compassion or expressive touch is unique to any particular profession. I think that there are doctors who are very expressive, loving, and compassionate, just as massage therapists.

So, I guess I would like to hear, Wayne, just a little more about this expressive touch, procedure touch, coding, opting in, opting out as far as policies and what we recommend, because partly what we are trying to do is figure out reimbursement, and we are trying to figure out delivery and access, and these kinds of issues, and do you have any advice for policy recommendations, taking into account the point of practitioners who are reluctant to get into a system that they see as having a lot of problems.

MR. SICKELS: Well, again, I find myself almost needing to sit and listen a good bit more in order to be able to come forward with something in the form of a policy recommendation because the world that I have been in is the world that you just described, as someone

outside the system who has essentially been concerned then and resisted even the contracts that I have received in recent years to become a preferred provider.

I hope, and I am open to all of the dialogue that I am hearing here, and within my own professional organization, that we can have both, people who opt in and can find appropriate ways to make a living and provide competent, quality care, and those who choose not to operate within the system and are not eliminated because the integration of the profession into the system makes it impossible for anybody to keep a viable private practice outside of it, but I have to admit I don't know how that would be structured. That would certainly be my desire.

MS. BEDELL-LOGAN: May I make a comment on that? The way that we have structured some of these integrative medicine centers do do that very thing that you are taking about, is that we have structured them as chronic disease management centers and wellness centers under the same roof, so that patients who want to come, who had a lousy day at work, can get a massage, can come and pad a pocket and not go through the hassle of all of

the HCFA 1500 forms, but people who have fallen down the stairs at home and have chronic low back pain can go and get a therapeutic massage or therapeutic body-work from somebody and have that reimbursed by insurance because they have a diagnosis that indicates that they need a treatment, which is very different than the wellness model.

Now, one of the things the insurance companies have really liked about that model is that as patients reach maximum medical improvement, they are referred to the wellness center. What that does is it keeps that patient at maximum medical improvement for a longer period of time than just sending them home and having them fall right back into the same lifestyle that they were doing before, which is probably not exercising properly, not eating properly.

So, what we do is we sort of, if you will, send the sick bill to the health care system and send the well bill to the patient, and it really is a wonderful way of splitting that out, so that the whole financial burden does not fall on the insurance company or the patient, it is a shared responsibility, and I think that is very

important to distinguish in a center.

DR. LOW DOG: Thank you.

MR. SICKELS: That was very clear, what she said.

[Laughter.]

MR. SICKELS: Because that is how my practice now operates. I get a lot of referrals from chiropractors, physical therapists, physiatrists. When a person is finished with their round of rehab or therapy that is under coverage, and they know that there is some more that can be done in terms of a person's ongoing wellness, education, and support, and that is a lot of what I do.

DR. GORDON: Charlotte.

SISTER KERR: I am with the kitty litter-grinding crowd. I actually feel anxious talking about this subject. I feel like I have some kind of code anxiety syndrome.

DR. GORDON: Code dependent.

SISTER KERR: But, if anything, in this whole being on the commission, maybe today will be helpful to me. There is something about me. In my every-day work,

I work as an acupuncturist, and I never quite feel like I am telling the truth when I deal with codes.

MS. BEDELL-LOGAN: You are not.

SISTER KERR: And having this part of me that wants to tell the truth about what is so, I go through this grind. I want to give you -- and I know we are limited on time -- a person I saw just the other day, a young girl, 33, with pain in her calf, and she heard acupuncture helps pain. Of course, it can do that, but I looked at her and I do a very thorough history, everything about her is important to me.

She had other Western labels like Reynaud's. She didn't come in for that. She had labels like allergic rhinitis, dysmenorrhea, history of kidney stones, fragile hair, she craved salt, just to mention a few.

From my point of view, I saw this issue as a deficiency in this chi, and that very simple things like the reason she was so worried about her leg is she couldn't run anymore, and she was a runner. Her body, mind knew she needed to run to move to keep the chi going, which would solve things like dysmenorrhea from

our point of view, get the fire for things we call Reynaud's, and even on this level of being a severe introvert, she lost her community of buddies. Do you see?

Now, I know if I have a diagnosis of things like Reynaud's, allergic rhinitis, I can label those, and those are probably likable codes, you know, they are going to like to fund that, and she is going to be surprised that that gets better.

But I have to tell you it is nothing about the truth about what is going on, and it goes back in this forum to the whole issue of research, and you say they gave codes for acupuncture, so that conversation is over. I have no idea what we are ever going to do about that, and I would love your input.

MS. GIANNINNI: I am going to jump in because I have been thinking about this one a lot. The International Classification of Diseases, ICD-9, Ninth Edition, is developed by the World Health Care Organization, not coders here in the United States. They are clinically modified for morbidity, they were for mortality, they are modified for morbidity in the United

States.

I have suggested to all of the national acupuncture associations that they go to the World Health Care Organization and build appropriate ICD-9 codes for acupuncture diagnosis, because no, they are not listed in the current body of information, and certainly a lot of the world is using acupuncture, and that needs to be resolved.

So, if this commission could take a recommendation that would be really meaningful, not to just the United States, but to the world, it would be that the World Health Care Organization support diagnostic tools for acupuncture.

MS. BEDELL-LOGAN: The way that we have done our billing piece with what you are talking about is that the 977.80 and the 977.81 doesn't give you very many tools to objectify the services that you render.

So, what we do is when we put on, they are super-billed together, so that they can check off the services that they have rendered, it is 977.80 MO, which is moxibustion, or it is cupping, or it is needling, or it is electrical stimulation, or whatever it is, but we

actually track that at the billing company level, and when we bill it, the insurance company, to be perfectly honest with you, and I have heard this from many insurers, they don't care whether they are getting cupping, moxibustion, what they are doing.

They only care that the person is receiving acupuncture for what they feel is an efficacious reason, whether it be dental pain, the NIH consensus information, whatever that is, but that the care is appropriate.

But from a data collection standpoint, if you are not showing the difference between moxibustion, cupping, needling, electrical stimulation, you are not allowing yourself to even define best practices within your own practice.

So, there can be ways to enhance your own data without bombarding the big system. It depends on what you want to get out of coding. If what you want to get out of coding is best practices, we have to do it very differently, but if all we are looking for is utilization data, it is a different thing.

DR. GORDON: Wayne. I'm sorry, we are already 15 minutes over our allotted time, so Wayne has got the

last question. Obviously, this is a subject of considerable interest.

DR. JONAS: I am not sure, Charlotte, whether you actually had your code and reimbursement anxiety syndrome addressed. I am going to redefine that as CRAS.

[Laughter.]

DR. JONAS: But is there a code or is there even the possibility of a code for the treatment of chronic disease in general, because what I hear happening often in these conversations is that what we are about when someone walks in the office with a chronic problem is a syndrome that takes multiple forms and that can be addressed using multiple avenues and usually requires that it be addressed using multiple avenues, and that the goal of it is to stimulate reparative self-healing processes, and that this is the most efficient and effective way to treat chronic disease, but we don't have a code for reimbursement for that.

It is the flip side of your wellness coin, if you will, except someone just now crosses the diagnostic barrier and gets labeled with something.

MS. BEDELL-LOGAN: Exactly.

DR. JONAS: But the process is the same.

MS. BEDELL-LOGAN: What we have done in the integrative centers, for instance, at the University of Minnesota, the University Medical Center has a mind-body spirit clinic, Mary Jo Kreitzer's clinic and Marge Page, and all of them.

It is a really wonderful thing because we were able to take a fibromyalgia program, which includes massage, healing touch, acupuncture, and psychiatric care, and therapeutic exercise in a group level.

We were able to take that to Health Partners and say to them here is the code that it is going to look like. It is just a local code, we made it up, here is what we need to get paid for, and we will save you X amount of dollars because these patients aren't going to be running around getting services all over the place from all kinds of people who aren't even really coordinating their own care in the conventional medical sense.

But what we have done is we have staged disease, we have staged it as this is Stage I, this is Stage II, this is Stage III, depending on what the onset

of that disease was because, as you know, the longer a patient goes with a disease, the harder it is to treat that disease.

So, what we have done is stage it, so that we have some people with Stage III fibromyalgia, and maybe that bill to the insurance company is going to be $2,500 for one shot of a whole group of services that are rendered in an integrative manner.

However, if somebody comes in with Stage I, there may be an $800 bill to that insurance company where we are very clear that we can treat Stage I fibromyalgia within an $800 period, but again, that is one code. It is a local code, we made it up, they took it. So, it is very interesting to see how these things can be worked out on a local and regional level, because every region suffers from different diseases.

DR. JONAS: That is a very interesting idea. Perhaps we could come up with eight stages of chronic disease in general and various subcategories, whether it is fibromyalgia or chronic back pain or whatever, and devise some kind of coding system for the management of that depending upon how severe it is.

DR. GORDON: We need to close, but I do want to second what Wayne said. Part of what we are looking at is integrative and individualized care, and the more ideas, I don't mean huge numbers, but if you can give us a few good ideas about how to address this and where to address our recommendations, Secretary of Health and Human Services, maybe WHO, about some of these issues, that will be enormously helpful.

So, thank you, thank you all very much.

[Applause.]

DR. GORDON: If the commissioners could sit down, we have the next panel, and it is a panel of one. Welcome, Max Heirich.

Presenter: Max Heirich, Ph.D.

DR. HEIRICH: I am going to have some very specific recommendations to make about how we could develop a CAM reimbursement policy. These recommendations grow out of three levels of experience I have had over the last 25 years.

I have been a CAM practitioner and teacher, I have done NIH-funded research, and I have also served as a broader health policy analyst and consultant, and have

worked with businesses and unions, and with the staff of various congressional committees and with the Michigan Senate's Health Policy Committee. That consulting has been about ways to develop, to finance, and to evaluate innovative health care delivery that changes the focus for care.

I think it is clear that reimbursement policies are going to have a very important influence shaping the future of CAM. They could possibly also have implications for the economic pressure of the country and the effect on health status.

It is a moment of unusual opportunity, and I think, as has become clear, it is also a moment that presents some very real dangers. There is inconclusive evidence about the clinical effectiveness of most CAM approaches and real questions that are being raised about whether our present assessment strategies are the appropriate ones to use. There is very little evidence of any kind about costs for CAM and how those affect other utilization of health care services.

There are real issues, which we have just heard, about how we protect the integrity of non-

allopathic approaches as they become more nearly integrated into the health care system, and there also are issues of social equity.

Now, many of us believe in our hearts that if more people in this country would use CAM products and services, our health care would be better and the costs for care would go down.

We have to face an awkward moment right now because 40 percent of the public now is using CAM, but we, at present, see absolutely no change in the cost dynamic of constantly increasing care, nor have we seen any change in the dynamic which is leading America to fall constantly on international indicators of the health status of the population.

It is not that CAM is doing nothing, it is the usual problem that we have excellent services that go to the majority of the public, while an increasing proportion of the population have no access to care; 42 million people have no health insurance. That is an increase of 10 million during the eight-year period when use of CAM increased 30 percent.

Now, if we are serious about wanting to make a

real change in the health of this country, we are going to have to proceed in some different way.

As many of you know, there are at least three strategies that we could use for reimbursement. We can depend on market mechanisms, which has been what most of this conversation has been about, we can mandate insurance reimbursement for CAM treatments that have demonstrated effectiveness or for which there is wide public demand, or we can reimburse through the mechanism of tax relief.

Let me say something very briefly about each of these and some of their advantages and disadvantages. It is clear that market mechanisms are working to some extent for the majority of the public right now. Eighteen insurance companies are now offering insurance riders for CAM services, the majority of Blue Cross/Blue Shield companies are exploring this possibility, 65 HMOs offer some services.

So, clearly, the market demand is creating a response. It will never cover costs because insurance depends on a number of people not using a service in order for it to break even.

We heard in December, as I read your transcripts, testimony from some experts that the present administrative procedures for insurance are likely to increase the cost of CAM services, while decreasing the income that goes to CAM practitioners, so it is a system that works to a certain extent, it is flawed, and the main problem is that it simply does not bring access to the people who are now left out, the market is not going to do that.

Well, can mandatory insurance do any better? In an ideal world, any CAM treatment which has demonstrated effectiveness and which costs no more than its alternatives ought to be eligible for reimbursement, and then the reimbursers ought to choose to reimburse those methods that do the best job at the lowest cost.

Unfortunately, insurance does not work that way. Any procedure which has been approved for use with a diagnostic code gets reimbursed, and it gets reimbursed no matter what other procedures are in use at the same time.

What that means is that if we have mandatory insurance reimbursement for CAM procedures, the use of

them is sure to increase, the costs will be added to the larger health care system, but there is absolutely no mechanism in place that then reduces the use of other services.

We could be setting in motion another cost escalation dynamic, probably not as great, but rather similar to what happened after Medicare and Medicaid were put in place. In that situation, the costs for care increased 400 percent in five years. We want to be careful about how we proceed there.

But what about tax relief? We could give tax relief to the users of services, and we could do that simply by allowing medical expense deductions and IRS 1040, we could give tax relief to providers of care by allowing charitable contributions credit for pro bono services or sliding scale fees, or we could provide tax credit to the third-party payers, and that could be performance based. I will come back and talk about that a little bit more.

I have five very specific proposals to make about how we might proceed. In choosing them, as I thought about the variety of possibilities, I used four

principles.

The first principle was that any CAM procedure of demonstrated clinical effectiveness that doesn't cost more than other procedures really ought to be eligible for reimbursement.

The second principle that I felt important was that we want to encourage use of other CAM procedures that can improve health, but we probably should not encourage them through the insurance system, because if we do that, it will simply increase the costs for care, and I will get to the implications of that in a moment.

The third principle I tried to bear in mind was that I thought we should have as little regulation of either providers or insurers as is practical within the problems of protecting the public.

Finally, and this comes from my health policy side rather than my CAM side, we have to be sure that whatever we do does not shift insurance risk pools in ways that raise the cost of insurance and leaves still more Americans without basic health care coverage.

So, with those in mind, and with the realization of how limited our state of evidence is at

the moment, I would like to recommend that we proceed in stages, that, first of all -- and this will be my first proposal -- I think Congress could instruct NIH and AHRQ to create a website that will bring together the full range of evidence that will be relevant for decisions about CAM.

This would include not only clinical trial results from NIH, but peer-reviewed journals, studies of the effectiveness of various CAM approaches, whatever cost data is available. We need to gather systematic evidence about larger use of health services by those who use CAM, and that needs to be available on this site.

It needs to be updated on an ongoing basis, and it needs to be regularly drawn to the attention of those who could use it most fruitfully: the insurers; providers; continuing medical education groups; managed care plans; and the like. So, that is my first proposal.

Secondly, I think we need to be clearly committed to excellence in patient care and client-centered managed care and open to CAM approaches.

The data that is gathered should be both on outcomes and on use of other health care services to see

through time what the effects are, so that as we make strategy suggestions, we can see whether they will actually lower health care costs and improve care, or whether that is simply a hope.

Proposal Number 3. I think we should encourage other groups, such as the Federal Employees Health Benefit Plan and perhaps one or two of the Fortune top 50 companies to try equivalent exploration. They would work with different population groups.

They could include such things as making CAM reimbursement eligible for flexible spending accounts with pre-tax dollars, and we can see then, with data gathered through time, what impact this has, not only on health status, but on larger health care uses.

Proposal Number 4. I hope I am not going too fast. I think we should offer performance-based tax credits to businesses that can demonstrate that a sizable portion of their work force is actively engaged in health improvement efforts and that they are reducing health risks in that population group. We can encourage the use of CAM as part of that procedure.

If we do that, I think it would be a very good

use of tax dollars because we already have evidence that as health risks decline in a population group, use of other medical services goes down.

So, to encourage it in this way would not only allow businesses to proceed in the most creative ways possible to encourage their population to improve their health, but could actually reduce cost spending immediately.

Finally, I would like to suggest that we encourage IRS to do some experimenting. We could, for example, choose one state or one region for comparison with comparable population groups elsewhere, and I would see the following kinds of things possible.

For the Medicare population, we might trade the amount of money that is being discussed as needed for reimbursing prescription drug coverage to be used by the Medicare population as it sees fit including the use of CAM services.

That would provide a cap limitation, and these then could be medical deductions on IRS for those who have incomes of a proper level, and we could allow and encourage CAM practitioners to do pro bono services and

sliding scale fees for the lower income Medicare group, which would then count as charitable contributions on their own tax returns.

We would see what the costs are for the care of the Medicare population over, say, five years, 10 years, whatever period of time we think is appropriate, in that region as this catches on and gets used, in comparison with what happens elsewhere.

I think it could make a real difference in the present dynamic struggle between the pharmaceutical industry that wants to have no coverage because they fear control, and the public which demands some help with services. I think it could be a very interesting test of where we are.

In short, what I am suggesting are a series of very clear trials, gathering of information and making it ready, seeing what that will do, demonstrations of various kinds designed to evaluate how different CAM approaches and different protection of the integrity of the approach work out in terms of cost, in terms of health outcomes, and a series of experiments with the IRS system itself, which would not commit it to a loss of

public revenues that could be disastrous, but would let it try and see what is going to happen. Thank you.

Panel Discussion

DR. GORDON: Thank you very much, Max, for your long and deep thought on the subject, and for these very specific and interesting, good recommendations.

Joe, and then Tieraona, and Tom, George, and Bill.

DR. FINS: Thank you very much.

That sort of strategy of incrementalism seems quite prudent and appropriate, given the state of current knowledge, and it is a way of generating the knowledge without creating new benefits for interventions which are not yet proven without robbing resources from other things which are efficacious. So, it seems very prudential, and I want to ask you, specifically, two questions.

One, this infrastructure that you propose, where should it be; do we have an existing federal agency that could run it; where would you put it?

Secondly, how would you link this sort of HRSA-like, AHRQ-like sort of study; how would you relate that

to the basic science work that is done at NCCAM and the NIH; how do we create the whole infrastructure that marries the scientific evolution with the health services evolution; and where would you put the federal government?

DR. HEIRICH: A very important question. I assume you are thinking primarily to my first proposal here. I think the website might best be staffed by AHRQ. It clearly needs to be done in cooperation with NIH, and it needs to include, as you point out, a wider range of information than simply clinical trials.

It needs to gather financial information. It needs to gather quality assessment, which is not a clinical trial type assessment of outcomes. I don't think NIH is a good site to do that. I hope that AHRQ might have, within its staff, people with the range of sensitivity and competence to put it together well.

DR. GORDON: Tieraona.

DR. LOW DOG: I wanted to know who was going to coordinate that, as well, so I am just going to make a quick comment.

Please take this in the respect that it is

intended. My grandfather used to tell me all the time that when I had a problem I couldn't figure out, to go find a white hair, and I want to tell you that your presentation represented to me absolutely one of the most clear, well thought-out approaches.

What also struck me was that it was absolutely open to all of the possibilities, but just saying in a very wise way, let's take this one step at a time, maintain the integrity of the professions, and let's not overburden a system and just go down the same tracks that we have gone down before.

So I just really want to honor you for all that you put into this, because I can tell it was a lifetime of work and thought.

DR. HEIRICH: Thank you.

DR. GORDON: Tom.

MR. CHAPPELL: Yes. I, too, deeply respect and thank you for the fine proposals and thought.

One of the things that I find distinguishing about your proposals is that it is addressing both the therapeutic nature of health care, as well as the wellness issues.

To date, we have been focusing in reimbursement on, it seems to me, beginning to look through the tunnel of the treatment side of health care, and not the wellness side, as if to say we should not be providing an incentive to those who are addressing wellness techniques.

Where I see that is in the tax relief, whether it is business driven or individually driven. I am not sure I am clear on my question yet, but do you think this exhausts the possibilities of incentives for wellness as opposed to treatment? Or, do you see these as the most practical?

By the way, you made a point earlier that we do not have services or reimbursement practices that fully reimburse cost. I don't believe they should, because unless we are in this together, that is, me, the person helping to pay for some of my wellness, then I am not going to have the same interest in wellness if it is a free ride. So I think it should be a shared burden of care, the individual and the reimburser.

DR. HEIRICH: We have opened up a number of things, and I will speak to as many as I can remember.

First of all, about the shared burden, I think that is right. I think we have to remember that what portion of the burden people can pick up varies enormously by their social situation.

We need a variety of strategies that allow people to have self-respect and investment as they proceed. I think our insurance arrangements almost discourage that at present. So, as we proceed, we want to do a better job with that.

There are some dangers to the tax relief area, and let me just make them clear. This opens up a tremendous possibility for fraud, and I think you can be sure that fraud will be attempted.

That means that the IRS is going to get involved in a very different way, in surveillance, perhaps harassment, and we want to proceed very carefully to minimize that kind of disruption of the kind of relationships we want to create.

That is why I did not suggest a general medical deduction expense allowance. I thought we could do that with caps, and I said no, that is going to reduce federal revenue. It is not clear that the people who could make

use of it would not get services in other ways.

The people who most need our services can't afford to pay out of pocket and wait a year to get their tax refund, so it wouldn't help them. So, I dropped that, and then I thought about Medicare, and I said wait a minute, we are talking about opening up a new area, why don't we use that to actually find the potential and the problems that would be involved. So, that is why I made that specific suggestion.

Earlier, I had been very enthusiastic about pro bono payments becoming part of charitable contributions, a relatively small change in the tax law. Of course, it would have to go to all practitioners, and that might be beneficial, as well, but again, it opens up many opportunities for fraud, much necessary keeping of records, interaction with IRS, and I thought, oh, Lord, do we really want to get into that in the midst of everything else that we are doing.

But it occurred to me that for the Medicare beneficiaries who have no use for the itemized medical deductions because their income is too low, we need some way to encourage clinics. I forgot to mention I have

been thinking about the medical clinics that we were hearing about yesterday.

Certainly, CAM practitioners could volunteer at such clinics. They are under tremendous pressure to see people in short periods of time. They can't afford apparently to hire CAM practitioners for longer periods, but a number of CAM practitioners that I know would be delighted to volunteer services particularly if it helped them in terms of their own tax liability later.

So, there are any number of ways. I am sure that anytime we come up with ideas, somebody else is going to come up with better ones. I would love, as a researcher, to help design the demonstration projects to see how they could be put together, how we could protect the integrity of CAM as it is occurring, so that we don't simply replicate all the struggles we have had in the last 25 years between integrated clinics, between doctors and CAM practitioners, and what have you. There would be ways to do this, but it would take some thinking and demonstration.

I guess my last point and comment in reply to your general statement is that there are other interest

groups besides the insurance industry that have something to gain, and that is the reason I would suggest to you performance-based tax credits.

Businesses pay out a lot right now. They have a real interest in healthier employees from many levels. There is a methodology that has been developed which works to engage a large portion of the work force and to begin to reduce health risks.

If it was enlarged with more CAM inputs, I think it would work even better, and I have had some research experience to suggest that this is true. I think we could design a lot, and, yes, there are many ways we could go. I will stop.

DR. GORDON: George.

MR. DeVRIES: I want to thank you for balancing idealism and reality in bringing us to a very prudent middle ground which gives us real direction and a real potential for success.

My thoughts relating to currently where we are at today, it is health plans today, what are they doing with CAM in terms of providing actual benefits for members and employers who are actually spending

additional amounts for CAM benefits. You mentioned earlier in your presentation kind of an overview of the real change that is happening out there.

We have heard presentations. There is a few health plans that are doing benefits for CAM on a core basis across the board for all members, but that tends to be rare.

More what is happening are more towards supplemental benefits where an employer will purchase a CAM benefit for their members, much like they might buy a dental or a vision plan in addition to the basic medical, and this is for everything from 2 and 10 life employer groups, all the way up to the Fortune 50.

I guess I would like to know what your thoughts are, how we can continue to encourage health plans to offer benefits and promote those benefits to their employer groups, as well as perhaps how we can encourage employer groups to broaden the coverage beyond basic medical to also include CAM benefits.

DR. HEIRICH: An important question. I mean they all have been, I don't mean to rank them, but there are a couple of dilemmas here that have to be addressed.

One is that the insurance market, by its very character, depends on the majority of people not using a service. The rate is lower because those who need it only turn up occasionally.

So, if we want the public to use these services and try to reimburse them through insurance, we have got a serious problem. The cost for insurance will have to go up. If there are individual riders, those who want the most can get them, but the people who need the most may not be able to pay for them.

So, there are real problems I think in using insurance as the route out of this. I think insurance can help, I think it is great that it is moving in those directions. I wouldn't discourage it at all, but my sense is that this commission doesn't need to put a lot of energy into correcting the insurance field and how it is working.

I think it will self-correct as much as it can if we make the proper information available to it, but now there is a different matter when it comes to employers and insurance and what they pay for, and let me give you an example of proposals we are currently

discussing in Michigan where the employers are now seeing the very real benefits that come to them if they reduce health risks for their population group, but they recognize that they have had a 20 percent, 30 percent to 40 percent increase in premium costs this year, that it takes three to five years of investment before health spending goes down as health improves.

They are saying how in the world do we pay for it, and a number of them are beginning to explore what they call partial self-insurance in which the risk gets shared between the third-party payer and the insurer.

So, for example, you can take out insurance policies for your employee group in which the employer is responsible for the first $2,500 of expenses that would normally be on the 80 percent that the insured is going to have. Thereafter, the insurer takes over.

Now, what that does is to protect the employer from the very expensive cases that come in and gives them a stake in minimizing the use of other services as they improve the health of the employee population.

It sounded good when I first heard about it. It was developed by a benefits company that was set up by

labor unions, and it works with a number of school systems, small employers, and the like. I said, well, that is fine, but suppose everybody went to the maximum benefit, wouldn't you be wiped out.

The answer was yes, but we have actuarial evidence, because we have been doing this now for 10 to 12 years, about what actually happens. For most companies, about 18 to 20 percent of the employees will actually go to the maximum -- I'm sorry , I said that wrong. The maximum liability that the employer uses will be about 18 to 20 percent of what they could have had, that is, a few people use a lot of health care, most people use only a little.

The range goes from wellness-oriented programs where it is sometimes as low as 8 percent to a higher end, often among school systems where you have women teachers who are having maternity leaves and more use of the health care system, and so forth, to as high as 33 percent.

What we have been able to demonstrate as we put all of this actuarial evidence together is that by taking on partial responsibility, the employer can actually

finance the costs of other services which keep people healthy out of the savings that are going in to simply protect them against high risks for a few of their population, but they still remain protected.

So, in short, there are any number of possibilities that can move the field forward, can pay for it without requiring more funds than are now in use.

DR. GORDON: Bill.

DR. FAIR: Well, in this general field, I am often more concerned about what we do than what we don't do, and maybe it is implicit in your excellent discussion here, but I was surprised not to see any mention of education.

For instance, we know that two-thirds of cancer deaths are due either to smoking or poor nutrition. Now, if we could eliminate two-thirds of cancer deaths by educating people in both of those areas, and certainly if you educate people to stop smoking, you are not costing anything, they are having more money in their pocket. So, I would think maybe this would be an excellent opportunity for employer-based tax breaks or something to do programs in education on nutrition and smoking

cessation that would have potentially immediate benefits with very little outlay, and I think that education should be a major portion of your excellent recommendation.

The second thing was in proposal 2, you mentioned that the demonstration should be located in selected HMOs whose physician leadership has demonstrated a commitment to evidence-based medicine, and I would include there that you have to have a CAM leadership with the same dedication, otherwise, it is not going to work.

DR. HEIRICH: Yes.

DR. FAIR: So, I would put that in there. The third thing I would like to point out, because we have heard so much about research, I served on the Cancer Advisory Panel for NCCAM, and last year we could not spend the amount of money that was allocated because we didn't have the grants, so I think that the CAM community has to be alert and put in more information.

I mean Jeff White has done a tremendous job even going out and saying just send us 10 of your best cases, we don't need a randomized trial, just give us 10 of your best cases, and we will examine them.

We had two homeopaths from Calcutta, wasn't it, that came over.

DR. HEIRICH: Yes.

DR. FAIR: You know, they had their x-rays and their pathology. So, I think NCCAM is willing to spend the money, and all we need are the grants that are worthwhile to spend it on.

DR. HEIRICH: Those are excellent points. I don't know how we are doing on time. Shall I respond or shall I take another question here?

DR. GORDON: One thing, we are in a bit of a bind as far as time goes, because we need time to discuss recommendations for this whole day and a half that we have had.

DR. HEIRICH: Let me say just one sentence then.

DR. GORDON: Go ahead, Max.

DR. HEIRICH: The work site wellness programs do precisely what you are talking about in terms of education, and I think that is the most effective place to do the work, because most people are at work, they are easily accessible, and you can find ways to relate this

to their other concerns.

DR. GORDON: I am wondering if there is a way. I have a feeling as I am seeing people around, I know there are other questions, I know the questions require some time and some energy, I am wondering if, Max, if what we can do is perhaps call on you to consult with us, if that feels right to other people since you have spent some much time, and maybe arrange a time when you can both initially, where the Commissioners can give us recommendations and we can give them back to you and ask for your input, and then perhaps another time in the future where you can come and talk with us, and sit with us, and discuss some of these things.

Does that feel okay to everybody, because even if we did the questions, we would give short shrift to the answers and the discussion, and we wouldn't have time for our other discussion.

So, if we could do that, that would be --

DR. HEIRICH: Sure, I would love to do that.

DR. GORDON: Terrific. Thanks so much and thanks for your wisdom.

[Applause.]

DR. GORDON: We have until 11:00 for the small groups, which means we have to be back in here at 11:00 for the presentation to the large groups.

Steve, are you going to read the order?

DR. GROFT: Again, we have two breakout sessions. The first group will be chaired by George DeVries. That group will look at employer, health insurers, and plans and state issues. Joe Kaczmarczyk will be the staff person who will be present. They will meet in the upper conference room, I believe it is E, that is back behind us.

DR. GORDON: Upstairs. Don't get lost on the way back.

DR. GROFT: The second group will meet right across the way, and that will be chaired by Conchita Paz, and Corinne Axelrod will be the staff contact. They again will look at federal agency issues, states, and national organization issues.

Again, we will ask the public, you are welcome to attend either session, but you must refrain from questioning or participating in the discussion. If you have any questions or recommendations or suggestions,

please pass them on to the staff person who is present, and then we will bring that back to the Commission's attention after the meeting. We will look at the issues and then proceed in such a manner. We just don't have enough time for public participation in all the issues.

DR. GORDON: Great. Each of the leaders of the subgroups, please bring back your recommendations here, and we will discuss them at 11:00.

Thank you very much. We will see you back here then.

[Breakout sessions.]

DR. GORDON: Let's get started with the Group 1 [sic] report. Conchita.

Group IIB: Federal Agencies, States, and National Organizations

DR. PAZ: I dealt with the Federal Agencies, States, and National Organizations. So the first was, what overriding principles should be considered in developing policy recommendations related to coverage and reimbursement.

We came up with four. One of them, any treatment would be eligible for reimbursement if there is

scientific evidence of safety and efficacy published in peer-reviewed journals.

The second one was access for all populations including special populations like hospice and others. Payment solutions on the federal and state level.

DR. GORDON: Conchita, I'm sorry, could you start with that one again, please.

DR. PAZ: The payment solutions was Number 3, and we are basically leaving that fairly comprehensive because we talked about each of the different types of payments, especially those that have been mentioned today with not just Medicare and Medicaid, but also other insurances, pro bono, government, the South, co-pay riders, and whatever else we can think of, but to endorse payment and cost-sharing methodologies that expand choice for consumers. That is our underlying theme on that.

The next one is to design demonstration projects that should be inclusive of CAM professionals and conventional professionals and others with appropriate methodology, expertise of the areas that would be studied.

The next one would be what recommendations

regarding coverage and reimbursement could be made to federal agencies.

Again, we mentioned some demonstration projects on a federal level with HCFA and including state levels needing to include vulnerable populations, such as those without any money or insurance, but also to include like community health clinics.

Also, this would be in association with federal health employee benefits, and we especially liked the proposals that Max Heirich recommended, so we are suggesting all of them on both the state and federal level, and with each of these organizations to have a partnership for learning, as well.

Now, there was a separate one here on recommendations to be directed at the state governments. Again, we liked the state portion that were on those five proposals, but also we included on the state level, regulators of the insurance and the Medicaid, and to provide a partnership with them to show learning of CAM providers and appropriate stakeholders in addition to those other proposals.

Other recommendations that could be made

regarding the activities of national organizations, we didn't list any of the organizations, we just know that there is multiple groups that we would like to try and partner with.

DR. GORDON: What kinds of national organizations?

DR. PAZ: Well, we have talked about the National Hospital Association and National Governors Association, Western Governors Association.

MS. SCOTT: Mainly, there are a lot of associations we felt needed to be brought along as we are going through this process as a way of getting feedback and even review of some of these recommendations, so that we bring in partners.

DR. GORDON: One thing that I think will be useful is if we had a list and any contact people with those organizations, because part of our work over this next nine or 10 months is really doing exactly this kind of dialogue with different national, as well as local, organizations.

So, informing them of what we are thinking about, getting their feedback about it, and sort of